The Application of Western Models of Psychotherapy by Indian Psychotherapists in India: A Grounded Theory

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THE APPLICATION OF WESTERN MODELS OF PSYCHOTHERAPY BY INDIAN PSYCHOTHERAPISTS IN INDIA: A GROUNDED THEORY

A Dissertation

Presented to the Faculty of
Antioch University Seattle
Seattle, Washington

In Partial Fulfillment
of the Requirements of the Degree
Doctor of Psychology

By
Gurjeet Sidhu
June 2017
THE APPLICATION OF WESTERN MODELS OF PSYCHOTHERAPY BY INDIAN CLINICIANS OF INDIA: A GROUNDED THEORY

This dissertation, by Gurjeet Sidhu, has been approved by the committee members signed below who recommend that it be accepted by the faculty of Antioch University Seattle at Seattle, WA in partial fulfillment of the requirements for the degree of DOCTOR OF PSYCHOLOGY

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Abstract

THE APPLICATION OF WESTERN MODELS OF PSYCHOTHERAPY BY INDIAN CLINICIANS OF INDIA: A GROUNDED THEORY

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The following study explored the experience of Indian psychotherapists applying Western psychotherapy to Indians. Charmaz’ (2006) Grounded theory methodology was utilized. Seven Indian psychotherapists were interviewed. Interview data yielded the theory of Modification as Resistance. Modification as Resistance captured Indian psychotherapists’ attempts to modify Western psychotherapy to resist the erosion of local ways of healing due to the dominance of Western science. Results add to existing critiques of Western psychotherapy applied to Eastern populations. Recommendations based on results are offered to facilitate evidence-based practice (American Psychological Association [APA], 2006) with diverse populations. This dissertation is available in open access at AURA http://aura.antioch.edu/ and Ohio Link ETD Center, https://etd.ohiolink.etd.
Dedication

This dissertation is dedicated to my grandfather, Bikram Singh Sidhu Brar and to my father, Lal Singh Sidhu. My grandfather was a freedom fighter. As a child, I listened to his stories of non-violent activism, imprisonment, and determination to free India from British rule. My father taught me every individual is important and to advocate for the voiceless. Both of their teachings inspired me to bring indigenous psychotherapist voices forward.
Acknowledgements

I would like to thank my dissertation committee, Dr. Jude Bergkamp, Dr. Michael Sakuma, and Dr. Barbara Bettelyoun. Each supported my dissertation topic, challenged me, and helped me conceptualize my thoughts. Especially Dr. Bergkamp, who provided the framework for my dissertation and made himself available at all hours for questions. He brought his expertise in thought and multicultural study. In addition, special thanks to Dr. Bettelyoun and Dr. Sakuma for providing invaluable feedback. I am especially grateful for their added clarity of the subject matter.

I would also like to thank Dr. Bryce Doehne. He coached me on how to write strong and to be critical when it mattered most. He empowered me throughout the dissertation process by providing encouragement, support, edits, and the motivation I needed to finish. Additionally, my older sister, Gurmeet remained my cheerleader throughout the dissertation process. My dear friend Tressa Anderson, whose dining table remained my study table for a year, provided support when I most needed it; she helped me out in the most difficult times of the doctoral program and probably kept me from quitting entirely. Finally, I thank my dear friends and classmates Liz Schmitz-Binnall, Melissa Mulick, Julia Hustler and Jessica Stark for supporting me through the long process and showing faith in me; their kindness boosted my confidence. Liz allowed me to speak with her about my ideas and talk through difficult moments of impasse. Jessica and Melissa reminded me that a dissertation could, in fact, be finished.
# Table of Contents

Dedication ................................................................................................................................. iv  
Acknowledgements .................................................................................................................. v  
List of Tables ............................................................................................................................ viii  
List of Figures ........................................................................................................................... ix  
I. Introduction .......................................................................................................................... 1  
  Introduction to Knowledge Claims of Indian Psychotherapy .............................................. 4  
II. Literature Review ............................................................................................................... 8  
   Western and Eastern Concepts of Mental Health ................................................................. 8  
   Case Example: Western Psychotherapies are Not Universal ............................................... 10  
   Misconceptions: Application of Western Psychotherapy to Indians ................................. 12  
   Misunderstanding Indian Psychotherapy ........................................................................... 14  
   Addressing Gaps in the Literature by Creating Grounded Theory ..................................... 16  
III. Methodology .................................................................................................................... 18  
   Positivism and Postpositivism ............................................................................................ 18  
   Symbolic Interactionism ........................................................................................................ 20  
   Inductive Versus Deductive Analysis .................................................................................. 21  
   Grounded Theory: Knowledge Claims and the Researcher ............................................... 22  
   Grounded Theory: History and Charmaz's Theory .............................................................. 23  
   ...................................................................................................................................................... 26  
IV. Procedures and Data Analysis .......................................................................................... 26  
   Data Collection ...................................................................................................................... 27  
   Participants ............................................................................................................................ 27  
   Initial Coding ......................................................................................................................... 27  
   Focused Coding ...................................................................................................................... 29  
   Memo Writing ......................................................................................................................... 29  
   Data Analysis Process .......................................................................................................... 30  
V. Findings ............................................................................................................................... 32  
   Conceptual Categories – Definitions and Quotes ................................................................. 32  
   Modification as Resistance ................................................................................................. 33  
   Absence of Depth .................................................................................................................. 37  
   Internalized Preference of West as Best ............................................................................... 42  
   Local Knowledge of Indian Culture is Needed .................................................................... 45  
   Individual Orientation Versus Collective Orientation .......................................................... 47  
   ...................................................................................................................................................... 51  
VI. The Grounded Theory ...................................................................................................... 51
Evaluation of Grounded Theory .................................................................................. 53

VII. Application of Grounded Theory .......................................................................... 55

VIII. Limitations, Implications, and Conclusion............................................................. 58
  Limitations ....................................................................................................................... 58
  Implications .................................................................................................................... 59
  Conclusion ...................................................................................................................... 60
  General Implications for Applied Psychology ............................................................... 63
  Research Implications .................................................................................................... 63
  Concluding Recommendations: General Guidelines for Psychotherapists .................. 64
  References ...................................................................................................................... 65

Appendices ..................................................................................................................... 69

Appendix A: Screening Questions .................................................................................. 69
Appendix B: Interview Scheduling Script (Sample) ......................................................... 71
Appendix C: Interview Questions ..................................................................................... 73
Appendix D: Informed Consent ......................................................................................... 76
Appendix E: IRB Application ............................................................................................ 79
Appendix F: Memos ......................................................................................................... 89
Appendix G: Codes .......................................................................................................... 95
# List of Tables

<table>
<thead>
<tr>
<th>List of Tables</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Conceptual Categories and Definitions</td>
<td>33</td>
</tr>
</tbody>
</table>

## List of Figures

<table>
<thead>
<tr>
<th>List of Figures</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Modification as Resistance</td>
<td>51</td>
</tr>
</tbody>
</table>


Chapter I: Introduction

The proliferation of psychotherapy across the globe stems from its acceptance in mainstream Western culture as the method for promoting mental health. This acceptance within mainstream Western culture is often rooted in beliefs that Western psychotherapy is universal in its healing ability due to its use of science. However, the acceptance and utility of Western psychotherapy needs to be critically examined in the context of local culture, knowledge, and understanding in the countries in which it has spread through the globalization of Western psychotherapy. The following dissertation limits the scope of this examination to Indian psychotherapists using Western methods of psychotherapy in India. Data gleaned in qualitative interviews from said psychotherapists shaped a Grounded theory that challenges taken-for-granted assumptions of Western psychotherapy applied to Eastern populations. Such a Grounded theory is needed to give voice to concerns of psychotherapists in India and avoid intellectual colonization continued in the form of Western psychology as superior to Eastern tradition.

The number of psychologists working cross-culturally and internationally has increased exponentially, however, Western values and knowledge claims related to psychology may not fit or accurately assist the populations that they are intending to help (Christopher, Wendt, Marecek, & Goodman, 2014). Beyond the philosophical recognition that knowledge claims may not be appropriate when applied cross-culturally, the application of Western methods of healing applied to Eastern populations has the potential to be harmful (Christopher et al., 2014) and replicate colonization (Said, 1978). Western definitions of “colonial psychology” are over a half of a century old:

We may define “colonial psychology” as the frame of reference that determines the attitudes of “metropolitans” vis-à-vis the “colonial problem.” By “metropolitans” we
mean the inhabitants of those Western societies that are linked to part of the non-West by the historical, political, economic and psychological ties that have always accentuated the dominance of the West…It is not thought necessary to study this group intensively; at most, some interest is shown by bestowing a moral disqualification upon it. (Hoetink, 1961, p. 629)

Western models of psychotherapy applied outside the west tend to denigrate local populations, disavow their systems of knowledge, and pressure the population to accept Western models of psychological healing in an oppressive manner (Christopher et al., 2014). Such a forceful, oppressive endeavor replicates colonization, where Eastern ways of healing are disregarded and Western theories are seen as the “true” ways of healing.

Western methods of psychotherapy rely upon a tradition of positivist scientism, generalized from the physical sciences, as the vehicle to dominate the cultural and social sciences. Western positivist science ostensibly claims it is superior to Eastern methods of knowledge, which are viewed as being rooted in mysticism, outdated tradition, and seen as “less-than” (Said, 1978). This claim extends to the field of psychology, as Western methods of psychological healing are viewed as superior to Eastern methods of psychological healing (Christopher et al., 2014). Western methods utilize specific tactics to strip culture and tradition from Eastern populations to claim intellectual superiority and uphold a knowledge hierarchy where the west is “proved” to be dominant through positivist science (Said, 1978).

It has been an historical convention for Western scientific methods to be applied in a reductionist manner, typical of positivist research, which has resulted in colonization because local populations are in effect forced to abandon their local traditions and accept the science of the west as the truth (Said, 1978). This Western scientific tradition relies upon the creation of an
“other,” who is infantilized and viewed as a “savage,” whose self can only be cured through “true” methods of Western scientific healing (Nandy, 1983). Said (1978) defined Orientalism "as a Western style for dominating, restructuring, and having authority over the Orient" (p. 11). The creation of an inferior “other,” such as an Orient, allows Western science to impose power over definitions of mental health. This is because the “other” is viewed as unable to understand their own health due to being viewed as less-than, and requires an adult figure (Western science) to intervene and teach Eastern populations how to properly psychologically heal. The historical tradition of Western science continues today in the field of psychology and has the potential to result in a very harmful form of colonizing: one in which the hurt mind can only be cured by disavowing traditional ways of healing and internalizing Western psychological science as the only true path to health. However, ways of knowing are multiple and more understanding is needed as to the effects of Western methods applied to Eastern populations.

According to Manickam (2010), Western methods of psychotherapy have been applied within South Asian countries for years. Application of Western psychotherapies have created dilemmas, appearing to have only moderate success in large cities where Western culture is valued, while most rural areas in South Asia need more relevant psychotherapies (Manickam, 2010). Like Manickam, many other psychotherapists are voicing their concerns in the literature regarding the utilization of Western models and their lack of effectiveness with their clients and the risk of harm these models pose (Christopher et al., 2014).

Additionally, the large population of South Asians in the United States may be receiving inadequate mental health services as there are more than 2.1 million South Asians living in the U.S. (U.S. Census Bureau, 2013). Currently, South Asians represent the fourth largest population in the United States and the effects the application of Western methods of psychotherapy has on
this population need to be explored. Although Western methods of psychotherapy are understandably applied to South Asians within the U.S., it remains highly questionable as to how, or why, Western methods of psychotherapy are being applied to South Asians within their own countries and cultures. While it is outside the current scope of this dissertation to explore all South Asian populations receiving Western methods of psychotherapy, it is within reason to explore how the applications of Western methods of psychotherapy by Indian psychotherapists are applied to Indian populations.

**Introduction to Knowledge Claims of Indian Psychotherapy**

Currently, there is a gap in the understanding of how Western methods of psychotherapy are applied to Indians by psychotherapists on a day-to-day clinical basis. In addition, there is a lack of understanding as to their experience of providing Western methods to Eastern populations. Knowledge limited to linear methods of exploration that are replicable, agreeable, and data-supported are necessarily Grounded in culture and associated societal norms, yet positivism fails to acknowledge this reality in discussions of findings. Positivist explanations Grounded in the perspective that knowledge is scientifically based, measurable, and even quantifiable seek cause and effect answers that miss the richness and nuance of culture (Driscoll, 2009) and will not appropriately produce a theory Grounded in the experience of Indian psychotherapists. In any study of the “other” there is a potential to reduce the humanness and richness of participants (Said, 1978). As such, this dissertation seeks to avoid the cultural and human reductionism that can occur in a positivistic model by approaching the subject matter through a Grounded theoretical approach. Such an endeavor toward understanding is consistent with literature, as Manickam (2010) highlighted how current ways of knowing are inadequate and do not capture the multiplicity of ways of healing within the Indian population.
Epistemological assumptions are needed to change the current understanding and a Grounded theory approach can avoid the colonizing ways of understanding Eastern healing and ways of being by placing the experience of Indian psychotherapists at the core of study.

Most relevant to this dissertation is a postmodern approach that goes beyond existent research to incorporate multiple perspectives and probabilities that are not limited in scope by positivist epistemological underpinnings. Social constructivism, which incorporates socially constructed narratives and qualitative methods of inquiry (Creswell, 2012), is thus more fitting for this study’s development of a Grounded theory. Social constructivism assists in the creation of this Grounded theory by focusing on how knowledge is constructed, which enables a new exploration of how Western psychotherapy methods are being applied by Indian psychotherapists to Indian populations and, in a broader sense, how themes within participant discourse identify a theory of knowledge.

Philosophical claims to knowledge underlie differences between approaches that reinforce colonialism and those that do not. Positivism has focused on reductionism in an attempt to identify absolute truths in research (Creswell, 2009), while postpositivism recognizes that absolute truth cannot be found, but can be explored through conjectural knowledge claims using the scientific method (Philips & Burbules, 2000). Postpositivism looks for causes and effects. Alternatively, the social constructivist view recognizes that knowledge is constructed through historical and cultural meaning, which is developed through mutual interaction with others (Crotty, 1998). Social constructivist research is inductive, qualitative, and fits with a Grounded theory approach to understanding knowledge and creating theory. Social constructivist research seeks to understand the context of participants by gathering knowledge and generating meaning. The meaning generated inevitably involves the researcher's bias and perspective, which makes it
imperative for the researcher to enter the process and not minimize their influence on the study (Charmaz, 2006).

Within this dissertation, Charmaz’s (2006) method of Grounded theory is utilized to co-construct knowledge related to the experience of Indian psychotherapists applying Western methods of psychotherapy with Indian populations. Indian psychotherapists were interviewed and their voice is valued. Positivist assumptions were avoided. Based upon the interviews with Indian psychotherapists, a general theory was developed to help provide a framework for future research. The theory was Grounded in the participants’ experiences who have applied Western methods of psychotherapy with Indian clients. The process explored was psychotherapy. Knowledge from the interviewer and interviewee was co-constructed to explore the process, and how it impacts individuals. It was an interpretive exploration, differing from colonial methods of explaining cause and effect, avoiding descriptions from the outside of Occidentals explaining the Orient (Said, 1978), and instead rooting the knowledge in the participants.

The following study and resultant theory has at is core sought to heed Hoetink’s (1961) warnings from over a half a century ago that continue to this day. Hoetink aptly described how a “moral disqualification” could occur by simply avoiding the study of historically colonized groups (p. 629). There is scant information related to how Indian psychotherapists are applying Western methods and clear opposition against Western methods being appropriate cross-culturally (Christopher et al., 2014). The disqualification of local voices and dominance of colonial psychology (Hoetink, 1961) must stop (Nandy, 1983), and a Grounded theory approach is needed to return the power back to Indian psychotherapists to define their experience of providing psychotherapy to Indian populations.
It is necessary to highlight the voices of psychotherapists applying Western methods with Indian populations to avoid the uncritical, moral acceptance of Western psychotherapy as the “good” way to heal and Eastern methods as “bad” paths toward healing. An understanding that explores the applied depth of this moral and colonial process is needed. Charmaz's (2006) methodology was used to explore the process of Indian psychotherapists applying Western methods of psychotherapy to Indian populations. The theory of modification as resistance was created. It expresses the ongoing colonization of Western science in the process of psychotherapy. It captures the internalized moral pressure to use Western psychotherapy by Indian psychotherapists and their resistance to the historical power structures that continue today in the form of psychotherapy.
Chapter II: Literature Review

There is an academic tradition of orientalism and colonial psychology applied by Westerners who define South Asians in a manner that results in oppression (Hoetink, 1961; Said, 1978). Said's (1978) discussion of Western academic traditions of intellectual colonization has resulted in current reluctance, caution, and exposure of the risk of how this is expressed through the academics in social sciences, in particular, the role of Western methods of psychology applied to Eastern populations (Christopher et al., 2014). However, an understanding of Western and Eastern concepts of mental health is needed and literature on each is explored. Eastern methods of healing will focus on Indian concepts of mental health, along with a case example disputing the universal application of Western psychotherapy to Eastern populations. Throughout exploration of Eastern and Western concepts of mental health a unifying theme occurs in the form of colonization and silencing of the apparent lack of fit between Western and Eastern methods of healing. In closing the literature review, the case is made for the need of a Grounded theory approach to assist with understanding the lack of fit; specifically, what are the critiques of Indian psychotherapists applying Western models of mental health to Eastern populations?

Western and Eastern Concepts of Mental Health

Manickam (2010) discussed the many types of Western psychotherapies: psychodynamic, humanistic, behavioral, cognitive, spiritual, and integrative models. Each claim to make positive changes, some supported by experimental research to earn the moniker of evidence-based, and some espousing change models and theories supporting constructive change processes. Western models rely upon the view of an individualized self, one that must be viewed as separate from community and transcend spiritual health through the secular health of Western psychology (Cushman, 1995). Secular psychological tools are developed to help clinicians choose
appropriate techniques that match the circumstances of each client; however, this is not always effective because different cultures require different measures.

In Western cultures, health consists of a controlled, autonomous self, with the capability to regulate emotional states and behavior to function socially and occupationally, often in a manner that supports capitalism and upholds socioeconomic structures (Cushman, 1995). Psychology in the west has operated as a discipline, one that acts to support the state and keep individuals behaving in "appropriate" ways that are symbiotic to the status quo of Western governments and cultural institutions (Foucault, 1965). The application of Western methods applied to Eastern cultures is not only intellectual colonization (Said, 1978), but has the risk of harming the mind, body, and spirit of Eastern populations (Christopher et al., 2014) by imposing a psychological discipline that does not fit the cultural state of Eastern populations.

Differing from Western concepts of how to heal, an exploration of South Asian psychotherapies can provide a more nuanced and effective understanding of concepts to assist with healing and change that is rooted in spiritual tradition and the value of community. For example, Indian psychological constructs such as Upanishad, Ayurveda, Bhagavad Gita, and Yoga are essential components of mental health (Rao, Manickam, & Kallivayalil, 2013). Ancient India also considered thought containing three Gunas (qualities): Satva, Rajas, and Tamas, with a person having five dimensions: physical, psychophysiological, psychological, intellectual, and spiritual. These concepts were originated from Vedas, which are Hindu Scriptures (Kumar, 2010). Moreover, Kumar (2010) discussed similar perspectives related to the concept of Aurobindo (integral yoga and the concept of freedom). Kumar also noted the need to understand the origin of different psychopathologies at different planes of consciousness through physical, vital, and mental states to provide optimum care for South Asians. In Hindustan, a person is
considered more than a body, mind, soul, or set of cognitive functions (Manickam, 2010). Clearly, these concepts are not a part of mainstream, Western psychology.

Each of the aforementioned South Asian concepts surpass the metaphysical boundaries of Western psychotherapies that often address psychopathology within a limited, narrow, individual unit described as the concept of “self.” Limitations and inadequacies require a paradigm shift from the present concept of “self” in Western scientific psychology to an understanding that exists beyond body, mind, brain, and behavior (Manickam, 2010). A paradigm shift is difficult due to many South Asian psychotherapists viewing Western psychology as universal (Sinha, 1986).

**Case Example: Western Psychotherapies are Not Universal**

The following case example highlights the inappropriateness and potential harm of applying Western psychotherapy to Eastern populations. Christopher et al. (2014) described the possible harm and risk of the application of Western psychotherapy during the Sri Lanka Tsunami of 2004. The authors pointed out the importance of having cultural awareness because imposing assumptions, concepts, and practices onto other societies can further cause harm. Christopher et al. (2014) emphasized how most U.S. research and theory is vastly Eurocentric and most of the research is based upon only 5% of the world's population. Additionally, this population contains samples of Westerners who are educated and advanced, wealthy, and from democratic societies. During the tsunami, many workers and psychotherapists rushed to Sri Lanka, and even though these workers had good intentions, they arrived at the location with the assumption that they would be treating posttraumatic stress, depression, and suicide.
The cultural misunderstanding did not end there. Western psychologists were ready to deliver Western originated interventions such as stress debriefing, eye movement therapy, grief therapy, and exposure therapy. Christopher et al. (2014) reported:

Some foreign psychologists organized group-based programs and therapeutic exercises in ways that violated the stricture of segregation by caste, religion, and sex, and underpinned local social organizations and stratification. For the most part, these violations were unwitting, but sometimes they were deliberate ("We need to teach those people some things"). (p. 2)

Local people's worries were heightened by the cultural inappropriateness that they experienced and called the “help” from Westerners a second tsunami. Needless to say, Western models were not helpful. Rather, the aid appeared to be an ostensibly colonial act as if the helpers were denigrating the local population by teaching them how to heal because they were viewed as “less-than” and childlike.

