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Emilija Zabiliūtė

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Care without heart: kinship, chronic illness, and the emotion of care in Delhi

Emilija Zabiliūtė

Department of Anthropology, Durham University, Durham, United Kingdom

ABSTRACT
Drawing on ethnography of one family's life with diabetes in a poor settlement in Delhi's suburbs, this paper examines the relationship between emotional structures of care and kinship in the face of chronic illness. While anthropologists have argued for a relational understanding of care and discussed how, in India, modernity and social transformations have resulted in crises of familial care, less attention has been paid to the emotional terrains of care and its difficulties as they unfold in concrete relationships over time. This paper demonstrates how emotional intensities define the possibilities, limits, and ambivalence of kin care for the chronically ill. Described as *care without heart*, this mode of attention implies a continuation of care labour that maintains kinship ties and holds the possibility of kin futures, but is disinvested emotionally and feels unsatisfactory. The analytic of care without heart expresses a particular mode of care by which persons navigate dominant moral regimes around gendered family responsibilities and imperatives of love in relationships, but without fully subscribing to them. Care without heart at once signifies an inadequate form of care, invokes North Indian normative moral regimes around family care responsibilities and emotions, and acknowledges the shortcomings of these regimes and norms of relatedness.

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Introduction

I came to pick up Kalavati[1] from her home in the periphery of Delhi. I found her still sleeping, along with her large extended family. Everyone was scattered over the floor and the few available beds, with warm blankets sheltering them from the crisp December cold. After a journey of almost two hours by auto-rickshaw and metro, me and Kalavati reached the hospital in central Delhi. Kalavati showed me through the confusing complex of one of Delhi's largest public hospitals to the department of endocrinology. She had to make this lengthy journey monthly to receive her course of medication and the check-ups necessary to manage her diabetes. She often went there and to other clinics alone, standing out in the crowds of patients accompanied by family members. Today I, an ethnographer, accompanied her, despite our friendship being relatively recent. Now, we sat on the lawn outside the

CONTACT Emilija Zabiliūtė emilija.zabiliute@durham.ac.uk Durham University, South Rd, Durham DH1 3LE, United Kingdom

hospital while Kalavati snacked on *pakora*. She told me that while this snack of deep-fried batter with vegetables was not good for her, since she has diabetes and takes insulin every day, she had no choice. She could not bring home-cooked food to the hospital. Her daughter-in-law, who often bought ready-made food, did not take care of the household properly. Earlier, when she still- lived in her natal home, her daughter had cooked for Kalavati, cleaned the house, and accompanied her to the hospital.

Like most of the times when we talked about her illness, Kalavati spoke about the inadequacy of the care she received from her family. This underscored the aetiology and experience of her chronic condition, and was a source of her continuous anxiety in everyday life and in encounters with medical care providers. She was less concerned about how her condition could be better attended in Delhi's patchy public health landscape. Few patients expected healthcare institutions to give them full care due to a lack of medication, long queues, and, often, rushed consultations with different practitioners. Yet another, overlapping, expression of the limits of care – one embedded in family relationships – underlay Kalavati's difficulty with 'chronicity'.

Kalavati felt the care she received from her sons and daughters-in-law as an elderly, chronically ill family member, was lacking, even if this did not extend to abandonment. In her accounts, she repeatedly expressed longing for her daughter, who had provided loving care, different from the ambivalent modes of attention from her daughters-in-law. Kalavati yearned for more affectionate relationships, and a different *kind* of familial care. Her daughters-in-law, on the other hand, insisted they were committed to their duties of care for their mother-in-law, but also noted that their care was 'without a heart' (*dil*).

How are the limits of care posited in family life? How are these limits conceived and absorbed over time into everyday life with significant others? How do they constitute a departure from normative regimes surrounding family life and care in the face of chronic illness? My ethnography with Kalavati and her family reveals how the difficulty of care – its limits and ambivalences unfolding over time – are underlain by emotional intensities, and by a distinction between an ethic and a positive emotion of care. Kin temporalities, such as the experience of loss, generational change, familial conflict, household tensions, and the increasing weight of burdensome relationships in Kalavati's family, resulted in *care without heart*: a continuation of care labour that maintained kinship ties, and held the possibility for kin futures, but was emotionally disinvested and unsatisfactory for Kalavati. This difficulty of care at once disrupted and invoked the moral regime which asserted that, in some desired place, in a world that was not quite attainable, care *should be* imbued with love.

In North India, this moral regime is *seva* – an intergenerational familial service for the elderly, structured within hierarchical and asymmetric kin relationships, determined by age and gender, and involving both embodied forms of labour and emotions (Cohen 1998; Lamb 2000, 2005). Younger family members, especially women (daughters or daughters-in-law), are expected to care for the elderly by attending their bodies, such as by giving foot massages, and care acts must also be accompanied by love (Lamb 2000). As Brijnath (2014) shows, love and *seva* are deeply entangled and shift in the face of ageing and illness.

