

Clinical Psychology in India: A Meta-analytic Review

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Abstract

This meta-analytic review based on a sample of PsycINFO database entries, journals, books, and postings on Indian Association of Clinical Psychologists's website, describes trends limiting empirical growth of clinical psychology in India. At the systemic level, there are debatable guidelines for credentialing clinicians, neglect of code of ethics, and premature "campaign" for indigenization. At the practice level, hypotheses are validated through case studies, personal experience, and misinterpretation of poorly collected data. Reviews to date (Avasthi, 2011; Manickam, 2008; Prabhu, and Shankar, 2004) have either downplayed or avoided addressing these issues. This review *supplements* other reviews in drawing attention to literary tradition and suggests measures for improving empirical base of clinical psychology. After describing systemic and practice issues, and highlighting progressive developments (Indian Association of Clinical Psychologists, *Indian Journal of Clinical Psychology*, and national institutes training clinicians), we recommend creating a national licensing board, expanding on the currently available (sketchy) code of ethics, regulating self-proclaimed clinicians, and conducting clinical trials that document not only (a) incremental validity of Indian concepts but also (b) inapplicability of Western research in India.

Keywords: clinical psychology, credentialing empiricism, indigenization, ethics code

1. Introduction

The purpose of this review of clinical psychology in India is to (1) address significant (a) systemic, and (b) practice-based issues, and (2) suggest steps to improve its data-informed scientific basis for understanding and helping persons suffering from mental disorders. Looking at a cross-section of publications in (a) PsycINFO database under the keyword, "Clinical psychology in India", (b) papers in Indian journals of psychology, (c) books about clinical issues, and (d) postings on the Indian Association of Clinical Psychologists, IACP's website (<http://www.PsychologistsGroup@yahoo.co.in>), we look at conceptual and empirical studies in areas of clinical psychology, specially, the issues that have been either downplayed or just avoided in currently available reviews (e.g., Avasthi, 2011; Prabhu, and Shankar, 2004; K. N. Rao, 1998).

Generally, clinical psychology in India illustrates Garb's (2005) *romanticist* (vis-à-vis, *empiricist*) tradition.

Both empiricists and romanticists base their judgments on a combination of scientific findings, informal observations, and clinical lore. A key difference is that those in the romantic tradition are likely to accept findings based on clinical validation, whereas those in the empiricist tradition are likely to maintain a skeptical attitude (Garb, 2005, p. 82).

Here are a few examples: Bhatnagar, and Asthana (1998) for instance, explain an otherwise high-functioning male "closet" transvestite as suffering from "masked psychosis" with schizotypal features. Paranormal events are "real" argues Pasricha (2011) because people in a self-report survey admitted having such experiences. Radhi (2002) "proved" that *vipassana* [insight] *meditation* reduced problem behaviors in adolescents in spite of the fact that according to him, both "experimental" and "control" groups received the same intervention because, he adds, it would have been "unethical" to deprive the subjects in "control" group of the "benefits enjoyed" by the experimental group. K. R. Rao (2008), without citing any references "declared" that presently, psychology in India is in "such a sorry state" we need to salvage it by invoking concepts from ancient Indian tradition. K. N. Rao (1998) coined, "Personality-trait change therapy", based on his clinical experience. And, lastly, Wig (2004) developed the concept of, *Hanuman complex* (derived from a story in Hindu mythology) and recommends its resolution as

effective therapeutic intervention. These practice-based concerns exemplify continuation of Barnette's (1955) observations of poorly trained psychologists, preoccupation with projective testing, using poorly constructed tests and outdated norms, and using textbooks by foreign authors.

In addition, there are several systemic concerns obstructing growth of scientific clinical psychology: debatable credentialing of clinicians, minimal sensitivity to code of ethics, premature campaign for indigenization.

A search in PsycINFO database under, "Clinical psychology in India" generated 1,471 entries between 1900 and 2012. The first entry is the case of a French lady's (fraudulent) claim of being a princess in her past life in Rajasthan, India (Flournoy, 1900/2010). Interested readers may want to consult Jastrow's (1900) review of Flournoy's (1900/2010) work describing this non-story of past life existence.

Reincarnation is still a hot topic today. Remembering past life is considered not only real but also pathological indicating need for treatment. There are many websites offering past-life regression therapy (e.g., Kandhari, n.d.).

This review *supplements* other comprehensive reviews by drawing attention to a mostly literary, romantic approach to clinical psychology and offers some recommendations for improving scientific foundation of clinical psychology in India.

