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Research Paper

Issues Faced by Aspiring Clinical Psychologists in India

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ABSTRACT

15% of Indian adults are already in need of active intervention for one or more mental illness (National Mental Health Survey, 2015-2016). The increasing demand for mental health care needs to be met with an increased supply of trained professionals. The generation that will soon bear the reins of this community needs to find practicing in India a lucrative option. Issues faced by aspiring clinicians at the start of their professional trajectory such as lax standards of licensure, inadequate training facilities, low remuneration, deficits in research funding and neglectful enforcement of code of conduct may dissuade them from practicing in India. This paper discusses challenges and recommendations keeping in mind the status of clinical psychology in other countries. A survey was conducted on practicing clinicians (N = 41) to integrate varying viewpoints.

Keywords: *Clinical Psychology In India, Mental Illness In India, Mental Health.*

The purpose of this paper is to (1) discuss issues faced by aspiring clinical psychologists which may dissuade them from practicing in India, (a) systemic, and (b) practice-based issues, and (2) give recommendations to make practicing in India lucrative. A pilot study (N = 41) was conducted on practicing clinical psychologists to understand the issues and suggestions from the standpoint of a professional in the system, which will be discussed in a later section.

Changing health and lifestyle patterns in India have pushed mental, substance and behavioral disorders in focus of health systems. According to the National Mental Health Survey (2015-2016), almost 15% of Indian adults are in need of active intervention due to one or more mental health issue. For a population of 1.3 billion (Government of India, 2011) the estimated number of mental health professionals in India is 3800 psychiatrists, 898 clinical psychologists, 850 psychiatric social workers and 1500 psychiatric nurses (Ministry of Health and Family Welfare, 2015). World Health Organization (2005) estimated 0.03 psychologists per 100,000 people in India (0.2 psychiatrists and 0.05 psychiatric nurses). Moreover, the disparity in demand and supply of professionals is suspected to be the reason behind

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professionals with varying qualifications (diploma courses, master's degree and certification courses) giving intervention (Isaac, 2009). There is a pressing need to attract competent professionals to aid the development of mental health services in quantity and quality. This paper concentrates on clinical psychology.

Clinical psychology's lack of impact on clinical and public health can be largely pinned to the lack of adequate scientific training. Personal experience is given value over scientific evidence for assessment and interventions. The scientific revolution of medicine in the 1900s was marked by the valuing of scientific research over personal experience, which plays a major role in the current status of medicine. This was an effort by the American Medical Association to increase scientific training at medical schools. Prior to that medicine was much like clinical psychology today (Baker, McFall and Shoham, 2009). This stands true for India as well, although not the sole reason behind the profession's lack of status. A personal experience elucidated the appalling state of practice; the following case study took place in Jaipur though similar accounts from cities like Mumbai and New Delhi are frequent (A. Chaudhry, personal communication, 2017). *I terminated a 3-month internship (in 4 days) at a reputed psychiatric clinic due to unethical practices at the organization. Premature diagnosis (sometimes in the first session), unchecked sanitation standards, questionable credibility of professionals, and over prescription of drugs were few of the surface level adversities.*

Respondents (N = 41) of the pilot study had 0-30 years of work experience. From 36 respondents, 15 were registered and 21 were not registered with RCI. They had varied qualifications, MPhil, PhD, MA, and MSc. The primary objective was to assess (a) what are the current issues, and (b) suggestions to address these issues. Training, credentialing of professionals, and regulating code of ethics was given emphasis in the survey. According to the respondents, the top five pressing issues of clinical psychology in India are, (1) lack of a regulatory body, (2) lack of awareness about mental health and professions of the industry, (3) unsatisfying professional environment (low salary, bleak professional prospects for practice and research, professional rivalry with psychiatrists, and lack of specified job roles between counsellors, psychiatrists and clinical psychologists), (4) licensing of professionals and standardization of practice, and (5) inadequate training in psychotherapy and a limited number of recognized institutions.

Systemic and practice-based issues are discussed in this section.