As a respectful form of attention towards the elderly, *seva* is under threat by modernity and social change (Cohen 1998; Lamb 2000; Simpson 2022). In some ways, Kalavati's complaint could be read as the lament of an ageing voice and weakened, chronically ill body, articulating her transition to being elderly within the household, to widowhood and anxieties about modernity. Yet, Kalavati and her family's experience was not reducible to discourses about social change. And the ethics of care was not embedded in the cultural scripts of idealised familial norms and care.

While *seva* constitutes a moral regime of familial care and serves as a prescriptive discourse, how care unfolds in everyday life between persons often falls short of idealised notions of family care and gendered roles. Cultural discourses on gender and kinship do not 'exhaust and fully define women's subjectivities in South Asia' (Raheja and Gold 1994, 8; see also Das 1976). The lived realities of care among the urban poor in Delhi suggest that while love is desired in transactions of care, it can also be lacking, and care can involve complex emotions towards significant others. The difficulties of care are, I contend, integral to the contingencies of everyday life and kinship. Kalavati's complaint asserted a certain modality of relational care ethics – that is, its inevitable difficulty and ambivalence. This moral ambivalence of care reveals gaps between gendered norms and everyday vagaries, and between the emotion of care and its praxis. Care without heart simultaneously engages and disrupts *seva* as a discursive moral regime: it reasserts the impossibility of achieving that moral ideal in the context of contingent and conflictual relational everyday life.

Here, I draw on a conceptualisation of care as a moral practice, embedded in relational responsibilities, and orientation toward significant others (Das 2020; Kleinman 2009; Livingston 2012; Mattingly 2014; Pinto 2014; Snell-Rood 2015). These accounts pay attention to how care is attuned not only to imperatives posed by a suffering body and disease (Mol, Moser, and Pols 2010; Yates-Doerr and Carney 2016; Mol 2008), it is a practice that constitutes kinship and may be directed at embodied relationalities (Borneman 2010; Carsten 2000). Yet, if care is relational, it is also subject to conflicts and injustices that characterise kin relationships and intensify at times of affliction (Carsten 2013; Banerjee 2020; Segal 2018; Das 2020; Garcia 2010; Pinto 2014). Even when care is valorised, women who suffer chronic illness often fail to receive care due to their own excessive care responsibilities for others and gendered positionalities (Qureshi 2019; Weaver 2018). Beyond being a desired ideal (cf. Borneman 2010), kin care may collapse to violence, coercion and neglect (Garcia 2010; Pinto 2014; Das 2020).

At the heart of this inquiry are questions about the limits of relational care, which can result in what Biehl (2005) has called 'social abandonment'. Veena Das (2015) shows how, in urban poor neighbourhoods in Delhi, abandonment occurs not as a single wilful act, but is dispersed in larger and smaller everyday events, relationships, and ecologies of healthcare. It results, in Das's words, 'from an exhaustion of the will and the capacity to marshal yet more energy, yet more love, to be able to offer care' (Das 2015, 113). I examine how this difficulty to care results not in its complete withdrawal, but in a transformed emotional terrain of care that is hesitant, detached, and less invested with love. This terrain has profound implications for how families deal with and experience chronic illness care over time (see also Qureshi, this issue). I show how family members express ambivalence about care even as they continue to orient themselves relationally.

This difficulty around the ethics of care is akin to what Mattingly (2014) has called *moral laboratories*, in which moral selves are born from experimentation with relationships, whilst acknowledging the shortcomings of moral ideals around care. Families with chronic illness in Delhi faced ethical dilemmas about care that arose from sharing lives with others and that could not be contained by expectations of *seva*. However, while families tried to attend to contingent relationships and family needs, scenes from Kalavati's family life reveal inter-relational conflicts, and question the ethics of care itself. These conflictual kinship dynamics calibrated the emotional structure of care in a way that allowed relationships to continue without what is seen as full investment in service to significant others. The analytic of *care without heart* encapsulates a mode of care by which persons navigate dominant moral regimes around family responsibilities and the imperatives of love in relationships, but without fully subscribing to them.

Here, emotion and love are features in culturally-situated and relational care transactions and normative regimes around care. Western feminists have criticised the emphasis on positive emotions in care work, arguing that, historically, emotions were a prioritised aspect of care among higher- and middle-class Western women, while care labour itself was devalued (Graham in Fisher and Tronto 1990). This resulted in a normative view that 'real' care should be imbued with the appropriate emotions such as affection. Similarly, Aulino (2016) has argued for moving away from prioritising emotion in anthropological accounts of care because, viewing emotions as intrinsic motivators of care that make care 'truly' meaningful, reifies Christian and Western ethics. In this paper, I too move away from implying that affection and love are necessary motivators of care. However, I contend that emotions, particularly love, are powerful in defining socially situated meanings of care. Examining care as relational, and subject to kinship contingencies and contestations, recentres the role of emotions in navigating care in the face of chronic illness.[2] In many everyday and relational contexts, emotions and care labour are entangled and difficult to separate. Care is therefore ambivalent, as it demands labour and involves a spectrum of emotions, from fulfilment and love to exhaustion and resignation (Danely 2017; Diodati, this issue; Fisher and Tronto 1990). Examining care that is subject to kin conflict highlights emotions of care, both as a normative moral ideal in particular contexts with specific historical genealogies, and as a quality of concrete relationships between persons who care and are cared for.

