CHAPTER 10 – THROUGH THE LENS OF MULTICULTURALISM

“In our culture… we are survivors, we don’t give up easily, and I am saying this for all of India… the surviving capacity, the bouncing back capacity is tremendously strong and that is what the therapist should tap.” (Samira)

Situated in the Indian cultural context, with cultural diversity as a given, the present study was located in the multicultural paradigm. Multiculturalism concerns itself with the key cultures of ethnicity, class, primary language, gender/sex, religion, age, geographic region, urban-suburban-rural, and exceptionality, and any study addressing these variables could be labeled a multicultural study. The multicultural perspective emphasizes how an individual’s specific values, beliefs, and actions are determined by their ethnicity, gender, religion, socioeconomic status, sexual orientation, geographic region, and historical experiences with the dominant culture (Wright, Coley, & Corey, 1989). It highlights how diversity factors salient for the individual may inform or shape an individual’s identity, behavior, worldview, attitudes, values, and beliefs (Roysircar, 2004).

With a growing emphasis in psychotherapy practice on diversity competence amongst therapists, focus on how diversity factors influence the clients, the process and outcome of therapy and also the therapist self, has increased. This chapter is a discussion of the influence of the Indian cultural context with its diversity factors on psychotherapeutic practice and the therapist self.

The Experience of Practicing in India

The client and the therapist world-views are both influenced by the cultural matrix that they are embedded in. Thus, psychotherapeutic practice has to be attuned to the zeitgeist and the culture in which both the therapist and client operate. This section attempts to zoom into the experience of therapists practicing in India. It is well
recognized that indigenous beliefs and practices influence psychotherapeutic practice. However, there is limited documentation of this influence from the lens of the therapists. Thus, giving the cultural context a rightful place in discussions of psychotherapeutic practice from the therapist perspective is imperative.

During the in-depth interviews that were conducted, therapists shared how they believed cultural beliefs and practices in India interacted with their therapeutic practice.

The chapter begins with a quote from Samira, as amongst all that was shared by the therapists on culture and psychotherapy, this belief stood out in being extremely positive. Therapists identified areas where cultural factors interfaced with their work as including help seeking, as well as the therapy process: however, the factors listed under each wore the tone of being a barrier.

Factors Influencing Help Seeking

Seeking therapeutic help has been steadily gaining ground in India. In the interviews with the participant therapists, they highlighted how culture influenced individual beliefs on causality, healing and treatment, and how this mediated help seeking for mental health concerns in India.

Gender. Deepak stated that the initial barrier in seeking psychotherapeutic help was denial of psychological concerns amongst the people. This led to limited acknowledgment of psychological and emotional problems, particularly in men, and that in turn interfered with their help seeking and further aggravated the intensity of the concern.

As a culture I think we breed a lot of denial. It’s more about males… They believe that nothing can go wrong with them. So that a lot of times that
interferes with help seeking… Causes a lot of psychosomatic issues. Yeah that is how stress usually starts expressing itself. (Deepak)

Men in India seeking help more reluctantly than women has been well researched and documented (Beck, 2014). Vogel, Wester, and Larson (2007) in the review on help seeking mentioned that women tend to have more positive attitude than men towards help seeking and also sought help more willingly for less severe issues: they mentioned that there is a need for researchers to clearly examine the relations among sex, gender roles, different avoidance factors, and help-seeking behavior.

**Lack of awareness and social stigma.** Lack of awareness of psychological disorders, compounded by the social stigma associated with mental illness leading to delays in seeking treatment in India has been widely acknowledged (Kishore, Gupta, Jiloha, & Bantman, 2011; Gaiha, Sunil, Kumar, & Menon, 2014). The therapists discussed both factors during the interview.

Culture determines how we seek help… the urban, the forward looking, corporate seek help more easily and they are ok going to a psychologist and talking their issues out… but a little older and those who have not moved out much, they are more stuck… about the stigma and not seeking help. (Sarah) 

Like Sarah, Keshav mentioned that there was still a lot of stigma associated with seeking professional help and though there were changes in a small sub set of urban population, the change was a very small one.

