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Clinical Psychology in India

P. S. D. V. Prasadarao[1,2] and Paulomi Matam Sudhir[1]

Scientific Psychology in India has seen steady development since its inception in the early 1900s. With clinical psychology developing as an independent profession, clinical psychologists have been functioning in various roles, offering a wide range of services in consultation, training, research, and private practice on multidisciplinary teams as well as in independent practice. This paper focuses on the historical roots of clinical psychology in India and highlights the role of clinical psychologists in the general mental health care and the contributions made by the profession in a wide range of public and private health care settings. Ancient Indian systems of Medicine, mental health care and psychotherapy in India, and training-related and organizational issues are discussed. This paper reflects on the growth and development of clinical psychology that has occurred in India in spite of current difficulties and the challenges that lie ahead.

KEY WORDS: clinical psychology; psychology; mental health; India.

DESCRIPTION OF INDIA

India is one of the world's oldest civilizations with a rich cultural heritage. It covers an area of 3,287.263 km^2 extending from the Himalayan heights to tropical rain forests of the south. India is the seventh largest and second most populous country in the world and accounts for 2.42% of the world's land area. India has a population of over 1 billion people. India's population is 73% rural and 27% urban. The population per square kilometer is 287. The average life expectancy for the Indian male is 62.1 years and for the female, 62.7 years.

India has 25 states and 7 union territories. There are 15 officially recognized languages, each having multiple dialects, resulting in approximately 1,652 spoken languages (Ministry of Information and Broadcasting, New Delhi, 1986, 1994). Because the country has diverse populations, cultures, languages, and practices, the needs of the people are also varied. The country cannot boast of a health delivery system that reaches everybody in all parts of the nation effectively. Although "health for all by the year 2000" was the desired goal according to the "Alma Ata declaration" (1978), it does not seem to have been fulfilled. Although the system is struggling to deliver primary health care services, there is still a long way to go before effective mental health care services can be thought of as an attainable goal.

Mental health in India has been struggling with problems such as limited financial resources, lack of trained personnel and organized psychiatric services for rural areas, ignorance of and superstitious beliefs about mental illness among people, limited availability of drugs, high drop out rates, and lack of awareness among general medical practitioners (Sethi, Gupta, & Lal, 1977). This paper focuses on the mental health in the Indian context, in which clinical psychologists have been playing a significant role.

Historically, in India, mentally ill patients were treated using various approaches such as herbal or ayurvedic medicines, yoga, music, religious activities such as exorcism, counter magic, talismanic, and faith healing (religious and ritualistic activities such as prayers, offerings in temples, etc.). Even now, the

[1]National Institute of Mental Health & Neuro Sciences (NIMHANS), Bangalore, India.

[2]Correspondence should be addressed to P. S. D. V. Prasadarao, Department of Clinical Psychology, National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore 560 029, India; e-mail: psdvprao@nimhans.kar.nic.in.

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families of mentally ill approach religious and pilgrimage centers spread out in the country looking for "cures," and such services are popular, especially in the rural areas. It is the common experience of mental health professionals that the first agency to be consulted by the family members to seek help for their mentally ill members is either a religious shrine or a traditional healer (Chandrashekhar, 1999; Chandrashekhar, Isaac, Kapur, & Parthasarathy, 1981; Wig, Murthy, & Hazrding, 1981).

GENERAL HEALTH CARE SYSTEM IN INDIA

The Primary Health Care (PHC) system in India focuses on the preventive, promotive, curative, and rehabilitative aspects as well as community developmental activities. The principles of PHC ensure that health care is shaped around the life pattern of the people and is an integral part of the national health care system. When offering services for the community, interventions are made at the most peripheral level by trained medical officers and paramedical workers (NIMHANS, 1990).

Each PHC serves a population of 80,000–100,000. In this system, frequently occurring health problems (communicable and noncommunicable diseases) are treated; in addition, maternal and child welfare, provision of essential drugs, food and safe water supply, and immunizations are ensured. As part of the National Mental Health Program for India (1982), progress has been made toward integrating primary mental health care with the existing PHC system. With community participation as one of its objectives, both community leaders and ordinary citizens are encouraged to participate in community mental health programs (NIMHANS, 1990).

