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Psychotherapy Model for the Training of Counselors in India

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A Clinical Research Project submitted to the faculty at the Illinois School of Professional Psychology/National Louis University, Chicago Campus in partial fulfillment of the requirements for the degree of the Doctor of Psychology in Clinical Psychology

Schaumburg, Illinois
June, 2019

ISPP/ARGOSY UNIVERSITY, SCHAUMBURG CAMPUS
Clinical Research Project Approval/Tracking Form

Student Name VINI KALRA Student ID ____________

Title of CRP Psychotherapy Model for Training of Counselors in India

Chairperson (print name) Mudita Rastogi, Ph. D.

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   Mudita Rastogi, Ph. D. — 06/21/18 (MR)
   Chairperson (signature) Date

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   Carolyn Grabowski — 6-21-18
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ACKNOWLEDGEMENTS

I would like to show sincere gratitude towards my professor and advisor, Dr. Rastogi, without whom I would not have been able to do full justice to my clinical research model. I admire her genuine interest in field of global mental health that motivated me to pursue my research. I would also like to thank my committee member, Dr. Gralewski for her thoughtful advice that helped me improve my dissertation many folds. I am thankful for her time, effort and support throughout this process. I would also like to thank my parents for supporting my academic endeavors, without them this journey would have been impossible. They are my pillars of strength and the reason of my successful doctoral program journey thus far. Lastly, I would like to thank my fiancé Sagar who motivated me and provided emotional support during times when I could not see light at the end of the tunnel.

DEDICATION

This project is dedicated to the millions of Indians suffering from mental illnesses who do not have access to mental healthcare services.

Abstract

Common mental disorders in India are on the rise and are adding to the national burden of mental health care on a day-to-day basis. The demand for treatment of mental illnesses has risen considerably, though there is a shortage of mental health professionals who can deliver counseling services. The Indian government has made efforts to improve the scalability of services by training lay health counselors to diagnose and conduct brief counseling with the mentally ill and those involved with their care. Despite efforts to scale up services, the treatment gap still exists, as mental health services are not uniformly distributed. Considering that psychotherapy is based on Euro-American concepts of mental health care, but India is a complex amalgamation of cultures, there is a need for a culturally sensitive model of counseling. Thus, this clinical research project was geared toward creating a culturally sensitive model of counseling that can be used to train lay health counselors to conduct culturally appropriate therapy. Hence, this theoretical model of counseling uses sociocultural factors to conceptualize the mental health issues of Indian clients and indigenous methods along with an evidence-based approach to inform psychotherapy interventions. Finally, the Indian sociocultural aspect is integrated into the fundamentals of therapy to improve client retention and reduce the treatment gap.

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Chapter 1: Introduction

Background of the Problem

The purpose of this clinical research project was to develop a culturally relevant psychotherapy model for lay health counselors (LHCs). In order to bridge the existing treatment gap in mental health field, the author attempted to integrate indigenous concepts in existing Euro-American concepts to treat some of the most common mental disorders in India.

Psychotherapy in India

The inception of psychology in India occurred in the 1900s when it was still a part of philosophy and was embedded in spirituality. Gradually, it became separated from philosophical thought through scientific experiments and the observation of behavior (Arulmani, 2007). Despite there being available resources, very little contribution from India in terms of research in psychology has resulted in the poor implementation of Euro-American counseling techniques, causing them to have a limited effect. The Indian psyche proudly embraces the ancient teachings of Bhagvad Gita, the Ayurveda, and other teachings that show the path toward living each stage of life. The spiritual basis of understanding the human mind strongly emphasizes turning inward and using this subjective experience to understand not only the human mind, but also the purpose of one's existence. This kind of spiritual understanding strongly influences the thoughts, emotions, and actions of Indian people. On the other hand, Euro-American psychology is based on an objective, valid, and reliable observation of human behavior (Arulmani, 2007). As a result of this disconnect between Euro-American psychology and the Indian way of living, psychotherapy has not had the intended effect.

India is no longer a solely collectivistic society, as individualistic ideals have begun to be incorporated into society (Raney & Cinarbas, 2005). It is rapidly evolving into a country that is more Euro-American in thought. Therefore, some authors argue that a Euro-American approach to therapy in India can be beneficial, yet others call for an integrative approach and emphasize that no one psychotherapy model is suitable for such a complex amalgam of cultures (Ng et al., 2014).

Globalization has led to an increase in social, economic, and other stressors, some of which have resulted in mental health problems such as depression, anxiety, domestic violence, marital discord, and substance abuse problems (Bhatt, 2015). Recently, there has been an increase in the number of Indian citizens seeking professional mental health counseling, though this does not mean counseling services will completely replace other healing practices. Current research shows mental health professionals are not equipped to provide quality services in India, as there are no set guidelines to become a professional counselor. Counselors are also considered to be a last resort and are looked upon as guides, teachers, and advice givers. This kind of perspective originates from the deep Indian rooted philosophy of guru (i.e., teacher) and shishya (i.e., disciple), in which the shishya is expected to completely surrender to the teacher to seek guidance (Arulmani, 2007). They do not serve as the traditional therapists where the locus of control is usually in the client’s hands. This is especially true for rural people who usually have low literacy levels and do not understand the differences among doctors, psychologists, and counselors. Therefore, in addition to increasing the mental health literacy of workers, it is important to develop a model of training that is based on a

common ground between the two different psychological schools of thought and is relevant to the ever evolving and modern India.

Magnitude of Mental Health Burden

Over the years, there has been an increase in the number of citizens in India suffering from mental health problems. Though mental health services are available, they are sparse and mental health problems are neglected. In India, mental illness accounts for 26% of non-communicable diseases and 6.5% of Indians have some form of mental illness (A. Kumar, 2011). The mental health burden has been estimated to rise 15% daily until the year 2020 (Reddy, Gupta, Lohiya, & Kharya, 2013). For a population of about 1.3 billion, there are only 3,000 psychiatrists and even fewer psychologists and other mental health professionals (Paudel et al., 2014; Virudhagirinathan & Karnunanidhi, 2014). This reflects that there is only one psychiatrist per 100,000 citizens to render mental health services (Paudel et al., 2014). These psychiatrists are involved in providing 15 to 30 minutes of face-to-face care over a period of 12 months (A. Kumar, 2011). Clearly, the national deficit of mental health professionals has led to overworked psychiatrists and a treatment gap that will take ages to overcome. In reality, there is a need for 140,000 psychiatrists, which means there is a 90% treatment gap in mental health services.

Attitudes Toward the Mentally Ill

Factors including stigma, discrimination, unemployment, lack of education, and lack of social support and financial resources catalyze the existing mental health crisis in India. The first two factors become important when considered in the context of rural areas, as out of the total mentally ill population, about 72.2% live in rural areas (A.

Kumar, 2011). Stigma and discrimination are prime factors responsible for the lower use of mental health services. The social fabric of India restricts the ability to discuss mental health issues as a result of labeling, stereotyping, and status loss that results in discrimination. Often, community members in rural areas do not recognize mental health problems and do not seek professional help. Instead, they consider mental illness to be a dosh (i.e., fault) or badha (i.e., obstruction; Shidhaye et al., 2015). Community members do not recognize mental illness as a "real illness" and instead associate mental illness with socioeconomic causes, as psychosocial models are more acceptable in the community as compared to biological models (Kermode, Bowen, Arole, Pathare, & Jorm, 2009). Indian families who go the route of arranged marriages do not wish to marry their children to someone who has a mental illness because they fear the next generations will also become the bearers of such mental illness. As mental illness is perceived from a psychosocial model, it fosters the kind of attitude that causes communities to think that marrying a mentally ill person will cure them of their problems by providing the bearer of symptoms a support person who can help alleviate his or her problems.

Indian communities are highly misinformed regarding common mental disorders. For example, in a survey conducted in the rural area of Maharashtra, many villagers reported they were scared of people with psychosis (Armstrong et al., 2011). They considered psychosis to be a sign of weakness and preferred to socially distance themselves from those who were mentally ill. Families usually hide mentally ill family members from society because they anticipate low social acceptance as well as shame and embarrassment (Kermode et al., 2009). The mentally ill are also vulnerable to harsh conditions. Even today, the mentally ill are chained, tortured, beaten, abused, and raped

(Ginneken, Jain, Patel, & Berridge, 2014; Koschorke et al., 2014). Shame and embarrassment adversely affect medication compliance (Jayaram, Goud, & Srinivasan, 2011). Recently, Chakraborty, Das, Dan, Bandyopadhyay, and Chatterjee (2013) explored perceptions about mental illness and the help seeking patterns of families with mentally ill members. Their results showed an overwhelming 96.8% of the participants believed mental illness occurred as a result of supernatural causes. The participants attributed mainly God, spirits, stars, astronomy, black magic and witchcraft, harm caused by an envious neighbor, past life karma, and bad fortune as the causes of schizophrenia and other related psychotic disorders. The researchers noted those who reported supernatural beliefs about mental illness also sought help from alternate medicine, religious remedies, physical exercise, yoga, and meditation.

The existing inverse relationship between the prevalence of mental illness in rural areas and the focus of mental health professionals to deliver services puts those in rural communities at risk of remaining untreated. About 72.2% of people with mental illness reside in rural areas and a majority of mental health care professionals either cater to an urban population or refuse to serve in poverty stricken rural areas (A. Kumar, 2011). Medical students and psychiatric residents are only trained in large hospitals and do not have experience working with rural populations. Efforts to train psychiatric residents are unorganized and the training they receive is theoretical in nature and bares a minimal resemblance to real-life clinical mental disorders. Moreover, psychiatrists do not welcome leadership from other mental health professionals because they do not consider other professionals to be as qualified (A. Kumar, 2011). Thus, the political nature of psychiatry affects rural populations as they do not receive adequate care and cannot

afford services that are far and costly, thus causing them to turn to faith healers, astrologers, and self-proclaimed doctors for help.

Political History of Indian Mental Health

The political scenario in India is such that more attention is paid to curative diseases and mental health is still not considered to be a priority. The current mental health budget only accounts for 0.83% of the total health budget, and even this budget is not fully used for mental health services (A. Kumar, 2011). When the National Mental Health Program (NMHP) was initially started, the government had a budget of about 10 billion rupees. However, this budget dwindled over the years as officials observed that the allocated budgets were not being fully utilized (Ginneken et al., 2014).

The Mental Health Act (MHA), originally known as the Indian Lunacy Act (ILA), was introduced by the British for the welfare of Indian soldiers who served in the British army. Post-independence, the MHA replaced the ILA in 1987 (Deshpande, Kaur, Zaky, & Loza, 2013). This act established guidelines for the development, regulation, and coordination of mental health services. For the first time, there was a law that recognized and protected the human rights of the mentally ill and penalized those who breached this law. However, the law had limitations, as the mentally ill could not be discharged on their own will. They lost all their legal capacity; they could not marry, own property, or vote; and they experienced other violations in their personal lives, family lives, economic affairs, and political status. In 1995, the Persons with Disabilities, Equal Opportunities and Full Participation Act (PWDs) was passed to protect the rights of the disabled. The goal was to educate, train, and employ the disabled so they would become fully participating and functional members of society (Deshpande et al., 2013). However, the

act was met with resistance because it did not recognize persons with mental illness as being disabled. Instead of compensating for the flaws of the Mental Health Act, the law made matters worse for those who were mentally ill. The National Trust Act was then created in 1999 to help persons with autism, mental retardation, cerebral palsy, and multiple disabilities; however, it again left out the mentally ill (Deshpande et al., 2013). This act made it impossible for those with mental illness to receive treatment because in order to qualify for services, they had to first prove their disability. The disability could not be easily proven as there was a lack of advocacy from mental health professionals to certify the mentally ill as disabled.

Only recently, with the new and revised MHA, has the position of the mentally ill improved, as they are now central to treatment and planning. However, the improved legislation has had a limited effect because the legislation has not been put into action by many districts. For example, initiatives taken by the NMHP did not materialize as a result of a lack of central and state level leadership and cooperation. This type of government functioning is shaped by the colonial ideology that the federal system does not interfere with the local initiative.

Thus, until recently, receiving mental health treatment in India has been complicated as a result of the unnecessary policies and procedures that are in place and the tendency of government bodies to sideline the importance of mental illness. This has resulted in people shying away from receiving proper treatment. In India, mental health is often integrated into spirituality and religiosity, which diminishes the importance of seeking services from mental health professionals and makes it difficult for people to

trust or show interest in such services. Additionally, many practitioners operate without proper training and experience with evidence-based psychotherapy.

Bridging the Treatment Gap

In order to bridge the treatment gap, it is important to realize that people living in rural areas have limited access to mental health services. Training those who are directly or indirectly serving in the rural community (e.g., primary health care workers, NGO workers, village health workers, etc.) can begin to fulfill this gap (Ginneken et al., 2014). Integrating mental health care into primary health clinics can solve the existing mental health treatment issues at many levels. People living in rural areas will not be forced to go elsewhere to seek treatment for their mental health problems. They will have an easier way to access mental health services because their first point of contact is in fact such places. They will also have a less a stigmatizing attitude toward mental health because they will be able to talk about their mental health under the umbrella of general health (Kermode et al., 2009; Patel et al., 2013). Several research studies have indicated providing training to local community workers through skits, role-plays, and vignettes increases their understanding of the mental illness (Paudel et al., 2014; Singla et al., 2014). This is an important aspect because workers in primary care as well as the mental health area do not have the requisite skills and knowledge to detect and treat mental health disorders.

Armstrong et al. (2011) reported that Indians somaticize their symptoms, and in a study conducted in the slums of Mumbai, they found that 28% of patients who had mental health issues went undetected in primary health care settings. To address this issue, Armstrong et al. conducted a study in which they trained community mental health

workers mainly by using vignettes that demonstrated the signs and symptoms of common mental disorders such as depression and psychosis. The authors reported that knowledge and understanding of mental disorders are poor among communities, including the mental health workers. Their aim was to improve the quality of services provided and increase access to treatment. They hypothesized that the training would increase workers' mental health literacy and improve their ability to recognize the disorders presented in the vignettes. Results showed the participants were able to increasingly recognize depression and psychosis post-training; however, at 3 months follow-up, more than half of the participants still had problems identifying these disorders.

Purpose of the Study

Despite the policies in place, the mental health care bill has not had the desired outcome. This is because the current mental health care ideology is not unique to the needs of the Indian population, and instead is borrowed from the Euro-American culture. There is a dire need for mental health workforce, finances, and political will for the proper implementation of the bill, especially in semi-urban and rural areas. The available resources are used for general health care services instead of mental health services in rural areas. In addition to stigma and discrimination, there is a lack of knowledge regarding mental illness among policymakers, mental health workers, and society. Therefore, the question becomes: If the system is indifferent and uninformed regarding mental illness, how will the general population understand and deal with the day-to-day misery of mental illness? This author proposed that a model to train therapists to deliver counseling services needed to be created. The cultural nuances and heterogeneity of the Indian population should be kept in mind to facilitate the delivery of mental health

services in underserved areas such as rural areas. Some studies have shown that by training lay mental health counselors, the interventions delivered are far more successful (Balaji et al., 2012). However, the effectiveness of these interventions is based on detecting mental illness and referring patients for psychiatric and medical services. It is unknown whether LHCs are efficiently able to provide psychotherapy services in rural areas.

The main purpose of this study was to design a culturally sensitive brief intervention psychotherapy model for therapists to use to deliver short-term psychotherapy services for common mental disorders. To achieve this purpose, the therapy model includes guidelines for the fundamental steps needed to approach the therapy sessions: building a therapeutic alliance, showing unconditional positive regard toward clients so as to reduce stigma and discrimination, displaying empathy, providing psychoeducation regarding the diagnoses in a culturally sensitive manner, understanding the mental illness from the client's perspective, and establishing therapy goals to achieve the desired outcomes. Another important factor in this model is the inclusion of the family members to maximize the benefit of the therapy sessions within a short period of time. The recent trend of an increase in seeking counseling services supports that Indian citizens are becoming increasingly aware of their psychological needs and are ready to receive help. There is a need for counseling services more than ever before but India is currently not completely equipped to meet the demands of mental health. Therefore, it becomes a moral responsibility to combat mental illness by producing quality therapists who can fulfill the mental health treatment gap. Mental illness burden is not only a

mental health issue but also a public health issue and it should receive the same urgency as other medical illnesses.

Chapter 2: Literature Review

The aim to create a psychotherapy model by better understanding the structure and function of Indian society is reiterated in this chapter. The review includes literature related to mental health in India and is divided into 12 sections. The focus in the first section is on the origination and evolution of mental health services in India; the second section includes the perspectives of the Indian population on mental health; the third covers important aspects of Indian culture that shape views toward mental health, such as multiculturalism, collectivism, casteism, religion, spirituality, and gender inequality; the focus in the fourth section is to look at the current mental health needs of the Indian population; the fifth section covers the etiology of common mental disorders in India, including suicide, depression, anxiety, schizophrenia, substance abuse, domestic violence, and mass trauma; the focus in the sixth section is on the use of yoga, meditation, Ayurveda, and naturopathy as alternatives to psychotherapy; the seventh section covers the similarities and differences between Indian and Euro-American paradigms of mental health and the limitations of the applicability of the Euro-American model to Indian mental health; the focus of the eighth section is on the psychological training in India in terms of its universities, governing bodies, training, research, and theoretical orientations; the ninth includes a discussion of the pros and cons of the recent developments in mental health policies in India; the focus in the 10th section is on the initiatives by global mental health leaders in other low- and middle-income countries and their applicability to India; the 11th contains information to support the need to develop a culturally relevant model of psychotherapy services in India; and the last section contains a summary of the key points of the chapter.

Mental Health in India, Traditionally and Now

The concept of mind and understanding of its functioning from an Indian context are explained in this chapter with a focus on understanding mental disorders from a psychiatric point of view because the information currently available mainly focuses on psychiatric care. Padmavati (2005) reported the literature on mental health in India dates back to circa 600, and included a mention of psychoses and the treatment of such disorders. Before the British reign, the Mughals ruled India; during this time, there was a large asylum in central India. The kings would hire European doctors to treat the mentally ill and these European doctors performed cupping and bleeding on the mentally ill patients (Jain & Murthy, 2006). Traditionally, mental health care was practiced in the form of community psychiatry and institutionalization was not so much in fashion. Religious institutions and rural communities played a role in taking care of the mentally ill and also provided refuge to those who had been discarded by their families. Gradually, asylums came into existence, and after India gained independence from the British, those in the field of psychiatry focused more on institutionalizing their patients.

During the colonial era, Dr. Charles Irving Smith kept detailed notes on Indian and European patients. His observations demonstrated the Indian population suffered from fewer mental disorders than their European counterparts (Jain & Murthy, 2006). He also reported that mania and psychosis occurred in Indian patients as a result of the abuse of spirits, bhang (cannabis), and ganja (marijuana; Jain & Murthy, 2006). Some patients developed depressive symptoms and complained of headaches. Later, in the 1930s, case studies of the mentally ill took into account other factors, such as medical problems, psychopathology, family history, and social functioning. In the 20th century, the use of

prescription medication was widely accepted and shock treatments prevailed. Some of the common treatments involved the use of cardiazol and ammonium chloride to produce convulsions (Jain & Murthy, 2006). In response to the growing needs of asylums, several medical students were sent abroad to gain training in the field of psychology. One such medical student was Dr. Gowindswamy, who trained in mental health but also had an interest in Indian philosophy. He understood the limitations of using the psychoanalytic approach with individuals from the Indian culture and called for a broader understanding of psychopathology that would incorporate both medical and philosophical models (Jain & Murthy, 2006).

Dr. Gowindswamy was instrumental in pioneering and establishing the All India Institute of Mental Health, which was later renamed the National Institute of Mental Health and Neurosciences, because of his avid interest in the field of neurology and neurosurgery (Barnes, 2004). However, the treatment provided to the mentally ill remained archaic and somewhat stagnant, causing the field of psychology to remain underdeveloped because there are no adequate services developed in response to the Indian population's clinical needs. After the establishment of a national mental health and district mental health program, psychiatry gained the impetus to further improve mental health services. In order to fulfill the treatment gap, several non-profit organizations and non-governmental organizations joined forces to improve the scalability of psychological services.

