DOI: 10.17846/aa-2025-17-1-78-92

Mysterious maladies of mind: A study of depression from a pathographic standpoint in Gayathri Ramprasad's *Shadows in the Sun*

Radhika Sharma - Nagendra Kumar

Radhika Sharma has completed her PhD from the Department of Humanities and Social Sciences at the Indian Institute of Technology, Roorkee, India. She works in the Department of Humanities Management and Applied Sciences, Indian Institute of Information Technology Kota, Rajasthan, India. Her research interests include Literary and Cultural Disability Studies, Corporeality and Culture, and South Asian Literature and Culture. She has presented her research work, delivered talks at major National and International Conferences, and published her work in noted journals.
Orcid Id: https://orcid.org/0000-0001-5163-065X

Nagendra Kumar is a Professor in the Department of Humanities and Social Sciences at the Indian Institute of Technology Roorkee, Roorkee, India. He has also contributed academically to many national and international journals. His teaching and research interests and publications cover Modern Literature, Contemporary Fiction and Critical Theories, Soft Skills, Cross-cultural Communications, and Technical Communications.
Orcid Id: https://orcid.org/0000-0002-8292-7947

Abstract:
By examining the biological, social, cultural, and political factors associated with mental illnesses, this paper examines the oppressive nature of the psychiatric system and criticizes the structural barriers and inaccessibility of mental health care in India. The study uses a qualitative methodology and critical discourse analysis to investigate how depression – from its onset to recovery – is portrayed in Gayathri Ramprasad's memoir Shadows in the Sun. *It also looks at how people manage their condition while putting on a "façade of normalcy" in a society that is largely ignorant and contemptuous towards mental illness. Ramprasad's illness narrative, according to this study, which focuses on individual experiences, emphasizes the episodic and fluid nature of depression by illustrating how it cycles from suffering to brief respite, then relapses, and finally, healing through a thorough holistic wellness plan of integration of mind, body, and soul. The study argues that depression is both a biological ailment and a socio-political and cultural phenomenon that intersects with gender, disability,*

and institutional discrimination. It also emphasizes the need for a bio-psychosocial approach to mental health, which recognizes the complex interplay between biological, psychological, and social factors that affect healthcare treatment and access.

Introduction

Gayathri Ramprasad, in her memoir *Shadows in the Sun: Healing from Depression and Finding the Light Within* (2014), chronicles her experience of negotiating the complex terrain of mental illness. By situating Ramprasad's struggles at the intersection of cultural displacement and individual suffering, the memoir, as a diasporic narrative, draws attention to the more general psychosocial elements of mental illness, specifically anxiety and depression. It skilfully handles the tensions of migration, patriarchal expectations, and identity, demonstrating how gendered and cultural oppression affect mental health in addition to biological and neurological factors. Thus, Ramprasad's account contributes to a growing collection of illness memoirs that function as "counter-discourses" to biological and institutional illness accounts. By emphasizing an individual's voice and agency, these counter-narratives subvert the dominance of medical language and recover subjectivity from the frequently dehumanising frameworks of psychiatric intervention (Diedrich, 2007, p. XIX).

The memoir explores themes of trauma, alienation, and self-reclamation while challenging the boundaries between psychoanalysis and diasporic studies. When attempting to explain Ramprasad's oscillation between convalescence and relapse, Sigmund Freud's (1920) notion of trauma as the recurrence of compulsion and the reappearance of the repressed is especially pertinent. Ramprasad's experience reflects Julia Kristeva's (1980) concept of abjection, which reveals the unconscious burdens of intergenerational trauma exacerbated by migration and cultural dislocation, consequently connecting the subject's crisis of selfhood to cultural estrangement. Ramprasad emphasizes the psychological rifts that occur when a person traverses two distinct cultural epistemologies – one rooted in Western biological paradigms and the other in Indian spiritualism and familial collectivism – by placing her suffering within the framework of gender subjugation.

According to Arthur Frank (1997), illness narratives are quest narratives in which people utilize storytelling to rediscover their identities and find meaning in their lives. This idea is supported by Ramprasad's memoir, which follows her journey from the early stages of depression in adolescence through her battles with psychiatric treatments, such as high dosages of Prozac and lithium, electroconvulsive therapy (ECT), and institutionalization, to her eventual recovery through a holistic wellness approach that unites the mind, body, and soul. In addition to highlighting the physical manifestations of mental suffering, her story engages with

the idea of feminist disability studies that reveals how gendered norms contribute to the stigmatization of mental illness. Pathographies, as described by Anne Hawkins (1993), are works that reveal the arbitrary and harsh nature of sickness, upending the assumed coherence of identity (p. 2). Following this line of thought, Ramprasad's story is an autopathography since it is both an advocacy tool for removing systemic barriers to mental health care and a very personal depiction of psychiatric suffering.

