Cognitive Behavioural Therapy in India: Adaptations, Beliefs & Challenges

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India, is said to be emerging as one of the 'super-powers' in the coming decades. The rapidly developing economy has enhanced the pace of social change, but the Indian society is struggling between deeply ingrained traditions, beliefs and practices on one hand, and massively transformed lifestyles on the other. Psychotherapy needs in the Indian context thus emerge against such a complex background.

In India, Psychotherapy (defined as "an interpersonal method of mitigating suffering") has existed since ancient times although in a submerged form, interwoven with social structures, religious practices, myths and rituals. However, modern psychotherapy / counselling services are poorly defined and currently anyone with little or no training can offer these services. There is no regulatory body to oversee practice and training of psychotherapists. In addition the existing training programs are insufficient and largely theory based.

Cognitive Behavioural Therapy is considered by some as befitting the Indian mindset due to its short, focussed and directive nature while it as a "Western approach" is criticised by others as unsuitable to the Indian culture, too simplistic to be appealing, restricted by language and outlook, and even questioned for its need here.

While Cognitive Behavioural techniques are widely used by mental health practitioners in India, Cognitive Behavioural practitioners per se are rare. This is because practitioners rarely follow a single systematised form of psychotherapy rather an eclectic mix is the reality. The authors suggest that to be more successful in the Indian context, CBT approaches probably need to adopt a 'Philosophic-Spiritual' underpinning and extend into SECBT (spiritual, emotional, cognitive, behavioural therapy). In addition, evidence based research as well as training cum supervision services need to be developed.

The future of CBT in both the East and the West lies in 'integration' and in discovering a conceptual framework with universal validity and flexibility as well as in developing opportunities for CBT exchange programmes.

India is one of the oldest civilisations in the world and also one of the rapidly emerging global economies. The country has huge variations of sub-cultures, populace, language, religion, customs, socio-economic aspects as well as lifestyles. The age old adage "Unity in Diversity" is the hallmark of all aspects of life in this country – and mental health services are no exception.

Indian society is characterised by deeply ingrained traditions and belief systems despite fast changing lifestyles and modernisation. In addition, while one section of society is becoming increasingly modernised embracing globalisation and having the resource advantage, the majority (mostly living in rural areas) still struggle for needs of daily living and basic amenities. There are obviously then huge variations in access to health and educational services as well.

Sinha (2000) has argued that given the pluralistic nature of the Indian society and its people, the openness to diversity among Indians, and the relative comfort with dissonance of an Indian scholar, no single route is best for the growth of psychology in India; rather a number of approaches to making psychology relevant will not only help but also ensure the survival of the indigenization movement.

The medical compendia of ancient India are replete with references to mental health covering a spectrum of diagnoses, classification and treatment methods. The great epics such as the Ramayana and the Mahabharata made several references to disordered states of mind and means of coping with them. The earliest example of counselling / Psychotherapy that Lord Krishna provided to his devotee Prince Arjuna in the battlefield has been explicitly covered in 'The Bhagavad Geeta' which was written around 200 BC and is central to the Hindu scriptures.

Systems of Psychotherapy as defined as "interpersonal method of mitigating suffering" have existed in India since centuries. Unlike Western approaches, these have lacked a clinical bias but have provided a more global framework (Neki, 1975).

According to Hall and Lindzey (1974) "the conception of personality in Indian thought is more spiritual than psychological. The scriptures say that the individual ought to have certain qualities, behave in certain ways and perform certain rites in order to attain 'moksha' (release from cycle of birth and death). The description of personality in Indian scriptures is 'what ought to be' and not 'what is'. Indian conceptualisations handle mental health in terms of growth towards the spiritual or transpersonal. According to Singh (1977), "This approach is useful not only to the abnormal but also to the normal individuals".

With the passage of time however, the traditional Indian knowledge and style of living receded into the background and blind copying of the West came about in the name of 'Modernism', especially so in Urban areas. On one hand, the Western approaches to mental health were widely criticised for their inapplicability in the Indian culture but at the same time they have blindly been aped and followed. The rich traditional knowledge systems were ignored and un-developed making them alien and un-applicable to the needs of common man. Nor were attempts made to integrate the old modes with new concepts.

However, post-Independence and specially during the last few decades, factors such as the break-up of the joint family, the collectivistic nature of family organisation, the overtones of caste-based social stratification, gender issues and urban–rural migration brought about widespread changes in Indian society. A decade or two of economic reforms pushed India towards becoming one of the world's fastest growing economies. This in turn enhanced the pace of social change and gave mental health needs a new complexion.