Christopher at el. (2014) further concluded that there was little attention paid to cultural grounding of individual experiences and local societies; United States psychology has attended to cultural differences; they have not attended to the concept of culture without appropriating it (i.e., mindfulness within third-wave behavioral theories). It has been difficult for Western psychology to accept traditional ways of healing. The provided reasoning was to translate religious and philosophical concepts in order to create psychological constructs to build a theory, which requires abandoning bias and historical traditions of oppression and colonization. This is because incorporating cultural nuances would interfere with the positivist tradition of attempting to find universal truths that apply to everyone no matter what their cultural background. Hence, United States psychologists have focused more on bracketing off constructs of culture by
attempting to operationalized culture in inadequate ways such as reducing culture to
demographic categories such as race or ethnicity.

**Misconceptions: Application of Western Psychotherapy to Indians**

Western ideas of health and human behavior are very different compared to Indians. Wolberg (1967) described mental health as removing disturbed patterns of existing behavior to improve self and personality growth in individuals. Western health is oriented around individuality, self, and personality. Frank (1961) described Western psychotherapy as a form of help that trained professionals engage in through a process of exploring feelings, attitudes, autonomy, and behavior through performance. Overall, treatment focuses on emotional or psychological problems. However, Varma (1982) stated:

> As compared to his Western counterpart, The Indian patient is more ready to expect and accept dependency relationships…. less ready to seek intrapsychic explanation… more ready to discard ego-bounds and involve the therapist in direct role relationships; and finally his ideal or idealized support is the good joint-family elder… [The Indian patient] more readily alluded to conceptual references like Karma, Dharma and traditional figures for orientation. (p. 210)

Varma (1982) further argues that people around the world are not the same; their culture differs in many important ways such as “religious philosophical background, the experiential repertoire, language, modes of affective expression, moral and social norms and at last culturally determined conflicts and defenses” (p. 211).

Varma (1982) described the main attributes of Indian patients as having needs of interdependence, lack of verbal sophistication, and a concrete need for metaphysical, and nonverbal communication (where much of Western communication is verbal). Indian patients
also typically display traits of social distance between patient and the professional (due to the power differential and 2,000 years of class consciousness in Indian society), philosophical and religious beliefs in rebirth and fatalism, guilt versus shame (where Indian patients are likely to experience more shame than guilt), confidentiality and the dyadic relationship (Indian patients do not mind sharing details of their illnesses in front of family and friends, instead they prefer to come with the family member), and lastly, decision making and personal responsibility (Varma, 1982). In Western psychotherapy, the psychotherapist and patient collaborate to make decisions and each individual is responsible for their individual roles. In contrast, Indian patients expect to be given direction and hesitate to use their own voices (Varma, 1982). However, all the above traits of an individual would likely be considered pathologies within the Western mental health.

Many authors (Gergen, 1993; Kakar, 1982; Misra & Nandy, 1974) have voiced how most psychological beliefs in India are Western or euro-American. They have stated how these psychological perspectives are faulty, claiming that Western theories are largely ethnocentric and dismissive in psychological variations without addressing local contextual influences or cultural sensitivities. Above all, most psychological approaches have been used in ways that have ignored or rejected the cultural experiences and realities within the individual psyche.

Nandy (1989) discussed how colonialism in India has continuously impacted psychological thought. Imperial British influence in India led to the development of a culture where the British viewed Indians as childlike counterparts to their adult personae. There were also undercurrents of misogyny as the British considered themselves the masculine conquerors and viewed Indians to be more feminine and less deserving of power. Kumar (2010) stated that due to considerable social differences within their belief systems, metaphysical systems (at a deep level), epistemologies and cognitive processes, the way they understand the world is
different. Moreover, East Indian culture supports holistic rather than analytical thought, as well as an evolving view of modern psychology that should not be considered universal. He discussed how "Indian psychological thought represents the psychological insights available in different Indian philosophical systems like Vedanta Samkhya, yoga, Jainism, Buddhism, and other" (Kumar, 2010, p. 97). Indian psychology requires a combination of Indian philosophy and spirituality, which reflects the Indian ethos. Kumar (2010) shed light on systematic differences of psychology that describe an Indian identity. This refers to terms such as Buddhist psychology, Hindu psychology, Jaina psychology, and Dravidian psychology.

Misra and Agarwal (1985) contended that mainstream psychology is primarily based on empirical inquiry and is overly committed to psychological universal truths. It "has been vigorously engaged in characterizing human lives in terms of mechanistic and individualistic constructions. Its aim is predicting and controlling the behaviour of acultural and decontextualized others" (p. 96).

**Misunderstanding Indian Psychotherapy**

Manickam (2010) stressed the need for an integrative model with change processes that account for holistic concepts of a person; however, there are many difficulties in translating concepts cross-culturally and linguistically. Rao et al. (2013) discussed how primal treatises are written in Sanskrit, which creates linguistic barriers resulting in many documents that have yet to be translated. There are also attitudinal issues that stop researchers from exploring South Asian psychotherapies authentically. For example, Rao et al. (2013) stated that many Western researchers claim they have a more accurate model of mental health than models advocated by Indian philosophers. Western researchers have continuously reduced the richness of Indian concepts so they can be compared to Western concepts. Equating yoga with relaxation or
biofeedback cuts, compartmentalizes, and ultimately reduces and changes the meaning of yoga. Such reductionism decreases interest and creates an unwillingness to explore and experiment through South Asian methods of healing.

Rao (1990) further emphasized, "Diminishing interest in psychotherapy may have many dimensions. In our country, this has been attributed mainly to (a) impracticability of psychotherapy of Western origin, (b) individualistic and unsystematic nature of psychotherapy, (c) insufficiency of practical training, besides other factors" (p. 249). Kallivayalil (2008) discussed the unique need to understand aspects of Indian individual mental health concepts. According to Kallivayalil (2008), the Indian individual is "…nobler, sacrifices for the welfare of others, being kind and humane, and overpowering evil through goodness and truth have been corner stones of the Indian thinking and philosophy. Most of the mental health concepts of India have been profoundly influenced by these values and thoughts" (p. 1). Kallivayalil (2008) not only talks about the concerns related to understanding the Indian individual, he also stresses the important role of a traditional healer in mental health delivery; he states that we need to collaborate from various disciplines when it comes to health.

Rao (2012) highlighted that the psychology of India unfortunately imitates or replicates what goes on in Western psychology, and it is common because most social sciences suffer from colonial syndrome, which is the colonization of knowledge through means of power to determine what type of knowledge is valued. Over time, the colonization of preferred knowledge can eliminate traditional ways of knowing in the form of knowledge genocide. Overall, Rao’s discussion of India’s imitation of Western social sciences highlighted the need for an analysis of how Indians apply Western models of psychotherapy to Indian populations to further examine
the underlying assumptions behind the privileging of Western psychotherapies over Indian ways of healing expressed within the aforementioned literature review.

**Addressing Gaps in the Literature by Creating Grounded Theory**

There is scant information related to how Indian psychotherapists are applying Western methods and clear opposition against Western methods being appropriate cross-culturally (Christopher et al., 2014). The disqualification of local voices and dominance of colonial psychology (Hoetink, 1961) must stop (Nandy, 1983), and a Grounded theory approach is needed to return the power back to Indian psychotherapists to define their experience of providing psychotherapy to Indian populations. Grounded theory represents an appropriate methodological inquiry, as it is antithetical to positivist research, in that it attempts to avoid intellectual colonization. Grounded theory utilizes the knowledge of the participants as local truths, rather than imposing Western models of knowing onto the research participants. Grounded theory operates as a methodological inquiry that fits the exploratory analysis of how Indian psychotherapists critique their use of Western methods of psychotherapy applied to Indians.

A Grounded theory is needed for two main reasons: (a) The voice of Indian psychotherapists needs to be marshaled within a unifying theory, in an attempt to avoid silencing and resist the intellectual colonization of Western psychology; and (b) such voices are likely to result in the creation of a yet unexplored, bicultural intellectual thought process due to Indian psychotherapists being immersed in both Western and Eastern thought, while being pressured to accept Western methods as the dominant truth for psychological healing. Centered within such a Grounded theory approach, the critiques of Indian psychologists of Western models of psychotherapy may prove to be an important addition to the voice of Indian psychology.
Specifically, Charmaz's (2006) social constructivist research is explored as the vehicle to begin understanding the application of Western models of psychotherapy to Indian populations, and how Indian psychotherapists critique such applications. In an attempt to avoid the tendency for Western research inquiries to label subjects as “other” or to replicate colonization through research pursuits (Said, 1978), the experience of Indian psychotherapists will be valued and utilized as the basis to construct theory. The following methodological section describes the constructivist approach of Charmaz and incorporates the philosophical understanding that all knowledge is through the participants, their history, cultural, and perception of the world.
Chapter III: Methodology

Grounded theory is a qualitative methodology. Qualitative methodologies distance themselves from objective truths. Differing from qualitative methodologies, quantitative designs are deductive and rooted in positivism, the idea that objective truth can be known, and postpositivism, which is the idea that objective truths are partially known (Creswell, 2009). Quantitative designs are experimental, such as true or quasi-experimental. Quantitative methodologies seek to distance the research from the subject, while qualitative designs place the research within the design (Denzin & Lincoln, 1994). Qualitative research is steeped in philosophical assumptions that are ontological (i.e., understanding of reality through multiple viewpoints) and epistemological (i.e., the claims of knowledge are subjective and quotes from participants can be evidence to support knowledge), incorporating inductive logic to create emerging theories. The process of understanding Indian psychotherapist’s critiques of Western models of psychotherapy requires the privileging of the voices of the Indian psychotherapists, their claims of truth, and an understanding of their experience to shape an emergent theory. Qualitative research fits well with the explorations of this process, and the Grounded theory of Charmaz (2006) provides the framework.

Positivism and Postpositivism

Positivism is linked closely with science. It is the dominant and supposedly logical understanding of science that comes from direct observed experience and mathematical derived methods of research instead of tracing close details closely (i.e., cultural and unique human experience). Neville, Worthington, and Spanierman (2001) stressed that the intentions of positivist science are to do “good” for indigenous populations; however, this scientific philanthropy has continued to result in indigenous populations being defined as the “other” and
reduced to a study variable. Moreover, it is reported by many authors that the legacy of positivism has continued to result in oppressive, repressive, and harmful psychological research and practice (D'Andrea & Daniels, 2001; Sue, Arrendondo, & McDavis, 1992; Sue & Sue, 2016).

Positivism believes in absolute truths or facts (Crotty, 1998). Driscoll (2009) contended that the term positivism can be loaded and that it is a type of empirical research that is replicable, agreeable, and supported by data. The research is collected and analyzed in a systemic way so others can replicate the studies and achieve similar results. Positivism is based on the idea that all true knowledge is logically based and all things are ultimately measurable. Driscoll (2009) suggested that empirical research based on positivism creates a conflict of interest between the lived experience of humanity and scientific inquiry. It is often a mode of study that has an institutional affiliation. He asserted that positivist research directly operates within the construct of the researcher's bias, which is an unethical basis.

According to Philips and Burbules (2000), the postpositivism school believes that there is no one-way of thinking or single truth. However, many people disagree on this issue and postpositivism appears to be more of a philosophical claim to discredit and deconstruct principals of positivism that claim universal understanding of human behavior and thought processes. In essence, postpositivism posits human knowledge is changeable even if there is good reason for the belief of a universal truth and any belief is changeable by further investigation; no knowledge has a solid foundation; knowledge is hypothetical and not definite. There are all kinds of sources of knowledge but none has authority. Philips and Burbules (2000) further stated:
No matter how many cases of "A" we observe to have characteristic X, no matter how large the "N" happens to be, it does not follow logically that all cases of A will have this characteristic; we are making an inductive leap beyond the evidence we have available, and there is no certainty about our conclusion. (p. 23)

Overall, the argument by postpositivism against the knowledge claims of positivism are rooted in humanist thought that upholds the idea of humans as unique entities that cannot be reduced to their parts to study isolated behaviors and thought processes. Although in the physical sciences (i.e., physics) positivism remains an accurate method of inquiry, positivism becomes an especially inadequate method with social sciences that focus on understanding humans. This is because humans do not exist in a laboratory or vacuum and their behavior is affected by a multiplicity of variables that cannot realistically be “controlled for” by positive research. Moreover, humans cannot be compartmentalized and have their richness reduced for the purpose of a study. Instead, postmodern approaches tend to focus on constructivism and inductive methods. Postpositivism claims that we can only know truth to a degree. Claims that there are universal truths are outdated and inapplicable to social sciences such as the field of psychology, which deals explicitly with the study of observable human behavior and thought processes.

**Symbolic Interactionism**

Symbolic interactionism is a key concept that informs ethnography and Grounded theory. Symbolic Interactionism was derived from social psychology for its pragmatism and developed by George Herbert Mead, who believed that individuals act on what subjective meaning they make about their world. Mead contended symbolic interactionism explains how people take actions because people do not simply respond mechanically in a predictable fashion (Park & Burgess, 1921). Hence society is constructed through human elucidation of one another's
behavior in a manner that is termed symbolic interaction to highlight the multiple interacting processes that occur prior to an observable behavior. Strauss (1993) further stated, “The external world is a symbolic representation, a 'symbolic universe.' Both this and the interior worlds are created and recreated through interaction. In effect, there is no divide between external and interior worlds” (p. 27).

Blumer's (1969) central tenets on symbolic interactionism apply to how Indian psychotherapists view their use of Western methods of psychotherapy. Symbolic interactionism recognizes how individual worldviews are shaped:

Human beings act toward things on the basis of the meanings that the things have for them. Such things include everything that the human being may note in his world - physical objects, such as trees or chairs; other human beings, such as a mother or a store clerk; categories of human beings, such as friends or enemies; institutions, as a school or a government; guiding ideals, such as individual independence or honesty; activities of others, such as their commands or requests; and such situations as in individual encounters in his daily life. The second premise is that the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows. The third premise is that these meanings are handled in and modified through, an interpretative process used by the person in dealing with the things he encounters. (p. 2)

**Inductive Versus Deductive Analysis**

Grounded theory uses inductive analysis, not deductive analysis. Inductive analysis is the process of building a whole from multiple parts. Inductive logic is "bottom up" as knowledge is built from patterns as research work to gather, assimilate, and incorporate increasingly complex, abstract ideas in a zigzag, recursive manner (Creswell, 2013, p. 45). Deductive analysis is taking
an accepted truth or principal, and then applying it to parts. Deductive analysis compares newly identified data with accepted "truths" that already exist. Both deductive and inductive analyses are useful research components; however, deductive analysis is more typical of positivist constructions of knowledge. Inductive knowledge can be taken as parts of the participant’s worldview is induced to apply to a theory by focusing on patterns and categories using Charmaz's (2006) Grounded theory.

**Grounded Theory: Knowledge Claims and the Researcher**

Grounded theory allows the researcher's conceptualization of ontological and epistemological understanding to occur from various angles and it follows the relationship between a researcher and participant to explain what can be known. Grounded theory covers mapping of situational and social worlds, which frames analysis to locate participants more authentically in the social world, they navigate in everyday life (Mills, Chapman, Bonner & Francis, 2007). Grounded theorists believe that theory will emerge from the data that they collect; they have unwavering faith in the idea of truths (Mills et. al., 2007).

Grounded theory requires the researcher to enter the research project. The researcher enters with minor pre-conceived ideas to remain sensitive to the inevitably subjective data; however, through an understanding of their personal bias, the researcher is asked to be open to how participants resolve their concerns with the researcher’s conceptualization of the research question (Charmaz, 2006; Glaser, 1978). This requires the researcher to avoid becoming too steeped in the literature related to the research question. Grounded theory’s foundation was developed by Glaser and Strauss to measure awareness of dying in patients (Glaser & Strauss, 1967). Later, Strauss and Glaser had disagreed with the meaning of Grounded theory, Glaser believed that Grounded theory approach needed to be open and not structured or too prescribed

The researcher’s objective is to understand the pattern of participants and their practice-based experiences (Glaser, 1998). Glaser (1998) noted:

all is data…what is going on is the resolving of an issue that must be figured out exactly for conceptualization, not description it is not just what is being, how it is being and the conditions of its being told. (p. 145)

Glaser (1998) asserted that Grounded theory develops a theory that justifies a pattern of behavior that is relevant or problematic to the participants. In general, Grounded theory has many stages: identifying areas of interest, collecting data by conversing and interviewing, transcribing interviews, identifying repeated themes with code that is extracted from the data; writing memos as data is collected and saturated core categories are selected, and these selected categories will become the concluded theory, followed by returning to the literature to find any evidence (Charmaz, 2006; Glaser and Strauss, 1967).

In summary, qualitative research will be utilized in this study and the dissertation will be based on Grounded theory methodology to explore psychotherapy with Indian populations as applied by Indian psychotherapists. Grounded theory is a research method that enables a researcher to develop a theory, which then explains the subject of interest or brings out the main concern and how that concern is resolved or processed. Specifically, Charmaz’s (2006) Grounded method will be utilized.

**Grounded Theory: History and Charmaz’s Theory**

As stated above, Glaser and Strauss first developed traditional Grounded theory in 1960. The first guidelines for conducting Grounded theory appeared in *Discovery of Grounded Theory*
Both Glaser and Strauss (1967) tried to close the gap between theory and research to improve the researcher’s capacity to generate theory by systematically collecting data, then coding and analyzing data. They stated:

> Our principle aim is to stimulate other theorists to codify and publish their own methods for generating theory. We trust that they will join us in telling those who have not yet attempted to generate theory that it is not a residual chore in this age of verification. (Glaser & Straus, 1967, p. 8)

Glaser remained faithful to the original version of Grounded theory; however, Strauss made some changes to the original version with Corbin and they took a stance as relativist, and pragmatist. Their focus turned towards process and structure of the theory (Corbin & Strauss, 1990). Glaser (1992) continued Grounded theory with induction and theory emergence, but Strauss (1987) believed that induction, deduction, and verification of the theory was an integral part of the Grounded theory. Another difference between their theories was that Glaser’s method had two types of coding (substantive and theoretical) in comparison to Strauss who had three types of coding (open, axial, and selective; Heath & Cowley, 2004).

Karen Charmaz, who trained under Corbin, was the first researcher to develop a constructivist Grounded theory. Charmaz took a step away from Corbin in including more interpretive positions. She eventually moved away from Glaser and Strauss as well as Corbin's versions of Grounded theory. Charmaz views Grounded theory as a "set of principles and practices, not as prescriptions or packages…Grounded theory methods can complement other approaches to qualitative data analysis, rather than stand in opposition to them" (Charmaz, 2006, p. 9). Her approach is a postmodern criticism of traditional Grounded theory and is situated between positivism and postmodernism. Charmaz’s theory is from a social constructivist
viewpoint. This viewpoint emphasizes local worlds, many realities, complexity and a pragmatic approach. Her approach encourages an interpretive perspective, which is embedded in the context of the world, individual's experiences, situations, relationships and invisible hierarchies of power. In addition, she also notes the importance of participants' views, belief systems, feelings, and traditions. She invites the practice of gathering rich data, coding the data, writing memos, and theoretic sampling (Charmaz, 2006).

Constructive Grounded theory fits this dissertation author’s research question because it assumes that culture, experience, and the self are constructed through interaction and depends on language and communication. Furthermore, it views human beings as active agents in their lives instead of submissive receivers of social forces. In the last 60 years, India has been fighting with attempts of continued colonialism and institutionalization (Nandy, 1983). I believe open interaction with clinicians will create an authentically Grounded theory of Western psychotherapy applied by Indians to Indians.
Chapter IV: Procedures and Data Analysis

Data collection, coding, and memo writing followed transcription of seven participant interviews. Interviewees were selected through snowball sampling starting with a committee member providing initial participant contact. Interviews were by phone and recorded. The interviewees’ first language was not English; therefore, grammar is noticeably affected within transcription of data although the meaning of participant statements remained clear.

The method used throughout data collection and coding relied upon inductive, Grounded theory (Charmaz, 2006; Glaser and Straus, 1967). Charmaz (2006) outlined steps to gather rich data through interviewing. Charmaz described two main coding processes: initial and focused. Initial can mirror a line-by-line approach of other Grounded theorists, but can also be expressed in thought-by-thought or segments. Charmaz’s coding process was utilized and segment coding was selected.

Initial coding in this study relied upon viewing thoughts of participants as segments within transcribed paragraphs. Segment coding was used rather than line-by-line, due to the structure of participant responses. Participants framed their thoughts in a way that expressed a single subject or thought that most often exceeded a line-by-line analysis. Dedoose was utilized as an online program to manage coding. Dedoose allowed organizing the transcription of data for both initial, focused, and memo writing.

Coding and memo writing permitted the separation, sorting, and synthesizing of large amounts of data from transcribed interviews into concept categories. Charmaz’s (2006) criteria for meaningful data was utilized to isolate concepts that fit into distinct categories across participants. Conceptual categories that were distinct, meaningful, and shared across participants were selected as findings and created the emergent theory of Modification as Resistance.
Data Collection

Eight Indian psychotherapists residing in India were interviewed. All eight were provided informed consent in accordance with IRB. Each participant was asked general questions outlined in the questionnaire in the appendix with the longest lasting slightly over an hour and each averaging approximately 45 minutes in duration. Only seven of eight interviews were recorded due to electronic error in recording. Therefore, seven interviews were complete and the eighth interview was excluded from data analysis and further inclusion in this study.

The first analysis of data began as data was collected. After each interview, memos of thoughts and reflections occurred. Thinking about the data and reflections became memos to inform each stage as codes added further data. Analysis of the researcher’s own thoughts and experiences allowed memos to shape emergent theoretical categories.

Participants

All participants were doctoral level therapists except one, who was a master’s level therapist. Each practiced in India. Specific data on university attended and training qualifications, such as licensure, were not gathered. Transcribed interviews included were from four women and three men. Specific ages are unknown, but all were over thirty years of age. Participants conducted psychotherapy in different parts of India: two in Punjab, another in Gujarat, one in South India, two in Uttar Pradesh, and another in Hyderabad. All were clinicians practicing psychotherapy weekly. Two participants conduct ongoing research. Most worked in community mental health type settings and one at a primary care hospital.

