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VIEWPOINTS

Navigating psychotherapy in India

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Background: Historically, psychotherapy training in India was largely restricted to Cognitive Behavioral Therapy (CBT) and psychoanalytic models, often sidelined by pharmacological interventions due to time constraints and limited specialized personnel. However, the last two decades have seen a paradigm shift characterized by increased patient awareness, a diversification of therapeutic modalities, and the emergence of structured interventions for complex conditions like Borderline Personality Disorder (BPD).

Objectives: This paper aims to reflect on the evolving journey of psychotherapy in India, specifically examining the practical application, challenges, and clinical utility of Mentalization-Based Treatment (MBT) and Dialectical Behaviour Therapy (DBT).

Methods: The authors utilize a reflective, practice-based narrative drawing from their clinical experience as psychiatrists trained in both Indian and international settings. Case vignettes are employed to illustrate the cultural adaptations and systemic barriers encountered while delivering structured therapies in the Indian context.

Results: The transition to specialized therapies reveals unique socio-cultural challenges: systemic barriers like the dual role of the psychiatrist as both a prescriber and therapist necessitating clear boundary setting; cultural dynamics: collectivistic family structure challenging autonomy and confidentiality; implementation hurdles: scarcity of trained supervisors, high training cost, lack of a centralised database particularly outside urban centres.

Conclusion: While psychotherapy in India has gained significant momentum and acceptance, there is a pressing need for standardized training, peer supervision networks, and culturally sensitive adaptations of Western models. The shift from symptom management to addressing underlying psychological distress through MBT and DBT represents a vital maturation of Indian psychiatric practice.

Keywords: psychotherapy in India, mentalization-based treatment (MBT), dialectical behavior therapy (DBT), borderline personality disorder, cultural adaptation, psychiatric training

Psychotherapy has been an integral part of mental health interventions for a very long time. When we first started training in psychiatry, in the late 1990s and early 2000s, there were only a handful of therapies we needed to learn. Practical exposure to therapy was limited to cognitive behavioral therapy (CBT) formulation and psychoanalytic models and a few behavioral paradigms for trainees in India. Therapy learning varied between institutions and relied a lot on the training lead and what their therapy orientation was. We did not see many psychiatrists delivering therapies, and access to psychologists who were delivering therapies was also scarce. On the clinical front, the psychiatrists had the responsibility to decide what therapy to offer the patients. In most training institutions time was also a huge barrier in offering therapy, especially for psychiatry units.

Awareness amongst the patient population regarding therapy was limited (1). In most training institutions time

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was also a huge barrier in offering therapy, especially for psychiatry units.

Today the scene is very different. We are currently in a phase where almost all alphabets of the English language feature in abbreviations of therapies. The number of psychologists and psychiatrists delivering therapy is increasing. The menu for therapy is also expanding around the world.

The field of psychotherapy in India has seen progress too. An increasing number of psychiatrists, psychologists, counselors, and social workers deliver therapy. Available therapies in India have grown and include almost all therapies quoted in literature, like psychodynamic psychotherapy, CBT, Rogerian client-centered therapy, family therapy, mentalisation-based treatment (MBT), dialectical behavior therapy (DBT), and mindfulness-based treatments. There are also options for group therapies. Online psychotherapy is getting increasingly popular, especially after the covid pandemic.

The landscape of mental health help-seeking in India is changing too (2). There is an openness to getting help for various problems ranging from marital problems, domestic violence, and substance abuse to severe mental illnesses and personality disorders. Therapy is also sought for autistic spectrum disorders and attention deficit disorder. Many mental health organizations are working hard to raise awareness about mental illnesses and treatments and therapies. The internet has equipped people with knowledge about therapies. More people come asking for therapy, and there is an increasing demand for specific needs ("queer affirmative therapists" to "I want a middle-aged experienced female marital therapist"). Structured therapies are more readily available. However this is weighted towards urban centers and there are still not enough psychiatrists or psychologists to meet the needs for therapy, more so in tier two cities or rural settings. The quality and availability also vary from place to place.