We are finally doctors for mad people... So unless you start throwing stones on the street, abusing people on the street, you are not supposed to go to a shrink of any kind. So that still operates to a large extent. But at the same time I also see people being more open about seeking help. Both sides are equally
true. I mean the more traditional stigma still operates but people also are more open about things. That’s something that’s changing yes. At a speed which I would like? No. Not at a speed which I would like. I would like better. But it’s changing, that’s good. (Keshav)

In an extensive systematic review of 144 studies, Clement et al. (2014) identified social stigma as a critical barrier to help seeking world-wide, particularly in men, and more so in Asian sub groups. Despite changing trends and increasing awareness, social stigma was still seen as a strong impediment to psychological help seeking.

**External locus of control.** In terms of causality, Ameesh noted that there was a strong belief in external factors influencing personal lives, and an external locus of control that interfered with individual help seeking.

Cultural belief of Astrology, is so widespread… I think Indians have a very strong external locus of control. Counseling and psychotherapy are all about internal LOC, I have to deal with you and not your stars. I wonder how much our culture helps us believe that, and we blame too much, nothing changes, people don’t believe that their actions change anything. I feel we will have more people in therapy if we believe in Internal LOC. (Ameesh)

Kohli, Batra, and Aggarwal (2011) explain that individuals in India have a dependent-type locus of control. Firstly, they are dependent on others such as family, doctors, medicines, which leads to a ‘loss of freedom’. Moreover, religious and spiritual coping within the collectivistic culture leads the individual to externalize the situation. Research cites locus of control to be a factor influencing help seeking. Conducting surveys on individuals with a diagnosis, Malin (2002) explored self-efficacy and locus of control in relation to attitudes towards seeking professional
psychological help, and found that those with an external locus of control related to less positive attitudes about seeking professional help, whereas those with an internal locus of control had better rated participation in treatment.

**Accessing alternative healing systems.** Apart from highlighting the link between LOC and therapeutic help seeking, Ameesh further elaborated that accessing alternative healing strategies took clients away from actively seeking therapeutic help and was not very helpful.

People don’t come to us they go to temples and they believe in miracles, and wearing rings. So our culture makes you an escapist, you believe, in astrology, vastu, etc. these are all illusions... I feel it is harming us. (Ameesh)

Clients seeking help during psychological disorders from astrologers and priests was acknowledged by other therapists as well, including Samira and Deepak, with both mentioning that they were not the one to judge if it was effective or not.

Oh yeah, they say that I went to my ‘jyotishi’ and he said this, and who am I to say that it won’t work, that might work much better than anything that happens here, good for you if it does. (Deepak)

Apart from astrologers and priests, participant therapists reported that clients were accessing homeopathic, ayurvedic and other healers by the participant therapists, either as a first option or often at the same time. Accessing complementary medicines and consultations through traditional healers is widely acknowledged in India (Saravanan, 2005, as cited in Jacob, 2013).

A study by Naik, Pattanayak, Gupta, and Pattanayak (2012) exploring help-seeking pathways of caregivers of people with severe mental illnesses (SMI) in India, showed individuals believed that, since the presentation of illness was not physical, the root had to be supernatural. For this reason, help seeking was directed towards a
religious person rather than a medical professional. Kishore et al. (2011) found a huge urban rural divide in terms of social stigma acting as a barrier to help seeking in North India. As part of the study, they found that participants attributed psychological disorders to supernatural causes and extensively sought help with traditional and faith healers, particularly in rural areas.

When comparing an urban setting (New Delhi) and a small town (Bilaspur), individuals in the small town attributed the influence of supernatural causes on illness more than the city dwellers, who preferred to pay heed to a biopsychosocial causation (Naik et al., 2012). The authors explain that participants from the urban setting, having greater access to information were more likely to move away from indigenous concepts to a more biomedical explanation. In contrast, participants from the small city showed a higher reliance on faith healers, consequently delaying their access to formal sources of healthcare.

R. P. Worthington and Gogne (2011), in discussing challenges in providing primary care in India, highlight that client health seeking beliefs can lead to delay in seeking help, particularly in rural health settings. They associate this with causal beliefs and social practices prevalent in India. This trend for help seeking has also been accounted for by the limited availability of mental healthcare services, that results in a use of alternative systems of mental healthcare (Raguram, Venkateswaran, Ramakrishna, & Weiss, 2002), particularly in semi-urban and rural areas.

A study ascertaining the help-seeking behavior of patients with mental health problems interviewed two hundred patients in a tertiary centre in north India. It was found that alternative systems of care were availed of due to easy accessibility, good reputation, ample time for consultation, belief in the system of healing and recommendation from a trusted source. Further, traditional faith healers and
alternative medical practitioners helped to mitigate the stigma associated with mental illness; hence they were visited even though the services were substantially more expensive than a formal source of care (Mishra, Nagpal, Chadda, & Sood, 2011).

