

Beyond the Confident Smile: Mental Health, Social Expectations and the Culture of Silence in Contemporary Indian Society

Kumar Bahukhandi

Editor, Prime Look

Assistant Professor, Journalism & Mass Communication, Pragati College, Raipur,
Chhattisgarh, India

Abstract

This critical narrative review examines the relationship between mental health, social expectations and the reluctance to disclose psychological distress in contemporary India. Its central proposition is that a confident public presentation cannot be treated as reliable evidence of private wellbeing. Rather than diagnosing silence or treating Indian society as culturally uniform, the paper examines the social and institutional conditions that may make disclosure difficult. The discussion draws on the National Mental Health Survey of India, state-level disease-burden estimates, Indian studies of adolescent mental health and help-seeking, the Mental Healthcare Act, 2017, and international guidance used selectively for conceptual comparison. It considers academic competition, family expectations, workplace cultures, digital communication, service availability and media representation. National survey estimates and systematic reviews establish substantial mental-health needs, but they do not establish that any one social pressure directly causes a particular disorder. The paper therefore distinguishes empirical findings from interpretive arguments. It proposes that mental-health communication in India should connect compassionate listening with rights-based care, confidential institutional support, locally appropriate information and critical attention to structural barriers. Its contribution is an interdisciplinary framework for understanding the culture of silence without mistaking privacy for pathology or compassion for clinical treatment.

Keywords

Mental health; India; human behaviour; stigma; psychological distress; help-seeking; academic pressure; social expectations; mental-health communication.

1. Introduction: The Limits of the Confident Smile

Public life supplies many visible indicators of achievement: educational qualifications, professional titles, promotions, family responsibilities and the appearance of composure. None is a clinical measure of mental health. The familiar image of a confident smile is therefore useful as a metaphor for the limits of outward observation. It should not be taken to mean that every cheerful individual conceals distress. The more defensible argument is that social performance does not provide sufficient information to judge another person's emotional condition.

The distinction matters in India, where conversations about wellbeing intersect with different languages, family structures, educational opportunities, occupations and patterns of healthcare access. General statements about an inherently silent Indian culture obscure this diversity. A person may choose not to disclose difficulties because of privacy, mistrust, financial

constraints, anticipated judgement or simply because no trusted support is available. The reasons are not interchangeable, and the response to each should differ.

The World Health Organization (2022) describes mental health as a public-health concern shaped by social environments and access to services. India-specific evidence makes that broad principle concrete. The National Mental Health Survey (NMHS) estimated current mental morbidity at 10.56% among surveyed adults, with lifetime prevalence of 13.67% (Gururaj et al., 2016; Murthy, 2017). These figures relate to the survey's definitions, population and period; they should not be presented as a measurement of all mental-health experiences in 2026. The purpose of this paper is to place such evidence alongside a social analysis of achievement, vulnerability and the conditions under which help becomes accessible.

2. Research Questions and Objectives

The central question is: under what social and institutional conditions might individuals in contemporary India hesitate to disclose psychological distress or seek appropriate support? Four subsidiary questions guide the analysis. First, how do ideals of achievement and emotional strength affect the meanings attached to vulnerability? Second, what do Indian studies reveal about the scale of need and the obstacles to accessing services? Third, how can families, educational institutions, workplaces and media organisations support wellbeing without imposing unwanted disclosure? Fourth, how might rights-based policy and culturally sensitive communication strengthen routes to care?

The objectives are analytical rather than predictive. This paper does not seek to estimate new prevalence rates, identify causal effects or generalise from personal experience. It evaluates how existing evidence can inform a humane, institutionally responsible account of mental-health communication in India.

3. Methodology and Limits of Evidence

The study is a critical narrative review supported by a conceptual argument. It draws purposively on publicly traceable Indian epidemiological research, systematic reviews of children and adolescents, government policy documents and selected international scholarship on stigma and mental-health systems. The main Indian evidence includes the NMHS (2015-16), the India State-Level Disease Burden Initiative's analysis of 1990-2017, Jayasankar and colleagues' analysis of common mental disorders, and recent reviews of school climate and adolescent help-seeking. The Mental Healthcare Act, 2017 and the National Mental Health Programme provide a legal and service-delivery context.

This is not a systematic review. No registered protocol, exhaustive database search, independent screening of all eligible studies, meta-analysis, original interviews or participant survey has been conducted. Accordingly, the analysis cannot establish how often a particular social pressure leads to concealment, nor can it compare every Indian state or population group. Where evidence derives from global studies, its applicability to India is considered rather than assumed. Interpretive claims are explicitly presented as propositions, not empirical results.