Several scholars have examined the models of care used in treating the mentally ill and have repeatedly come to the conclusion that the adaptation of Euro-American constructs to the mental health needs of Indians is a mistake. This is because there is

great diversity across states in terms of culture, customs, traditions, language, food, religion, and other factors. In urban areas where mental health services are more available, people heavily rely on prescriptions to take care of their mental problems. On the other hand, people in rural areas are more inclined to use indigenous healing methods for both mind and body ailments (Ahmad et al., 2015). Despite there being an increase in the number of people receiving services, counseling remains at a crossroads. The rural population is more likely to stick to the ancient and culturally relevant methods of healing because they are affected to a lesser degree by rapid globalization, and the medications prescribed by traditional healing practitioners are more affordable. Modern medicine has not completely taken over public health and traditional healing practices will never be wiped out completely. For the field of psychology to prosper in India, it is imperative for mental health professionals to adapt to the indigenous practices and integrate the indigenous constructs into modern psychology.

Understanding of Mind from an Indian Perspective

As Hinduism is the oldest religion and is largely practiced in India, it is imperative to understand the mind through ancient Hindu philosophy and teachings. A variety of ancient Indian philosophical constructs, such as Vedanta, Samkhya, Yoga, Jainism, and Buddhism, can be used to provide an understanding of mind (Srivastava, 2012). The holistic approach emphasizes looking at the mind and body as a single entity. Vasudev (2016) provided an in-depth understanding of mind through his book, *Inner Engineering: A Yogi's Guide to Joy*. Understanding of the self occurs through the understanding of the mind. The self is referred to as atman, Antahkarana, or the soul. A well-rounded understanding of the self includes knowing the four functions of the self:

buddhi (intellect), manas (memory), Chitta (awareness), and ahamkara (ego; Vasudev, 2016). The buddhi is the driving force behind an individual's functioning. It has a discriminatory quality to it and is essential for survival, as a well-functioning buddhi ensures the proper functioning of the manas, the part of the mind that constantly receives sensory information from the external world (Vasudev, 2016). Every conscious or unconscious sensory input accumulates over time and is stored by the manas in the form of wishes, desires, wants, and dislikes. If the buddhi is not consciously governed, then the manas will overpower the buddhi and will tend to do whatever the sensory input is demanding (i.e., the individual does whatever he or she wishes, desires, or wants). People can be mindful of their manas by consciously being aware of all five senses. Thus, the manas governs sensory and cognitive processes (Vasudev, 2016). The sensory and cognitive inputs received from the manas are usually in the form of experiences and impressions that are then stored as memories by the Chitta. There are a number of experiences and impressions that remain dormant in this part of the mind (i.e., the Chitta). When the Chitta is not coordinated with the manas, the experiences and impressions urge the manas to act on the wants associated with the external world that may not be beneficial (Vasudev, 2016). However, people can train the Chitta by simply witnessing the experiences and impressions that may arise in front of the manas and understand that when they choose to just witness the emotions, thoughts, sensory inputs and experiences, and impressions, they slowly recede back into the Chitta (Vasudev, 2016). The last dimension is ahamkara, from which a person gets his or her sense of identity; it is commonly known as the ego. The nature of ahamkara is to separate oneself from the Brahman (the universe) and identify with the experiences and impressions in the Chitta

(Vasudev, 2016). However, by heightening the awareness of the Chitta, people can diminish the discriminatory quality of the buddhi and see themselves as one with the universe. When an individual is able to do this, the psychological illusion is replaced by existential reality.

The concept of self is also explained in Upanishads. The Vedas comprise 12 Upanishads that explain different stages of thought development that are related to experiential reality. Out of the 12, the Mandukya and Taittiriya Upanishads have significantly contributed to the concepts of consciousness and personality. Humans consist of five layers or five bodies: (a) annamayakosha (food layer), (b) pranamayakosha (vital air layer), (c) manomayakosha (mental layer), (d) vignanamayakosha (intellectual layer), and (e) ananadamayakosha (bliss layer; Manickam, 2013; Srivastava, 2012). Vasudev (2016) explained that these are not mere layers but a powerful tool that can help people tap into higher levels of reality. The layers are commonly referred to as mind, body, and soul. The first layer is made up of food, which essentially means the body is made up of the food the person eats. Thus, a person is a sum total of the foods he or she has eaten over the years (Vasudev, 2016). The next layer is manomayakosha, which is essentially the mental layer. The mental layer is associated with intelligence and every cell in the body has its own intelligence; intelligence is not restricted to the brain. Therefore, any changes happening in the mental layer will cause a change in the physical body and vice versa. The physical problems occurring as a result of chemical changes in the mind are viewed as psychosomatic illnesses (Vasudev, 2016). The next layer is the invisible layer known as pranamayakosha, and is the backbone of the previous two layers. The meaning of this layer can be derived from part of the word "prana," which

means breath. If this layer malfunctions, the other two layers will also have problems and the end of this layer means the other two layers will also cease to exist. Thus, there is much emphasis on balancing the pranamayakosha (Vasudev, 2016). The balancing act is a pathway to a disease-free mind and body. The next layer is called vignanamayakosha, also known as the etheric layer. This layer is beyond the perception of the five senses. It connects the physical body to the non-physical body and through spiritual practices it can be accessed when the person is in a state of heightened awareness or increased consciousness (Vasudev, 2016). The last of the layers is the ananadamayakosha. Ananda means “bliss” and bliss is one of the most underdeveloped koshas. Therefore, it is completely beyond perception. This layer is beyond the physical realm and when it is reached it is defined as a state of blissfulness (Vasudev, 2016). The goal is to maneuver through all these layers to attain self-realization and join one’s existence with that of the cosmos.

Indian Culture and Mental Health

Multiculturalism

The concept of *multiculturalism* by definition means the acceptance of a society comprising varied cultures. The ancient concept of “Vasudeva Kutumbhakam,” which literally means that the world is one big family, is a common practice in Indian culture. Based on this ideology, India has become a perfect blend of varied cultures, sub-cultures, languages, religions, castes, and belief systems (Dominic, 2016). Dr. Pattanakayak, a social scientist, reported there are about 3,000 languages; 4,600 castes and communities; and 4,000 faiths and beliefs in India (Sukhdev, 2016). Even the boundaries of the states are determined by the local ethnocultural factors of the state so as to preserve the culture

of that state (Sukhdev, 2016). Despite Hindi being the national language, there are hundreds of languages with different dialects and origins in India. One might expect that diversity would be celebrated and honored among Indians but the diversity in India can be a double-edged sword. On one hand, citizens are tolerant of such ethnic and racial differences, and on the other, diversity has stratified the social structure much to the dismay of minorities (Yarram & Shetty, 2014). The multicultural atmosphere is also a cause of discrimination and animosity among social groups (Dominic, 2016). Culture plays a major role in shaping behaviors, patterns of thinking, and ways of living and how Indian people relate to other people in the world. Thus, the understanding of mental health in the context of this multicultural diversity is complex and different as compared to Euro-American culture.

With such diversity, the presentation of common mental disorders will differ and will not fit the criteria listed in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM–5*; American Psychiatric Association, 2013). With such diversity, it is apparent that the application of the gold standard for assessing psychopathy will have limited success in India. As the Euro-American style of counseling is generic in its approach, it is not surprising to find literature criticizing this approach. Indian mental health professionals have made some efforts to tailor some of the existing assessment measures according to the Indian population to increase their cultural sensitivity (Chadda & Deb, 2013). Thus, it is important to take into consideration the role of culture in understanding mental health issues in India.

Collectivism

The structure of Indian families remains collectivist in nature. In Indian families, *collectivism* essentially means living together and helping each other grow emotionally, financially, and spiritually (Chadda & Deb, 2013). Family members living together share household responsibilities as well as earning responsibilities. Usually, women marry and live with the groom's family. Indian families usually have stereotypical gender roles as women take care of the kin and the house whereas men earn the money. Sometimes when men run family businesses, the source of funding is also shared and used for the common good of the family (Chadda & Deb, 2013). At the crux of this living arrangement is the value of interdependence, which originates from mutual trust and loyalty.

Chadda and Deb (2013) pointed out the distinct aspects of collectivism, namely horizontal and vertical, that provide more structure to Indian families. *Vertical collectivism* is responsible for determining the hierarchical structure and with whom the power lies; usually, it is in descending order starting with the oldest member of the family. *Horizontal collectivism* is responsible for collective decision-making, which is usually equally determined by members of the same generation. These structures are sometimes harmful to the individual family members because they are too rigid and suppress individual identities and voices. This is especially true when it comes to gender roles because the collective decision does not always take into account the views and opinions of women. The allocation of resources and support is sometimes not uniform within families and those at the lesser receiving end live with the inequality without addressing the issue (Chadda & Deb, 2013). In light of the power differential and the

inability of some to freely express their views, the expression of mental issues often occurs in the form of somatoform disorders. Families absorb a lot of learning from their social environment and instill these values in their family members (Chadda & Deb, 2013). Thus, the functioning of a family member is a result of the sum total of learning he or she has acquired over the course of his of her life from family members.

For more than a decade, India has witnessed rapid economic growth and, as a result, a great number of families have adopted a nuclear family setup (Sinha, Sinha, Verma, & Sinha, 2001). This has disturbed gender roles, marital roles, and the traditional value system in Indian society. These changes are seen as a cause of mental problems and there has been a rise in a unique set of problems that did not exist until a few years ago, such as those related to women trying to balance jobs and households and there being a lack of experienced older members to raise children. From a therapeutic point of view, addressing familial support in treating those with common mental disorders is important because Indian families are able to provide resiliency and support (Sinha et al., 2001). In fact, the prognosis of schizophrenics in India is much better as compared to developed nations as a result of the collective structure of Indian families. There is also a provision in the mental health care bill to include family members with regard to the treatment and hospitalization of the mentally ill (G. P. Rao et al., 2016). Individualism is an inevitable part of changing India. It is good to evolve with the changing times, though forgetting one’s roots and accepting the values espoused within other countries can result in a loss of identity of not only individuals and families, but also of the nation as a whole. Therapy services should, therefore, focus on helping individuals find a balance between two different ways of living (i.e., collectivism and individualism).

Casteism

Understanding the caste system in India is important because those belonging to a lower caste experience more mental turmoil (Pal, 2015). They experience oppression and violence when they violate caste-based norms. The caste system negatively affects the social identity of those belonging to the lower caste. The Varna system or the caste system is a method of social stratification that was created to cluster humans into a horizontal hierarchy based on their cognitive capabilities (Jogdand, Khan, & Mishra, 2016). The Varna system mainly included four types of castes: (a) the Brahmins, (b) the Kshatriyas, (c) the Vaishyas, and (d) the Shudras. The Brahmins usually served as priests and scholars and were employed in places that required higher literacy and intellectual functioning. The Kshatriyas belonged to the warrior class and served as protectors and fighters as they possessed bravery and artillery skills. Those who worked in import, export, owned businesses, or were merchants by profession were categorized as Vaishyas. The Shudras were essentially the labor class and were categorized as such because they were experts in manual labor. Finally, there was a separate category of people who worked in the hygiene and sanitation department known as Dalit, or the untouchables. As societies evolved, these social hierarchies became vertical and the Brahmins were at the top of the social hierarchy whereas the Dalit were at the bottom of the social stature (Jogdand et al., 2016). The Indian society considers the Brahmins to be upper caste and the Dalit to be the lower class (Jogdand et al., 2016). The Indian population has suffered at the hands of this rigid and crude caste distinction because Indians discriminate among themselves, which gives rise to inequality and injustice. The caste system causes problems with marriage, employment, right to services, and

education. Even the political system is gripped by the caste because elections run by political parties rely heavily on the support of certain castes to win elections (Jogdand et al., 2016). Keeping in mind the years of unjust practices faced by lower caste people, the Indian government has made reservations and quotas for lower castes to provide them with opportunities in higher education institutions and government sectors. It is unfortunate that such practices prevail because opportunities in India are not based on merit. Based on the caste system, deserving candidates do not get opportunities and those who are less deserving occupy important positions. Efforts to demolish the caste system by the Bharatiya Janta Party (BJP) were met with much resistance because the lower caste people would then lose their reservations and the upper caste people would lose their societal influence and power (Jogdand et al., 2016). Thus, this system continues despite so much progress and globalization.

Religion

Religion is an important aspect of life, not only in India but across the globe. Secularism in India led to religious freedom, and Hindus follow a number of religions based on thousands of Gods and Goddesses. Religion affects ways of living, beliefs, traditions, and customs (Behere, Das, Yadav, & Behere, 2013). The concept of karma in Indian religion has a direct impact on how people feel and act. It is believed that the results of bad karma carry forward into the next life and so karma is a deterrent to negative actions among Hindus (Avasthi, Kate, & Grover, 2013). Religious practices prohibit the consumption of alcohol and drugs and overindulgence in sex, and weigh heavily on morality and values (Behere et al., 2013). These teachings, though in the name of God, act as buffers against mental health problems. The flip side of religious

practices is that they can instill false beliefs and superstitions in minds of the ignorant. People who blindly follow religion fail to look at some practices objectively and cause more harm to society than good (Behere et al., 2013). There have been a number of instances where religious prescriptions attracted people more than medical and professional help. Religion is the enemy of mental health when it comes to treating the mentally ill. Under the pretext of relieving people from their bad deeds, religious leaders and faith healers perform rituals that are not only superstitious, but also a money-making practice (Avasthi et al., 2013). Those who believe that whatever is happening in their life is controlled by something external, such as God, are more likely to fall prey to religious practices and are less likely to seek mental health services. However, it does appear that mental health professionals can use religious teachings in therapy to not only build a working alliance, but also explain concepts related to mental health in a way that is more acceptable to clients (Avasthi et al., 2013).

Spirituality

Spirituality in ancient India was not a separate profession, but a way of living and being for humans. As times changed, spirituality lost its importance because it became immersed in religion and politics and rulers emphasized religion more than spirituality as it gave them an agenda with which to conquer and rule. The concept of self-realization is the essence of spirituality (Srivastava, 2010). Self-realization implies that people develop a greater awareness by exercising the consciousness to come to an understanding that they do not exist in isolation and are a part of a higher self, and that higher self is the Brahman (universe), which encompasses all the human beings on this earth (Srivastava,

2010). An individual can achieve self-realization by mastering the ego and all five senses.

Gender Inequality

Most Indian families adhere to traditional gender roles because, unlike in high-income countries, most women in India continue to live as housewives. The traditional role of women in India was suitable during the previous generations where there was a clear-cut division of labor and less need for women to work and earn money. For centuries, women were raised to raise their families and to be subordinate to their husbands (Marrow, 2013). Women play a major role in the upbringing of their children and extended household. However, in light of the rapid changes in society, the roles of women and men have changed drastically. It is unfortunate that women who have now started becoming independent in their thought continue to experience discrimination and suppression because of the very apparent power differentials in society. Practices of suppression and discrimination prevail because the larger mindset is that no matter how much women can progress or compete with men, they will always be inferior (Marrow, 2013). It will be challenging to change this attitude because women also encourage and agree with this attitude. A lack of education about gender equality and gender-based rights oftentimes clouts the minds of ignorant people (D. Rao, Horton, & Raguram, 2012). Gender inequality stems from the fact that women are considered to be a burden and a liability. Archaic practices such as dowry, female infanticide, and the desire for male heirs play major roles in perpetuating gender inequality. Thus, women who experience serious injustice on a daily basis are more likely to form mental disorders. Even the research statistics show that more women develop common mental disorders

than men and are more likely to commit suicide in India than men (D. Rao et al., 2012). The role of mental health professionals in such matters is to advocate for fair treatment and encourage women to stand up against discrimination. It is also important to teach families to view women as separate individuals with separate identities and to not underestimate their contributions to the family.

Current Mental Health Needs in the Indian Population

The mental health needs within India are varied and many. Epidemiological surveys demonstrate the lifetime prevalence of mental illness in India is around 7.3%, and India bears an estimated 10.8% of the global burden of neuropsychiatric disorders (Thirunavukarasu, 2011). Despite efforts made by the District Mental Health Program (DMHP), some of the most fundamental infrastructure needs, such as hospital beds, mental health clinics, and mental health workers, are either scarce or not well maintained. The National Human Rights Commission reported that even today, poor mental health hospital conditions exist as patients are kept in unclean and unhygienic rooms, some mental health hospitals do not have restroom facilities, and patients follow barbaric practices such as shaving their heads and staying in closed cells. The ratio of available hospital beds is 1:1.4, which translates into a majority of mentally ill individuals sleeping on hospital floors (Thirunavukarasu, 2011). In terms of resources, there is an unbalanced distribution of services and uniformity in the availability of resources is imperative. Chronic illnesses such as bipolar disorder and schizophrenia have greater ramifications in the long term. During the acute phase of these illnesses, antipsychotic medicines help. However, once the conditions are stabilized, there is great concern for the management of social skills and cognitive functioning of such patients as there is a shortage of long-term

care and rehabilitation services (Chavan & Das, 2015). Thus, the development of rehabilitation care is equally necessary. A large population of India succumbs to suicide annually but incidents are reported less often because, until recently, suicide was considered to be a crime in the eyes of the law (G. P. Rao et al., 2016). The high prevalence of suicide occurs as a result of various factors and rates vary according to age groups. Additionally, other common mental disorders such as anxiety, depression, substance abuse, domestic violence, and mass trauma are occurring more than ever before and require urgent attention.

Common Mental Disorders in India

Suicide

Suicide is controversial in India because there are legal implications for those attempting suicide. The recent change in the mental health care bill of declaring suicide as a mental illness may have given some people some relief; however, it cannot be forgotten that for a long time the Indian government viewed suicide as a punishable crime. According to Patel et al. (2012), the World Health Organization reported an estimated 170,000 people in India annually commit suicide. In light of the stigma and political and societal factors, there is conflicting information on suicide and the statistics vary. Among low-income countries, India and China alone account for 49% of suicides (Rane & Nadkarni, 2014). The reasons for committing suicide remain unclear. However, some of the possible risk factors include gender, single status, low education, and having a mental illness such as mood disorders, alcohol/substance abuse disorders, and personality disorders (Rane & Nadkarni, 2014).

In comparison to high-income countries, in low-income countries, substance abuse is the leading cause of committing suicide and mood disorders, such as depression, are the least important factor in suicide. The most common way to commit suicide is to ingest agricultural pesticide, followed by hanging, burning, drowning, and other methods (Patel et al., 2012). Suicide rates are also higher in rural areas as compared to urban areas as there is easy access to agricultural pesticide and a scarcity of mental health services (Patel et al., 2012). Additionally, rates are higher among younger adults age 20 to 29 and there are studies to support that more young women commit suicide as compared to young men (Rane & Nadkarni, 2014). The higher rate of younger women committing suicide is attributed to the fact that women experience abuse and harassment in their marriages because of dowry demands, they are suppressed, and they are often forced to stay in abusive relationships (Rane & Nadkarni, 2014). Among older adults, more men commit suicide as compared to women (Rane & Nadkarni, 2014). Ironically, in a nation where the population is in the billions and the society is largely collectivist, the research supports that psychological stressors, such as an absence of networks and social support, contribute to suicide (Rane & Nadkarni, 2014). Other psychological stressors include conflict with a spouse or family members, extramarital affairs, domestic violence, academic difficulties, legal problems, and chronic illnesses (Rane & Nadkarni, 2014). Suicide is a serious public health concern and efforts to help the suicidal population are past due. Keeping the risk factors in mind, one intervention could be to prohibit the use of pesticides by the general public. The use of pesticides should follow strict guidelines such as the production of a certificate for agricultural use, age limit, quantity purchase limit, safety instructions, and education about the potential lethality of pesticides. There

is also a strong need to open crisis intervention centers. Additionally, aggressive educational campaigns should be periodically conducted with an aim to destigmatize suicide, spread awareness about suicide being a mental health problem, and encourage the public to seek help if they are contemplating suicide.