Schoonover et al. (2014) interviewed forty-nine individuals at a general hospital and in eight villages surrounding Vadodara. Using a qualitative interview they elicited attitudes toward faith healing for mental illnesses and found that participants were largely dissatisfied with their experiences with traditional healers, but traditional healing was still a common first-line practice in Gujarat. Because traditional healers are such integral parts of their communities and so commonly sought out, collaboration between traditional/faith healers and medical practitioners would hold significant promise as a means to benefit patients. This partnership could improve access to care and decrease the burden of mental illness experienced by patients and their communities. In the state of Gujarat, the Dava Dua setting at Unava is a unique setting where the state government, an NGO and trustees of the Sayyad Ali Mira Dattar dargah have joined hands to help those suffering from psychological disorders who flock the shrine in Unava village for a cure (Kirmayer, 2014).

Considering that the participants for the present study were from an urban context, these concerns and barriers were perhaps not as stark as they would be in a rural or semi-urban context. In spite of the awareness and openness an urban context would provide, there were diverse groups of clients with varying access and help seeking patterns. The trend to seek help from alternative healers is a trend in not just mental health, but health in general in India and working with other healing systems is a part of providing treatment and care in India.

Having said that, practicing in the urban context came with its own challenges, where lack of awareness and different available healing options, each with its own
credibility and effectiveness, could create distrust in clients. To provide a comprehensive analysis of help seeking patterns in India is beyond the scope of the study, as there are a multitude of mediating factors that determine if eventually the client will reach the therapist and stay in therapy thereafter. However, it is worth noting that a sample of urban practitioners underscored that the client population was variegated in terms of awareness of mental health concerns, services and rights of psychological help seeking and factors such as gender, social stigma, causal beliefs and alternative healing systems interfere with individual help seeking. However, there was also a discussion on how these trends were changing, slowly but steadily.

What has changed is the courage of clients to come in… when we started, it was different, people just would not open up. But now you have counselors, psychologists, it's much more spoken about in Mumbai, this was not so years ago. (Rita)

The positive trend that Rita amongst others mentioned was heartening, but advocacy and awareness for mental health issues is a critical responsibility of a practitioner. The fact that the therapists had a steady clientele indicated that they reached out to a particular group who had the awareness, the motivation, the money to access therapy. However, therapists would need to move beyond and create opportunities to increase access of mental health services. If help seeking has to be made easier, and not just for the upwardly mobile, there has to be some way to minimize the barriers that delay access, hinder therapeutic help seeking and there has to be an effort to demystify therapy.

**Impact on Therapeutic Process**

Therapists also shared specific client needs in India that emerged in psychotherapy, as very often clients did not have prior exposure to counseling and
psychotherapy practice. Due to limited exposure, some sections of clients were not aware of, or took some time to adapt to, the structure and framework of counseling and psychotherapy.

**Late/ missed appointments.** Ameesh, along with Keshav and Sarah, spoke freely about the challenges in dealing with late and missed appointments in their therapeutic practice.

So managing time and missed sessions, I think… that Indians are terribly bad at keeping appointments and you call them the day before, yes we are coming and the next day they are not there. You call at the time of the session, “Yes we are coming”. Then also they will not tell that they are not coming. And then you call again after half an hour the phone is switched off. (Ameesh)

**Seeking advice and direction.** That apart, Keshav and Ameesh believed that clients sought advice in terms of actionable to-do lists / recommendations, the way they would receive a prescription from the doctor, as there was limited awareness about the counseling profession. Ameesh mentioned how therapists’ refusal to comply with these demands could also lead to drop outs.

There are people who come to us and want advice; instead of ‘goli’, give advice, if you don’t give it they get frustrated and don’t come back next time. People don’t know much about counseling, the human mind, how emotions affect us… (Ameesh)

**Expecting quick change.** Hina shared a similar concern in clients seeking quick change and immediate recovery from their concerns or condition, “Sometimes people have very rigid beliefs about therapy, they see you in a doctor’s role and expect very quick changes… The psychologist will do something magical”. Keshav
shared a similar concern, “People expect that you will read minds and so they expect magic”.

