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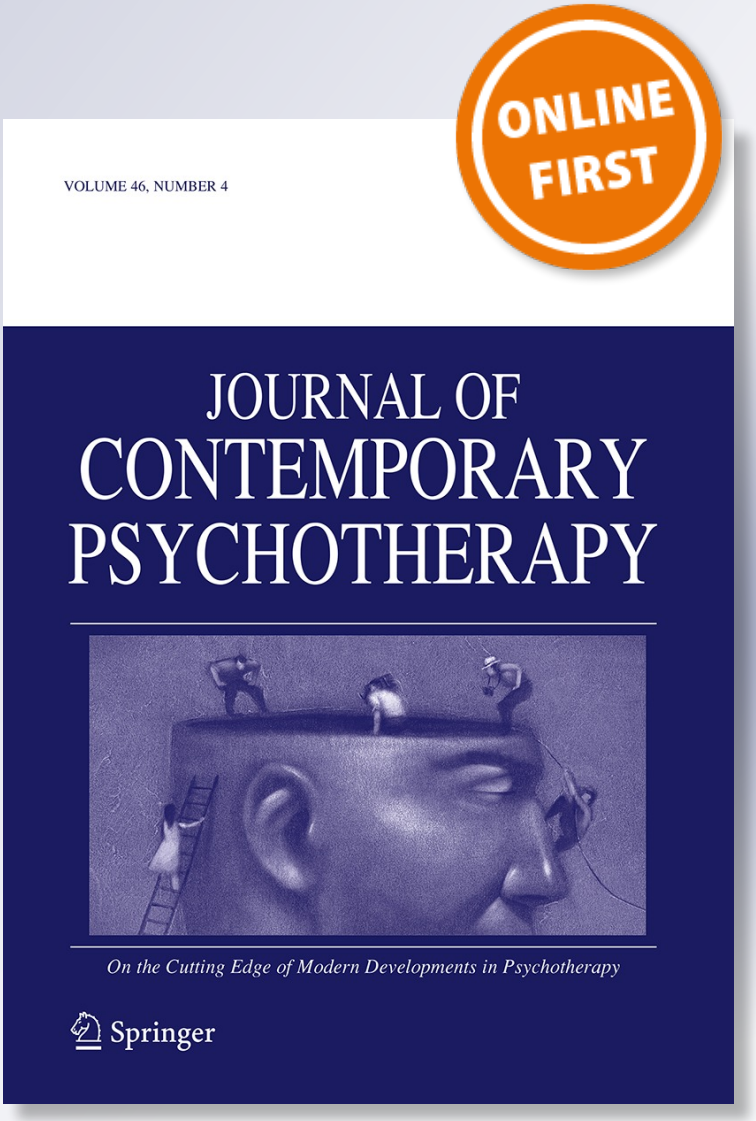

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ORIGINAL PAPER

Indian Perspective on Psychotherapy: Cultural Issues

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Abstract India is in a state of transition between massively transformed 'modern' lifestyles on one hand and the influence of traditional values and customs on the other. In view of the current realities of urbanization, migration, globalisation and societal transformation, the mental health treatment needs have become complex. The article highlights the existing mental health issues and traces the development of various psychotherapeutic techniques in India. An effort has been made to look into the basic tenets of the Indian culture which have a bearing on the conceptualisation and practical application of psychotherapy in the Indian setting. The cross-cultural relevance and adaptability of western psychotherapies in multi-ethnic and collectivistic Asian culture are discussed. In view of the differences between the eastern and western approaches to mental health, challenges in culturally-responsive adaptations are highlighted. It is seen that psychological interventions among masses are beneficial if indigenous approaches based on paradigms like themes from Gita, are cross-fertilized with western psychotherapy. However, there is a need to generate empirical evidence for indigenization of psychological treatments.

Keywords Indigenous psychotherapy · Indian perspective · Cultural adaptation · Cross-cultural differences · Indian concepts of psychotherapy

Introduction

Diversity and multiculturalism have always been hallmarks of the Indian society. The vastness of its geographical area is complemented by its socio-demographic and cultural complexity. The technological advancements, urbanization and globalization have impacted on traditional collectivistic nature of family organisation and gender roles and have accelerated the pace of social change. This has lead to the rise in mental health needs (Kumar and Gupta 2012).