An additional methodological caution concerns the distinction between distress, diagnosed disorder, self-reported symptoms and service use. These are different constructs. Public discussion often collapses them into a single category, which can exaggerate conclusions or

medicalise ordinary emotional experiences. This paper maintains those distinctions while arguing that people deserve respect and support across the full range of experiences.

4. The Indian Evidence: Prevalence, Burden and Treatment Gaps

The NMHS, coordinated by the National Institute of Mental Health and Neuro Sciences, remains a foundational national source. Its adult household survey estimated a weighted current prevalence of mental morbidity of approximately 10.6% and a lifetime prevalence of approximately 13.7% (Gururaj et al., 2016; Murthy, 2017). The survey also reported substantial gaps between identified need and treatment received, varying markedly by condition. Its summary describes treatment gaps for several major disorders exceeding 60%, with the figure for alcohol-use disorders reported at approximately 86% (NIMHANS, 2016). Such figures are evidence of service and access challenges, not proof that stigma alone explains non-treatment.

A different analytical approach was taken by the India State-Level Disease Burden Initiative Mental Disorders Collaborators (2020). Drawing on the Global Burden of Disease framework, the study estimated that 197.3 million people in India were affected by mental disorders in 2017, equivalent to about one in seven residents. It estimated 45.7 million people with depressive disorders and 44.9 million with anxiety disorders. The estimated share of India's total disability-adjusted life-years attributable to mental disorders rose from 2.5% in 1990 to 4.7% in 2017. These are modelled estimates using a wider set of conditions and different methods than the NMHS; their apparent differences should not be treated as contradictions.

State-level variation is central to the disease-burden study. Patterns differed across conditions and socio-demographic contexts, indicating that a single national narrative is insufficient for planning services. Access, recognition and reporting can also vary across rural and urban settings and between linguistic communities. The implications for communication are substantial: public messaging must be understandable, locally credible and accompanied by pathways to care. A national campaign without district-level service capacity risks raising awareness without meeting the need it reveals.

Jayasankar et al. (2022) analysed common mental disorders within the NMHS framework and reported a weighted current prevalence of 5.1% for the conditions covered by that analysis, with a treatment gap of 80.4%. This narrower figure is not an alternative estimate of all mental disorders. It illustrates how definitions and case selection affect reported prevalence. Read together, the studies show substantial needs, marked service gaps and the importance of precise reporting. They do not establish that everyone who does not receive treatment has chosen silence: distance, cost, availability, knowledge and suitability of care may all be relevant.

5. Stigma, Self-Stigma and the Social Meaning of Disclosure

A useful distinction separates public stigma from self-stigma. Public stigma involves negative stereotypes and discriminatory responses associated with a condition; self-stigma arises when such judgements are internalised. Corrigan (2004) and Vogel, Wade and Hackler (2007) describe how stigma can influence attitudes towards professional assistance. Their findings provide conceptual mechanisms, but the latter study's student sample cannot automatically represent the experiences of Indian communities.

In India, concerns about reputation, confidentiality, marriage prospects, employability and family expectations may shape some individuals' decisions about disclosure. These are plausible social pathways, not claims that all families share the same beliefs. A responsible interpretation must allow for differences across gender, caste, class, age, religion, disability and locality without making unsupported comparisons between groups. Social silence may be protective in one context and harmful in another. The ethical question is not whether everyone speaks openly but whether people can seek help without being humiliated or penalised.

Stigma is also different from inadequate services. A person may be ready to seek care and still face a long journey, unaffordable consultation or lack of continuity. Conversely, a well-resourced service can remain unused if people fear disclosure. Effective policy must therefore address demand-side concerns and supply-side barriers together. Treating mental-health awareness as a substitute for affordable services shifts responsibility unfairly onto individuals.

6. Educational Pressure, School Climate and Student Wellbeing

Schools and colleges are important sites for examining the social meaning of achievement. Marks, entrance examinations, rankings, career uncertainty and family expectations may shape how young people interpret success and failure. It would be scientifically careless to claim that examination pressure alone produces depression or anxiety. Nevertheless, a growing evidence base indicates that educational environments matter for emotional health and help-seeking.

Balamurugan et al. (2024) systematically reviewed 31 studies involving 30,970 Indian schoolchildren and adolescents. The review identified a range of reported concerns, including depression, anxiety, behavioural and emotional difficulties, psychological distress and problematic technology use. Because the included studies differed in design, measures and populations, the findings should not be turned into a single national prevalence estimate. Their value lies in demonstrating the range of issues educational institutions must be prepared to recognise and address.