In addition, Frank (1997) appropriately notes that narratives about illness are dualistic in nature, combining the societal and the personal. While the social component of the story draws from cultural narratives surrounding illness, the personal component vocalizes the body's nonverbal cues of suffering. Ramprasad's memoir serves this purpose by blending Western medical discourse with Indian cultural views on mental health. In addition to navigating biological terminology and psychiatric treatments, the narrator also navigates the stigmas and beliefs surrounding depression. Because of the interaction of indigenous and Western epistemologies, her story becomes a site of cultural hybridity. This aligns with Homi Bhabha's (1994) concept of the "third space", where knowledge systems and identities intersect.

Ramprasad's story breaks the taboo and contributes considerably to the growing corpus of Indian women's life writing on the sensitive and taboo subject of mental illness. Other Indian memoirs on depression, such as Shreevasta Nevatia's *How to Travel Light* (2017) and Shaheen Bhatt's *I've Never Been (Un)Happier* (2018), similarly examine the intersections of gender, mental illness, and societal expectations. However, Ramprasad's account is diasporic in contrast to these stories since *Shadows in the Sun* adds a layer of cultural dislocation and the impact of migration on mental health. By situating herself in the tension between her Indian heritage and her American experience, Ramprasad illustrates the corporeality of depression as an illness that transcends national and cultural boundaries.

The intersections of race, gender, and migration have received more attention in recent scholarship on disability studies and illness narratives. Critical disability studies scholar Lennard Davis (2013) argues that disability is a social construct mediated by institutional and ideological frameworks and a medical condition. Similarly, Susan Wendell (1996) contends that minority voices are often excluded from public narratives of illness, reinforcing the notion that certain illnesses are invisible. Ramprasad's memoir interrupts this discussion by highlighting the lived experience of an Indian woman, balancing the consequences of both the diasporic status and mental anguish. Ramprasad's identity is also influenced by the conflicting demands of her American environment and Indian upbringing, highlighting the psychological

and emotional toll of juggling cultural hybridity. As a result, Ramprasad's memoir is a critical work that not only describes her psychological struggles but also looks at the sociocultural elements impacting mental illness. Her experiences of being classified as "weak and hypersensitive" (Ramprasad, 2014, p. 43) are similar to how patriarchal and colonial frameworks have historically controlled female subjectivity. In doing so, *Shadows in the Sun* engages with feminist critiques of medical discourse and adds to the global dialogue on mental health.

This study contends that by highlighting Ramprasad's struggle with depression, her memoir externalizes mental illness by introducing it into the public domain, thus increasing awareness and encouraging community involvement. Beyond just describing a person's mental anguish, the story places depression in a larger sociocultural context, showing that mental illness is not a singular or exclusively medical occurrence but rather a condition intricately linked to migration, gender, and structural oppression. The study also emphasizes the fluidity of mental illness as a continuous, non-linear process by highlighting the way Ramprasad's narrative alternates between convalescence and relapse.

The paper uses a qualitative approach and critical discourse analysis to examine Ramprasad's path from the onset of her mood disorder to her advocacy and healing, drawing on theoretical insights from critical disability studies. The study, which is divided into three sections, provides a thorough examination of (i) the beginning of symptoms, diagnosis, and treatment, (ii) the sociocultural barriers to mental health care, and (iii) the relationship between advocacy and personal healing. The study highlights how anxiety and depression are debilitating disorders exacerbated by systemic injustices by looking at the structural barriers to receiving mental health care. The study also examines Ramprasad's journey from a psychiatric patient to a mental health awareness activist, establishing her memoir as an essential resource in the conversation on psychiatric survivorship and feminist mental health advocacy.

In this manner, the text opens up relevant discussions on mental health in gendered and diasporic contexts by challenging monolithic ideas of illness and recovery and argues for the necessity of intersectional approaches to mental health discourse. By presenting Ramprasad's tale as an act of epistemic resistance, the study highlights the importance of personal storytelling in questioning dominant paradigms of illness and identity.