Depression

There is considerably more research in the area of depression as compared to other mental disorders. The prevalence of depression in India has varied from 7.8 to 8.9 per every 1,000 people (Grover, Dutt, & Avasthi, 2010). The lifetime prevalence of depression is 2% to 15% and it is one of the leading causes of mental health burden in India (Jonas et al., 2014). There is some discrepancy regarding the prevalence of depression in urban versus rural areas, with some reports supporting that depression is more prevalent in urban areas. Twice the number of women as men are depressed in India (Poongothai, Pradeepa, Ganesan, & Mohan, 2009). Women who are in difficult relationships, experience domestic violence or rape in relationships, or have female newborns are more prone to experiencing depression (Grover et al., 2010). The major depressive disorder is common among the geriatric population who also reside in rural areas (Grover et al., 2010). The higher prevalence of depression in the geriatric population occurs because they are more likely to experience death, financial problems, and loss (Grover et al., 2010). Depression is also comorbid with suicide, substance abuse, schizophrenia, and anxiety disorders. The etiology of depression includes biopsychosocial factors such as low social status, unemployment, lower education, living alone, and increasing age. Somatization of symptoms of depression, especially pain, is a

common phenomenon among Indian clients. Other somatic symptoms include insomnia, hypochondriasis, gastrointestinal symptoms, and genital symptoms (Grover et al., 2010).

Some researchers have reported that guilt occurs in depressed clients but others, such as Venkoba Rao, believe guilt is a consequence of depression (Grover et al., 2010). Some clinical studies in which the researchers compared depression in children and adults showed children exhibit more somatic symptoms and adults exhibit cognitive and behavioral problems (Grover et al., 2010). The symptom presentation of depression differs in the Northern Indian culture because people report anhedonia, impairments in social functioning, reduced self-confidence, and sleeping and eating problems (Grover et al., 2010). A great number of clients, especially women, perceive depression as a result of the will of God, fate, weakness of nerves, evil eye, bad deeds, and family problems (Chakraborty, Das, Dan, Bandyopadhyay, & Chatterjee, 2013). Women are also more likely than are men to attribute symptoms of depression to supernatural causes. Clients living in urban areas are more likely to attribute loneliness as a cause of depression. With rapid urbanization, the family structure has drastically changed and people reside away from their extended families. The breakdown of large families into nuclear families is likely a reason for loneliness that later becomes a cause of depression. Karma-deed-heredity is another major belief that is reported as a cause of depression (Chakraborty et al., 2013). This concept entails that one's actions and deeds are automatic and are not controllable, and therefore cannot be changed. Overall, even though the rates of prevalence vary, psychosocial factors are mainly responsible for the onset of depression (Grover et al., 2010). Unfortunately, because there is a scarcity of mental health professionals and despite the integration of mental health into primary care, surveys in

India show a large proportion of adults are not formally diagnosed and depression is largely self-reported (Bishwajit et al., 2017). However, depression can be easily treated with cost-effective medications and simple psychological interventions.

Anxiety

Results of meta-analyses using a large number of epidemiological studies indicated neurotic disorders or anxiety disorder account for 20.7% in India, out of which phobia accounts for 4.2%, generalized anxiety disorder (GAD) for 5.8%, obsessive compulsive disorder (OCD) for 3.1%, and hysteria for 4.5% (J. K. Trivedi & Gupta, 2010). Some commonly used terms to conceptualize symptoms of anxiety among rural populations include uljhan (anxiety), chir-chira paan (annoyance), gussa (anger), and kamzoree (weakness; Jain & Jadhav, 2009). The symptoms of anxiety are more prevalent among women as compared to men and also more in rural as compared to urban areas (J. K. Trivedi & Gupta, 2010). However, this difference is largely related to the fact that rural people tend to shy away from discussing their mental problems and urban people are more open to discussing mental illness (J. K. Trivedi & Gupta, 2010). With respect to GAD, clients have a tendency to somaticize their symptoms. Panic disorder is often times comorbid with GAD and the symptoms are less cognitive and more physiological, such as a fear of losing control and fainting (Khambaty & Parikh, 2017). Social anxiety disorder (SAD) has been studied and reported in adolescents as they report a fear of public speaking and a lack of interpersonal relationships with family and peers (Khambaty & Parikh, 2017). Clients with alcohol dependence have reported agoraphobia. Even though women are more likely to develop anxiety disorders, some anxiety disorders are unique to men, such as dhat syndrome and koro syndrome, and are

extreme manifestations of anxiety. Dhat syndrome is also commonly known as semen loss syndrome. It is estimated that almost 50% of the cases dealing with dhat syndrome have depression and 18% have an anxiety disorder (Khambaty & Parikh, 2017).

Dhat syndrome is best understood as the loss of semen during urination, masturbation, and sleep. It is a way for men who believe that semen loss is attributed to change in mood, cognition, and somatic symptoms to report distress (Khambaty & Parikh, 2017). Semen loss is a culturally relevant means to report distress and is often a subject of a cure for faith healers (Prakash, Sharan, & Sood, 2016). Another syndrome related to men's sexuality is koro syndrome, which is described as an acute fear of the possibility of the retraction of the penis into the abdomen that causes panic attacks and symptoms of anxiety. Koro syndrome is a cultural expression of anxiety in men and has been reported in Northeast India among migrant laborers who belonged to the poor class, who were in their 20s to 40s, and who were poorly educated (Khambaty & Parikh, 2017).

Schizophrenia

Although the prevalence of schizophrenia in India is only 4.6 per 1,000 individuals, the management of this disorder is complicated and demanding (Balaji et al., 2012). Several cultural factors are responsible for both the poor and positive outcomes associated with this disease. In order to manage schizophrenia, India may have an upper hand as compared to high-income countries because the collectivistic nature of the families allows for greater cohesion and distribution of caregiving among family members. However, cultural factors such as stigma and discrimination are not only prevalent in society but also among the family members who are responsible for caregiving and are counterproductive in terms of the management of this disorder

(Koschorke et al., 2014). Stigma prevails in society because patients also hold a negative view of their illness. Balaji et al. (2012) studied these views and found the anticipation of negative experiences reinforced stigma factors among persons with schizophrenia (PWS). Often times, PWS believe they are a burden on their family members, they will not be accepted by society, society will outcast them, and they will be subjected to cruelty, shame, and disrespect (Balaji et al., 2012). Research has supported the existence of such practices at present and in the past. For example, PWS are often physically and emotionally abused. Some are chained, tortured, and subjected to cruel practices by religious and faith healers, such as burning and beating PWS to please the gods (Dhanasekaran, Loganathan, Dahale, & Varghese, 2017). Superstitious beliefs regarding auditory and visual hallucinations are that they are punishments by the God and Goddesses. Thus, the cycle of negative reactions by society and the negative view of the illness in patients' minds reinforce the stigma and discrimination, and the poor outcomes of schizophrenia perpetuate.

Women suffering from schizophrenia are more likely to be divorced or separated; this is a matter of grave concern because divorce is looked down upon and is considered socially unacceptable (Koschorke et al., 2014). Men who suffer from schizophrenia are more likely to be unemployed (Koschorke et al., 2014). The outcome of schizophrenia is even poorer in rural areas as a result of low income, lower education, poor medication compliance, and limited access to services. Some studies have shown the integration of spiritual and religious practices in addition to medical care leads to better treatment outcomes for schizophrenics (Dhanasekaran et al., 2017; Koschorke et al., 2014). Usually, a delay in receiving medical help occurs because people first resort to religious

practices, as they do not understand the medical and psychological etiology of the disorder. Family members feel the burden of caregiving because of the difficulty in managing aggressive behaviors, medication compliance, regular availability of drugs, and lack of governmental support after the passing away of family members (Jagannathan et al., 2011). Thus, there is a great need to combat the stigma and discrimination to ensure better outcomes for those dealing with this debilitating disorder.

Substance Abuse

Substance abuse is a growing concern in India not only among men but also among women and young children. The drug abuse epidemic has been rising since the 1980s (Dhawan, Rao, Ambekar, Pusp, & Ray, 2017). Alcohol is the most commonly abused substance followed by cannabis and opioids (Murthy, Manjunatha, Subodh, Chand, & Benegal, 2010). Epidemiological studies show the national prevalence of substance abuse is 6.9 per 1,000 in urban areas and 5.8 to 7.3 per 1,000 in rural areas (Murthy et al., 2010). The prevalence of substance abuse among men is 11.9% and among women is 1.7% (Murthy et al., 2010). It should be noted that the largest epidemic of substance abuse is occurring in the state of Punjab, as almost half of the population in Punjab is addicted to drugs (Basu & Avasthi, 2015). A large proportion of youth in Punjab have also fallen victim to this epidemic. Reportedly, a study conducted in one of the colleges of Punjab showed young men are more likely to consume substances because of easy availability, social status, and peer pressure, and use them for the enhancement of sexual pleasure and to reduce stress (Gupta, Sarpal, Kumar, Kaur, & Arora, 2013). Large quantities of drugs are also notoriously smuggled into the state of Punjab. Substance abuse has resulted in deaths, loss of family, and loss of employment (Basu & Avasthi,

2015). Sharma, Sharma, and Barkataki (2016) conducted a study in New Delhi to examine criminal behavior among juveniles and substance abuse, as there is a known relationship between drug use and violence and such a relationship has been observed in children who use drugs. Delhi has witnessed an increase in crimes such as rape, burglary, and murder, and the responsible parties are mainly juveniles consuming substances such as cannabis, opioids, and inhalants (Sharma et al., 2016).

Poverty-stricken areas, or slums, have a different set of sociocultural dynamics that make them more prone to substance use, as sometimes they have no access to basic amenities and children engage in child labor, whereas adults are non-skilled and have low employment (Ghulam, Verma, Sharma, Razdan, & Razdan, 2016). Results of a study conducted in the capital of Madhya Pradesh showed the most common forms of substance abuse were tobacco and gutka (non-tobacco panmasala), at 53.9% (Ghulam et al., 2016). Other substances were alcohol (46.5%), cannabis (8.9%), sedatives and hypnotics (2%), opiates (4.9%), solvents (1%), and cocaine (0.1%; Ghulam et al., 2016). These rates are much higher in slum areas and have greater implications for public health. Studies have also shown that a family history of substance abuse, harsh socioeconomic environments, and neglect in childhood are important factors to consider when it comes to substance abuse (Sharma et al., 2016). The rules and regulations regarding substances vary and only some states have stringent requirements. The Indian government's approach to managing this issue can be grouped into three main categories: (a) supply reduction, (b) demand reduction, and (c) harm reduction (Basu & Avasthi, 2015). Supply reduction is employed via appropriate policies and procedures, whereas educating, treating, and rehabilitating those in need address demand reduction. Finally, harm

reduction is primarily focused on reducing the spread of HIV among those who inject drugs, a process that is handled by the National AIDS Control Organization of India (Basu & Avasthi, 2015). Despite the existence of laws and policies, drugs are easily available to the general public. This calls for stricter guidelines that are uniformly implemented nationally. The treatment of substance abuse is more focused on providing inpatient care and little attention is given to outpatient centers, community mental health centers, and primary health care clinics. Much like non-governmental organizations developed in response to the treatment gap, drug de-addiction centers were created in response to the limited reachability of the Ministry of Social Justice and empowerment for substance abuse problem.

Domestic Violence

Domestic violence in India occurs as a result of social injustice and social inequality. The pattern of domestic violence is intergenerational and is considered a rightful action on behalf of the perpetrators. From a patriarchal point of view, this mainly means that if women do not adhere to the traditional role of being the primary caregivers, their roles in society are subject to scrutiny. Unfortunately, regardless of women adhering to their traditional roles, many deal with physical, emotional, sexual, and financial abuse frequently. The implications of domestic violence are far-reaching and have resulted in years of mass humiliation, frustration, and suppression among Indian women. The stigma associated with domestic violence has prohibited women from being able to reach out for help and to realize that domestic violence is not normal (Sabri, Sanchez, & Campbell, 2015). Domestic violence occurs behind closed doors mainly because family respect and pride are at stake. In South Asia, the prevalence of domestic

violence is somewhere between 30% and 61%, but this is not an accurate measure of domestic violence as it is underreported (Rood, 2015). Two out of every five married women report experiences of domestic violence (Kalokhe et al., 2016). Harassment for dowry is the most common form of violence that married women experience (Sabri et al., 2015). The tradition of paying the groom's side in cash or kind is customary and sometimes mandatory in many Indian households. When a bride's parents are not able to live up to the expectation of the dowry amount, she can suffer some negative and sometimes life-threatening consequences that often take the form of emotional and physical abuse by her husband and in-laws. Reports of women being tortured, humiliated, burned, poisoned, and removed from the home are all too common. Other reasons for domestic violence include infertility or the inability to bear a male child (Kalokhe et al., 2016).

Women do not always get help for domestic violence because seeking legal help is an unsafe and complicated task. Case studies revealed police personnel do very little to help the victims and actually subject the women to more harassment (Rood, 2015). The idea of dealing with the law is traumatic for victims. Thus, women rely more on neighbors, in-laws, and parents to help with such matters (Rood, 2015).

Some studies have shown that higher incomes and education levels between both spouses can serve as protective factors against domestic violence (Koenig, Stephenson, Ahmed, Jejeebhoy, & Campbell, 2006). Women experiencing abuse in their relationships are more likely to have mental health problems, gynecological problems, and sexually transmitted diseases such as HIV (Kalokhe et al., 2016). Additionally, they may experience medical problems such as malnutrition and asthma (Kalokhe et al.,

2016). Similarly, children of such women are more likely to have malnutrition, asthma, lower vaccine coverage, and early mortality (Kalokhe et al., 2016). A statistical survey on suicide cases of women revealed women who are victims of domestic violence are 2.44 to 2.60 times more likely to attempt suicide than are those who do not experience domestic violence (Sabri et al., 2015). Several factors, such as the pressure to sustain abusive marriages for the sake of children and family respect, abusive in-laws, financial dependence, and unreasonable dowry demands contribute to the higher rate of suicide among Indian women. Therefore, domestic violence is a major safety concern for Indian women.

Ironically, the Indian government sees equality as a fundamental right and mandates the prohibition of gender-based discrimination. More than 50 laws have been enacted to curb domestic violence and the injustice done to Indian women (Ghosh & Choudhuri, 2011). However, the laws have had a limited effect when it comes to changing the patriarchal mindset within Indian society. To compensate for this limitation, another law, the Protection of Women from Domestic Violence Act (PWDVA), was passed to not only punish the offenders but to ensure the protection of women and their children (Ghosh & Choudhuri, 2011). The PWDVA has a lot of positive aspects, such as speedy legal proceedings and easy case filings to bring justice to battered women (Ghosh & Choudhuri, 2011). Unfortunately, those working in the government do not understand the law and it is not uniformly implemented. It seems women in urban areas are aware of this law but women in rural areas are not educated about this law (Ghosh & Choudhuri, 2011). There is still a great need to educate women about their rights and support them openly so more women can seek governmental

assistance. The government should deal with domestic violence as a mental health issue and victims as well as offenders should be encouraged to seek mental health services because domestic violence is a problem related to the deeply ingrained patriarchal mindset.

Mass Trauma

India is affected by both natural and man-made disasters, though the effects of these types of disasters on mental health are different. Over the course of several years, India has experienced natural disasters such as tsunamis, earthquakes, cyclones, and droughts (Kar, 2010). On the other hand, man-made disasters such as the Bhopal gas tragedy, communal violence in Gujarat and Mumbai, and terrorist attacks on Kashmir have contributed significantly to mass trauma and affected thousands of people mentally, emotionally, physically, and economically (Kar, 2010). Research on mass trauma demonstrates that natural disasters have fewer negative repercussions as compared to man-made disasters (Kar, 2010). The most vulnerable and affected populations are children, adolescents, and the geriatric population. The victims, as well as extended family members, neighbors, and rescuers, experience the ill effects of disasters on mental health. Those who have experienced natural disasters are reported to suffer from posttraumatic stress disorder (PTSD), major depression, generalized anxiety disorder (GAD), and panic disorders (Kar, 2010). As a result of natural disasters, victims suffer displacement, loss of property, and loss of family members. In this situation, the main role of the government is to provide food, clothing, and shelter. It has been noted that, generally, the government provides a lot of aid during the initial aftermath of a disaster, though these efforts decline with time (Vijaykumar, Thara, John, & Chellapa, 2006). The

need for mental health services is greatly felt in these situations but victims usually rely on each other and community support to recover from such incidents. Nevertheless, there has been increased involvement of psychiatrists in terms of rehabilitating victims or even providing electroconvulsive therapy for those who experience psychosis as a result of trauma.

Regarding man-made disasters, mass killing, which leads to mass trauma, has occurred in the name of religion and politics. Innocent people who have nothing to do with the matter are killed or caught in the crossfire. The widely known communal violence among Indians occurs as a result of a long history of animosity between the Hindus and the Muslims (Vishwambharan & Priya, 2016). Qualitative studies conducted with victims of the Gujarat riots demonstrated lifelong effects as people were forced to change their religious identities just for the sake of survival. The first-hand accounts of victims of the Gujarat riots who endured extreme violence revealed some horrific truths (Vishwambharan, & Priya, 2016). The victims witnessed killings in the form of the burning and stabbing of family members, rapes, murders, ripped wombs of pregnant women, and setting of fires (Vishwambharan & Priya, 2016). A number of victims of the Gujarat riots were forced to flee their homes. Muslims residing in Gujarat were denied jobs and their businesses suffered because others in their communities were reluctant to have any ties with them (Vishwambharan & Priya, 2016). The victims lived in constant fear and distress. The communities and the political system reinforce the perception of being hated, considered evil, and acute experiences of social prejudice and injustices. PTSD alone is not sufficient to understand the symptoms and functioning of these victims because the damage done is deeper than at individual level.

Kashmir is at the heart of the major political conflict with the neighboring country, Pakistan. Kashmir has gone from being one of the most beautiful states in the country to one of the most dangerous places to live in India. Terrorist activities such as bomb blasts, shootings, abductions, and torture have forced Kashmiris to live under extraordinary circumstances (Hassan & Shafi, 2013). Over the years, a large number of Kashmiris have been displaced and now the scenario of the state is such that there are more militants residing in Kashmir than there are civilians. Mental health professionals have reported that since 1989, the number of trauma cases has increased tenfold (Hassan & Shafi, 2013). A large number of people suffer from acute stress, anxiety, and psychosocial problems such as substance abuse. Kashmir has the highest suicide rate (Hassan & Shafi, 2013). It is difficult for people to recover from mental disorders because they live in chaotic environments devoid of peace. People mainly rely on physicians who prescribe them antidepressants and tranquilizers for quick relief. It seems that faith and God, though superstitious, are major coping resources and known psychiatrists like Dr. Mustaq Margoob proclaim that their job in the Kashmir community is more of a faith healer than a doctor (Hassan & Shafi, 2013). In places like Kashmir, where mass trauma occurs on a daily basis, it is important to establish community groups for therapy because collectivist efforts can be much more powerful and effective as opposed to individual therapies. Moreover, it appears there is low awareness among people regarding trauma and the mental effects of such traumatic conditions. Thus, awareness campaigns about mental health to educate the public and active efforts to provide mental health services are desperately needed.

Alternatives to Psychotherapy in India

Yoga

Yoga and meditation have recently received increased attention from professionals in the health industry. Both yoga and meditation come under the umbrella of spirituality. In recent times, the general population has used these ancient tools for mind–body wellness merely as forms of exercise (Khalsa, 2013). Though the Euro-American culture only realizes the physical and physiological benefits of these practices, Indians devised these measures as a means to increase consciousness and the physical benefits were a byproduct. Yoga is a science of body postures and breathing techniques known as asana and pranayama, respectively. Scientific studies on yoga show that yoga helps alleviate symptoms of anxiety, depression, and schizophrenia (Khalsa, 2013). Additionally, it is known to help with mood and emotional irregularities, cognitive functioning, and stress reduction (Khalsa, 2013). It is apparent through the results of scientific studies that yoga is useful in treating mental anomalies. However, yoga cannot replace medication and in modern times can work as a preventative measure. In a time when people are searching for quick fixes and fast relief, yoga requires a level of dedication and patience to experience its effects on mental health. Therefore, yoga should be used as a coping tool for well-rounded treatment.

