University of Glasgow

School of Education

EDUC 5839: Dissertation

Student ID number: [redacted]

Date: 18th August 2023

Word count: 11,123

Supervisor: Chris Hand

Title: Practitioner's Reflection on Mental Health in India

Declaration: In submitting this report I acknowledge that I have read and understood the University of Glasgow guidelines on plagiarism and declare that this piece of work is entirely my own work. All sources have been acknowledged in the text and included in the reference section. All quotations from other authors are marked as such in the text.

I have read and understood the University of Glasgow's statement on plagiarism which can be found here:

https://www.gla.ac.uk/myglasgow/apg/policies/uniregs/regulations2022-23/feesandgeneral/studentsupportandconductmatters/reg32/

Occasionally we share dissertations to support future students. Please note below whether you consent to your dissertation being used as an example for future students. All identifying information will be removed from the dissertation before it is shared (delete as appropriate).

Title: Practitioner's Reflection on Mental Health in India

Abstract

This dissertation focuses on the state of mental health in India and the various aspects leading to its growth and depreciation from the outlook of Indian practitioners. Over the years, India has developed religious myths, societal stigmas, and ignorance around mental health, causing a spike in psychological disorders while the mental health care system suffers due to these embedded notions. This study aims to analyse this imbalance of psychological care and mental health patients by addressing the role of government, society, credibility of the mental health professionals, the educational sector, and social media.

Using a qualitative approach, this paper recruited seven mental health practitioners and conducted semi-structured interviews to inspect their first-hand experiences and insights on the subject. Thematic analysis was applied to interpret the collected data and attain themes and sub-themes which satisfy the research questions. The participant's contributions and perspectives provided a deeper understanding of why there is an immense lack of awareness around mental health in India by addressing issues of accessibility, stigmatisation, societal pressures, mental health illiteracy, cultural dominance, and inadequate support from the government.

The findings of this paper suggested the scope of psychology in India and how the country could overcome its barriers to achieve productive and better mental care facilities. The 2019 Coronavirus pandemic was recognised as a constructive and positive moment as it changed the negative opinions on mental health in India. The paper also statistically and evidently

investigated the demand for mental health aid in India and correlated it to Western advancement in diagnosing and treating mental disabilities. It emphasised on need for mental health education especially in schools. The evidence and research provided this paper with the false beliefs to do away with and the future implications for creating a safer space for the mentally ill.

Keywords: Mental health practitioners, India, stigmas, societal pressure, psychoeducation, diagnosis, credibility, governmental support, media, unawareness, COVID pandemic.

1. Introduction

1.1 History of Mental Health Concepts

According to the World Health Organisation (2022), "mental health is a state of mental well-being that enables people to cope with the stresses of life, realise their abilities and work well." It is a person's emotional, psychological, and social well-being affecting their feelings, thoughts, and actions (American Psychological Association, 2000). Therefore, it plays an extensive role in everyday activities and impacts a person's personal and social development.

It was not until 1946 that mental health received technical and scientific recognition as a concept at an established organisation (Bertolote, 2008). At the World Health Conference, the

notion of 'mental hygiene' was established as a social movement (Lewis, 1974) which directed maintaining one's mental health. Later the World Health Organisation (WHO) changed it to 'mental health' and established it as an official domain to maintain the subject's credibility (Bertolote, 2008). Adding significance to the concept of mental health from a movement to regulation, in 2001, WHO inserted three chief proficiencies in its report, which implemented 1) efficacy in the treatment and precautions of mental health, 2) increase amenities and organisational groundwork, 3) providing more funds and eliminate the stigmas attached to mental health (The World Health Report 2001, 2001). However, the successful establishment and acceptance of mental health by credible bodies or amongst the society were only seen in the Western countries and hence lacked awareness in most other parts of the world (International Committee on Mental Hygiene, 1948), for instance, India.

Even though mental health has been a developing part of Indian society and has created ventures to understand the psychological disorders or the significance of mental well-being (Mills, 2001), there were many barriers and misbeliefs it had to endorse before its evolution. For instance, the belief system towards the mentally ill was strongly linked to the ancient scriptures, which directed its cause to 'demonic possession' or the 'evil eye' (Weiss, 1986). These old scriptures were called Vedas, and each Veda contained different information on mental illness. While the Rig Veda laid down a more clinical side of mental health like surgical operations, the Atharva Veda introduced ten sections of teachings on black magic, witchery, sinfulness, and enviousness as it considered mental disorders a curse of God (Wig, 1999). Godly techniques, prayers and religious mantras were initiated to preclude or eliminate mental disturbances, for example, depressive thoughts or feelings of fear (Avasthi et al., 2013). Hence, the scriptures aimed to assist people struggling with mental health by

helping them regulate their emotions and creating a more assertive and self-disciplined mental state. However, India was not the only country to perceive mental disorders as a possession of demons.

In the 18th century, many cultures and countries in the West had also accepted the idea of evil spirits possessing the mind and involved religious contexts in the psychotic symptoms of the patients, especially the Catholic texts (Gearing et al., 2011). Exorcism (removing the presumed evil spirit from a person) and trephining (surgically making a hole in the human skull for the release of the evil spirit from the body) were commonly used methods to treat mentally ill patients (Szasz, 1960). Such religious delusions embedded false beliefs in society, which leaked onto many cultures worldwide. People with mental health illnesses were treated faultily, brutally, and seriously misread. According to a study by Hemphill (1966), all around the world, thousands of mentally sick people were killed because of incorrect treatment procedures or for being under the influence of demonic spirits. Therefore, the effect of such false apprehensions was experienced worldwide and led to numerous untrue notions of mental health before accepting the modern, academic, factual, and accurate rationale of mental disorders and mental health. However, due to the intense domination of culture and religious values in Indian society, India developed additional and alternate theories on mental health which were more acceptable and benefited the Indian environment (Sharma & Chadda, 1996). An example of such alternate theories is the Ayurvedic treatment of mental and psychiatric disorders.

Ayurveda is a form of medical care which emerged in India 3,000 years ago. It focuses on a natural remedy technique as it believes the illness occurs because of distress or disparity in the patient's consciousness (Johns Hopkins Medicine, n.d.). Hence, it adapts a spiritual strategy by bringing a positive balance to one's spirit, mind, body, and identity. Terms such as 'doshas' describe the emotional instability or psychological disruptions caused by the negative thoughts and feelings in the mind, leading to depression, anxiety, insomnia and more (Wig, 1999). The treatment for mental disorders in Ayurveda is based on a) balancing the digestive system of the body, b) examining the waste (urine and stool) passed and the functioning of the organs, and c) connectivity between the soul, intellect and parts of the body using herbal medications, spiritual awakening, practising mindfulness or meditation, special diets, and massage therapies (Behere et al., 2013). As defined by Isaac Ray, "the art of pressurising the mind against all incidents and influences calculated to deteriorate its qualities, impairs its energies, or derange its movements" (Mandell, 1995), hence Ayurveda aims to satisfy its research based on these frameworks. However, after years of research and careful investigation on Ayurveda, the herbal drugs often fail to achieve the desired results, and the treatments do not always showcase positive remedies, especially amongst serious illnesses such as Schizophrenia or severe anxiety disorders (Jaiswal & Williams, 2016).

1.2 Current study on India's mental health

Following WHO, the latest statistics showcase that around 20% of Indians suffer from mental health problems, of which 56 million have been diagnosed with depression, and 38 million have anxiety disorder (Rana, 2021). According to a study issued in the Lancet (an

accomplished medical journal in England) in 2021, India experienced a 35% rise in mental health disorders, resulting in the demand for immediate mental health services (Nawab, 2022). Since there are only three practitioners for every hundred thousand persons suffering from mental health problems, the supply of services was left unfulfilled due to the severe lack of mental health practitioners in India (Rana, 2021). The second dominant cause of death in 2019 was all types of mental disorders, and the tenth significant cause was self-harm and anxiety disorders (Dandona et al., 2018). Many states in India confronted a 40% spike in the rate of suicides between 1990-2016, deducing it to be the third major cause of death (Dandona et al., 2018).