Initial Coding

Grounded theory includes two core phases (Charmaz, 2006). First, initial coding involves identifying each word, line or segment of the data. Second, focus coding further refines and
synthesizing larger amounts of data. Initial coding was conducted incident by incident, which was often line-by-line if thoughts were concise, but primarily replied upon segments of data. Specifically, several sentences were used to create one action code due to the narrative manner of participants’ expressed ideas. Action verbs delineated participants’ voice into coding, which were initial codes of interview excerpts. Many of the codes were similar to each other and some were different.

Initial coding of data into word-by-word or segment-by-segment evoked the researcher’s thought process, showing action of data, as codes became the foundation of Grounded theory. The researcher's goal was to keep an open mind by understanding the context of participant expressions to analyze data critically. The data was thoroughly read multiple times and the researcher remained open to all theoretical directions. Charmaz (2006) communicated that first step of coding is gathering bones from the data into making the skeleton of the theory.

Charmaz (2006) noted, "I lay out coding strategies for developing the frame. Try them. See how they work for you. Grounded theory coding fosters studying action and process” (p. 46). Dedoose, a software program, was used to aid with data management and analysis process. I had taken an online tutorial to learn how to use this software. This software was used for line-by-line and segment-by-segment coding. I found myself analyzing data manually in addition to using the software.

Initial coding was conducting following the completion of all interviews. Segments were used as a coding style, which helped the researcher by condensing core thoughts and ideas into single units of expression. Following each interview, memos and analysis began within 24 hours while thoughts and data were fresh. Overall, the researcher remained open, stayed close to the
data, kept the codes as simple as possible, and used short codes that preserved expression of action.

**Focused Coding**

Focused coding involved utilizing the most repeated initial codes to sort, synthesize, desegregate, and organize large amounts of data. The researcher went back and forth between initial coding and the data to sort, synthesize, and integrate to pinpoint and develop the most significant, focused codes. The researcher used different colors for different categories and interacted with data over and over to find meaningful and significant categories. The researcher thought about why participants made specific statements in certain contexts and why some participants responded to certain explicit content, but also, what was implicit in their statements. Charmaz (2006) advised researchers to ask why questions because what people say, and what there implied meaning is, it is not a linear process. Focused coding involved active involvement in the process as the researcher sought to explore emerging threads of their analysis to create the foundation of theory. The researcher revised, sorted, resorted and made footnotes for different repetitions.

**Memo Writing**

Memo writing is an essential process between data collection and writing analysis (Charmaz, 2006). Creation of memos and analysis of memos was conducted immediately as data was collected. Memos were like unrestricted writing as the researcher was having a deeper, free-flowing internal conversation. The researcher wrote what was heard from participants, which later helped with developing categories. Memo writing occurred from data collection, initial coding, focused coding, and throughout the data analysis process. Memos assisted the researcher with analytic thinking. They helped synthesize data and resulted in the emergence of concepts.
Memo writing aided with further exploration of focused coding until large amounts of transcribed data became conceptual categories. Memo writing captured fleeting ideas and thoughts that were evoked by the interview process, observation, and through free writing. Memos facilitated the researcher’s exploration of ideas, helped to expand and clarify concepts, and focused thoughts that occurred during the study.

**Data Analysis Process**

Interviews were conducted in English. If the interviewees had difficulty with specific words, I assisted them with translation and understanding. The assistance with translation was noted within the transcription.

Data was continually revisited to inform analysis. Data was adjusted as the study progressed and meaningful categories emerged. Notes were written relating thoughts and observations, including beginning ideas and analysis of theory. Concepts were developed and later compared with literature reviewed. Theoretical notes were integrated into longer analytic memos that helped focus study. The data analysis process continued during and after data collection, until a guiding theory was created that included a general outline, and overall pattern that would justify all the observed experiences/phenomena. These were termed conceptual categories.

Synthesis of thought and idea between participants began to present distinct categories throughout coding, and especially, memo writing. Categories informed findings. Findings of memos became the initial theory as thoughts, analysis, and observations were gathered. Memos became the early process of the emerging theory as participant data was sifted and sorted to form conceptual categories.
An overarching Grounded theory emerged comprised of distinct conceptual categories following data analysis. Modification as Resistance is posited as the overarching, Grounded theory representing conceptual categories of (a) Absence of Depth; (b) Internalized Preference of West as Best; (c) Local knowledge of Indian Culture is Needed; and (d) Individual Orientation versus Collective Orientation. In Chapter IV, these findings were presented and Chapter V presents the Grounded theory.
Chapter V: Findings

Conceptual Categories – Definitions and Quotes

Interviewees were asked four questions:

1. What about psychotherapy models do you find particularly exciting, productive, or joyful?

2. Do you find the application of Western models of psychotherapy with Indians challenging and if so, how?

3. What is the most important part of your experience you would like to share?

4. Any additional questions that arise based on the content of the participant’s responses that will help to provide a more complete description of the experience are allowed.

After transcribing data, there were 318 initial codes listed as fragment codes. There were 25 focused codes explaining larger segments of data and 19 memos. Some categories were repeated many times and some only a few times. Five main categories were created, which were (1) Modification as Resistance; (2) Absence of Depth; (3) Internalized Preference of West as Best; (4) Local knowledge of Indian Culture is Needed; (5) Individual Orientation versus Collective Orientation.
Table 1

Conceptual Categories and Definitions

<table>
<thead>
<tr>
<th>Category Name</th>
<th>Definition</th>
<th>Theory Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modification as Resistance (32)</td>
<td>Resistance of oppression within Western models by adaptation.</td>
<td>Unaltered Western models of therapy do not fit Indian populations and can perpetuate historical oppression or result in harm.</td>
</tr>
<tr>
<td>Absence of Depth (16)</td>
<td>Western models are superficial and do not address spiritual depth of Indian (i.e. soul or rich inner world).</td>
<td>Indians require models that focus on spirituality and soul.</td>
</tr>
<tr>
<td>Internalized Preference of West as Best (13)</td>
<td>Indian psychotherapists prefer Western science without questioning it.</td>
<td>Suggests internal process of colonization of thought and unexamined bias.</td>
</tr>
<tr>
<td>Local knowledge of Indian Culture is needed (22)</td>
<td>Cultural is something you can understand but not learn.</td>
<td>Competence models are inappropriate and cannot be taught.</td>
</tr>
<tr>
<td>Individual Orientation versus Collective Orientation (11)</td>
<td>Individuals do not view themselves as a single unit of suffering. Suffering comes from “we” not “I”.</td>
<td>Family intervention may be more effective than individual therapy.</td>
</tr>
</tbody>
</table>

Modification as Resistance

Modification as Resistance was a code that all interviewers mentioned. Modification as Resistance represents the actions of Indian psychotherapists that are viewed as resistance to the dominance of Western methods of psychotherapy. These actions occurred 32 times and expressed the need to modify and change Western models for distinct reasons. It was portrayed that Western models do not take culture into consideration. It was difficult for participants to translate Western models into Indian models. Participants used Western psychotherapies,
theories, and interventions, however they modified citing various reasons. Clinicians talked
about tailoring the theories accordingly.

Some reported guilt or emotional turmoil when they facilitated modification. They
reported inadequate fit, depth, and range. Participants expressed that they learned psychotherapy
from the west, which allowed them to understand psychology, however, the application to Indian
populations was difficult. Clinicians changed the linear model to make it more applicable to the
Indian patient accordingly. Few of them mentioned that they can't seem to work with CBT
specifically, but they try to use aspects of it, while others change it into a conversational way to
help the patient.

Analysis of responses of abandoning Western models in practice yields data that
participants were doing what they could to help clients in the context of the dominance of
Western psychology that they clearly knew did not represent a path toward healing. Participants
appeared to resist imposing assumptions, concepts, and practices on Indians to avoid causing
harm or neglecting the cultural importance of patients.

There is a cultural bias based on the cultural competency of a psychotherapist. I use
psychotherapy that does not resist their culture. We need to look at the Indian values and
the psychotherapy approach. We are not comfortable modifying the psychoanalytical
therapy in some circumstance. All psychotherapy is based on an individual context not
community context. (14254-14612)

I feel that for emotional well-being of a client, if psychotherapists do not practice
cultural context, then there are big problems. Sometimes I do not know how to
incorporate the psychotherapy model with the cultural context. (12199-12579)
Also, you have to modify Western models of psychology to make it culturally appropriate; you really have to understand their culture, family, and social context. I cannot use Western models they are, you have to decide what part of the model can be used and what can be eliminated. (40690-40974)

Let me think, I am not sure how to answer that. I believe that we have adapted Western models, as far as I am concerned, I see myself using the same theory. You have to understand a person. You have to understand them. You have to apply your thinking and you have to understand them and how to match your approach to the need of the client. (64619-64717)

You have to understand the social and cultural context and accordingly have to modify treatment. (60578-60679)

I use culturally accepted ideas. Sometimes I change Western models because I am also … I also think that the resiliency is different. When I feel for a particular thing, I need to develop something else. (4441-4637)

Well, I have been saying that one can use Western models with Indian patients but you need to modify Western models and you yourself have to be flexible and be okay to change some parts of the model you are applying. (47512-47725)

Umm the cultural context is important in our groups. I believe that there is an appropriate way in which cultural context is kept in mind. Most of the models we apply are originated in Western culture. (790-1012)

We do not have Indian theories, this means that I am adapting to an Indian focus. I feel modifications are required based on the client's need. (67660-67797)
The fact that an Indian client is different and their cultural context is different means these models need a different approach. For example, if you have an Indian woman who is in a domestic violence situation you don't make plans to get her out of the man’s house. (49878-50112)

Yes, I am practicing cross-cultural practices to make it more relevant in a cultural context. I have to incorporate the cultural context in Western models to make it applicable. (10083-10260)

Like… it is just frustrating. I don't seem to be applying theories that I have learned. They are hit and miss and I feel like I am really applying any theory I have learned. (33100-33276)

Yeah! I feel like I have nothing but negativity, but on a better note, mindful therapy and mindful psychotherapy is useful for our people because it is coming from a cultural context and cultural values. (15566-15768)

Whatever theory it is you have to modify it to make it applicable to that certain individual that walks into your office. My biggest frustration is that people are writing about it, and talking about it; that Western science does not work, but it’s not Western science that it is different, psychology is the same, it is the culture is different. (72587-72935)

Understanding Indian patients are not part of Western models. I use relaxation and I know that I am using relaxation and cognitive behavioral techniques. But I know that the model lacks understanding of the cultural aspects. (26133-26411)
Western models have no idea about these cultural components and that is why I end up using what is more applicable according to the culture even if it’s not part of the model. This makes me more comfortable to use cultural context to understand them and where they are coming from. (8725-9006)

Ah! Let me see… hmm. It is difficult to answer for me. I think I try to forget what models I have learned. I try to forget about the problem-solving approach, or that I have to do something for the client, or that I have to apply interventions that I have learned. Instead I try to understand my Indian patient's context. Why XYZ is happening and why they are behaving or experiencing pain. Then it is easier to solve the pieces of the puzzle. (42217-42641)

Absence of Depth

It was mentioned 16 different times within the coding process that Western models lack depth. As clinicians talked about their experience with Western models, they shared that Western models don't have depth that could match their Indian client’s spirituality and value system.

Participants stated Western psychotherapy lacked understanding of religions, traditions, and spirituality. They suggested Indian patients heal through their religious tales, religious scripture, fasting, songs, and dances. Depth was a central limitation expressed by participants. This limitation appeared to stem from the present concept of treating a “self” in Western scientific psychology, which most often fails to include understanding that exists beyond body, mind, brain, and behavior (Manickam, 2010). An Indian person's identity is woven through their social context, their families, and in their patriarchy. South Asian concepts surpass the metaphysical boundaries of Western psychotherapies that often address psychopathology within a limited, narrow, individual unit described as the concept of “self.”
Participants noted their thoughts were shaped from an understanding of the cultural depth of their patients and how they process information. They expressed an inability to help the patients with Western models that do not make room to understand spiritual depth. Participants mentioned that suffering was healed through religious and local traditions that were better equipped for facing the adversity and suffering common to local communities.

Participant reports were consistent with literature. Christopher et al. (2014) reported there are misconceptions even within positive intentions when Western methods are applied cross-culturally. Moreover, Christopher et al. (2014) suggested practitioners of Western methods fail to consider local traditions, overlook important details, and do not consider alternative culturally appropriate methods that may attempt to achieve similar goals of health. Such literature captures the historical and continued disavowal of traditional ways of healing.

Kumar (2010) stated that due to considerable social differences within belief systems, metaphysical systems (at a deep level), epistemologies and cognitive processes, the way South Asians understand the world is vastly different than the west. Moreover, East Indian culture supports holistic rather than analytical thought, as well as an evolving view of modern psychology that should not be considered universal. He discussed how "Indian psychological thought represents the psychological insights available in different Indian philosophical systems like Vedanta Samkhya, yoga, Jainism, Buddhism, and other" (Kumar, 2010, p. 97). Indian psychology requires a combination of Indian philosophy and spirituality, which reflects the Indian ethos. Kumar (2010) shed light on systematic differences of psychology that describe an Indian identity. This refers to terms such as Buddhist psychology, Hindu psychology, Jaina psychology, and Dravidian psychology.
Misra and Agarwal (1985) expressed concern related to Western science’s focus on finding universal truths. Such striving for universality often neglects the uniqueness of ways of healing that can only be understood in a local context. For example, Indian psychological concepts such as Upanishad, Ayurveda, Bhagavad Gita, and Yoga are essential contextual components of healing (Rao et. al., 2013). Ancient India also considered thought containing three Gunas (qualities): Satva, Rajas, and Tamas, with a person having five dimensions: physical, psychophysiological, psychological, intellectual, and spiritual. These concepts were originated from Vedas, which are Hindu Scriptures (Kumar, 2010).

Manickam (2010) stressed the need for an integrative model with change processes that account for holistic concepts of a person; however, there are many difficulties in translating concepts cross-culturally and linguistically. Rao et al. (2013) discussed how primal treatises are written in Sanskrit, which creates linguistic barriers resulting in many documents that have yet to be translated. There are also attitudinal issues that stop researchers from exploring South Asian psychotherapies authentically. For example, Rao et al. (2013) highlighted how those from the new profession of Western psychology challenge the historical tradition of Indian philosophers and ways of healing by attempting to reduce traditions to measureable processes (i.e., yoga). Such depth of tradition and history was reported as difficult to capture within the bounds of Western scientific psychology.

About the psychoanalytic model, folk lives, and religion: all of that is really important and you cannot put that in most models. Most models do not understand or capture that depth of Indian culture. (7987-8193)

We need Western psychotherapy to not leave parts of the Indian person out; it needs to honor an Indian person. (19254-19694)
I am thinking about this new behavioral wave that is coming through India. It is really not working, but is being forced upon clients saying that after 11 sessions, this and that will be fixed. It is all so linear. Those therapy models do not have a depth to them and because our culture has a lot of depth, it has failed here and we are just applying it because it is the next new thing and the West has approved it. (74080-74499)

The new models of psychotherapy are behavioral focused and linear. They do not have depth to them. Even though these new models seem very sound, when you apply them they are quite ineffective. I have students that complain about them all the time and that a lot of these new models are not authentic. (74500-75244)

We need to use this psychotherapy within the cultural context. Because these models do not understand the cultural context or depth, so these patients do not approve of these Western modalities. (9753-9936)

…because most Western models do not understand the deeper level of culture or context. (436-522)

Because our psychotherapy is deeper than the Western psychotherapy, I found that our psychotherapy is more relevant to our culture. (18395-18532)

…in my experience Western psychotherapy models are difficult to apply on our people because most Western models do not understand the deeper level of culture or context. (1-820)

For example, consider the concept of "navratre" (traditional Hindu prayers for several days). I utilize the songs of “navratre”, which bring resiliency to my clients and they are able to find internal strength. (5216-5411)
There is one week a year where they are playing and singing the cultural tradition of "veorda." There is resilience within these groups. I used to use "veorda" and our cultural melodies of folk singing. There will also be things with the song that makes them heal from their pain. (5936-6211)

First a patient's thought and how that thought is shaped by culture. Second, how the patient processes things comes from their culture and their culture is not understood by west. (13782-13970)

According to their family tradition, they will do certain kinds of worship and spiritual practices to get relief from the trauma. It is hard for them to go to a psychotherapist. (38170-38369)

For me it is really exciting and satisfying to know our people, culture, their religion, traditions, and local stories. I find myself just using that to help them through their suffering. (37194-37428)

Specific aspects in psychotherapy make it more applicable to our clients. Like within yoga, there are specific things that are integral to positive psychology. Being kind is one of the core values of Indians, so I use this in psychotherapy and within our philosophy. (18995-19254)

One has to look at the client’s sociocultural context. What they are giving you is only a piece of the puzzle and not the whole puzzle, so you have to dig deeper. A lot of Western models only work on the surface and an Indian person requires deeper interventions. (41821-42073)
Internalized Preference of West as Best

Internalized preference of the west as best is the often-uncritical acceptance of Western science as historically justified due to status quo power differences in Western science versus Indian healing. It appears to be rooted in India’s history of colonization. Participants mentioned 13 different times how they accept Western models as better despite their seemingly contradictory acknowledgment that they do not fit Indians or help them heal absent modification. They expressed a view of Western science as superior in their sense that there was not an Indian psychology that was accepted enough to oppose the power of Western psychotherapy. One reported Western teachers come to India to teach new, trendy evidence-based models. Psychotherapists attend the training, despite learning later that these models do not work, and are a waste of time. College students of psychology complained about such models to participants; however, supervisors and higher systems continue to promote Western theories. Participants noted a need for a top-down change, but their voices seemed to be ignored.

The literature was consistent with a need for a systemic change. A paradigm shift is difficult due to many South Asian psychotherapists viewing Western psychology as universal (Sinha, 1986). This could be due to the academic tradition of orientalism and colonial psychology applied by Westerners who define South Asians in a manner that results in oppression (Hoetink, 1961; Said, 1978). Said's (1978) discussion of Western academic traditions of intellectual colonization, has resulted in current reluctance, caution, and exposure of the risk of how this is expressed through the academics in social sciences, in particular, the role of Western methods of psychology applied to Eastern populations (Christopher et al., 2014).

According to Sinha (1986), Indian psychologists believed that Western psychology was effective and should be applicable to all cultures. As such, they worked to maintain the Western
approach and worked to keep it free of any Indian cultural influences. India considered Western psychology as a pre-made package that could be imported and readily applied (Sinha, 1986). Published research reflected these Western approaches and ignored the cultural and contextual realities of the Indian people it impacted (Subba, 1994). Many authors (Kakar, 1982; Misra & Gergen, 1993; Nandy, 1983) have voiced how the majority of psychological beliefs in India are Western or euro-American. They have stated how these psychological perspectives are faulty, claiming that Western theories are largely ethnocentric and dismissive in psychological variations without addressing local contextual influences, or cultural sensitivities.

Concepts of psychotherapy itself are coming from West. We see this as help with relationships and figuring out how to exist in society rules. (36286-36420)

We used to just go to monks and religious leaders to help us out with our life difficulties. In some ways it is still true, but we continue to follow Western science when it comes to health. Our country is so poor and it does not have resources to do research and find effective ways to work with our people. We have for years followed the west and we are still following the west. (36420-36787)

Yes, I don't want to take the position of ‘Let me tell you what's wrong with you.’ Historically that has happened with Indians and they can be very agreeable with you. I think it is rather detrimental. (48358-48549)

Western models are like, ‘lets put a bandage on it and forget about it.’ I would have no problem with it if the West had the same standards for the Western counselor.

Does it mean the Indian client deserves less? (49674-49860)
Hmm… maybe I just don't question that, maybe I believe that Western science is better. I don't know… my intention is to help people and I try to figure out a way to help people.

(36819-36996)

I am not saying that I completely disregard the theory, but truly we do not have Indian theories or Indian text on psychological theories. We have only Western theories.

(67515-67653)

We are not talking about cultural context. The values of Indian culture and the little tiny things that matter to people are not valued in Western culture. The small nuances of the Indian culture are undervalued and not included in Western models.

(10635-10884)

We are trained in Western models, our training is very Western, and I also teach the Western model in a university. We have the same theory that is part of the world.

(64772-64941)

You are in a place of power, but if you don't give your client power you end up being in a place of problem solver. I don't think that works because most of the Indian clients don't have a voice; you have to empower them to find their own way. (45402-45640)

My superiors believe that Western models work amongst people who are influenced by the West or are highly intellectual. Our people are highly emotional beings and these new models have more of a cognitive aspect to it, which is not as transferable.

(33418-33668)
The focus should be on building a relationship long enough so they feel validated, heard, and empowered. They have been oppressed for years and a ‘one up’ position does not have to happen. (48104-48285)

**Local Knowledge of Indian Culture is Needed**

During the interviews, participants mentioned aspects of culture 22 times in a manner creating a distinct category indicating local knowledge of Indian culture is absent in Western psychotherapies they use. Participants indicated local knowledge needed is the spiritual, cultural, familial, and geographical knowledge of each client's history. Local knowledge can be learned or incorporated within a theoretical model that espouses general cultural competence, however, models use by participants fell short of accounting for local folklore and spiritual understanding.

Exploration of South Asian psychotherapies within literature reviewed compliments the identification of participant data citing the need for understanding of local knowledge outside Western psychotherapy. For example, Indian psychological concepts such as Upanishad, Ayurveda, Bhagavad Gita, and Yoga are essential components of healing (Rao et. al., 2013). A person is considered more than a body, mind, soul, or set of cognitive functions (Manickam, 2010). These concepts are not part of mainstream Western psychology, but participants reported knowledge of such local tradition and culture is essential for health.