Podiya, Navaneetham and Bhola (2025) examined school climate, emotional health and academic achievement in Indian adolescents. Their review highlights the significance of supportive, respectful and connected school environments. This is relevant to the present argument because the possibility of speaking about difficulty depends partly on whether students expect a fair response. A classroom culture that equates distress with laziness may deter disclosure; a supportive culture can create a safer route to assistance. These are institutional design questions, not merely matters of student resilience.

Gadgil et al. (2025), reviewing barriers and facilitators to adolescent mental-health care in India, likewise underscore the importance of family, schools, knowledge and service access. The practical lesson for colleges is to provide confidential referral routes, trained personnel, clear information and safeguards against ridicule. Awareness events can begin a conversation, but annual observances cannot replace ongoing counselling arrangements or pathways to specialist assessment when necessary.

Teachers have a particularly delicate role. They should not be expected to diagnose students, yet they can avoid public humiliation, respond to requests for support, recognise changes that warrant a private conversation and guide students towards qualified professionals. Academic standards and compassion are not mutually exclusive. The goal is to make educational

achievement compatible with dignity rather than to treat performance as a complete measure of personal worth.

7. Family Expectations, Care and the Right to Privacy

Family relationships can provide practical assistance, emotional security and encouragement to seek treatment. They can also become sites of misunderstanding when expectations about obedience, achievement or endurance leave little space for disagreement. Both possibilities must be acknowledged. Indian families are not a single cultural type, and there is no basis for assuming that intergenerational disagreement invariably causes mental illness.

The language of care matters. Advice to be stronger, remain positive or ignore a problem may be offered with good intentions, but it can make a person reluctant to speak if the concern is repeatedly dismissed. Listening without immediate judgement is valuable precisely because it does not presume a diagnosis. At the same time, family members should not be encouraged to become informal therapists or to override a person's preferences. Respect for privacy, autonomy and informed decision-making must remain central.

The Mental Healthcare Act, 2017 provides an important legal framework. Section 18 recognises a right to access mental healthcare and treatment through government-run or funded services and describes accessibility, affordability, quality and non-discrimination as relevant standards (Government of India, 2017). Rights in law do not automatically guarantee equal access in practice, but they offer a stronger basis for public discussion than appeals to personal kindness alone. Supportive relationships are most useful when they coexist with meaningful professional options.

8. Work, Productivity and Institutional Responsibility

Professional environments can reward visible confidence, constant availability and the ability to perform under pressure. These expectations may encourage employees to hide exhaustion or avoid requesting assistance, particularly where disclosure is perceived as a threat to career progression. The argument is not that demanding work invariably causes a mental disorder; rather, work organisation and management practices can influence psychosocial risk and willingness to seek support.

Indian evidence on the general population does not, by itself, establish the prevalence of particular disorders in every profession. Workplace-specific conclusions require workplace-specific studies. Nevertheless, the WHO and International Labour Organization (2022) offer a useful framework for preventing psychosocial risks, supporting workers with mental-health conditions and improving organisational responses. Their recommendations can be considered alongside Indian labour conditions, including informal employment, contractual insecurity, long commutes and uneven access to occupational health resources.

Employers should avoid making wellbeing an individual obligation while leaving harmful organisational practices unchanged. Reasonable workload design, respectful supervision, predictable leave, anti-discrimination safeguards and confidential referral arrangements are institutional measures. A wellness seminar cannot compensate for persistent harassment or unsafe working conditions. The social value of work should not depend on requiring employees to conceal every difficulty.

9. Digital Life, Visibility and the Pressure to Appear Well

Digital media complicate the relationship between public presentation and private experience. Online profiles often foreground achievements, celebrations and carefully chosen photographs, while difficult experiences remain unposted. Yet this selection is not necessarily deception: individuals have legitimate reasons to maintain boundaries. The risk arises when viewers treat curated visibility as a complete account of another person's life and compare it uncritically with their own private difficulties.

Digital platforms may also offer information, peer communities and access to support. The Indian government's Tele Mental Health Assistance and Networking Across States programme, known as Tele-MANAS, illustrates how telecommunications can widen entry points to mental-health services. The Directorate General of Health Services describes the programme as a 24-hour service intended to connect callers with counselling and further care; its helpline includes 14416 (DGHS, n.d.). These channels are important, but availability of a telephone line does not establish that all callers receive equivalent follow-up or that digital delivery can replace local in-person services.