Suicide due to mental distress was recognised as the leading cause of death amongst the youth (15-29 years) as India recorded the rate of suicide for every hundred thousand persons as 15.7, which was more than the worldwide average of 10.6 (WHO, 2016). The situation of suicide among Indian students is astonishing, with more than 26,000 students killed by suicide in 3 years which accounts for one suicide each hour (Bhattacharya, 2018). Further investigation displayed involuntary career decisions or failing examinations, which exhibited intense mental pressure on the students (Bhattacharya, 2018). However, studies also report that India's older population is likely to suffer from depression and anxiety disorders, while developmental and behavioural disorders affect the younger community (Rana, 2021). These studies showcase the unavailability and lack of importance given to mental health in India, even after recording severely high numbers of people suffering from the disorder.

Predominantly, India has one of the highest numbers of mental health disorders worldwide yet lacks gravely to provide the needed services. For a population of more than 1.4 billion people, there are less than 7,000 mental health practitioners, including psychologists as well as psychiatrists, which led the current President Ram Nath Kovind to label the mental health situation in India as a 'mental health epidemic' and emphasised on the instant requirement of medical facilities for the patients of mental disorders (The Economic Times, 2017). Therefore, statements from a governmental authority displayed a recognition of the problem and the desire to improve India's mental health amenities.

The Observer Research Foundation (ORF) found that in accordance with the population and the growing need for mental health specialists, India needs more than 27,000 mental health service providers, while presently, only 700 psychologists graduate each year (Nawab, 2022). Hence, the statistics show that more than a hundred thousand mental health practitioners need to support the situation. However, achieving such estimations will take more than 45 years of persistent education and training of psychologists (Nawab, 2022). Therefore, it is highly evident that actions must be taken concerning the extent of disinterest amongst the Indian community to consider mental health as a career option. Thus, observing the necessity of mental health protection services, the Government of India in 1982 had initiated the National Mental Health Programme (NHMP), but due to negligence and slow progress, it had to be reinforced in 2003 with contemporary healthcare institutions, improved research, stronger psychiatric team, and skilful mental health practitioners (Wig & Murthy, 2015).

The NMHP constituted policies to encourage mental health, provide attainable and affordable mental care and spread awareness amongst society by validating the concept of mental health (Mishra & Galhotra, 2018). For instance, in 2017, India recognised suicide as an act of crime and penalised it under Section 309 because the Mental Healthcare Act passed in 1987 did not acknowledge the rights of mentally ill people and the Act was amended to create healthcare for the people with mental disorders (Mishra & Galhotra, 2018). Therefore, positive changes were being established in the country to create a safe space for the Indian community, as mental instability does not only affect the person but also the individuals surrounding the patient.

The operation of NMHP was effortful and impressive, but its impact could have been faster and more effective. The division of different departments lacked teamwork; the healthcare centres were heavily understaffed, displayed amateur skills and needed an authoritative command over their actions (Van Ginneken et al., 2014). Although, the key obstacle was the scarcity of funds. Even though the budget for the fluent working of the NMHP was more than 900 million per year, the organisation did not spend more than 50 million yearly, which displayed underconsumption and fallacious finance application (Ministry of Finance, 2021). Furthermore, the budget in 2019 was reduced by 100 million with no clarifications (Ministry of Union, 2021), demonstrating future financial and health liabilities for the country's economy. The degradation of NMHP had much to do with the lack of awareness in Indian society and the stigmas attached to mental health (Gupta & Sagar, 2018). Therefore, India has yet to achieve a credible and accepting approach towards mental health. Hence, it has become essential to scrutinise the reasons it fails to achieve that. Consequently, the following section aims to satisfy these grounds of exploration.

Another critical input of this study is addressing the gap in the literature referring to India's mental health status. As mentioned above, there are existing studies which statistically present the need for India to advance its mental health provisions and display the prevailing amenities; however, this current paper aims to provide an empirical analysis of the academic curriculum in schools and the training and qualification factors of psychologists which operate towards abolishing stigmas and myths attached to mental health in India. It is essential for more literature to address the significance and themes of such qualifications or the presence of a regulatory body to provide licensure to the existing psychologists. Therefore, the main aim of this study is to address this situation through the governmental, educational, and social lens.

1.3 Reasoning India's approach to mental health

As stated earlier in this chapter, India has constantly improved its mental health facilities and policies. However, it is still deprived of changes due to its illiteracy on mental health. Moreover, "Beware of false knowledge, it is more dangerous than ignorance," stated George Bernard Shaw (1946), highlights the hazards of misunderstandings and delusions, which signify India's distorted assumptions about mental health as fabricating a damaging environment for psychological well-being. Since its social norms and conventional opinions heavily influence India, this section explores the cultural grounds for generating deceiving information on mental health and stigmatising mental health.

People suffering from mental health in India are repeatedly labelled as 'mad', 'insane', 'out of one's mind' and so forth by society (Hussain, 2021). They exhibit insensitive and oblivious behaviour towards the issue, which forces the patient to endure feelings of shame and solitude (Hussain, 2021). Hence, it has become mandatory to ask why the need for a psychologist is considered a humiliating idea or a requirement only for the manic by Indian society. Unlike the West, the structure of the Indian community relies mainly on collectivism which lacks personal boundaries and experiences a loss of individualism because of substantial dependency, attachment, and family harmony on the cost of self-direction, consistent cooperation, and blinded acceptance (Mullatti, 1995). This can be demonstrated using the Hofstede Cultural Compass' (2010) score on India and the United Kingdom's (UK) individualism, in which India scored 48 while the UK scored 89. In this test, India's lower score than the UK exhibits how India builds its relationships and decisions collectively while the British display an individualistic or private attitude (Hofstede, 2010).

Furthermore, personal freedom and space are not regarded in relationships hence, putting others first is accepted and expected out of habit (Markus & Kitayama, 1991). As a consequence of such traditional notions, individuals in distress hesitate to seek mental health as the family concludes it is an act of weakness or disgrace to the family (Patel & Saxena, 2014). Thus, there is a definite advantage of having family support when enduring mental health issues. However, withstanding a deeply involved family structure and ignorant and misconceived presumptions on mental health can be overwhelming and unfavourable for the sufferer. Studies show that constant overstepping on personal boundaries can lead to anxiety and obstruct a person's mental well-being (Roy, 2021).

However, the most applied misconception of Indian society is that they confide in religious temples and prayers instead of psychologists for mental health treatment and analysis. Indian medical sciences have an ongoing conflict with religious groups; the victors are usually religious shrines (Kennedy, 2010). More than 75% of Indians prefer religious healers to cure mental disorders such as Schizophrenia or developmental disorders with prayers and holy practices instead of seeking medical aid (Khandelwal et al., 2004). In her paper, Miranda Kennedy (2010) mentions that the widespread use of 'temple doctors' seems impossible to be ignored in India. This societal domination can be spotted as the result of the "what will people think" mentality, which has taken away the power from professional psychologists and led to the rejection of their competence.

Therefore, lack of awareness seems to play a massive role in India's false labelling of mental health. As discussed, society is judgmental and unsupportive towards the mentally ill; hence, families or individuals are inclined to seek advice from the family itself or disregard their symptoms. For instance, Schizophrenia can be triggered due to traumatic events and is also genetic; however, studies show that people with Schizophrenia in India are deeply misunderstood, and their symptoms are often coupled with 'possession of evil spirits' or 'God is punishing them for their sins' (Akundi, 2019). Thus, treating mental illness like any other disorder under professional medical supervision is vitally important.