Tryst with terror: The onset of losing the mind to depression

Gayathri Ramprasad's upbringing was a complex paradox – between her father's support for a contemporary, aspirational, independent woman – and her mother's romanticization of Sita, a symbol of unshakable loyalty and submission. The stifling expectations that would later worsen her psychological torment were put in motion by this cultural contrast, which was not just an identity conflict but also an ideological battlefield. Ramprasad describes the dissonance she experiences as "a mixture of mantras and miniskirts—a dizzying blend of two cultures, two continents, worlds apart" (2014, p. 24). This double life, however, was a sign of alienation rather than merely a balancing act between tradition and modernity. In sharp contrast to her father's ostensibly progressive viewpoint, the patriarchal construction of Indian womanhood, which promotes obedience and self-effacement, exposed the underlying contradictions in even the most well-meaning family goals. Her life was an intellectual prison that made such a breakdown all but inevitable, not just a fairy tale ripped apart by sadness.

The pivotal moment – her "tryst with terror" (ibid., p. 177) – was the result of a life characterized by a systematic disregard for mental health, not a singular instance of psychiatric collapse. Her suffering was not just the result of parental misunderstanding; instead, it was a reflection of a larger cultural mentality that dismissed her early signs of depression as "adolescent angst" (ibid. p. 27). Even her father, usually her defender of independence, rejected her hopelessness with a harsh "Get a grip over yourself" (ibid.), highlighting the dichotomy in his parenting style. When encouragement of independence ignores the vulnerabilities that accompany it, it turns into an adverse irony. In an atmosphere where "strength is measured by how well one can suppress emotions, not express them", any departure from the anticipated resilience is viewed as a personal failure; therefore, her attempts to suppress her suffering simply served to strengthen the grip of depression (ibid.). In addition to fighting against mental illness, she is also fighting against a society that does not accept it.

Ramprasad's situation is similar to Andrea Nicki's finding that "Women who display mania are doubly deviant, defying norms of femininity and challenging an Aristotelian paradigm of humanity as self-controlled and moderate" (2001, p. 90). Ramprasad's story is representative of the gendered scrutiny that is directed at women's mental illness, which perpetuates the notion that emotional discomfort is either self-inflicted or exaggerated. Her gut-wrenching battle with food becomes evident in her visceral aversion to meals: "I cannot keep any food down. Not even the bland buttermilk and rice […] I survive on tender coconut water and fresh watermelon juice" (Ramprasad, 2014, p. 42). This is not just a sign of depression but

an act of somatic defiance, illustrating how depression in Indian women frequently takes the form of physical ailments rather than emotional expression (Reed, 2021, p. 146). The medical industry, however, brushes off her suffering as just another aspect of teenage melodrama, reflecting the societal propensity to label women's psychological discomfort as attention-seeking behaviour or hysteria. Physicians who claim that children "these days are not resilient like we used to be" (Ramprasad, 2014, p. 45) are indicative of the institutional gaslighting that makes female suffering invisible.

Furthermore, Andrea Nicki critiques that the pressure from society to maintain constant cheerfulness makes people with mental illnesses "deny their disorders" (2001, p. 93), and Ramprasad masters disguise, perfecting a "façade of normalcy" (Ramprasad, 2014, p. 45). Kristeva writes about her feelings after being trapped in a similar situation, "absent from other people's meaning, alien, accidental concerning naive happiness, I owe a supreme, metaphysical lucidity to my depression" (1992, p. 4). It is not an uncommon prevalence of unacknowledging or not addressing a person's mental well-being and paying sole attention to the physical symptoms while disregarding the actual psychic agony. A twisted relationship between the person with the mental illness and their condition is fostered by the idea that they should repress their illness instead of addressing it. The lack of conversation about depression is not the same as its purposeful erasure when pain is only recognized when it can be pathologized and classified, never when it necessitates compassion or action. Her ultimate descent into marriage – an institution that ought to provide stability – becomes yet another way for her to hide the reality of her illness. In addition to being afraid of being found out, she is also scared of being expelled from the life she has been taught to protect at all costs. This is shown in her statement, "For years I have hidden behind a façade of normalcy, and now I fear that my mask is coming undone" (Ramprasad, 2014, p. 80). Ramprasad experiences disillusionment because she has to look "normal" while feeling crazy, and this divulges the afflicted person into a sense of alienation because "to disclose one's hidden status, anxiously anticipating the possibility of being found out, being isolated from similarly stigmatised others, and being detached from one's true self" (Pachankis, 2007, p. 328). Depression is one of the most prevalent concealed conditions because it is associated with negative traits or stereotypes, consequently leading to social exclusion and deterioration of social standing (Cooper, 2020, p. 2). It is because depressed individuals are likely to be significantly more attuned to adverse interactions in society and less prone to feelings of inclusion because of their social information-processing inefficiencies that seem to render it least plausible that they would identify indications of belonging and acceptance in interpersonal situations (Steger & Kashdan, 2009, p. 2)