As psychiatrists with a special interest in psychotherapy, we have worked in this area in India and other countries. In this article, we want to share our experience of psychotherapy practice in India, particularly in the field of DBT, and MBT.

What interested us in working in psychotherapy?

AB: Soon after my internship, my first job was as an Senior House Officer in psychiatry in India. I remember my consultant telling me, "Talk to the patients and spend time listening to them…that's the only way you can understand them." What felt very alien at that time soon became interesting and probably stayed with me while I was at a crossroads needing to choose my super-specialty in Australia. I still remember the moment when I decided to do my advanced training in psychotherapy. One of my consultants, who was also a psychotherapist said, "Therapists get down to the bottom of the problem. That is actual treatment. Medications are just managing symptoms that emerge from the underlying psychological distress and not really treating anything." I find that to be true of most of the people I see, and that's the reason I chose to train in psychotherapy and why it forms an integral part of my practice.

LV: Some of my teachers clearly introduced the biopsychosocial models during training, and this helped to keep an open mind to use psychotherapy as an active intervention with my patients. Early introduction to psychoanalytic psychotherapy in undergraduate days, even though it was in the form of lectures, kept my interest in psychotherapeutic approaches alive.

What is the experience of delivering MBT in India?

LV: During my psychiatric training in India and the UK, I had experience in psychodynamic psychotherapy and CBT. Over the years, I retained my role as a psychiatrist diagnosing and prescribing medications and referred patients to other therapists and used an eclectic approach in my own practice with some of my patients, borrowing from different models depending on the patient's needs. When I returned to India 10 years ago, I noticed a lot of patients with borderline personality disorder (BPD) in my practice, and I could not find many trained therapists around me. I had been introduced to MBT when I was working in the field of eating disorders in the UK, and with the opportunity to be trained in MBT by Prof. Anthony Bateman, I decided to pursue this training, and in the last few years, I have been practicing MBT and participating in peer group supervision.

Whilst both psychologists and psychiatrists who are trained in MBT can deliver the intervention, it is advised that the psychiatrist does not do both medical management and therapy for the same patient. This dual role by the same clinician can create a conflict of interest and affect the therapeutic alliance.

When I started seeing patients for therapy referred by fellow psychiatrists, I initially found it challenging to remain a therapist and not focus on diagnosing or using pharmacological interventions. Very often patients would ask me for advice about the medical management, and in the very early stages of my therapy practice, I would intervene. It certainly affected the therapy space, and I started floundering. As I got more experienced, I am now able to draw boundaries at the very start and ensure that the patient understands what my role is and what it is not. When there are medication-related issues, I readily refer back to the psychiatrist.

Peer group supervision has been the backbone of my MBT practice. Discussing cases, learning from other practitioners, and refreshing MBT skills and theory have all been very useful.

In the last 4 years, I have been seeing more and more patients being referred for therapy. I have referred my patients to other therapists for MBT. This is a good trend, as it indicates the awareness on all sides.

The mental health professional pool is still small for the proportion of patients needing therapy. The cost of training

and time commitment plays a role in trained therapists being available and the number of patients that one can take in for therapy. Also, most of the therapists are concentrated in specific pockets of the country (3). Many psychologists and psychiatrists around the country are not aware of the training opportunities. There is no centralized database of therapists, and this is a challenge when patients have to be referred. The referrals mostly happen by word of mouth, and this is far from ideal.

AB: Working through stigma and educating family members forms a main part of delivering therapy in India.

For example, TN, a 24-year-old girl, was one of my earliest patients after returning to India, who met the criteria for BPD but did not engage in any high-risk behaviors. She associated depression with trauma and felt guilty having developed the condition even with a seemingly normal upbringing. Her family also didn't know how to approach me and would often tell me things about her behind her back. Explaining the context and framework of therapy, setting boundaries without upsetting the family, and continuing to encourage connections between them helped in maintaining improvement for this girl.