Psychology as a discipline grew tremendously and attempts were made to put it out of the 'academic closet' and make it relevant to the common man. As such, awareness as well as research on the integration of Indigenous traditions and concepts into modern mental health services increased. However, there has been and still continues to be lack of evidence-based psychotherapy practice as well as severe shortage of training, supervision, and professional regulatory services, which make psychotherapy services in India largely un-systematic, un-researched and un-professional, in the current scenario. In addition, their relevance is questioned amongst the larger background of physical healthcare needs as well as diverse mental health practices.

Mental health services and service providers in India –

India is a country with a population of over 1 billion, and immense diversity in the languages spoken, levels of literacy, and social and cultural practices. Organising mental health services for this predominantly rural population is indeed a daunting task. Compounding this problem are low budgetary resources, the presence of competing and conflicting healing systems, scarcity of mental health personnel, 'brain drain', and the stigma of seeking help for problems related to the mind (Thara et al., 2004).

Patients with severe mental disorders consume most mental health resources: thus, much of the scarce specialist mental health system is largely concerned with the care of adults with severe mental disorders**.** However, even this care cannot be considered as adequate for most**.** Second, most patients with mental disorders, particularly less severe disorders, prefer to seek care from their own family or primary care health care providers**.**

The traditional Asian beliefs like mental illness being equated with insanity and thereby the stigmatisation attached to having such problems and seeing a mental health practitioner not only leads to denial of the existence of a problem but also creates barriers to help-seeking. External explanations whether it originates from organic or moral/spiritual sources, has far greater acceptance than psychological explanations, and thus psychological distress is commonly manifested in somatic symptoms for Asian people. Consultations with medical practitioners or traditional healers for somatic complaints often legitimises help seeking for problems which may have psychological origins (Williams et al., 2006).

Indigenous systems of medicine as well as traditional healers play a large part in the treatment seeking pattern of patients (Das et al., 2002). Large numbers of patients from rural areas are initially seen by religious healers and spiritual gurus (Kapur, 1975) and only later or rarely get seen by a Psychiatrist, who are mostly Urban based.

Many patients seek treatment from alternative systems of medicine (such as Ayurveda, Homeopathy, Yoga) and visit a Psychiatrist only if problem persists. In Urban areas, although people are more open to seeking professional mental health services, they still largely confuse between Psychiatrists and Psychologists and prefer quick / medicine-based cures more than 'talking therapies'. Psychologists and therapists as Independent practitioners are few and unregulated even in Metro cities like New Delhi. The lack of training and regulatory services also compromises the credibility of the existing Psychotherapy practitioners. All these aspects makes the Indian Mental healthcare scene extremely complex and challenging.

Discrepancy in the psychiatry literature about the relevance and acceptability of CBT –

The basic question is whether psychotherapy is really necessary in the treatment of mental illness. In view of certain Psychiatrists, it is ineffective, no better than placebo, doing as much harm as good, and having no scientific foundation. But in spite of various limitations, it is hard to find any psychiatrist who does not follow Psychotherapy of some kind or the other (Agarwal, 1989).

He also goes on to say that among the other reasons for psychiatrists not using psychotherapy is the enormous workload on them and the inability of the Indian patients to appreciate psychotherapeutic methods owing to the low level of education prevalent here.

However, the present authors is of the opinion that times have changed and although psychiatrists are still quite regardless of Clinical psychologists and psychotherapy, they do realise that 'talking therapies' are an essential tool in the therapeutic armamentarium. However, those psychiatrists who still harbour such conservative views as those expressed above, are suffering from a lack of proper training and awareness or just plain and simple denial.

Shamasundar (1979) argues on the positive side that if psychotherapy from one culture is not relevant in another despite all of us being human beings (and thereby sharing commonalities) then how can one psychotherapy be relevant in different sub-cultures as well. In addition, he says that no society is exclusively oriented towards individual independence or towards social dependence.

He further questions that "if in recent times, a western Psychiatrist finds our traditional meditation technique useful, why cannot a western technique be capable of useful adaptation in India?"

Writers such as Neki (1976) have suggested that in comparison to non-directive psychotherapies developed in the West, those that follow the "Guru-Chela" (teacher-disciple) paradigm is more suitable to the Indian Culture and CBT is one such approach. In addition, since it is comparatively easier to learn, many Psychiatrists have come to take interest in it and have found it effective in many of their patients (Kuruvilla, 2000).