The relationship between gender and mental illness reaches a terrifying crescendo when Ramprasad's superstitious and ignorant in-laws ask a priest to "exorcise" her. In addition to being an act of personal abuse, the abuse she later experiences – "the priest's hands roam inside my sari blouse, purportedly to locate the pulse of the demons that possess me" (Ramprasad, 2014, p. 161) – is a critique of a society that abuses and infantilizes mentally ill women in the name of spiritual intervention. This susceptibility is highlighted by Nicki, who claims that "women who are manic are particularly vulnerable to others' abuse" (2001, p. 90). Forty percent of women surveyed undergoing severe mental disorders had either been raped or experienced rape attempts as adults (UCL, 2022). This unsettling fact demonstrates how mental illness does more than make women helpless; it also serves as a means of additional abuse, further solidifying their sense of helplessness in the eyes of those who ought to be protecting them. According to Dein and Illaiee (2013, p. 290), the historical conflation of possession and mental illness highlights societies' ongoing inability to discriminate between psychological disorders and supernatural diseases, frequently at the expense of those who suffer from them.

Another wave of psychological disintegration follows the birth of Ramprasad's child in America, this time in the form of postpartum depression, which she addresses by saying that the "Old sentiments of fear and anxiety have crept back into me. I try to stop my thoughts from rushing by thrashing my head with both hands and wailing like a trapped animal" (Ramprasad, 2014, p. 129). Although postpartum depression is a well-established clinical reality that affects "more than 20% of women worldwide" (Radzi et al., 2021, p. 2), her suffering is unknown to her immediate family as well as to the larger cultural context, which inhibits discussion of maternal mental health. She is shackled into silence by her worry of being judged unfit for parenthood, illustrating how the stigma associated with depression is institutional as well as social, controlling essential facets of a woman's life.

Ramprasad's final diagnosis, which came more than ten years later, is both a branding and a revelation, which reduces her to a clinical entity even though it gives her the words to express her sorrow. The claim made by her psychiatrist, that "depression does not discriminate...It can afflict anyone" (Ramprasad, 2014, p. 155), questions her mother's deeply held conviction that wealth and security should protect against mental illness. She is now labelled as "depressed, deranged, demented, dangerous, crazy, lazy, weak, possessed," suggesting that the diagnosis itself has a burden of its own (ibid., p. 171). According to McPherson and Armstrong (2006, p. 50), the diagnosis process reduces a person's identity to their illness, which perpetuates the notion that mental illness is a stigma to be endured rather than just a symptom that needs to be treated. As Corrigan and Watson (2002, p. 6) contend, the

stigma becomes a hindrance to recovery, making society's attitudes just as problematic as the illness itself.

In this manner, Ramprasad's experience highlights how gender, culture, and mental illness are intertwined. Her anguish is a reflection of a society that routinely minimizes suffering if it occurs to a woman rather than regard it as a singular human battle. Her tale is a critique of the social, medical, and cultural systems that support stigmatization and ignorance, showing that depression is an externally imposed silence as much as an interior struggle.

Torments of treatment: A patient of the psychiatric system

Under the pretence of providing care, the psychiatric system frequently serves as a tool for coercion, control, and surveillance. The first step in the procedure is the diagnosis, a classification that immediately exposes people to medical examination. Although diagnosis is portrayed as the initial stage of treatment, it also functions as a tool for social control, deciding who is considered capable of functioning in society and who needs to be restrained by medical means. This classification has several challenges, as Ramprasad's experience shows, such as cultural stigma, a lack of mental health resources, and a shortage of qualified experts in India. The Indian government's statistics expose the severity of this systemic failure: out of 1.2 billion people, only 37 mental hospitals exist, and a single psychiatrist treats 400,000 patients, meaning that 50–90% of mentally ill people are not given treatment (Ramprasad, 2014, p. 156). The total number of mental health professionals, including clinical psychologists, psychiatrists, psychiatric social workers, and psychiatric nursing staff, is 7,000, according to the National Crime Records Bureau 2015. In contrast, the required number is closer to 55,000 (Sharma, 2018). However, this lack of care is a reflection of the priorities of the psychiatric system as well as institutional negligence. Instead of addressing the cultural and socioeconomic factors that contribute to mental suffering, psychiatry focuses on using institutional and pharmaceutical methods to impose order.