Meditation

Meditation is commonly known as mindfulness. Iqbal, Singh, and Aleem (2015) reported there are two other types of meditation known as concentrative and dynamic meditation practices. Different meditation practices differ in their methods and goals. The aim of meditation is to achieve a higher level of consciousness to explore those

dimensions that are ordinarily not known to humans, ultimately leading to self-realization. The practice of concentrative meditation includes concentrating on the here and now by maintaining focus on the breath. The practice of here and now leads the individual to focus on the present and this practice lowers mind wandering (Iqbal et al., 2015). A great benefit of meditating can be seen with depressed clients because meditation reduces the tendency to ruminate and worry about the future. The practice of mindfulness meditation has several variations where an individual can focus on objects, use the five senses, use the breath, or even engage in mantra chanting (Iqbal et al., 2015). The third type, which is active/dynamic meditation, involves a series of steps that starts with heavy breathing and ends with the deliberate expression of emotions (Iqbal et al., 2015). Osho, a spiritual leader, believed catharsis was important for the resolution of unprocessed feelings and only then could an individual achieve a meditative state. Human beings experience pain and pleasure as a result of the give and take with the external environment (Iqbal et al., 2015). The external environment influences people as they remain entangled in the worldly nuances and it becomes difficult to achieve self-realization. Yoga and meditation are practices to minimize the influence of the environment on the mind and build the resiliency to ultimately achieve a neutral state of mind that is not affected by the outside world (Iqbal et al., 2015). In this way, people can achieve mastery of the mind and alter the state of consciousness. Scientific studies on subjects practicing meditation have shown that meditation helps in personality integration, builds resiliency, improves attention and awareness, and leads to better control of actions and enhanced perception (Iqbal et al., 2015).

Ayurveda

Ayurveda is as old as the Vedas and Upanishads. Until modern medicine came into existence, Hindus derived a holistic cure for the mind, body, and soul from the ancient teachings of Ayurveda. Hindus know about the teachings of Ayurveda through Charak Samhita and Sushruta Samhita literature (Srivastava, 2012). The two ancient texts describe mental illness, different personality types, and the cure for mental illness. There are three important characteristics (gunas) used to describe human personality (Prakriti) and functioning: (a) sattva, (b) tamas, and (c) rajas. They are together known as trigunas in Ayurveda and different combinations of the gunas form different personalities (Srivastava, 2012). Sattva guna represents an ideal state of mind that is balanced, tamas guna represents a dull state of mind, and rajas guna represents a restless mind state (Srivastava, 2012). According to Ayurveda, the human body is made up of five dhatus or elements: fire, earth, water, air, and ether (Srivastava, 2012). These elements combine to form three doshas or humors known as vatta, pitta, and kapha (S. Kumar & Nathani, 2014; Srivastava, 2012). Any change in the doshas will affect the three gunas as they are the psychological correlates of the doshas. If all the doshas are balanced, then the mind and body will be healthy as well. Ayurveda teaches that alternation in the trigunas gives rise to mental disorders and alternation in the tridoshas gives rise to physical disorders (S. Kumar & Nathani, 2014; Srivastava, 2012). However, changes in mental states are also related to poor physical health and vice versa. Therefore, Ayurveda not only treats the symptoms but also recognizes the root cause of mental illness is biological as well as psychosocial factors. Ayurvedic treatment of the mentally ill prescribes changes to

biopsychosocial factors through various modalities, such as diet change, meditation, or yoga (S. Kumar & Nathani, 2014).

Naturopathy

Nathuropathic practice is based on the premise that the body has the capacity to heal from within (Ahmad et al., 2015). In rural areas of India, traditional medicine is more popular than allopathic medicine (Samal, 2014). At present, less than 30% of households use traditional healing systems (Ahmad et al., 2015). In rural areas, where people cannot afford allopathic medicines, the use of naturopathy is more popular because of its lower costs as well as the belief in the healing properties of natural prescriptions (Samal, 2014). The use of naturopathy is higher in Northern states mostly because of its origin and development in these regions. The Central Council of Indian Medicine has implemented AYUSH (Ayurveda, Yoga, Unani, Siddha, Naturopathy, and Homeopathy; Samal, 2014). Naturopathy comes under the umbrella of a program called AYUSH that trains, certifies, and encourages research, including in the field of naturopathy, to implement evidence-based healing practices. The government has tried to preserve the traditional medicine because misinformed people or people with little knowledge falsely present themselves as experts to generate business (Samal, 2014). This trend is also seen in the field of psychology. As there is a great awareness of traditional medicine among the rural population, it is feasible to integrate psychological services within traditional medicine. Despite there being a lack of primary health care centers, traditional medicine centers can definitely help promote the use of counseling services to those in need.

Euro-American Influence on India's Mental Health

Similarities and Differences Between the Paradigms

Some of the paradigms in Indian cultures, such as stages of living, understanding of thoughts, behaviors, and actions, and personalities, are similar to Euro-American models of psychology. Other areas, such as human functioning and the influence of the external environment, are understood differently in Indian and Euro-American cultures. Both cultures have divided human development into distinct stages of life. In Upanishads, stages of living were divided into four parts, each with a specific purpose and role. The first stage, the brahmacharya stage, is focused on attaining education and devoting one's life to preparing for the upcoming professional and social stages (Abhyankar, 2015). Then the individual graduates into the grihastha stage (householder stage). During this stage, men and women come together as a single unit to fill gender-appropriate roles and to run a household. Individuals live in pursuit of fulfilling material desires, extending kin, and fulfilling social duties (Abhyankar, 2015). The next stage is the vanaprastha stage (retired stage). During this stage, an individual is expected to take the role of an elderly and to oversee the upbringing of grandchildren and play an advisory role in the family. During this stage, an individual should accept the reality of aging and gracefully retire from materialism and the duties of the previous stage. Finally, the last stage is the sannyasa stage (renunciation stage), during which a person is expected to completely devote his or her life to achieving enlightenment (Abhyankar, 2015). This phase is especially important because Hindus believe in the concept of reincarnation. The cycle of birth and death continues until the individual successfully attains enlightenment. It is believed that people carry forward the karma of the past life and so

the way an individual's life takes shape is also partly influenced by how he or she lived in the previous life. This is the juncture at which Euro-American philosophy takes a U-turn. The Euro-American culture believes in the concept of going to hell or heaven depending on the deeds an individual has committed in the present life. Renowned psychologist, Erik Erickson, talked about eight stages of life that shape the personality of an individual (Karkouti, 2014). During each developmental stage, personality evolves but the roles of individuals are similar to those seen in Hindu culture with some variations. However, these roles are not followed rigidly in either culture, as family structures have changed and the roles and aims of families are fluid.

There are similarities in the teachings of the Bhagwad Gita and psychotherapy in modern times (Bhatia, Madabushi, Kolli, Bhatia, & Madaan, 2013). Some commonalities include the use of a conversational style, the therapist as a guide, the inclusion of psychoeducation, and modifying behavior. Cognitive behavioral therapy (CBT) works toward resolving the cognitive distortions that impair functioning. CBT also focuses on how the views of the self, others, and the world can affect functioning. Thus, it appears symptom alleviation is contingent upon addressing the person's view. Gita, a holy scripture, is a part of the famous epic Mahabharata (Bhatia et al., 2013). In Mahabharata, Arjun is the main character who is instrumental in winning the battle of good over evil. However, Arjun is in a great moral dilemma because his enemies are the army of his own brothers. Lord Krishna acts as a guide and advisor who helps Arjun with this dilemma. This whole explanation is in the form of a recital Bhagwad Gita. Arjuna worries about the outcome of the battle and becomes extremely anxious and worried. He imagines the death of his family members and feels guilty about fighting

and does not want to participate in the battle. Lord Krishna solves this impaired thinking by educating Arjun about the duties of a warrior and explains that experiencing worry is a transitioning phase. He reminds Arjun that action (karma) should take place without anticipating rewards or consequences. Krishna addresses Arjun's cognitive distortions by telling him that he should not attach to the consequences of any kind and action is in the service of the Lord. Krishna tells Arjun to free himself of the distorted view of the world by not focusing on imaginary things and understanding that he alone is not responsible for the death of his enemies, which addresses the personalization of the problem. Lord Krishna reminds Arjuna that by killing his enemies he is only destroying their bodies and their atmans (souls) will continue to exist, which remedies his guilt (Bhatia et al., 2013). Thus, Lord Krishna prepares Arjun for action while alleviating his symptoms of anxiety. Bhagwad Gita addresses Arjuna's dilemma by teaching him to change his thoughts, emotions, and actions (Bhatia et al., 2013). Although not completely similar, CBT revolves around a similar concept of bringing change in functioning by addressing thoughts, emotions, and actions.

Besides CBT, interesting approaches in Gita have equivalent concepts in other orientations such psychodynamic, interpersonal, and substance abuse therapies (Bhatia et al., 2013). The personality components of the id, ego, and superego are similar to the three gunas (i.e., rajas, tamas, and satvic) from Ayurveda and also mentioned in Gita. In Freud's psychodynamic theory, the unconscious mind consists of the id and superego and the conscious mind consists of the ego. The function of the id is to act on instincts and has an impulsive quality. The superego supports the morals and values learned from parents and society. Finally, the ego is the mediator between the id and superego and

modifies commands from both that are appropriate for situations. The constant conflict between the unconscious and the conscious generates stress (Bhatia et al., 2013). However, the evolved nature of the ego understands the demands of society and keeps the functioning of the id and superego in check. Personality is mainly determined by the unconscious mind (Bhatia et al., 2013). In Gita, the tamas guna's function is similar to that of the id because tamas represents self-centeredness and there is lack of regard for consequence. Rajas guna is representative of action and is reward seeking in nature, similar to the ego, and satvic guna is related to noble thoughts and action without expectation of reward. Similar to psychodynamic theory, stress occurs when the three gunas are in conflict with each other. In Gita, Lord Krishna emphasizes the satvic qualities in Arjuna because it is through these qualities that Arjuna can not only fight the battle, but also work toward the path of self-realization (Bhatia et al., 2013). In interpersonal therapy, one area of focus is role transitions, in which a person experiences distress when leaving previous responsibilities and transitioning into a new role (Bhatia et al., 2013). In Gita, role transition should take place without expecting rewards or worrying about the consequences and the focus should be on duty. Just as in interpersonal therapy (IPT), improving self-esteem aids in role transition. In Gita, Lord Krishna emphasizes the positive qualities of Arjuna, including purusharestra (noblest of men) and parmathapa (destroyer of enemies), among several others (Bhatia et al., 2013). The teachings of Gita can be compared to substance abuse treatment in the context of motivation. People dealing with substance abuse usually struggle with a lack of motivation to change their habit. Substance abuse treatment involves developing discrepancy, promoting self-efficacy, and following resistance to go from stages of pre-

contemplation to action (Bhatia et al., 2013). Lord Krishna, during the Gita recital, acknowledges that Arjuna understands the difficulty in gaining mastery over the mind and it can be achieved through hard work (Bhatia et al., 2013). Krishna uses this to point out the discrepancy in his actions as well as thoughts. Krishna tells Arjuna that he can gain mastery over the mind by practicing good sleep, nutrition, and yoga. Thus, he prepares Arjuna for action by instilling hope and promoting self-efficacy (Bhatia et al., 2013).

Applicability of Western Psychology

The framework of Euro-American psychology is largely different from Eastern thought because Eastern thought emphasizes a therapist taking the role of an advisor. Second, the largely collectivistic nature of society, though in a transitioning state, works on the collective conscious. Hence, it is difficult for the Indian population to remove themselves from the collective framework and solely work for their betterment. The Euro-American culture is capitalist and emphasizes growth through materialism. The Indian population, no matter how progressive, is still trying to find the meaning of life through spirituality and religion. In a greater perspective, the applicability of the Euro-American psychological model will remain deficient in treating the Indian psyche in light of the complexity and diversity in various aspects of life.

Psychological Training

Institutions for Psychology

Psychology in India is taught mainly at the undergraduate level. Courses in general psychology, applied psychology, and developmental psychologies were originally taught. Recently, universities have started offering courses in sports, cognitive, clinical,

rehabilitation, and counseling psychology (Yadav, 2017). Hardly any major public universities in India offer degrees in counseling and only a handful of private institutes, like Amity University, CARE, and Christ University, offer degrees such as MA, MSc, and MPhil in counseling (Yadav, 2017). Recently, there has been an increase in the number of institutes offering certificate and diploma courses in counseling psychology. Leaders in the field like Dr. Vikram Patel and Dr. Thornicroft have successfully implemented workshops to provide training to LHCs in diagnosing and providing entry-level counseling.

The counseling curriculum is devoid of a focus on the current sociocultural problems that exist in Indian society (Yadav, 2017). Most courses are taught to provide a basic understanding of disorders. The curriculum offered is obsolete and is highly based on Euro-American models with no reference to the indigenous methods largely prevalent in India.

Bodies Governing the Area of Psychology

There are a number of psychology institutions that are often associated with the universities. However, the institutions do not serve in the role of governing the profession of counseling and are instead focused on the development of academics. India does not have a licensing board or stringent requirements for practicing counseling. In India, the practice of counseling is not contingent upon licensure and there is no board that looks over the practice of counseling (Yadav, 2017). There is a regulatory board only for clinical psychologists called the Rehabilitation Council of India (Thomas & George, 2016). This explains the lack of supervised training. An assessment of the practical application of counseling is non-existent. Just like countries in the Northern

hemisphere, mainly women graduate with psychology degrees. It appears that completing a degree in psychology is merely a means of attaining an undergraduate degree. Thus, few psychology graduates turn their degree into a profession.

Theoretical Versus Practical Training

Counseling courses are heavily focused on theoretical training and rote learning (Thomas & George, 2016). Clinical experience is gained mainly in universities. Often, students in psychiatry and psychology are not able to gain hands-on experience and the coursework bears minimal resemblance to real-life situations (Yadav, 2017). Students of psychiatry gain some exposure in outpatient settings for a limited time during the final years of their post-graduation. Getting a doctorate is not contingent on the successful demonstration of clinical skills and passing the coursework is the only measure of competence.

Research in Psychology

Academic societies regularly conduct symposiums and workshops to facilitate information exchange on current trends and research in psychology (Thara & Patel, 2010). Despite the lack of research in psychology, there are national societies and associations that provide students and young psychologists the opportunity to present their research as well as network with other experienced professionals (Thara & Patel, 2010).

Counseling Theories in India

Originally, the use of a psychoanalytic theoretical orientation was quite popular with therapists. Later on, the field started using experimental as well as cognitive psychology (Barnes, 2004). Similar to the Euro-American curriculum, a number of

theoretical orientations, including cognitive-behavioral therapy, psychodynamic, existential, marriage, and family therapy, have been introduced (Kishore, Shaji, & Praveenlal, 2010). Of late, psychiatrists, policymakers, and therapists have begun to recognize the importance of family therapy in treating those with common mental disorders. Some universities have started including indigenous methods like yoga, pranayama, and mediation in their programs (Samal, 2014). Psychologists recognize the role of diversity in therapy and many call for the integration of different therapy orientations.

Recent Developments in Mental Health Policies and Practices in India

Loopholes in the Mental Health Care Bill

The recent mental health care bill, passed in the Rajya Sabha (Upper House of the Parliament) in 2016, failed to look beyond those being treated in inpatient settings (G. P. Rao et al., 2016). This leaves out a large proportion of the mentally ill who reside in the community and have common mental disorders. The bill advocates for just and affordable care for the mentally ill, protection from cruel and inhuman practices, and medical insurance that will cover the costs of mental illness. It includes clauses for advanced directives and a nominated representative (G. P. Rao et al., 2016). These clauses are impractical and ambitious in nature and complicate the already critical condition of the mentally ill. To initiate involuntary treatment, mental health professionals have to approach the Mental Health Board without taking the consent of the guardian. Advanced directives enable a mentally ill person to choose the type of treatment and services that could be costly and not affordable for family members (G. P. Rao et al., 2016). Additionally, the mentally ill person can withdraw, cancel, or change

the advance directive multiple times in a day, and only the Mental Health Board has the authority to approve changes to the advanced directive. Considering the fact that there are sparse resources and the technicality of advanced directives is not easy to follow, it appears families of the mentally ill may experience difficulty complying with this clause. Similarly, with the nominated representative clause in place, there is a possibility that the nominated person may request costly services, not taking into consideration the family's viewpoint or position. This can cause conflict within the collective structure of Indian families because care decisions are generally made through mutual agreement by the family members (G. P. Rao et al., 2016). Instead of excluding the family members, the mentally ill can be protected by providing family members psychoeducation, information on the treatment process, medication information, and co-therapy. Additionally, the bill mandates licensure for mental health professionals (G. P. Rao et al., 2016). In theory, this sounds like an ideal policy, though the licensure requirements may force hospitals to refuse to provide care to the mentally ill as many workers do not meet the minimum qualification requirements. This law is currently not only impractical but counterproductive because the purpose of the bill is to make mental health services easily available and reachable.

Advantages of the Mental Health Care Bill

Over the years, policymakers for mental health have strongly advocated for the rights of the mentally ill through the Mental Health Care Bill. The rules and regulations of the bill have been modified in a positive manner and in favor of the mentally ill. For example, people who try to commit suicide are no longer required to stand a trial and their act is not considered criminal (G. P. Rao et al., 2016). Those committing suicide are

now viewed as people experiencing acute stress. The government is making efforts to provide continuity of care to prevent relapse. There are provisions for affordable care and good quality mental health services, making the bill more patient-centric in nature. Those with mental illness are protected from cruel and harsh treatments. One of the greatest and most important contributions of this bill is the provision of insurance coverage for mental health services. Finally, the bill emphasizes the need for the government to act upon planning, designing, and implementing policies to prevent suicide and also train medical officers and other workers.

Operating from his main base in Goa, through the Sangath Foundation, Dr. Vikram Patel has conducted considerable research in the area of global mental health, and specifically India. His research in the field of global mental health shed light on the limited availability of psychological services in many underdeveloped and developing nations. He and his colleagues have conducted numerous studies, both qualitative and quantitative, to gauge the prospects as well as challenges in implementing and improving the scalability of mental health services. Dr. Vikram Patel is a great advocate of using the available resources smartly through cost-effective treatments and training local personnel in providing brief treatments for common mental disorders as well as appropriately triaging those who require advanced and specialized care (Buttorff et al., 2012). The MANAS trial demonstrated the treatment gap could be filled by task sharing among medical professionals, mental health professionals, and non-specialist workers. This will lower the cost of treatment and reduce disability (Pereira, Andrew, Pednekar, Kirkwood, & Patel, 2011). LHCs can aid in sharing the global mental health burden in response to the shortage of qualified mental health professionals. Another important

reason for using them is their ability to understand the local culture and how mental health is interpreted in their areas (Mendenhall et al., 2014). Local LHCs have the power to establish rapport with clients in a culturally friendly way that can help with retention.

Common mental disorders can often be treated with prescription medications. A large proportion of people in rural areas who have disorders that can be treated with medication are still beyond reach and do not receive treatment. It is clear that more of the rural population is suffering from mental illness than the urban population (Patel, 2005). The rural population that is most likely to be mentally ill has high morbidity and mortality rates and they are also less likely to be employed and come from a lower SES (Patel, 2005). Thus, the untreated rural population has public health implications. It is reiterated that there is a lack of uniformity of services because rural areas usually have fewer options for treatment and urban areas have better availability of services. The involvement of the local governance directly affects the availability or lack of resources for mental health treatment. Because for a lot of the population the first point of contact is primary care practitioners (PCPs), integrating mental health care into primary care settings can reduce the response time for providing care. The latest trend in the clinical mental health field is to offer crash courses or master's-level courses to those interested in working in mental health. Some private organizations conduct their own classes and teach the fundamentals of a specific theoretical orientation. However, these courses are not as structured and organized because the practical training is not conducted and supervision on the implemental of therapy skills is usually either not provided or sporadically delivered. Moreover, there is a lack of research on the applicability of these courses in real life.