Kuruvilla (2000) further says that he would like to see more and more psychiatrists using CBT in their practice and conducting large scale evaluative studies to see what aspects of CBT are more relevant in our culture, for example, what methods can be used to help a illiterate client who cannot make a daily written record of his cognitions.

The Indian Mindset

There are various factors and aspects that make the Indian psyche different from the Western, These factors include both those intrinsic to the individual such as the inability to differentiate between cognition and emotion, as well as those extrinsic to him such as social stigma.

In the present authors' practice as well it has been observed that Indian clients frequently use 'I think' for feelings and 'I feel' for thoughts. This makes socialisation into the cognitive model as well as use of thought records and cross-sectional conceptualisations difficult. Although, clients understand the difference between thought (explained as those arising from the mind) and emotion (those arising from the heart), when it comes to applying it to real life or analysing it, they stumble and get confused.

In addition, in the Indian culture, it is not considered socially appropriate to talk too much about one's emotions and also at times to not show emotions as it can be interpreted as a sign of weakness, especially in males. This makes the task of therapy challenging.

As an offshoot of stigma related to mental illness, we have found that Indian clients prefer to not do therapy tasks or homework assignments outside the sessions. Further, drop-out rates are quite high and compliance low for working on emotional disorders, either due to quick symptom relief in the earlier sessions or an inability to tolerate actual behavioural change. I have recently had a case of a middle aged lady suffering from OCD since past 25 years. She was extremely enthusiastic in the initial sessions when she was 'talking' about her widely generalised symptoms but abruptly stopped coming for therapy as soon as exposure work was begun.

The various differences in the Indian and Western mindsets are outlined in the box below.

Factors differentiating the 'Western' mindset from the 'Indian'

- Autonomy Vs Dependence
- Individualism Vs Collectivism
- Cognitive focus Vs Spiritualistic orientation
- Psychological sophistication Vs Metaphysical/Mystical orientation
- Confidentiality Vs Sharing of problems
- Time-limited goal setting Vs Expectation of 'magical cure'
- Personal Responsibility and decision making Vs. Support/Direction
- Guilt Vs Shame ("I am bad" Vs "What will people say")
- Free Will Vs Fatalism/Destiny
- Therapeutic Collaboration Vs 'Guru-Chela' (Teacher/disciple) relationship
- Internal Vs External Locus of control
- Psychotherapy Vs Medication/Alternative Therapies
- Paid Psychological services Vs Free Advice
- Openness to Mental health services Vs Social stigma
- Bio-Psycho-Social model Vs Prevalence of several systems of healing

(Source: Kumar (2007)

According to Neki (1975), western form of psychotherapy is not appropriate to Indian culture because the Indian psyche looks for the sources of problems outside the self, in astrological influences, evil spirits, witchcraft or transgressions, or karma.

Sethi and Dube (1982) concluded from their own experience in psychotherapy, that the sense of guilt in the Indian culture has a much more impersonal character, because seen as a consequence of karma, than it does in others societies where this notion does not exist.

Indian Clients also seem to have problems with concrete thinking and in setting SMART targets. Their goals as well as problems statements are quite often abstract and vague.

Challenges in the delivery of evidence-based psychological therapy in India

- Concept of Psychological therapy still an emerging concept although trend catching on especially in Metro cities.
- Lack of an organisation to regulate practice, ethics, provide guidelines, etc.
- No uniformity in the profession and inability to follow a single systematised form of therapy
- Most practitioners follow eclectic approaches including various kinds of therapeutic techniques as well as alternative therapies.
- Complicated family structures and presence of other protective socio-cultural institutions.
- Simultaneous use of multiple therapies/treatments making evidence-based study difficult.
- Social stigma attached with seeing a 'mind doctor'.
- Client non-compliance and desire for 'magical cures'
- Inability to separate cognitions and emotions or to think in purely cognitive terms.
- Variety in Literacy and language.
- Lack of opportunities for specialised training and supervision in any one particular form of psychological therapy.
- No statutory body in India to provide professional registration to clinical psychologists.
- No mechanism for the monitoring, evaluation, and official accreditation of training programmes.
- No existing provision for legislation or insurance of practitioners.
- Existing training courses deepen trainees' knowledge base, but do very little to enhance skill literacy.
- Relatively little stress on documentation or research. Audio/video recording of sessions is rare.