Pharmaceutical intervention, the cornerstone of psychiatric treatment, embodies the biomedical model's reductionist approach, which views pharmacological treatments as the only effective remedy and equates mental health issues with brain diseases (Deacon, 2013, p. 846). Ramprasad's terrifying experiences with psychiatric medication, however, highlight the dehumanizing consequences of this approach to treatment. After taking doxepin at first, she suffers from severe anxiety, thoughts of suicide, and a variety of incapacitating physical symptoms, such as fatigue, nausea, and impaired vision (Ramprasad, 2014, p. 155). The psychiatrist's reaction is telling – instead of re-evaluating the efficacy of this treatment strategy,

he is adamant about either raising the dosage or postponing reconsideration until she gets back to the United States. Nortriptyline, lithium, and Prozac are the subsequent prescriptions that she gets, and each one makes her problems worse rather than better. According to Ramprasad, the adverse effects include "heightened anxiety and panic, restlessness, recurring bouts of debilitating depression, dizziness, mental confusion, muscle spasms, exhaustion, dry mouth, stomach cramps, constipation, headaches, joint pain, nausea, blurred vision, rapid heartbeat, and, worst of all, constant thoughts of suicide" (ibid., p. 224). Her body is reduced to a site of medical experimentation as a result of the methodical trial-and-error procedure, turning it into a battlefield for pharmaceutical dominance.

The system's reaction, even in cases where treatment fails, is to intensify its interventions rather than re-evaluate its underlying assumptions. The next course of treatment is electroconvulsive therapy (ECT), which the psychiatrist "insists on immediately administering ECT" despite its well-established side effects (Ramprasad, 2014, p. 157). According to Johnstone, psychological trauma brought on by ECT results in "feelings of humiliation, increased compliance, failure, worthlessness, betrayal, lack of confidence and degradation, and a sense of having been abused and assaulted" (1999, p. 69). This is in addition to cognitive impairment. This decline into forced submission is best illustrated by Ramprasad's treatment path, where she is stripped of her autonomy at every turn – medication, ECT, and institutionalization – and reduced to a passive object of psychiatric power.

The final step in this medical control approach is institutionalization. Ramprasad's cultural background, in which mental hospitals are viewed as prisons instead of places of rehabilitation, influences her anxieties about being admitted to this facility as she recalls the terrible reality of this type of hospital in India. According to Addlakha, patients in India are frequently left behind by their relatives, overcrowding surpasses 200%, and fatality rates are startlingly high. The idea that those who are considered mentally ill must be kept apart from society is reinforced by the asylum, which has historically served as a tool of colonial power and still serves as a place of confinement rather than care (2010, pp. 47-49). Her encounter with her psychiatrist, who dismisses her objections and instead depends on her mother and husband to enlighten her about her illness, emphasizes the dehumanization that comes with institutionalization. As she puts it, "Paranoid that wrong answers might get me institutionalised, I decide not to speak at all" (Ramprasad, 2014, p. 169). The psychiatric system's ultimate control mechanism – the patient's loss of agency – is embodied in this erasure of her voice.

A more comprehensive criticism of psychiatry as a societal control mechanism is reflected in Ramprasad's experience. According to Price, a mental diagnosis renders a person

permanently injured. It justifies the denial of their rights unless they follow medical orders, which may involve electroshock therapy, forced medication, or incarceration (2011, p. 337). By constructing mental illness as an internal pathology through its reliance on MRI scans, genetic markers, biochemical imbalances, and psychotropic drugs, psychiatry absolves the system of addressing the external factors that contribute to psychological distress, such as poverty, gender oppression, and systemic violence (Addlakha, 2010, p. 47). The continual monitoring and manipulation of marginalized people, especially women, whose suffering is frequently pathologized rather than comprehended in light of their lived experiences, is made possible by this move from social to biological explanations.

Eventually, psychiatry serves as a disciplinary tool that polices and controls abnormal conduct rather than as a liberating force. Through constant medicalization, forced therapies, and institutionalization, the psychiatric system obliterates personal identity and substitutes it with a diagnosis that warrants ongoing monitoring. Ramprasad's experience with this system highlights the subtle ways that psychiatric intervention can be used as an oppressive tool, systematically disempowering those it purports to assist rather than providing respite.