The analytical task is therefore to distinguish digital communication as a tool from the social expectations attached to it. A person may be highly connected and still lack trusted conversation; another may find meaningful support online. Neither outcome is universal. Public education should promote critical digital literacy without portraying technology as an inevitable cause of distress.

10. Journalism, Language and Mental-Health Literacy

The media influence the terms in which mental health is discussed. Headlines can normalise informed help-seeking, or they can turn complex conditions into shorthand for danger, incompetence or personal weakness. Journalism must distinguish a verified diagnosis from speculation and avoid using clinical language casually as an insult. The responsibility is particularly significant in a multilingual country where readers may encounter inconsistent or inaccurate terminology across languages.

Indian journalism can contribute by explaining what survey statistics actually measure, identifying where care is available, reporting barriers to service delivery and protecting the dignity of people whose experiences appear in stories. The NMHS and the India State-Level Disease Burden Initiative offer an instructive example: both are legitimate sources, but their estimates are not interchangeable. A reporter who presents them as competing counts without explaining methods may unintentionally mislead readers.

Mental-health literacy should be practical rather than merely inspirational. Readers need to understand that ordinary sadness and clinically significant conditions are not identical, that professional evaluation may be appropriate when distress persists or affects functioning, and that treatment choices depend on individual needs. Compassionate language cannot cure illness, but careless language can discourage the conversation through which someone reaches appropriate care.

11. Policy, Service Delivery and the Limits of Awareness

India's policy landscape has moved beyond treating mental health solely as a private matter. The Mental Healthcare Act, 2017 establishes a rights-oriented framework, while the National Mental Health Programme and District Mental Health Programme aim to strengthen service delivery. The Directorate General of Health Services identifies activities ranging from primary-care integration to school counselling, community outreach and tele-mental health provision (DGHS, n.d.). These measures recognise that awareness without services cannot resolve a treatment gap.

The practical challenge is implementation. A legal right may be difficult to exercise when specialists are unavailable, information is inaccessible, travel is costly or confidentiality is uncertain. Institutional plans should therefore specify referral responsibility, language accessibility, continuity of care and mechanisms for receiving complaints. Telehealth can complement district services, but evaluation must look beyond call volumes to assess the quality and timeliness of support.

India's diversity also argues against a single communication template. Programmes designed for metropolitan colleges may not suit rural schools, informal workplaces or communities with different linguistic needs. Locally adapted information should retain evidence-based standards and avoid romanticising traditional silence or dismissing family-based support. The aim is a continuum of care in which informal understanding and professional services reinforce, rather than replace, one another.

12. Discussion: A Framework for Understanding Silence

The evidence considered here supports a three-part framework. The first component is social meaning: expectations about competence, endurance and success can influence whether vulnerability feels acceptable. The second is relational safety: people are more likely to consider disclosure when they expect confidentiality, respect and a non-punitive response. The third is structural opportunity: willingness to seek help has limited practical value if affordable, appropriate services are inaccessible. The culture of silence emerges as a possible interaction among these components, not as an innate trait of Indian society.

This framework helps explain why exhortations to speak up may be inadequate. A student may understand mental health and still fear academic consequences. An employee may trust a colleague but have no confidential support pathway. A family may wish to help but lack reliable information about services. In each case, the solution requires more than a change in attitude. It requires institutions that make seeking help possible and safe.

The metaphor of the confident smile adds a communication-oriented insight: observers should neither infer wellbeing from achievement nor infer illness from reserve. Respectful attention involves allowing people to set boundaries, offering support without coercion and making reliable care available. The framework is an interpretive contribution and has not been validated as a psychological scale or causal model. Future empirical studies could examine how its components operate across regions, languages and institutional settings.

13. Recommendations and Future Research

Educational institutions should provide visible confidential support pathways, train teachers to respond without stigma and evaluate whether disciplinary and assessment practices inadvertently discourage students from seeking assistance. Workplace leaders should assess organisational psychosocial risks rather than relying solely on individual coping workshops. Public authorities should connect awareness campaigns to staffed services, referral mechanisms and information available in regional languages. News organisations should adopt evidence-based reporting practices and check the meaning of statistical estimates before publication.

Research priorities include qualitative interviews on the meanings of emotional disclosure across different Indian communities; comparative studies of student and employee experiences; evaluations of district mental-health referral systems; and studies of how regional-language news frames mental illness and recovery. Such work should use appropriate ethical review, informed consent, confidentiality safeguards and transparent sampling. Quantitative studies should distinguish symptoms, diagnoses, treatment-seeking and treatment receipt rather than combining them into a single indicator.