The presented study's objective is to explore the rationale behind India's approach towards mental health over the years and how these influences would impact the future of mental care

in India. However, this investigation aims to achieve its review through the lens of Indian mental health practitioners to gain a first-hand insight into the situation. The goal is to generate the latest notions and simultaneously debunk the negative orthodox standards of remedies. The research would use thematic analysis and semi-structured interviews of the practitioners to perform the investigation. Lastly, the qualitative data would assist in identifying the causes, solutions, and structure for the future of India's mental health. The focus of this study is to discover:

1. Why is India, in the 21st century, still a victim of intense stigmatisation and ignorance of mental health?
2. What is the scope of India achieving better mental healthcare in the future? If yes, what measures can help attain the same?

2. Methods

2.1 Ethics

The credibility of qualitative research is highly influenced by the standards of ethics registered for the study (Fossey et al., 2002). Since the study was qualitative and the data collection method was to interview, it was necessary to contemplate specific ethical considerations considering the sensitive information shared during interviews. When

reviewing ethics, the interviewee's anonymity remains a prominent concern (Francis, 2009). Therefore, all interviews were carefully transcribed and used pseudonyms to maintain the anonymity of the interviewees.

The ethical approval was authorised by the School Ethics Committee of the University of Glasgow (Appendix 2). All participants were over 18 years old and were asked to participate in the study voluntarily. If there was any discomfort or hesitation to engage, they were given the freedom to pull out of the study. Participants signed a consent form which elaborated on the contents of the ethical application. A sample of the signed consent form is attached to the Appendix 3. The form contained basic information about the researcher, such as their occupation and degree programme. It also informed the participants regarding the reason and use of this study with a description of the project. Principles on handling and protecting sensitive information disclosed during participation were set forth. Lastly, to ensure complete data security, the transcriptions and participant data were only accessible to the researcher and supervisor.

2.2 The Approach

This study used a qualitative approach to explore the stance on mental health in India from the Indian practitioners' point of view. A qualitative approach for this paper was selected as it admitted questions which allowed the researcher to gain a more robust and deeper understanding of the experiences and circumstances of its participants, which was essential for a unique perspective (Cleland, 2017). Semi-structured interviews were executed, and the data was collected to explore the topic further. The aim was to accumulate each participant's

distinctive happenings and learnings concerning the research subject and find commonality for further analysis. Even though in qualitative research, the relationship between the researcher and the participant is not as formal as it is in quantitative research (Pathak et al., 2013) yet a prime limitation of the qualitative study was the unfamiliarity between the researcher and the interviewee, which could result in biased or uncandid answers (Whorton, 2016). Therefore, a few rapport formation questions were specially set for the interview to reduce the loss of genuineness and originality in the answer of the participants. The aim was to eliminate any motivation of the participants to please the researcher and only answer candidly and straightforwardly. This would lead to more accurate data for the research paper.

To determine and analyse the different notions responsible for the current mental health situation in India, using interview-based qualitative research gave voice and expression to the participants, which allowed this study to receive first-hand, fresh, critical, and descriptive perspectives (Gibson et al., 2004). Furthermore, it recognised a diverse set of opinions which could help develop novel ideas and characteristics for future research and give the study more exposure. Applying this idea to my research, I uncovered the latest principles and concealed rationales attached to mental health in India, which were not explored in previous studies.

2.3 Participants

It was necessary to proceed with a qualitative approach using interviews as the research method, to set a suitable recruitment process. Since this research established the ground of India's mental health, I decided to select participants who rightly understood and experienced direct association with mental health. Therefore, Indian mental health practitioners were the leading choice as they were a part of the mental health community in India and could share

their happenings, giving the study an internal understanding of the subject. Therefore, a combination of selected sampling and a brief analysis of the participant's spirit was used for the recruitment process (King & Hugh-Jones, 2019).

Participants were recruited using social media portals such as WhatsApp and Facebook groups designated for mental health practitioners. A message was sent to all the practitioners on the social media groups requesting the participation of the ones interested in offering their insight on the topic of study. To my amazement, several practitioners reached out to participate in the study since they were intrigued by the topic and believed in its significance. However, a small sample involving only seven participants was enlisted to conduct an extensive analysis of the gathered data. In a qualitative study, participants are identified as "responders" and not mere subjects; therefore, they bring truth and authenticity to their answers (Maxwell, 2012). Consequently, I decided to choose a small sample for this study to achieve the genuineness of the study with an attentive approach.

The recruitment was settled by sending an invitation letter of participation via email to the participants, to which they were asked to send confirmation hence involving them in the study. To satisfy the paper's analysis, the recruited participants were all practising mental health in India. However, I selected seven participants from different parts of India to achieve a more diverse and unabridged data. All seven participants were practising and professional mental health practitioners. A detailed demographic information of each participant is provided in Table 1. Most were counselling psychologists, some were clinical psychologists, and there was one philosophical counsellor. A follow-up message was also sent to the social

media groups, thanking the rest of the practitioners for their enthusiastic interest in participating in the study.

Table 1.

Displaying the profiles of all seven participants

	Pseudonyms	**Age**	**Gender**	**Profession**	**Location**
Participant 1	Rosy	29	Female	Counselling Psychologist	Delhi
Participant 2	Tehreem	31	Female	Philosophical Counsellor	Chandigarh
Participant 3	Ankit	28	Male	Counselling Psychologist	Chennai
Participant 4	Asha	29	Female	Clinical Psychologist	Bangalore
Participant 5	Riya	27	Female	Counselling Psychologist	Chennai
Participant 6	Mehak	27	Female	Counselling Psychologist	Mumbai
Participant 7	Eesha	36	Female	Clinical Psychologist	Delhi

2.4 Interviews

The target of my data collection was to attain the individualistic viewpoints of the practitioners from their personal experiences with their clientele and the detailed inspection of understanding society's outlook and psychological response towards mental health. To achieve such elements with utmost quality, semi-structured interviews were the most appropriate choice for the paper as they encouraged an expressive statement style (Hiles et al., 2017). Even though qualitative research includes methods such as a focus group or case studies, they were not suitable for the current research paper as they implemented a group study or a particular case study respectively, which would not have satisfied each

practitioner's unique standpoint on mental health in India or provided the researcher with a chance to execute an uninfluenced and uncensored discussion (Sutton & Austin, 2015).

Interviews were set online as a one-on-one discussion with the researcher. The structure and development of the in-depth interview were created using the guide by Adeoye-Olatunde & Olenik (2021). For instance, the goal of each question was to address the purpose of the research paper, and the arrangement of the interview started with opening questions to build rapport with the participants and further raised detailed questions in relation to the topic with frequent follow-up questions. This semi-structured approach allowed an honest flow to the discussion between the interviewee and researcher, producing an exclusive dialogue with every interaction.

The interview was carried out via Zoom Video Communications, and the invite was sent to the participants in their emails. The email also contained the consent form which the participants were required to sign and send back as it offered written consent from the participants permitting them to participate in the current study willingly. The questions asked during the interviews can be found in the Appendix 1 for reference. Before the interview call, the participants were asked if they had a free and stable internet connection. They were also reassured that they attended the interview in a private/secure space. However, participants were informed that in case of a loss on the internet, the interview would be paused before it could reconnect and start again. The Zoom call was recorded to detain the data productively and avoid overlooking any dialogue for an efficient investigation (Adeoye-Olatunde & Olenik, 2021). Questions were not given out to the participants before the interview to contain the originality of the interview. The duration of each interview was 20-25 minutes

long, with the first 3-5 minutes assigned to rapport formation. The Zoom call was recorded and transcribed for further generation of codes, hence performing thematic analysis. To maintain accuracy, no auto transcription was used; hence, the researcher completed it manually. During the transcription anonymity of each participant was protected, and pseudonyms were used in place of any leading information.

2.5 Methods and Strategy of Data Analysis

Data analysis is one of the most complicated and crucial stages of qualitative research and the one that is given the least attention in research (Thorne, 2000). For a credible research paper, it is essential to elaborate on how the research was analysed and the method used for it (Braun & Clarke, 2006). This paper selected thematic analysis to scrutinise the collected data and acknowledge the research question. Since the research question demands a combination of descriptions and insights of the Indian society on various grounds of their mindset revolving around the situation of mental health, it is vital to use an analysis which can construct perspective and original discoveries (Braun & Clarke, 2006) which is signified by thematic analysis.