In this paper, **Section 2** presents a brief summary as well as current update of, by far, the most comprehensive review of psychology in India by Barnette (1955) and evidence that his observations are still evident today. **Section 3** draws attention to new systemic areas of concern like, confusing credentialing of clinicians, sketchy code of ethics, emotional appeals for indigenization. In **Section 4**, we highlight progressive developments: Indian Association of Clinical Psychologists, IACP (1968), *Indian Journal of Clinical Psychology*, IACP's website ("chat-room"), and national training institutes. Lastly, **Section 5** lists some suggestions for improving scientific status of clinical psychology, e.g., creating a national licensing board, expanding current code of ethics, regulating self-styled practitioners, and generating hard data demonstrating need for indigenization.

2. Barnette's (1955) Review and Update

Leslie W. Barnette was a Fulbright Visiting Professor of Psychology at Central Institute of Education, Delhi, in the early Fifties (1952-53). He not only conducted several workshops but also visited psychology departments in a number of cities, namely, Calcutta (now, Kolkata), Bombay (now, Mumbai), Patna, Lucknow, Delhi, Benares (now, Varanasi), Mysore, and Madras (now, Chennai).

Based on his extensive travels Barnette (1955) summarized his observations:

1) Clinicians seem *preoccupied* with Rorschach, and TAT.

2) Clinical testing is done by poorly trained people:

"...experts are apt to appear on the scene after one reading of Klopfer and Kelly; there are as many 'local adaptations' of the TAT as there are schools where this type of research secures sponsorship. The situation in this respect is such that one of the recommendations of the members of workshop...led by the writer in Delhi in the spring of 1953, stated that '*projective techniques should be used only by specially trained persons* [emphasis added]." (p. 105).

3) A test-retest data on an IQ test showed an average gain of 7.5 IQ on retests, "*...increases being greater where less experienced examiners conducted first tests* [emphasis added]." (pp. 107-108).

4) "...one reads this volume (Menzel's [1952], *Suggestions for the use of new-type tests in India*, [as cited in, Barnette, 1955], with disappointment because of lack of validity data...and there is not a single mention of any attempt at cross validation." (p. 108).

5) "The interesting comment [in one of the universities he visited] was that *girls, after marriage, appeared to show 'deterioration,' i.e., they then cease to move in as stimulating an environment as before when they were in school* [emphasis added]." (p. 111).

6) A graduate student was studying the relationship between personality factors, using eight TAT cards, with students' successes and failures in Grades VIII-IX, as judged by last year's exam results (p. 114).

7) "I was informed of one young man, with only an M.A. degree in philosophy, who was 'practicing' psychoanalysis." (p. 120).

It seems little has changed over the past 57 years.

2.1 Barnette (1955): Update

2.1.1 Poorly-trained Psychologists

-A clinical psychologist (Atreya, 2010), asked for suggestions for treating a patient suffering from, *dual diagnosis* of schizophrenia and psychosis;

-Deepa (2010), a psychologist, requested suggestions for a tool to assess defenses among patients suffering from manic disorder. A psychologist, Nair (2010) critiqued this project because it would be a “waste of time and energy”, and suggested, it may be more useful instead, to study defense mechanisms in “neurotic and alcoholics”. Nair (2010) did not give any reasons why one study would be “waste of time and energy” and the other, “useful.”

-Puneet (2011), a school psychologist, asked for help in counseling adolescents about sexual issues. Parathasarthy (2011), reportedly, an M. Phil., RCI-registered, psychologist, expressed concern about this question, and “defined” that counseling is “sought,” rather than, “given.”

2.1.2 Preoccupation with Projective Tests

In the PsycINFO database, use of projective tests was reported in 605 publications out of which only 146 studies reported using non-projective tests.

In spite of several reports about its psychometric limitations (e.g., Garb, 2003;

Hunsley, and Bailey, 2001), the Rorschach test continues to be used liberally, using old outdated methods and norms.

Although, Exner’s (1974) Comprehensive System, ECS, has now been available for over three decades, we found only eight studies that reported using ECS, e.g., Mishra, D., Khalique, and Kumar (2010); Mishra, D., Kumar, and, Prakash, (2009); Singh (2001).

Among the objective tests, we did not find any study that used Minnesota Multiphasic Personality Inventory-2, MMPI-2 (Butcher, Dahlstrom, Graham, Tellegen, & Kremer, 1989), although MMPI-2 has been available for past 22 years.