The insurance sector in India is largely controlled by the central government. However, because most of the services provided at the government health centers are free, the issue of insurance coverage has never gained momentum. A compulsory health insurance scheme for all does not exist in India (unlike most western countries). Nevertheless, certain industrial/governmental organizations do provide health care schemes for their employees through the Employees' State Insurance (ESI) scheme, and the Central Government Health Services (CGHS) scheme.

Health care in the urban cities is dominated by private practitioners, nursing homes, private hospitals, and hospitals run by certain charitable trusts and missionaries. A wide range of populations utilizes these facilities. The current trend in major urban settings is the development of corporate hospitals that offer super-specialty services, and cater predominantly to the patients with high paying capacity. A few teaching hospitals (attached to medical schools) also provide specialty medical care.

DEVELOPMENT OF PSYCHOLOGY IN INDIA

Like any other developing country with a colonial past, psychology in India has been dominated by the "Euro-American influence of theories, models, tests, inventories, text and research books and journals" (Pandey, 1988). Systematic attempts have been made to trace the roots of scientific psychology to ancient Indian philosophical and religious scriptures and folklore and to apply these insights to understanding behavior (Balodhi, 1990; Sinha, 1986; cited in Pandey, 1988). Paranjpe (1984) argued that both western and Indian thinkers, though being separated by distance, have independently arrived at strikingly similar observations about human behavior (Pandey, 1988).

Although the origin of psychological thought in India dates back to ancient times, scientific psychology was started in the twentieth century. As early as 1905, experimental psychology was introduced as an independent subject, and the first department of psychology was established in Calcutta in 1915. The Indian Psychoanalytic Association was organized in 1921 in Calcutta. Calcutta University was also the first to start an applied section in the psychology department in 1938 to develop psychological testing and to offer vocational counseling to students. The Indian Association of Clinical Psychologists (IACP) was started in 1968 (Prabhu, 1983; Prasadarao, 1998).

Prabhu (1983) classified the growth and development of clinical psychology in India in three phases. The first phase was characterized by "slow but steady growth of psychology including clinical psychology, in unison with the international thinking of the day, attempts at original theory building, a therapeutic orientation and a generalized state of harmony between related professions."

During the first phase (1905–55) the growth of psychology included emphasis on a dynamic approach in diagnostics and therapeutics, and founding of the Indian Psychoanalytical Institute (which later introduced training programs in clinical psychology). In 1945, the University of Calcutta introduced a certificate course in applied and abnormal psychology. In 1951, the Banaras University started a 1-year program

in clinical psychology. The other important developments were the contributions of Dr. G. Bose (1886–1959) in the field of analytical psychology (Prabhu, 1983). It is interesting that around this period in India, psychiatry had developed neither as a profession nor as a medical subject. In fact psychology enjoyed a more enviable position in providing therapeutic care, whereas psychiatry was merely providing custodial care. It was also a period when universities enjoyed academic and professional leadership (cited in Prabhu, 1998).

In the postindependence period, the government, particularly, the Defense Ministry began emphasizing the need for the inclusion of psychologists on research and selection boards. Although the growth in quantity was enormous, the same could not be said about the quality. To a large extent, western theories were applied, with little attention to their sociocultural relevance (Prabhu, 1998).

During the second phase, university departments of philosophy started introducing postgraduate courses in psychology. By the end of 1975, 51 universities offered psychology courses. Currently, psychology programs are offered in about 70 universities at various levels (Association of Indian Universities, 1995).

The third and current phase of development was marked by the publication of the official Journal by the Indian Association of Clinical Psychologists (IACP), the commencement of clinical training programs, and the onset of behavior therapy services and training (Prabhu, 1998).

Training

A postgraduate degree in clinical psychology and a 2-year post-Master's training with supervised internship from a recognized university is considered essential for practice in India (Prabhu, 1998). Prabhu (1998) describes the adequately trained professional as being competent, sensible, and capable of giving care to a range of problems. He further emphasizes that clinical psychologists cannot merely duplicate the activities of psychiatrists, but must make unique contributions because of their training in scientific methodology and the sociobehavioural aspects of human behavior.