Mental Health Scenario in India

The psychiatric morbidity in India as evident from meta-analysis of epidemiological studies ranges from 58.2 to 73 per 1000 (Mohandas 2009). However, the existing facilities in terms of mental health professionals and infrastructure are significantly inadequate. The number of psychiatric beds in the country is only about 0.2 per 1,00,000 population and there are only two psychiatrists per 10 lakh population (Mohandas 2009).There are only 898 trained clinical psychologists as compared to the ideal requirement of 17,250 (Ministry of Health and Family Welfare 2013). These statistics (about 0.05/1,00,000 population) are miniscule as compared to the ideal required norms (1.5/1,00,000 population). Further these services are mainly centred in urban areas in particular states. Another critical concern facing professional therapists across the country is to collaborate towards consolidation of ethical guidelines and regulation of counseling and psychotherapy practice in India (Bhatt 2015).

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Indian Culture and Psychotherapy

Over the past several decades, Indian mental health professionals (Surya and Jayaram 1964; Neki 1975; Varma and Gupta 2008) have debated extensively about the relevance and applicability of western psychotherapy in Indian population. There are several distinct social, familial and individual features of Indian population when compared with their western counterparts, which have implications on the psychotherapeutic process. Ignoring these culture-specific factors during assessment and psychotherapy may lead to breakdown of the therapeutic relationship and failure of treatment. The significant ones are:

Belief System

Indians firmly believe in *karma* (*deeds*) and *dharma* (*duties*) along with faith in superstitions, rituals and mythology and have the tendency to look for the sources of problems outside the self. Traditionally, Indians believe that verbal expression and overt display of emotion is undesirable as it is a sign of weakness and damages relationships. Hence, it may be hard for them to participate in exploration of feelings. Indian therapists of yesteryears who noticed this in their clients called it a 'cultural defence' (Varma 1988). In such cases, use of mythological stories or fables allow for a profound sublimation of difficult emotions in the presence of a compassionate observer.

Personality

The Indian society is 'collectivistic' in that it promotes interdependence and co-operation, with the family forming the focal point of this social structure (Chadda and Deb 2013). It values family cohesion, cooperation, solidarity, and conformity. For more collectivistic societies like ours, the self is defined relative to others, is concerned with belongingness, dependency, empathy, and reciprocity, and is focused on small, selective in-groups at the expense of out-groups. Application of western psychotherapy, primarily focusing on dynamic models, ego structure and individuals, therefore, becomes difficult in the Indian collectivistic context.

Indian Family System

The traditional Indian joint family is disintegrating due to urbanization but in most of the families, cohesiveness in terms of decision making is commonly observed in issues like treatment seeking, career options and so forth. Conflicts are frequently becoming common in marriages yet option of divorce remains an unwanted last resort. A married girl may remain unhappy with in-laws but she knows "after marriage, my parents will not happily keep me…. This is where I belong now". Need for autonomy is not usually the cause of conflict unlike west. Old legends like Savitri are what they relate with hence require an indigenous approach to deal with family conflicts. Savitri, wife of Satyavan was foretold that her husband was destined to die immediately after marriage. On the specific day, she accompanied her husband to the forest (work place). When yama (Lord of Death) arrived to take Satyavan's soul, Savitri pleaded iniatially and later followed him till Yama softened. To dissuade her from following him, Yama granted her wish for having 100 children. Thus, Savitri could bring back her husband from death. One can discern the concepts of walking inititally alongside of the patient, then the concept of implied or latent goal where an overtly acceptable goal implies the fulfilment of an unacceptable but necessary intervening step (Surya and Jayaram 1964).

Psychological Sophistication

The Indian patients attribute problems to extra psychic or somatic reasons rather than intra-psychic terms. Hence, treatment is sought from faith healer or physician rather than from a mental health professional. Also, the Indian patient is more synthetic in orientation as compared to the analytic orientation of western psychotherapies (Varma 1988).

Therapeutic Relationships

Neki (1992) opined that the concepts of confidentiality and privacy in the Indian context do not even exist in Indian socio-cultural setting, as the privacy can isolate people in interdependent society. Indians amongst other Asians who grow up in a Western environment often seem to function independently in some areas of life and yet in other spheres demonstrated deep-seated hierarchical attitudes as inculcated in their families (Kakar 2003). In a society that has a hierarchical structure, men, older members and individuals with valued qualities or qualifications are ascribed a higher place. Neki (1973) suggested the concept of Guru–chela (teacher–disciple) relationship as a more culturally appropriate model for therapeutic relationship.