2.1.3 Textbooks of Clinical Psychology

Barnette (1955) found there were no textbooks by Indian authors. This is true still today. Although, we did come across a text: (Bhatia’s, 2008, *Textbook of clinical psychology*), we also noticed that in spite of it being a commendable effort, the book has numerous substantive and editorial inaccuracies, e.g.,

-“the hypocrisy of a few and the curiosity of others has made this field [of psychiatry] also a victim of the fatal preposition [*sic*] ‘Divide and Rule’ and has resulted in new fields such as biological psychiatry, social psychiatry, cultural psychiatry...”(p. 1.1).

-“Erectile impotence include [*sic*] Opiate dependence Alcohol dependence, Polydrug [*sic*] abuse, Cannabis dependence etc.”(p. 1.5) and deterioration of relationships” (p. 34. 3).

-also, there are numerous citations but no references.

Bhatia (2008) may want to consider addressing these concerns in a future edition of this otherwise important work.

There are several special topic books. Most of these however, are either “romantic” or provide inadequate information about the topics.

Davar’s (1999), *Mental health of Indian women: A feminist agenda*, for example, “...emphasizes the need to conceptualize and differentiate between mental distress and illness. The emphasis must be translated into clear clinical strategies and service planning for women who suffer subjective distress” (p. 240).

Jena’s (2008), *Behavior therapy* is a comprehensive discussion of behavior therapy although there is no mention of two evidence-based behavior therapies: Dialectical behavior therapy (Linehan, 1993), and Mindfulness-based cognitive behavior therapy (Segal, Williams, and Teasdale, 2002). Additionally, while the book’s title implies its practical focus, there is only one case study where the therapists (Salzinger, et. al, 1965 [as cited in Jena, 2008] used behavior therapy visits every day, for nine months, totaling 256 sessions! Most of current, protocol-guided behavior therapies (e.g., DBT, CBT, M-CBT) are spread over once-a-week, upto 24 visits with if needed, “booster” sessions.

Vahila’s (2009) book, *Lives in exile*, a collection of narratives of Tibetan refugees in India. According to Vahila (2009), “...as a psychologist, I have been most concerned to reach the subjective meaning of one’s memories and experiences, for the individual recounting one’s life-story as for the Tibetan community as a whole” (Vahila, 2009,

p. ix). It is more a romantic, literary reflection rather than scientific, empirical study of an important social-cultural event.

These and several other special topic texts continue to “flirt” with somber reality of persons suffering with mental disorders.

There is need for evidence-based texts of clinical psychology, e.g., Hunsely, and Lee (2006); Pomrentaz (2011).

3. Systemic Concerns

Significant system-wide concerns in clinical psychology include, debatable credentialing of clinical psychologists, sketchy code of ethics, and premature appeals for indigenization.

3.1 Credentialing of Clinical (“Rehab”) Psychologists

The RCI (1993), a statutory body, mandated for credentialing clinical psychologists, has prescribed some hard-to-understand criteria. For example, irrespective of a person’s educational, professional background, she/he *has to* spend two additional years and spend extra money to earn an M. Phil., degree in clinical psychology from an RCI-approved institution before he/she could register with RCI to practice as a clinical psychologist. To use a cliché: *this just don’t make no sense*.

(Incidentally, we did not receive any response from the RCI to our request for clarifying these credentialing guidelines).

A recently revised syllabus for M. Phil. (Clinical psychology) course appears to be (unrealistically) comprehensive, e.g., courses on Psychosocial foundations of behavior and psychopathology, Biological foundations of behavior, Psychiatry, Psychotherapy and counseling, Behavioral medicine, Statistics and research methodology, Practical: Psychological psychotherapies and Viva Voce, etc. The syllabus lists about 104 “Essential references” (implying, required readings) for these courses.

Compared to this, M. A. (Applied psychology) syllabus in clinical psychology at Delhi University lists topics that overlap significantly with the RCI’s listing, e.g., Psychological assessment, Clinical and health psychology, Neuropsychological rehabilitation, Applied cognitive psychology, Research methods, etc., and lists about 27 “Suggested” readings.

Interestingly, in spite of the fact that RCI was created for credentialing clinicians back in 1993, a recent review (Prabhu, and Shankar, 2004) still claims lack of any credentialing for clinicians and advises IACP to take initiative in this area:

“At the time of [this] writing, there is no statutory body in India which can provide professional registration to clinical psychologists...*In the absence of a statutory body, it may be considered the responsibility of the IACP to maintain professional , standards and define what constitutes sound professional practice [emphasis added].*” (Prabhu and Shankar, 2004, p. 126).