This paper is based on ethnographic fieldwork among urban poor in Delhi. Over six months I and, occasionally, my research assistant followed and participated in the daily lives of families with diabetes, accompanying some to care institutions and conducting in-depth interviews with their family members. I also draw on over ten years of research I conducted in another urban poor neighbourhood in Delhi, and follow-up communications on the phone. Following families outside of medical institutions allowed me to examine care as a primarily intersubjective, multi-directional undertaking, where the starting point is relationality rather than the singular needs of one person, body, and bodily disorder. In this paper, I follow one family to illuminate the unfolding care dilemmas and conflicts, changing care projects, and emotional intensities over time. This ethnographic engagement – what Clara Han (2011, p. 26) has called 'movement in time with those with whom we work' – highlights the micropolitics of care actualised in the domestic, and the continuous balancing between actualisation and destruction of life. Following one family's life in time allows me to examine care beyond a care-receiver or care-provider perspective, revealing the contestations between those embedded in care relationships. In contrast to discursive readings of familial care, this approach allows me to explore the ambivalence of care that exceeds the dichotomies of care and abandonment; how emotions and the felt experience of care shift in tandem with household temporalities; and the gaps between care in everyday life and discursive moral regimes.

Spending time with this family, I have also become implicated in relationships of care, where I provided care to Kalavati which her family members did not always commit to. I am mindful, however, that my help and care were glimpses in the family's life. Fieldwork temporalities are fragmented, and they can shore up, but also reinscribe distance between an ethnographer and interlocutors. Upon my return to Europe, and the COVID-19 pandemic, I could only keep in touch with the family on the phone and rarely. Such Ethnography can certainly witness care and relationships over time, but it cannot claim to fully provide care, or replace kin-care, for I did not share the difficulties and constraints this family experienced, and my brief presence could not attend to their long-term care needs.

Urban poverty, kinship, and healthcare in Delhi

A widow of around 60, Kalavati was a mother of six sons and one daughter. Three sons and the daughter were married, but only one of the married sons lived with her, together with his wife and children. Her youngest daughter-in-law, Rinki, tended to most of the household duties. Rinki's sister, Babli, was married to another of Kalavati's sons and lived separately. Kalavati's family lived in a so-called urbanised village in South Delhi, on the edge of a poor *jhuggi-jhompri* (hutment) settlement, with little infrastructure, such as an open sewages, and which bordered more affluent regularised buildings. Most of the hutment was inhabited by Hindus from Scheduled Caste groups with direct or ancestral links to villages in Rajasthan and Uttar Pradesh. However, like most such areas in Delhi, it was also diverse: Muslims and Christians also lived there. In many families, men had casual or permanent jobs as labourers in the service and construction sectors, while women stayed at home.

Kalavati's family's dilemmas around care and chronic illness should be seen in the context of India's patchwork healthcare system and relational dependencies among the urban poor. Herself from Rajasthan, Kalavati had migrated to Delhi from her conjugal home in Uttar Pradesh when her eldest son was just a year old. Initially, she and her husband worked in a brick factory. Later, he secured a better job in construction. While Kalavati and her husband arrived in Delhi as labourers, they gradually improved their living conditions and achieved some degree of social and economic mobility with the help of their grown sons' incomes. While the area was a *jhuggi-jhompri*, their house was in a better condition than many others in this and other similar areas. It had a designated kitchen and two rooms that served as living and sleeping spaces on the ground floor. The first floor had a toilet but there was no running water. The family also owned another house in a nearby area, where another of Kalavati's son lived, along with his wife Babli, and their children.

Kalavati's social position was not exceptionally vulnerable. She was a widow, but she had six sons who worked as drivers, motorbike mechanics, and in a filtered water supply business, and she had family-owned property. Nevertheless, the family lacked resources or economic and social stability. Their living conditions were modest, with limited facilities and space, they did not own a car, and children were not expected to study beyond secondary school.

Her socioeconomic position also determined Kalavati's healthcare access. She and other family members mostly relied on public or charitable healthcare, which is normally used only by the poor in India. While public healthcare institutions in India, especially in Delhi, have doctors known for their expertise, gaps in primary care coverage, lack of funding, and overcrowding limit the quality of care for poor patients, particularly those with chronic illnesses (Banerjee 2020; Weaver 2018). Consultations with dieticians and lifestyle experts, available to the middle-class, are out of reach for the poor (Solomon 2016). The poor also use private healthcare, much of which is provided by unlicensed biomedical or traditional medical practitioners in the country's pluralistic health ecology (Das 2015; Weaver 2018).