The (then) All Indian Institute of Mental Health, currently known as the National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore, started a 2-year postgraduate professional training program in clinical psychology in 1955. Following this, the Postgraduate Training Center (currently known as the Central Institute of Psychiatry) began a training program at Ranchi in 1962 along similar lines. Later, in 1973, a third program was introduced at the B.M. Institute, Ahmedabad. Recently, a training program in clinical psychology leading to M.Phil. has been started at the Kasturba Medical College, Manipal. The training centers for clinical psychology are largely situated in psychiatric and mental health settings, where various mental health professionals—clinical psychologists, psychiatrists, psychiatric social workers, and psychiatric nurses—are trained, and who work together, using a multidisciplinary team approach (Prasadarao, 1998).

In the last 40 years, at least 600 clinical psychologists have been trained in India. Psychology in general, and clinical psychology in particular, has seen a dominance by women. However, not all of those who are trained continue to practice in India. Migration, matrimony, and "misplacement" are three of the reasons for the loss of well trained psychologists in India (Prabhu, 1998). Presently, there are between 300 and 350 working clinical psychologists in India (Prabhu, 1998).

The Contributions of NIMHANS to the Field of Mental Health

NIMHANS, Bangalore, is a deemed university, with a focus on multidisciplinary team approach. It provides clinical services, trains professionals, and carries out advanced research in mental health, neurosciences, and allied areas. The outpatient and inpatient clinical services are provided in mental health, neurology, neurosurgery, and allied specialties.

Since 1955, a 2-year Postgraduate Diploma in Medical Psychology, now called M.Phil. in Clinical Psychology, a full-time program with built-in clinical supervision and internship in a multidisciplinary team setting using scientist–practitioner model, has been offered through the Department of Clinical Psychology. The department trains 12 clinical psychologists at the M.Phil. level and 4 at the Ph.D. level each year. The faculty and staff to student ratio is about 1:1.5; this ratio ensures adequate individual supervision with trainees.

The aims and objectives of the department have been multifold: (a) postgraduate training in clinical psychology and allied specialties, (b) psychological services, (c) conducting research, and (d) advising other agencies in a consultative role on organization of clinical services.

Research is conducted in a wide range of areas of clinical psychology such as psychosocial foundations

of behavior, behavior therapies, cognitive behavior therapies, behavioral medicine, child and adolescent mental health, psychosocial rehabilitation, psychosocial aspects and management of substance abuse disorders, stress and coping, neuropsychology, parapsychology, family and marital therapies, and community mental health.

Role of Clinical Psychologists in India

Clinical psychologists in India do not have prescription privileges. The scope of clinical psychology in India is wide, although much more development is needed. At present, awareness of the potential contributions of the clinical psychologists is limited, and clinical psychologists are yet to be recognized as an essential part of care in various settings such as neurology, neurosurgery, psychiatry, and cardiology. Such comprehensive care incorporating psychological management is offered only in a few major centers (especially in academic institutes) where clinical psychologists are making significant contributions. On the brighter side, clinical psychologists are making inroads into settings such as general hospitals, schools, counseling centers, aftercare homes, child guidance clinics, rehabilitation and deaddiction centers, juvenile homes, university counseling and vocational centers, and into private practice.

Role of the Indian Association of Clinical Psychologists

In 1968, the IACP was formed. In 1974, the first issue of the *Indian Journal of Clinical Psychology*, the official journal of the IACP, was published. The Association celebrated its Silver Jubilee in 1999. Currently the IACP has 423 members.

The issue of licensing of clinical psychologists in India is conspicuous by its absence. This has been a long-pending and crucial issue under consideration.

The code of conduct has been recognized as being essential for clinical psychologists in view of legislation such as the Consumer Protection Act, the Mental Health Act, Rehabilitation Council of India Act, and People with disabilities Act. However, currently no body exists to evaluate, monitor, and control the standards of training and clinical services in clinical psychology in the country. Consequently, it is not uncommon to find individuals with no appropriate/adequate training providing consultation to a wide range of individuals (Prabhu, 1998).