Apparently, minimal emphasis on professional conduct and code of ethics is another area of systemic concern.

3.2 Code of Ethics

The IACP’s (1995) Code of conduct, although, sketchy, appears to be the *only* code of ethics for clinical psychologists by a professional organization. It is a two-page description of seven areas to be addressed by clinical psychologists: *Professional competence and services; Referrals; Method of expert opinion; Consent for treatment; Patient welfare; Court testimony; and Confidentiality*.

Compared to this very brief ethics code, American Psychological Association’s code of ethics (approved in, 2002, effective, June 1, 2003), *Ethical principles of psychologists and code of conduct*, is much comprehensive and detailed. It consists of five *General principles* of *Beneficence and nonmaleficence; Fidelity and responsibility, Integrity, Justice, and Respect for people’s rights and dignity*, and 79 specific principles covering a wide range of areas, including, *Resolution of ethical issues, Competence; Human relations; Privacy and confidentiality, Advertising and other public statements, Record keeping and fees, Research and publication, Assessment, and Therapy*. Recent, *Amendments to the 2002 “Ethical principles of psychologists and code of conduct* (American Psychological Association, 2010), modified original Standard, 1.03, *Conflicts between ethics and organizational demand* by making language changes in, “*Introduction and applicability*”.

It may be a good idea to expand the IACP’s (1995) ethics code incorporating applicable standards from the APA’s (2002; 2010) code of ethics.

3.3 Premature Campaign for Indigenization

Apparently, the movement of indigenization of psychology in India seems to be influenced more by (a) patriotic sentiment, and (b) Hindu mythology than by hard data. Manickam (2008) points inherent constraints in seeking empirical validation of faith-guided theories.

Indian philosophical concepts to the Hindu religion...The spirit of critically questioning these [formulations in the *Vedas*] in the light of contemporary evidence and the natural process of socio-cultural change is not encouraged. The line dividing the sacred and the secular is rather blurred.... these concepts are kept outside the realm of scientific enquiry... [e.g.,] The focus of karma as a religious concept hinders its value and relevance from a psychological perspective, thereby restricting research on karma as principle and as a belief... (Manickam, 2008, p. 493).

Adair (2004) in comparing the process of indigenization in India and Taiwan highlights the role of language in science, something indigenization enthusiasts may want to look into.

The language of science is English; the language of culture may be Hindi, Mandarin, Spanish, or German. This dilemma was vividly articulated for me by a psychologist I interviewed in India about indigenization of psychology in India. She said, 'As a psychologist I think in English; but as a person I feel in Hindi.' In other words, although writing and publication may need to be in the language of science, indigenous research is likely to be more successful if it is conceptualized and the data are collected in the native language. (Adair, 2004, P. 5).

According to K. R. Rao (2008), "...psychology in India is in such a sorry state that it is widely felt that it needs to take a round about [*sic*] turn to look back into its own tradition and learn from it..." (p. xvii). Significantly, there are no citations in support of this bold (and inaccurate) generalization.

Avasthi (2011) in a comprehensive review of diagnosis and treatment of mental disorders in India points out that there are *no* significant differences in nature and extent of mental disorders in India and elsewhere:

"...We are still at a loss whether mental illness in Indians manifests itself in a manner different from the prototypal Western man. Although there are subtle differences in the manifestation and course of mental illness in Indians, the available research *does not point toward distinctive syndromes and symptom complexes specific to Indians* [emphasis added]". (Avasthi, 2011, p. 7)

The DSM-IV-TR (American Psychiatric Association, 2000) lists *Dhat* [semen loss] *syndrome* as a culture-specific mental condition in India. There is evidence that it is *not* a culture-bound syndrome specific to India. "The idea of semen loss and consequent anxiety has been reported from Sri Lanka and China, and there is ample evidence of the same in the 19th century Western literature, indicating that *Dhat* syndrome is not an exclusive product of the Indian psyche" (Avasthi, 2011; p. 4).