These public health gaps and simultaneous plurality of health services often result in punctuated treatment and care. While those in the advanced stages of chronic illness can experience delayed diagnoses and extreme suffering due to such healthcare gaps (Banerjee 2020), most of my research participants were not yet facing serious complications of diabetes, and used the healthcare assemblage to access medication and improve their daily 'control' of the illness. However, this healthcare ecology also made it difficult to receive care that attended to the difficulties posed by chronicity – a social dimension of the temporality and experience of chronic illness (Estroff 1993; Manderson and Smith-Morris 2010; Weaver and Mendenhall 2014). Chronic illness requires continuous attention to a condition, its contingency, and continuity (Mol 2008). Such care is an ongoing response to the contingent temporality of chronicity, promising a cure, giving hope, and acknowledging possible deterioration of the condition (Greco and Graber 2022; Manderson and Smith-Morris 2010).

By contrast, for Kalavati, this healthcare ecology meant she got little sustained medical attention. She sought treatment and advice from local medical practitioners, pharmacists, an NGO, and from the public hospital where she went for regular check-ups and her free monthly supply of insulin. During my fieldwork, she also attended a primary health *mohalla* (neighbourhood) clinic, a new addition to Delhi's public healthcare ecology. This was not 'doctor shopping', a common expression of care and *seva* among middle-class families (Brijnath 2014), but, instead, a navigation, and patching together, of forms of healthcare. The NGO workers knew Kalavati well, but usually provided limited diagnostic and counselling services because their main goal was to raise awareness about diabetes among the poor. The hospital provided her with medications, but she saw a different doctor each time and could not go regularly. A doctor in the *mohalla* clinic was concerned with the multiple treatments and advice she might be receiving, and expressed doubt about the medication dosage she was prescribed. As a diabetes patient, Kalavati needed precisely calibrated doses, and too much or too little could have serious consequences (Mol 2008).

For the urban poor, such difficulties in accessing comprehensive healthcare usually mean that they must rely heavily on family support. This is particularly critical in chronic care, which requires continuity across domestic and clinical settings. In India, few patients seek healthcare alone, or show up in hospitals without family members accompanying them. Younger, literate family members are expected to accompany their relatives to hospital, provide food, and help bargain with healthcare institutions. Familial care and kin obligations in India are tightly braided together with healthcare and chronicities to the extent that practitioners read deviations from expected kinship norms and care as symptoms of disorder or relapses (Chua 2012; Pinto 2014; Saria, this issue; Ranganathan, this issue).

However, such diagnostic readings of kinship disorders are often accompanied by the imagination of normative kinship orders and accompanying moral regimes about family care that speak past the everyday lived realities of kin care. In an idealised version of *seva*, care is distributed across members of a joint family who are in hierarchical relationships with one another based on gender and age. Care for an elder affected by chronic illness is incorporated into these familial caring roles (Cohen 1998; Lamb 2000).

Such kinship arrangements and intergenerational care may be desired or lamented, but they are not fully upheld in urban poor areas in Delhi or elsewhere. Grover (2011) has described less strict conjugal arrangements and widespread divorce among the urban poor compared to the middle class and upper caste. Among my interlocutors, not only conjugal, but extended family arrangements and roles were somewhat fragmented. Families often sought to marry their daughters close to home in order to sustain close relationships with them and receive reliable care, which they preferred to what their sons provided. Many families lived with the wife's mother. For many, the lived experience of poverty simply did not allow to uphold the idealised familial structures deemed typical in South Asian anthropological literature, which is often based on research among rural or middle-class and high-caste persons. While Kalavati lived with her sons and a daughter-in-law, she longed for her daughter. Furthermore, the family of her daughters-in-law lived close by and provided support to their daughters in times of familial conflict, a pattern I have witnessed in many families in urban poor neighbourhoods in Delhi. As sisters, the two daughters-in-law, Babli and Rinki, also supported each other in familial disputes.

In this context, a normative gaze into familial relationships in healthcare institutions did not necessarily attend to the realities and familial preferences of the urban poor, but pathologised kinship contingency. Furthermore, healthcare access was seen as a family responsibility, and thus depended on specific familial arrangements, cohesions, and affective relationships. Frequently, during my fieldwork, I observed that it was daughters, who were close to their parents, who accompanied their mothers to clinics and organised their care more generally. In sum, everyday kinship arrangements in urban poor families were contingent, and so was relational care, which structured experiences of chronic illness.

Time of kin and time of illness

That day at the hospital was but one of the many times Kalavati voiced discontent with her daughters-in-law. Standing in lines at various hospital counters she chatted with other patients about the difficulties of diets and family care.

> These daughters-in-law of these new times don't do anything…They make *rotis* on a gas stove. [They say]: I will first watch a TV drama, and then make a *roti*, they don't make it, they keep on sitting. Alright, see the drama – but at least *then* make *rotis*… daughters in law – they don't tolerate beatings these days either. They say they'll call the police […]. Brother, I am telling you – I have got tension… I have got tension while watching after these daughters-in-law.