Finding a light within: A road to recovery and advocacy

The structural and societal constraints of psychiatric therapy in both India and America are revealed by Ramprasad's cross-cultural interaction experience through mental illness and recovery. Her tale highlights a deeper problem: the mistaken belief that mental disorders only exist within the individual, independent of more significant social and structural effects, even though she is lucky to receive a diagnosis – something that many people with mental illnesses are denied. Medical discourse frequently ignores the intricate interactions between neurological, genetic, and social variables and reduces mental disease to simple biochemical imbalances. A narrow perspective that ignores the patient's lived experience and outside reality is presented when mental illness is only viewed through internal elements, as Wendell criticizes (1989, p. 72). This reductionist approach reinforces the pathologization of behaviours considered socially deviant and isolates and stigmatizes people, perpetuating what Hogan refers to as an "exclusionist strain of medical model critique" (2019, p. 17). This paradigm is further illustrated by the use of psychiatric drugs as the primary treatment for disorders such as depression and anxiety since the efficacy of these drugs in reducing symptoms does not necessarily support the idea of a biological aetiology – just as the effectiveness of cancer treatment does not prove that all cancer cases are caused by genetic predispositions, especially when environmental toxins are a significant factor (Nicki, 2001, p. 81).

The limitations of medication as a stand-alone therapy strategy are illustrated by Ramprasad's experience receiving psychiatric care. Her psychiatrist directs her to a psychotherapist who looks more closely at the root causes of her distress after realizing that medicine alone is insufficient. Her difficulties are not just the result of biological anomalies but rather of deeply embedded psychosocial dynamics, as the treatment process reveals long-standing patterns of parental expectations and societal indoctrination. As she delineates, "I describe the specifics of my journey to India, the breakdown, the diagnosis, the ECT, the drugs, the return trip to Portland, and the hospitalisation" (Ramprasad, 2014, p. 173). As an investigator, her therapist reassembles the pieces of her past to identify the causes of her suffering: "the genetic predisposition to mental illness, my utter dependence on my family, my desperate need to please others, and my perfectionist attitudes" (179). This realization is important because it places the burden of her suffering in a context of cultural and familial conditioning rather than a merely biological paradigm.

The psychological toll of gendered socialization is demonstrated by Ramprasad's upbringing, which is characterized by conflicting parental expectations. There is an unworkable conflict between her father's demand that she adopt American ideals and her mother's emphasis on living up to the idealized Hindu woman, Sita. Her words, such as "continued to please my parents" (Ramprasad, 2014, p. 33), "I want to please him more than anything" (p. 41), and "ashamed at my inability to please them" (p. 86), demonstrate her relentless attempts to carry out these responsibilities. Due to broader societal norms reflected in this compulsive need for validation, women are conditioned to absorb self-doubt, remorse, and self-sacrifice as normal states of being (Nicki, 2001, p. 86). Women's psychological suffering is made worse by the constant pressure to live up to strict standards, especially for those who manage several frequently competing identities. The combination of cultural dissonance, familial control, and gendered oppression in Ramprasad's situation significantly contributes to her mental illness. Her experience supports the claim made by Nicki that toxic social situations are conducive to mental discomfort, particularly for underprivileged populations (ibid., p. 82).

Her inherited susceptibility to mental illness further complicates Ramprasad's situation. Her sister's battle with schizoaffective illness, her brother's crippling depression, and her father's struggle with suicidal thoughts all point to a generational transfer of mental health problems. However, the prevalent psychiatric framework isolates and individualizes patients rather than acknowledging the structural and societal ramifications of these disorders, which serves to further the idea that systemic change is not the answer but rather individual fortitude. "It is time to cut the umbilical cord with your family [...] express your emotions instead of

bottling them up" (Ramprasad, 2014, pp. 179-180). The advice given by her therapist represents an effort to regain independence from the deeply ingrained familial expectations that have influenced her psychological discomfort.

Ramprasad encounters more difficulties when she enters the workforce, which highlights the shortcomings of traditional mental health practices even more. Although she feels stable working at Intel, the constant demands of the corporate world make her more vulnerable and lead to regular breakdowns: "A depressive antisociality can accompany an insistence that the past is not over yet" (Cvetkovich, 2012, p. 7). She receives social support from her coworkers, which "ease[s] my anxieties and restore[s] my sense of self-worth", in contrast to traditional psychiatric settings (Ramprasad, 2014, p. 186). This supports Wendell's claim that people with mental illness can significantly benefit from changes to social structures and workplace standards (1989, p. 69). However, systemic barriers continue to exist since mental illnesses are still stigmatized in the workplace. There are still few workplace accommodations for mental disability. As Nicki highlights, genuine inclusiveness necessitates a fundamental shift in how psychiatric disorders are perceived and handled in professional settings (2001, p. 94).

