Some Cultural Aspects of Clinical Counseling in Indian Context

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Abstract

Clinical counseling is a distinct highly skilled profession that provides practical, flexible, consumer oriented and individualized therapy incorporating solutions to facilitate behavior change and efficient problem resolution for optimizing mental health status of affected individuals. This paper seeks to highlight few contemporary indigenous issues and problems involved in the routine practice of mental health related clinical counseling. The matrix of cultural background within which the counseling processes are embedded offers a unique opportunity as well as occasion to innovate out of necessity for optimum benefit of the recipients of such services. Contrasting westerns models and approaches such new practices are shared. The growing challenges for clinical counseling along with an agenda for immediate action are proposed.
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1. Introduction

Notwithstanding the lexical meaning of counseling as 'advising, recommending, guiding and exchanging ideas or opinions', clinical counseling, or more appropriately, '*clinical mental health counseling*' is 'a distinct highly skilled profession that provides practical, flexible, consumer oriented and individualized therapy incorporating solutions to facilitate behavior change and efficient problem resolution as applied to the amelioration of psychological health and well being' (Smith & Weikel, 2006). Ideally, clinical counselors carry a formal authorized membership and certification with license, jurisdiction, regulation and scope of practice from a legally endorsed national body. They are trained to use a variety of therapeutic techniques to address issues like depression, anxiety, adjustment problems, addiction and substance abuse, suicide tendencies, stress, problems of self esteem and grief. They also help with job and career concerns, educational decisions, family, parenting and marital problems (AMHCA, 2016).

The scenario of clinical mental health counseling is nascent in our country. Given the estimated population prevalence for mental illness at 150 million persons at the rate of 15/1000 with slightly higher rates of 17/1000 for rural against 13/1000 in urban areas (NSSO, 2002), available workforce of psychologists in the country is as meager as 0.047/100,000 (WHO, 2011). In other words, there are around 500 clinical psychologists equivalent of 3 per million or 1 for 343,000 people in the country as compared to 1 for 100 in Australia (Malhotra & Chakrabarti, 2015; Presadarao & Matamsudhir, 2001). The deployment of school counselors although recommended by educational boards continues to remain another elusive phenomenon in the country. An recent study showed that only 19 out of the surveyed 101 national and international schools located in Karnataka declared having counselors on their rolls (Venkatesan & Shyam, 2015). Against this resource crunch, no wonder, the tasks of professional clinical counselors are usurped by magical-religious practitioners, quacks, or charlatans (Patel & Thara, 2003). Faced with mental health problems, the first choice of affected individuals and/or their family is inertia. No treatment is sought. Much is left for time to heal or everything is condemned to fate (Carson, Jain, & Ramirez, 2009; Kumar, 2002).

2. Counseling in Indian Culture

Although the essence of what happens in counseling dates back to centuries beginning ancient Indian civilizations, the modern Euro-Anglo-American roots for this profession is a beginning-to happen only now in the country. The ancients recommended mental wellness, emotional well being, capacity to lea full and creative life through body postures, breathing exercises, diets, fasting, religious rituals and daily life practices. Attending spiritual discourses, visiting holy places, undertaking pilgrimages or having holy dips in rivers, or making donations, are all treated as means to periodically cleanse the body and soul (Cornelissen, Misra & Varma, 2014).

In modern mental-health parlance, counseling is seen as 'professional relationship between a counselor-counselee' with the objective of: (1) removing and modifying or retarding existing symptoms; (2) mediating disturbed pattern of behavior; and (3) promoting positive personality growth and development (Wolberg, 1977). This essence of counseling has always existed, albeit in different disguises, in many traditional practices in our country (Verma & Gupta, 2006).

The nature or extent of counselor-counselee relationship, help seeking behaviors, how the counseling is viewed and continued are all determined by cultural factors. In India, the stigma associated with matters related to mind, counseling or consulting a counselor continues to prevent many affected persons from seeking timely professional help. Even if it happens, the counselor-counselee dyad is viewed as god-devotee or teacher-pupil (guru-chela) relationship (Manickam, 2010). Some unique sentiments which influence this relationship in our country are listed below.