(a) **Loose licensing process:** Rehabilitation Council of India was setup in 1993 for registering qualified professionals but has failed to effectively achieve this in 24 years. Practicing without certification is punishable by the law (RCI Act, 2000), but no punitive actions are actively taken. Only 10% of practicing clinical psychologists are certified (Veeraraghavan and Singh, 2014) causing a ripple effect on the pay scale, medical insurance available for clinical sessions and status of the profession.

(b) **Lack of a regulatory body:** Barnett's (1995) inspirational virtues for practice include beneficence (maximum benefit to a client), no malfeasance (minimizing risk to a client) and

fidelity (obligation of a therapist to a client); though covered by the code of ethics formulated by Indian Association of Clinical Psychologists, they are not regulated. Besides regulation, formulation and construction of laws by the IACP (as of 2013) are less comprehensive as compared to the APA ethical code (2017). The United States of America saw a paradigm shift concerning the code of ethics post adversities via Nazi doctors. A committee was formed in 1947 where more than 2,000 psychologists notified dilemmas encountered during practice, which then became the guiding principles for enforced ethics in 1992 (with continued development through the years).

(c) **Inadequate training facilities:** It is RCI's role to standardize, regulate, and develop training programs/courses; currently twenty-nine centers (as of 22nd December 2017) are offering RCI recognized M.Phil. Clinical Psychology programs. The number of institutes and seats offered within these affiliated centers is insufficient to meet the current demand of qualified professionals. Quality control begins at universities; professional competency in clinical psychology is a 'multidimensional construct', it encompasses 'communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in psychological practices' (Isaac, 2009). The general trend for screening students in India is based on marks (with the exception of a few universities); this ignores evaluating the student's temperament and Fitness to Practice (FTP).

Barnette's (1995) review found foreign-authored textbooks being used for training in India. Till today, foreign-authored textbooks are largely being used for training. An information gap is present in these textbooks about (a) the developmental history of clinical psychology in the Indian context, (b) content of cases encountered during practice, and (c) intervention techniques adopted (like past life regression, hypnosis, vipassana) by Indian clinical psychologists. The trainee indigenizes his practice prematurely based on the limited knowledge of the Indian context and clinical experience. This raises the question of using therapeutic techniques having little (or poorly collected) empirical evidence (Misra and Rizvi, 2012).

Lastly, the essence of university education is being lost, summarized articulately by Jordan Peterson (Clinical Psychologist and Professor at University of Toronto),*"if you need a safe space, see a therapist. University is not a safe space. If university is done right, it's a radically unsafe space. If you want to go somewhere and get yourself taken apart, intellectually, and then hopefully get put back together, then go to university. Everything you believe should be challenged in every possible way.*"

(d) **Low remuneration and status:** Low remuneration is a major reason for professionals choosing to work abroad; according to PayScale (as of 23rd December 2017) the median salary of a clinical psychologist in India is INR 3, 71, 411 per year. In table 1 below a comparison is drawn to other countries (USA, UK, and Australia), relative to them and for a specialized course the compensation is low.

Low status of the profession in India is due to the (a) stigma attached to mental illness, (b) lack of awareness among the general population about roles and division of responsibility between counselor, psychiatrist, clinical psychologist and social workers, and (c) professional

rivalry among psychiatrists and clinical psychologists. A ubiquitous response by the layman in India regarding professions related to psychology is, '*can you read my mind or are you psychic?*' which is unacceptable in this 'progressive' era.

Table 1. Country-wise median salary of clinical psychologists

Country	Median salary per year	Conversion to INR
United States of America	USD 74,844	INR 48,00,494.16
United Kingdom	GBP 38,866	INR 33,52,952.78
Australia	AUD 74,472	INR 37,26,204.48

(e) **Research and bleak future prospects:** Research is a discouraging process in India due to deficits in funding and a lack of supportive intellectual climate. This reduces studies conducted on the Indian population; and indigenized practices without sufficient empirical data are adopted (Misra and Rizvi, 2012), however, this is not the sole reason for lack of empirically based practices. Empirically based practice was one of the main goals of the Boulder Model (1949) or scientist-practitioner model. Questions raised by Anchin (2005) need to be considered, (a) which of the two, researcher or clinician has 'greater claim to the truth' when deciding efficacy of a therapeutic practice? (b) is qualitative data (in the Indian context, use of religious scriptures and generational wisdom) or quantitative data 'close to the truth'? (c) how can the integration of diverse theories fall under one unified paradigm of therapy and guide its evolution (Isaac, 2009)? The underlying concerns being, application of western concepts to the Indian client and premature indigenization of practice (Isaac, 2009); both concerns don't have sufficient data currently. This issue overlaps with the use of foreign-authored textbooks for training as discussed earlier.