Participants reported disconnection of mainstream psychotherapy with culture. It appeared culture is too broadly defined within Western models to capture the local knowledge needed for participants to connect with and treat patients. Participants had difficulty with the application of Western psychotherapies due to the inability of these models to capture local knowledge in many forms including language, spirituality, and expectations of gender roles.
There is psychotherapy that is based on cultural values and some things are good. But when we are looking at Western psychotherapy, it is based on the right person and the right culture. All these psychotherapy components depend on the culture. So this is why I think that you must look at psychotherapy by doing research in Indian, Nepali, and Indonesia, so that one is able to understand the culture, and not necessarily cultural competency, which I am not sure if that can be learned. (20244-22801)

We look at the cultural competency and we forget to understand the culture. We need to understand how that cultural competency could negatively affect that particular situation. (13973-14252)

Yes, Indian people are unable to speak frankly in their languages and we are unable to understand them and unable to connect their emotions appropriately. (3809-3954)

It does not recognize the cultural difference and how a client processes work. Processes are different in the West versus the East such as cultural postures [body language]. (631-789)

Usually when couples get married and the woman has to adjust in the family, the husband is not supporting and there are problems with the in-laws. My job is to help the husband understand her perspective so that he gives more support to her and solves the problem. That only happens when you know the culture. (24925-25192)

We need to use psychotherapy in a cultural context because Western models do not understand the cultural context, and patients do not approve of these Western modalities. (9753-9936)
Actually there are two types of patients residing in the North part of India. There are a lot of cultural factors and the mindset of the people is not ready for cognitive therapy.

(59969-60230)

We need to know various things about the religion and society. There is a Hindu tradition that one-day, for one week, for the betterment of our future, we disconnect with our thought and sing. I end up using that in my work, which is not Western science; it is our very local ways of coping. (5427-5708)

Western psychotherapy does not understand an Indian cultural setting. For example Western models do not understand our values, we respect our elders, and Western models do not necessarily incorporate this. (10436-10633)

In cultural context and surrounding, you look at that particular case. Sometimes I use my cultural awareness to approach the problem and see how the cultural problem is applicable to that person's situation. I see how the different religion issues and context affect the person. (13439-13723)

**Individual Orientation Versus Collective Orientation**

In the interview process individual versus collective orientation was mentioned 12 times. It was portrayed that Indian identity is oriented around “we,” which is collective, and Western identity is built around “I,” which has a predominant focus on the individual self. Western models approach therapy by building the person an “I” that can be treated within a container of a self. However, Indian persons learn “We” first, they don’t become aware of an “I” until they are older. Western models are reversed in that order. Problems are solved by how the person fits in the family and community and one not fitting is what causes suffering.
Essentially, participants indicated that culture cannot be “learned” from a cultural competence standpoint espoused by Western psychotherapies designed to treat a self at the level of an “I” due to fundamental misunderstandings of cultural contexts organized around a “we” culture. All the clinicians talked about the existence of culture as a construct within a collectivistic framework. However, they ostensibly refuted an individual can “have culture." This was from a perspective that exists outside of a property value that the individual can own, meaning there is not a distinct proprietorship of culture that can be “had” inside an individual self that is outside the context of collective relations between individuals and systems such as family, village, or general local tradition. Participants suggested Western psychotherapies do not understand culture at a fundamental level that was almost inexplicable. It was said that culture is important to understand, but that it cannot be learned, which appeared to both represent resistance and protection of the client from inadequate treatment. Responses seemed to indicate that culture understanding cannot be “had” unless someone really learns it subjectively, however, clinicians can understand the uniqueness of culture of a particular person to assist with helping them.

Literature (Cushman, 1995; Manickam, 2010) is consistent with the limitations of applying Western psychotherapy without cultural and historical understanding of individualism and collectivism. Western models have had difficulty with incorporating collectivist traditions of mental health (Manickam, 2010). The secular abandonment of tradition, community, and general interconnectedness of individuals that occurred in postwar World War II America facilitated a focus on the individual at the expense of the collective (Cushman, 1995). These fundamental differences of cultural direction and focus highlight how collectivist and individualist societies have different ways of healing.
Participants suggested Indian patients might not have the language to incorporate the basic requirements of Western models that treat “self” due to fundamental differences in the organization of “we” and “I” cultures. Collective cultures comprised of Indian patients may more readily accept and require dependency relationships, seek direction, and elicit prescriptive advice from helpers (Varma, 1982). However, Western psychotherapies are designed for those who more readily accept an autonomous self that they are responsible for, must do “things” to heal it on their own in their “private” life; they must, and have the ability to, take ownership of their “self” in therapy to heal. These Western concepts differ from participant responses highlighting how Indian patients orient their life around their connection to others. Participant understanding of this difference captured their resistance to their patients being portrayed as individualistic selves that Western models could be readily applied to.

There is a difference between the collective approach and the individual approach you know… (7022-7326)

The cultural context is so important, all of Western psychoanalysis is based on an individually oriented mode. (7410-7652)

We follow the collective approach and the Western culture follows an individual approach. Western psychotherapy models are not as approachable for Indian patients. (10885-11120)

All of these Indian cultures are not able to use the individual Western psychotherapy model for their patients because most of them are oriented around individual identity. Yet, Indians are oriented around collectivism, and I feel we are not able to modify the Western psychotherapy model properly for our patients. In an Indian cultural setting, we need a holistic approach. (11766-12143)
We are trained in Western models, our training is very Western and I also teach the Western model in a University. We have the same theory that is part of the world. They may be cost effective and time effective, but with the Indian population it is a failed attempt. (74832-7493)

I have been saying some parts of these Western models work, but you have to continue to think of cultural context and a client's story. I want to be an Indian clinician who might be using Western models. I don't want to be a Western clinician. (49107-49347)

This practice understands collective identity and it understands the collective value of "we." (16392-16487)

There is a difference between the ‘We’ and ‘I’ within the language used. In the Western culture, you do not care as much about cultural context surrounding religion. (11125-11282)

The big picture is that Western psychotherapy is based on the individual, however, cultural upbringing is connected to our cultural competency. Therapy is more applicable if the cultural context could be brought in. They are using the trendy approach for psychotherapy and we are able to understand it in our collective culture. (11283-11601)

We need to have conversations about psychotherapy and see how it can be culturally relevant in our culture and culturally appropriate for our clients. (18764-18995)
Chapter VI: The Grounded Theory

The Grounded theory is Modification as Resistance. Comprising conceptual categories are (a) Absence of Depth, (b) Internalized Preference of West as Best, (c) Local knowledge of Indian Culture is Needed, and (d) Individual Orientation versus Collective Orientation (Figure 1). Modification as Resistance emerged as a distinct, yet overarching theory in that there were overlap into each other conceptual categories. Overlap occurred in the form of each other category being a reason for why participants chose to modify their delivery of Western models. Due to the other categories, participants' responses indicated their modification was a form of resistance to intellectual colonization they felt powerless to change. Their modification represented to them doing what they could to help their patients while being subjected to the dominance of Western psychotherapy in their field.

Figure 1. Modification as Resistance
Indian clinicians repeatedly expressed their frustrations regarding applying these models. Their critique was Western theories do not have depth and they don't fit Indian culture.

Participants indicated culture is something that is shared as nonverbal, religious symbols, and beliefs; beliefs that they often express through their local stories and narrative. Culture cannot be “had” by an “I” who studies cultural competence in the mainstream Western psychology sense. In as much as participants understood their patients who constructed their difficulties in a “we” fashion, it was presented as storied texts of narratives existing in a local, subjective manner. Most of the Indian clinicians echoed that Western models do not understand Indian identities, the depth, culture, or the collective identity.

British ruled India for 200 years, which appeared critical to understanding the mindset of Indian psychotherapists who are resisting the application of Western models to their patients. India obtained independence 60 years ago on Aug 15, 1947 and India still follows Western footsteps in many areas. In the area of psychology, Western psychotherapies represent the healing power of Western science. Participants believed that the Western models are better and they planned to continue to use them, teach them, study them; most participants appeared to acknowledge historical oppression, but were limited in expression of their own bias within the context of questions asked during the study. Specifically, responses indicated an internalized preference that Western psychotherapy is better, while simultaneous acknowledging its lack of fit. It appeared participants were doing the best they could to heal patients in the context of historical oppression and internalized intellectual superiority of Western science. Their resistance to this dominance represented a humane, humble representation of their clinical practice on a day-to-day basis in opposition to status quo ways of healing.
Evaluation of Grounded Theory

What constitutes an “acceptable” Grounded theory depends on the audience and the judgment of that audience based on their own bias (Charmaz, 2006). The Grounded theory of Modification as Resistance brings the concerns of the Indian psychotherapist to the forefront as important and not to be dismissed because this is a value of the researcher conducting the study. The research was a nebulous process. The researcher listened to each individual, transcribed their voices, organized, connected their thoughts, attempted to understand their meanings, wrote and rewrote, without knowing where participant voices would go. The researcher remained open, stayed very close to the data, tried to stay accurate to their voices, created codes, compared data with data and until a theory stuck.

The constant comparison, revision, reflection, observation, going back and forth with data until it reached down to draw abstraction to the data represented another very important aspect of Grounded theory. The researcher stayed authentic to reach her Grounded theory. In addition, the researcher considered social, historical, local, and the ongoing interaction between studies and participant data to strengthen the theory and scrutinized, uncritically accepted processes. Charmaz (2006) stated, “The generality arises here from scrutinizing numerous particulars and after developing a substantive theory may include analyzing and conceptualizing the result of multiple studies to construct a formal theory” (p. 180).

In addition to evaluation of unique bias of researcher and audience to determine what qualifies as acceptable Grounded theory, Charmaz (2006) notes what is generally accepted based on her experience. Grounded theory looks at credibility, originality and resonance. Credibility looks at how trustworthy one's research is; if is it dependable. The voices of Indian therapists within this study are credible because they are speaking directly to their experience. The theory
is dependable because distinct categories emerged across participant responses. Resonance occurred within the unifying theory of Modification as Resistance, which captured categories of Absence of Depth, Internalized Preference of West as Best, Local knowledge of Indian Culture is needed, Individual Orientation versus Collective Orientation. The concepts within Modification as Resistance express resonance that Indian psychotherapists are attempting to resist taken-for-granted concepts of Western psychotherapy such as multicultural competence and evidence-based models.

According to Indians, they must modify Western psychotherapy to make it fit for Indian populations. Not doing so results in at least emotional discomfort for Indian psychotherapists, and at most, a form of intellectual colonization. The resonance of this theory is significant and meaningful. Through qualitative research the researcher has brought the voices forward of Indian psychotherapists.

Another important aspect in evaluating a Grounded theory is originality. Originality looks at if the theory is fresh and offers new insights. There is scant research on how Western methods of psychotherapy are being applied by South Asian psychotherapists on a day-to-day basis. No research exists that incorporates historical oppression or colonization and the voices of Indian psychotherapists who are attempting to resist it today. Therefore, this theory is important because it is original and adds data to the dearth of information available on clinical applications of Western methods of psychotherapy by Indians.
Chapter VII: Application of Grounded Theory

According to the APA (2002), multicultural education guidelines acknowledge that historically psychology is based on Western biology, values, education, and research. It has been recognized that Western psychology has not always considered culture, race, and ethnicity, which can be extremely detrimental. APA guidelines have required that psychologists increase their skills in multicultural, education, research, and practice. In addition, the revised guidelines of 2017 emphasized addressing issues of all underserved and marginalized populations living in the United States and recognized the continued need of training and research. The Grounded theory of Modification as Resistance compliments, and adds to, intentions of the APA that recognize psychology needs education, research, and practice to improve delivery of psychotherapy to different cultures, race, and immigration status of those moving to, or residing in, the United States. The Grounded theory espoused in this research adds actual knowledge of the day-to-day clinical application of the intentions of the APA to add research and address their calls to action.

Relatedly, this study brings attention to Western psychology that holds dominance in India at most all universities that teach and practice Western psychology. Evidence Based Practice (EBP) and cultural competence goals are to improve mental health in diverse populations (Kirmayer, 2012). However, my research contradicts fundamental notions of cultural competence and EBP. The study challenges EBP as a linear application due to the inability of Western methods to actually have the spiritual depth to be applied with Indians. Moreover, the study questions, “whose evidence?” we psychotherapists rely upon when determining appropriateness of fit for healing local populations. While the American Psychological Association (2006) task force recommendations for evidence-based practice (EBP) guidelines
suggest an all-encompassing definition of “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (p. 273), this Grounded theory adds the voice of Indian psychotherapist participants who suggested needed modification to the “evidence base” requiring those using the moniker of EBP to consider their knowledge as a valid contribution to assessing the fit of Western models of psychotherapy to Indian patients.

Westerners are going to India and teaching newer methods such as evidence-based models, despite the rejection of evidence based models by locals, as expressed by participants. In addition, cultural competency means Western psychology should gain an in-depth understanding of Indian culture, which participants in this study suggested has been rejected. For example most participant of the study expressed Western psychology only scratches the surface of an Indian individual. To gain competence of such a spiritual culture is complex, however, being open and understanding can honor the culture and its indigenous psychology. This Grounded theory highlights Western psychology's dominance gone awry outside the bounds of APA (2006) definitions of EBP and how Indian psychologists have internalized the notion of west as best. However, Indian psychotherapists continue to show resistance to methods that discount their traditional ways. However, APA guidelines (2002) goals are to continue to evolve and make room for diverse populations and their mental health needs, which is consistent with this Grounded theory and appears to be an admirable aspiration consistent with what participants of this study felt was needed.

This Grounded theory highlights the need to accept different cultural philosophies, moral visions, worldviews, and traditional ways of healing. Christopher et al. (2014) made similar recommendations, including Western psychology needs psychological interventions that can be
respectful beyond national borders. Furthermore, Christopher et al. (2014) stated psychotherapists need the critical knowledge of local understanding in order to make room for folk ideologies and avoid dismissing non-Western psychologies. Clearly, there are no universal psychologies, especially one that is situated within Western science. Due to globalization (Christopher et al., 2014), the need for Western psychotherapy to have local understanding appears greater than ever.
Chapter VIII: Limitations, Implications, and Conclusion

Modification as Resistance is a Grounded theory that expresses the voice of Indian psychotherapists who are attempting to resist intellectual colonization in the form of Western psychotherapies. The theory speaks to needs espoused by the APA (2006) to integrate research that assists with matching intervention to culture. It is a needed addition to the field of psychology at a time when globalization has contributed to the proliferation of Western psychology at the expense of local ways of healing (Christopher et al., 2014). The Grounded theory captures the resistance of participants to historical antecedents (i.e., colonization, devaluation, oppression). Modification as Resistance organizes the attempts of participants to avoid the erosion of their culture and local tradition.

Limitations

One of the main limitations of this study was the number of participants; an increased number of participants may have widened the range of experiences of Indian psychotherapist. Another limiting factor was that participants were interviewed over the phone from US to India. It was difficult to have people on the phone in a completely different time zone. The 12-hour time difference and time limitations in general impacted the ability to ask follow up questions. At times their voice was not very audible and one of the interviews did not record at all, so I had to remove that from the data, otherwise I would have had one more participant.

Another limiting factor was that the participants' first language was not English; at times they struggled to fully articulate their thoughts. Additionally, the non-verbal language is a big part of conversation and I was unable to observe that part of the language. Some of the participants had strong Indian accents. I ended up repeating their thoughts in order to gauge meanings of their interviews. Also, I have an American accent, which might have been hard for
them to understand. I did not have any established relationship with these participants, and generally an existing relationship is very helpful in Indian culture for individuals to be more open.

Implications

Implications of the study focus on the application of the theory to contribute to the field of psychotherapy and giving voice to Indian psychotherapists. As a researcher one of my objectives was to contribute to psychology, especially applied psychotherapy. In conducting this research authentically trust was utilized throughout the research process. My study's main concern was to collect Indian psychotherapists’ experiences in applying Western models on Indian populations. One of the strengths of the study is giving a voice to original peoples and bringing their voices forward. Being born and brought up in Indian culture gave me a foundational understanding and some sense of the work of Indian psychologists. My study advocates Indian psychotherapists’ collective voice. All the clinicians agree that they need theories that are not Western; they wanted theories that understand the culture and depth of their patients. Participants attempted to make room for local religious tales and ancient cultures with deep roots in historical tradition. My study enables them to see their collective struggles and highlights their voice by recommending future action to address their difficulties.

The current study brings attention to existing psychological theories, highlights future study needs of this population and the need to take this research one step further. The current study highlights a need to make room for traditional ways of healing, and highlights the need for modification of existing models. The evidence-based models that are currently followed may not work with Indian populations. This is important because many Indians move to the U.S. For example, Indians have represented 70 percent of H-1B visas and 316,000 petitions approved by
the U.S., which has resulted in Indians comprising the second largest population of international students in the United States Citizenship and Immigration Services (USCIS, 2013).

My study advocates for the adaptation of Western models; for Western models to consider cultural differences when they are applied to Indians. This would entail modification of existing models espousing how psychotherapy is applied and how it should be applied. Not only does my study advocate for adaptation of Western models applied to Indians, it also brings attention to other groups who may require modification of psychotherapy to avoid similar barriers expressed by participants. My study highlights and makes contributions in many domains that are general to cross-cultural applications of psychology.

Conclusion

This qualitative study was done using Grounded theory. The voices of Indian psychotherapists were brought forward through the study. This empirical methodology was chosen due to the uniqueness of the subject and lack of research in this area. Most of the research done in this area has put South East Asian populations (Indians) in an Asian population category. Sue and Sue (2016) and many others have done significant research on Asian populations; however, more empirical data on Indian populations specifically is needed.

Research participants chosen for this study were psychotherapists who were born and raised in India and practicing with Indian populations. Participants were from different parts of the country to obtain diverse perspectives on their experiences when applying Western psychotherapy models on Indian populations. All the participants received their training in India. These psychotherapists shared both their positive and negative experiences of utilizing Western models of psychology. They shared their frustration, anger, and what was exciting to them during the interview. Charmaz's (2006) Grounded theory was utilized throughout the research
process. Open interviews were done with eight participants; each interview was an open
interview and lasted between 30 to 90 minutes. While only three questions were asked, the
researcher asked follow-up questions to increase depth and understanding of the participants' experiences. After open and focus coding, making memos and analyzing, comparing,
reanalyzing, and comparing data with data, conceptual categories emerged.

After thoughtfully analyzing interview data, five categories emerged: (1) Modification as
Resistance; (2) Absence of Depth; (3) Internalized Preference of West as Best; (4) Local
knowledge of Indian Culture is needed; and (5) Individual Orientation versus Collective
Orientation. The Grounded theory, Modification as Resistance, was acknowledged by the
participants. Participants expressed that they cannot apply Western models without making it fit culturally to Indian individuals. Collectively, all psychotherapists expressed that they change Western theory to help in the healing process with the patients. The Grounded theory of Modification as Resistance provides vital information, especially when working with indigenous population.

The concept of Absence of Depth indicated that Indian culture has rich depth and
Western models can only scratch the surface. Indian culture is deeply rooted in ancient culture
that needs cultural theories that address the whole person including their spirituality. An Indian
individual’s self is developed with deep-rooted spirituality within cultural tales and traditions.
This concept creates awareness as to why it might be that Western theories are not applicable to the Indian population.

The third concept of Internalized Preference of West as Best depicts that Indian
psychotherapists have internalized Western science as superior to their local ways of healing.
This category is proposed due to the apparent colonization of the participants’ intellectual
thought by virtue of academic systems holding up Western science as best and the participants continued use of it despite knowing that it does not fit within their culture. Participants stated that Western models are backed by research so it must be better, however, they have rejected it in their reports of practice-based experiences. Western teachers travel to India, teach and present accepted new age psychological theories. The exportation of Western methods to the east as “good” and better psychotherapy expresses the colonial tradition of power the west has had over Indian thought.

The fourth concept of Local Knowledge of Indian Culture is Needed appeared important to Indian psychotherapists. Most Indian patients value local tales and religious practices to heal through most emotional difficulties. These are represented by religious songs, dances, fasting, or tales to overcome psychological pain. This is an important concept to understand when working with Indian populations, especially during times of natural disasters or crises in India.

The last concept within the theory was Individual Orientation versus Collective Orientation. This finding prompts future psychotherapists to keep in mind a collective orientation versus an individual orientation. In the west, the first concept we learn about self is an “I” self. Most Western theories of developmental stages speak to such an individual orientation, however, in South Asia the first concept a person learns is “We”. The concept of “I” is not learned until they are in middle age. Most of the suffering of Indian people is experienced as coming from the family and social system and is oriented around their collective identity versus individual identity.

In efforts to create awareness about the experiences of Indian psychologists, the Grounded theory of Modification as Resistance as created to reflect their voices. The theory is supported by all the other findings of the data that there are so many reasons why there is a great
need to modify Western models; either it is a need to include the depth of the people, realize their collective identity, or significance of a local knowledge of Indian culture. All the findings support the Grounded theory, which is rooted in the historical tradition of the west overpowering Eastern ways, which has become internalized, as West is Best.

**General Implications for Applied Psychology**

Applied psychology, in accordance with evidence-based practice (2006), requires integration of research and theory to facilitate positive outcomes. The dearth of literature on Indian psychotherapists’ day-to-day practice was revealed as a starting point for clinicians to incorporate findings. Findings suggested current models of psychotherapy must be modified, which was consistent with APA (2006) recommendations. Results suggest clinicians look to research that highlights actual experience of clinicians using Western methods on diverse populations to receive “first-hand” advice on how modification can be done to incorporate local truths aimed at facilitating positive therapeutic outcomes.