Hina elaborated how she found that some of the Western models of therapy, such as CBT, could be difficult to translate into practice and some clients preferred a quick way to resolve their problems.

For example, CBT, how does it work in an Asian culture like ours where people have absolutely no connect with their emotions, no connect with their behavior patterns, no connect with their thoughts. So many homework exercises, what does it mean to put your thoughts down, what does all this do. So give us something quickly and sort all this out. The help seeking pattern is very different here. (Hina)

**Challenges in working with thoughts and emotions.** Ameesh highlighted how working with complexity of emotions could be very difficult for some clients, as his work was informed by the psychoanalytic theory and he worked primarily with emotions.

All the show we have is on TV and movies of emotions, the emotions are so exaggerated there, and they are not real. Watch an English film and see the variety of emotions that they show and how subtle that is, mix of emotions, you can count 100 emotions. In our films, they show 3 emotions, ‘gussa aata hai, phir pyar ho jaata hai, aur phir shaadi ho jaati hai’\(^{14}\). The variety and the complexity of emotions we are not able to see, we are not mature enough to see that. (Ameesh)

Research reveals that Asians are seen to be ‘high self-monitors’ (look for cues from the environment and adjust their emotions and behaviors accordingly) in

\(^{14}\) Translation: You get angry, then fall in love and then get married
comparison to Westerners, specifically North Americans. This is primarily due to the
difference in culture and values. Further, the collectivistic Asian culture emphasizes
interdependence and restraint of emotions as a sign of maturity and obedience (D.
Sue, 2012).

Cultural values are seen to be influencing an individual’s outlook to therapy in
terms of attitude towards psychological problem, how help is sought and how
problems are treated. Literature shows that individuals from collectivistic cultures
emphasize hierarchy, dependency and are limited in self-disclosure, aspects that may
tend to limit the therapeutic process (Helmes & Gallou, 2014). As is evident from the
section above, certain therapists spoke more extensively on the challenges that
cultural factors posed to psychotherapy practice.

Therapists who were working with clients across different contexts
highlighted more concerns. Ameesh, for instance spoke at great length on how
therapeutic practice was different in India. This could be due to the fact that, one, he
was using a psychoanalytic frame and, two, he was working with a range of diverse
clients, across different parts of the city, and across varied socio–economic
backgrounds. Keshav and Arindam also worked in a community mental health setup
in suburban Mumbai and that perhaps came through in their discussions on cultural
factors as their practice was based on working with people across different sections of
the society. These concerns, though expressed, were not generalized to all client
groups. With increasing awareness or increasing socialization to counseling and
psychotherapy process these challenges were circumvented.

Adapting Therapeutic Practice to the Indian Context

In the interview, therapists were invited to share if they felt that their
therapeutic practice was adapted in any way to work with clients in the Indian
context. While some therapists felt that therapy needed to be adapted to accommodate for practice in the Indian culture, others spoke differently.

A lot of it, so in EMDR you have to use certain specific words, and that needs a lot of adapting. In the US they have an assumption that people know what therapy is, or have even taken it once in their lifetime, here no! They work with a belief that the client already knows that they are there for a reason, here 90% of our clients need to be convinced… secondly, culturally also we are really different, language is very different, so we have to really adapt our work. (Hina)

Hina’s views were supported by Ameesh, who also mentioned how cultural differences and client contexts required different methods to be adopted, even though the model remained the same, and the human mind functioned in the same way. Interestingly Hina and Ameesh were also the two people who spoke extensively of how help seeking was impacted by culture. Sarah and Rita, on the other hand, thought differently and discussed that the model and its tenets were universal and there was no need for them to adapt their respective work to a particular culture. The therapists were divided in how much their work needed to be malleable to cultural needs and demands. About half the respondents who believed therapeutic practice needed tweaking in India, shared some of the ways in which this was happening in their work.

Educating clients and developing faith in the process. Due to the limited awareness about mental health concerns and services, education and information giving was mentioned as something that the therapists were finding themselves spending time with. To enable therapeutic work, therapists would initially need to prime and prepare clients.
This is the first responsibility of a psychologist, this is a need in India, because there are so few of us… educate the client and develop faith in the process, so whenever the person has a problem he should seek help… psychology has not evolved in Indian culture, therefore, people will not come to you, they will go to astrologer, or baba, or some senior person, because that is our tradition, they will go to Yoga… (Arindam)

Arindam linked this to available traditional healers and alternative healing systems that were accessible to people in India. Hina mentioned that therapists found themselves promoting or advocating for therapy almost to the extent that it seemed like selling a product.