Even though other analytical methods are used in a qualitative study, such as content analysis or groundwork theory, thematic analysis satisfies the current study with its ability to extract predominant themes from the gathered data. To elaborate, content analysis also builds new information from the data like thematic analysis; however, it constructs its research by deducing the information into keywords and examines existing literature and theories, while thematic analysis designs meaning by drawing out efficient and fresh ideas (Nowell et al.,

2017). Keeping in mind the demand of this study, it was critical to incorporate an investigation that assets correlation between the themes and develops a deep understanding of the same.

The interviews were then transcribed to complete the process of data collection. The transcribed data was used to conduct a thematic analysis. Going over the data repeatedly and recording the initial ideas and interpretations added to building initial codes for analysis. Familiarisation with the transcribed data is crucial for the researcher to build thorough and extensive codes (Braun & Clarke, 2006). The potentially applicable codes initially generated were further combined into groups to form themes (Braun & Clarke, 2006). According to Aronson (1994), themes are coherent once assembled on account of similar objectives or standpoints. Re-definition, perfection and a detailed exploration of the themes were undertaken by identifying the key subjects to achieve the final themes. For a researcher, it is crucial to review each theme and its relevance to the research question (Braun & Clarke, 2006). Therefore, significant reports on the themes were minded before establishing the final themes.

2.6 Researcher Reflexivity

This section depicts the reflectivity of the researcher and how it affected the research paper. According to Brinkmann and Kvale (2008), the researcher's reflection on their contribution to the paper brought objectivity to the study and the interview execution. During the interviews, I was watchful of asking 'leading' questions which could misguide the participants' responses or influence the nature of the conversation, creating an inexpressive space for the participants. The participants consisted of professional mental health practitioners who were

profoundly knowledgeable in their field, which slightly impacted my confidence and left my feelings of intimidation since I am still pursuing my master's degree. However, by training my reflectivity, I directed my intimidation into investigating the well-informed experience of my seniors and asking the right follow-up questions for a better research analysis.

Additionally, my cultural similarity with the participants was an advantage to the analysis and data collection. It allowed a more profound, quicker, and more substantial understanding of the insights and sensitive topics accumulated for the analysis. As a researcher, it is natural to have preconceptions and assumptions while taking an interview but to ensure accuracy in data collection; I followed the study of Willig (2017), which commends the researcher for examining their deductions and being adaptable during data analysis. Hence, during research, I would reflect on my thoughts while building unprejudiced data from the participants for analysis.

Lastly, the motive for using thematic analysis was attached to its accessibility and straightforwardness. Since this is my second research paper, thematic analysis was the leading choice for data analysis. From Braun and Clarke's (2006) point of view, thematic analysis offers a more obtainable grasp than other qualitative methods due to its uncomplicated procedures.

3. Results

3.1 Overview

This research study aims to investigate the shame attached to mental health in India, elaborating on the various factors preventing or reducing awareness around it and the scope of progress amongst the Indian society towards mental health by applying the viewpoints of Indian practitioners. This section will focus on displaying the findings using the data collected from the semi-structured interviews of the Indian practitioners. Its primary operation was to perform thematic analysis on the assembled data and carefully explore each participant's narratives. The thematic analysis would be accomplished by applying the six-step guidelines by Braun and Clarke (2006), which helps identify patterns and put them into perspective.

The first step of the six-step thematic analysis was to familiarise oneself with the data. Therefore, the interviews of the practitioners were re-watched, and the transcripts were read repeatedly to register their conceptions. Since most interviewees had their video on during the interview, it was possible to identify the non-verbal communication and register the facial expressions. Subsequently, connotations and notions were extracted and organised into a significant, structured framework labelled 'initial codes'. The initial codes were further investigated and interpreted into 'themes'. For instance, several initial codes were generated discussing the budget and financial responsibility of the Indian government on the institutions and services for the mentally ill. Hence, these codes were categorised into an initial theme termed the 'Government's funding on India's mental health'. The fourth step of the analysis was to review the themes. Therefore, this phase questioned the importance and accuracy of

the data of each initial theme. After attentive scrutinising, final themes were introduced. For example, the initial theme, i.e., 'Government's funding on India's mental health', lacked enough data; thus, it was re-grouped as a sub-theme to 'Government's role towards India's mental health'. As Braun and Clarke (2006, p.92) describe, identifying the 'essence' of each theme is crucial. Hence, a final table was created, capturing the character of each theme and sub-theme and organising it into a structure, making it easier for the researcher to analyse. Finally, an overview is provided for each theme to achieve an elaborative discussion of the research.

These themes intend to answer the queries this research study expects to acknowledge, such as why India ignores and stigmatises mental health and what awaits in the future of India's mental health. The study generated four themes with sub-themes attached to each. The table below displays an outline of these themes and the sub-themes (Table 2.). Furthermore, each theme and sub-theme will be explained and analysed independently.

Table 2.

The themes and sub-themes for analysis

Themes	**Sub-themes**
Stigmas attached to mental health	False beliefs and myths creating incorrect notions seeking help from religious values and God community driven Indian families lacking boundaries cultural shame attached to mental health
Lack of psychoeducation	absence of awareness about psychologists lack of opportunity and wages

	introduction of mental health in schools
Government's role	discussing the government's budget and services for mental health government's duty of providing mental health amenities like insurance improving psychological research addressing the issue of misdiagnosis
Scope of mental health in India	post COVID acceptance of mental health development of educational and professional space in psychology role of a governing body such as RCI (credibility) impact and role of social media and celebrities on mental health younger generation vs older generation for therapy lack of awareness in lower income groups and cities

3.2 Main themes and Sub-themes

3.2.a. Stigmas Attached to Mental Health

False beliefs

The theme 'stigmas' elaborates on a collective notion claimed by all participants as a factor influencing mental health in India. All participants stated that Indian society is easily convinced by false beliefs set historically and culturally in the nation. Each participant expressed the misconceptions they had witnessed from their clients or society.

For instance, Asha stated, *"the stigma attached… it's usually not seen as a point of self-care…sometimes people can be like, oh, what do you need therapy for…therapy is still seen as … something has to be extremely wrong with you to go to a therapist."* (Asha, line 107-119).

Also, Rosy shared, *"As a society we're kind of like … we have to push through… if you're sad, you're sad… this is life…the colloquialism of words such as 'paagal' (mad)."* (Rosy, line 72, 73, & 128).

Therefore, many participants asserted concern about attaching words like 'crazy' and 'mad person' to people suffering from mental health issues.

Religion and Culture

Participants also addressed how India's idea of religion and culture assign stigmas to mental health. Culturally speaking, participants declared India as a community-driven society that neglected boundaries and was heavily cautious of its reputation.

For example, Rosy said, *"stuff that is happening at home should just stay at home…whatever you were facing was not as important as how good you look…or the sort of front you have in front of other people."* (Rosy, line 120-123).

Additionally Eesha claimed, *"You'll get to hear…my family doesn't know because they'll think you have to be really crazy for taking therapy or they'll start mocking me or there will be embarrassment, or I won't get jobs."* (Eesha, line 95-99).

Claims such as these displayed hesitation, humiliation, a hush-hush school of thought and an overbearing attitude towards talking or seeking help for mental health. Few participants were further asked to elaborate on some reasons for such embodied notions and conservative viewpoints of most Indian families. Some affirmed religion as one of the primary grounds to stigmatise mental health, and others mentioned the belief of Indian society in demonic existence. However, participants also observed that religious and demonic manifestations were typically among the lower-income groups. However, the public image's safekeeping was seen in both higher- and lower-income groups.

For example, Tehreem reported, *"this is where God comes in…praying would bring you peace…you always pray because you know that God is going to take care of you, a lot of people make themselves okay with these kind of belief systems."* (Tehreem, line 113 & 122).