Global Mental Health Needs and Models in Low-Income Countries

Critics of global mental health have suggested that until now, low-income countries (LICs) have been the recipients of mental health knowledge from high-income countries (HICs). However, the flow of knowledge is like a one-way street. White, Jain, and Giurgi-Oncu (2014) reflected on the need for reciprocity of mental health knowledge in light of the fact that people in LICs use several other models of care. Approximately two-thirds of the world's population are users of traditional medicine (White et al., 2014). Thus, the trend of Euro-American leaders assuming the dominance of evidence-based approaches creates an imbalance between the Euro-American and non-Euro American models of mental health care. Perhaps global mental health can benefit from embracing non-allopathic approaches to mental health care. A concept of pluralism exists in low- and middle-income countries that enables users of mental health services to choose from a variety of models of care. In LICs, where varieties of options are available for treatment, recovery from symptoms is better than in HICs. In light of the high influx of immigrants in HICs, there is also a great demand for alternative and complementary medicine. The immigrant population's preferences for treatment support that culture remains ingrained in one's identity and affects treatment preferences to a great degree. This calls for a greater understanding of mental health in a culturally sensitive manner. Thus, various models of mental health care should be made available via global pluralism. Pluralism should be embraced to deliver a culturally sensitive model of counseling because it is not just "an option," but one of many options in mental health care.

A major barrier to reducing the mental health burden is the underutilization of mental health services. In LICs where people hardly receive medical care as a result of living in poverty and other environmental barriers, community case detection can facilitate the use of primary care. A pilot study conducted in two districts of Nepal used a community informant detection tool to remedy underutilization (Jordans, Kohrt, Luitel, Lund, & Komproe, 2017). The tool consisted of paragraph-long vignettes and pointers that helped match the observation of the people to the vignettes to detect mental health problems. The pictorial vignettes were designed to initiate help-seeking behavior and care was taken to only encourage and not impose visiting primary health care. This study proved to be successful in one rural district. The residents of the Pyuthan district were more likely to use primary health care because the communities were close-knit and they had great trust in the community health workers. This study demonstrated that proactive case finding in communities by using community informant detection tools can address the treatment gap in a culturally sensitive manner (Jordans et al., 2017).

P. Trivedi (2014) reported on the lack of user/survivor perspective through an article on global mental health. P. Trivedi was diagnosed with a mental illness after she moved to the United Kingdom. Based on her experience with the mental health care system in the UK, an HIC, and her LIC cultural roots, she urged leaders of global mental health to put the service users of mental health care at the forefront and center of decision-making (P. Trivedi, 2014). Her personal experience supports that only medicating and receiving different diagnoses over the course of years did nothing positive for her mental health. When she enrolled in individual therapy, she was able to get in touch with her cultural roots, which she had shunned in light of the superstitious

practices to which her family had subjected her. She also joined a Black survivor/user group that helped her deal with the stigma and racism she faced. The resolution of a sense of self-identity, oppression, and self-acceptance through these different therapy settings helped her get a grip on her mental health. Thus, she strongly advocated for global mental health leaders to consider individuals as a part of the solution, rather than part of the problem (P. Trivedi, 2014).

The World Health Organization (WHO) started an initiative known as the mental health Gap Action Programme (mhGAP) to revitalize primary health care by incorporating mental health services to close the treatment gap (Ventevogel, 2014). This idea is not new, as since the 1970s provisions have been made to decentralize mental health care services. The WHO mhGAP can be modified based on the local needs within the LIC. The existing health system can be modified with the goal of using multidisciplinary teams in primary care settings and strengthening primary care practices by training general practitioners to be better equipped to provide mental health services (Spagnolo et al., 2017). It has been argued that if the mental health services are integrated into primary health care, the social and psychological concerns of the mentally ill will be looked from a narrow medical perspective. However, Ventevogel (2014) discussed critical points that need to be considered to avoid the medicalization of such psychosocial problems. The method of task shifting involves training local community health workers to do limited mental health duties. They are an additional benefit to the mental health team because they are familiar with the terms used and the local presentation of mental health problems.

The WHO has created an intervention guide that comes with additional training materials, such as the use of clinical cases and the application of the intervention guide to make treatment decisions. This training has been used in at least 50 low- and middle-income countries (Ventevogel, 2014). Though non-specialist health workers are trained to implement simple interventions for common mental disorders such as depression, anxiety, and alcohol use disorders, there are other chronically disabling conditions that cannot be treated by simple interventions. In these cases, nurses teach patients to learn new skills and relearn old skills of daily living. Community health workers are often trained to improve their knowledge of mental disorders, though they also should be trained to look for practical solutions to the psychosocial problems. For example, in Uganda, people advocated for mental health services in their rural district in response to increasing suicide and alcohol abuse (Ventevogel, 2014). In Rwanda and Afghanistan, interventions such as self-help groups were successful because people conceptualized their problems in a non-medical way. Mental health initiatives in LICs can be more successful if they target social determinants, such as the eradication of poverty and reducing illiteracy.

Case studies from five middle income countries demonstrated that the delivery of interventions in a culturally sensitive manner can be accomplished using principles of leverage as well as creating social capital to enable the developing and scaling up of interventions (Kidd et al., 2016). When policymakers take up leadership roles and work at the ground level, they are better able to understand the needs of patients and their families. This way of implementing interventions creates trust among people and they are more likely to join hands in doing something about the issues they experience. This

can mitigate the issue of limited resources to a certain extent. A key aspect is to recognize that mental health issues for those living in rural areas are secondary to survival. Thus, generating opportunities to earn livelihood works to reduce stigma, increases family support, empowers mental health patients, and brings a sense of involvement for those who have been isolated as a result of their mental illness (Kidd et al., 2016). Another international level organization called the Emerald Programme is in place to improve mental health services outcomes by identifying barriers and scaling up the delivery of services (Semrau et al., 2015). The project uses the approach of involving key stakeholders in making health care decisions at the ground level and working intimately with service users to improve outcomes. The grassroots policymaking system provides leaders with greater insight into the problems and makes the models of care culturally relevant and acceptable. Thus, globally, the need to scale up mental health services in LICs has been recognized. Likewise, a number of organizations have put in a tremendous amount of effort in researching and implementing improved mental health services. The need for culturally relevant models of care is also given attention in global mental health. Similarly, there is a need to extend the already existing models of mental health care in India, keeping its culture in mind.

Developing a Model for Offering Culturally Relevant and Easily Accessible Psychotherapy Services in India

Many Indian psychologists have attempted to explain Indian philosophical constructs and their relevance to Euro-American psychology. However, these concepts are not actively used in therapy. Through this CRP, this author intends to create a working model that incorporates the use of culturally relevant concepts to deliver

counseling services. Considering the success of culturally relevant programs in other low- and middle-income countries, a similar structure with regard to counseling will be created. The traditional way of living in India is embroiled in mysticism, spirituality, religion, and faith, and mental disorders remain embedded in these cultural nuances. Prescription medications cannot completely fulfill the needs of the people. Indigenous methods have been in existence for more than thousands of years, and philosophical constructs can be guiding factors in promoting mental health. As it is natural for the Indian population to seek indigenous methods to treat their psychosocial problems, the proportion of indigenous healers is also higher compared to the number of mental health professionals. However, research has shown that indigenous methods do very little to help with common mental disorders (Mendenhall et al., 2014).

Common mental disorders that have biological underpinnings manifest in physical forms that are culturally acceptable. The biological aspect of mental disorders cannot be treated with indigenous methods alone and medical interventions should almost always be provided. For psychotherapy to prosper in rural areas, those in the medical and psychological fields should make peace with indigenous methods. Research in other low- to middle-income countries demonstrated that collaborating with traditional healers can be helpful in delivering psychotherapy services (Mendenhall et al., 2014). Such a model of care can be used to improve the scalability of services in light of the mutual benefits for both indigenous practitioners as well as mental health professionals. Globalization has increased some awareness regarding professional services, causing some people to demand to see trained mental health professionals as opposed to LHCs. Merging the two fields can be harmful to mental health professionals' reputation as the

public can equate them with "quacks." Until now, major work included integrating psychological services into primary care. However, these services are limited to diagnosing and prescribing, and psychotherapy is not included as a main focus of care, which limits the opportunity for the public to talk about their emotional issues. There is still a great deal of stigma surrounding mental illness. In rural areas, the concept of privacy is non-existent and there is a fear of people knowing about each other's business, which discourages people from seeking counseling. Integrating services should not be limited to just the training of primary care personnel. A multidisciplinary approach toward primary care will give various professionals the chance to provide holistic care to those in need. A clinical practice where general practice, traditional healers, and mental health professionals can share a common space to practice together can be an alternative to cost-effective treatment. In addition, the use of indigenous methods should be encouraged and offered as additional support for the client's recovery.

Summary

Post colonization, India has progressed tremendously when it comes to mental health. For a long time, research in psychology has lagged originality. In the past, Indian psychologists shied away from using Indian philosophical constructs because they are based on subjective experience rather than evidence-based methods. However, recent scientific studies have shown the utility of Indian methods in the treatment of psychopathology. There is also a great need to spread awareness of the misconceptions of mental illness because mentally ill individuals are still heavily stigmatized and subject to discrimination. Euro-American ways of conducting psychotherapy have not worked with the Indian population as evidenced by higher drop out rates. There is a need to

properly train upcoming psychotherapists about the population's needs and the applicability of theoretical as well as philosophical orientations to real life. Psychology needs to be introduced into graduate programs as mainstream courses. The Indian government has made great strides in improving the condition of the mentally ill. However, more work needs to be done as India continues to face a national burden of common mental disorders contributing to disability, morbidity, and mortality. A treatment gap largely occurs in rural areas where there is a greater prevalence of mental illness, as people in rural areas are also more inclined to use indigenous modes of treatment. In order to increase the appeal of psychological services in rural areas, multidisciplinary clinics that include holistic practitioners and mental health professionals who have an understanding of indigenous methods can play an important role in reaching the rural masses who need treatment for mental illness. Thus, keeping in mind the difference between urban and rural areas, it is emphasized that grassroots level therapy is imperative as a means to reduce the treatment gap.

Chapter 3: Psychotherapy Model

Leaders in India have only recently realized the need to address and serve the mental health needs of India's citizens in a manner that is comprehensive and multifaceted, leading to considerable efforts being made to conduct therapy with the Indian population. Because there is a lack of uniformity of services, the need for therapy is felt more in underdeveloped rural areas as compared to urban areas. To address this issue, India requires LHCs who can provide counseling services at the grassroots level to fulfill the treatment gap. In the previous chapter, this author discussed that counselors in India traditionally have conducted therapy based on Euro-American models of counseling that do not seem to fit the way Indian society functions. The Indian perspective on human functioning and alternate modalities of mental health care were also discussed in the previous chapter. With respect to common mental disorders, the author discussed the unique needs of the Indian population and provided a comparison of Euro-American and Indian constructs of mental health to highlight similarities as well as dissimilarities and to demonstrate they can be integrated to conduct culturally sound therapy.

The Sangath Foundation in Goa has been instrumental in training LHCs. In its "barefoot counseling" training course, the main focus is on dealing with depression and anxiety (Saxena & Andrew, 2003). This training course was initially formulated as a basic tool to treat depression and later Saxena used it to treat women who were victims of domestic violence. The first section of the barefoot counseling manual covers the basic skills required for therapy, the second section describes the cycle of anxiety and depression as well as the detection of anxiety and depression at a community level, and the third and the last section focuses on the interventions barefoot counselors or LHCs

can practice in therapy (Saxena & Andrew, 2003). The manual also provides resources for triaging clients when their treatment needs are beyond the counselor's competence. The manual describes that anxiety and depression occur in response to stress that becomes unmanageable. It provides the General Health Questionnaire (GHQ-9) as a measure to assess the presence of anxiety and depression. Interventions include providing reassurance about the resolution of symptoms, providing explanations of the relationships between the symptoms and stress, allowing the client to freely express problems, and providing specific interventions for the specific symptoms of anxiety and depression. However, the interventions are brief and the explanation of the disorders is given from a stress-related point of view. This restricts LHCs and enables them to do only surface-level counseling. Moreover, the barefoot counseling training is based on diagnosing only the two mentioned disorders (i.e., anxiety and depression).

Contribution to Existing Research

The focus in this chapter is on laying the groundwork for counseling in a manner that will enable LHCs in India to integrate the Euro-American, global, and Indian concepts of therapy as well as their knowledge of the local population and its culture to meet the counseling needs of those suffering from common mental disorders. This psychotherapy model provides a unique contribution through the use of sociocultural factors in understanding the mental health of Indian clients as well as in informing interventions based on indigenous and evidence-based treatment options. The comprehensive approach used in this model places the focus on the client as a whole and is more aligned with the collectivistic nature of Indian society. Thus, it is this author's

hope that this model of counseling will not only be implemented but also accepted by the larger masses who may have little faith in the effectiveness of psychotherapy.

As there is a shortage of mental health professionals in India, it is argued that LHCs should be further trained to provide advanced counseling. The following steps are proposed to make psychotherapy more culturally sensitive: (a) diagnose clients based on the ICD-10, keeping in mind the local representation of the disorders; (b) educate clients as well as those involved in their care about the diagnosis; (c) establish short-term goals for therapy; (d) use interventions that are evidence-based as well as locally acceptable; and (e) help clients locate and access additional resources during the course of their therapy.

Sprenkle, Davis, and Lebow (2009) discussed common factors that are aspects of therapy that remain fundamental to different theoretical approaches, and are constant or relevant in most therapy contexts. Similarly, the content of the modules in this proposed model incorporates fundamental counseling skills such as the therapeutic alliance, empathy, unconditional positive regard, attentive listening, and body language. Keeping in mind that clients seek resolution of their impaired states, something they cannot achieve on their own, it is important for counselors to instill the hope in clients that change is possible. In the context of the Indian population, instilling hope is even more important, considering the fact that most Indians seek counseling services as a last resort. The counselor should demonstrate allegiance in addition to hope because it will increase the chances of improving the client's faith in counseling services and improve retention.

Contemporary Indian Model of Counseling for Depression and Anxiety

To fulfill the first four criteria of the new model of counseling, the model contains six modules, which are described in this section. Modules 1, 2, 5, and 6 are generic as they provide the general framework for how to begin and end counseling service, whereas modules 3 and 4 are different for anxiety and depression because they demand symptom specific conceptualization and interventions. The six modules are as follows.

The focus of the first module is on the fundamentals of therapy, what it means to establish a therapeutic alliance with Indian clients and the approach of the therapist, and the importance of educating clients and families about the diagnosis and taking the necessary steps to clear up any misconceptions about the diagnosis. The usefulness of counseling skills in daily life and the significance of client retention are also discussed.

The second module details the importance of understanding sociocultural factors and their impact on the client's functioning. It also contains a discussion of the value of the therapist being aware of his or her own sociocultural background while conducting therapy with Indian clients.

The third module provides support for the relevance of understanding the client's view of the mental illness and using it to conceptualize the client's functioning from a Euro-American perspective.

The focus of the fourth module is on including the client's perspective to re-conceptualize mental illness and use the new conceptualization to better inform the treatment plan (e.g., encouraging the use of indigenous methods along with other treatment options).

The fifth module details the importance of including family members in conceptualizing clients' presenting problems and developing treatment plans. It emphasizes the importance of including family members or those involved in care to strengthen the improvements in the client's functioning and maintain compliance with treatment.

The focus in the sixth module is on the importance of summarizing the lessons learned in therapy at the time of termination to help clients carry forward the learning and maintain their new modified functioning without the therapist.

Table 1 presents an overview of the modules and their goals.

Table 1

Modules and Goals

Module	Goals for LHC
1) Therapeutic Alliance	• Establish rapport by explaining your role and the reason for referral. • Explain the disorder and establish the medical need for treatment. • Normalize the disorder to reduce stigma and shame. If possible, provide educational material about depression in the local language of the client. • Explain confidentiality and the terms and conditions of therapy. • Explain the benefits of counseling. • Establish a goal or goals for counseling.
2) Understanding Sociocultural Factors	• Gather information on symptoms to understand the local presentation of the disorder. • Use the ICD-10 to match local presentation to the diagnosis. • Gather information about client's functioning history to determine magnitude of the disorder and quality of life. • Gather information on client's culture (e.g., role in family, religious and spiritual beliefs, rituals practiced, etc.). • Clarify assumptions based on class, caste, SES, and gender.

(continued)

Table 1 (continued)

Modules and Goals

Module	Goals for LHC
3) Using client's view in conceptualizing the disorder from a Euro-American perspective	• Determine external or internal locus of control (e.g., whether client believes he or she can manage the disorder). • Determine client's beliefs about the disorder (e.g., punishment by God, past karma, or results of bad deeds). • Determine help seeking attitudes (e.g., use of home remedies, use of religious leaders, spiritual guru, prayer, astrology, Ayurveda, etc.). • Explain the method to identify triggers that give rise to the negative cognitive triad. • Educate about the cycle of negative thoughts, emotions, and actions by using cognitive triad. • Explain the method to alter the negative cycle and managing triggers. • Engage the client in session to alter negative cognitions, behaviors, and emotions and help develop a balanced perspective. • Encourage the client to practice identifying triggers and altering thought patterns outside of counseling.
4) Re-conceptualizing the disorder to culturally inform treatment plan	• Use client's beliefs about the disorder and encourage client to do module three in accordance with these beliefs. • Explore client's strengths and incorporate them in therapy. • Encourage client to follow traditional remedies along with techniques learned in therapy to manage the disorder.
5) Collectivist care approach	• Routine inclusion of family members. • Thoughtful exchange of pertinent information with family while keeping the client's integrity intact. • Transparency during information exchange. • Maintaining boundaries with opposite gender clients for the safety of the client and the counselor.
6) Termination of counseling service	• Review interventions learned in therapy. • Reiterate importance of medication compliance. • Caution about relapse and steps to take to manage relapse. • Provide additional resources such as NGOs, rehab centers, and other counseling services if available. • Seek feedback from client about the usefulness of counseling.

Therapeutic Alliance

Establishing therapeutic rapport in India is different because Indian clients may expect an LHC to be authoritarian, give advice, and be an active participant in their treatment. A counselor needs to clearly define psychotherapy and his or her role in the care of the client. The LHC should explain the confidentiality clause as determined by his or her agency and at the same time be prepared to share information with those involved in the client's care, such as children, spouses, parents, in-laws, and others. The LHC may make adjustments to seating arrangements, include family members, match the patient's body language, and provide reassurance about recovery. The therapist should appear credible and be able to demonstrate the effectiveness of counseling so clients trust in the counseling process and remain hopeful about the usefulness of counseling. It is important to normalize the client's diagnosis and provide alternate evidence-based education regarding the diagnosis (e.g., role of genetics, family dynamics, current circumstances, maladaptive thinking, etc.).

Educational materials available in the client's local language, such as videos, pamphlets, and brochures, should be made available. In addition to education, clients should receive an explanation of the benefits of counseling and the importance of taking medication as well as participating in therapy. In order to improve client retention, this author suggests that medication fees be forgiven if clients commit to and maintain their attendance in counseling, and this clause should be explicitly explained to clients and their families prior to beginning therapy. The LHC should be able to meet the client both with and without family members. Thus, the family's perspective is given equal importance even though the client is at the center of caregiving. Goals should be

established in the first session with the client and those involved in his or her care, and the client's immediate family should agree to work on the established goals.