Even those educated in the therapy model can find it hard to receive therapy. Like this 28-year-old therapist with complex trauma, who approached me for therapy for herself. Being a victim of child sexual abuse herself, she often felt overwhelmed when working with patients with similar histories. The difficulty I faced with her was getting her to stay in the role of the one receiving therapy. She often intellectualized her problems and used jargon to respond to my queries—never actually telling me what she actually felt. Another difficulty that we both faced was the regulations, or lack thereof, in reporting the abuse in India. The framework of MBT helped to overcome the barriers she posed to me. She was able to start being more vulnerable in the session, which in turn made her stronger when interacting with her parents, friends, and partner.

What are the challenges in delivering MBT in practice?

There are generic and therapy-specific challenges. In India, there can still be a significant stigma associated with seeking mental health treatment. Cultural beliefs, family norms, and societal pressures might discourage individuals from openly discussing their psychological struggles and seeking professional help.

LV: A gentleman walked into the clinic and when asked to sit down, he hesitantly looked up and, with a sly smile, said that he was here not for himself but for his nephew, who was waiting outside and needed "counseling" to get married. The nephew did not know that the consultation was for him. I talked to the nephew and realized that he was absolutely fine in his mental health, and he was as shocked as I was that he was sneaked into a psychiatric consultation without his knowledge.

A mother told me that the best way for the patient to get better was for her to be busy. She said, "Doc, work is the best solution; if she works hard and works all the time, she will not have time to think of problems at all."

A recently widowed 42-year-old doctor felt invalidated when the family wanted her to move on and not engage in therapy.

In our collectivistic society, decisions regarding healthcare are made by families, and a lot of the time, the individual does not have the choice (4). This certainly has an impact on the therapeutic alliance and the individual's ability to participate in therapy. This is not an uncommon scene in many psychiatric consultations today.

AB: This is especially relevant for younger patients. An 18-year-old college student was brought to me after being taken to several different doctors over a period of 2 years. When I insisted on seeing her alone first and that I would talk to the father afterwards for collateral information, he was appalled and angry. He felt he had to give me all the information about her otherwise, I would not get it right. But just seeing her alone before anyone else in her family had a chance to talk to me sowed a small seed of trust in her, which she had not been able to do with other therapists before. Parents of children/young adults find it very hard to concede autonomy, which often can be a barrier for engagement in therapy.

On the other hand, more and more people are engaging in therapy for various mental health issues ranging from grief management to eating disorders to personality disorders. In fact, younger people in urban areas specifically want psychotherapy over medical management of mental health issues like anxiety and depression.

Mentalisation-based treatment involves developing an ability to understand one's own mental state and that of others and interpret them. It is challenging because patients come from a culture where there is collectivism and the focus is on interpersonal dynamics rather than self-reflection.

A young woman lived in a joint family with her husband and mother. She was very engaging in therapy, but she struggled to talk about her perspective. Therapy was going around in circles with no progress. After several sessions, the therapist realized that whatever the client was talking about in sessions was not her own view of the world or herself but actually her mother's. This then allowed the therapist to modify the approach to constantly check if her interpretation is her own or that of her mother, and this has enabled the client to also reflect better on herself.

The other common challenge is the traditional hierarchy model in the society, which affects the therapist-patient relationship in MBT. Encouraging open discussions and exploring different perspectives might face resistance if clients are not accustomed to expressing their thoughts freely. A young man in therapy would send messages to the therapist when he was running late for sessions. He would interpret brief replies to mean that the therapist was angry with him

for being late to the sessions. He never brought this up in discussion, as he did not feel comfortable questioning the therapist. After several months in session, when they were discussing how he got anxious at work when he got mail from the boss, the man spoke about this in the session.