Notwithstanding these difficulties, Ramprasad ultimately comes to a pivotal moment, choosing a holistic approach over the biological model of the psychiatric establishment. "I suddenly realise that I am the only person who has the key to set myself free—an insight that frightens and frees me all at once", she says, recalling her long-term dependence on medicine and mental health treatments (Ramprasad, 2014, p. 207). A more comprehensive critique of the oppressive systems that contribute to mental disease is shown by her reference to J. Krishnamurti's statement, "It is not a sign of good health to be well adjusted to a sick society" (ibid., p. 201). She decides to establish a new route that puts self-determination ahead of compliance rather than obediently following social norms. The dominance of Western psychiatric models is challenged by her choice to adopt Eastern therapeutic techniques, such as pranayama and holistic wellness practices: "Western medicine is focused on controlling symptoms instead of fostering systems change" (ibid., p. 226).

Ramprasad's advocacy efforts highlight the significance of challenging popular beliefs regarding mental illness. By establishing ASHA International and carrying out wellness programmes, she hopes to eradicate stigma and promote culturally sensitive approaches to mental health treatment. Her experience highlights a crucial fact: mental illness is not merely an individual pathology but rather a complex intersection of biological, psychological, and social factors. As her story demonstrates, effective rehabilitation is not about curing symptoms

but establishing a meaningful existence within – and maybe even despite – societal constraints. Her work demonstrates the power of collective healing and the necessity of rethinking mental health beyond the boundaries of the medical model.

Conclusion

This study has critically evaluated Gayathri Ramprasad's memoir, *Shadows in the Sun*, highlighting how Ramprasad's lived experience serves as both a personal portrayal of mental illness and a broader critique of the structural and cultural barriers to mental health care. Her tale offers an epistemological counterpoint to the dominant psychiatric discourse by illuminating how migration, gender, and systemic oppression interact to influence mental health experiences. The study has highlighted the significance of intersectional methodologies in understanding mental disorders by focusing on the socio-cultural variables that contribute to mental suffering instead of ignoring it as a purely biological occurrence.

This study has a few limitations regardless of its contributions. One significant shortcoming is its concentration on criticizing the institution of psychiatry and therapies; while necessary, this focus has the potential to obscure the benefits that, when implemented delicately and with cultural sensitivity, psychiatric interventions may provide. Although the study criticizes the reductionist biomedical perspective and the coercive nature of psychiatric interventions, it should not ignore the need for medical therapies such as medication and treatment in the management of mental illness. A more objective discussion that acknowledges the limitations and successes of psychiatric treatment in many contexts would broaden the scope of this examination. Particularly in India, where mental health is commonly viewed through the lens of social deviance rather than individualism, the study also recognizes the severe cultural stigmas and prejudices surrounding mental and physical diseases. Addressing these stigmas through improved knowledge and systemic change is necessary to improve the conversation around mental health.

Despite these limitations, this work achieves several significant advancements. It has demonstrated how Ramprasad's memoir undermines dogmatic notions of mental illness by situating it within a sociocultural and gendered framework. The analysis reveals that, particularly for diasporic women, structural inadequacies in mental health care, cultural stigmatization, and patriarchal expectations often exacerbate mental illness. Ramprasad's journey from psychiatric patient to mental health advocate demonstrates the potency of storytelling as a means of resistance and self-reclamation. Her memoir contributes to broader discussions on psychiatric survivability and feminist mental health activism while also

challenging the stigmatization of women's psychological distress in social and medical contexts.

Essentially, *Shadows in the Sun* recognizes people's struggle to deal with mental health issues in socio-cultural contexts and criticizes institutional shortcomings. It highlights the necessity of holistic treatment approaches instead of a rigid biological perspective that solely addresses symptoms. Ramprasad's story highlights the need for an inclusive mental health system that considers medical and cultural factors, ensuring stigma-free, compassionate, and easily accessible care. This study emphasizes the need for an intersectional approach to the discussion of mental health, one that considers the lived experiences of those affected by mental illnesses and moves beyond clinical vocabulary. Future studies should keep examining these subjects and broadening the discussion on cultural hybridity, mental health justice, and gendered experiences of psychiatric care.

Works Cited:

Addlakha, R. 2010. "'Indigenisation' not 'Indianisation' of Psychiatry: An Anthropological Perspective." In: *Sociological Bulletin*, Vol. 59, No. 1, pp. 46–68.

Bhabha, H. 1994. *The Location of Culture*. New York and London: Routledge.

Cooper, K. M., Gin, L. E., & Brownell, S. E. 2020. "Depression as a concealable stigmatised identity: What influences whether students conceal or reveal their depression in undergraduate research experiences?" In: *International Journal of STEM Education*, Vol. *7*, No. 1, pp. 1–18.