The disorders of personality also are not unique to the West or to India. Cheung, F. M., Cheung, S. F., Wada, and Zhang (2003) review the relevance of indigenous measures of personality in Asian cultures and point out that in India,

"...For personality assessment there is little systematic study of indigenous measures and development of indigenous Indian measures, despite the theoretical discussion and development of Hindu concepts of personality. For example, in the clinical assessment of children and adolescents, Indian tools are translated from Western tests, and some of the translated tests are given new names, probably leading to the erroneous impression that these tests have been developed especially in India." (Cheung, F. F., Cheung, S. F., Wada; and Zhang. 2003, p. 216).

In a review of psychotherapies in India, K. N. Rao (1998), a psychiatrist, reports four different therapies that he found to be effective in his practice.

"...I am of the opinion that it is possible for a Psychotherapist to practise [*sic*] with more than one form of Psychotherapy and use different techniques in different patients... [namely] Existential Psychotherapy; Self esteem [*sic*] analysis...Personality trait changing therapy... [and] Psychophysiological Psychotherapy..." (K. N. Rao, 1998, p. 2).

In a brief overview of clinical psychology in India, Clay (2002) found an experienced clinical psychologist who had his patients go to attend yoga camp for a few weeks and learn relaxation techniques *before* engaging them in therapy!

There are also numerous websites implicitly suggesting remembering past life (a belief sacred to Hindu mythology) is mental illness and needs to be treated using, "past-life regression therapy," (dhyansanjivani, n.d.) (<http://www.dhyansanjivani.org/hypnotism>).

Wig (2004) a psychiatrist, points out a clinical syndrome, *Hanuman complex*, based on a story in Hindu mythology and reports its effectiveness as therapeutic tool for treating Indian mental patients:

“The rich heritage of Indian mythology has been very little explored and used in psychotherapy in India. The present article deals with the story of Hanuman. How he lost the knowledge about his power to fly due to a childhood curse by Rishis and how he regained his powers when reminded by Jambavan during a crucial mission in search of Queen Sita, is the subject of author...of Hanuman complex and its resolution... (Wig, 2004.” p. 25).

Jiloha (2004), also a psychiatrist, critiqued existence/usefulness of Wig’s (2004), *Hanuman complex*:

“The society in which Prof. Wig is trying to peddle patented divinity, by orchestrating it amidst temple rituals and mythological stories, is a house divided into believers and non-believers, knowers and the ignorant, masters and servants, clean and the untouchables...Behind the smoke screen of faith, manipulated by vacillating mythological warrants, our scholars are busy to enshrine a fossilized divine knowledge of their own self-serving image.” (Jiloha, 2004, p. 276).

So far, indigenization in psychology in India seems to have a strong patriotic tone. Adair (2004) reminds us that underlying our enthusiasm for indigenization is resentment towards colonialism.

“Assigning blame, well understood as part of an anti-colonial reaction, unnecessarily externalizes the problem facing psychologists in the country importing the discipline. Replacing this need to belittle or denigrate U.S. psychology with an emphasis on the need to modify, build upon and shape the imported discipline to the needs of one’s culture provides a constructive context and attitude for the psychologist who must now cope with the problem.” (p. 1).

So far, indigenization has been a conviction-informed, Hindu mythology-based movement. There is need for hard data to support need for indigenization of clinical psychology. In this context, it may want to recall Hollingshead, and Redlich’s (1958), classic community-based study pointing out that it is mostly, *content* not the *dynamics* of psychopathology that varies from culture to culture.

“...Cultural and social conditions are reflected in the content of mental illnesses. To give a simple example, in a republic, megalomaniac patients imagine themselves president, and not emperor. Shortly after World War II, Japanese and American psychiatrists noticed that some Japanese patients changed their paranoid delusion of being Emperor Hirohito to being General MacArthur.” (Hollingshead, and Redlich, 1958, p. 359).

4. Progressive Developments

The two important progressive developments are: (1) the Indian Association of Clinical Psychologists, IACP (1968), its publication, the *Indian Journal of Clinical Psychology*, a code of ethics (IACP, 1995), its internet forum, and (2) several national institutes are providing supervised training for clinical psychologists.

4.1 Indian Association of Clinical Psychologists

The IACP was formed in 1968 with a view to advancing concepts of mental health and profession of clinical psychology (<http://www.iacp.org.in>) According to its 2009 Annual report, there are currently, 852 members in the Association. Its office-bearers include, President-elect, Manju Mehta (Delhi), Honorary General Secretary, L.S.S. Manickam (Mysore), and Treasurer, Adarsh Kohli (Chandigarh). The Association’s last annual meeting was held in January 2011, at Gandhinagar, Gujarat. The next annual meeting is scheduled for January, 2012, in Pune, Maharashtra. Beginning, 1974, the Association also publishes a bi-annual, *Indian Journal of Clinical Psychology*.