Recommendations are made reviewing the status of clinical psychology in other countries, and survey responses. Some recommendations are based on existing guidelines that aren't currently regulated.

Systemic Recommendations

- A regulatory body (like American Psychological Association) for regulation of practice and certification of professionals is needed (this is apparent). Rehabilitation Council of India and Indian Association of Clinical Psychologists should vest their power in a centralized body for psychology in India. In 1917, 49 clinical psychologists came together and created the American Association of Clinical Psychologists (AACP), which was incorporated within two years into American Psychological Association (APA) as Section of Clinical Psychology (Brems et al., 1991 as cited in Hecker and Thorpe, 2005). Clinical Psychologists in 1937 frustrated with APA (due to membership criteria and ignorance towards practice-based issues) joined American Association of Applied Psychology (AAAP). To retain its position as the primary organization of representing psychology, APA redefined its objectives in a joint effort with AAAP; the latter then voted itself out of existence (Hecker and Thorpe, 2005). Indian clinical

psychologists to look at this anecdotally, recognizing a need for similar changes and centralizing power. The APA system of division within the association (e.g. division 12 of clinical psychology) can be followed. The aim will be standardization in all facets of psychology and its varied fields.

- Licensing renewal to be conditional on Continuing Education (CE) hour requirement (in America it's between 20-50 hours approximately, depending on the state's rule) from which few hours to be devoted to the ethical practice of clinical psychology. Although RCI has a license renewal requirement of Continuing Rehabilitation Education (CRE) centered around workshops and conferences, more emphasis has to be laid on ethical practices and education of new intervention methodology; and credibility of programs need to be evaluated.
- Development of infrastructure (technologically and procedurally) to make the licensing process friendly.
- Claim for medical insurance would be a derivative of certification, as the insurers want to ensure legitimacy and credibility of the resource. Mental Healthcare Act, 2017 has made a provision for this, *"every insurer shall make provision for medical insurance for treatment of mental illness on the same basis as is available for treatment of physical illness",* but insurers may be hesitant due to lack of credentialing system in the industry and lack of awareness among the insurers.
- Indian Association of Clinical Psychologists should take the initiative to understand the dilemmas encountered during practice to act as guiding principles for culture relevant code of ethics.
- The regulatory body to have a system laid out to file, investigate and resolve complaints of unethical conduct and awareness to be created about the guidelines among the professional community.
- Fraudulent and unethical practices to have punitive consequences setting a restraining example for the industry.

Training Related Recommendations

- Training centers offering clinical psychology courses to increase in number as well as in number of seats. As suggested by Virudhagirinathan & Karunanidhi (2014), they should be affiliated with a medical/healthcare institution.
- Indian authored books to be used or Indian context to be emphasized during training with the help of additional readings (beginning from undergraduate education).
- Scientist-practitioner model (1949) should be followed to aid scientific training and encourage research-based practice (as currently followed by NIMHANS). Equal weightage to be given to research and clinical practice.
- Ways to assess Fitness to Practice (FTP) demands a radical change. Screening process for enrollment into courses to be made multifold (aggregate score, letter of recommendation, statement of purpose, achievement tests and oral interview with the supervisor) akin to foreign universities (a minority of Indian universities follow this system). Besides academic competency, psychological fitness should be assessed. Deficits to be met with vocational counseling of the candidate, academic support,

special tutoring, psychotherapy, and mentoring (Isaac, 2009). Sofronoff, Helmes and Pachana (2011) explain how universities can regulate FTP, (a) clear FTP policy to be laid out by the university, (b) students and training staff to be aware of them, (c) student progress to be recorded, and (d) procedures to deal with the student when the need arises has to be laid out. Other disciplines (dentistry, social work, psychology, nursing, and medicine) that have employed FTP policies in the past decade have seen a monumental growth (Sofronoff, Helmes and Pachana, 2011). Three main areas covered under FTP policy should be (a) knowledge and application of professional standards, (b) competency, and (c) personal functioning (Sofronoff, Helmes and Pachana, 2011).