In addition, Rosy commented, *"the religious aspect kind of makes us believe…God is going to get us through things… it's fine…we need to be grateful for what we have."* (Rosy, line 112-116).

Moreover, the interviews asserted the Indian society's association of mental health disorders with the possession of evil spirits.

As explained by Mehak, *"therapy myths exist in India…it being associated with ghosts…when someone is either having delusions or when they are schizophrenic it's usually associated to them being possessed by a spirit."* (Mehak, line 41 & 68).

The interviewee, Mehak, also raised the link between culture and religion when catering to such notions. She underlined the misbelief of evil spirits causing mental illnesses to the religious connotations of spirits, which were also reflected in the interviews of other participants.

To give an example, Mehak detected, *"it is similar throughout the cultures and religions…for a Hindu someone who is delusional plus for a Muslim someone who is delusional could be the same."* (Mehak, line 70-72).

Therefore, participants showcased sincere concern towards India's flawed and out-dated approach to mental health due to the faulty and conservative ideas circling society. The participants also displayed dissatisfaction and misfortune towards their professional careers in connection to such deep-rooted Indian concepts.

As evidence, Riya stated, *"it is very necessary to take care of your mental health…but…knowledge of this fact is extremely poor in our country… and it's very difficult to convince people about it in our country, I think it's like that."* (Riya, line 42-48).

3.2.b Lack of Psychoeducation

Psychoeducation

All participants displayed unanimity and like-mindedness towards India lacking essential mental health and psychological well-being knowledge. They discussed how most of Indian society was utterly unaware of the symptoms, diagnosis and fundamental concept of mental health, which created a massive bubble of ignorance leading to an unprogressive mental healthcare.

Ankit stated, *"it's not serious work, it's not actual job… it's just listening… it's social work… you're helping people, you're doing it out of good faith…why are you making business out of it…why are you earning money."* (Ankit, line 98-102).

Furthermore, Riya attested, *"when I say things like this is how much I charge a lot of people are like why? You're just sitting there and listening, there's not much to do…the amount of hard work that goes into it, people don't realise."* (Riya, line 49-54).

Practitioners also declared common consent on the biggest challenge of professionally practising psychology in India: the obliviousness of mental health in India. The ignorance led to challenges such as lack of opportunity, insufficient wages and societal misinterpretations.

For instance, Rosy stated, *"places want experienced people, but they won't give experience…so who is going to hire who? How are you going to choose someone to hire if you want someone with experience already…it makes it really murky."* (Rosy, line 49-53).

Furthermore, Riya stated, *"people know what an engineer does…doctor does…teacher does…so they get a lot of respect and we don't, for me this is the biggest challenge…they feel it's not required."* (Riya, line 54-62).

In addition, Asha declared, *"therapists are not as well paid as in other countries and other places."* (Asha, line 59 & 60).

Schools

Participants strongly reported the need to inculcate mental health as a part of the school curriculum. In addition, they announced confidence in including school counsellors or mental healthcare for the children and parents in school to inflate awareness. Expectation from society and aid from the government towards this scheme was set forth.

Tehreem suggested, *"School is the first place where the learning takes place essentially…so the child…if they want to talk to someone about their problems…can talk to someone and they can have a safe space which is not shared with parents…also awareness programs could be conducted in schools for students and for the parents also."* (Tehreem, line 188-199).

And Rosy asserted, *"making mental health a part of the education system…we are very very terrible the way we treat school counsellors."* (Rosy, line 161-164).

3.2.c Government's role

Economical factor

All participants, when asked about the government's role in India's mental health, raised concerns about the budget set by the Indian government for it. They claimed that the amount of finances for the mental health sector compared to the population in need of those services was severely low.

For example, Mehak insisted, *"Budgeting more money towards this sector because that is where a huge lack happens and also the distribution of that budget has to be properly done…there is definitely a lack from the government."* (Mehak, line 113-126).

Further, Ankit added, *"there is no major government support…there are no social security nets or safety nets for us to rely."* (Ankit, line 21-23).

Participants presented an evident objective from the government for better facilities and care for mental health to ensure awareness, importance and necessity. Also, the significance of providing insurance and financial amenities to the mentally ill was a shared notion amongst the participants.

Like Rosy discussed, *"if the government was more involved, if they were offering insurance… it's a game changer because right now people think therapy is luxury…not necessity."* (Rosy, line 82-86).

Also Asha added, *"The government budget is so less for mental health in India, that has to be expanded, policies have to be expanded."* (Asha, line 144-145).

Research

Another difficulty the practitioners discussed was the absence of examination for contemporary mental health services and research for new psychology concepts in India. Many stated the contrast between the notions of West and Indian concepts. Therefore,

participants reasoned the use and execution of service policies and studies from an Indian outlook.

As Rosy said, *"all the research has happened in the West…so the actual education and knowledge obviously has happened in the West…and then it trickles down to us…we still have to accommodate it to…dialogue that would fit the Indian narrative."* (Rosy, line 102-107).

The participants also exhibited the government's duty to advocate mental health research and set criteria to avoid misdiagnosing people with mental disorders. The use of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Indian patients was questioned by a few participants. The rest criticised the structure of diagnosing in India, referring to it as incompetent and weak.

For example, Tehreem expressed, *"I would really like them to set standards for diagnosing because if you check…the percentage of misdiagnosis in India in terms of mental health, the number is surprising, you would just be taken aback…and these are the reported cases I am talking about."* (Tehreem, line 174-180).

Moreover, Mehak stated, *"our psychiatrists and psychologists really heavily rely on ICD and DSM which I think is not working out very well for us clearly… plus also the amount that it takes to get a diagnosis, add to that the limitation of services." She also added, "studies for diagnostic criteria…is not done in context of our sense of living, our cultures, our definition of life."* (Mehak, line 215-222).

Overall, participants proposed absolute government participation towards mental health in India to gain public awareness, better services and more substantial policies.

Eesha stated, *"as individuals we look for sources that have power…if the people in power are not doing anything about it, why would the general public raise awareness around mental health."* (Eesha, line 128-136).

3.2.d Scope of Mental Health in India

Extent of Acceptance

Participants revealed factors and citations leading to a positive change in people's attitudes towards mental health in India. One of the most common factors disclosed by the participants was the period after the 2019 pandemic, i.e., coronavirus or COVID. According to the interviews, the pandemic, which led to a global quarantine, made the Indian society realise the effects or dangers of mental health and its importance. Participants shared their experiences in relation to the increase in clientele and awareness about their profession after COVID, which was severely lacking before.

Ankit testified, *"a more positive approach towards help seeking behaviour is coming in…it has a lot to do with the pandemic…after that we as a society have become slightly more receptive at least to the idea that we can talk to someone."* (Ankit, line 46-50).

Also Riya attested, *"Covid made people realise there is something called mental health…mental health does exist…everybody went through some mental health issue or the other during covid…people realised the need."* (Riya, line 122-128).

Furthermore, acceptance was also noted in providing education and professionalism to future Indian psychologists by some interviewees. They elaborated on the advancement of college programs and the introduction of workshops to improve the skills of mental health practitioners.

For example, Riya discussed, *"more courses are being introduced, more universities are providing a degree in psychology…more people trained."* (Riya, line 150-153).

She also mentioned, "during covid…more courses on psychology that came about since 2000, so therefore more psychologists, therefore more people talking about it." (Riya, line 126-135).

Even though participants showcased positives concerning the educational advancements for students considering psychology as a profession, they also displayed the drawbacks. Participants raised concerns about the need for more expertise and resources with the educational systems.

For instance Rosy informed, *"education here is not universal…some colleges in masters…they will start having students practise with supervision, my college didn't do that, a lot of colleges don't do that, so our first interaction with clients is directly a professional*

set-up…a lot of inconsistency…I went in feeling very unprepared into the field." (Rosy, line 19-25).