(Source: Kumar, 2007)

Adapting CBT for Indian clients

A purely empirical method may not be suited to a collectivistic, developing world culture that has its roots in an intuitive and experiential approach to reality. This philosophic mismatch might lie at the heart of the failures of which modern psychology in India is accused. Subjective experience and intuition are given primacy over objective observations and measurements

Asian people regard professionals as authority figures, knowledgeable, and to be respected. Thus it would be preferable to adopt an instructive and didactic style early in the therapeutic relationship, with less emphasis on collaborative empiricism and guided discovery in the initial stage of therapy. Once rapport has been firmly established then guided discovery and collaborative empiricism can be used. This will increase confidence and trust in the therapist's ability to help and develop a therapeutic alliance. A facilitative client-focused approach to counselling does not conform to the image of a traditional cultural healer and taking this approach may negatively impact on the engagement of the client into a therapeutic relationship (Williams et al., 2006).

A 'Holistic approach' – SECBT – spiritual, emotional, cognitive behavioural therapy

Perhaps the most uniting factor in the Indian Context is that Indians are by and large believers. The core difference between traditional psychology, so deep-rooted in the eastern culture, and modern psychology is that the latter is based on pathology and has the overarching goal of

'return to normalcy', that is, in practice, a return to the average; traditional psychology is founded on the idea of the evolution of the human being, leading to the perfect being.

According to Dr Rajendra Chokani, a Mumbai-based psychiatrist: " Psychotherapy treats symptom-specific illnesses, while spirituality takes the total personality into consideration".

In the last few years, researchers coming from a range of disciplines including psychology, psychiatry, medicine, neuroscience, theology, gerontology, and nursing have found evidence using modern scientific methods that spirituality helps in allaying various mental and physical illnesses.

Overwhelming suffering that accompanies almost all mental and physical illnesses is reinterpreted within a spiritual framework as a journey or pilgrimage that fosters hope and individuals are able to locate meaning within their suffering. In modern societies where cohesive and supportive family structures are fast getting obliterated, spiritual and religious organizations provide much-needed social support which protects people from social isolation, bestows upon them a sense of belonging and self-esteem thereby equipping them to cope with stress and negative life events. Many psychotherapists are of the opinion that psychotherapy by itself is a spiritual enterprise as it provides insight that human beings are interdependent and need each other (Sharma et al., 2009).

From a practitioner's viewpoint, an indigenised Indian psychology often means incorporating Indian techniques such as yoga and meditation into psychotherapy. Aruna Broota, for example, developed a relaxation technique that combines four yogic postures and repetition of a religious word like *shanti* (peace). Such techniques make thoughts more accessible, says Broota, which facilitates Western techniques like cognitive behaviour therapy. And the technique is effective for everything from depression to panic disorder to stress management, she says, in part because yoga is so familiar to Indians (Clay, 2002).

This application of ancient religious Indian psychology may not be that widespread, but it has led to growth in the popularity of the discipline outside academia into the public arena, and contributed to the understanding of Western psychological principles in the context of Indian culture (Jain, 2005).

A Philosophic-spiritual model of CBP was presented by the present author (Kumar, 2007) in the WCBCT held in Barcelona. The major aspects of such a model are outlined below:

- Philosophic/spiritual outlook inherent in culture/way of life.
- Need to address the 'whole person' rather than parts.
- Spiritual awareness and cultural adaptability in therapy a necessary ingredient.
- Not just symptom-relief but general well-being as a goal.
- Inclusion of family/other significant affiliations in the therapy context.
- More element of support and direction rather than 'self-help' and socratic dialogue
- Themes in Core beliefs might be different than those in Western CBT such as "I am unlovable, a failure, worthless". They may be more external such as I am fortunate, I am

accepted, Others value me; spiritual such as My life is worthwhile, God is happy with me, God will save me; and value-based such as I am valuable for my family, I have done my duties well, I am an honest and sincere person.

- Beliefs will also change with age, maturity, gender, socio-cultural aspects (religion, caste, region, education, etc) and cohort (time period one belongs to).
- The cognitive restructuring might need to be emotional or spiritual restructuring.
- The fatalistic attitude to be dealth with philosophic-spiritual dialogue and guidance.
- Having more frequent sessions instead of setting homework tasks or suggesting self-therapy techniques

Some Case vignettes – highlighting spiritual attributions, nutritional guidance, emotional catharsis, counselling and guidance, philosophic/existential overtones, local customs and superstitions, therapy as last option, doubts about purely talking cure, external locus, re-assurance seeking, dependence.