- Baker, McFall and Shoham (2009) suggest a strategy to improve the impact of clinical psychology on mental health, a new accreditation system for training programs that keep scientific training at its core. Improved training standards in medicine impacted the quality of health care in America; clinical psychology in India needs this push too. Baker et al. go on to claim "such a system will (a) allow the public and employers to identify scientifically trained psychologists; (b) stigmatize a scientific training programs and practitioners; (c) produce aspirational effects, thereby enhancing training quality generally; and (d) help accredited programs improve their training in the application and generation of science."
- Intellectual climate at training centers to be conducive for the evolution of student's critical thinking, writing, reading and effective communication skills.
- Legal education (RCI Act, Mental Health Act, Disability Act, etc.) to be given to students as a part of the curriculum (during graduate education), making them informed professionals and able for contribution to the law or discourse.

Research Related Recommendations

- Quality and quantity of research in India needs to evolve. Publications to be encouraged in peer-reviewed and indexed journals.
- Research to be encouraged at the undergraduate level, making one original research work compulsory to attain the degree.
- The atmosphere at conferences and classrooms to be challenging and encouraging. All departments should be actively involved in producing and reviewing literature. An increase in budgets for funding research to be considered by institutions.
- Though not a concern unique to India, journals should be made more accessible, currently, due to the high price of articles and limited university access to information, there is exclusivity to quality journals.

Practice-based Recommendations

- Randomized Controlled Trials (RCT) in evaluating therapeutic interventions to be conducted by organizations. Especially when indigenization of practices and applicability of western concepts is a bouldering issue. However, acknowledging the limitations of RCT, it should be supplemented with other forms of evidence (Clay, 2010).

- The salary of clinical psychologists should increase; besides appropriate compensation for an intensive career path it will encourage students to pursue clinical psychology. Change needs to begin at the organizational level, hiring of under qualified professionals (with a diploma or a certification course) is creating the cleft as employers look at hiring minimum wage employees. This mentality needs to be forgone via discourse in conferences and workplaces.
- Workshops to be held at institutions to keep pace with developments worldwide, and to increase awareness amongst the educated ignorant.
- Current lack of clinical psychologists practicing in rural areas is a challenge the government needs to deal with, as no effective body is looking into it. Creating more jobs for the trained professional in the public sector.

Recommendations to Professionals

- Each professional in their microcosm needs to have a keen eye for noticing unethical practices. Due to foundational problems of illiteracy in India and no formal regulation of ethics in the field, therapists have to be more conscientious during practice. APA recommends the therapist to play an active role in monitoring their peer's practice (Isaac, 2009).
- Current unethical practices should be revealed with the help of experiments and studies, a cue can be taken from Rosenhan's experiment (1973).
- The power of social media needs to be maximized by professionals, to educate and create awareness about mental health, and its use as a tool for therapy in the changing times.

The initiative should be taken by the government to create specialized committees to deal with these issues. Division of responsibility and accountability of the committee would help in regulating these challenges. Members of the committee should be clinical psychologists (academic or clinician).

In conclusion, the current disparity of demand and supply of competent professionals in the mental health industry needs to be met by implementing bold changes in the system. There are peripheral issues in India (such as stigma attached to mental health, a strong belief in faith healing, low resources and illiteracy) that dilute the industry's impact; with changing times mental health will be given a fertile atmosphere. This paper hopes to give a platform for researchers to look further into these issues.

Limitations of the paper are, a topic as wide as this restricted delving deeper into each issue and the paper has an idealistic tone that may have overseen certain fundamental barriers due to the inability of physically visiting clinics and clinicians.

Lacunae found during the period of research are, (a) lack of credible literature available for the Indian context, (b) region specific research should be considered due to diversity in India, and (c) each issue needs to be supported by recent quantitative data. The survey and interaction with clinical psychologists revealed a unanimous cry for help, which is evidence for the dire need of change in clinical psychology in India.

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Conflict of Interest

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