4.2 IACP Sponsored Website

An internet forum (<http://IndianPsychologists@yahoo.co.in>) was started in November, 2006 (Manickam, 2011). It is an extremely popular forum. There are over 4000 members. This website provides a “safe” environment to talk about (literally) anything. Reading through the mails posted on website one is nostalgically reminded of informal groups of people in coffee-houses, wayside tea-stalls, and village-well or river-banks providing a non-judgmental platform to exchange thoughts and opinions.

4.3 National Institutes for Training Clinicians

Among national institutes for providing supervised training to clinical psychologists the two oldest ones are, the Central Institute of Psychiatry, Ranchi, and National Institute of Mental Health & Neurosciences, Bengaluru.

Central Institute of Psychiatry (CIP), Ranchi (<http://www.cipranchi.nic.in/>)

The Central Institute of Psychiatry, Ranchi, is a Government of India, institution, and only of its nature [sic] in eastern India. The British established this hospital on 17th May 1918 with the name of, Ranchi European Lunatic Asylum (<http://www.cpi.org>). It had then capacity of 174 patients (92 male and 82 female). It catered to the needs

of the European mental patient only and it was under the direct control and management of Government of Bihar...[1922], its name was changed to European Mental Hospital...[the same year] the institute was affiliated to the University of London for the Diploma in Psychological Medicine [now called, M.Phil.] examination. (<http://www.cip.org>)

In 1962, this Institute started a course in Diploma in Psychological Medicine, now, renamed, “M. Phil.” in clinical psychology.” A doctoral program in clinical psychology was introduced in 1972. Currently, there are 12 seats in M. Phil. and four in Ph.D., program. Admission in these programs is through a qualifying national entrance examination.

National Institute of Mental Health and Neurosciences (NIMHANS), Bengaluru, Karnataka (<http://www.nimhans.kar.nic.in/aboutnimhans.htm>)

Back in the 19th Century, NIMHANS started as, Lunatic Asylum. It was renamed, Mental Hospital, by the state government of Mysore. An All-India Institute of Mental Health was established in 1954. Twenty years later, in 1974, Mental Hospital and All-India Institute of Mental Health, were combined and renamed, National Institute of Mental Health and Neurosciences (NIMHANS). In 1994, the institute was designated as equivalent to (called, “deemed”) university.

In summary, clinical psychology in India has struggled over the years alternating between science, art, and romance. Interestingly, we also noticed little/no discomfort with it. Most of the reviews are significantly silent about its unscientific status. Here are a few suggestions for seeking empiricism in understanding and treating mental disorders.

5. Recommendations

1) Credentialing of clinical psychologists is in a “big mess.” There is need for creating a national licensing board of psychology to conduct written and oral examinations for credentialing clinicians.

a. A person with a Master’s degree, and courses in clinical psychology, or, doctoral degree in clinical psychology be allowed to appear for the licensing board’s written and oral examination.

b. License may be renewed every *two* years.

c. License renewal be contingent upon completing continuing education requirements, say, 20-25 (clock-hours) of training in clinical areas, including, exclusive 3-4 hours of training in professional ethics.

2) Until, India developed its own, data-informed diagnostic system, it may be advisable for diagnosing mental disorders using the current edition of a standard diagnostic system, like, DSM-IV-TR (American Psychiatric Association, 2000), or ICD-10 (World Health Organization, 1993).

3) For indigenization, there is need for verifiable and replicable body of data demonstrating not only incremental validity of using Indian concepts but also, inapplicability of Western concepts in India.

4) It is also recommended that practitioners consider using *evidence-based* therapies like, CBT (e.g., J. Beck, 2011), DBT (e.g., Linehan, 1993), or M-CBT (e.g., Segal, Williams, and Teasdale (2002).

5) There is need to expand the current IACP’s (1995) code of ethics by including areas covered in more comprehensive codes of ethics, e.g., American Psychological Association’s (2002), British Psychological Society (2009), Canadian Psychological Association (2000), or IUPsyS (2008).

Concluding, for over 100 years, clinical psychology in India appears to have flirted with a “soft” romantic view of mental disorders. There is need to strengthen the empirical base for diagnosing and treating mental illness within a comprehensive framework of professional ethics and code of conduct.

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