In respect to this, participants raised another crucial point when asked to discuss the essence of clinical psychologists, counselling psychologists and psychiatrists in India. The credibility of the psychologists was noted, highlighting the importance of a regulating body in India for mental health. Participants informed about the prevalence of such a body, i.e., the Rehabilitation Council of India (RCI) for the clinical psychologists, but displayed displeasure as it did not certify counselling psychologists.

For example, Ankit said*, "in psychology we are only technically relying on clinical psychologists, psychiatrists are in medical science, so we have put huge responsibility on these two kinds of people…we need to include other psychologists as well…counselling psychologists are only employed in the helpline the government has set up… that's it."* (Ankit, line 126-153).

He also added, *"we created the national allied healthcare commission…technically a governing body…but it doesn't do much of the accountability work… as much as BACP or ACA or even in Scotland they have their own body."* (Ankit, line 174-178).

Social Media influence

Participants in their interviews had a mixed review on the influence of social media platforms on mental health in India. While some provided the researcher with a positive outcome of social media on the awareness and upcoming young psychologists in India, others presented a disapproving viewpoint towards the content on social media and the perspectives of celebrities about mental health; thus they believed that the social media misconceived the notions of psychology.

For instance, Tehreem mentioned*, "movies that are being made on it, in order to spread awareness and social media is playing a huge role…young therapists/psychologists are really doing their bit who have their private practice in terms of spreading awareness."* (Tehreem, line 234-239).

But on the other hand, Eesha stated the negatives of the same, *"if a celebrity is talking about mental health concern…we need to understand that we are providing very half-baked knowledge to people…if I start giving interviews on depression…I am talking to a society that has absolutely no knowledge…as a celebrity the person is doing their bit…but society has no idea what depression is…so you start following blindly."* (Eesha, line 158-173).

The importance of mental health amongst different demographics

Participants presented another essential domain to measure the scope of mental health in India, focusing on a more demographic approach. Most participants revealed that the younger generation was more interested in and aware of therapy than the older age group. They stated

that even though the older generation needed mental health support more than the upcoming generation, it was witnessed that they were far more receptive towards acknowledging and actively spreading awareness on mental health too.

For instance, Riya mentioned, *"mainly in older generation…stance is you should handle problems by yourself…why pay someone else to handle your problem. People who are below 40-45, nearing to our generation, are more understanding and want to go to therapy more."* (Riya, line 108-117).

Rosy also stated, *"I think the younger generation are still like we need therapy…millennials are still going to therapy but the generation above which possible has the most trauma, they don't address… and that becomes an issue because…it is passed down through generations."* (Rosy, line 75-80).

However, aside from the age group, most participants claimed that the economic disparities in India played an influential role in the mental health sector. The interviews displayed a consensus among the participants on how the lower-income groups were wholly ignorant and deficient in mental health services. Participants also condemned that these disadvantaged groups established and performed most of the misconceptions, especially religious myths.

For example, Tehreem explained, *"people from lower-income groups who aren't aware of these practices…due to lack of resources…and have a very typical mindset when it comes to mental health."* (Tehreem, line 108 & 127).

Meanwhile Eesha claimed her thoughts on therapy, *"somebody who belongs to the lower would not be able to afford it…the only two segments of the society that can actually afford is…upper class…majority of population gets excluded."* (Eesha, line 61-68).

Lastly, it was noted by almost all participants that there existed a disparity in mental health awareness and services between the different cities in India. They stated that while the urban and more developed cities benefited from the accessibility, recognition, societal support and open dialogue for mental health, the non-metropolitan cities did not profit or attend to such mental health facilities.

For example, Tehreem mentioned, *"in metropolitan cities, yes there is a good response because people are aware these days, people are open towards it."* (Tehreem, line 131-134).

Furthermore, Asha stated, *"remote villages or cities, they might not have the best psychologists because opportunities are very restricted…psychologists are only restrained to those in metropolitan cities or where jobs are easily available…not easily accessible."* (Asha, line 167-173).

4. Discussion

Introduction

This research study answers the research questions presented in the introduction, which aim to scrutinise the stance on mental health in India from the viewpoint of Indian practitioners

and dive into the factors leading to its positives and negatives. The research engrossed the experiences and insights of Indian mental health professionals to attain a first-hand review for analysis. The revelation by the psychologists did not just focus on the people seeking mental health aid and the ones around them but also on the general public's idea of mental health and the circumstances, the psychologists encountered professionally. Moreover, it focused on the various elements such as the challenges, cultural notions, strict ideologies, responsibilities, public perceptions, and circumstances leading to the positives and negatives of India's mental health. This section aims to discuss the results obtained through thematic analysis, and its implications, interpret the data/draw connections and, most importantly, answer the research question. The section would also include a reflection on the strengths and weaknesses of the research, propose the future potential and present a conclusion.

The research questions demanded to elaborate on the various stigmas and unawareness attached to mental health, identify the causes of these conservative thoughts, evaluate the scope of India's growth towards mental health and its potential to abolish such obstructing systems and practices and locate measures for future advancement to build a healthier mental healthcare structure. To acquire the study's objective, seven mental health practitioners (clinical psychologists, counselling psychologists and counsellors) were recruited to provide their insightful perceptions of India's mental health by participating in the semi-structured interviews. Participants provided a candid one-on-one interview with the researcher, and each participant shared their individual story on practising psychology, being a therapist, especially in India and the several inputs they had from their professional and personal experiences.

Further, the interviews were studied and examined to fulfil the research purpose. Themes were constructed, which helped identify several patterns of correlation, evaluation and building categories for qualitative analysis (Braun & Clarke, 2006). Using this approach, the researcher produced a deeper understanding of India's standpoint on mental health. The viewpoints included governmental, societal, educational, and professional opinions.

Discussion of Themes

In this part, the alignment of the themes has been created by considering the importance of each theme and the connection between them. For the flow of discussion, several factors discussing India's mental health would be divided into four platforms: cultural, governmental, educational, and developmental. Each section will examine the research question using the findings from the data analysis and by exploring several literatures for the same.

Cultural:

As mentioned in the introduction section, the historical myths and influence of cultural and religious stigmas attached to mental health are one of the primary causes of the lack of awareness and poor mental health understanding in India. The practitioners also seemed to raise concern around such stigmas as it impedes people to seek help. Even though the Indian culture believes in protecting its own and operates around a community-driven society, instead of effortlessly accepting mental health issues, people are afraid to display their problems to avoid judgements and adhere to such stigmas (Math & Srinivasaraju, 2010). According to a survey of Indians between the ages of 15 and 60, none of the psychiatric symptoms or mental disorders were identified, acknowledged, or understood by them (Gaiha

et al., 2014). Hence, this showcases how the stigmas are embedded amongst all age groups, leading to immense illiteracy towards mental health. For instance, a person showing symptoms of dissociative identity disorder would be given the aid of a religious shrine instead of a psychologist.

As identified by the participants, India's belief in religious and spiritual practices can be dangerous towards mental health issues; thus, this study brings forth the importance of addressing these practices. This can be elaborated using the mass suicide case in India, which is a powerful example that mental health must not be kept a 'family secret' or 'hidden'. Eleven family members of different characteristics and ages decided to commit suicide by hanging themselves after believing they would achieve redemption and not death (Magan, 2021). The case's evidence captured several superstitious religious practices and diagnosed one of the members (Lalit) with a delusional disorder, which led to a shared psychosis amongst all family members (Ajayi, 2022). This horrific incident displayed that the chief reason for these deaths was India's stigmas towards not treating mental health problems and not discussing concerns outside the family (Magan, 2021).

After scrutinising the findings of this study, it can be deduced that since mental health problems are often ignored, and psychological disorders are misinterpreted as 'mad' or 'crazy' (Shidhaye & Kermode, 2013), it is necessary to create a framework of mental illnesses which suits the cultural system of India. India's culture is very different from the West and can reshape the perception of mental health disorders, which was also evident in the Burari case (Naraharisetty, 2021). For instance, Lalit's delusional disorder was interpreted as an act of demonic possession by the public and the Indian investigators (Naraharisetty, 2021). The relevance of doing away with India's cultural norms is essential for its mental health.