Psychology is such a budding field, so they don’t take it seriously. Why should we go for therapy? Why do we need it? They don’t understand it. So unlike other countries where people are aware, here you have to spend the entire session, telling them and trying to convince them that they need therapy. It’s like marketing, you have to sell yourself and therapists who don’t agree to it are not in tune with their field. In India you really need to sell your profession and what can you really do and convince your clients. It’s a big challenge that you have to convince them that they need help. (Hina)

**Charging lower fee or taking fewer sessions.** Charging lower fee from clients who could not afford therapeutic services, was an accommodation made by several therapists. In India, mental health care services are neither covered by insurance, nor available free of cost easily, and there are no guidelines or standardized service provision rate / fee based on income stratification. Therapists who would work with low – income groups would need to reduce number of sessions or charge lower
fee from such clients using personal discretion and consideration for client circumstances.

So there are some people who came only for three sessions. They can’t pay more than that. There’s a house help who was coming, there was the wife of a driver who was coming. They can’t come for more than 3 sessions or 5 sessions even if I made the sessions from Rs.500, I made it to Rs.50. Still they can’t pay... So then you work in those limited sessions. Then you leave that work undone… And you stop there. I learnt that. Of course it’s uncomfortable. Of course it feels that it would have been good if they could have come... But I think how much ever could be accomplished, was good and intense. (Ameesh)

**Being directive.** Deepak shared that Indian clients needed direction and therapists might find themselves more directive than in other countries, considering that in India people were used to being told what to do by experts.

I began to understand that here, the need for people to be told by an expert what to do… rather than find their own way through… people would come and say that yes I have told you everything now you tell me what to do… and am not denying the value of people finding their own way through but I also realize that just sitting and listening to someone is not enough… (Deepak)

**Using appropriate language.** Arindam shared the value of using simple, easy to understand terminology in the local language to make mental health services accessible to clients in India. Samira mentioned how she was sensitive about using the client’s language while working with clients across different regions in India.

Hina believed that the only thing that needed to be modified in adapting EMDR to Indian clients was language. She mentioned that she made an effort to convert all protocols into Hindi from English and also used pictures and images to
ensure her clients understood the model and the workings of the brain and her therapeutic method was not diluted. Ishrat again brought up how critical it was for her to use the appropriate language in a sensitive manner when working with children and their families, this time in the context of making interpretations in play therapy.

Sometimes I have to be a little careful you know about what I say, knowing the background of the patient or knowing the culture of the patient. Sometimes you need to be a little careful. You can’t be… if there is an indication of a sexual activity, for example, in the play … sometimes you need to be a little careful if the child is not used to it. So you need to bring it in very subtly… in a way that the patient would understand. (Ishrat)

Sarah, however, believed that for her practice of somatic therapy, language was not at all a barrier.

Not really, because the way somatic work is… you just observe and make sense of it in the client’s context… and being in India or abroad that really doesn’t make a change… and that is the beauty of the therapy and you can do it with anyone… at times training is done with people who don’t even know their language… language is not a huge barrier… you need to know a little bit to ask what is happening to you and where are you feeling it… which area… so little language is needed in work and you need to understand their needs that are important. (Sarah)

**Being sensitive and self-aware in dealing with family and cultural contexts.** Although most therapists brought up aspects of the Indian joint family at different times during the interview, Ameesh and Dirghayu specifically mentioned this as an aspect to be cognizant of while working with Indian clients.
Adaptations in the sense of understanding the context… in India a person does not come alone, you have to understand the whole context. If a 30 year old a man comes into therapy, who is living with his mother, you can’t tell him stop living with your mother, that’s not done, you could do that in the US, of course that is part of the process, helping him stay in the family and also be his own person… (Dirghayu)

Jiya detailed out how psychotherapeutic practice in a country like India with clients from diverse religious and regional backgrounds might lead to conflict in beliefs and required sensitivity and self – awareness on the part of the therapist.