Understanding Sociocultural Factors

During the initial sessions, the LHC should ask questions about the client's functioning and assess for depression or anxiety based on the ICD-10 criteria. It can be expected that clients will talk about their mental illness as an external factor they cannot control and will generally lack any understanding of anxiety or depression. The client's perspective on his or her mental illness will often involve traditional and cultural beliefs (e.g., the role of religion, karma, past deeds, supernatural powers, God, etc.). Respecting such beliefs will generally strengthen rapport and provide insight into the local presentation of mental illness, which the LHC can then use to translate the client's narratives and match them with the ICD-10 symptoms. Although it is necessary to clear up any misconceptions about mental illness, they should not be targeted right away because the first session should be used to understand the client's functioning from the client's perspective.

This module is particularly important because it will provide the LHC with maximum information on the client's functioning. As a result of the interdependent way of functioning, the therapy process in the Indian context should consider society and culture as the main influencers. There is a great overlap between the client's functioning and the role of culture and society. For example, a rural family may still follow strict stereotyped roles and the woman, even though considered the backbone of the family, may still have the least amount of help and the most responsibilities that may cause her to feel depressed. The men in the family may feel depressed because they do not earn

enough but at the same time may not want their wives to work. Therefore, understanding such cultural and social factors will provide insight about the client's impairments in functioning. The LHC should ask questions about factors such as the client's role in his or her family, financial independence, ability to express emotions, freedom to make decisions or voice opinions, and support from the family when assessing for the cause of mental illness. The LHC should clarify any assumptions regarding the client and his or her family because not all clients will have the same traditional and cultural beliefs. For example, a client may be an atheist, may be extremely religious but not spiritual, or may belong to a certain caste but may not have experienced discrimination or prejudice.

Using Client's View in Conceptualizing Depression from a Euro-American Perspective

In this module, the client's view of depression should be explored. The person-centered approach of this module provides an opportunity to demonstrate empathy and understanding of the client's problems. The narratives will help present a picture of the beginning, progression, and maintenance of the mental illness. The LHC can help the client reflect on symptoms by summarizing and probing further. Often times, clients will not share their view but will share what others think about them or their functioning. If clients concur with this view, then the LHC should also accept it, but if clients demonstrate doubt then by all means the LHC should help them gain insight into this view. Asking clients about depression will provide the LHC with information about situations, irrational beliefs, triggers, and maladaptive pattern of negative thoughts, emotions, and behaviors that give rise to depressive symptoms. Additionally, clients should be asked about how they manage their depression and what methods they have

tried to manage their illness. Examining sociocultural factors will also help the LHC understand each client's readiness and willingness to adhere to counseling approaches and interventions. The therapeutic alliance is necessary to deliver interventions and help clients adapt psychotherapy approaches.

In this module, the use of cognitive behavioral therapy (CBT) is deemed appropriate in light of the short-term nature of therapy and its similarity to some of the cultural teachings in India. The concept of CBT is relatively easy to explain and it can be applied to multicultural settings. The tenets of CBT of focusing on conscious thought processes and the idea of altering thoughts are largely accepted in the Indian culture. The LHC should follow the fundamentals of CBT and conceptualize the client's functioning as healthy or unhealthy based on the presenting thoughts, emotions, and behaviors that may contribute to the mental illness. A pattern of such functioning should be explored to determine major events contributing to the client's present condition. LHCs should help clients explore their triggers, including persons, places, or things, and then help clients understand how these triggers cause them to have maladaptive patterns of thinking, feeling, and behaving. Once this is established, LHCs should then teach clients to break these patterns by targeting their unhealthy thoughts. Practices such as keeping thought logs, daily activity logs, and determining pros and cons should be taught in sessions and clients should be encouraged to practice them on their own.

Using Client's View in Conceptualizing Anxiety from a Euro-American Perspective

Similar to the conceptualization of depression, the client's view of anxiety should also be explored. It is common for clients to verbalize physical symptoms as opposed to emotional or cognitive symptoms. Clients may use cultural adjectives to describe

somatic symptoms such as pain, heaviness in the chest, nervousness, fatigue, and other such physical symptoms when talking about anxiety. Sometimes, they may talk about supernatural causes of their anxiety. The LHC can inquire about situations that provoke physical and physiological symptoms of anxiety. They can explore any thoughts, emotions, or behaviors that occur before and after experiencing the physical symptoms. If clients are not readily able to recall situations and label their emotions and thoughts, they may be asked to be spectators of their anxiety-provoking situations and produce a written or verbal account to better understand how they are affected by their anxiety. It will be helpful if clients are engaged in discussing how they previously handled emotionally charged situations. This will provide insight into their ability or inability to manage their anxiety, inform the LHC of the client's strengths, and instill hope regarding the client's ability to manage emotions.

Once the unhealthy pattern of functioning is determined, LHCs should help clients explore their triggers, including persons, places, or things, and then help them understand how these triggers cause them to have anxiety and explain how their thoughts, emotions, and behaviors contribute to their physiological anxiety response. Once this is established, LHCs should teach clients to break these patterns and target their unhealthy thoughts, emotions, and behaviors. Practices such as keeping thought logs, daily activity logs, and determining pros and cons should be taught in sessions and clients should be encouraged to practice them on their own.

Using a Modified View of Depression to Culturally Inform Treatment Plans

The LHC should capitalize on the client's view and increasingly use it to explain the utility of Euro-American paradigms in therapy. The LHC should not hesitate to ask

questions about the client's beliefs, views, and ideas about his or her functioning because this will provide insight about the most appropriate approach to use with the client. It is equally important to use the client's language and help the client understand his or her functioning in layman's terms. The frequent use of idioms, proverbs, mythological stories, wisdom of older people, excerpts from holy books, and local sayings should be incorporated to help clients gain a better understanding of their thoughts, emotions, and behaviors and their implications for functioning.

Just like the CBT approach of altering the cognitive triad, the karma approach also contains a focus on changing thoughts and behaviors. For example, if the client talks about present functioning as being a result of bad karma, the client should be engaged in understanding the meaning of karma and how it affects his or her daily life. The LHC should be able to draw similarities between karma and action. The LHC could discuss the types of karma and actions such as past, present, and future. The ability to bring any change in future karma or action is dependent on how the present action or karma takes place. Even though an individual cannot do anything about the past karma or action, if that individual is the one performing the karma or action, then he or she is the one who can change the future and present karma or action. Karma is not limited to physical action, as it can also apply to mental and emotional action (i.e., the type of thoughts and emotions one generates). A conscious practice of changing karma through various actions (e.g., mental, emotional, and physical) will result in positive karma. This is just one of the approaches LHCs can use to help clients understand their functioning.

Before formulating any treatment interventions that incorporate indigenous methods, the LHC should first determine whether the indigenous methods will be helpful

for the client. This is recommended because the LHC's job is to use the client's indigenous strengths in functioning and not blindly use the indigenous interventions that may be affecting the client's functioning in a negative fashion. For example, if the indigenous practices risk the client's safety, isolate him or her from society, give rise to superstitious beliefs, or make the client emotionally and mentally more vulnerable, such practices should be explicitly discouraged. On the other hand, if clients are benefitting from practices such as through more inclusion in the family and community and improved mental and emotional functioning, then such practices should be included in treatment plans. The scope of interventions may not always include indigenous practices but they can be helpful when LHCs want to help clients achieve treatment goals. As years of research have shown that successful therapeutic outcomes are related to clients practicing therapeutic interventions on their own outside of therapy, it is imperative that clients first learn interventions in therapy and how to practice them outside of the therapeutic setting. For this reason, the clients should be provided with exercises they can do outside of therapy (Wenzel, Dobson, & Hays, 2016).

Using a Modified View of Anxiety to Culturally Inform Treatment Plan

To incorporate cultural considerations in anxiety treatment planning, LHCs should proactively ask about any current remedies used by the clients. There are a number of practices in the Indian culture that are used in the management of anxiety. For example, the first line of treatment in many households may be to use home remedies to calm the nerves. A large number of people follow religious and spiritual leaders and use their teachings or stories to understand their suffering of mind. Still other people may use herbal remedies, religious gatherings, or rituals such as prayers and trips to holy shrines

in an attempt to reduce their anxiety. Anxiety can manifest in other forms, such as guilt and shame (Khambaty & Parikh, 2017). Ancient teachings in Bhagwad Gita are examples of the symptoms and cognitive remedies understood by Hindus.

Vipassana, a type of Buddhist meditative exercise, is based on three concepts: change is constant, everything is interrelated, and misconceptions cause suffering. Through the practice of stillness and observation, a person can gain insight into the temporary existence of emotions, thoughts, bodily sensations, and the external world. Thus, the regular practice of Vipassana is known to alleviate symptoms of anxiety (Khambaty & Parikh, 2017). A parallel can be drawn between Vipassana and CBT as both approaches focus on correcting cognitive distortions and understanding the links between thoughts, emotions, and behaviors. Hence, counselors can use psychoeducation based on ancient teachings to explain the misconceptions of the mind that trigger anxiety via cognitive labels such as overgeneralization, catastrophizing, and discounting the positives. These teachings can be used to incorporate behavioral interventions such as breathing exercise, yoga, and meditation, as they are largely acceptable and understood within the Indian culture.

For some clients, simply changing their thoughts may not be adequate to reduce anxiety. An integrative approach, such as mindfulness-based cognitive therapy, may be used to help clients generate greater insight by understanding rather than changing thoughts. Meditation can be used to help clients become passive observers of their anxious thoughts and learn that not acting on the thoughts will diminish the power of their anxiety, as this gives the client more control. Thus, controlling the mind leads to control of actions, emotions, and behaviors. CBT is a flexible approach that can be

modified and adapted culturally to make it understandable and easy for clients to practice to reach their goals.

Collectivist Care Approach

In order to provide sound cultural counseling, this module should be given great attention. The LHC should keep in mind that it is common for Indian families to be intimately involved in the care of their members. To maintain the therapeutic alliance throughout the counseling process, the LHC needs to practice appropriate boundaries. The LHC and the client can decide how much information they would like to disclose to the family regarding the client's care. The routine involvement of family members in sessions is a must. Male LHCs should be transparent about the counseling process when dealing with female clients, children or adults included. Any interventions that may disrupt the collectivist functioning must be modified. The counselor should welcome any feedback and questions from the client's family members. If appropriate, the LHC can use any indigenous remedies suggested by family members, obviously keeping the client's best interest in mind.

Termination of Counseling

During the termination phase, the counselor and the client may spend time reflecting on the things learned in therapy. The discussion should involve ways of practicing the interventions after therapy. The LHC should reiterate the importance of compliance with medication, interventions, and follow-up on other care to bear the fruits of therapy. The counselor should caution the client about the resurfacing of symptoms (e.g., re-experiencing triggers that may exacerbate depression or anxiety) and what steps the client and his or her family can take if the mental illness becomes unmanageable. The

LHC should provide the client with any resources available that the client can use after counseling to maintain the current level of functioning. Finally, the LHC should ask the client for feedback on the effectiveness of counseling and any feedback or suggesting should be kept in mind in case the client returns for counseling purposes.

The LHC may start the modules in any order and it should take approximately six to eight sessions to implement all six modules. For example, the LHC may immediately start conceptualizing from the client's view and require very little effort to build a therapeutic alliance. However, novice counselors may not be used to the counseling process and it is highly recommended that they stick to the sequence of the modules. Some modules may take less time to implement than others and the number of sessions may exceed the recommended limit, depending on the client's functioning. Finally, the best course of action is to use the modules and interventions at the LHC's discretion and level of expertise. Of most importance is the understanding that a LHC may not have the capacity to deal with high acuity clients. In situations where clients are actively suicidal, homicidal, or experiencing auditory/visual hallucinations (SHAVH), it is best to consult with doctors and other experienced personnel. A score in the severe range on the PHQ-9 should alert the LHC about the possibility of active SHAVH. The LHC can then consult with the referring physician on the appropriate level of care.

The World Health Organization Mental Health Pyramid

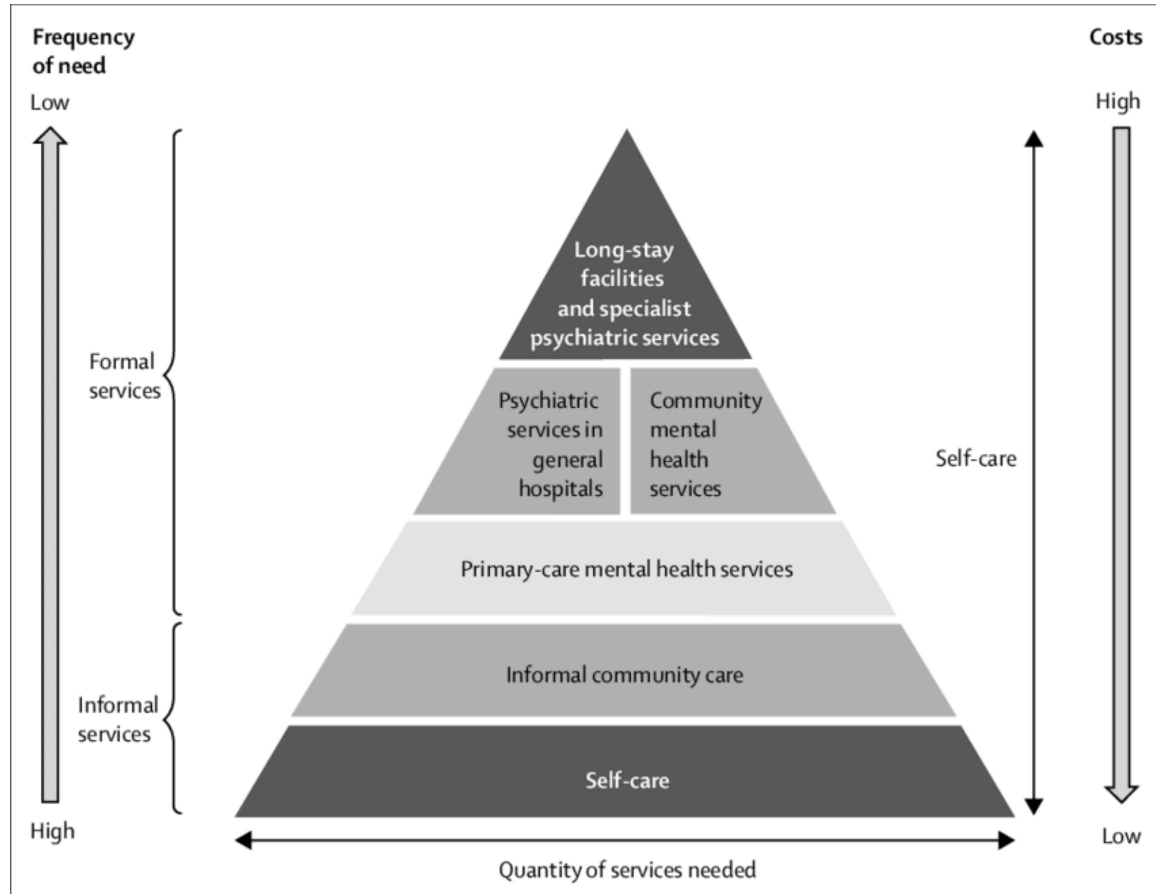

Figure 1. illustrates WHO mental health pyramid demonstrating optimal mix of services and various levels of care based on the severity of mental illness. Reprinted from "Health Care Platform Interventions" by Patel, V., Chisholm, D, Dua, T., Laxminarayan, R., Meina-Mora, M.E., Mental, Neurological, and Substance Use Disorders: Disease Control Priorities, Third Edition 4(3).

Chapter 4: Contemporary Indian Model of Counseling for Depression and Anxiety

Case Examples

Case Example 1

Background Information

Ram and his wife, Lata, reside in Bavla taluka of Ahmedabad city in Gujarat state. They belong to a lower SES and live in a rural neighborhood. They have been married for 7 years and have two children, and Ram's parents reside with them as well. Ram works for a construction company as a welder and Lata works as a maid in a number of houses in a distant society. Ram and Lata earn barely enough to sustain the family. Ram's parents retired a few years ago and now stay at home and take care of the children while Ram and Lata go to work. They rely on their son and daughter-in-law to take care of them financially. Lata is mainly responsible for the household chores, looking after her in-laws, and taking care of the children, in addition to her work as a maid. Ram regularly drinks with his colleagues at their shop. Lata is opposed to Ram's drinking but often bites her tongue and blames her fate that instead of sending her to school, her parents married her off and she had to bear two children very early in her marriage.

Presenting Problem

For the past 6 months, Lata has had frequent absences from her work because she has been experiencing insomnia, excessive crying, and an inability to wake up the next morning. As a result, the homeowners cut her salary, her children have missed school, and she gets into frequent arguments with her mother-in-law. Ram blames Lata for being inconsiderate and lagging behind as a wife. Ram often taunts her and insults her in front

of other family members because he thinks Lata is lazy and deliberately skips work. Ram brought Lata to the government hospital to see a general practitioner because Lata was complaining of severe headaches that did not go away with home remedies or over-the-counter medications. During the initial checkup the doctor gave her medications for insomnia and headache. As a part of routine, the doctor then administered a Gujarati translation of the Patient Health Questionnaire (PHQ-9) as a measure of depression. Lata's score on the PHQ-9 was in the moderate category. Her case was then shared with an LHC who was a native of Gujarat. The LHC belonged to an upper caste but had a few years of experience working in the mental health field, specifically with the rural population.

Session 1

The LHC explained that Lata was sent to her care because the general practitioner suspected she was experiencing some emotional and mental problems based on her performance on the PHQ-9 and medication would not suffice to treat her adequately. The LHC then gave a personal example of her own problems and how talking to a counselor who understood mental issues helped her recover. She further communicated that she was genuinely interested in providing mental and emotional support to Lata's family. Lata was confused and did not believe she had a mental disorder. The LHC explained that just as fever, weakness, sore throat, and coughing are signs of flu, similarly insomnia, lack of interest in work, a tendency to stay in bed, and irritability over a period of 6 months are signs of depression. She normalized Lata's diagnosis and educated her that depression is one of the most commonly experienced mental health problems but can

be treated and Lata can take charge of it with the help of medicine, counseling, and support from her family.

The LHC conducted the first session in the presence of Ram and provided opportunities for him to ask questions about the LHC's role in the treatment of his wife. Ram worried about his wife's mental illness and thought a diagnosis would bring shame to his family and people would look down upon them. The LHC explained that she was bound by the clinic's confidentiality policy, no third party would be informed about Lata's mental illness, and written consent would be obtained from the family if a need arose to share this information with other professionals for her care.

The LHC reassured the couple that dealing with a mental health issue was not a matter of shame and the scientific approach of counseling would help them because it had benefited a number of other citizens in the past. When the LHC explained that receiving counseling would help Lata get back to work and better take care of other family members, Ram gained confidence and agreed for his wife to try counseling services. The LHC entered into a six-session agreement and the terms of the agreement were that if they attended all six sessions without a gap, their medical expenses would be eligible for forgiveness. This encouraged the couple to come once a week for 6 weeks in order to benefit from counseling services.

As a summary, the LHC achieved the following in Session 1:

- Established rapport by treating Ram and Lata as equals.
- Educated the couple on the signs and symptoms of depression in layman's terms by drawing similarities between flu and depression.

- Normalized depression by sharing her personal story and educating the couple on the prevalence of the mental illness.
- Explained the confidentiality agreement meant to protect Lata and Ram from shame and explained the agreement to receive free treatment contingent on Lata attending all six sessions.
- Explained the benefits of counseling by ensuring Lata would be able to regain her prior level of functioning with the help of counseling.
- Established goals of counseling for Lata, such as returning to work and taking care of her family as before.

Session 2

The LHC built a therapeutic alliance by offering Lata and Ram tea and biscuits, and by seating herself at an equal level. The LHC took these steps to ensure her status or position did not make Lata and Ram feel inferior or indifferent. She created an atmosphere of openness and genuineness by talking to them in Guajarati. She further explained that being in therapy meant working in a collaborative manner and exchanging information in a two-way process. She also stated that she might have suggestions to offer, keeping their best interests in mind. The LHC's friendly demeanor made the couple feel comfortable and they shared intimate details about their family.