Developments in Psychotherapeutic Interventions in India

The essence of psychotherapy existed in India since time immemorial submerged in social structures, religion, ancient scriptures, mystics and alternate system of

medicine including Ayurveda, Unani tradition, Siddha and Yoga and so forth. Girindrasekar Bose who brought modern psychoanalysis to India, made original contributions on the theory of mental life and on the *gunas* (temperament). He drew substantially on the cultural, religious and psychological ethos of India, as he worked on concepts related to repression, defiance, ambivalence, free association and opposite wishes (Bose 1931).

The first half of nineteenth century saw rise in applied psychology with recognition to the therapeutic approach. By the early 1950s, at a time when psychiatry provided little more than custodial care to severely mentally ill patients in psychiatric institutions, psychology had acquired professional status. With the establishment of All India Institute of Mental Health (AIIMH) at Bangalore in 1954 which is known, since 1974, as the National Institute of Mental Health and Neuro Sciences (NIMHANS), the last five decades witnessed a metamorphosis in the area of mental health, yet evidence based psychotherapeutics was far behind. This could be due to several factors: time restraint, inadequate centres for supervised training and client's perspectives about secrecy, privacy and stigma (Manickam 2010).

Different approaches used in India in dealing with mental health issues have been broadly subsumed under two headings: indigenous approaches and western approaches.

Indigenous Approaches

Ancient Scriptures and Mythology

India has some of the oldest scriptures (Upnishads, Vedas and BhagwatGita) whose value and meaning have withstood the ravages of time. They are perceived (Satyananda 1972) as masterly pieces of work but the spiritual, practical and philosophical message continues to be used as a source of psychotherapeutic paradigm. Mythological stories continue to hold tremendous hold in day to day lives of people. Since the content is deeply ingrained in Indian psyche irrespective of age and strata, the use of epics help therapists to connect with the client easily, and also to convince in cognitive restructuring. Shamasundar (1993) viewed the themes that can be used for (a) stimulating association and insight, (b) in explaining aetiology and developing alternate modes of coping, and (c) stimulating the therapist to experiment with a new therapeutic strategy.

Various primary Vedas have helped in the understanding of mental disorders, their prevention and promotion of mental health. The Bhagavadgita is based on a discourse between Lord Krishna (Hindu God and a charioteer) and Arjuna (virtuous pandav and a warrior) at the inception of the Kurukshetra war (described in Mahabharatha) between cousins kauravas and pandavas (Vartak 1990). Though an accomplished archer, Arjuna developed feelings of guilt and doubt for fighting his own relatives and gurus. Krishna guided him to the right path which has been detailed in Gita. Many authors have drawn parallels between the Gita and contemporary psychotherapies (Satyananda 1972; Bhatia et al. 2013). Similarities between psychodynamic theories of drives and psychic structures, and the concept of three *gunas* have been elucidated (Reddy 2008; Bhatia et al. 2013). Krishna's analytic (therapeutic) function was not interpretative per se, but more an object that facilitated the development and maturation of Arjuna's ego (psychic). Specifically, it is Krishna's allowing Arjuna to use him as a transformational object from a psychoanalytic viewpoint. The cardinal techniques of abstinence, anonymity, and neutrality were both observed and violated by Krishna. The pivotal and transformative violation of anonymity, by Krishna's self-disclosure promoted the therapeutic regression and psychic reorganization that lead to Arjuna's existential transformation. Arjuna under duress exhibited elements of distorted thinking. Lord Krishna help remedied this through a process akin to Cognitive Behavioral Therapy (CBT) (Balodhi and Keshavan 2011) Hence Gita lends ways of dealing with issues from psychodynamic as well as cognitive approaches.

Another famous legend used in psychotherapy session is that of Hanuman. Wig (2004) talked of 'Hanuman complex' using 'hanuman' (patient), son of wind who had forgotten his powers to fly due to curse and once reminded by Jambavan (therapist) is able to perform heroic deeds. The concept has received critique for its interpretation (Jiloha 2004) yet the belief in Hanuman in the lives of Indian psyche is deep rooted. Such eastern concepts for use in psychotherapy remain largely unexplored empirically.