Kalavati was not the only diabetic patient in the family. Her eldest son, Babli's husband, also had the condition. He occasionally took medication but resisted his wife's admonitions about eating healthier food. Kalavati's grandchild and Rinki's son, Rakesh, who was ten years old at this time, had type-1 diabetes, and had been diagnosed when he was four years old. Rakesh took daily doses of insulin provided by a charity foundation and attended weekly yoga sessions for children. Where 'diabetes runs in the families', in the popular parlance, so too does knowledge about the illness, especially the importance of daily routines and good or bad foods for their bodies. Usually, however, this knowledge did not dictate daily rhythms and diets in Kalvati's family.

Kalavati was complaining about Rinki, Rakesh's mother, and held her responsible for the worsening conditions in her home, and, consequentially, her own health. Her condition started worsening slightly more than a year ago, with her daughter Mamta's wedding. Her departure had visibly saddened Kalavati. The wedding seemed to be out of proportion with the family income, and also brought them great pride. Afterwards, Rinki assumed responsibility for household chores, and Kalavati started complaining how she would rush through them. Meals for the family, too, were often not ready on time. Recently, Kalavati's diabetes had become even worse. Her blood sugar levels spiked when Mamta had a caesarean section. Hinting to the link between mental state and chronic conditions (Weaver and Mendenhall 2014), Kalavati told me that she was so worried about Mamta being hospitalised, she had stopped eating and taking her medication.

Kalavati's illness was linked to kinship intensity, temporality, and family events in even more direct ways, because she traced the onset of her diabetes to the death of her husband, when she started having tension. The 'tension' – distress, often associated with illnesses and their aetiologies in South Asia (Weaver 2018) – that followed his death made her feel unwell. After visits to different practitioners and hospitals, she was diagnosed with diabetes. Since then, she had had a difficult time. At first, Mamta used to inject her insulin, but later, Kalavati learned to do it on her own. 'I wanted her to start it on her own – I knew I will not be at home all the time', Mamta recalled. She also used to accompany Kalavati to the hospital for her regular check-ups and medications.

Kalavati's complaint must be understood by paying attention to the temporality and singularity of her experience. Laugier (2016) suggests that words matter not only for their content but also for how they are spoken. Read this way, complaints and accusations may express specific issues in conflicts, but they also place one in the world and speak to the history of that placement. To examine this temporality of Kalvati's complaint, I build on Das's (2020, 7) distinction between two modes of eventfulness to explain how an event poses a threat to everyday life. The first mode is when a spectacular form of violence or an event leaves a mark on the ordinary. The second is when events are scattered and unfold in the course of the ordinary. Chronic illness and care in the lives of Kalavati and her family did not mark a biographical rupture or a complete remaking of life and self, but rather appeared and were accumulated gradually (cf. Bury 1982). Chronicity here took shape in the course of familial history and events. Biography, which was relational, was not disrupted by chronic illness as an event, but articulated the illness: bodily suffering could only be understood in the course of familial events and ageing. The tensions around the limits of care were also inseparable from these relational temporalities.

This unravelling familial biography includes a sequence of events and changes in the household, each of which seemed to further encumber Kalavati and make her condition worse: the death of her husband, the marriages of her sons and the arrival of daughters-in-law to her home, the conflicts with them and, finally, the departure of her daughter and subsequent lack of care. This sense of loss and vulnerability deepened with her daughter's departure and complicated her ability to welcome and live well with new members of her family.

An emptied house

When her family underwent household reconfigurations and conflicts, Kalavati's complaints intensified. A few weeks after our trip to the hospital, the family was arranging for Mamta and her newborn to visit her natal home. Kalavati was delighted. The home had a merry, anticipatory atmosphere. Meanwhile, Rinki had gone to visit her own natal home, located in the same area, only 200 metres away. When Mamta arrived, she took over the household chores. She cooked, cleaned, and took care of her newborn: 'it's like that, often, isn't it? Mothers-in-law often fight with daughters-in-law', she told me, commenting upon Rinki's departure due to a conflict that was apparent but only carefully spoken about at home. Later that day, Rinki invited me to her natal home and came to pick me up from Kalavati's house, without talking to anyone in the house. When I asked why she spent time in her natal home, she avoided a straightforward answer. Her silence and unwillingness to talk about the issue indicated that her move was related to family quarrels. In the beginning, her stay at her natal house seemed temporary, but on subsequent visits and calls I gradually learned that Rinki had moved back for a few weeks while her children shuttled back and forth between their grandparents' *jhuggi*s. One morning some weeks later, she and her husband loaded a rented van with their belongings and left to live with Kalavati's eldest son and Babli in the family's other house.

Only at this new home did Rinki speak more openly about her disagreements with Kalavati. Both sisters were agitated by recent events. The biggest quarrel, they told me, happened when Kalavati took Rinki's jewellery, gifted to her on her wedding day, and usually considered the bride's possession in North India. Seeing this as a serious transgression, and with her husband's support, Rinki quarrelled with Kalavati and left.