Even though this session was for Lata, Ram took the lead and started discussing how Lata's absence from work caused them to be short of money at the end of the month and he had to ask for his salary in advance to pay for the remaining expenses. Ram reported that he felt ashamed and had to work harder to meet his boss's impromptu demands. Ram could not oppose these demands because he was obligated as he was paid

some income in advance. He looked up to the LHC with an expectation that she would be able to solve everything for them. At this point, the LHC understood Ram's frustration. She further educated the couple that Lata was not to be blamed for her condition and that social, biological, and environmental factors had played a role in her depression. However, Lata's thoughts, behavior, and emotions were in her control and with the help of therapy Lata could alter them, which would aid in her return to normal functioning. The LHC then discussed the goals of therapy and gave Lata the choice to make her own goals. Lata reported that she would like to reduce the frequency of absences and take better care of her family. Keeping the collectivist structure in mind, LHC suggested that in the following sessions she would meet with Lata individually for the first half and have a joint session with the couple for the second half.

As a summary, the LHC achieved the following in Session 2:

- Continued establishing rapport and familiarized the couple to the process of counseling.
- Gathered information on Lata's depression as Ram reported Lata's absences from work affected the family's functioning and put a strain on finances.
- Brought to light Lata's inability to speak because of her lower position in the family hierarchy.
- Educated the couple about the social, biological, and environmental factors that contribute to depression.
- Informed Lata that working on thoughts, emotions, and actions would help her alter her functioning and subsequently achieve her counseling goals.

- Encouraged Lata to openly share about her depression and divided the consecutive sessions where Lata would be seen for the first half of the session alone and her husband would join for the second half.

Session 3

During this session, the LHC asked Lata about her daily routine and her life in general. Lata reported that she woke up early to finish all the household chores and then went to work as a maid in around eight houses in a nearby colony. During festivals, the homeowners made her do extra chores around the house and paid her minimally. Lata reported that she had to walk for 30 minutes to get to work, as she could not afford bus fare. Lata reported that commuting on foot was hard because of the extreme heat and was more difficult during a monsoon because of water accumulation around her house. Sometimes the homeowners offered food and sometimes they did not. Lata then returned around 4:00 p.m. and had to cook for the entire family. In between she was able to spend little time with the children and sometimes took them along to run errands for the house. Lata felt burdened by her responsibilities and felt she was the least appreciated at work and home. Lata received very little help from her in-laws and felt guilty asking for their support because they were elderly and they expected her to help them in their daily living tasks.

Lata felt extremely frustrated about living in poverty. She reported that in her past life she must have done bad deeds and her karma could be blamed for her poverty and her difficulties. No matter how hard they worked, they would still live in poverty and her situation would never improve. Lata demonstrated hopelessness and a lack of control. Additionally, she reported that she stayed up in the night thinking about how her

life would be if they were financially sound. Lata stayed up thinking about living in a bigger house, having access to amenities, and having a bright future for her children. However, the next morning she would see the pile of work and duties waiting for her and this reality made her feel more hopeless about her situation. The hopeless thoughts constantly ran through her mind, resulting in headaches and body aches. During the night she excessively focused on her misfortunes, causing her to feel stressed and unable to sleep.

The LHC empathized with Lata's difficulty and agreed that her circumstances at home and work were very difficult and Lata was trying very hard to survive. The LHC pointed out that Lata started experiencing bodily ailments whenever she was stressed and thought about the hardships of her life. The LHC further explained that Lata was depressed because when her thoughts were negative, she felt sad and hopeless and this kept her up in the night. This action resulted in sleep deprivation and a lack of energy the next day to go about her daily life. Lata had fallen into this pattern unknowingly and this aggravated her headaches and her feeling hopeless. The LHC then asked Lata about any remedies she had tried to manage her depression. Lata reported that she sometimes talked to her friend or mother, though talking to them did not always help. She also tried to drink warm milk in the night to sleep but she kept having such thoughts. The LHC asked if there was something else that Lata would like to try and Lata reported that she would like to pray. Taking Lata's faith into consideration, the LHC encouraged Lata to visit the temple with her family as everyone in her family prayed to the same God. Lata agreed that it would be a positive step toward her well-being.

As a summary, the LHC achieved the following in Session 3:

- Lata verbalized feeling hopeless when she thought about her future and experienced a lack of control because she thought the situation would not change.
- Lata's cultural belief was that her past karma was responsible for her financial crisis and family problems.
- Her past help seeking behaviors were talking to a friend or her mother and drinking warm milk.
- The LHC helped Lata make the connections among her thoughts, emotions, and actions. They discussed the cognitive triad. Lata's negative thoughts about finances caused her to feel hopeless about her future, which kept her up during the night and made her sleep deprived. This continuous pattern caused physical problems such as headaches and body aches.
- They discussed any additional home remedy that Lata would like to attempt and came to the conclusion that praying with other family members by visiting a temple would improve Lata and her family's well-being.

Session 4

During this session, the LHC got an update from Lata and Ram. They reported that going to temple had given them some hope and taking the medications had helped Lata improve her physical functioning. The LHC then conducted the rest of the session with Lata alone. The LHC pointed out that even though Lata considered her present mental and physical functioning to be a result of bad deeds and past karma, she still had the ability to shape her current karma and deeds. The LHC explained further that whatever Lata did to herself, either positive or negative, was also a form of karma that

was building up. Thus, taking care of herself or neglecting herself was a result of good karma or bad karma and karma did not limit how she behaved, felt, or thought about others. Therefore, if she chose to get well, her first step should be to do good to herself by taking care of her health and her mental state, and this convinced Lata to take her antidepressants. The LHC explored Lata's strengths and learned that she was a great believer of God. The LHC helped teach Lata to distract herself from negative thoughts by using prayers more often. She encouraged her to pray every night considering it had a soothing effect on her and encouraged her family to join her in prayer. Lata agreed that prayer helped her feel calm because in that moment she surrendered to the God and thought that God would guide her to remove the misfortunes.

As a summary, the LHC achieved the following in Session 4:

- Upon return, Lata's functioning supported that visiting the temple (client's strength) and taking prescription medication had somewhat improved Lata's physical and mental functioning.
- Lata's view of her past karma was used to reconceptualize her functioning. The LHC helped her alter her cognition by suggesting that altering thoughts would also affect her present and future karma.
- Lata understood that she could build positive karma through positive actions such as taking care of herself, taking her medication, and going to work.
- Encouraged culturally informed treatment, such as praying during the night, to help Lata distract herself from negative thoughts.

Session 5

In this session, the LHC administered the PHQ-9 and Lata's performance showed improvement in physiological functioning and she reported fewer absences from work, but she still felt hopeless and had some trouble concentrating during her chores. The LHC helped Lata think through situations that triggered hopelessness. Lata stated that she felt hopeless while working at the homes whose owners had more money and a better quality of life than her. This made her feel frustrated and sad. The LHC helped Lata realize that if she wanted to become better financially, she would have to keep performing her duties or karma in order to slowly work toward her goal because accumulating positive karma would give her positive results, meaning that if she continued performing her job diligently, she would reap the benefits of the work. The LHC provided Lata with various cultural idioms, such as "Tipe Sarovar Bharay" (Little drops of water make an ocean) and "Purusharth safadta ni chavi che" (Hard work is the key to success), and explained how Lata could apply these sayings to her situation to think about it in a healthy way. The LHC brainstormed ways Lata could ask for help from other family members so she would be able to more efficiently run the household (e.g., arranging for a ride with her husband to reduce her commute time to work).

The LHC then involved Ram in the session and informed him of the changes they needed to make so Lata could feel better and the family could function better. She advised that the changes made had to be long-term so they could benefit from them in the future as well. The couple came to an agreement that Ram played an important role in Lata's care and she would be able to manage her depression if Ram fully supported her in her efforts.

As a summary, the LHC achieved the following in Session 5:

- Lata continued to alter her cognitive triad by identifying triggers that made her feel hopeless and the LHC included cultural idioms to help Lata think about her situation in a healthy way.
- They worked on practical ways to ease Lata's daily struggles, such as asking Lata's husband for a ride to work.
- They included Ram in the session to help him understand how he could contribute in their daily life to help Lata achieve her counseling goals that would ultimately benefit the family.

Session 6

The last session was conducted with both Ram and Lata. The LHC encouraged Lata to communicate with Ram about her daily struggles. She encouraged the couple to use each other's support and set up a goal of saving some money because Lata was depressed because of the money crunch. The LHC explained to Ram that if he cut back on his drinking, he would not have to work extra hard at his job and this way he could save that money and use it whenever an emergency arose. She also provided Ram with a referral to the rehabilitation clinic and encouraged him to come for therapy with the similar arrangement of free treatment if he attended all appointments.

The LHC summarized the therapy for Lata and reminded her to maintain medication compliance, seek support from her family, and pray. She reiterated the idioms and reinforced altering negative thoughts and performing daily duties because it meant collecting good karma, which was essential to reaching the couple's goal of improving their financial situation.

As a summary, the LHC achieved the following in Session 6:

- Conducted couples counseling and encouraged Lata to improve her communication with Ram.
- Encouraged collective goal setting to address the couple's financial crisis by asking Ram to reduce his drinking.
- Provided Ram a referral to a rehabilitation clinic for his drinking behavior and encouraged him to seek help.
- Together, they summarized what the couple learned in therapy, such as medication compliance, altering cognitions, seeking family help, and focusing on Lata's strength through performing prayers.
- Reinforced negative thought altering and performing duties as a means of collecting positive karma that would help Lata achieve her goals even after the termination of counseling.

Case Example 2

Background Information

Raziya is a 25 year old Muslim woman who resides in Bajwa, a rural district of Vadodara. Her husband, Rahim, is 30 years old and together they have three children. During the 2001 riots in Godhara, Raziya's immediate family was killed. When the villagers became aware of the attacks, Raziya, along with several other families, fled their homes to save their lives.

Raziya and her husband managed to escape the wrath of the Hindu-Muslim fight. Since then, they have changed houses several times and maintain very little contact with people in the community. Only recently, the perpetrators of the 2001 riots were

convicted. Raziya and her family sought closure but this was not the end of their troubles.

Presenting Problem

Raziya's anxiety has become severe and she frequently experiences anxiety attacks and has difficulty completing the normal household chores. She paces around the house and constantly watches the windows and doors for any perpetrators or the possibility of yet another attack. Raziya is convinced that she and her family will never live a normal life. She had earlier sought help from a pir (spiritual guide) at a dargah (shrine) who bestowed his blessings on her and gave her a locket that would protect her from evil. Despite this measure, Raziya still felt nervous and presented to the clinic along with her husband to seek help for her anxiety symptoms. The doctor prescribed Raziya anti-anxiety medication. He also administered Raziya a Hindi version of the Beck Anxiety Inventory (BAI) and it was apparent that her symptoms were in the severe category. Upon consultation, Raziya and her husband agreed to see an LHC.

Session 1

During the first session, the LHC explained to Raziya and her husband that Raziya was experiencing some severe emotional and mental health problems. Raziya was reluctant to share details about her past and her symptoms because the LHC was a Hindu and Raziya had very little faith in her capacity to help. She made her displeasure known by talking about the injustices Muslims have to face despite being born and raised in India. Raziya had strong opinions about discriminatory and racist practices that divided humans on subjects that were trivial and not something worth being killed over. The LHC joined Raziya to empathize with her point of view. The LHC further

emphasized that the riots did a lot of harm to the Muslim community to reinforce that Raziya's opinion indeed made sense. In this way, the LHC began establishing rapport with the couple. The LHC ensured that the couple would not be discriminated against and the facility's intention was to help them and not harm them in any way.

The LHC invited Raziya to share her ordeal and informed her about the privacy policy that strictly prohibited the LHC from sharing information with other people. Raziya was suffering because she never got a chance to share her story in a healthy way. Her painful experiences had been concealed for far too long and this was causing her to think, feel, and act in a way that was impairing her daily life. The LHC further explained that a person experiences anxiety when he or she has a stream of negative thoughts that are usually catastrophic in nature. Such thoughts have the capacity to cause physiological problems like a rapid heartbeat, sweating, numbness, tingling, and nervousness. A person may become fearful, scared, or even irritable as a result of such anxiety. Psychotherapy has been scientifically proven to treat anxiety and a lot of other people have dealt with anxiety and have found relief from their symptoms with the help of counseling.

The LHC reiterated that the clinic would not discriminate in providing services to Raziya and her husband. Additionally, she pointed out the benefits of taking medicine and seeking counseling services. The LHC informed Raziya that the counseling sessions were a safe atmosphere. The LHC suggested that if Raziya attended all six sessions, she would be eligible to receive free medications. Raziya decided to try counseling and the LHC provided Raziya educational materials on anxiety and its treatment.

As a summary, the LHC achieved the following in Session 1:

- Established rapport by adopting a neutral approach toward religion but at the same time joining Raziya and her husband in empathizing with their struggle of living with the aftereffects of the riots.
- Keeping in mind the client's reason for referral, the couple was informed about the nondiscrimination and confidentiality policy of the clinic.
- Educated Raziya about the symptoms of anxiety and their impact on her physical health. She also provided her with educational material on anxiety.
- The LHC entered Raziya into a free six-session agreement contingent on regular attendance at counseling sessions.

Session 2

The LHC engaged Raziya in exploring her anxiety to better understand its presentation. During this session, Raziya talked about how her religion had become her identity and how society does not look beyond that. Raziya was terrified of wearing her burkah while visiting the masjid (mosque) with her family on Fridays. Ever since the attack, she had tried to shun Muslim cultural practices and this caused her to constantly live in a dilemma. On one hand she wanted to be a practicing Muslim and on the other she was afraid to follow her cultural practices because she thought it would attract negative attention and she would become the subject of further scrutiny. She talked about experiencing becheni (discomfort), ghabarahat (nervousness), kampana (shakiness), and sans fulna (breathlessness) on various occasions throughout the day. On further exploration, she explained that her symptoms could be in relation to anything like her children playing outside, her husband arriving late from work, a stranger at the door, or even going out in the market to buy groceries. Raziya explained that her swabhav

(personality) was now affecting her children and husband. She felt inept in performing any duties, whether of a mother or a wife.

The LHC informed Raziya that her symptoms were a result of generalized anxiety disorder. She explained that Raziya had gotten into a habit of catastrophizing that caused her to think of the worst outcomes for different situations. The riots were a significant event that had altered her functioning in an unhealthy way. She assured Raziya that she could restore her healthy functioning and revert back to her prior healthy self. She urged Raziya to think about her life prior to the riots. Raziya reported that she was a happy person, liked socializing with other women in the community, and often went out with her family for various activities. Previously, her religion never interfered with her psychological functioning and she freely practiced her religion without fear of persecution.

The LHC helped Raziya understand that her fears were valid when the event had occurred. However, it had been a long time since the riots and the LHC had seen many people from the Muslim community and other religions practicing their faith without any fear. She encouraged Raziya that goal setting would be helpful to achieve relief for her symptoms. Raziya wanted to reduce her anxiety so she could live her life the same way she lived previously. For this session, the LHC taught Raziya basic anxiety calming skills, such as deep breathing, that she could use whenever her anxiety was triggered. She encouraged Raziya to practice this every day and gave her educational material on the benefits of deep breathing and educated her on how she could practice the technique at home.

As a summary, the LHC achieved the following in Session 2:

- Gathered information on Raziya's anxiety symptoms that she verbalized in Hindi.
- Engaged Raziya in exploring how her religion was the cause of her acute anxiety.
- Explored Raziya's cognitions about living in a largely Hindu society and its impact on her as a Muslim woman.
- Raziya explored her life prior to and after the Hindu-Muslim riots to understand the extent of impairment in her present life.
- Raziya practiced basic anxiety management skills such as deep breathing. She was also provided with self-help materials for anxiety management.
- They agreed to work on Raziya's goals to resume her prior level of functioning by helping her become a practicing Muslim and manage her symptoms of anxiety.

Session 3

In this session, the LHC explored Raziya's beliefs about her anxiety. Raziya reported that if she lived in an all-Muslim community, she would be safe and not experience anxiety symptoms. The LHC gently challenged this belief by reminding Raziya that she previously lived in a community with people from other faiths and she did not have anxiety symptoms. She explained that if Raziya could control her thoughts, then she could control her physical symptoms of anxiety. The LHC further explained the mind–body connection and educated Raziya on the cognitive triad. They worked on several of her personal life examples to demonstrate that Raziya's thoughts were not always true and they caused her unnecessary stress.

Raziya learned to connect the negative thoughts, emotions, and behaviors that caused her anxiety. For example, she had thoughts such as "someone is following me" that made her feel nervous, and as a result she covered her face with her veil. She hurriedly completed her tasks and rushed back home because she would be out of breath and experiencing other anxiety symptoms. The LHC asked Raziya how many times anyone had followed her. Raziya reported that no one had followed her. Further, the LHC suggested that when Raziya was having such thoughts, it would be helpful to slow down and look at the facial expressions of those passing by. The LHC explained that the aim of practicing real-life anxiety-provoking scenarios in counseling was to help her practice healthy responses so she would be better equipped to respond in a healthy way when real situations occurred.

The LHC helped Raziya alter her interpretation of her triggers by role-playing with the couple. The LHC then encouraged Raziya to do this activity in the market along with her husband before she returned for the next appointment. The LHC inquired into whether Raziya would need any additional support to carry out the activity. Raziya reported that it would be helpful to perform a dua (prayer) before stepping out and to keep her locket handy that would protect her from evil (buri nazar). The LHC encouraged Raziya to mentally recite her dua even during the experiment. If Raziya would perform her dua mentally, only she would be aware of it and it would not attract negative attention. The couple agreed to carry out this experiment and come back with feedback for the therapist.

As a summary, the LHC achieved the following in Session 3:

- Engaged Raziya in identifying anxiety triggers and challenging thought distortions related to faith, religion, and community.
- Raziya learned about the connections among her thoughts, emotions, and actions and also practiced ways to alter them in session.
- Raziya practiced exposure via role-playing to alter her response to situations that triggered her anxiety symptoms.
- She also learned to use her faith (reciting dua and keeping her holy locket) in performing interventions to strengthen her Muslim faith and learned about the Euro-American approach to managing anxiety.

Session 4

In this session, the couple gave an account of the experiment. Raziya shared that though she experienced anxiety in the market, an occasional glance at the crowd was manageable. She reported that others were too busy walking through the market and hardly anyone looked at her. No one stared at her because of her appearance and no one followed her back home. She also reported that her constant recital of a dua may have saved her from any danger. The LHC informed Raziya that the experiment helped her see that even though she held a belief that she would attract negative attention, there was nothing that occurred that would validate her beliefs. She encouraged Raziya to similarly check the validity of her thoughts in other situations that may provoke anxiety. Together they formed a list of triggers and one by one discussed how they could alter the perception that would help Raziya manage her anxiety. The LHC encouraged Raziya to continue to keep her locket for protection and recite a dua in her mind. She assured her that this practice would help Raziya follow her faith and at the same time get additional

support in managing her anxiety. This way, the LHC introduced both evidence-based interventions and culturally suitable coping skills that together would help Raziya improve her mental health.

As a summary, the LHC achieved the following in Session 4:

- Raziya conducted an exposure experiment in the marketplace to practice techniques learned through role-playing.
- The exposure helped her check the validity of her thoughts and understand that her beliefs were not accurate.
- Raziya learned to apply both evidence-based interventions and culturally suitable coping skills.

Session 5

During this session, the LHC invited Raziya's husband to discuss her triggers and what steps they could take together to help Raziya strengthen her coping skills. The LHC used a scenario to explain Raziya's condition. She explained that when a person has an accident and becomes bed ridden, he or she becomes dependent on additional support from others to get back on his or her feet. In addition to doctors, the person will require physical therapists to retain functioning. In Raziya's case, Rahim would have to be her crutch to get her mental health on her feet. The LHC suggested it would be helpful if Rahim could take Raziya to the market to ensure adequate exposure to anxiety-provoking situations. This would benefit Raziya because the more she practiced her anxiety management skills with Rahim, the more independently she could do it in the future. Therefore, their partnership on this task was crucial.