Corrigan, P. W., & Watson, A. C. 2002. "Understanding the impact of stigma on people with mental illness." In: *PubMed*, Vol. 1, No. 1, pp. 16-20.

Cvetkovich, A. 2012. *Depression: A Public Feeling*. Durham: Duke University Press.

Davis, L. J. 2013. *The Disability Studies Reader*. London: Routledge.

Deacon, B. J. 2013. "The biomedical model of mental disorder: A critical analysis of its validity, utility, and effects on psychotherapy research." In: *Clinical Psychology Review*, Vol. 33, No. 7, pp. 846–861.

Dein, S., & Illaiee, A. S. 2013. "Jinn and mental health: looking at jinn possession in modern psychiatric practice." In: *The Psychiatrist*, Vol. 37, No. 9, pp. 290–293.

Diedrich, L. 2007. *Treatments: Language, Politics, and the Culture of Illness*. Minneapolis: University of Minnesota Press.

Frank, A. W. 1997. *The Wounded Storyteller: Body, Illness & Ethics*. Chicago: University of Chicago Press.

Freud, S. 1920. *Beyond the Pleasure Principle*. London: Hogarth Press.

Hawkins, A. H. 1993. *Reconstructing Illness: Studies in Pathography*. Indiana: Purdue University Press.

Hogan, A. E. 2019. "Social and medical models of disability and mental health: evolution and renewal." In: *Canadian Medical Association Journal*, Vol. 191, No. 1, pp. E16–E18.

Johnstone, L. 1999. Adverse psychological effects of ECT. In: *Journal of Mental Health*, Vol. *8*, No. 1, pp. 69–85.

Kristeva, J. 1980. *Powers of Horror: An Essay on Abjection*. New York: Columbia University Press.

Kristeva, J. 1992. *Black Sun: Depression and Melancholia*. New York: Columbia University Press.

McPherson, S., & Armstrong, D. G. 2006. "Social determinants of diagnostic labels in depression." In: *Social Science & Medicine,* Vol. *62*, No. 1, pp. 50–58.
Nicki, A. 2001. "The Abused Mind: Feminist Theory, Psychiatric Disability, and Trauma." In: *Hypatia: A Journal of Feminist Philosophy*, Vol. 16, No. 4.
Pachankis, J. E. 2007. "The psychological implications of concealing a stigma: A cognitive-affective-behavioral model." In: *Psychological Bulletin,* Vol. 133, No. 2, pp. 328–345.
Price, M. 2011. *Mad at School: Rhetorics of Mental Disability and Academic Life*. Michigan: University of Michigan Press.
Radzi, C. W. J. B. W. M., Jenatabadi, H. S., & Samsudin, N. 2021. "Postpartum depression symptoms in survey-based research: a structural equation analysis." In: *BMC Public Health*, Vol. 21, No. 1.
Ramprasad, G. 2014. *Shadows in the Sun: Healing from Depression and Finding the Light Within*. New York: Simon and Schuster.
Reed, S. 2021. "Being Sita: Gayathri Ramprasad's Shadows in the Sun." In: *Re/Imagining Depression Creative Approaches to "Feeling Bad"* (eds.). London: Springer Nature, pp. 139–155.
Sharma, K. 2018. "We need more mental health care professionals in India." *The Times of India*. Available at: https://timesofindia.indiatimes.com/life-style/health-fitness/health-news/we-need-more-mental-health-care-professionals-in-india/articleshow/66146320.cms?utm_campaig=&utm_medium=text&utm_source=contentofinterest
Steger, M. F., & Kashdan, T. B. 2009. "Depression and everyday social activity, belonging, and well-being." In: *Journal of Counseling Psychology*, Vol. 56, No. 2, pp. 289–300.
UCL. 2022. *40% of women with severe mental illness are victims of rape or*. UCL News. Available at: https://www.ucl.ac.uk/news/2014/sep/40-women-severe-mental-illness-are-victims-rape-or-attempted-rape
Wendell, S. 1989. "Toward a Feminist Theory of Disability." *Hypatia: A Journal of Feminist Philosophy*, Vol. 4, No. 2, pp. 104–124.
Wendell, S. 1996. *The Rejected Body: Feminist Philosophical Reflections on Disability*. London: Routledge.

Radhika Sharma
Department of Humanities, Management and Applied Sciences
Indian Institute of Information Technology Kota
Rajasthan, India – 325003
rsharma@hs.iitr.ac.in

Nagendra Kumar
Department of Humanities and Social Sciences
Indian Institute of Technology Roorkee
Roorkee, Uttarakhand, India – 247667
nagendra.kumar@hs.iitr.ac.in