After Mamta had gone back to her affinal kin, Kalavati was left home alone with her sons, and the responsibilities of housework and cooking fell to her again. One day, on the way back from Rinki and Babli's home, I passed by Kalavati's house and found her sitting alone in a dark room: the neighbourhood was experiencing a power outage. Kalavati complained to me about being ignored by her sons, and that none of her three daughters-in-law lived in the house to take up the responsibilities for the home. The empty and dark house seemed an apt metaphor of Kalavati's claims about her family's neglect.

A few days after Rinki moved out, I went to visit her and Babli in the new house. We sat on *chaarapai* (a bed with a net of ropes) on a sunny terrace, separating the stems of leafy greens. As we talked about the family conflict, I asked if they would go to Kalavati's house again soon. Both sisters looked puzzled by my question, and Rinki said: 'I will go, of course we will go. It is our husbands' home. We are family'. She then paused and sighed. 'But – we will not go there with our hearts (*dil se nahi jaenge*)'.

Following the conflict, Kalavati's sons and daughters-in-law often continued to visit her and the rest of their brothers. During these visits, Babli and Rinki cooked for the family and cleaned the house. Two months later, I found that Rinki was back at Kalavati's home. She hinted that her husband and mother-in-law wanted her to stay and take care of the home. In the days that followed, she said repeatedly that she would be going back to the new house the next day, but her departure was delayed each time. However, despite her return and the resumption of labours of care, there was also tension in the family.

One day in April 2019, just a few days before I left Delhi, I visited Kalavati's family for the last time. I began talking to Babli, but soon Kalavati joined our conversation. Because her interruptions silenced the daughters-in-law, the room grew tense. Kalavati was angry and agitated, talked about the many injustices she had experienced in the family, and cursed at her daughters-in-law. She also complained that she did not see Mamta enough, and that she often had to go to the hospital alone. Listening to her angry words, family members exchanged embarrassed looks around the room. Rinki entered the room from the kitchen, and sat on the ground, restlessly rocking against the wall, watching her mobile phone screen, not looking up. Kalavati's swearing and complaints were suddenly interrupted, as Babli snapped: 'You cannot expect us go to the hospital with you, there is so much work at home. We have small children to look after. Think of it, if you had to choose', she said, looking at me and my research assistant, 'what would you choose: to bring your son to the hospital, or your mother-in-law? I think a child cannot go there on his own. She can go on her own!'

'It's a difficult decision', I said, and Babli laughed in response. Before this quarrel, one month after my visit to the hospital with Kalavati, Mamta called me, asking me to accompany her to the hospital once again. Having been repeatedly invited to be part of these relationships and participate in the transactions of care, I was subsequently allowed to witness the complaints by my interlocutors, and asked to participate in conversations about ethical choices: 'what would you choose?' After I left Delhi, I learned during our catch-up calls that, eventually, Rinki moved back to the new house.

While Kalavati's complaints about care centred on daily matters, such as the lack of home-made food and the untidy house, they also exposed larger relational tensions, claims for better care, and desires for different family, more power, and control. In the face of chronic illness, *seva* absorbs the needs and care for an ill body. Visits to doctors, searches for healing, the administration of medication, and feeding, for instance, are gestures of *seva*: such acts not only attend to ill bodies, but also reconstitute relationalities (see also Brijnath 2014). Visiting doctors alone was a challenge for Kalavati. This was not only because of the practical demands of such visits (although there were many, including the fact that Kalavati could not read or write, and had to rely on strangers to navigate the signs in the city, metro stations, and the hospital). In a context where familial care and kinship aberrations are assumed in medical modes of attention in healthcare institutions, she could be neglected due to her vulnerable status as a lone widow. The difficulty of care that Kalavati experienced, and the lack of *seva* from daughters-in-law, not only neglected her diabetes, but also her personhood, and familial place of a respected elder whose ageing body marks the transfer of power to the younger ones (Cohen 1998; Lamb 2000). In one reading, the limits of care in Kalavati's family would add to accounts of how modernity and social change erode older forms of family and relationality in India, as younger members of families withdraw their care and reciprocal obligations for elders (Cohen 1998; Lamb 2005; Simpson 2022).

Yet Kalavati was not simply yearning for the culturally established scripts of care or attributing the difficulty of care to social change and modernity. Instead, the difficulty of care was structured by the biography of concrete familial relationships and their uneven emotional textures. She continuously longed for her daughter, whose care was different: more loving, committed, and less ambivalent than that provided by her daughters-in-law and sons.

Rinki and Babli wanted to establish independent households and even to find jobs – as indeed Rinki asked me to help her do – indicating that they aspired to a different, perhaps nuclear, family life, more independent, and aligned with emerging ideals among aspirational women in India. Yet solely focusing on how *seva* is threatened by modernity or social change would not allow us to attend to their ambivalence, and the ongoing relational and care work that Rinki and Babli did, despite familial conflicts. Labour and care for children, which was oriented toward family futures, provoked a different type of commitment among these women than care of their mother-in-law. Rinki's young son who also suffered from diabetes, required his mother's care. Babli summarised the conflict of commitments as an ethical choice about care, where there was little space for choice grounded in individual autonomy (Mol 2008). The daughters-in-law were committed to family and did not reject their expected familial roles completely.