**Research Implications**

Results of the current study suggest it would be fruitful to continue to gain knowledge of how psychotherapists in non-Western geographical areas are attempting to apply Western methods of psychotherapy. Future research of qualitative design could continue to highlight the voice of diverse psychotherapists applying Western psychotherapy to diverse populations. Quantitative designs could continue to build upon or revise the well-established efficacy of incorporating culture into psychotherapy (APA, 2006). Research could also assess the efficacy or outcome implications of the following concluding recommendations.
Concluding Recommendations: General Guidelines for Psychotherapists

Recommendations for clinical practice are offered based on theoretical findings. Essentially, results of participant interviews suggest psychotherapists should modify Western psychotherapies when practicing with Eastern populations in accordance with the proliferation of evidence-based practice (APA, 2006). While a standardized modification of how to do so is outside the scope of this study, the following recommendations encapsulated within the theory of Modification as Resistance are offered for both non-Western and Western psychotherapists:

a) Incorporate depth. This could include spirituality, tradition, folk stories, and cultural wisdom.

b) Externalize colonial tradition. Question your own bias or assumptions that Western methods are superior for all populations.

c) Focus on collective systems of clients. Understand the client’s “self” in relation to others with shared cultural values.

d) Increase understanding of local knowledge. Gain knowledge of traditional ways of healing and mental health to incorporate into clinical practice.
References


Appendix A

Screening Questions
(An answer of “no” to any of the questions below will result in exclusion from the study)
1. Are you age 18 or older?
2. Are you a psychologist or psychiatrist practicing psychotherapy?
3. Have you had experience in working with Indian population in any capacity?
4. Are you willing to share your experiences/perspectives of using Western models of psychotherapy with Indians?
5. Are you willing to talk to me over the phone or in person for a tape-recorded in-person interview that may last between 1-2 hours?
Appendix B

Interview Scheduling Script Sample
Hello, and thank you for agreeing to participate in my study! Based on your answers to the preliminary questions I asked it sounds like you are exactly the type of person I’m looking for to share your experience of clinical work. I’m anticipating that the interview should take between 1-2 hours. Can we schedule that now? Whatever time or hours that is the most convenient for you.

The interview will be audiotaped. You will be assigned a random identification number. Do you have any questions or concerns regarding confidentiality? Do you have any additional questions for me regarding this study, its purpose, or confidentiality?

I will have a waiver explaining all of this in more detail for you to sign electronically or in person before we begin the interview. If you think of additional questions between now and then please do not hesitate to call or email me directly.

I will be asking very open-ended questions regarding your experience of Western Models of Psychotherapy and its application when working with Indian populations. Because I am seeking to understand the essence of your experience I am going to try not to ask too many specific, leading questions. With that in mind, you may want to spend some time between now and then thinking about what your thoughts are on the subject.

Thank you so much and I look forward to seeing you on ____________!
Appendix C

Interview Questions
Primary Interview Questions

1. Please describe for me your experience of working with patients utilizing Western models of psychotherapy.
   a. (If inadequate response) What about psychotherapy models do you find particularly exciting, productive, or joyful?
      i. How do you mean?
      ii. Going beyond the surface of the described experiences
   b. Do you find the application of Western models of psychotherapy with Indians challenging and if so, how?
      i. How do you mean?
      ii. Going beyond the surface of the described experiences
      iii. Requesting more details if needed
   c. What is the most important part of your experience you would like to share?
      i. How do you mean?
      ii. Going beyond the surface of the described experiences
      iii. Requesting more details if needed
   d. Is there anything else that you find important when using Western psychotherapy with Indian populations that you would like to share?
      i. How do you mean?
   e. What clients, situations, or events have influenced or affected your experience of being a psychotherapist?
      i. How do you mean?
2. Any additional questions that arise based on the content of the participant’s responses that will help to provide a more complete description of the experience are allowed.

Closing Demographic Questions

3. What is your current zip code?

4. In what zip code have you spent the most years of your life?
Appendix D

Informed Consent
The Application of Western Models of Psychotherapy by Indian Clinicians of India: A Grounded Theory

Researcher: Gurjeet Sidhu, Psy.D. Student in Clinical Psychology

You are invited to participate in a research study. The purpose of this research study is to explore your voice and experience as a psychotherapist who has provided counseling or therapy to Indian populations utilizing Western models of psychotherapy. You are being asked to participate because you are an Indian psychotherapist who has worked with Indian populations sometime in your professional experience.

If you participate in this research, you will be asked to partake in a 1-2 hour audiotaped interview. The content of this interview will consist of any topics you deem relevant to your personal experience as an Indian clinician. You will also be asked basic demographic questions such as your date of birth, place of work, and the city of your current residence.

The risk inherent in this study is the potential distress of speaking of unspoken feelings or difficult thought that may result as part of the interview process. Know that sharing personal experiences related to professional or systemic difficulties can be uncomfortable or overwhelming for some people.

If, while answering the survey questions, you become overwhelmed by these feelings you are encouraged to: reach out to a psychotherapist or support person that you identify. A potential benefit of participation in this study may include the personal satisfaction of sharing your experiences with others.

Your participation will take approximately 1-2 hours and you will be not be given any compensation of your time; however, a gratitude and a thank you note from the researcher will be provided because your participation is valued.

Your participation in this research is strictly voluntary. You may refuse to participate at all, or choose to stop your participation at any point in the research, without fear of penalty or negative consequences of any kind.

The information you provide for this research will be treated confidentially, and all raw data will be kept in a secured file by the principal investigator. Results of the research will be reported without the inclusion of any individually identifiable information.

You also have the right to review the results of the research if you wish to do so. A copy of the results may be obtained by contacting the principal investigator at the phone or email below:

Gurjeet Sidhu
(333) xxx-xxxx
gsidhu@antioch.edu

There will be no direct or immediate personal benefits from your participation in this research;
however, you may find the exploration of this topic to be beneficial to your practice.

I understand that this research study has been reviewed and certified by the Institutional Review Board, Antioch University, Seattle. For research-related problems or questions regarding participants' rights, you can contact Antioch University’s Institutional Board Chair, Mark Russell, PhD at: mrussell@antioch.edu.

The primary researcher conducting this dissertation study is Gurjeet Sidhu, Psy.D Student. The supervising dissertation chair is Jude Bergkamp, PsyD, who can be contacted at jbergkamp@antioch.edu. If you have questions later, you may contact Gurjeet Sidhu at (xxx xxxx-xxxx or gsidhu@antioch.edu).

I have read and understand the information explaining the purpose of this research and my rights and responsibilities as a participant. My signature below designates my consent to participate in this research study, according to the terms and conditions outlined above.

Participant Name (printed): _________________________________________________

Participant Signature: __________________________ Date: _________________

Participant Phone Number: ________________________________________________

Is it OK to leave you a voicemail message on this phone?  Yes ☐   No ☐

In addition to agreeing to participate, I also consent to having the interview audio-recorded.

Participant Signature: __________________________ Date: _________________

Printed name of person obtaining consent _____________________________________

Signature of person obtaining consent: ________________________ Date: __________
Appendix E

IRB Application
1. Name and mailing address of Principal Investigator(s):
   Gurjeet; xxx xxx LN S.W #1; xxx, WA 9xxxx

2. Academic Department:
   PsyD

3. Departmental Status:
   Student

4. Phone Number:
   (xxx) xxx-xxxx

5. Name of research advisor:
   Jude Bergkamp, PsyD

6. Name & email address (es) of other researcher(s) involved in this project:
   N/A

7. Project Title:
   The Application of Western Models of Psychotherapy by Indian Clinicians of India: A
   Grounded Theory

8. Is this project federally funded:
   No

   Source of funding for this project (if applicable):
   N/A

9. Expected starting date for data collection:
   June 15, 2016

10. Expected completion date for data collection:
    February 20, 2017
11. **Project Purpose(s):** Due to the lack of available research and nature of the research question, qualitative research will be utilized in this study and my study plan will be based on Grounded theory methodology to explore the effectiveness of Western psychology when working with Indian populations as an Indian clinician. I plan to conduct interviews with Indian psychotherapists who work with Indian populations to develop open-ended questions to gain their insights about the experience of utilizing Western models. The interview will be based on open-ended questions. My goal is to explore themes that can be utilized by also reviewing literature regarding Indian psychotherapists’ concerns about and critiques of Western models. I will evaluate literature that explores the voices of Indian psychotherapists who utilize Western models with their patients. Themes emerging from the interviews will be organized and analyzed. It is my intention and hopes that mental health professionals will be provided with a valuable exploration of Indian psychotherapies so that they may provide effective services to a population that is in great need of cultural understanding.

12. **Describe the proposed participants- age, number, sex, race, or other special characteristics. Describe criteria for inclusion and exclusion of participants. Please provide brief justification for these criteria. (Up to 500 words):**

   Approximately 7 - 10 participants will be interviewed. The exact number used will be determined through the process of data analysis based upon obtaining a full and saturated description of the phenomenon of lesbian marriage.

   Inclusion criteria are participants must be a psychologist or psychiatrist who was raised in India who has been practicing as psychotherapist or has practiced in the past. The exclusion criteria is delineated through the following five questions:
1. Are you age 18 or older?

2. Are you a psychologist or psychiatrist practicing psychotherapy?

3. Have you had experience in working with Indian population on any capacity?

4. Are you willing to share your experiences/perspectives about the effectiveness of Western models when utilized with Indian clients and your experience of adapting these models?

5. Are you willing to talk to me over the phone or in person for a tape-recorded in-person interview that may last between 1-2 hours?

13. Describe how the participants are to be selected and recruited. (Up to 500 words)

   In order to recruit for this study, word of mouth, chair referral, and committee member referral will assist with gathering a convenience-based sample. Once participants have expressed interest in the study they will be asked five screening questions (see question 12). If they respond yes to all five questions, they will be invited to participate in the study.

14. Describe the proposed procedures, (e.g., interview surveys, questionnaires, experiments, etc.) in the project. Any proposed experimental activities that are included in evaluation, research, development, demonstration, instruction, study, treatments, debriefing, questionnaires, and similar projects must be described. USE SIMPLE LANGUAGE, AVOID JARGON, AND IDENTIFY ACRONYMS. Please do not insert a copy of your methodology section from your proposal. State briefly and concisely the procedures for the project. (500 words)

   Once participants are selected, they will sign an informed consent form and
engage in a 1-2 hour, audio-recorded interview. Each participant will participate in one semi-structured individual interview. Participants will be asked to speak freely about their clinical experience of psychotherapy when working with Indian or Indian population with none to minimal direction from the researcher. The researcher will ask follow-up questions to topics that the participants introduce, but will not initiate specific topics beyond generic questions related to the overall topic of (see attachment for potential interview questions).

Participant interviews will be audio-recorded (not visual) and then textually transcribed by the researcher. All personally identifying information that is recorded on the audio recorder will be redacted from the textual transcription.

While contact with participants once the interview has concluded is not anticipated, individuals may be contacted if questions arise as a result of data analysis. Participants will be informed via the informed consent that if they would like to receive a copy of the results of the study they may request it. Once the research project is finished all the audiotapes will be destroyed.

15. **Participants in research may be exposed to the possibility of harm - physiological, psychological, and/or social - please provide the following information: (Up to 500 words)**

   a. **Identify and describe potential risks of harm to participants (including physical, emotional, financial, or social harm).**

   The potential risks of harm to participants include emotional distress and divulgence of private information. Participants will be asked to disguise and exclude identifying information of their clients, and will be reminded as needed.
Participants may experience emotional distress if the topic(s) of their interview cover experiences that elicit negative emotions. They may retrieve memories of painful experiences that cause them to become upset. Participants might also experience harm if their confidentiality is breached and others find out private information such as their personal opinion, participation in this study, and/or any details that are disclosed throughout the interview or recruitment processes.

b. Identify and describe the anticipated benefits of this research (including direct benefits to participants and to society-at-large or others)

Because the currently available research on Indian psychotherapists’ experience of applying Western models with Indian populations does not exist other than editorials and articles on need of Indian models or fit of Western models with Indian population, very little has published about what psychotherapists are actually experiencing or how they are reconciling with themselves. The perceived benefit of this study is to contribute a study with minimal bias to the current body of research on Indian psychotherapists when applying Western models of therapy with Indian populations. Readers will benefit by gaining a better understanding of may or may not be effective about Western models when working with Indian population. It will create an understanding of psychotherapists in general and what might be helpful to know when working with Indian populations. It may also advocate for the voices of Indian psychotherapists in need of Indian models. Additionally, participants of this study may benefit from the therapeutic experience of sharing their individual and authentic stories.
c. Explain why you believe the risks are so outweighed by the benefits described above as to warrant asking participants to accept these risks. Include a discussion of why the research method you propose is superior to alternative methods that may entail less risk.

In order to illuminate and learn about the experiences of Indian psychotherapists when utilizing Western models of psychotherapy, that population should be studied in a manner that it advocates their voice and is not detrimental. The benefit of having current research that is providing a voice to them and exploring the area that has not been explored outweighs the risks of emotional distress and disclosure of private information. Participants will be well informed of inherent risks and allowed the opportunity to discuss those risks and withdraw from the study if desired.

Qualitative Grounded theory research is the best way to allow participants to describe their own experiences without a lot of pressure as to what to say or how to say it. The goal is to collect the participants’ individual and unique descriptions of each of their experiences, regardless of what they are or how they are described. Also, Grounded theory is utilized best when the subject area has not been explored or well researched.

d. Explain fully how the rights and welfare of participants at risk will be protected (e.g., screening out particularly vulnerable participants, follow-up contact with participants, list of referrals, etc.) and what provisions will be made for the case of an adverse incident occurring during the study.

While risk is minimal, it is possible that a participant may become
emotionally distressed during their individual interview. Participants will be given a copy of the informed consent form, which includes contact information for where they can seek support. Further, if participants become visibly upset during the interview, the researcher will ask if they are okay and whether they would like to continue with the interview. The researcher will remind the participants they may discontinue the interview at any time without negative repercussions.

16. Explain how participants' privacy is addressed by your proposed research. Specify any steps taken to safeguard the anonymity of participants and/or confidentiality of their responses. Indicate what personal identifying information will be kept, and procedures for storage and ultimate disposal of personal information. Describe how you will de-identify the data or attach the signed confidentiality agreement on the attachments tab (scan, if necessary). (Up to 500 words)

The participants in this study may be compelled to share information that they believe that they have not shared or have fear of any consequences. As a necessity of this project, names will be collected throughout participation recruitment and signing of informed consent. Once participants have been secured they will be assigned a participant number (P1, P2, P3, etc.). These aliases will be used to identify all data within data analysis software.

A master list of real names and their assigned aliases will be stored in a password-protected Excel document on a private laptop. The laptop will be carried with the researcher or stored in a locked home at all times. Copies of the signed informed consent documents will be stored in a locked drawer in the researcher’s locked home, separate from the master list of names and aliases.
If participants use their own names or provide other personally identifiable information while speaking during the recorded interview, the name will not be included in the transcription. Any reference to a person’s name will be replaced by their alias (P1, P2, etc.) Additionally, the informed consent documents will be scanned and stored on the researcher’s private laptop under password protection. Hard copies of the signed informed consent forms will be shredded.

17. Will electrical, mechanical (electroencephalogram, biofeedback, etc.) be applied to participants, or will audio-visual devices be used for recording participants?

An audio-recording device will be used to record all interviews. Following interviews, the audio will be transcribed into textual documents. The audiotapes will be stored in a locked drawer in the researcher’s home.

18. Type of Review:

Expedited

19. Informed consent and/or assent statements, if any are used, are to be included with this application. If information other than that provided on the informed consent form is provided (e.g. a cover letter), attach a copy of such information. If a consent form is not used, or if consent is to be presented orally, state your reason for this modification below. *Oral consent is not allowed when participants are under age 18.

Please see informed consent statement attached.

20. If questionnaires, tests, or related research instruments are to be used, then you must attach a copy of the instrument at the bottom of this form (unless the instrument is copyrighted material), or submit a detailed description (with examples
of items) of the research instruments, questionnaires, or tests that are to be used in the project. Copies will be retained in the permanent IRB files. If you intend to use a copyrighted instrument, please consult with your research advisor and your IRB chair. Please clearly name and identify all attached documents when you add them on the attachments tab.

Please see sample of semi-structured interview questions attached. No additional questionnaires, test, or related research instruments will be used.
Appendix F

Memos
Memo 1/19
Title: P1 & P2
Created On: 4/2/2017 by Gurjeet Sidhu
Groups:

Participant 1 and Participant 2 both stressed on importance of understanding culture and its context; otherwise theories or models don't work. Both participants discussed how Western models do not have room for culture. They seem frustrated and their voice was higher pitched.

Memo 2/19
Title: P4:
Created On: 4/27/2017 by Gurjeet Sidhu
Groups:

Almost all participants expressed the need to modify Western models before applying. All of them expressed passion in terms of why there is a need to modify these models.

Memo 3/19
Title: P1
Created On: 3/23/2017 by Gurjeet Sidhu
Groups:

P1 was the only one talked about non-verbal communication. People communicate by nodding and their facial expressions of agreement or disagreement is important to understand. He points out how an Indian individual does not keep the eye contact, which is very different than a Western, individual, for them it might be very disrespectful when someone does not look at you.

Memo 4/19
Title: P1
Created On: 3/23/2017 by Gurjeet Sidhu
Groups:

P1 talks about local religious traditions are extremely important to understand before anyone can work with an Indian individual. According to him Western models does not acknowledge or make room for such healing because it is scientifically proved. P1 incorporates cultural practices and the ways that are known by locals; it is important, effective and productive. It was expressed passionately that an Indian person has this depth of spirituality, tradition and ritual; it is interwoven in their whole self. Western models only touch the surface of an individual.
Memo 5/19
Title: P1
Created On: 3/24/2017 by Gurjeet Sidhu
Groups:

P1 has expressed many different times that Western models does not understand Indian culture, Indian person identity, cultural context, or the values, as a result he uses local healing traditions. At this point P1 was angry because of the history of the country for Indians it is difficult to trust west.

Memo 6/19
Title: P1
Created On: 3/24/2017 by Gurjeet Sidhu
Groups:

Participants repeatedly pleaded that Western models do not consider culture. The participant was very extremely frustrated and their sense of helplessness when they talked about cultural and therapy models. Cultural competency is not valued. Most Western models are viewing an individual from individual lenses not collective lenses. I as an interviewer felt the sense of oppression.

Memo 7/19
Title: P1
Created On: 4/1/2017 by Gurjeet Sidhu
Groups:

P1 stressed many times Western does not make room for Indian values, tradition or its ways of healing. There is a sense of institutionalized psychology?

Memo 8/19
Title: P1
Created On: 4/27/2017 by Gurjeet Sidhu
Groups:

Throughout the interview P1 progressive more and more frustrated, expressing the need to understand cultural context and wish Western models would understand ethnic values. He repeatedly implied that we are oppressed culture, and that there is a need to work from individual strengths. He used the word resiliency for people's strength. They were rejecting of Western models and hope that there was some research was done just on Indian population.
Memo 9/19
Title: P2
Created On: 5/4/2017 by Gurjeet Sidhu
Groups:

P2 also expressed her frustrations regarding Western models, frustrated about how linear Western models and they are culturally relevant. They also rejected Western models.

Memo 10/19
Title: P3
Created On: 4/3/2017 by Gurjeet Sidhu
Groups:

P3 is also rejecting Western models, they express that we are trained in Western models because we as country also believe Western is better, and somehow, we have internalized the oppression.

Memo 11/19
Title: not right now, I will let you know if I
Created On: 5/4/2017 by Gurjeet Sidhu
Groups:

As I interview P3 the sense I got is Western models have more authority/power over Indian ancient ways because the Western models have research backing them and Indian ways have no research supporting them.

Memo 12/19
Title: P3
Created On: 4/27/2017 by Gurjeet Sidhu
Groups:

As P3 talked about we don't have resources to do much research. Psychologist and people seem to think that Western means better.
Which reminds me people also have internalized what they have is less good then what western culture has to offer. Years and years of west deciding what it better for Indian people now people have started to believe Western is better and devaluing their own assets. Only when west has extracting some of the Indian ways of healing. For example: yoga, meditation as such Indian clinicians also started to utilize those techniques. And they feel compassionate about applying
Memo 13/19
Title: P1 P2 & P3
Created On: 4/27/2017 by Gurjeet Sidhu
Groups:

P1 P2 & P3 all three mentioned traditional ways of healings and knowing local cultural tales, so people can relate better as relationship is very important to them. Which reminds me of my work with Native American population. I utilize native stories to connect with children. I used stories that were Coastal and Salish, so children can instantly relate, connect and trust therapist and therapeutic work.

Memo 14/19
Title: P4
Created On: 5/4/2017 by Gurjeet Sidhu
Groups:

P4, throughout the interview talks about power. Power between patient and doctor also the great need to empower clients. What I hear is using power and telling patient what's right for them can be detrimental based on Western ways. People have been oppressed for years they need to be empowered, so they can find their voice and solutions to their problems.

Memo 15/19
Title: G: F -Participants
Created On: 5/4/2017 by Gurjeet Sidhu
Groups:

Female participants expressed themselves very hesitantly and seem to be only positive in their interview, however male participants expressed themselves very openly and were able to discuss their experiences.

Memo 16/19
Title: women are less open to opposite gender.
Created On: 5/4/2017 by Gurjeet Sidhu
Groups:

P2 and P6 expressed that it is easier to work with the same gender as them, opposite gender is hard to work with because psychotherapist can't close their door during the therapy; which then takes away confidentiality from the patients.
Memo 17/19
Title: Real learning happens during the super
Created On: 5/4/2017 by Gurjeet Sidhu
Groups:

P7 brought to attention that one could become a good clinician without a good supervisor, no matter where they are getting their training. They stressed that throughout their interview.

Memo 18/19
Title: Psychological theories are the same ever
Created On: 5/4/2017 by Gurjeet Sidhu
Groups:

P7 brings to attention that psychological theories are same everywhere what is different is culture and Western models does not necessarily address culture. One must modify the model and develop their approach and understand their client well. Western theories are very much science but one must become an artist to mold these theories, so they can applicable to people.