Religion and Spirituality

Religion in Indian culture provides a buffer to various life stressors. It adds to multidimensional aspect of coping with feelings like guilt, death, distress and so forth. Some philosophical, religious concepts like rebirth i.e. reincarnation is helpful in reducing fear or loss of death. Soul is considered to be immortal and keeps on taking different births till it realizes self and unites with the creator. This is also called as *Nirvana.* Therefore, a Hindu's ultimate goal is to live a life by ways of conduct as described by *Dharma*. Such a life progresses in self-realization (Juthani 2001).

Another prevalent belief among common masses is that in past Karma (action). This law of *Karma* states that we can change what happens to us by our awareness and efforts to change ourselves. Therefore, such beliefs are used in the therapeutic situations to improve the motivation of the patient to change for betterment.

Techniques like 'sankalpa' (self determination) confession, infusing confidence, suggestion, generating self understanding (insight), sacrifice, prayers, rituals etc. have been used for therapeutic purposes for healing emotional disturbances (Balodhi 1999).

Indian System of Medicine

An alternative system of medicine that has been in use since decades is Ayurveda. Of the various texts, *CarakaSamhita* deals with medical diagnoses and treatment. It also suggests the type of living that would promote psychological health. According to the *Caraka*, the mind provides direction to the senses, control of the self, reasoning, and deliberation (Avasthi et al. 2013). Ayurveda conceives a set of emotions like Kama (Lust), Krodha (Anger), Lobha (Greed), Moha (Affection), Irsya (Jealousy), Harsa (Happiness), Visada (Grief), Cittodveqa (Anxiety) etc. These are considered as basic components of psychopathology and the treatment involves developing strategies to replace the pathogenic emotions with the opposite ones (Behere et al. 2013).The technique of replacement of emotion is compared to shuttling in Gestalt therapy, while refraining of ideas is compared to Ericksonian hypnosis. Caraka speaks of "objective" mind control involving the doctor's "interference", thus saying that in sattvavajaya "a physician wins the mind of the patient" (Liu et al. 2008).

Yoga and Meditation

One of the major contribution of Indian techniques to mental health promotion is yoga and meditation. The ultimate goal of yoga is to control one's own body, to handle the bodily senses, and to tame seemingly endless internal demand (Liu et al. 2008). With the help of different techniques, it helps in reducing tension besides improving physical and mental well being. They are essentially practiced in context of liberation from the phenomenal word which also set them apart from simple breathing exercises. They are used in combination with YAMA and NIYAMAS—the ethical do's and don'ts (Kapur 2002).The importance of these techniques find mention in the scriptures (Murthy 2010b) and empirical literature (Janakiramaiah et al. 2000; Vedamurthachar et al. 2006; Duraiswamy et al. 2007) with a wide range of mental disorders.

Yoga has been compared with standard treatment in psychoneuroses, anxiety, drug addiction, and psychogenic headache. (Vahia et al. 1973; Murthy 2010a). The efficacy of the techniques like SudarshanKriya Yoga (SKY) have been examined in dysthymia, depression, schizophrenia, and drug and alcohol dependence (Janakiramaiah et al. 2000; Rohini et al. 2000; Raina et al. 2001). Transpersonal psychotherapy (Walsh and Vaughan 1993) is based on Indian concepts of transcendence and recommended practices.

Meditation originated in the Eastern spiritual traditions of India, Tibet, China, and Japan. The technique has been adopted in western countries both as a spiritual practice and a mind–body therapeutic intervention (Cohen et al. 2005). According to Geller (2003), meditation, specifically can also be viewed as an extension of psychotherapy, as it helps a person let go of the illusion of self after a healthy sense of self-integration is established in therapy. Meditation techniques include yoga, transcendental meditation, autogenic training, breathing exercises and Vipassana. Transcendental Meditation and its physiological effects have been found to be useful in children as well as in adults (Barnes and Orme-Johnson 2012).