Kalavati's familial conflicts reveal how, in everyday life, care, like kinship, is contingent, and takes shape in concrete relationships. They also reveal how care is always underwritten by its limits and falls short of idealised scripts. This problematisation of moral regimes of care in the family by Kalavati echoes a popular image in North Indian kinship dramas, where intergenerational conflict and tension around the succession of the head of the family serve as antitheses for idealised notions of care and familial life (Das 2020). This trope, which often focuses on familial conflict between mother-in law and daughter-in-law, is present in numerous Hindi movies, soap operas and mythology, including the classic Hindu epic, the *Mahabharata*. These discourses on familial tensions highlight the knowledge that care has limits and can never be fully assumed.

Moral regimes and care without heart

In her work on the limits of moral regimes in shaping ethical subjects, Mattingly (2014) shows that, among African American mothers, the discourse of the 'superstrong black mother' is not rejected, but cannot be fully incorporated into the moral striving of women caring for chronically ill children. Similarly, Kalavati and Rinki did not reject, but explicitly longed for, idealised forms of care, invested with what is perceived to be true feelings and intentions, which uphold familial hierarchies. However, caring in everyday life amidst poverty, chronic illness, and loss is not easy, and it yields contradictions.

Mattingly's interlocutors have a shared vision of care relationships in families, and their moral formation is grounded in mutual agreement on what is good for the family. In a similar vein, moral selves are born out of the necessity of caring for others and entail a humanising perspective (Kleinman 2009; Livingston 2012). Differently, Rinki and Babli did not think they did their best for Kalavati, who, in their view, had unreasonable demands. They continued to care for her whilst drawing limits to their care, and acknowledging them. For Rinki and Babli, these difficulties meant that they had to make compromises in their daily care for their children and mother-in-law. They questioned *seva*, the idealised form of care, by invoking the realities of everyday life and the conflicts that arose in the family.

The difference between idealised expectations and everyday care realities was epitomised by Rinki's distinction between complete care and care 'without heart'. In her reconsideration of the concept of care, Aulino (2016) critiques the preoccupation among anthropologists with care grounded in emotion, internal orientation and motivations, often reflecting Western and Christian values. Among Thai Buddhists, Aulino contends, care achieves the meaning of a moral act by means of embodied ritual and acts of repetition. Yet ethnographic readings of love in South Asia attest to the significance of love and affective inner states in caring relationships. They indicate that heart-emotions are recognised as truthful and express the true inner self and intentions.

The heart (*dil*) has multiple meanings in South Asia. As in Western contexts, it can be perceived as a repository for a wide array of feelings, emotions, thoughts, and intentions (Krause 1989). In India, the heart usually expresses affects and love, passion and sincerity, and its poetics figure in popular Hindi songs. The emotional and mental aspects of the heart are associated with a person's sense of self. Sometimes, the heart has a capacity to express feelings that are unknown to the person herself and that threaten the social order or social norms, as suggested by the South Asian expression that 'you should not say what is in your heart' (Krause 1989). Similarly, an interlocutor who had a love marriage which did not comply with her caste or community customs, said that she 'went where her heart was'. Deference to heart-emotions may threaten the social order and kinship norms, in which love is socially approved when it is rational rather than emotional and passionate (Pinto 2011). Among kin, this rational, contained love is integral to *seva* and familial transactions of care and intimacy (Brijnath 2014). Furthermore, affects of the heart express closeness and intimacy toward a person, distinct from how consideration is expressed in public (Das 2020, 102).

Love is a powerful affect that organises social relationships and familial belongings, and has a force of desirability. Yet, animated by fantasy, love as a desired ideal can never be quite fully achieved (Berlant 2012). Furthermore, love is increasingly politicised and occupies a central place in defining the possibilities for intimacy and life in India (Mody 2022). This imbrication of love with moral injunctions, politics, and capitalist cultural ethics of desirability (Berlant 2012; Mody 2022), allows us to think of love in kinship relationships as an idealised norm: one that can be difficult to assume in everyday life.

Deeds that come from the heart may therefore indicate authenticity of feeling and care. Care that comes from the heart implies a meaningful and truthful act, oriented toward an intimate other. It can be desired, but is difficult to cultivate in the face of relational vagaries. It was this form of care that the daughters-in-law withdrew from Kalavati. They differentiated it from the detached completion of domestic duties and labours which enabled to sustain family bonds even in the face of conflicts but were devoid of love. Such a view of structures of care echoes the observation of Western feminists that care is ambivalent because it includes positive emotional aspects, such as love, as well as burdening, for it requires labour (Fisher and Tronto 1990). It can also be emotionally straining (Danely 2017). Yet, a withdrawal of emotion and love from care speaks of relational disruption. Both Rinki's expression and Kalavati's complaints around inadequate care show that attention to emotions and inner states, and conflicts between carers and care receivers, complicate a view of uncontested ethics of relational care.