Memo 19/19
Title: P7: Western people do not have to adapt
Created On: 5/4/2017 by Gurjeet Sidhu
Groups:

Western clinician does not have adapt to Indian ways of healing however an Indian clinician should adapt Western theories. They expressed towards the end of the interview that Western teachers are imposing newer behavioral models they are not working and will not work. His students are very frustrated. Hence the oppression continues in the academic world as well.
Appendix G

Codes
Appendix G: Codes

Feels bitter when talking about Western models
Excerpt - Document: Data.docx, Position: 15566-15768
Yeah! I feel like I have nothing but negativity... but on a better note, mindful therapy and mindful psychotherapy is useful for our people because it is coming from a cultural context and cultural values.

Cultural psychotherapy works the best
Excerpt - Document: Data.docx, Position: 4078-4236
Okay! In my work, I use psychotherapy models that I find more socially acceptable models. I see where their culture is and if the clients can understand me.

Being passionate about Western models
Excerpt - Document: Data.docx, Position: 21760-21870
Yeah! I am passionate about cognitive behavioral therapies and relaxation, I enjoy utilizing these models.

Confirmed that Narrative, Exposure, and Art therapy works the best with trauma clients
Excerpt - Document: Data.docx, Position: 2445-2643
I work with trauma, a lot of suicidal clients, and many other struggling people. It makes me more excited when I use narrative therapy, exposure therapy, and art therapy when working with trauma clients.

Informs that language is a big barrier
Excerpt - Document: Data.docx, Position: 3101-3567
Sometimes there is a language barrier with a South Asian person and there are different cases that are delivered differently. Sometimes they cannot speak Hindi, and they can only speak their native language (language barrier). Sometimes it is hard to understand what they are saying which is a difficult conversation for me. Can you understand me? Can you tell me more about what doesn’t work? I find myself challenged with that particular situation. Do you follow me?

Expressed that the Rogerian model honors culture
Excerpt - Document: Data.docx, Position: 2645-2821
I feel more productive and I am excited and able to solve their problems using psychotherapy, and the Rogerian model. It is a very respectful model for cultural differences.

Emphasized that cultural traditions give clients strength and healing
Excerpt - Document: Data.docx, Position: 5216-5411
For example, “Navratre” (traditional Hindu prayers for several days) is used. Sometimes, I utilize the songs of “Navratre,” which bring resiliency in my clients and they are able to find internal strength.
Debated that local cultural knowledge is essential

Excerpt - Document: Data.docx, Position: 5427-5708

We need to know various things about the religion and society. There is a Hindu tradition that one-day, for one week, for the betterment of our future, we disconnect with our thought and sing. I end up using that in my work, which is not Western science; it is our very local ways of coping.

Suggested that incorporating religious traditions is healing

Excerpt - Document: Data.docx, Position: 5936-6211

There is one week a year where they are playing and singing the cultural tradition of "veorda." There is resilience within these groups. I used to use "veorda" and our cultural melodies of folk singing. There will also be things with the song that makes them heal from their pain.

Stressed that collective approach is different than individual approach

Excerpt - Document: Data.docx, Position: 7022-7326

There is a difference between the collective approach and the individual approach you know...

Identified that Western models are individually oriented

Excerpt - Document: Data.docx, Position: 7410-7652

The cultural context is so important, all of Western psychoanalysis is based on an individually oriented mode, but cultural competency is based on the culture that is not applicable to our cultures. They do not trust Western models such as CBT.

Reinforced that Western models are lacking room for culture

Excerpt - Document: Data.docx, Position: 6394-6533

I believe, and I feel frustrated, that Western models are not culturally appropriate and don't look for resiliency and strength in psychotherapy.

Communicated that most Western theories do not capture depth of an Indian individual

Excerpt - Document: Data.docx, Position: 7987-8193

About the psychoanalytic model, folk lives, and religion: all of that is really important and you cannot put that in most models. Most models do not understand or capture that aspect of Indian culture.

Expressed that he has stopped using Western models

Excerpt - Document: Data.docx, Position: 8193-8413

I am mentioning that psychotherapy is searching for this way and that way. And I finally use the model that is culturally accepted in our culture; Veodra, Chandre. Psychotherapy is part of understanding their culture.

Specifies that folk songs are valuable

Excerpt - Document: Data.docx, Position: 8414-8565

(Sings an Indian song…) There is a model that is more useful and also there is a main part, 1,2, to understand the context that these songs are used.
Expressed that applying cultural context is comfortable

*Western models have no idea about these cultural components and that is why I end up using what is more applicable according to the culture even if its not part of the model. This makes me more comfortable to use cultural context to understand them and where they are coming from.*

Emphasized that Western models do not understand Indian values

*Western psychotherapy does not understand an Indian cultural setting. For example Western model does not understand our values, we respect our elder and Western models does not necessarily see this*

Reemphasized that collective approach is not thought of in Western culture

*We follow the collective approach and the Western culture follows an individual approach. Western psychotherapy models are not as approachable for Indian patients. G: Say more about the collective approach with the individual approach?*

Expressed that Indian identity is oriented around 'We' not 'I'

*There is a difference between the We and I and the language used. In the Western culture you do not care as much about cultural context surrounding religion.*

Expressed that popular approaches do not suit Indian culture

*The big picture is that psychotherapy is based on the individual and cultural upbringing is connected to our cultural competency. Therapy is more applicable if the cultural context could be brought in. They are using the trendy approach for psychotherapy and we are able to understand them in our collective culture.*

Emphasized that identity development in Indian culture is different than Western identity development

*All of these Indian cultures are not able to use individual Western psychotherapy models for their patients because most of them are oriented around individual identity, yet Indians orient identity around collectivism, and I feel we are not able to modify the Western psychotherapy model properly for their patients. In an Indian cultural setting we need a holistic approach.*

Believes that one cannot be helped without knowing their social context

*Yes, I think that we can use cultural need and in that context we can help the patients.*
Expressed that cultural awareness is essential
Excerpt - Document: Data.docx, Position: 13439-13723
In the cultural context and surrounding you look at that particular case and sometimes I use my cultural awareness to approach the problem and see how the cultural problem is applicable to that person’s situation. I see how the different religion affects issues and how context affects the person.

Articulated that thought and process are shaped by culture
Excerpt - Document: Data.docx, Position: 13782-13970
First, a patient’s thought and how that thought occurs is shaped by culture. Second, how the patient processes things comes from their culture and the West does not understand their culture.

Articulated that most psychotherapies resist cultural values
Excerpt - Document: Data.docx, Position: 14254-14612
There is a cultural bias based on their cultural competency, I use this for therapy and use psychotherapy to resist their [the West’s] culture. We need to look at the Indian values and the psychotherapy approach. We are not comfortable modifying the psychoanalytic therapy in some circumstances. All psychotherapy is based on an individual context and not community context.

Expressed that Western models are disconnected from cultures
Excerpt - Document: Data.docx, Position: 15186-15356
The most important part I remember when using these Western models is that there was such disconnect that it did not touch base with an Indian person or his or her identity.

Verified that culturally relevant therapies work
Excerpt - Document: Data.docx, Position: 15804-16069
It is based on our "Vedas and Sutra," on the basis that the thought we focus on comes to be mindful in order to understand different things. Some of these mindful practices are based on Buddhist values, which has been part of Indian culture for thousands of years.

Emphasized that modification of models is required
Excerpt - Document: Data.docx, Position: 16173-16391
Right now we use the same process and sometimes we can modify clearly and speak to historical and cultural values. There is a collective society in India so this model of psychotherapy is applicable to most of our people.

Expressed integration of Eastern ways of healing with Western models
Excerpt - Document: Data.docx, Position: 16610-16891
The Eastern model examines the culture and when combined with the West, we take an integrative process of Western psychotherapy with Indian/Eastern psychotherapy. We have to focus on the important aspects of this. We have to use the Eastern/Indian cultural therapy in our society.
Expressed the need to know Eastern values in order to help

We have to follow Eastern psychotherapy and establish psychotherapy based on our cultural values, so we apply these values within the cultural context. This is something that is useful and culturally accepted within our society.

Suggested that dialogue is needed to take practice-based evidence into consideration

We need to have conversations about psychotherapy and see how it can be culturally relevant in our culture and culturally appropriate for our clients. We need to work on evidence on this form of psychotherapy and see how it works.

Verified that some psychotherapy techniques work such as Yoga

Specific aspects in psychotherapy make it more applicable to our clients. Like within yoga, there are specific things that are integral to positive psychology. Being kind is one of the core values of Indians, so I use this in psychotherapy and within our philosophy.

Advocated for Western models needing to consider Indian individuals and honor Indian psychologists’ voices

We can evaluate evidence on this form of psychotherapy and how the Western model can be applied. We need the Western model to work with us on Eastern psychotherapy on this cultural context so that we can work together on how we can combine Western and Eastern psychotherapy together. We can understand Eastern psychotherapy in this way. We need Western psychotherapy to not leave part of the Indian person out, it needs to honor the Indian psychologist.

Expressed need of research on Indian, Indonesian, and Nepali individuals to understand their culture

They say there is a psychotherapy that is based on cultural values and some things are good. But what we are looking at in psychotherapy is based on the right person, right culture, and all these psychotherapy components depend on the culture. So this is why I think that you must look at psychotherapy and that they must work with research in Indian, Nepali, and Indonesia so that they are able to understand the cultural competency and what they are doing.

Described what happens if one of the couples does not participate

In those situations, we look at all the situational changes and if one of them is not cooperating it does not work.

Described lack of participation from male client

Yes, men participating in the treatment; they are not used to doctors. One of the couple does not participate and usually it is male.
Expressed how culturally, males have more power

_Culturally males have more power and they both need to participate and that is frustrating._

Described clients’ return to therapy after a long gap

_Yes, some of them do come around and then they go away and in another year they will have another problem and come back._

Described efforts to encourage patients to participate in their treatment

_They do not come, we cannot do anything. For some patients, we call them back. If they do not come we cannot do anything._

Expressed preference for emotive therapy

_I am comfortable applying emotive therapy._

Preferred relaxation technique of CBT

_Relaxation is a type of mediation that is part of cognitive behavioral therapy._

Focused on family problems

_We look at the family problems that we see?_ _We look at alcoholism. Okay, okay, traditionally and see how low income in the culture influence alcoholism. Middle classes have a problem with their children and some domestic violence._

Understood cultural context before applying any theories

_We look at their job and their marital status and how the culture influences this. We looked at the immediate cultural issues before we apply theories._

Found financial problems frustrating

_There are a lot of financial problems as well and it is difficult for me to solve._

Stated trust is in an issue with Indian clients

_Nothing comes to mind but it is frustrating when people have issues trusting and sharing their real issues with themselves._
Expressed Western models lacking culture and understanding

Excerpt - Document: Data.docx, Position: 26133-26411

Not right now, I will let you know if I think of one. Understanding Indian patients is not part of Western models. I use relaxation and I know that I am using relaxation and cognitive behavioral techniques. But I know that the model lacks understanding of the cultural aspects.

Expressed that Indian patient reject Western models

Excerpt - Document: Data.docx, Position: 26438-26536

(Sigh) Indian patients are not very accepting of Western psychotherapy. Relaxation and yoga works.

Talked about some Western techniques do not work some do

Excerpt - Document: Data.docx, Position: 26597-26718

Yes because the Western style homework and behavioral charts do not work. So we just tell them to do yoga and relaxation.

Expressed frustrations regarding Western models

Excerpt - Document: Data.docx, Position: 26813-26961

We have the assumption that they do not do it at home knowing the culture. There is frustration with the Western psychotherapy model only a few do.

Stated that in time, patients comeback

Yeah, after one year they come back and do more therapy and see more doctors.

Talked about making a contract with patients

Excerpt - Document: Data.docx, Position: 28232-28437

Due to the cultural context, I do not care because you cannot do anything about it. You get used to it. Sometimes I have contracted with them that if the problem is reduced even by 10% they will come back.

Described educational background

Excerpt - Document: Data.docx, Position: 28999-29138

No, I just want to tell you that I have done masters in clinical psychology and counseling psychology, so I have two masters in psychology.

Expressed that patients do not have buy into therapy.

Excerpt - Document: Data.docx, Position: 29749-29899

Like, talking between two people, one is a therapist and another is a client so it can be difficult. It is hard for us to make them believe in therapy

Expressed lack of professional opportunities

Excerpt - Document: Data.docx, Position: 30127-30307

So... umm most challenging part is that I think we still can't have private practice and in other setting we are not well paid. In our culture it is not a sought out our profession.
Described the first session to establish first session
Excerpt - Document: Data.docx, Position: 30544-30794
In initial sessions, I describe how it works, and how it is going to help them. I try to convince them and as a psychotherapist in India we do bring lots of awareness also, sometimes we go to speak with the group of people in the communities as well.

Talked about lack of effective treatments
Excerpt - Document: Data.docx, Position: 31267-31363
Umm sometimes they can't afford it or some times we don't have effective mechanism to help them

Stated that psychological impairments are neglected
Excerpt - Document: Data.docx, Position: 31367-31510
Also, they would go for medical help but not psychological help; only physical impairment is seen as a problem but not psychological impairment.

Described difficulties while applying Western models
Excerpt - Document: Data.docx, Position: 32092-32203
During my education I have learned many Western models during my education but it is very hard to apply them.

Saw Psychoanalytic and Existential models as good fit with Indian patients
Excerpt - Document: Data.docx, Position: 32325-32552
They want us to give some medication and fix everything. Personally, I enjoy psychoanalytic and existential models they can be a good fit with an Indian patient. But then again I don't really get to apply these models either,

Brought to attention that Western ways are more valued
Excerpt - Document: Data.docx, Position: 32711-32908
In context of our country some people go for behavioral therapy because it is said by Western society that these models are well documented and they work. They say it is evidence based or something...

Expressed frustration in applying Western models
Excerpt - Document: Data.docx, Position: 33100-33276
Like... it is just frustrating I don't seem to be applying theories that I have learned they are hit miss process and I feel like I am really applying any theory I have learned.

Expressed Western models do not match emotional depth of an Indian patient
Excerpt - Document: Data.docx, Position: 33418-33668
haha well... my superiors believe that for me those models works amongst people who influence by west or highly intellectual. Our people are highly emotional beings and these new models have more cognitive aspect to it, which is not as transferable.
Stated that Indian psychologists don't have to cater to insurance companies

Also, what I know in west insurance policies forces psychotherapist to use those models. Thankfully we don't have anything like that, but we seem to value Western theories ideas and anything is presented to us you know... I feel they are superficial in some ways and

Described the power differential between the psychologist and the patient

P3: ummm like the way psychotherapy says relationship between psychotherapist and a client is egalitarian and something that is based on equality between them in terms of power, but here therapy is still seen as a relationship between doctor and patient. Doctor has a lot of power and tells the patient what to do and patient complies with whatever doctors say.

Expressed powerlessness when working with Indian patients

My frustrations are a client expect psychotherapist to do the work, they don't want to do the work and make them feel better. I find myself powerless even though the client does give you all the power... their expectations change everything.

Described gender-relevant difficulties with patients

Umm... like I said first the individual believe in psychotherapy, if they do they put you in a powerful place and want you fix everything quickly. And then with female clients it is even harder, you can't close the door and have a session. Women are often venerable when sitting opposite to a male and then if you close the door they shut down. When I have a female client I try to have another woman come and sit in the session.

Talked about confidentiality complexities

Yeah! especially in rural areas. We are permitted to sit with the room closed like Western world, which makes confidentiality difficult.

Stated urban areas are easy to work with

Urban areas it is much easier

Focused on culturally relevant work

I feel comfortable using relaxation, exposure or meditative models knowing their culture and faith. Then, later I try to figure how to document the work

Expressed that Western models do not consider culture

Hmm... sometimes my clients are presenting to me what they are in certain circumstances, and realize that there is cultural difficulty, which Western model would not understand at that time I look for cultural ways for surviving and being resilient.
Stated how the notion of psychotherapy is Western not Eastern
Excerpt - Document: Data.docx, Position: 36286-36420

Concept of psychotherapy itself is coming from west we see as help with relationship or figuring out how to exist in society rules.

Wished to follow traditional ways of healing over following Western science
Excerpt - Document: Data.docx, Position: 36420-36787

We used to just go to monks, religious leaders to help us out with our life difficulties. In some ways it is still true. But, we continue to follow Western science when it comes to health. Our country is so poor, does not have resources to do research and find effective ways to work with our people. We have years we have follow west and we are following west.

Stressed that you need to know your client’s fabric and its threads
Excerpt - Document: Data.docx, Position: 37194-37428

Yeah! Mostly that is true for lot of families. But for me it is really exciting satisfying to know our people culture, their religion, traditions, local stories. Like I find myself just using that to help them through their suffering.

Stressed on values and tales of culture
Excerpt - Document: Data.docx, Position: 37429-37571

For example, I would ask my patient about the mahatma, guru of their family and just helping them to connect with traditional ways of healing.

Talked about mental health being a taboo in Indian culture
Excerpt - Document: Data.docx, Position: 37805-37954

Hmm the only thing I forgot to mention is Indian people find mental illness as taboo they seem to say black magic or bad karma has come over someone

Expressed that spirituality is a big part of Indian clients healing
Excerpt - Document: Data.docx, Position: 38170-38369

P3: Yeah according to their family tradition they will do certain kind of worship and spiritual practices to get relief from the trauma. It is hard for them to go to psychotherapist.  
G: does it work?

Talked about faith
Excerpt - Document: Data.docx, Position: 38370-38507

P3: Client does get immediate help and they don't have to face taboo of therapy. I am not sure if that is always helpful people do that.

Talked about how Indian patients felt suffering through their body
Excerpt - Document: Data.docx, Position: 39623-39792

Yes definitely! First of all, Most of the Indian clients chief complain is somatic symptoms. The moment you mention psychological difficulty they become very defensive.
Talked about Indian patient expressing suffering through their body

Excerpt - Document: Data.docx, Position: 39623-39792
Yes definitely! First of all, Most of the Indian clients chief complain is somatic symptoms. The moment you mention psychological difficulty they become very defensive.

Expressed how mental illness is a taboo for an Indian person

Excerpt - Document: Data.docx, Position: 39793-39936
Because there is lot of stigma in terms of mental illness, going to see a psychologist means you are crazy and something really wrong with you.

Expressed the need to modify Western models

Excerpt - Document: Data.docx, Position: 40690-40974
Also, you have to modify Western models of psychology to make it culturally appropriate; you really have to understand their culture, family and social context. It cannot use Western model as it is, you have to decide what part of the model can be used and what you can be illuminated

Shared that CBT does not work with Indians

Excerpt - Document: Data.docx, Position: 41142-41500
For example, if I have an Indian client who is struggling with anxiety or depression mostly Western model would require to utilize CBT or behavioral models to help them, but that does not necessarily going to work because they are not willing to do logs or do homework to monitor their thoughts …that kind of stuff because it is not an Indian concept to them

Expressed that the Narrative model works because it honors the culture

Excerpt - Document: Data.docx, Position: 41502-41821
I would say I would mostly likely to use narrative therapy with them which works really well or an eclectic approach then the most Western interventions, sometimes I find some parts of Western models useful but most of the time I realize that narrative approach is close their way of thinking and that works with them.

Stated how Western model only works on the surface

Excerpt - Document: Data.docx, Position: 41821-42073
One have to look at the client sociocultural context what they are giving you is only piece of the puzzle not the whole puzzle so you have to dig deeper. Lot of Western models only work on the surface and an Indian person requires deeper interventions.

Talked about how model covers social context, culture, values

Excerpt - Document: Data.docx, Position: 43886-44190
Hmm I like narrative model is about a story of clients whole life, it depicts their story, which include social context, culture, values of the client. And, when you look at socio culture factors then you start looking at the symptoms and then you start understanding what it is like to be in their shoes
Talked about empowering the client
Excerpt - Document: Data.docx, Position: 44818-45048

*They guide me what their process is what they are looking for? I don’t tell them anything and they hold the power. It is empowering for them to be involve in their process.*

G: I see, so they hold the power more then psychologist?

Expressed frustration of being forced to use Western models
Excerpt - Document: Data.docx, Position: 46182-46345

*Very good question, well it depends your supervisor, if they have an agenda of XYG and they are forcing you to apply certain model or work through certain lenses.*

Expressed frustrations on patient drop out due to Western models
Excerpt - Document: Data.docx, Position: 46876-47041

*P4: I believe patient was there for the goal she wanted to able talk to me she felt in charge and validated. I pushed her to make a goal and she did not come see me.*

Emphasized on forming an empowering relationship with the Indian patient
Excerpt - Document: Data.docx, Position: 48563-48758

*My first step usually, how can I build the relationship, how can I empower them, so they find their own freedom own way. I don’t want to fix anything and I don’t want to solve anything for them.*

Expressed frustration and anger towards rigidity of Western models
Excerpt - Document: Data.docx, Position: 48823-48868

*Yes, I get really mad with newer age models.*

Critiqued and expressed anger towards evidence-based models
Excerpt - Document: Data.docx, Position: 48893-49102

*Yes! The evidence based models where you have to follow the protocol. I can’t even go there I will be talking forever. The bottom line it following a model that has strict protocols is useless on our people.*

Expressed anger towards Western teachers enforcing evidence-based models on Indian clinicians
Excerpt - Document: Data.docx, Position: 49384-49674

*If I were to be a Western Clinician I will be outcome oriented like lately, in India some Western teacher are coming over to teach community individuals to train them in these evidence based steps and protocols to utilize on people. It may make therapy accessible, but I know it is useful.*

Conveyed that Western teachers are insulting of Indian culture
Excerpt - Document: Data.docx, Position: 49384-49873

*If I were to be a Western Clinician I will be outcome oriented like lately, in India some Western teacher are coming over to teach community individuals to train them in these evidence based steps and protocols to utilize on people. It may make therapy accessible, but I know it is useful. Those models are lets put a bandage and forget about it. I would have no problem with it if west had the same standard for their counselor. Does that mean Indian client is deserves less.*
Identified the need of unconditional support and reduced power in therapy
Excerpt - Document: Data.docx, Position: 51567-51665
P4: what worked was unconditional support, non-judgmental stance. Psychologist has so much power.