I would go out of the way to understand that community and how they function, what is right or wrong according to them and bring it into the therapy… such things do interfere, For example, this Muslim client I was struggling to understand their religion, because I was feeling a lot of anger when he talked about a couple of things, and I was aware of it, so I was constantly evaluating myself, bringing myself down… so I think I needed to talk to myself between sessions do some work on myself, before the session just calm down bring myself in that frame of mind, I had to do that… then I met two people from the same religion, two maulvis who were teaching Islam, I had a short conversation with them, and they told me about a website which I can surf and get more information about the religion because such things help… so then it was fine… this is what you believe, I may not believe in it… I think some families have different beliefs or faiths, so you just can’t challenge them. Sometimes again as a therapist I cannot expect them to shift completely, let them be wherever they are, and then do things accordingly.

(Jiya)
Chandras, Chandras, and DeLambo (2013) highlight certain cultural characteristics seen in Asian groups, such as close family ties, conformity within the family, traditional role structures to name a few. They emphasize that India is characterized by tremendous diversity and recommend some counseling strategies for working with Asian-American Indian clients such as, preparing and priming the client about therapeutic work, being directive in the counselor role, and keeping the counseling short and focused on concrete resolution of problems.

In the present discussion, participants in the study were divided in terms of cultural adaptation required in therapy. While some therapists acknowledged the need to include culturally sensitive practices, others believed that therapeutic models translated across populations without the need for too much adaptation. This brings up a dilemma: on one hand multicultural competence is being promoted amongst students and practitioners globally and there is a movement sensitizing professionals to utilize strategies in counseling and therapy to accommodate the client’s cultural context, on the other hand, in India we have been adopting Western models and methods to address client concerns.

One reason cited for this could be the nature of clients seen in therapy. In working with an urban, sophisticated, English speaking clientele, a Western model of practice might not be very hard to translate to practice. However, for those who were working with regional, religious, and cultural diversities these adaptations might be critical to ensure therapeutic benefit for the clients.

The other reason, for not bringing changes to Western models of practice by participant therapists could be to avoid diluting the model of practice and maintaining its structure and form, or as mentioned by Sarah and Rita, that the model did not require any change. Patterson (2004) mentioned that all individuals are multicultural
and all counseling is multicultural and there is no need for specific methods or a separate multicultural approach to work with diverse clients.

**Discussion points**

This section illustrates therapist voices on practicing in the Indian context. What emerged was that despite the fact that all therapists were practicing in a metropolitan environment, there were variations in their experiences with clients, depending on the client segment they catered to and the cultural background of their clients. While some participants mentioned general positive changes and trends, with increasing awareness and more clients accessing therapeutic help and taking charge of their treatment, there were also voices that brought to focus specific challenges and concerns in working with clients across gender, culture, religion and educational and economic backgrounds. Client beliefs on causality and treatment of psychological disorders, help seeking patterns, treatment expectations were at times deemed detrimental to seeking therapeutic help and receiving it.

Tseng (1999) mentioned that cultural understanding needs to be integrated into psychotherapy by taking into consideration the socio-cultural milieu, examining and clarifying the clients’ expectations of psychotherapy, establishing and moving towards a culturally suitable client-therapist relationship, modifying one’s communication style with respect to the clients’ cultural background, accepting and being open to culturally adjusted theories of psychopathology, including culturally sanctioned coping strategies and forming therapeutic goals which are in accordance with the clients’ cultural background and expectations.

Some of these aspects were highlighted by the therapists, such as changing the therapy format or therapeutic style, using appropriate language and, most importantly, being sensitive to cultural beliefs and practices in planning intervention. However, not
all therapists contributed to this discussion on culture and psychotherapy as actively during the interview, as this was usually the last section that was explored if it had not emerged during the interview. Also, while Samira briefly mentioned the resilience fostered in India, and a few others highlighted increasing urban trends in help seeking, the discussion on client and caregiver strengths in the Indian cultural context was limited. This suggests that this area would need focused research effort.

While some trends emerged, this section ended up raising more questions. Should Western theoretical models be adopted without any changes to ensure therapeutic purity? Or should there be specific therapeutic models or therapeutic styles to cater to Indian clients that incorporate culture sensitive practice? Were the therapists really practicing purely Western models or were they creating their own indigenous frameworks of practice? Do we need to have elements in training programs to sensitize young professionals to working with clients in the Indian culture? While some questions were limited to therapeutic practice, others were directed towards the larger sociocultural context that we exist in. What would be required to bring more change at the macro level to increase awareness and reduce stigma towards mental health concerns? How could the barriers to help seeking be systematically tackled? The breadth of questions ranged from the need to practice culturally sensitive techniques and practices to developments needed in training, policy, and advocacy: all requiring further deliberation and study.