Governmental:

After reviewing statements given by the participants, it is evident that people in India are inclined to choose religious or spiritual treatments for mental disorders because most of them fail to afford psychological drugs or therapeutic treatments for the mentally ill (Kennedy, 2010). The Indian government does not provide aid such as insurance or financial amenities to needy patients or build mental health clinics, research departments, diagnostic centres, or awareness programs (Welle, 2022). Therefore, the underfunded mental health department faces a sincere lack of resources and services to abolish the stigmas and build educational divisions in India, which, as stated, are the root cause of India's deficient mental health (Shetty, 2023).

As mentioned in the literature of this study, NMHP was an initiative by the Indian government to improve these issues and build better mental healthcare facilities, but it was not entirely successful. However, most of the Indian community afflicted with mental health disorders resides in rural areas or is financially backward; thus, without any governmental aid, they cannot seek professional help (Psychologs Magazine, 2023). Therefore, it can be deduced that with better governmental support, India may have the potential to address mental health disorders increasingly.

Literature also revealed that Indians rely on spirituality, ayurvedic treatments or religious practices for treating mental health, therefore indulging leaders, and promoters with vast following to psychoeducate with professional psychologists or advocate the importance of

medical help for treating mental health disorders can be more prominent and influential (Shetty, 2023).

This study stated the various policies and acts initiated by the Indian government and their neglect; however, to achieve favourable outcomes of these measures, research displays that the government's approach to NGOs or the community reformers for creating awareness programs and provide efficient experience to the mental health service providers for further bridging the gap and encouraging early diagnosis (Sehgal & Kapoor, 2021).

Thus, this current study is convinced by the necessity for the Indian government's role and responsibilities towards implementing schemes for growth in mental healthcare and acknowledging that the Indian society heavily depends on it due to its inefficient, insufficient, inaccessible and, most importantly, unaffordable mental health services. As discussed, it is also essential for the government to focus on the educational sector of psychology due to the undersupply of practitioners; therefore, this study would focus on India's academic standards and scope of knowledge, qualifications, opportunity and dependability among the students and the psychologists.

Educational:

The primary concern regarding the education and training system of psychologists is the credibility and expertise of Indian psychologists. As discovered in the findings, India needs to regulate bodies and establish training structures for psychologists, except for the RCI, which only provides licences to clinical psychologists. The RCI licence provides psychologists with a standard for qualified and authoritative regulation to work for people with mental disorders.

It also takes strict disciplinary action against unlicensed or underqualified clinical psychologists (Moses, 2021). Such criteria are crucial to be implemented since supervising and managing the mentally ill requires experience, qualification, and professionalism (Moses, 2021).

However, intense, and dangerous mental health cases such as Schizophrenia, addictions or anxiety disorder have also shown successful improvement through counselling therapy (WebMD, 2021). Therefore, supervising counselling psychologists is also essential, but India, unlike other countries such as the UK or America, fails to admit a governing body. For instance, the UK has more than ten psychological governing bodies, such as the British Psychological Society (BPS) or the British Association for Counseling and Psychotherapy (BACP), which focus on providing a stamp of authenticity on completing a series of qualifications to not just clinical psychologists but counselling psychologists as well for ethical and high-quality services. Reports indicate that counselling psychology in India is at risk since a master's degree in psychology or any short-term course can qualify a person as a counselling psychologist who registers under-qualified and inexperienced counsellor (Matharu, 2023).

According to a case registered in the Karnataka (southwest state of India) high court, an Instagram influencer posed to be a therapist without any genuine qualification or certification and gave therapy online through her webpage, which led to the misguided conduct of the therapist (The Economic Times, 2022). Further studies reveal that India is facing various fake therapists who, without any qualification, are running websites and apps to provide therapy, which is dangerous for Indian society, which has only recently started to accept the notions of mental health (Matharu, 2023). Also, misdiagnosis and misguidance from an incompetent

therapist can negatively affect an already vulnerable person and create distrust towards therapy (Tripathi, 2023). Therefore, India must adopt practical experience and a standardised educational structure which proceeds beyond assigned course books and nominal training and legitimately regulates Indian therapists.

Additionally, the findings of this study also reveal the need to teach mental health in the school curriculum and inculcate qualified school counsellors for the kids. Participants raised genuine worry towards the situation of mental health in schools and the misuse of school counsellors in India. According to the National Mental Health Survey, the biggest group of children and teenagers in the world reside in India, where 7.3% were diagnosed with mental disorders (Ministry of Health and Family Welfare, 2016). Hence, the importance of providing mental health services in schools is an increased need, as ignorance can cause severe issues in children's development, social skills, and overall growth (Gaur, 2019).

However, India needs to fulfil this requirement. For instance, a survey of schools in Karnataka showcased that out of 101 schools, only 19 had hired school counsellors for their students (Gaur, 2019). Since research shows that 70% of mental health issues can be effectively treated with an early diagnosis, India must direct more diagnosis and mental care facilities to broaden the potential of mental health in schools (Stephan et al., 2007). Lastly, this research understands that increasing school counsellors and mental health studies in schools can reduce stigma, create more opportunities for an early diagnosis, reduce developmental disorders in children and give students a safe space to talk away from home.

Developmental:

The current study's findings exhibited an increase in the relevance of mental health in India after the COVID-19 pandemic. The outbreak of coronavirus required quarantine which caused a lot of panic, anxiety, stress, and feelings of depression all over the world, including in India (Majumdar et al., 2020). The grave disturbance in a daily routine accompanied by fear of death caused the people intense psychological strain and misery (Das, 2020). Moreover, the people working at offices and school's children due to the home quarantine revealed stronger symptoms of depression and anxiety (Majumdar et al., 2020). This led to a 20% rise in mental issues, according to the Indian Psychiatry Society (Kumar & Nayar, 2020). Therefore, Covid increased mental health awareness and led to inflation among Indians seeking help (The Times of India, 2022). Indian Psychiatrist, in her interview with Times of India (2022), attested that online therapy became popular during Covid, but there has been a more considerable spike in face-to-face therapy sessions after the quarantine was lifted.

Therefore, it can be deduced after examining the findings and the statistics that the 2019 pandemic had a somewhat positive impact on the mental health of India, hence making the Indian population more accepting of seeking professional therapy.

Another domain discussed in this study was the effect of social media, celebrities, and cinema on India's stance on mental health. Participants displayed a diverse viewpoint on this and claimed that the social media content on mental health influenced psychological awareness; however, concerns were also raised with the reliability and legitimacy of such content. For instance, a character with Schizophrenia was portrayed in the Indian movie Atrangi Re, and

the character's treatment towards her trauma was shown through humour, which was questioned by professional psychologists (Srivastav, 2023). Since Indian media has a powerful impact on the Indian population, it is acknowledged as its soft power nationally and internationally (Gupta, 2022); therefore, it must be used responsibly. Despite the shaming and mocking content on mental health, India has witnessed a gradual change in the presentation of its content on social media and cinemas by spreading awareness of mental diseases and breaking away with stigma (Chandramouleeshwaram et al., 2016). Also, movies such as three idiots carefully and accurately portrayed the suicide rate among Indian students; and Dear Zindagi was the first film to revolve entirely around a therapist dealing with his client with depression (Srivastav, 2023). Hence, it can be concluded that India's media is bringing a progressive change in its content; however, it can bring better and increased content using its power of influence.

Conclusion

This section ties up the objectives of the findings and its implication to satisfy the research questions of the current study. It also illustrates the strengths and weaknesses/limitations of the study. One of the biggest strengths of the current study was its capacity to identify the main themes or grounds and structure them into economic, political, religious, cultural, social, and financial objectives for India's mental health situation. This is the first research to present the viewpoints of Indian practising psychologists and create an extensive study on India's mental health. However, this also meant that the study was limited to the voice of mental health psychologists and did not provide the Indian society's or the government’s

input on the subject. Furthermore, due to the constraint of words, only seven participants were recruited, which restricted the range of insights of the research paper.