Rinki claimed that two forms of care exist – care with and without heart – and that they are contingent on relationships: one could slide into another in the face of relational tensions. In this family there was a continuity of care, even if the *ethics* of care had changed. As the youngest daughter-in-law, Rinki continued customary care for her conjugal home. What was lost, for her, was care imbued with intimacy and affective connection. While Kalavati herself did not articulate this distinction, her experience and complaint expressed the consequences of gradually losing 'the heart' in relationships of care. Her nostalgia for her daughter's care attested she was also a yearning for something that was more loving, more truthful, and dedicated.

Care without heart visible in Rinki's repeated efforts to move out of Kalvati's home – reveals acts of subversion in women's speech and everyday labours in the context of patriarchal familial structures. This attests to the subtle and more overt ways women assert themselves and seek to defy power in the intimate spaces in northern India (Raheja and Gold 1994). Banerjee (2020) discusses how, among women who cared for their spouses with cancer, withdrawing love was a form of self-assertion and an attempt at recognition in the face of the gendered injustices of the past. The terminal illness entailed the transfer of conjugal power to the wife, which was asserted by withholding intimacy. Yet, assertions of conjugality can also be a subversion of patrilineal ideals (Raheja and Gold 1994). Similarly, care without heart allowed Rinki and Babli to reassert agency in the context of gendered expectations to provide *seva* to their mother-in-law. Rinki and Babli were frustrated and, in Kalavati's absence, vehemently created alliances and spoke of how to navigate this conflict whilst upholding their roles as wives and mothers. Yet, their frustration was contained and, mostly, expressed subtly. Care without heart was a restrained and ambivalent care which withheld positive emotions, and avoided overt expressions of negative ones or signalled resignation. Withdrawing love from care for a mother-in-law did not make care completely futile and meaningless. Continuing the labours of care asserted kin relationships and conjugal futures.

Conclusion: the difficulty of care

In this paper, I have examined familial care relationships, and how care presents its limits in the face of kinship temporalities, conflicts, and chronic illness. I have shown how withdrawal of love from labours and relationships of care that are frustrating and demanding allow a continuation of care relationships without full subscription to moral regimes in the hierarchical and gendered order of North Indian kinship.

To understand people's experiences of illness, Kleinman (2006) suggests that one needs to tend to 'what really matters' and to ask larger questions about what unsettles the moral experiences of affected persons and families. The conflictual terrain of care in Kalavati's family suggests that, at times, 'what really matters' cannot be agreed upon in places where the intimate sphere is imbued with by anxieties about power, familial conflict, and gendered positionalities. Kalavati's illness experience was embedded in kin temporalities: the changing composition of her family, fraught relationships, aging, widowhood, and anticipation of familial future that would further change and weaken her place in the household. Meanwhile, Rinki had to attend to competing demands, labour expectations, and frustrations. Her attention to Kalavati was limited, ambivalent, and 'without love', as she had to care for her sick child and wanted to establish a different kind of household altogether, thus articulating a critique of the expectations placed upon her. At the same time, she had to maintain familial relations and avoid abandonment and a breakup of the family caused by her transgressions of kinship norms and her disregard of *seva*.

The conflicts over 'good' care reveal, first, the limits of moral regimes regarding kin care. Kalavati's family members invoked idealised forms of care whilst acknowledging their impossibility amidst everyday life realities. Second, the vision of care was not unified among family members. Situating my inquiry between the carers and those being cared for, and following the micro-events of familial everyday life, I have demonstrated how care and its limits emerge in the spaces between persons, through ordinary acts and deeds, but are contingent and never fully accomplished or defined. Yet, the moral worlds in this family were not completely incommensurable. If familial conflicts and disagreements allowed them to question and articulate different visions of family and ethics of care, they also illuminated the possibilities for the continuation of labours of care that still bound the family, despite these conflicting positionalities.

My ethnography makes a case for exploring care and chronicity structured by the logic of kinship and relationships of everyday life, not only by biomedical protocols. My aim in this paper is not to pathologise kinship as purely problematic, or to romanticise it as purely supportive. Such a view slips too easily into inaccurate assumptions that families necessarily care for each other, or that kin obligations thwart 'self-care' of people with chronic conditions. Instead, I have sought to show that in the face of chronic illness the limits of care are inseparable from dilemmas and burdens of kinship relationalities. Where care and service for the family define 'normal' family life, abandonment marks the other extreme of the moral order of *seva* in Indian kinship structures (Pinto 2012; Das 2015). In some cases, both institutional and familial forms of care might decay (Biehl 2005). The ethnography of Kalavati's family suggests more ambivalent scenarios also exist, where care continues, but falls short of ethical fulfilment. This happens in the event of unresolved relational tensions that leave open the question of what constitutes 'good care', and where there is no mutual agreement about the ethical horizons of care.

Notes

1. All names were changed in this article.
2. Aulino (2016) examines care as a care-giving practice to non-responsive persons. By contrast, I explore care among family members who actively discuss and contest care, whilst also engaging in care as a practice. This methodological difference re-centres emotions in an inquiry to care.

Ethical approval

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