- The counselor must act as agent, representative, proxy or alternative adult figure for or on behalf of the elders in the family (Venkatesan, 2016);
- The counselee is seen as a suffering, ailing, erring or punishable offender usually for the mistakes on sins committed by him or her in present or past life (Jain, 2005);
- Secrecy, not only privacy and confidentiality, must be maintained in the transactions between the counselor-counselee with psychological problems (Laungani, 2004);
- Directive or authoritarian approaches to counseling are preferred, expected and insisted rather than non-directive or democratic approaches in so far as the counselees as well as their family members expect directions on what needs to be done. A non-directive counselor would be in fact deemed ineffective (Spang, 1965);

Additional features noted (Venkatesan, 2010) about the uniqueness of Indian culture and its families are:

- Mother-child affections are glorified and even worshipped as normal and natural. Any differences or deviations are viewed as sacrilege. Filial piety or parent child bond supersedes all other forms of interpersonal relationships;
- Interdependence rather than independence is expected to be in harmony with ones social context. Dependency, especially of women, elderly and children, is considered normal, natural and expected.
- Emotions are expressed though actions rather than words. Overt and excessive expressions of sexuality are considered taboo.
- Avoidance of greed, limiting ones desires and wants is considered a virtue. Means are valued more than attainment of ends. Materialism and consumerism is looked down compared to sense of detachment, spiritualism and value based living.
- Central role given to family, community, or group instead of the individual. Socialization takes place within the context of an extended family and family activities foster the development of a collective consciousness;
- Hierarchical relationships are established and maintained. Respect for authority is expected and implemented.

Contrast these features with typical stereotypes on an 'ideal' western culture which stress on nuclear family, individualism, competition rather than cooperation. For example divorce in India is still viewed as disgrace and bad name for the family. The typical American views it as a sign of good respect for individual freedom. All this becomes relevant to the practice of clinical counseling in our country (Bhatt, 2015; Shallcross, 2012).

3. Counseling Process

Literature from the West identifies typical stages and processes in the counselor-counselee dyadic relationship. Beginning with an oral or written contract, it proceeds through opening, middle and termination phases. The counseling objectives are well laid, boundaries are defined, do's and don'ts are delineated, trespassing is forbidden, timelines are demarcated, ethical guidelines are respected and weaning or termination is pre-planned. Since the whole affair is a qualified transaction, they fall under the ambit of a professional body which serves as monitor or watchdog for the entire deal (Claringbull, 2010; Corey, 2009). All this may not fully apply for our country. The preceding scenario or rather, the absence of it is common for the Indian practitioners of professional counseling. Where needed, one can devise, design, or develop need based counseling processes, procedures and practices by innovation. Given below are few experiences unique to the practice of clinical counseling in our country:

3.1 Prestige Suggestion

What may be used as an occasional adjuvant may become a rather regular or main course intervention technique for most of our counselee clients. Since the counselor is frequently viewed as 'guru-god-teacher' sitting on a higher pedestal, any persuasive message delivered by tat source gathers credibility. It gets accepted by the counselee who is at the receiving end (Atkinson & Carskaddon, 1975). It is not uncommon to hear the following comment from many parents who seek counseling for their wards: 'He will obey if you tell him to do so!'

3.2 Counseling Expectations

The idea of seeking counseling is viewed as intimidating or weird by many people. What will the counselor think of me? Why should I go and tell my problems to a total stranger? What will others think about me consulting a counselor? Have I gone mad? What if I go there and cry? I guess, I can fix my own problems? Many are directed by others to undergo counseling. They do not come on their own. They are not self-directed or self-motivated. Therefore, establishing a counseling relationship with them will be complicated, complex and challenging. Ice

breaking activities are frequently needed depending on their age and developmental levels before engaging them in actual counseling. Nonetheless, they must be informed about their problems, and their consent must be taken in an appropriate manner. Some demand secrecy by wanting to see the counselor as a 'friend' or 'uncle' or they just want to 'talk it over'. Many Indian parents, for example, also end up unabashedly proclaiming in front of their wards: 'We have tried telling, advising, lecturing, threatening, scolding, bargaining, begging, punishing or even intimidating him to mend his ways…but, to no avail. Hope this counseling would at least put some sense into his head!'

3.3 Inappropriateness of Western Models

Although attractively packaged, embellished and laced with evidence based practice, many western models of counseling may not be applicable to an average Indian consumer. The Freudian explanations based on sexuality are not readily accepted even by the most erudite among the Indian masses. The importance of local language, situational variables and customs, rather than classical intra-psychic explanations would be welcomed. Wherein dependency, cooperation and collectivism more than independence, competition, conflict or individualism is appreciated, clients find non-directive approach to counseling as unpalatable (Mullatti, 1995).