The IACP is also concerned with improving the standards of services and research in mental health. It aims at continuing education of professionals, educating the public about mental health, and functioning in a consultative capacity to government agencies and universities. Registration of clinical psychologists and legal protection to the profession are important roles of the IACP. There is a shortage of human resources in mental health, and trained clinical psychologists from India continue to migrate to other countries. Registration of clinical psychologists will help to demarcate a professional group with sharply defined roles and responsibilities (Prabhu, 1974). Other issues include meeting the needs of a growing population as well as in keeping with most recent scientific advancements.

MENTAL HEALTH CARE IN INDIA

Prevalence of Mental Disorders

Epidemiological studies conducted in India indicate that mental disorders exist in all sections of the community. A meta-analysis of 13 psychiatric epidemiological studies consisting of 33,572 persons in 6,550 families indicated an estimated prevalence rate of 58.2 per thousand. Higher prevalence for urban sector, females, the age group of 35–44, lower socioeconomic status, and nuclear family members was evident. The findings indicate that there are 15 million people suffering from severe mental disorders (psychoses) in India (Venkataswamy Reddy & Chandrashekar, 1998).

Traditional Models of Mental Health Care in India: Ayurveda and Allied Indian Healing Traditions

Traditional Indian system of medicine has its roots in the religious scriptures—the *Vedas*, and specifically in *Atharvaveda*. *Ayurveda*, an Indian holistic approach to medicine, aims to bring about harmony between body, mind, and soul, and focuses on preventive, curative, and promotive aspects of mental health. This system promotes a combination of rituals, exercises, diet, and medicines for the treatment of various ailments (Balodhi, 1987, 1999).

Charaka described the causative factors in mental illness; these include (1) diet (incompatible, vitiated, and unclean food substances); (2) disrespect to gods, elders, and teachers; (3) mental shock due to emotions such as excessive fear and joy; and (4) faulty body activity. Thus, ayurvedic system considers biological, psychological, and social factors in formulating the causative factors in mental disorders. Charaka classified mental disorders

into three broad categories; these include (1) purely psychological or emotional disorders (e.g., jealousy, fear, inferiority, grief, etc.); (2) "psychosomatic disorders" (e.g., epilepsy, obsession, hysteria, etc.), and (3) unspecified/exogenous disorders (diseases caused by ill effects due to anger of gods). According to Charaka, psychological and unspecified abnormalities can be treated with psychological approaches such as chanting mantras, using precious stones, participation in auspicious rites, oblations, offerings, fasting, benedictions, worshipping gods, and pilgrimage, whereas, the "psychosomatic" disorders are treated with approaches such as cleansing of body, drugs, and adjuvant psychological strategies (Balodhi, 1999; in press).

Yoga is another Indian approach that integrates various aspects of human life. Patanjali advocated an 8-step approach dealing with these aspects. These steps include *yama* (observance), *niyama* (discipline), *asana* (posture), *pranayama* (deep breathing exercises), *prathyahara* (withdrawal of senses), and three stages of meditation, namely, *dharana* (concentration), *dhyana* (meditation), and *samadhi* (enlightenment). Such a comprehensive holistic approach focuses on an individual's well-being that goes beyond a simple curative dimension (Balodhi, 1986).

Siddha, another ancient system of medicine, with principles and doctrines similar to Ayurveda, is practiced in southern India, especially in Tamil Nadu. There are about 11,532 registered practitioners who provide services in the villages of Tamil Nadu and Pondicherry. There are 105 Siddha Hospitals and 316 dispensaries (Shankar, 1992; cited in Balodhi, in press).

Ill-health and well-being are conceptualized in the Indian systems as different levels of an individual's mind, body, and spirit; further, forces from the environment are said to interact with the individual in a complex manner to bring about health or ill-health. Hence, the treatment must also be complex and holistic. As compared to the western approaches, which focus on single or simpler aspects and "scientific respectability," the eastern holistic approach emphasizes a more complex manner of evaluation and management (Kapur, in press).

Mental health professionals have started examining the medical, physiological, and psychological aspects of yogic techniques (Satyavathi, 1988). Nespor (1982) examined 120 articles on yogic practices from the medical literature. He highlighted the role of yoga in the management of various ailments, and there has been a steady increase in the application of yogic techniques. Although studies using yogic techniques have been sincere efforts, there are methodological limitations, and there is a need for well structured multicenter studies with specific clinical groups (Thimmappa, 1980). Balodhi (in press) advocates the amalgamation of indigenous methods of treatment with modern health care system.