- ❖ "I am angry with God. I want him to change things and give me what I had wanted and could have had".
- ❖ "My unnecessary and forced admission to the ICU has given me depression".
- ❖ "Can I get cured without medication by just talking to you?"
- ❖ "I want you to tell my mother-in-law that she is the one who is wrong not me"
- ❖ "I have tried everything, when nothing has worked psychotherapy is my last option"
- ❖ "All the fault is with my husband, all my problems are because of him, why should i change"
- ❖ "please make me better quickly"
- ❖ "I don't want to write a diary...it doesn't help"
- ❖ "I can't do anything when I go home, whatever is to be done, do it here in session"
- ❖ "I don't want anyone to find out I visited you, they will think i am mad"
- ❖ "I was totally fine, but its my fate / destiny that is bad"
- ❖ "This is my destiny, talking and changing my thinking won't make a difference"

While doing CBT some other pointers that maybe helpful in this part of the world are:

- Rapport and trust development is more important than following a structured format
- More directiveness and support initially and guided discovery later
- Handling and using 'Thought-Emotion fusion'
- Awareness of negative thoughts is not enough for behavioural change
- Cognitive errors such as Personalisation and 'Musts/Shoulds' are culture driven
- Reasons for problems and also possibility of change as often external to self
- Knowledge of the problem and solutions does not automatically bring about change
- Inner strength equated more with 'suffering' in problems than working through them

CBT with Indian Children:

Psychotherapy for children and adolescents, as a service still finds a comparatively limited acceptance in the Indian scenario. Where many would contest on the faster acceptance and increasing trend of accessing child mental health services in the past 4-5 years, there exists a vast gulf in both reference by primary level professionals and parent's accessing the services. This being further coupled with a lack of 'exclusive' or 'dedicated' services for children makes for a vicious cycle of availability and need mismatch. Further, mental health professionals are accorded low status in public health policy and priorities (Patel, 2002).

Even when the trends of "service use" over various countries are viewed, research comparing rates of attendance of Asian children at mental health clinics reveals under representations of Indian families since many Indian parents do not recognize certain behaviours as problems and tend to contain mental health concerns within the family due to cultural norms.

A part reason comes from the 'illness' view that exists within the Indian culture. In the urban Indian setting, academic achievement is treated with utmost priority to the extent that a child performing poorly in school is often shamed. Achievement and education are status symbols in Asian society (Sue, 1997). Hence achievement and excellence in school tends to be a source of pride for parents who see their children as an extension of themselves and also a measure of their successful parenting (Ranganath & Ranganath, 1997). Many Asian American parents develop an agenda for their children's future career when the child is fairly young. At the same time, they take any academic failure or disturbance in their children's career path personally. As a result of these concerns, Asian parents are more willing to see a counsellor for their children's academic problems than they would for a personal problem.

Most Indian families inculcate, as family values, the children's role and obligation in maintaining their families' positive image. The family may hence be reluctant to search for help and choose to keep their personal struggles secret due to their loyalty to the family image. While deviations from prescribed norms are curbed by inducing shame, guilt and showing nonverbal disapproval, conformity and obedience are rewarded by emotional nurturance.

It is only when symptoms of psychological distress are manifested in the form of a physical or neurological disability, which parents recognize and seek help from a general practitioner or paediatrician. However, the stigma associated with psychiatry usually makes Indian parents reluctant to utilize mental health services and makes them continue exploring alternate avenues.

Looking at the above factors, it emerges that majority of the focal reasons for seeking help lie in academic underachievement, compliance with family's behaviour rules /ideas and somatic complaints. This is understandable since Asian Indian parents find psychological distress couched in somatic complaints more acceptable and rarely equate academic underachievement as arising from emotional disturbances. A study in socialization of emotions in Indian children (Pai, 1999), revealed the range of problems reported among these children included mostly depressive and somatic complaints.

Raguram et al (1996) in their understanding of Stigma, depression and somatization in South India found that the tendency to perceive and report distress in psychological or somatic terms is influenced by various social and cultural factors, including the degree of stigma associated with the particular symptom.