Liked Cognitive Behavioral models.
Excerpt - Document: Data.docx, Position: 52473-52727
Well, when I work with Indian people I mostly use cognitive behavioral psychotherapy. I really spend time to build relationship and to understand the client before I apply cognitive behavioral therapy. I do not find anything frustrations with the models

Believed in productive techniques
Excerpt - Document: Data.docx, Position: 52767-52915
P5: In my experience when we provide some productive devices to our people in psychotherapy than we get more out of psychotherapy with the clients.

Conveyed that most Western models are coming from the East
Excerpt - Document: Data.docx, Position: 53748-54183
Most models of psychotherapy are derived from Indian models like yoga, karibe yoga.... I use them according to the need of the client. I use all different types of models Eastern or Western. For instance, I find that relaxation with any patient. The relaxation technique is part of yoga, so I do not see models any different. I do not get frustrated with any models. I really understand my patient and connect with them where they are.

Supported therapy models that are derived from Eastern models
Excerpt - Document: Data.docx, Position: 55326-55513
In terms of the Western models I believe most of these models are stemming from Eastern models and most of them are derived from Indian values. Sometime I am frustrated
G: Is that right?

Found herself frustrated in terms of women's and their parents
Excerpt - Document: Data.docx, Position: 55549-55679
P5: I am not frustrated... but sometimes I feel frustrated in terms of the women that I saw. I get disappointed with their parents.

Emphasized providing support to the clients
Excerpt - Document: Data.docx, Position: 56184-56272
P5: Yes! Also, I do not impose myself on my patients. I provide them a lot of support.

Wished to have models that understand Indian person
Excerpt - Document: Data.docx, Position: 56758-56821
P5: No, I am waiting to have model that just works for Indians.

Preferred CBT and relaxation techniques
Excerpt - Document: Data.docx, Position: 58574-58724
6: I use relaxation techniques when I am working with them. To deal with their emotional issues, most of the time I use cognitive behavioral therapy.
Advocated for involving family when working with an Indian patient
Excerpt - Document: Data.docx, Position: 58755-58950
P6: I use positive aspects of therapy and I ask them if they want to invite family and then I call them if I say yes. Which is understandable as Indians do better if they have family in therapy.

Extended clinical knowledge to make it applicable for the Indian people
Excerpt - Document: Data.docx, Position: 59012-59129
P6: It is a very content type of experience. I am extending a clinical knowledge to make it applicable to the people.

Expressed CBT as difficult to follow for people
Excerpt - Document: Data.docx, Position: 59297-59474
P6: cognitive behavioral therapy is hard for people to understand, so I change it into a conversation so that people can understand it. That is more than just talking to people.

Felt the need to modify CBT into a conversation
Excerpt - Document: Data.docx, Position: 59297-59474
P6: cognitive behavioral therapy is hard for people to understand, so I change it into a conversation so that people can understand it. That is more than just talking to people.

Expressed frustration regarding the medical model
Excerpt - Document: Data.docx, Position: 59544-59863
P6: Most people don’t understand the CBT; it is a very medical model. Although they would listen to the doctors when they use science. Of course that is frustrating because they do not allow enough time for counseling. They do not give enough time for cognitive behavioral therapy; they want to fix everything quickly

Stated medical doctors are more valued by the Indian patients
Excerpt - Document: Data.docx, Position: 59969-60230
Actually there are two types of patients residing in the North part of India. There are a lot of cultural factors and the mindset of the people they are not ready for cognitive therapy as such. When they come to the doctor, they want them to be a medical doctor

Stressed on the importance of gender roles in therapy
Excerpt - Document: Data.docx, Position: 61660-62036
P6: Especially understanding a women and a family in the culture. When you understand a woman and her position in her family. One woman comes to mind who was highly educated and she was working outside the home, but she would come home to her in laws family and she had to do everything in the house as well as being a wife, a daughter-in-law, she was burdened to find balance

Talked about how to balance power in gender roles
Excerpt - Document: Data.docx, Position: 62665-62878
Once her husband realized what was going on for her, he helped navigate a lot of concerns for him due to his gender and the power he had in his family. He talked to his parents and became more supportive as well.
Highlighted the need of a female client to see a female therapist
Excerpt - Document: Data.docx, Position: 63598-63645
P6: I am more comfortable with female clients.

Shared own comfort with the same gender
Excerpt - Document: Data.docx, Position: 63718-63976
P6: Maybe, because they are comfortable with me and I am more comfortable with them and I have a deeper emotional understanding. Even though, I was trained with both genders it was given in this culture. They are more open with me mainly because of culture.

Emphasized on understanding a person and matching your approach accordingly
Excerpt - Document: Data.docx, Position: 64619-64717
P7: Let me think, I am not sure how to answer that. I believe that we have adapted Western models. As far as I am concerned, I see myself using the same theory. You have to understand a person, you have to understand them. You have to apply your thinking and you have to understand and how do you match your approach to the need of the client.

Complained that Indian psychologists have to adapt Western models
Excerpt - Document: Data.docx, Position: 64951-65103
P7: Western people do not have to adapt to Western models, but we do. I do not know if I have done anything to change Western models into Indian models.

Tailored Western models to the Indian population
Excerpt - Document: Data.docx, Position: 65766-65800
P7: I am not sure how to say that.

Concluded that the human mind is the same but there are cultural differences
Excerpt - Document: Data.docx, Position: 66043-66198
I always think that the human mind is the same and that there are cultural differences. I do not see myself translating Western models into Indian models.

Stated that understanding a person should be an ongoing effort
Excerpt - Document: Data.docx, Position: 66507-66713
Or me, even if I am working with a Western person, I am applying psychological theories not models. It is not a Western person or Eastern person, it is about understanding a person and going with the flow.

Found their relationship with clients most important
Excerpt - Document: Data.docx, Position: 66902-67038
P7: Yes, yes for example my focus is relationship with the client. Part of my work is to understand the emotional aspect of the client.
Rejected accepting psychological text directly
Excerpt - Document: Data.docx, Position: 67039-67202
I do not see myself following the text mostly. For example, in cognitive therapy there are certain techniques as such dysfunctional thinking and negative patterns.

Re-stressed that clinical learning comes from a supervisor
Excerpt - Document: Data.docx, Position: 67856-68112
P7: I have completed some work with formal case studies, which are based on the cognitive approaches for example. In my clinical experience, most of clinical learning comes from your experience with your supervisor, and your learning from your supervisor.

Stated that depth of an Indian could not be understood by theories
Excerpt - Document: Data.docx, Position: 68111-68304
Those things you do not get to learn from a text. You have this discuss about a client with your supervisor. For example, there is such a thing Guru chala a relationship (teacher and student).

Conveyed that therapy is art, which can only be learned from the teacher
Excerpt - Document: Data.docx, Position: 68899-69091
When it comes to clinical work, science is the same either it is for Western psychotherapist or Eastern psychotherapists, the art is that you learn from your teacher to work with your client.

Emphasized on importance of gender roles in Indian culture
Excerpt - Document: Data.docx, Position: 69705-70471
For example once when I was going through my own training, I worked in-patient and out-patient and I did assessments which was similar to a closed door and then I talked openly to out patients. One time, I remember in a group discussion, my supervisor who was female and there were more females in the group, she always valued my voice as the only man, her value of my voice allowed me in the future to hear every voice in the room. She included me in the discussion, even though I was a male because she wanted to give me a chance in the discussion to express my voice. She taught me how to include gender issues. That taught me how to do a genderification. Me who did not have access to male colleagues or a male professor meant a lot for my clinical experience.

Asked permission for depth of the conversation
Excerpt - Document: Data.docx, Position: 71772-71903
P7: I do not think that I see individual differences. I am going beyond the individual differences; I do not how deep I should go.

Expressed frustrations on divide the between East and West when the science is the same
Excerpt - Document: Data.docx, Position: 72298-72586
P7: My one frustration is there are so many editorials and so many papers that are trying to divide Western and Eastern models when I really think they are the same. Science is the same, whether they are Eastern or Western, it is how to deliver that science is different based on culture.
Identified therapy as an art and stated it is different in East and West.

Weighted: False Description
Excerpt - Document: Data.docx, Position: 72587-72935

Whatever theory it is you have to modify it to make it applicable to that certain individual that walks into your office. My biggest frustration is that people are writing about it, and talking about it that Western science that does not work but its not Western science that it is different, psychology is the same; it is the culture is different.

Stated having a million thoughts about this subject
Excerpt - Document: Data.docx, Position: 73944-74030

P7: I have a million of thoughts coming through my mind which one would you want here?

Expressed frustration about the behavioral wave that is being forced on Indians
Excerpt - Document: Data.docx, Position: 74080-74279

: Actually I am thinking about this new behavioral wave that is coming through India is really not working but is being forced upon clients saying that after 11 sessions, this and that will be fixed. It is all so linear. Those therapy models do not have a depth to them and because our culture has a lot of depth, it is failed here but we are just applying because it is the next new thing and the West has approved it.

Expressed frustration about being forced to use newer models
Excerpt - Document: Data.docx, Position: 74279-74499

It is all so linear. Those therapy models do not have a depth to them and because our culture has a lot of depth, it is failed here but we are just applying because it is the next new thing and the West has approved it.

Expressed that newer models don't have enough depth for an Indian patient
Excerpt - Document: Data.docx, Position: 74500-74595

The new models of psychotherapy are behavioral focused and linear and do not have depth to them Even though these new models seem very sound but when you apply them they are quite ineffective. I have students that complain about them all the time and that a lot of these new models are not authentic. I do not know about how much of my perspective is correct or incorrect, this is just what I have observed?

Stated that in East true learning happens with the supervisor
Excerpt - Document: Data.docx, Position: 76117-76295

P7: The core is called training models. Real learning is in the shadow of a good supervisor. I do not know what works in the Western world, but this is what is required in our world
Complained about constraints on the number of sessions

Weighted: False Description
Excerpt - Document: Data.docx, Position: 76440-76636

P7: no not all, we have not started applying it yet; it would not work well in India. I find it very amusing that this will work in India. How do you treat clinical depression in 5 to 7 sessions?

Expressed the ways science can't help Indian patients
Excerpt - Document: Data.docx, Position: 37956-38146

And they would do set prayers or religious ceremonies to help and often that works as a placebo effect people get better. So, as a result people will go to traditional healers after a trauma

Persuaded that the social context is not considered by Western therapy models
Excerpt - Document: Data.docx, Position: 12199-12579

I feel that for emotional wellbeing, and I feel that if they do not use cultural context there are big problems. Sometimes I do not know how I can incorporate the psychotherapy model with the cultural context. We are collecting specific information; holistic approach includes what we can do to support them socially and what resources we can connect them so they can function.

Stressed that Indian patients only need to be listened to
Excerpt - Document: Data.docx, Position: 44588-44729

Also, as Indian client comes to me with somatic symptoms as they tell me their story the go deeper into what is hurting and they end up guide

Accepted Psychodynamic, Humanistic-like models that provided depth
Excerpt - Document: Data.docx, Position: 74597-74829

But old models like psychodynamic, and humanistic, these models are based on relational models. I do not know where this wave is going to take us we are forcing our graduate students to learn these new different models and apply the

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Acknowledged differences between East and West
Excerpt - Document: Data.docx, Position: 73246-73346

In a similar way, you need to know whatever the difference is in an Indian versus a Western person.
Acknowledged women's powerlessness in the culture
Excerpt - Document: Data.docx, Position: 62039-62372

*His is a common problem that I see in therapy. She was feeling very powerless and I had to help her set boundaries. If a therapist is not aware of the family system and the culture, then they would not be able to help this woman safely. So in therapy those kinds of things are the case. So CBT does not play much a role in this case.*

Acknowledged barriers to psychological care
Excerpt - Document: Data.docx, Position: 31779-31806

*P3: Yes yes! That is true.*

Addressed that people are more expressive when they are not labeled
Excerpt - Document: Data.docx, Position: 2229-2443

*It makes our people more comfortable when models are not labeling and people are expressing their views. So, when they are expressing their views they are more comfortable not afraid to be labeled, it helps them feel*

Added cultural aspects when uses CBT
Excerpt - Document: Data.docx, Position: 59246-59288

*P6: yes yes, I do a cultural input in it.*

Advocated for the female client within the nuclear family
Excerpt - Document: Data.docx, Position: 24925-25192

*Usually when couples get married and the women has to adjust in the family and the husband is not supporting and there are problems with the in-laws. My job is to help the husband understand her perspective so that he gives more support to her and solves the problem.*

Advocated for providing a voice to women
Excerpt - Document: Data.docx, Position: 62425-62664

*P6: I talked to her and with her permission, I had her husband come into the session and helped her communicate that was is happening for her now that she is working outside the home and playing the role of an Indian women inside the home.*

Advocated knowing the fabric of the Indian client
Excerpt - Document: Data.docx, Position: 73868-73884

*P7: yes yes yes!*

Again expressed the need to modify Western treatments
Excerpt - Document: Data.docx, Position: 60578-60679

*P6: You have to understand the social and cultural context and accordingly have to modify treatment.*

Brought attention to how Western models can be detrimental
Excerpt - Document: Data.docx, Position: 75810-75889

*We have taken a road to see symptom worsen instead of restoration of a person.*
Brought attention to how Western models are backed up by research

Excerpt - Document: Data.docx, Position: 18532-18762

The Western psychotherapy usually has the research backing them up. However, the Eastern model does not have as much evidence that it works in the field. We need to do more research utilizing our models in the field of psychology.

Claimed psychological theories are universal, however people are different

Weighted: False

Excerpt - Document: Data.docx, Position: 66333-66505

P7: The word, Western, does not come to my mind. To me they are psychological theories. Psychological theories are the same everywhere; yes there are cultural differences.

Communicated that Indian patients reject Western ways

Excerpt - Document: Data.docx, Position: 9753-9936

We need to use this psychotherapy in a more cultural context. Because these models do not understand the cultural context so these patients do not approve of these Western modalities.

Conveyed that culture needs to be considered when it comes to number of sessions


P7: They do not take into account the culture. I do not see treating someone in 4 to 5 sessions. In order to treat a person, you have to learn where the suffering is coming from. It is more than a 5-session thing.

Conveyed that supervision the key to clinicians learning

Excerpt - Document: Data.docx, Position: 65592-65684

P7: Real learning happens during the supervision, where you tailor your theory to the client.

Conveyed that culturally competent models are necessary

Excerpt - Document: Data.docx, Position: 13973-14252

Thirdly, you look at relative issues. We look at the cultural competency and we need to understand the particular cultural competency. We need to understand how that cultural competency affects that particular situation. We need to see how the different therapies connect to this.

Discussed the Indian people's unique way of being

Excerpt - Document: Data.docx, Position: 14615-14853

E has to understand there is a specific cultural ways in that situation. Sometimes there is cultural bias, which affects cultural ways of being. I think there are consequences that make it difficult for me to use the psychotherapy model.

Emphasized how Western models are another form of colonization

Excerpt - Document: Data.docx, Position: 48358-48549

Yes, I don't want to take a position let me tell you what's wrong with you, historically that has happened with Indians and they can very agreeable with you I think it is rather detrimental.
Expressed how the depth of an Indian person must be understood

Excerpt - Document: Data.docx, Position: 42217-42641

P4: Ah! Let see hmm. It is a difficult question to answer, for me I think I try to forget what models I have learn. I try to forget about problem solving approach or I have to do something for client or have to apply interventions that I have learned, but I try to understand my Indian patient's context why XYZ is happening and why they are behaving or experiencing pain then it is easier to solve the pieces of the puzzle.

Expressed the importance of knowing and positioning of gender in the culture

Excerpt - Document: Data.docx, Position: 69705-70471

For example once when I was going through my own training, I worked in-patient and out-patient and I did assessments which was similar to a closed door and then I talked openly to out patients. One time, I remember in a group discussion, my supervisor who was female and there were more females in the group, she always valued my voice as the only man, her value of my voice allowed me in the future to hear every voice in the room. She included me in the discussion, even though I was a male because she wanted to give me a chance in the discussion to express my voice. She taught me how to include gender issues. That taught me how to do a genderification. Me who did not have access to male colleagues or a male professor meant a lot for my clinical experience.

Expressed that Indian patient asks when they need help

Excerpt - Document: Data.docx, Position: 43130-43484

When my addiction clients were committed to their sobriety inpatient treatment they usually ask directly what and how they feel stuck in a certain way when they go back to their usual life, so it is little different. It has been a while when worked with addiction clients directly. They usually have a big support from their family to overcome addiction.

Expressed not being authentic to Western theories

Excerpt - Document: Data.docx, Position: 67386-67513

For example cognitive therapy, downward arrow method. I don’t find myself leaning towards a particular way of cognitive therapy.

Found confidentiality is difficult to navigate

Excerpt - Document: Data.docx, Position: 63063-63491

P6: yes, yes, yes and the confidentiality part that I had to talk to her husband, her family, and I had to navigate around the confidentiality. You have to understand people and the woman was very scared about what would happen when I shared her thoughts to her husband and to her in-laws. It was hard for her to relax until I was able to communicate her needs. Initially, it was hard for me to take those needs to her husband.

Stated how Indian psychologist are trained in Western models

Excerpt - Document: Data.docx, Position: 64772-64941

P7: we are trained in Western models, our training is very Western and I also teach the Western model in a University. We have the same theory that is part of the world.
Stated that newer models may be cost effective but for Indians it is a failed attempt

Excerpt - Document: Data.docx, Position: 74832-74931

They may be cost effective and time effective but with the Indian population it is a failed attempt

Suspected that his/her view is unique

Excerpt - Document: Data.docx, Position: 68688-68897

P7: Correct, most of my colleagues may not agree with me, but I feel that most of your learning is coming from Guru Chala relationship (teacher and student.) You are in a position of one down with your teacher

Stated that those models may be appropriate for hospital settings

Excerpt - Document: Data.docx, Position: 76014-76090

P7: yes, yes, those models are ok in hospital setting and care coordination.

Talked about population they worked with

Weighted: False

Excerpt - Document: Data.docx, Position: 39078-39476

P4. I graduated from Punjabi university of India and right after I worked at addiction issues clinic. Mostly adults working with alcoholics and the families who's members were alcoholics. I saw how parental addiction affected children and their psychosomatic symptoms and their cognition. My second job was working with teenagers' range of issues, such as health, optimism, their coping strategies.

Attested that the language barrier limits emotional expression

Excerpt - Document: Data.docx, Position: 3809-3954

Yes, they are unable to speak frankly in those languages and we are unable to understand them and unable to connect their emotions appropriately.

Apologized for messing anything up for the dissertation objective

Excerpt - Document: Data.docx, Position: 72022-72102

P7: I do not know your dissertation objective; I do not want to mess anything up

Believed in having true relationships with the clients

Excerpt - Document: Data.docx, Position: 55159-55324

P5: I get really involved with a patient in order to help my client, if my client needs mother I become that mother through the relationship I provide during therapy

Called him/herself an activist for women

Excerpt - Document: Data.docx, Position: 54691-54763

5: I am a strong activist in women's rights, I have some disappointments.

Called him/herself a women's activist

Excerpt - Document: Data.docx, Position: 54691-54763

5: I am a strong activist in women's rights, I have some disappointments.
Clarified how non-verbal communication is accepted
Excerpt - Document: Data.docx, Position: 1690-1815
*I think there is a book that is pretty commonly use for teaching nonverbal such as
humming, nodding, touching, hugging is ok.*

Complained Western philosophy forgets about the relationship
Excerpt - Document: Data.docx, Position: 68304-68376
*For example, in Western philosophy often forgets about the relationship

Concluded Western models to psychological theories
Excerpt - Document: Data.docx, Position: 65946-66198
*P7: For some reason, I do not see them as Western models, I see them as psychological
theories. I always think that the human mind is the same and that there are cultural
differences. I do not see myself translating Western models into Indian models.*

Conducted research and therapy
Excerpt – Document: Data.docx, Position:
P6: *yes, I do research and therapy.*

Conveyed the need to modify models to the clients' culture
Excerpt - Document: Data.docx, Position: 4441-4637
*I use culturally accepted ideas. Sometimes I change Western models because I am also
...also thinking that the resiliencies are different and feel for a particular thing need to
develop something else.*

Conveyed that Emotive therapy is applicable to Indian population
Excerpt - Document: Data.docx, Position: 24593-24694
*I am comfortable using emotive because emotive part is culturally appropriate but it is
not required.*

Conveyed that Indian patients are obedient, cooperative, and agreeable
Excerpt - Document: Data.docx, Position: 55730-55922
*P5: Like my client, she did not want to cooperate and we needed cooperation
surrounding her family. Behavior of being obedient, cooperative, agreeable is important
values for Indian patients.*

Conveyed that using a Western approach breaks therapeutic alliance with an
Indian patient
Excerpt - Document: Data.docx, Position: 46595-46835
*My supervisor said she needs to have goal in order to see you and I was very hesitant, I
knew if I told her that we would need to make a goal for therapy she might not see me. I
was right when I tried to make a goal with her, she did not come.*

Critiqued colonization of Western models
Excerpt - Document: Data.docx, Position: 48104-48285
*The focus should be on building a relationship long enough so they feel validated, heard
and empowered. They have been oppressed for years; one up position does not have to
happen.*
Critiqued the level of cultural awareness by Western models
In my experience Western psychotherapy model is difficult to apply on our people

Described how culturally, touching is not acceptable
Excerpt - Document: Data.docx, Position: 1558-1672
Sorry not a model but some research says that it is ok to touch a client when they are devastated to comfort them.

Described how Indian clients’ problems are typically relational
Excerpt - Document: Data.docx, Position: 22352-22634
Generally, their problems are between husband and wife and couple issues. But I am thinking when sometimes when the couples come to therapy usually issues with in-laws. Another thing they come for two or three sessions and expect change, which is difficult and they do not cooperate.