A final recommendation concerns humility. No single study can represent the diversity of India, and no general social theory can determine what an individual is experiencing. The strongest scholarship connects robust evidence with careful interpretation, acknowledges uncertainty and avoids reducing mental health to either private willpower or cultural stereotype.

14. Conclusion

A confident smile can signal many things, but it cannot reliably establish the absence of psychological distress. Indian epidemiological studies document substantial mental-health needs, and research on young people demonstrates the importance of educational environments and access to support. These findings do not prove that achievement pressure or social silence causes mental illness. They do show why a narrow focus on individual strength is insufficient.

The paper argues that a meaningful response requires three linked commitments: language that protects dignity, relationships that make voluntary conversation safer, and institutions that provide accessible professional care. The right to privacy is as important as the opportunity to speak. Compassion should not be mistaken for treatment, and policy should not be reduced to slogans. In contemporary India, mental wellbeing is best understood as both a personal experience and a shared social responsibility.

References

- Balamurugan, G., Sevak, S., Gurung, K., & Vijayarani, M. (2024). Mental health issues among school children and adolescents in India: A systematic review. *Cureus*, 16(5), e61035. <https://doi.org/10.7759/cureus.61035>
- Corrigan, P. W. (2004). How stigma interferes with mental health care. *American Psychologist*, 59(7), 614-625. <https://doi.org/10.1037/0003-066X.59.7.614>
- Directorate General of Health Services. (n.d.). National Mental Health Programme. Ministry of Health and Family Welfare, Government of India. <https://dghs.mohfw.gov.in/national-mental-health-programme.php>
- Gadgil, M. K., Darak, S., Jadhav, S., & Rakshase, B. (2025). Barriers and facilitators for accessing mental health care and support for adolescents in India: A systematic review. *Indian Journal of Community Medicine*,

50(Suppl. 1), S22-S29. https://doi.org/10.4103/ijcm.ijcm_307_24

Government of India. (2017). The Mental Healthcare Act, 2017 (Act No. 10 of 2017). <https://www.indiacode.nic.in/bitstream/123456789/2249/1/A2017-10.pdf>

Gururaj, G., Varghese, M., Benegal, V., Rao, G. N., Pathak, K., Singh, L. K., et al. (2016). National Mental Health Survey of India, 2015-16: Prevalence, pattern and outcomes. National Institute of Mental Health and Neuro Sciences.

India State-Level Disease Burden Initiative Mental Disorders Collaborators. (2020). The burden of mental disorders across the states of India: The Global Burden of Disease Study 1990-2017. *The Lancet Psychiatry*, 7(2), 148-161. [https://doi.org/10.1016/S2215-0366\(19\)30475-4](https://doi.org/10.1016/S2215-0366(19)30475-4)

Jayasankar, P., Manjunatha, N., Rao, G. N., Gururaj, G., Varghese, M., & Benegal, V. (2022). Epidemiology of common mental disorders: Results from National Mental Health Survey of India, 2016. *Indian Journal of Psychiatry*, 64(1), 13-19. https://doi.org/10.4103/indianjpsychiatry.indianjpsychiatry_865_21

Murthy, R. S. (2017). National Mental Health Survey of India 2015-2016. *Indian Journal of Psychiatry*, 59(1), 21-26. <https://pmc.ncbi.nlm.nih.gov/articles/PMC5419008/>

National Institute of Mental Health and Neuro Sciences. (2016). National Mental Health Survey 2015-16: Summary. <https://cdn.who.int/media/docs/default-source/searo/india/health-topic-pdf/summary.pdf>

Podiya, J. K., Navaneetham, J., & Bhola, P. (2025). Influences of school climate on emotional health and academic achievement of school-going adolescents in India: A systematic review. *BMC Public Health*, 25, Article 54. <https://doi.org/10.1186/s12889-024-21268-0>

Vogel, D. L., Wade, N. G., & Hackler, A. H. (2007). Perceived public stigma and the willingness to seek counseling: The mediating roles of self-stigma and attitudes toward counseling. *Journal of Counseling Psychology*, 54(1), 40-50. <https://doi.org/10.1037/0022-0167.54.1.40>

World Health Organization. (2022). World mental health report: Transforming mental health for all. <https://www.who.int/publications-detail-redirect/9789240049338>

World Health Organization & International Labour Organization. (2022). Mental health at work: Policy brief. <https://www.who.int/publications-detail-redirect/9789240057944>