Take the example of self disclosure, which happens when the counselor has to share personal views or experience to improve the emotional or mental state of the client. An excessive use of it or a poorly timed disclosure may send wrong signals to the client. It could undermine the balance of power in the relationship between the counselor and counselee (Simone McCarthy & Skay, 1998). There are well-laid out or prescribed guidelines for facilitative self-disclosure. As applied to our country, self-disclosure might be expected or insisted by older clients from their younger counselors (Bhola et al., 2015; Avasthi & Grover, 2009).

Mythology and influence of Hindu epics are deep and intense on any typical Indian psyche. The cultural symbols of Lord Hanuman as bachelor hero, or goddess Lakshmi as personification of wealth is widespread. Available training programs in counseling, if at all any, in the country are heavily loaded on western models. The Gestalt, Cognitive-Behavioral, Psychoanalytic, Existential, Humanistic, Directive-Non Directive, or others may not meet adequate success in clinical practice. Instead, an eclectic approach tailor made to the needs of given patients or problems may be more appropriate in our conditions.

3.4 Impossibility of 'Deep' Counseling

Wolberg (1977) recommended three degrees or levels of psychological interventions based on depth, duration and/or degree of engagement between the therapist-client as supportive, re-educative and reconstructive respectively. In doing so, counseling was reserved as a term used to designate the first level of professional support to promote development of maximal or optimal use of counselee assets. Along a continuum, re-educative therapy attempt giving insight into the more conscious conflicts, efforts at goal modification and maximal utilization of existing potentialities. An example of re-educative therapy is relationship therapy or attitude therapy. Much deeper are reconstructive therapies attempt at giving the client insights into their unconscious conflicts, or make alterations of their character structure. An example of reconstructive therapy is psychoanalysis. Given the constraints of time, cost and labor intensive nature of re-educative and re-constructive therapies combined with the available demand-supply scenario in our country, the most reasonable option left out is to avoid 'deep' therapies. Instead, short term and supportive individual or group counseling become the wisest option for optimum benefits to affected clients (George & Pothan, 2015).

A Junior Scientific Officer working in a prestigious research organization came with presenting complaints of being continually 'harassed' by his supervisor much to the 'amusement of others' and 'loss of dignity' in front of his colleagues. Following clinical interviews, case history and psychometric evaluation, he was diagnosed as having 'avoidance personality disorder'. He showed behavioral patterns of social withdrawal, self loathing and heightened sensitivity to criticism. He reported feeling frustrated with close family members in everyday settings. He showed excessive tendency towards seeking perfectionism, blaming, denial, or dependency on others for approval, repeated escape to fantasy, low self esteem, and self loathing. A problem focused, individualized and tailor made long term periodic counseling may be required in such instances. Establishing the initial strong base of therapeutic relation between the counselor-counselee is needed for such interventions. This is likely to be arduous and challenging. The moot question against all this is whether a meaningful long term investment in terms of time and effort can be expended for a single individual when there are equally deserving several hundreds of waiting cases for appointments at the doorstep of the counseling professional.

3.5 Counseling Following Observation Linked Testing

Text books on psychological testing routinely recommend examination of children in isolation (Glutting, Oakland & McDermott, 1989), obtaining their reactions (Saldana & Du Bois, 2006) or those of their parents (Tew, Payne, Laurence & Rawnsley, 2004) after testing. The option of testing children in the presence of their parents as moral support for the young subject being grilled with questions by an unfamiliar examiner was first explored in an

indigenous study (Venkatesan, 2013). Results showed that parents reacted either against the child, themselves, teachers, or the school system. Upon witnessing the failing performance of their child during the testing situation, they reacted with hurt, shame, guilt, resentment, disappointment, helplessness, blame, defense, or upset. Child directed reactions included smiles, prompts, reprimand, smirking or even hitting. Outer directed parent reactions comprised of faulting teachers, blaming the school, alleging deficient school facilities, or complaining about syllabus load. A counseling session immediately after such a revealing experience was invariably found to be relatively more cathartic and accepting by the parents (Venkatesan, 2015a).