Described how Western models lack deeper cultural context
Excerpt - Document: Data.docx, Position: 436-522
Because most Western models do not understand the deeper level of culture or context.

Described conducting assessments
Excerpt - Document: Data.docx, Position: 21443-21608
Yes, yes. I do marital assessments, alcohol and addiction issues and there are often there is an extra marital affair that comes in. I look at problems that come in.

Described affordability for clients
Excerpt - Document: Data.docx, Position: 31033-31182
They do have problems and they do need certain kind of help...also sometimes they want to go to therapist, but because they find it hard they don't go.

Described how Emotive therapy works
Excerpt - Document: Data.docx, Position: 23762-23981
Emotive therapy focuses on problems involved with the irrational part of thinking. We are working with that. We are trying to find the problems and from those problems we are trying to find a rational thought from that.

Described a lack of cultural understanding
Excerpt - Document: Data.docx, Position: 50406-50507
They will lose their patient then you don't even get to empower them, let alone making a safety plan.

Described the population
Excerpt - Document: Data.docx, Position: 57341-57493
P6: I work with the chronically ill and HIV patients and I will do my best to talk about my experiences, today I am fasting so I might be in low energy.
Described the population
Excerpt - Document: Data.docx, Position: 21053-21327
I mostly work with behavior issues of children, couples issues or any family issues. Parenting difficulties, interactional issues amongst the family issues ok and how to handle these issues ok! Depression, anxiety ok and assessments, such as assessing children's with problems.

Described the population
Excerpt - Document: Data.docx, Position: 29285-29547
Have worked with students from university, while I am working with students in college there are times I work with clients out of the college and I have used some of the techniques from the Western models and psychotherapy. Anything particular you want to know?

Discussed utilizing cultural strength as important
Excerpt - Document: Data.docx, Position: 4238-4440
Sometimes I look for resiliency. I look for a culturally appropriate resiliency. This makes them to change their perspectives towards those things and to their cultural settings and cultural identities.

Discussed that the patients want to get better right away
Excerpt - Document: Data.docx, Position: 27394-27572
Ahh. Ok. If they do not want to do the therapy and do not participate we cannot do anything. They start going from one doctor to another doctor to get help with their problems.

Drew attention to deficiency in Psychoanalysis
Excerpt - Document: Data.docx, Position: 530-630
Like in psychoanalysis, this model is very difficult to implement in daily therapies in our culture.

Emphasized listening to the Indian patient
Excerpt - Document: Data.docx, Position: 35751-35812
Mostly, with Indian people I end up listening to them deeply.

Emphasized empowering clients and the relationship
Excerpt - Document: Data.docx, Position: 54244-54679
The most important part of my experience is for example is that I shared the story of my client with depression. I listened to her, aligned with her and talked to her parents. She was powerless and I provided that power to her and in no time she was better and that was really important to me. I held more of her problems and helped through her issues. I gave her time to talk about her problems, her experiences, and her as a person.

Emphasized on knowing the cultural context of the patient
Excerpt - Document: Data.docx, Position: 36125-36285
Hmmm I am in this profession to help people the thought itself is very satisfying. Many of relationship issues can be solved just knowing the cultural context.
**Emphasized setting expectations with Indian patients**
Excerpt - Document: Data.docx, Position: 35606-35696
True! I try to explain in the very beginning what I can do or not do knowing the culture.

**Expressed that Indian culture has deeper roots that need to be understood**
Excerpt - Document: Data.docx, Position: 18395-18532
Because our psychotherapy is deeper than the Western psychotherapy I found that our psychotherapy is more relevant to our culture.

**Expressed a difficulty in reconciling with him/herself after using Western models**
Excerpt - Document: Data.docx, Position: 47726-47930
Lot of Indian clients specially women who come from place of powerlessness and you have to spend lot of time so they feel like they can complain about something before you can even go towards solving it.

**Emphasized that flexibility in number of sessions is important**
Excerpt - Document: Data.docx, Position: 12626-12947
Yes, we can look at the overall context and see how it is applicable to their situation. We are more flexible on how many times we see patients, what context we see the client how and connect them with whatever we can; sometimes you see a patient for 2 to 3 times and sometimes you see a patient more than 10 to 12 times.

**Expressed frustrations in pathologizing patients**
P4: I feel excited about narrative kind models exciting because it fits indigenous population and it is less pathologizing.

**Expressed feeling guilty and resentful due to Western models**
Excerpt - Document: Data.docx, Position: 47173-47304
I felt horrible, I wish I would've done it, then I felt really guilty, whatever she was getting from me I closed the door on her.

**Expressed the importance of knowing cultural stories**
Excerpt - Document: Data.docx, Position: 72936-73128
It is most important part is to know the cultural stories and using those stories within the model. It is a social context that a clinician must know when he or she is working with her clients

**Expressed the importance to understand clients' cultural context**
Excerpt - Document: Data.docx, Position: 61395-61631
P6: as far as I'm concerned, it is not so much of the model; it is the cultural context and understanding of a person that works rather than the model. I like the aspects of CBT model easier to fit into the social and cultural context.

**Expressed how Indian women are less expressive**
Excerpt - Document: Data.docx, Position: 64016-64099
P6: yes and I am living in a rural area and women are less open to opposite gender.
Expressed the inequality in standards to serve Western patients vs. Indian patients

Western models are like put a bandage and forget about it. I would have no problem with it if west had the same standard for their counselor. Does that mean Indian client is deserves less.

Expressed the relevancy of psychotherapy with the patients

We need to look at the type of patients and see how psychotherapy works.

Expressed sadness for not questioning Western models

P3: hmmm maybe I just don't question that; maybe I believe that Western science is better. I don't know... my intention is to help people I try to figure out a way to help people.

Expressed that some people cannot afford therapy

So, we can see that in our society as well, like not very many people come for psychotherapy, counseling, or consultation. In college, not many people were coming to see me even if that service was free of cost.

Expressed that building trust with the patient is important

Think, the first thing is you have to build the trust with the client; trust is the most important thing. First of all, you have to tell them it is okay to speak with you openly that takes them a while; they don't open up with you in one or two sessions. My experience working with Indian population is that they assess you what kind of person you are, if they can trust you or not?

Expressed that Indian patients are often reduced to problem solving

You have to listen to an Indian client long enough to find their own answer in order for it work. Focus should not be on symptom reduction, problem solving or interventions. The focus should be on building a relationship long enough so they feel validated, heard and empowered

Expressed that newer models only exist on the surface and can't treat the cause

These models are not like psychodynamic or old school traditional models. These models just on the surface may take the symptoms for 3 weeks or 6 weeks, but they only treat the symptoms and not the cause of the problem.
Expressed that patients seek immediate relief
Excerpt - Document: Data.docx, Position: 32204-32323
One of the reasons is the Indian patient think that Counselors are like medical doctors and they seek immediate relief.

Expressed the great need to modify Western models
Excerpt - Document: Data.docx, Position: 47512-47725
Well, I have been saying that one can use Western models with Indian patient but you need to modify Western models and you yourself have to flexible and be okay to change some parts of the model you are applying.

Expressed uncertainty regarding problems and feelings
Excerpt - Document: Data.docx, Position: 22352-22634
Generally, their problems are between husband and wife and couple issues. But I am thinking when sometimes when the couples come to therapy usually issues with in-laws. Another thing they come for two or three sessions and expect change, which is difficult and they do not cooperate

Expressed anger about being forced to use goal-oriented therapy
Excerpt - Document: Data.docx, Position: 46406-46594
That is really hard for me I feel like I am breaking my therapeutic alliance with my patient. For example I had a patient who had PTSD she would talk to me little each time she would come.

Expressed how sometimes, Western models can be offensive
Excerpt - Document: Data.docx, Position: 44453-44586
I feel frustrated because I feel like I am offending my clients, so lean towards models like narrative, which seem not to be abrasive

Expressed his/her dislike of linear models vs. circular models
Excerpt - Document: Data.docx, Position: 44192-44449
I think as it increase my understanding of the client, they seem to be more open and you are able to provide them what they are looking for. I find really comfortable to use narrative over CBT or other behavioral models because they seem to feel cut and dry

Expressed the importance of taking cultural context into consideration
Excerpt - Document: Data.docx, Position: 790-1012
G Can you say more about that?
P1- umm the cultural context in our groups I believe that there is an appropriate ways in which cultural context is kept in mind, Most of the models we apply are originated in Western culture

Felt helplessness in changing the theories
Excerpt - Document: Data.docx, Position: 67515-67653
I am not saying that I completely disregard the theory but truly we do not have Indian theories or Indian text or psychological theories, only Western theories.
Found him/herself taking own approach instead of using theory directly
Excerpt - Document: Data.docx, Position: 67204-67285
I do not see myself using that theory directly, I integrate the theories instead.

Found value in yoga and meditation in therapy
Excerpt - Document: Data.docx, Position: 52980-53137
P5: productive devices is like meditation and giving them advice. When I see irritated person who is having difficulty I just give them yoga and meditation.

Highlighted the need to not abuse power
Excerpt - Document: Data.docx, Position: 51687-51809
P4: Lot of time when people know you are a doctor people give you lot of power it is important that not to miss use power.

Identified differences in the processing techniques used by Western and Eastern cultures
It does not recognize the cultural difference and how a client processes work. Processes are different in the West versus the East.... Such as cultural postures

Implemented religious values as a method to help coping
Excerpt - Document: Data.docx, Position: 5605-5764
Sing I end up using that in my work, which is not a Western science it is our very local ways of coping. It help people if break from their obsessive thoughts.

Implicated the effectiveness of Western models
Excerpt - Document: Data.docx, Position: 22031-22260
It used more frequently and effectively. You can look at the cultural perspective. Sometimes you are not sure about their emotions and problems and once I figure out their problems and feelings, then I can change their problem.

Identified how cultural values are misunderstood and misinterpreted
Excerpt - Document: Data.docx, Position: 50608-50921
Yes definitely! In our culture women are taught to keep the family together, maybe new generation might be open to safety plan but what I seen in my work women feels responsible to keep the family together and there is a stigma with divorce or leaving her husband, asking her to leave family is not going to work.

Identified with being positive
Excerpt - Document: Data.docx, Position: 54800-54935
P5: No, no, no, I had no disappointment. I am a very positive person I do not see anything negative in life. I have no disappointment.

Identified the need to empower the patient
Excerpt - Document: Data.docx, Position: 50406-50507
They will lose their patient then you don't even get to empower them, let alone making a safety plan.
Invited clinician to know the gender, age and the time
Excerpt - Document: Data.docx, Position: 73610-73698
P7: Yes, age of the person, gender of the person, time of the person, the person's story

Identified the need to empower
Excerpt - Document: Data.docx, Position: 51007-51522
Well Important part is empowering your client; a client comes to my mind. She was in a D V situation. She would come see me twice a week; her husband did not let her sleep on the bed. She was suffering I listened to her week after week, empowered her, made her feel like a person who is strong. One day she decided to pack her bag and decided to leave him. She told me I don't care about him I don't care about people. I am sure my parents will bare my wait. I will be okay. I was so happy for her finding her own way.

Justified the modification of Western models
Excerpt - Document: Data.docx, Position: 67660-67797
We do not have Indian theories, this means that I am adapting to Indian focus. I feel modifications are required based on the client's need.

Learned to be positive over many years
Excerpt - Document: Data.docx, Position: 54972-55056
P5: I have published, in my 60 plus years of my life I have learned to be positive.

Looked at psychotherapy from cultural context
Excerpt - Document: Data.docx, Position: 28014-28159
Once they get tired from going from one doctor to another doctor then they come back to you. We look at psychotherapy from the cultural context.

Stated that minimal eye contact is required
Excerpt - Document: Data.docx, Position: 1014-1215
In the Western culture you keep the eye contact with the client. In our culture when you are talking to your senior citizen it is not good to make eye contact or a female client you don't look at them.

Opposed becoming a Western clinician who reduces an Indian patient
Excerpt - Document: Data.docx, Position: 49107-49347
I have been saying some parts of these Western models works but you have to continue to think of cultural context and a client's story. I want to be an Indian clinician who might be using Western model I don't want to be a Western clinician.

Outlined the cultural strength to recognize resiliency
Excerpt - Document: Data.docx, Position: 4637-4807
The resiliency takes shape and makes things more accepting more people. I also think that it works better for the cultural setting and cultural context. Do you follow me?
**Persuaded that collective identity needs to be understood**

Excerpt - Document: Data.docx, Position: 16392-16487

This practice understands collective identity and it understands the collective value of "we."

**Pledged that patients are not universal**

Excerpt - Document: Data.docx, Position: 49878-50112

The fact that Indian client is different their cultural context is different these models need a different approach for example, if you have an Indian woman who is in D.V situation you don't make plans to get her out of the mans house

**Proposed cross-cultural practices as relevant**

Excerpt - Document: Data.docx, Position: 10083-10260

Yes, I am practicing cross-cultural practices to make it more relevant in a cultural context. I have to incorporate the cultural context in Western models to make it applicable.

**Re-stressed the importance of listening to the patient**

Excerpt - Document: Data.docx, Position: 45915-46106

Yes and it works. It is more suited with them... I am not sure how to explain that. In my experience when an Indian client comes to you all you want to do is listen and validate their concerns.

**Questioned why newer models are superficial**

Excerpt - Document: Data.docx, Position: 75366-75487

P7: I do not know if the Europeans follow the same model or not but these models are totally entering clinical psychology

**Reflected that Indian values are undermined by Western theories**

Excerpt - Document: Data.docx, Position: 10635-10884

We are not talking about cultural context. The values of Indian culture and the little tiny things that matter to people are not valued in a Western culture. The small nuances of the Indian culture are undervalued and not included in Western models.

**Shared frustrations in regards to Western models**

Excerpt - Document: Data.docx, Position: 38548-38620

P3: No I think I have shared all my frustration and excitments of work.

**Re-stressed that the Indian community understands local ways of healing**

Excerpt - Document: Data.docx, Position: 9479-9752

Those cultural dance models are both trusted by our people. If we are using those dance forms than we may be able to connect easily with our patients. If we do not use these models there is a lack of awareness at a community level. Using this psychotherapy models in India,
Shared a story how a teacher teaches you how to have a meaningful therapeutic relationship

Excerpt - Document: Data.docx, Position: 70785-71647

For example, once I was having a discussion in a professor's room and there was a girl who came to consult and I was sitting with my supervisor and the door was closed. This girl wanted to speak with the professor I was sitting with; she did not knock at the door. Then she was peaking through the window. I noticed that this woman is peaking through the window, why can she not knock on the door? Then that professor told me I will see you later and let me speak to this person. She played the role of as a supervisor and she did not have to respond in an inappropriate way, but she responded her as if the girl was a client. But I responded to her and put me on hold and attended to her as if she was the client. She did not get frustrated from being interrupted in the meeting. It teaches how to see another person's point of view. That makes it meaningful.

Shared the value of involving patient in diagnosis

Excerpt - Document: Data.docx, Position: 45402-45640

You are in place of power but if you don't give your client a power you end up being at a place of problem solver and I don't think that works because most of the Indian client don't have a voice... you have empower them to find their own way.

Stated how endless patience is needed by clinician

Weighted: False

Excerpt - Document: Data.docx, Position: 69561-69704

P7: The way they relate to you, how you relate back to them, and the endless patience they showed to you, that is what you take to your client.

Stated that all teaching comes from the teacher

Excerpt - Document: Data.docx, Position: 68688-68897

P7: Correct, most of my colleagues may not agree with me, but I feel that most of your learning is coming from Guru Chala relationship (teacher and student.) You are in a position of one down with your teacher

Stated that confidentiality is one of the reasons for patients drop out

Weighted: False

Excerpt - Document: Data.docx, Position: 28557-28583

2: In some situations yes.

Stated that there are not Indian psychological theories

Excerpt - Document: Data.docx, Position: 67515-67653

I am not saying that I completely disregard the theory but truly we do not have Indian theories or Indian text on psychological theories.

Stated a higher drop rate in patients

Excerpt - Document: Data.docx, Position: 28457-28504

Sometimes after one consultation they drop off.
Stated that psychotherapy does not work for everyone
Excerpt - Document: Data.docx, Position: 27049-27147

*It is difficult to look culturally how it works for them. Psychotherapy does not work for everyone.*

Stressed on focusing on the relationship with the client
Excerpt - Document: Data.docx, Position: 56584-56712

*P5: No at this point, I focus more on the relationship I do not focus on the models themselves, so I do not have more to share.*

Stressed that knowing context of a person is essential
Excerpt - Document: Data.docx, Position: 29602-29735

*In our country context of a person is important, it is very difficult to make people understand you know ... that psychotherapy works.*

Stressed that modifying of Western models really works
Excerpt - Document: Data.docx, Position: 60751-60785

*P6: what I do work. It does work.*

Stressed to know historical and social context of the client
Excerpt - Document: Data.docx, Position: 73130-73245

*There are certain stories that children grew up with in their era; you have to know these stories to be effective.*

Stressed how a lack of cultural understanding of an Indian is detrimental
Weighted: False
Excerpt - Document: Data.docx, Position: 50114-50278

*It would be detrimental you have to work with her long enough to empower her so she can protect herself not only from the husband but also, from the Indian society.*

Took culture into consideration
Excerpt - Document: Data.docx, Position: 22181-22260

*Hence I figure out their problems and feelings, and then I can change their problem.*

Talked about HIV and therapy
Excerpt - Document: Data.docx, Position: 57673-57855

*P6: Most of the time I use screenings before I start therapy. Sometimes I talk to the people who have contracted the illness and they are not very open with about their experiences.*

Talked about different types of relationships
Excerpt - Document: Data.docx, Position: 68504-68585

*So you have to play all types of relationships, one down, one up, and one equal.*
Talked about how therapy is made available for individuals

Excerpt - Document: Data.docx, Position: 30796-31031

And though not being able to do private practice, but with some NGO (Government company) makes it possible to have therapy free of cost. For some Indians we are providing services to community people where they do not need have to pay.

Talked about the importance of supporting vs. problem solving

Excerpt - Document: Data.docx, Position: 42644-43003

Some Indian clients are coming to you to solve the problem most of the time they just want to share what they are going through and they just want you validate what they are going through and want support. So, most of the time I have seen they come they talk to me I am actively listening and creating a space for them and it is not problem solving with them.

Talked about listening to the clients feeling on a deeper level

Excerpt - Document: Data.docx, Position: 60871-61218

P6: The most important part is that when a person comes to the second session, something you did in the first session worked. You can focus on the feelings and the things that they have taken from you on the first session when they come back. The person is looking at you as medical advisor and then you can delve deeper into the emotional level.

Talked about power positions with the client

Excerpt - Document: Data.docx, Position: 68378-68504

I am sure that must happen in Western world sometimes you have to take one up position or one down position with your client.

Talked about secrecy due to AIDS

Excerpt - Document: Data.docx, Position: 58249-58494

This is really frustrating for me. They do not want to tell their in-laws or a family member that they have contracted AIDS. I spend enough time with them that living with HIV is better than living with AIDS. I go over the pros and cons of HIV.

Talked about sitting with AIDS and pain

Excerpt - Document: Data.docx, Position: 57970-58065

P6: I talked to people who have already developed AIDS and I sit with the pain of the patients.

Talked about trust in spirituality vs. diagnosis

Excerpt - Document: Data.docx, Position: 58094-58248

P6: They do not understand the seriousness of the disease and they want to lean towards to the spiritual things. There is a mistrust of medical diagnoses.

Talked about the relationship between trauma and somatic symptoms

Excerpt - Document: Data.docx, Position: 39947-40186

So, there chief complains are I have stomach pains, pain behind my neck or I have body aches and it could be for number of reasons. But often it is depression or some trauma or some other thing, the first main complain is somatic complain.
Utilized the Relationship model in therapy
Excerpt - Document: Data.docx, Position: 56909-57091
P5: Yes! Lot of things that you are asking is like I can't put words to but I think I will stick with my answer that I work via relationship with my people and it is quiet satisfying

Valued listening in therapy
Excerpt - Document: Data.docx, Position: 55923-56106
I keep listening to people complaining about and hearing about what is it is that is disappointing to the context of cultural and family context. I listen so much before I help them.

Valued the relationship in therapy
Excerpt - Document: Data.docx, Position: 53169-53468
P5: Once upon a time, I had a client who was suffering from depression. Most of her depression came from her parents. I helped her with what she was not getting out of her parents and she was just a young person and just providing her with that relationship she was able to stand up to her parents.

Warned Western clinicians not to impose their views
Excerpt - Document: Data.docx, Position: 51842-52049
I would say sometimes when we get too involve in client and lose boundaries. There is countertransference happens which you have to careful, you have to be careful not to impose your views on your client.

Wished to practice traditional ways of problem solving
Excerpt - Document: Data.docx, Position: 36997-37148
We always had generations living together under the same roof, so your grandparents, your parents become problem solver for all one goes through life.

Focus coding

Culture context is extremely important
Western models do not grasp deeper level of Indian person
Culture cannot be learned but it can be understood
Cultural is not taken into consideration by Western models
Local ways of healing need to be considered
Cultural ways of healing are dismissed by Western models
Compassionate about Western models
Western models are oriented around individuality
One cannot apply Western model without modifying
Western ways can be oppressing
Feels frustrated in regards to Western models
Cultural competency cannot be earned
Practice based evidence needs to be valued
Power difference is found amongst the genders
Feels sense of oppression and frustration
Newer models are extracting Indian Ancient practices
Western teachers impose Western ways
Feels powerless as a clinician
Western ways are more valued and colonization continues on
Western models are pathologizing to Indians
Indian patient somaticized their emotional pain
Trust is difficult
Feels guilty when authentic to Western models
Newer models that follow protocol are useless w/Indian patient
Spirituality is big part of Indians psyche
Supervision is a most important part of psychologist's training
Newer behavioral wave is being forced on Indians
Western models are exact science and science is hard to apply without changing