**Therapist Weltanschauung and the Cultural Bedrock**

This section focuses on the discussion on how therapists’ beliefs and values impact therapeutic practice by underscoring the fact that the development of therapist world-view is also culturally determined and strongly influences therapeutic practice.
The therapists that participated in the study were from culturally diverse backgrounds, and differences in religion and gender were welcomed during sample selection. What came together as a participant group for the study was a very diverse group of individuals, bound together by a common identity of a counselor/therapist. While the research aimed to understand the beliefs and values of the therapists and how it impacted psychotherapeutic practice, what stood out was how the cultural weltanschauung truly percolated into the personal weltanschauung of the therapist and shaped the therapists self and their therapeutic practice.

In the context of multicultural counseling, D. W. Sue and Sue (2013) propose a tripartite framework in exploring and understanding the formation of personal identity when working with diverse clients. In the model (D. W. Sue, 2001) they outline three concentric circles – denoting individual, group, and universal levels of personal identity.

Figure 3. Tripartite development of personal identity (D. W. Sue, 2001)
The model outlines how beliefs and values at the individual level are deeply influenced by the social, cultural and political matrix at the group level. They further emphasize that certain group markers such as gender are relatively more stable and less subject to change, as compared to others such as socio economic status that might be more fluid and changeable. The idea that people may belong to more than one cultural group, that some group identities may be more salient than others has been emphasized.

Ratts and Pedersen (2014) opine that the importance of the group dimensions of identity identified by D. W. Sue and Sue (2013) lies in explaining how individual people experience the world as members of various social groups. They further this idea through the dimensions of identity model (Ratts & Pederson, 2014) where they categorize group dimensions of identity into internal, external, and sociopolitical dimensions. Depending on the degree of salience, a certain aspect of identity may find itself on the internal or external dimension. Therapists are encouraged to adopt a holistic approach and acknowledge the existence of individual, group and universal levels of personal identity and how they affect an individual’s life. There is a need to understand the significance and influence of culture on identity development, sense of self, family relationships, interpersonal relationships, and also life choices. Caution that there may be a focus only on individual and universal aspects, and the group level may be missed has been central to the thrust of multiculturalism in counseling and psychotherapy. If we borrow the same lens to look at the therapists and how their identity evolves and their world-view is shaped, the same group level factors become critical.

Through the arcs of their lived experiences therapists too constructed their own identities in the context of the social reality that they were part of. Despite
sometimes having some similar experiences, in terms of training, or theoretical orientation or gender, the construction of the psychotherapeutic practice each person had was unique based on their world-views and the zeitgeist that they were part of. The discussion below identifies how aspects of gender, culture, religion, ability and their construction in society impacted individual therapists and their world-view. Through the therapist interviews, they themselves drew connections between these domains and with some aspects of their therapeutic practice frameworks.

Father Joseph brought up this aspect of how being a boy in a large Christian family impacted his personal identity and how he eventually trained to be a priest just as his family had expected. However, he also brought up aspects of his religious training and how that impacted his beliefs on availability, acceptance and care, leading him to create a unique counseling context in the college where he was practicing.

I come from a large family. In the old days one of the family’s sons generally joined because they were large… And it was a family joke that I was becoming a priest… So I think the priesthood started technically that way and then ultimately the whole process of training… So I am a counselor more than a priest but my priesthood helps me in my counseling because I have been brought up this way… in the priesthood values and principles or whatever. All that I have learnt as a priest and as a Jesuit, all that has helped me.

As suggested by D. W. Sue and Sue (2013) to understand how personal identities are constructed, and how the world-view evolves, a sum of all experiences and contexts is needed. The interrelationships of many identity dimensions such as male, Christian, educated all created a unique world view for Father Joseph and that could not be ignored while looking at his practice of counseling and therapy.
The role of religion in influencing individual world-view is accepted and this was also an aspect that became evident through the therapist narratives. Ishrat’s clear disclosure of how Islam, a religion that she and her family followed, influenced the values she held and moderated her beliefs on healing and care, furthered this idea. Ishrat shared, “my main values as a person comes from the teachings of the Islamic education” and as discussed in chapter 9, she elaborated on how these beliefs and values taught in the religion her family practiced molded her ideas of providing mental health services. The search for truth, the role of intention and the value of compassion that became part of Ishrat’s world-view as a result of her socialization in Islam, became the lens through which she saw viewed her work and chose her theoretical orientation.