Traditional Healing in India

In India a large number of mentally ill patients visit traditional healers. In addition to certain rituals, the faith healers also advocate strict dietary habits, moral and ethical rules, and physical exercises (Balodhi, 1991).

Chandrasekhar et al. (1981) reported that irrespective of the presence or absence of mental health facilities in a particular rural area, traditional healers are consulted. These healers provide "health care services" as the first contact to most patients, especially in the rural areas. Trivedi and Sethi (1980) reported that 33.2% of their psychiatric patients sought help from traditional healers. The perceived causes of mental illness among people in India include (1) sins/wrong deeds of previous life; (2) sins/wrong deeds of present life; (3) faulty diet; (4) changes in physical state of the body (heat, cold, dryness, etc.); (5) displeasure/curse of ghosts, spirits, deities, gods, etc.; (6) physical causes (somatic, including infection) (7) social and psychological factors; and (8) magic and sorcery (Pandey, Srinivas, & Muralidhar, 1980).

Historical Roots of Modern Mental Health Care in India

The custodial care for severely mentally ill was started during British rule in India. The first mental asylum was established in 1787 in Calcutta, and the most recent mental hospital in 1966 in Delhi. Currently, there are 39 State Government run mental hospitals and 25 private mental hospitals with a total bed strength of 21,189. Although some states have adequate facilities for mental health care, others do not have mental hospitals. Because each mental hospital is required to cater to the needs of a large group of people (one bed for a population of 32,500), some of these hospitals are not easily accessible to people. Overcrowding, poor living conditions, lack of adequate human resources (Sharma, 1990), inadequate treatment facilities, and stigma have made mental hospitals "unpopular" in the community. Despite this more than 50,000 patients get admitted and

discharged every year. These hospitals are also providing custodial care to more than 10,000 patients. It is estimated that only 5% of the mentally ill population are making use of the available modern treatment facilities in the community (Chandrashekhar, 1999).

Apart from clinical psychologists, about 1,500 psychiatrists, 300 psychiatric social workers, and about 500 psychiatric nurses are working in the mental health settings in India (Prabhu, 1986). Thus, there is one mental health worker for every 300,000 people (cited in Chandrasekhar, 1999).

The National Mental Health Program for India

The National Mental Health Program for India (NMHP) was formulated in 1981 to offer mental health services in the country to ensure availability and accessibility of minimum mental health care for all, to encourage application of mental health knowledge in general health care, to promote community participation in the mental health services development, and to stimulate efforts towards self help in the community (Directorate General of Health Services, 1982). While focusing on these goals, there has been a gradual shift from mental illness to mental health, recognizing the preventive aspects of mental and neurological disorders. Various psychological and psychosocial factors such as life style patterns, life stress, coping skills, and family factors influence the mental health of individuals (Srinivasamurthy, 1999). The role of clinical psychologists at the community level is discussed in terms of formulating and monitoring community care, and program evaluation (Prabhu, 1986).

Psychiatry in General Hospital Settings

The setting up of general hospital psychiatric units (GHPUs) is an important phase in the development of mental health services in India. The GHPUs have facilitated the greater acceptance of mental health services by the public without social stigma. In the last three decades a rapid development has occurred. Medical schools have started psychiatric services; this approach helped patients in seeking early help, decreased duration of stay and reduced the stigma of mental illness (Srinivasamurthy, 1999).

Mental Health Delivery Through Satellite Clinics

Satellite clinics were started in four taluk headquarters 50–115 km from NIMHANS, Bangalore, by multidisciplinary neuropsychiatric teams to provide mental health services. These clinics predominantly cater to the needs of patients who require long-term medication for such disorders as epilepsy and psychosis (Narayana Reddy et al., 1986).

Alternative Settings for Mental Health Care

With deinstitutionalization of mental health care, alternatives in the form of day care centers, halfway homes, hostels, sheltered workshops, and foster care facilities have been initiated. Currently, such facilities are available in certain major cities such as Bangalore, Delhi, Madras, Mumbai, and Trivandrum, and are limited. With such facilities becoming more effective in the care of the mentally ill, the need for such facilities is increasing (Srinivasamurthy, 1999). These approaches are welcome to the extent that they alleviate the distress of the psychiatrically ill. However, their effectiveness needs to be assessed through short- and long-term outcome and the cost benefit analysis (Kapur, in press).