Guru–Chela Relationship

Neki, a leading psychiatrist in the 1970s, observed that Indian clients often tended to look up to the therapist as a *Guru* (Neki 1979). In a society that traditionally promoted social dependency and dependability, clients considered a therapist as a teacher who could show them a way out of dilemmas. The word guru has twin connotations in Indian tradition, of being a teacher and a spiritual preceptor. The guru acts as a physician of mind and soul with objectivity and competence. The guru takes Chela (his disciple) through an experiential journey of self-exploration with an aim to liberate the disciple from all sufferings. The Guru–Chela relationship is polyvalent, polyvibrant and multidimensional and therefore, much wider than the transference relationship of western psychotherapy (Moodley and West 2005). The path of liberation is guided by Guru who unlike a therapist would not be worried about transferences but allows himself to be used. He himself is beyond phenomenal world yet represent authority of the culture. Neki (1973) explained the phenomena as a paradoxical situation where Guru resolves it by becoming a paradox himself. He is in this world but not of this world.

However, this attitude seems to be waning. Today's therapist is more likely to be seen as a consultant or a collaborator, going by the comment made by a patient Viswanathan, in a magazine "If the middle mental space between the body and the soul needs repair, the doctor or the guru is no use, it needs its own specialist to heal it" (cited by Wadhwa 2005). Based on conversations with professionals across several cities of India, Wadhwa (2005) reported that over the last decade, urban Indians openly acknowledged their vulnerabilities and sought therapy proactively compared to earlier days. Some clinicians still

maintained that talk therapy was less effective when patients presented with physical complaints. These individuals spoke less and still expected the doctor to understand their mental state (Wasan et al. 2008). When hard pressed for time, many psychiatrists use medications to get maximum impact in shorter time. There are, however, psychiatrists who keenly practice psychotherapy or refer their patients to counsellors. Furthermore, there are therapists who also advocate other forms of healing that their clients can benefit from. The alternate methods are seen to address the person's inner conflicts through different but equally plausible interpretations mediated by metaphors and archetypes relevant to their cultural identity.

Western Approaches in Indian Context

Though psychoanalysis laid the roots for psychotherapy in India but because of inadequate training, it was practiced by few professionals. Moreover, its concepts were aligned differentially to Indian belief system. Neki (2000) stated that in eastern cultures, 'conscious' and 'unconscious' appeared to function simultaneously in the mind rather than two separate compartments. However, Kakar (2003) commented that the eastern healing discourse goes considerably beyond most traditional psychoanalytic formulation.

Behavior therapy (BT) in India entered in early 1970s and gradually was extensively used in children with behavioural and conduct problems and psychosomatic conditions as well as in a variety of specific disorders in adults. Main models of BT in India has been observed to be classical conditioning. Operant conditioning which has emerged as a more effective approach has few adherents here (Kuruvilla 2010). Jacobson's Progressive Muscle Relaxation (JPMR) is commonly used as part of BT in most of the conditions. Similarly, other behavioural techniques have been used randomly without adequate mention of their justification. Individual based behavioural techniques for single males have been used in sexual dysfunction (Kuruvilla 1984; Gupta et al. 1989) in order to overcome common difficulties faced in Indian clinical setting as opposed to couple based approach (Master and Johnson technique) that is followed in the west. However, there have been mainly case reports to substantiate the work. A few small group studies and case control designs (Rao 2010) too have been undertaken.

The emergence of Cognitive behaviour therapy (CBT) as an effective treatment approach for many conditions like depression and anxiety disorders had an impact on Indian scene too. Some modifications and adaptations have been made to suit the Indian psyche (Kuruvilla 2000a, b).

Challenges in the blind application of Western psychotherapy concepts on culturally diverse clients are frequently encountered by therapists. For instance, when using CBT, patients show non-compliance to completing home tasks. Despite rationalizing regarding individuals' tendency to forget daily situation and need for preciseness to understand automatic thoughts, people from all strata tend to perceive recording as therapists' rigidity rather than a technique to achieve goals. The common statement is "You can ask me anything…I remember everything"! In addition, compliance to therapy sessions and especially to in-between therapy tasks is extremely difficult as clients do not find it worthwhile. The expectation for pharmacological treatment for their 'physical illness' and lack of psychological sophistication may contribute to this. Providing scientific evidence remains ineffective with individuals belonging to lower-middle socio-economic strata.

In a'Philosophic-spiritual model of CBP' (Kumar and Gupta 2012, p. 71) some suggestions for modification in the traditional CBT model to better suit it to Indian clients were: a Philosophic/spiritual outlook inherent in culture/way of life; need to take a holistic approach; 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. It was also suggested that the 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. Research focusing specifically on uncovering belief patterns in Indian clients may be beneficial in this regard.