For the percentage of children who do access the available services, the understanding of parents with regards to the therapist's role tends to be more educational. This sort of a cultural mind set makes CBT as both a good therapeutic tool as well a difficult one at the same time.

Indians favour treatment that is directive (owing to the view of the therapist as an expert, expecting and accepting authority), structured, and short-term (to maintain anonymity and secrecy of such treatment from their social group). In this respect, CBT being structured (and directive in that sense), and a problem focused short-term psychotherapy is favoured. More so, psycho-education, increase in coping skills and emotional management are the favoured goals for the children's' families as well integral to CBT principles.

However, talking about somatic complaints or issues of a more practical nature, such as academic problems are easier for families than expressing emotional mental health symptoms. Open emotional expression is not the norm in Indian families with emotional restrain and control given higher value. This presents potential problems as identification of emotions is central to CBT.

To be effective, CBT must build on an accurate understanding of the value system, the cultural heritage, and life circumstances of the clients. In view of these differences in the culture and mind-set of Indian clients, the authors would like to enlist few guild lines that inform their practice, and hope that it would benefit other therapists working with Indian children, both within India and abroad.

1) The CBT therapist may begin working by establishing the goals of therapy (Capuzzi & Gross, 2007). Tendency to include the family in this procedure gets the 'burden' of therapy off the children's shoulders as the expectations are not only clear between the child-therapist team, but also the family at large to whom the child is responsive.
2) The initial goals would often be the academic and somatic complaints that seem to be reported by both the child and family without contesting the psychological underpinning.
3) Since a feeling of 'failure' is rampant in this child population, highlighting the areas of strengths and there use in achieving the said goals often makes the child enthusiastic towards the therapy process, taking away the 'doctor –patient' thinking.
4) The therapist need to be acutely aware of the language 'exported' from their 'western' training while applying to the children here. Even though the child maybe 'English-speaking' , the connotation of words in the same language across cultures is fairly different and their implication or intensity differs widely. e.g. meaning of hate, love
5) Due to the stigma on open emotional expression, in my opinion, a substantial portion of the work would be in 'emotional' literacy and this often reveals substantial psychological gains even without going into the thought-behaviour-feeling link.
6) This part of the work allows children to (i) experience an emotion and (ii) accept this experience which itself maybe novel for them.

7) Many well-researched "child friendly" techniques then seem to work well, once the therapeutic setting and pace has been set as thus. This includes 'bag of feelings', use of metaphors, creative play materials, behavioural experiments and stories. The later being a very strong aid since India as a culture is extremely rich in folklores and stories, especially with religious and moral underpinnings have usually been an integral part of their growing up.
8) More than 50% of the children and their families are able to see a substantial change with just this part of the work and often gain the confidence to open channels of feeling-based communication within the family and achieve a more realistic, collective understanding of the problem at hand; hence arriving at appropriate problem solutions and coping strategies. A therapeutic closure often ensues.
9) For others, this groundwork makes it easy for the children to see the 'good' and 'bad' self perpetuating cycles and accept themselves as the agents of change, people who have the capacity and control over breaking a 'bad' cycle and perpetuate a 'good' one.

Summary and Concluding Comments

An integrative approach that incorporates therapeutic elements if traditional Indian healing systems into the western models of psychotherapy and counselling will improve the efficacy and acceptability of treatments in the Indian setting. Of course increased flexibility and enhanced understanding of a vastly rich healing tradition would reciprocally contribute to the wider applicability of psychotherapy (Moodley and West, 2005)

Indian systems of psychotherapy start from inner preparedness and awareness and then lead to action. It is in juxta position to Behaviour Therapy which starts with modifying overt behaviour and believes that outward changes will lead to changes in inner values and attitudes. The goal of all Indian systems is cleansing the consciousness, elevating it to higher levels, leading to super conscious states in some cases. It is above rational since it transcends reason also (Veereshwar, 2002).

Cognitive-Behaviour therapy (CBT) a flexible mode of treatment because it allows for the modification of schemas in a way that is respectful to cultural underpinnings and allows the family the freedom to change in a manner that does not compromise their cultural values (Dattilio and Bahadur, 2005). However, the practice of CBT in India will benefit from sensitivity to the complexities of the Indian culture and society as well as development of research, training and supervision facilities.

The future of psychotherapy in both East and West lies in discovering a conceptual framework with universal validity within which ad hoc therapies--for symptom relief, personality development, or interpersonal adjustment--can be developed (Neki, 1975).