3.6 Counselor Characteristics & Behavior

The importance of counselor characteristics and behavior in meeting client expectations and providing consumer satisfaction has been emphasized (Heppner & Heesacker, 1983). This is a great challenge for counselors working in a pluralistic, multi-lingual, heterogeneous, and diverse society such as India. Clinical counseling targeted for a rustic, for example, may require different constellation of techniques, use of language or dialect, cognitive or socio-cultural medium of expressions compared to another elite upper class highly educated individual presenting with the same problem. Similarly, counseling children require different skill set, intellectual or language use as against dealing with their siblings, parents and/or even their grandparents. It would be indeed a tough challenge for a middle-aged or young counselor to be accepted by a senior citizen in our settings. If young student or trainee counselor in their twenties or thirties is recruited, they fail to impact or get accepted across populations who foresee helping professionals to be typically aged, experienced and worldly wise. In the west, a young counselor with professional degrees is readily accepted and appreciated. The same is not true in our country (Varma & Gupta, 2006).

3.7 Growing Popularity of Alternative Medicine

In the contemporary time, people are easily fascinated by quick fixes and easy forms of get-well cures. There have no time for long term, time consuming and expensive counseling interventions. Supportive counseling and/or speedy recovery techniques by means of alternative treatments, whether proven or otherwise, are growing by demand. Diet-based, exercise-driven, laughter induced, animal assisted, sensory activated, movement ridden, email or application oriented or gadgetry controlled treatments are gaining attraction over face-to-face interactions as required for traditional counseling practice. Unless one keeps pace with such rapid changes, the profession runs the grave risk of losing the race (Kiruba et al., 2013; Mallen & Vogel, 2005).

3.8 Treatment Seeking Behaviors

Also known as care seeking behavior, this refers to the active process of seeking remediation by an individual or group following an perceived experience of being physically or mentally ill (Aston et al. 2013). The typical route of help seeking behaviors in Indian families for psychological problems is one of delay, defensiveness and/or denial. Their recognition as needing professional help is a bottleneck that cannot be easily overcome. The typical first course of action would be to attempt within-the-family advice-giving, lecturing, reprimanding, pleading, or coercing for behavior change. When all such attempts fail, then an elderly person or family guru is requested for direction. Traditional faith healing therapies, magical-religious treatments, and/or alternate forms of cure is attempted. When all these efforts come to naught, professional counseling is opted under compulsion. It is noted how lay people, especially in Hindu context, are moved by a sentiment of fear or reverence to name children affected by cleft palate resembling monkey gods as 'Anjaneya' or 'Hanumantha' and also, by recommending prayers, appeasement of gods and rituals as the only cure available for such condition (Venkatesan, 2015b).

4. Challenges for Future

Counseling has gone global. The importance of mental health and wellness is being increasingly acknowledged. Numerous organizations have sprung across the country claiming to help people through counseling. Apps based, internet enabled, or television and online assisted pre-paid or post paid counseling services are gaining popularity. It is not known how many of them are permitted, professionally qualified, accredited, ethically and legally mandated or monitored for whatever they are doing. Professional training programs in counseling is yet to take off in a big way within the country (Kapur, Shamasundar & Bhatti, 2001). Quackery is rampant disguised as gemology, astrology or numerology based guidance. Simple one-shot solutions are dispensed to gullible customers seeking immediate nirvana. The time is ripe for professional counselors to unite under one single banner as a strong and vibrant professional body. In-service training, periodic internal audits must be mandated before up-gradation of practitioner skills, licensing or certification is given. A well laid out career growth map must be in-built within the given scheme of things.

It is also time to move away from theories and instead focus on individuals, couples, children, adolescents, elderly and their families. They need to move out of their entrenchment into medical models of the past to enter into health or positive psychology, embracing holistic and wellness perspective, strengths supporting, multi-cultural, rights enabling and evidenced based systems approaches. It has been argued that counseling as practiced in west might be suitable only for the few educated elite in urban India. There is greater dissociation between thinking

and feeling within a typical Indian psyche as compared to west. One may have great knowledge on a given topic but may still harbor disconnect between their thoughts and action. The terms privacy and confidentiality highly cherished in western practice flouted in the daily clinical practice within Indian settings. We have multitude of languages and dialects in the country. Unless one is conversant with as many of them, success as practicing counselor is difficult to achieve. A family oriented approach may be more pragmatic than dyadic therapies prized in the west.

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