Family Therapy in Indian Context

India is one of the pioneer to understand the role of family involvement in psychiatric disorders. At a point of time when the family of a person with mental disorder was considered 'toxic' in western countries, Indian psychiatrists recognized them as partners in mental healthcare (Murthy 2010a). Whether by choice or lack of facilities for organized care, the need for families' involvement in mental health care has been emphasized as early as post independent India by Vidyasagar (1971).

The wide use of family therapy has remained restricted to metropolitan cities. Most publications are experiential accounts or deal with issues in practicing rather than generating evidence for its efficacy in Indian setting. Even then, most studies on interventions have reported significant benefits whenever families were involved in management of psychiatric disorders (Chadda and Deb 2013)

like schizophrenia (Chandra et al. 1994), alcohol Dependence (Channabasavanna and Bhatti 1982), eating disorder (Chandra et al. 1995), adolescent conduct disorder (Anant and Raguram 2005). There is some evidence to support that family involvement in the care was, and continues to be a preference of families (Murthy 2010a). Structured family oriented psychotherapy is not practiced in India in most places (Chadda and Deb 2013). Issues like self, boundaries due to collectivistic society necessitates Indianized family therapy model. Additionally, religious belief system also need to be integral part of psychotherapy in issues like marital conflict. e.g. Surya and Jayaram (1964) have used the legend of Savitri as a framework in psychotherapy. Family therapy in modern India offers ways to strike a balance between the "tyranny of the collective and the alienation of individualism" (Oommen 2000; as cited in Carson and Chowdhury 2000, p. 398). Imhasly-Gandhy (2001) has documented using Radha-Krishna myth of eternal love in resolving conflicts within or outside marriage. It recommends that western psychological concepts can be built upon by introducing ancient Indian wisdom through myths for reaching the subconscious psyche.

Comparisons Between Western Approaches and Eastern Approaches

The differences between Indian and western approaches in the attribution of mental illness, distribution, phenomenology, treatment seeking behaviour, and prognosis of people with mental illness have been well established (Kulhara and Chakrabarti 2001; Saravanan et al. 2004; Paralikar et al. 2007; Sumathipala et al. 2004; Avasthi et al. 2013). In terms of treatment, the overarching aim of western psychotherapy is symptom reduction while the approaches born in the East strive towards general well-being and self-awareness (Ryff et al. 2014). Psychotherapy aims to strengthening of the Ego while Indian spirituality tells you to misidentify with the Ego (Kapur 2002).

Both western and eastern approaches accept that all suffering is due to non-fulfilment of needs and desires whether conscious or unconscious. In contrast to western approach that uses formal techniques of psychotherapy, the asian population accept spiritual practices (e.g. in Gita) and religious beliefs (e.g. in Buddhism) advocating detachment from materialistic world. Hence, a trained psychotherapist aids in dealing with mental health illness in the west where as in India, therapist could be a faith healer too.

Laungani (1997) stated that Western society operated on a cognitive mode while Indian society operated on an emotional mode. Westerners are able to engage in contractual arrangements with their therapists and are able to maintain an equal relationship with them. This can be attributed to individualism, which is one of the distinguishing features of Western society. Asians, on the other hand, tend to be collectivistic and relation-centred (Chadda and Deb 2013; Ryff et al. 2014). They desire greater emotional connectedness with their therapists to express their dependency needs. Therapists are perceived as "Guru" with "special powers" (Neki 1975) who can guide them. 'Dependence' which has not been viewed positively in western culture is seen as an integral phenomena in the eastern psyche (Ryff et al. 2014).

As in the west, where many of the folk lore are used in narrative therapy, in India too, mental health professionals have documented the use of mythologies in psychotherapy for few decades. Shamasundar (2008) illustrated the use of excerpts from Indian mythologies in psychotherapy.

Lessons and Insights

There is a growing body of evidence supporting the effectiveness of adapted psychological treatments (PT) for various disorders in non-Western countries, many of which have been adapted to the local context (Rahman et al. 2008; Patel et al. 2011; Chowdhary et al. 2014). Chowdhary et al. (2014) systematically reviewed 20 studies on adaptations of PT on depressive disorders among ethnic minorities in Western countries and for any population in non-Western countries. The types of PT adapted consisted of CBT, interpersonal therapy, psychoeducation, problem-solving therapy and dynamically oriented therapy. Adaptations were mainly in the dimensions of language, context and therapist delivering the treatment which was in congruence to an earlier meta-analysis too (Griner and Smith 2006). Replacing technical terms with colloquial expressions, ensuring therapist–patient matching and cultural competence of therapists were some of the important adaptations reported. Other adaptations of salience were the incorporation of local practices into treatment, extending the goal of treatment to include the family, attention to the somatic/physical illness model and simplification of treatment including the use of non-written material. Several aspects of the PT that did not require adaptation included the phases in which the treatment was delivered, the use of problem-solving techniques and the empathic nature and other 'non-specific' aspects of the therapeutic relationship.