The family dynamics in India affect privacy and confidentiality, and this affects the ability of the person to share openly their feelings and thoughts with the therapist (5). A 24-year-old woman was being seen for individual therapy. The family was concerned and wanted information from the therapist. They also revealed "secrets" to the therapist but insisted that this not be shared with the patient.

The other big challenge for patients engaging in therapy is the cost of sessions. Therapy works best with regular and consistent participation for an extended period of time. Weekly sessions for 6 months to a year is the minimum duration. People find it difficult to spare the time and money for this. Whilst teletherapy has been a useful approach to overcome the time factor, it certainly does not work for everyone. Many people do not have private space that they can use at home to have uninterrupted secure time. There have been dogs, grandmothers, and maids intruding into the virtual sessions!

Dialectical behavior therapy

AB: When I first commenced psychotherapy training in Australia, I was fortunate to work for 2 years as part of a comprehensive DBT team, where I had to see a patient for individual therapy, co-facilitate skills group therapy, be part of a supervision group, and provide crisis support to patients.

Dialectical behavior therapy is a structured therapy that focuses on harm minimization and social skills training. Ideally, the patient is enrolled in weekly individual therapy and a concurrent group therapy program. The group therapy focuses on skills training, and individual sessions focus on reducing risks, building therapeutic alliance, and improving quality of life. The skills are taught with a combination of didactic and experiential formats, and cover emotional regulation, distress tolerance, interpersonal effectiveness, and mindfulness. While I found this modality very useful, I also began to learn about my own preferred style. DBT is a form of behavior therapy and directive in its approach. For the first year or two, the focus is deliberately on immediate factors and not on deep trauma. My style is a little less directive, and I had to work hard on sticking to the model prescribed in therapy, which wasn't often easy. For example, my first DBT patient was a 30-year-old financial analyst who had a history of sexual abuse from a male nurse during her psychiatric admission at the age of 14 for an eating disorder. Each session of ours required us to begin and end with a mindfulness exercise; many of the common ones focused on breathing and body scanning. It took me at least four sessions to figure out that she just couldn't relax if she paid attention to her body due to the history of abuse, and she couldn't tell me this because she hadn't yet begun to fully trust mental health professionals. It's only when we delved a little into her trauma that we figured out one of the reasons for her resistance, and then we were able to devise alternative mindfulness exercises that did not focus on her body. Seasoned DBT therapists are able to adapt and yet stick to the model. Because I was new to this model, it took me time and good supervision to help this patient. There are very few therapists in India who are fully trained to offer the comprehensive DBT system. But many are able to offer DBT-informed therapy, which can be a starting step to more comprehensive therapy.

Conclusion

In conclusion, we feel that it's a good thing that there are many forms of therapies available, because we are seeing patients present with a range of problems and clinicians present with various styles. A particular therapy or therapist style may not suit everyone, and it's helpful to have a range of models to choose from, train in, and develop expertise in. Despite all our training, we are still learning from our patients, and our confidence as therapists is growing by sharing and learning from each other.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

References

1. Manickam LS. Psychotherapy in India. *Indian J Psychiatry.* (2010) 52(Suppl 1):S366–70. doi: 10.4103/0019-5545.69270
2. Shamasundar C. Some personal reflections relating to psychotherapy. *Indian J Psychiatry.* (2008) 50(4):301–4. doi: 10.4103/0019-5545.44756
3. Singh AR. The task before psychiatry today. *Indian J Psychiatry.* (2007) 49(1):60–5. doi: 10.4103/0019-5545.31521
4. Thomas B. Treating troubled families: therapeutic scenario in India. *Int Rev Psychiatry.* (2012) 24(2):91–8. doi: 10.3109/09540261.2012.656302
5. Chadda RK, Deb KS. Indian family systems, collectivistic society and psychotherapy. *Indian J Psychiatry.* (2013) 55(Suppl 2):S299–309. doi: 10.4103/0019-5545.105555