Psychotherapy in India

Psychotherapy in India has a long history but no past. Girindrasekar Bose, the founder of the Indian Psychoanalytic Society, was considered to have initiated the practice of western psychotherapy in the subcontinent. At Ranchi, Lt. Col. Berkley-Hill introduced another stream of British orientation; at Mumbai a third stream of influence came from the Italian analyst Emilio Servido (Prabhu, 1988). There has been a noticeable resurgence of interest in this area over the past two decades (Raguram, 1996). Psychotherapy in India, unlike in the west, is yet to take roots in clinical practice, and little psychotherapy research has occurred (Kapur, in press).

From the time of its inception in 1954, the Department of Clinical Psychology at NIMHANS, Bangalore, has been providing training in and services of psychotherapy. The training program in psychotherapy, with a focus on a patient-centered approach, emphasizes two objectives: (1) to provide a broad-based theoretical foundation and (2) to develop generic and specific skills necessary to be an effective psychotherapist. The training is provided in three broad stages, namely, (1) learning of nonspecific skills, (2) learning of conceptual skills, and (3) learning of specific skills (Rao, 1996). The trainees are acquainted with psychodynamic,

humanistic, existential, supportive, cognitive behavioral, directive, and group approaches along with eclectic and other western approaches. The trainees are provided with skills that can be effectively used in various settings (e.g., general hospital, mental hospital, university or school counseling centers, or private settings) and with various clinical disorders. They are also trained in formulating psychopathology, in assessing suitability of clients for therapy, indications and contraindications, and to plan and select specific goals and techniques (Kapur, 1996). No comprehensive Indian model of psychotherapy has been developed so far. However, efforts have been made to conceptualize psychotherapy in Indian perspective (cited in Neki, 1996).

Western psychotherapy was initially considered to be ineffective with Indian clients, essentially because it was felt that compared with their western counterparts, the Indian clients were less independent and resistant to personal responsibility and decision-making process (cited in Prabhu, 1988). However, this point was refuted by others who argued that western techniques are eminently suitable to the Indian clients (Chatterji, 1988; Prabhu, 1988; Shamasundar, 1988). Hoch (1990) also indicated that western psychotherapy can be used with Indian clients. Shamasundar (1988) believed that as one goes deeper into the basics of human behavior, one transcends geographical and cultural boundaries.

Current Trends and Recent Developments in Clinical Psychology in India

According to the Institute for Scientific Information (ISI) database of publications and citation statistics of psychology, among the top 30 countries, India ranked 20th with a world share of 0.35% (in terms of number of papers published). India ranked 23rd (impact 1.93) among the top 30 countries for number of papers in psychology in a cumulative 15-year period ranked by citation impact (Fava & Montanari, 1997).

Compared to previous years, the research done during the 1980s is characterized by a "wider coverage and depth" in the study of mental health problems in phenomenology, assessment, psychosocial correlates, and therapeutic strategies. Kapur (in press) has enumerated such a growth in her survey.

There has been a dramatic increase in the number of research publications along with an increasing trend toward publication of books and proceedings of seminars/symposia. Although some of the studies are prospective, well planned and well executed, a large number of them continue to be retrospective and descriptive in nature. Research conducted in universities may be less relevant to important mental health issues than research conducted in clinical settings. Clinicians, on the other hand, are less inclined toward research because of paucity of time, manpower, and financial resources. Kapur (in press) argues for a better interface between researchers in the university settings and clinicians.

FUTURE CHALLENGES

To be in unison with the recent developments in clinical psychology in the west and at the same time to cope with the demands within our own country, clinical psychologists in India face multiple challenges. Some of these challenges include the need to create more public awareness, educating and creating awareness among other health professionals about clinical psychology's role in medicine for providing most efficient services and liaison, development of more ethnospecific interventions, focus on developing more indigenous approaches of understanding mental illness, providing adequate and appropriate leadership models for younger psychologists, enhancing the training facilities and accepting more educational roles, and equipping Indian psychologists to deal with new and challenging problems such as HIV or AIDS.

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