Non-traditional treatments like yoga and meditation have gained increased interest and recognition recently in Asian and western settings (Liu et al. 2008). According to Ho (1995), many authors tend to speak of the East in global terms, without giving sufficient attention to differences among the four Asian religious-philosophical traditions: Confucianism, Taoism, Buddhism, and Hinduism. Cultural adaptations and understanding of ethnic, cultural and

religious interpretations are still underdeveloped (Rathod and Kingdon 2009). However, reviews and meta-analysis (Choudhary et al. 2014) substantiate the fact that adaptations are required only in methods of implementation rather than in core content of therapy.

The Way Forward

The contemporary western psychotherapeutic models are based on differing theoretically standpoints. To what extent are they universally applicable especially in Asian culture has been a challenging issue requiring vigorous exploration (Tseng et al. 2005). However, with globalization, increasing levels of education, higher sense of awareness on human rights and the wider use of electronic media even among the rural population, whether these observations stand today is a pertinent question. Adaptations usually maintain the core elements of CBT but modifications in terms of frequency of sessions, delivering the treatment in a convenient setting or contacting over the telephone, and at times inclusion of family members are required to enhance compliance and gain trust of the patient. The reluctance in recording home tasks may also be overcome by increasing frequency of sessions. This is possible in cases who are staying in close vicinity. The time limited structured psychotherapy acts as a motivating factor to deal with clash with work schedule etc. The therapeutic relationship in which the patient idolizes the therapist (Guru), also ensures adherence to treatment regime even if the patient may be lacking in psychological sophistication. However, efficacy of these adaptations in treatment need to be examined systematically. Further, the teachings of the Bhagavad Gita are deeply embedded in the Hindu psyche and may be effectively used in different ways in PT.

Limited resources, population size and stigma in seeking help for mental health issues especially among the poor rural masses, pose a significant challenge for formal psychological interventions. Rural masses accept faith healers with ease hence it may be worthwhile to develop evidence based flexible, pragmatic approaches and empower non-professionals like faith healers, community workers for resolving mental health problems. In the field of mental health, there is robust evidence that lay counselors (a person without professional qualification in mental health care) can be trained to deliver PT effectively for people with depressive and anxiety disorders in low- and middle-income countries (LMIC) (van Ginneken et al. 2013).

In India too, efforts have been made to develop pragmatic approaches like training of lay counsellors in primary care setting (Patel et al. 2010), group interpersonal therapy for common mental disorders in primary care setting (MANAS project, Chatterjee et al. 2008), Brief Intervention module based on contextual factors (Nadkarni et al. 2015; Roberts and Montgomery 2015; Joseph and Basu 2016), stepped care model with self-help and manualised therapy (Beck et al. 2015). These empirical efforts lack nationwide implementation and need to be strengthened for developing effective integrated indigenous approaches.

In addition, it is most important to simultaneously set in place training and supervision systems for the professionals delivering these services. And since more and more nations are becoming multi-ethnic and multi-cultural, a cross-fertilisation of practitioners, trainers and supervisors will also be beneficial.

Conclusions

Rao (2010) reviewed the Indian literature on psychotherapy and reported that Individual psychotherapies have largely been supportive and psycho-educational, and together with cognitive behavioural approaches have replaced psychoanalysis and dynamically oriented psychotherapies. This could largely be due to the fact that latter therapies required formal training and supervision. The practice of psychotherapy in India is moving towards integration of divergent theoretical approaches with a consistent concern to assimilate indigenous concepts to meet client needs. Culture impacts the expression and understanding of psychopathology and also determines the acceptability of treatment. Recent literature underscores the efficacy of the western models in Indian context when embedded in Indian concepts like '*BhagvadGita*' and 'guru–chela' relationship. However, much of the psychotherapy practice in India continue to lack evidence-base.

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