Samira mentioned that belonging to the Agha Khan Ismaili community, she believed that she had an intuitive business sense and she was lucky when it came to getting returns in business. This belief permeated into her work as she started her own organization, diversified into many centres, and structured fee to make the centres remunerative. Her perspective of psychotherapy service provision was influenced by her beliefs, as she tried to create economically viable models to generate revenue through her centres.

Sheetal shared in her interview her experiences while growing up involving regular visits to her maternal grandparents home in a small district in UP. She disclosed experiencing discrimination as a girl child that led her to question the patriarchal system and over her years as a therapist work from a gender sensitive framework and uphold her own values about justice.

My mother comes from a small district in UP... Whenever I went there, even when I was small, there were so many restrictions… ‘don’t go stand in the
balcony’, ‘never step out of the house’... I remember if there’s some function then my mother used to give Rs. 21 to the boy and Rs. 11 each to the girls. So I would say, “Why are you doing that?”... she would say, “They are girls and he is a boy”... I was always for justice. I don’t know where it came from but my value of justice comes from my belief that people from different gender should be treated fairly if not equally... I think one of my values is justice... a very important value. You should not be unfair to anyone. And I think that is why I feel so strongly about domestic violence or any kind of abuse... as long as I can remember I felt very strongly about gender discrimination. So I think this justice thing comes from that.

Sheetal’s practice involved stating her values on violence upfront with clients and also working to empower clients. Liu (2011) discusses that the world-view that gets formed is the lens through which one views the world, and experiences of marginalization also become part of this world view – and therefore the lens through which we process further information. Dirghayu’s experiences of marginalization when he sought to join the work force after he lost his vision and during his psychology training, led to him to be part of the Disability network and create sensitization training for students and advocate against discrimination.

The turning point for me was around the age of 18-19, when I lost my sight and for me that was a huge turning point... and the second turning point came for me around the same time, around ‘98 when I had a lung infection and I almost died. So when you actually get so close to those experiences, then it kind of shapes you in a different way… these experiences changed the way you look at life, the way you look at how you spend a life and radically changed a lot of things for me.
He believed that therapists come with their own biases and prejudices and reflective work was very critical and not only himself sought regular supervision, but also provided training for other mental health professionals through experiential groups.

The counselor’s experience in culture about healing beliefs and treatment can impact their therapeutic practice, stood out from Hina’s narrative. Her negotiations with the healing methods she was exposed to and the psychotherapeutic methods of the professional community she belonged to brings up another aspect how culture influences the therapists choice of treatment methods.

In my background, my mother is a healer, she does Reiki, Pranic and natural healing, so there was a lot of that influence on my methods with my clients...

In both positive and negative ways, not all positive, because she practices in metaphysical sciences. She is into past life, spirituality… and I started merging this that and everything initially... So that was the negative influence. How it helped me? It was the basic things like compassion and caring that I learnt, that I saw my mother doing with her patients. So those values were given to me how to always be there and the person is more important than the methods... But like I said it was not all positive, I had to do a lot of looking within... I would receive a lot of flak from my community for believing all these things, because a lot of the people in my community would not believe in it… now I respect it, but I would not use anything for which there isn’t any evidence and rather use what I am trained in.

Hina had to reorganize her beliefs on healing practices and negotiate what she had learnt about healing methods from other traditional healing models with therapeutic methods advocated by the professional community she belonged to. Hina
had named her clinic on a tenet from Zoroastrianism, had religious prayers and idols in her clinic and used aroma oils in her clinic for clients and herself and at the same time used the therapeutic model of EMDR based on its outcome effectiveness in therapy.

The discussion so far suggests that individual belief systems are shaped by various forces and develop and progress through the life. These beliefs are determined by the dynamics of what could be more dominant – subordinate sub cultural factors that therapists are part of. This complex interplay of diverse cultural dimensions intersect to develop a web of beliefs and values that then guide therapists in their therapeutic work.

Considering that most professional training in counseling and psychotherapy is extremely culture-bound, as many of the assumptions that underlie training and practice are distinctly Western (Fukuyama, 1990; Pedersen, 1987) it becomes even more imperative for practitioners in India to take cognizance of cultural factors. The cultural influence on the clients and the therapist, and the subsequent impact on the therapy process is undeniable.