As a summary, the LHC achieved the following in Session 5:

- Conducted family therapy with Raziya and her husband.
- Helped Raziya's husband understand the importance of exposure and his role in helping Raziya meet her anxiety management goal.
- The importance of collective effort was reiterated.

Session 6

During this session, the LHC reiterated to Raziya the importance of complying with medication, practicing mindfulness skills, performing a dua, and exposing herself to triggers to practice the altering of thoughts, emotions, and behaviors. The LHC once again administered the BAI and Raziya's performance indicated her symptoms were now in the moderate category. Raziya was asked to summarize the lessons learned in counseling and how she would use them moving forward. The LHC instilled hope that if the couple together complied with the suggested changes and interventions, Raziya's symptoms would be in the mild range.

She also forewarned them about the resurfacing of symptoms and communicated that it was common for anxiety symptoms to have an up and down trajectory. However, if the symptoms became severe and Raziya was having extreme thoughts such as suicide or self-harming thoughts, then it would be important to contact the doctor or receive higher care, for which she provided them with additional resources. Together they reviewed the warning signs of anxiety and the interventions they practiced in session. Raziya was asked to frequently look over the pictorial description of anxiety management for daily practice. Finally, the LHC affirmed Raziya's progress and ensured the couple that a collective effort would bring Raziya great relief and freedom from her anxiety.

As a summary, the LHC achieved the following in Session 6:

- Performed a review of medication compliance, anxiety management skills, and the use of culturally suitable interventions.
- Discussed the importance of exposure in managing anxiety.
- Made the couple aware of the pitfalls in the course of anxiety management and further steps such as seeking professional help in the case of acute symptomatology.
- Encouraged a collective effort in order to continue successful anxiety management.

Chapter 5: Discussion

The field of mental health in India has evolved over the years. In ancient India, the practice of psychology was embedded within spirituality, and post-colonization it became heavily influenced by the Euro-American methods. This fundamental shift in studying the mind took over and soon there was a mental health treatment gap because the Euro-American measures were limited in their capacity to understand and treat the cultural nuances of the mental illnesses found in the Indian population (Arulmani, 2007). At present, the lack of mental health professionals and uniformity in mental health treatment services has created a 90% treatment gap that is daily adding to the national health burden (A. Kumar, 2011). As a result of this treatment gap, current psychiatrists can only provide 15 to 30 minutes of consultation and there is only one psychiatrist per 100,000 citizens to provide mental health services (Virudhagirinathan & Karnunanidhi, 2014). Most efforts to meet the mental health needs of the community have been through prescribing medications for various mental disorders as high quality psychotherapy is only available and affordable to a few. This clinical research project was designed to shed light on the need to address the counseling needs of the Indian population.

There are few mental health professionals in India who can deliver counseling services even though there has been a steady increase in the demand for such services (Arulmani, 2007). To address this gap, the purpose of this clinical research project was to develop a training model for LHCs to be able to provide a cost-effective way of using their limited resources. At present, mental health professionals have made efforts to scale up mental health services by integrating mental health into primary healthcare services. However, these services are limited to providing prescription medication and doing

surface level therapy that is mostly in the form of mental health first aid. Moreover, the literature review provided evidence that the primary healthcare sector can avail mental health counseling services with the help of LHCs (Singla et al., 2014).

Global mental health research has put into perspective the need to address the disparity in mental health services in many low-middle income countries (LMICs) that results from the assumed dominance of Euro-American counseling methods. The use of alternate approaches to mental healthcare by most of the populations in LMICs is highly neglected. A lack of cultural sensitivity by mainstream psychology has resulted in the underutilization of mental health services. To make counseling more universally applicable, leaders in the field of global mental health have recognized the need to adopt culturally relevant methods such as using grassroots level workers. For example, Nepal, a country neighboring India, experimented with using locally trusted people who detected mental health issues in two rural districts (Jordans et al., 2017). The employed local workers had greater success in increasing their communities' help seeking behaviors because they were trusted, respected, and capable of understanding the local presentation of mental illness (Jordans et al., 2017). The WHO, through its mhGAP, has attempted to decentralize mental health services by incorporating local community workers who can deliver limited mental health services into primary healthcare (Ventevogel, 2014). These locally trained community workers can help people look for practical solutions, and decentralizing mental health services expands the scope of mental health treatment because it allows for the inclusion of cultural and social concerns that are heavily contributing to the root cause of mental health issues in LMICs. International organizations such as Emerald Programme have policymakers working with mentally ill

people at an intimate level to ensure more culturally acceptable mental health services are in place (Semrau et al., 2015). As the need for culturally relevant models of care has begun to gain attention among those in the field of global mental health, there is a great need to develop and implement such a culturally relevant model of mental health care in India.

In response to the lack of a culturally relevant counseling model in India and the scarcity of counseling services, this author created a Contemporary Indian model of Counseling for Depression and Anxiety (CIMCDA). The focus within the CIMCDA is on depression and anxiety because they are the two most prevalent mental disorders in India. Drawing from the global mental health research, this model was designed to train LHCs because they are well versed with the communities' cultures and have greater success at client retention and implementing culturally sensitive therapy.

The CIMCDA framework includes establishing therapeutic rapport, understanding the impact of sociocultural factors on the client's functioning, using the client's view in case conceptualization, and developing interventions informed by this conceptualization. The integrated interventions will foster faith in indigenous healing as well as Euro-American ways of treating mental illness. LHCs can learn to use the principles of CBT as a basis for explaining impairments in functioning to clients. They can use clients' words to assist them in understanding their thoughts, emotions, and behaviors.

Great emphasis is placed on identifying the local presentation of the disorder and understanding how the culture within the family setup and other spheres of life (e.g., community, workspace, religion, etc.) can affect the manifestation of the mental illness.

Special consideration is given to the collectivist setup as the routine inclusion of families can help LHCs achieve greater rapport, thereby successfully implementing therapy interventions. Thus, there is a shift from the traditional implementation of the Euro-American framework of counseling because multiculturalism is the focal point of counseling and other parts of counseling are tailored accordingly.

Application of CIMCDA to Depression

To illustrate the CIMCDA, two case scenarios were discussed in the CRP. The first scenario used a classic example of a lower SES traditional Hindu family structure. In this case, Lata was suffering from major depression and was referred by her general physician to the LHC's clinic based on her higher scores on the PHQ-9. The first session comprised establishing therapeutic rapport by treating the couple as equals and educating them on the signs and symptoms of depression in layman's terms. Lata's depression was normalized and they were informed of the benefits of counseling. They were also made aware of the confidentiality policy of the clinic and the procedure to receive free treatment by attending all six sessions. Lata also took part in identifying goals for therapy.

During the second session, the LHC continued to establish rapport. She gathered information on Lata's symptoms and explained how symptoms such as skipping work and the inability to sleep resulted in financial strain on the family. Within the family setup, Lata's depression came across as laziness that attracted insults from her husband; as a result, Lata felt guilty. However, she could not talk about her struggles as she occupied a lower position in the family hierarchy. The LHC then proceeded to help Lata understand the negative cognitive triad and the role of social, biological, and

environmental factors in her depression. She also addressed Lata's ability to effectively communicate about her struggles with her husband. In order to facilitate better processing and the ability to talk freely, the LHC spent the first half of the session with Lata and the later half of the session with the couple.

During the third session, Lata was able to process her feelings of helplessness and hopelessness about the future that stemmed from her view that nothing would change. She also verbalized her belief that her past karma was responsible for her financial problems and current situation. The LHC then helped Lata make a connection between her thoughts, emotions, and actions and understand how this pattern was also causing her physical problems. They agreed to include a traditional coping method such as praying in the temple with the family to bring some sense of hope.

During the fourth session, Lata provided positive feedback on visiting the temple and using prescription medication, as her functioning had somewhat improved. Lata's view of past karma was used to reconceptualize her functioning and help her understand that altering her cognitions would also alter her present and future karma. Lata understood that building positive karma was possible by doing things such as taking care of herself, taking her medication, and going to work. Along with this, the LHC encouraged culturally acceptable coping skills such as praying in the night to help Lata distract herself from negative thoughts.

During the fifth session, Lata continued to identify triggers that made her feel hopeless and the LHC taught her to use cultural sayings to manage her negative thoughts in a healthy way. They also focused on managing daily struggles through practical suggestions, such as asking her husband for a ride to her workplace. Ram was also

encouraged to help Lata achieve her counseling goals that were meant for the greater good of the family.

During the sixth and the last session, couple's counseling was the focus and Lata and Ram were encouraged to improve their communication skills. The LHC suggested changes to Ram's drinking behavior to manage the family's financial crisis. He was provided with a referral to the rehabilitation clinic and encouraged to seek help for his drinking behavior. Lessons learned in counseling, such as medication compliance, altering cognitions, seeking family help, and focusing on Lata's strengths through performing prayers, were summarized and reiterated. Finally, negative thought altering and performing duties as a means of collecting positive karma that would help Lata achieve her goals even after the termination of counseling were emphasized and reinforced.

Application of CIMCDA to Anxiety

The second case scenario was of a Muslim family coping with the aftermath of riots that occurred in the state of Gujarat in 2002. Raziya developed extreme anxiety that caused her to confine herself within four walls, and ultimately most areas of her life had become impaired. Her symptoms of anxiety were in the severe range. She was also referred to the counseling department by a general practitioner. The first session involved the LHC establishing rapport by joining Raziya and her husband in empathizing with their struggle of living with the aftereffects of the riots. The LHC emphasized the confidentiality agreement and the clinic's non-discrimination policy. Raziya was educated about the signs and symptoms of anxiety and was provided educational

materials about the same. The couple was made aware that they could receive free counseling contingent on them attending all six consecutive sessions.

The focus in the second session was on gathering information on Raziya's anxiety symptoms. Raziya verbalized her dilemma about her religion that resulted in her having acute anxiety. She explored the cognition that living in a largely Hindu society had an impact on her Muslim identity. She compared her life before and after the riots and this made her aware of the extent of impairment on her current functioning. Raziya learned basic anxiety management skills and was given educational materials for self-help purposes. Raziya established goals for therapy such as resuming prior functioning, meaning practicing Islam and managing her symptoms of anxiety.

In the third session, Raziya learned to identify anxiety triggers and challenge her negative thoughts related to her faith, religion, and community. Additionally, she learned to alter the negative triad of thoughts, emotions, and actions. She practiced exposure via role-playing situations that triggered her anxiety symptoms. The culturally relevant interventions of saying a dua (prayer) and keeping her holy locket were introduced as strategies she could use while performing a real-life exposure exercise in the market.

In the fourth session, Raziya reflected on lessons learned while doing the marketplace exposure. She learned to check the validity of her thoughts and understand that not all her beliefs were accurate. She also learned to apply both the Euro-American way and culturally relevant way of managing anxiety. The exposure helped strengthen her Muslim faith, which was one of her counseling goals.

In the fifth session, the LHC conducted counseling with Raziya and her husband. She helped Raziya's husband understand the importance of exposure and his role in

helping Raziya meet her anxiety management goal. Thus, the importance of collective effort was reiterated.

In the sixth session, the LHC performed a review of medication compliance, anxiety management skills, and the use of culturally suitable interventions. They discussed the importance of exposure in managing anxiety. The couple was made aware of the pitfalls in the course of anxiety management and encouraged to seek further professional help in the case of acute symptomatology. They were also encouraged to collectively work to continue successful anxiety management.

Referral for Higher Care

The two case scenarios discussed are straightforward and do not need additional therapy or intervention. Sometimes, lay health counseling may provide the groundwork for clients who qualify for a higher level of care. These clients may present with comorbid disorders and LHCs may be able to address only the most pressing issues. For this reason, it is important to determine whether the clients present with other signs or symptoms of mental illnesses. For example, some clients may also exhibit suicidal and self-harming ideation or behaviors. Some qualifiers for immediate referral for higher care are active suicidal ideation and self-harming behaviors that may endanger the client’s safety. Some clients may also present with hallucinations, delusions, and paranoia. In such cases, if the clients are highly unstable and an imminent danger to their own or other people’s safety, they should be immediately referred to a psychiatric facility. There might be other issues present that may be causal of depression and anxiety, such as domestic violence, abuse, trauma, marital conflict, and others. The CIMCDA model does not prepare LHCs to deal with such issues; therefore, it would be

ideal for LHCs to determine whether such factors are in fact present and need to be dealt with before dealing with depression and anxiety. However, referral for higher care does not mean that clients should be entirely turned away. If the clients are willing to see other professionals, then simultaneous care can be provided. Regarding suicidal and self-harming ideation, some clients may express themselves in an extreme fashion and this may be resolved through better processing of symptoms in counseling sessions. Additionally, peer-to-peer supervision and consultation with other mental health professionals may help LHCs understand whether the case is beyond their competency skills, at which point referral for higher care is essential.

Strengths of the CIMCDA

This CIMCDA includes a consideration of the counseling needs of Indian population, thus making it more culturally appropriate. The idea of integrating mental health into primary health care is retained because medical professionals can provide symptom focused care and mental health professionals can get to the root cause of mental health issues. In fact, the CIMCDA is an extension of the barefoot counseling that was originally developed for training LHCs in the Sangath Foundation. However, the unique contribution of this model is the ability for LHCs to not only use the basic tenets of therapy, but also use some in-depth principles of CBT that bear resemblance to various aspects of the Hindu culture.

The model provides an in-depth counseling framework for both depression and anxiety, which are two of the leading causes of health burden in India (Jonas et al., 2014). LHCs can use this model based on their expertise and in any order. The model uses a top-down approach that helps the counselor and the client understand how various

spheres of life may be contributing to the current impairments in functioning. However, the interventions still allow the client to be the focal point in therapy. Overall, the CIMCDA is a strength-based model because it is meant to capitalize on the client's individual, cultural, and societal strengths and use them to alter impaired functioning.

Limitations of the CIMCDA

The case scenarios demonstrated that each module can be completed in a single session (i.e., six modules can be implemented in six sessions), thereby finishing the course of therapy. However, the case scenarios are idealistic and there are a variety of factors that are not accounted for that may hinder the course of therapy. It is common to encounter skeptical and resistant clients who may initially attend sessions but may not continue the course of therapy despite provisions for incentives. There are many systemic issues that are difficult for clients to overcome. Therefore, sometimes desire is not enough to seek mental health services. As stigma and discrimination prevail to such a great extent in Indian societies, it should be expected that clients may not always be receptive to a proposition of change.

LHCs may find it difficult to adopt a less directive and authoritarian approach that is the traditional approach to counseling in India. It may be difficult to adopt a balanced Euro-American as well as indigenous viewpoint. This is because some counselors may feel adopting indigenous methods may give rise to misconceptions and undermine the scientific evidence-based approach. However, giving clients the freedom to include indigenous methods in their treatment is designed to help them strengthen their faith, something that will ultimately help them achieve improved mental functioning. Furthermore, the efficacy of the counseling may depend on the attitudes toward

counseling espoused by medical professionals. This means that just integrating mental health into primary healthcare is not enough. General practitioners should have a positive attitude toward counseling so they can then ready clients to take the first step toward counseling.

Future Research

Future research should focus on designing models specific to other common mental disorders, including suicide, schizophrenia, substance abuse, domestic violence, and mass trauma, discussed in the literature review. Prior to this, it will be of great importance to gauge the efficacy of the CIMCDA and its practical implementation to carefully analyze whether it reduces the treatment gap. Both qualitative and quantitative research are required to examine whether the inclusion of sociocultural factors makes counseling more acceptable, whether a six-session model is enough to work on these sociocultural factors, and whether the incentive to receive free treatment truly improves client retention. In order to have a greater impact, the CIMCDA should be implemented nationwide in settings where primary healthcare and mental healthcare are integrated and vice versa, as more primary healthcare centers should provide mental health treatment. The CIMCDA is designed to reduce stigma, shame, and discrimination and increase clients' belief in the efficacy of mental health services, though future research into this claim is needed. This additional research will shed light on limitations of the model and enable researchers to modify the model to compensate for the anticipated limitations.

Clinical Implications

The CIMCDA will greatly help in reducing the treatment gap. The integration of sociocultural factors will improve the therapeutic alliance, reduce client dropout rates,

and increase faith in the efficacy of counseling services. The implementation of this model will reduce the disparity and the disproportionate availability of mental health services in rural and semi-urban areas. It will also strengthen the use of indigenous, more traditional approaches to healing the mind. This model is designed to avoid the medicalization of the field of counseling by putting enough emphasis on all aspects of mental health that are necessary for the overall healthier functioning of an individual. Therefore, there is a balance among the use of prescriptions, counseling, practical interventions, and other culturally prescribed remedies. This model does not imply that the efforts to train people in professional mental health programs should be done away with. The CIMCDA was created in response to the current scarcity of mental health resources. Meanwhile, there should be simultaneous efforts by the government to use the model to deal with the present shortage and proactively make efforts to encourage the Indian population to take up careers in the field of mental health. Nevertheless, a systemic effort is required to build a solid mental health infrastructure so the Indian population is not ashamed to seek services and providers are equally interested in meeting the mental health needs of the population.

Conclusion

The purpose of this research project was to identify the current gap in the treatment of common mental disorders, specifically psychotherapy services, and create a model of counseling that can act as bridge between culture and counseling, thus making it more socially acceptable. The 90% treatment gap exists as a result of a variety of factors, such as a shortage of mental health professionals, a lack of training for current therapists, societal factors such as stigma and discrimination, the lack of an inclination to seek

mental health services, and a lack of uniformity of mental health services in India. The CIMCDA was created to compensate for this treatment gap. The approach of this model is such that it enhances those cultural factors that are the client's strengths and addresses or works on those sociocultural factors that may be getting in the way of the client's mental health. The Euro-American method of counseling serves as a framework to make the counseling more focused and goal oriented whereas sociocultural factors inform various elements within this framework. Therefore, the complete harmony between the two essential elements of counseling (i.e., the Indian approach toward understanding the mind as well as the more technical nuances of Euro-American counseling) makes the CIMCDA more acceptable and easier to implement in Indian society. The global mental health approach also informed this model as LHCs can look for practical solutions to problems such as survival, stigma, discrimination, and oppression in the context of mental health issues.

All those who are aspiring to become LHCs or those who are already practicing should know that counseling does not always work by the books. In India, the presentation of mental illnesses can vastly differ from standard case examples. Therefore, using this model presents an opportunity for LHCs to harness their creativity in the realm of counseling, obviously with the main aim to do no harm and maintain client integrity and confidentiality at all times. The interventions administered should be sustainable and their utility should extend beyond the scope of counseling sessions. The measures of psychology may become obsolete, but the ancient teachings and traditions are always going to be the gold standard of Indian society. Therefore, counseling should be implemented in conjunction with the culture of the client and not vice versa. It is

possible that the clients become efficient in managing their symptoms but that does not necessarily imply an absence of mental illness. Therefore, clients and LHCs should be cautiously hopeful and understand that novel triggers or situations may result in the resurfacing of symptoms. This will prepare clients to better face future challenges in terms of their mental illness. Thus, the idea of counseling is to help clients structure their lives in a way such that mental illness can become more manageable. The greatest measure of the efficacy of a counseling approach is feedback from the client and the client's family. Therefore, a regular check in with the client and his or her family about the client's functioning is very important.

Even though supervision for mental health counselors in India is sparse, they can always adopt a multidisciplinary approach and collaborate with other mental health personnel to gain a better understanding of clients. A peer group approach where LHCs can exchange ideas, brainstorm interventions, assist each other in looking for possible solutions, and refine their counseling skills is also recommended. It is of great importance to conduct periodic training for LHCs to help them become efficient in their task of counseling. Finally, the CIMCDA can be successfully implemented if there is an honest effort from both the LHCs and the clients as well as those within the primary healthcare sector.

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