Why is India unable to disregard its stigmas around mental health? Through the study's findings, it can be deduced that the factors leading to strong stigmas and unawareness towards mental health are interdependent. There is an equal need for government support, societal support, and individualistic change to bring a faster and healthier change. According to the results, while the absence of government contributions creates a lack of authoritative fostering and insufficient aid for the people seeking mental health care, at the same time, without any social acceptance or psychological awareness, even the government's aid seems worthless. Since the study also suggests that India's firmly embedded traditional and religious values and its community-driven outlook can be harmful to the growth of mental health, this research paper is convinced that the first step towards better mental health is to change the Indian mindset towards mental health which as mentioned is possible through awareness programs, educational insights, and governmental foundation. Overall, India needs the understanding and encouragement of all sectors mentioned in this study to address the mental health question.

Furthermore, this study recognises the need for the educational credibility of psychologists as a significant drawback in India, especially in other countries. After interviewing the participants, India's training and academic services displayed an unqualified, undertrained, and unregulated system of mental health practitioners, which can be dangerous for the already less-informed Indian society. Thus, this study promotes a regulatory body and licensure for all mental health practitioners to ensure reliability and acceptability. Social media content and Hindi cinema should be regulated to avoid any future misinterpretation or

misconstruction of mental health notions. Also, creating psychological content adhering to the Indian context and lifestyle can help the Indian population relate more and leave a more significant impact, leading to positive mental health development.

Even though cultural barriers, educational blocks and many more factors still affect the lack of mental health acknowledgement and facilities in India, there is evidence showcasing the potential for growth in the psychological field. For instance, the scope of mental health is on the rise in India since the coronavirus outbreak. Findings also exhibit a positive attitude towards therapy and mental health care, especially amongst the younger generation. This can be a constructive affair since the younger generation is the upcoming age group, and India is adapting new concepts and contemporary ideas towards life, which signify an advancement towards its mental health. To end, keeping a constant check on the factors discussed in this study and adapting to the changes with each sector doing its bit can aid in improving the mental health stance of India.

5. References

1. Adeoye-Olatunde, O. A., & Olenik, N. L. (2021). Research and scholarly methods: Semi-structured interviews. *JACCP: Journal of the American College of Clinical Pharmacy, 4*(10), 1358–1367. https://doi.org/10.1002/jac5.1441

2. Ajayi, D. (2022, March 28). Reflections on house of secrets: The burari deaths " psychology & psychiatry# " Cambridge core blog. *Reflections on House of Secrets:*

The Burari Deaths. https://www.cambridge.org/core/blog/2022/03/28/reflections-on-house-of-secrets-the-burari-deaths/

3. Akundi, S. (2019, May 20). Is the Indian understanding of schizophrenia sufficient. *The Hindu.* https://www.thehindu.com/sci-tech/health/people-with-schizophrenia-open-up-about-the-myths-and-assumptions-surrounding-the-condition/article27186122.ece

4. American Psychological Association. (2000, June 1). Change your mind about mental health. *https://www.apa.org/topics/teens/mental-health-attitudes*

5. Aronson, J. (1994). A pragmatic view of thematic analysis. *The Qualitative Report*, 2, 1–3. Retrieved from http://www.nova.edu/ssss/QR/BackIssues/QR2-1/aronson.html

6. Avasthi, A., Kate, N., & Grover, S. (2013). Indianization of psychiatry utilizing Indian mental concepts. *Indian Journal of Psychiatry*, 55(Suppl 2), S136–S144. https://doi.org/10.4103/0019-5545.105508

7. Behere, P. B., Das, A., Yadav, R., & Behere, A. P. (2013). Ayurvedic concepts related to psychotherapy. *Indian Journal of Psychiatry*, 55(Suppl 2), S310–S314. https://doi.org/10.4103/0019-5545.105556

8. Bertolote, J. (2008). The roots of the concept of mental health. *World Psychiatry*, 7(2), 113–116. https://doi.org/10.1002/j.2051-5545.2008.tb00172.x

9. Bhattacharya, A. (2018, January 8). *In India, one student commits suicide every hour*. Quartz. https://qz.com/india/1174057/in-india-one-student-commits-suicide-every-hour

10. Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77–101. doi:10.1191/1478088706qp063oa

11. Brinkmann, S., & Kvale, S. (2005). Confronting the ethics of qualitative research. *Journal of Constructivist Psychology*, 18(2), 157-181.

12. Chandramouleeshwaram, S., Edwin, N. C., & Rajaleelan, W. (2016). Indie insanity—misrepresentation of psychiatric illness in mainstream Indian cinema. *Indian Journal of Medical Ethics*, 1(1), 1–2.

13. Cleland, J. A. (2017). The qualitative orientation in medical education research. *Korean Journal of Medical Education*, 29(2), 61–71. https://doi.org/10.3946/kjme.2017.53

14. Dandona, R., Kumar, G. A., Dhaliwal, R. S., Naghavi, M., Vos, T., Shukla, D. K., ... & Dandona, L. (2018). Gender differentials and state variations in suicide deaths in

India: the Global Burden of Disease Study 1990–2016. *The Lancet Public Health*, 3(10), e478-e489.

15. Das, N. (2020). Psychiatrist in post-covid-19 era – are we prepared? *Asian Journal of Psychiatry*, 51, 102082. https://doi.org/10.1016/j.ajp.2020.102082

16. The Economic Times. (2017, January 2). India facing possible mental health epidemic, warns President. *Economic Times.* https://economictimes.indiatimes.com/news/politics-and-nation/india-facing-possible-mental-health-epidemic-warns-president/articleshow/62308115.cms?utm_source=contentofinterest&utm_medium=text&utm_campaign=cppst

17. Fossey, E., Harvey, C., McDermott, F., & Davidson, L. (2002). Understanding and evaluating qualitative research. *The Australian and New Zealand Journal of Psychiatry*, 36(6), 717–732. https://doi.org/10.1046/j.1440-1614.2002.01100.x

18. Francis, R. (2009). Ethics for Psychologists (2nd ed.). UK: *Blackwell Publishing Ltd.*

19. Gaiha, S. M., Sunil, G. A., Kumar, R., & Menon, S. (2014). Enhancing mental health literacy in India to reduce stigma: The fountainhead to improve help-seeking behaviour. *Journal of Public Mental Health*, 13(3), 146–158.

20. Gaur, P. (2019, May 11). Indian Schools Need Counsellors as *Mental Illness Strikes Early in Children*. IndiaTimes. Retrieved from https://www.indiatimes.com/news/india/indian-schools-need-counsellors-as-mental-illness-strikes-early-in-children-367015.html

21. Gearing, R. E., Alonzo, D., Smolak, A., McHugh, K., Harmon, S., & Baldwin, S. (2011). Association of religion with delusions and hallucinations in the context of schizophrenia: implications for engagement and adherence. *Schizophrenia Research*, 126, 150–163. doi:10.1016/j.schres.2010.11.005

22. Gibson, G., Timlin, A., Curran, S., & Wattis, J. (2004). The scope for qualitative methods in research and clinical trials in dementia. *Age and Ageing*, 33(4), 422-426.

23. Gupta, A. S. (2022, February 17). Popularity of Indian films wields more influence, power than its politicians. *The Siasat Daily*. https://www.siasat.com/popularity-of-indian-films-wields-more-influence-power-than-its-politicians-2277606/

24. Gupta, S., & Sagar, R. (2018). National mental health programme-optimism and caution: a narrative review. *Indian Journal of Psychological Medicine*, 40(6), 509-516.

25. Hemphill, R. E. (1966). Historical witchcraft and psychiatric illness in Western Europe. *Proceedings of the Royal Society of Medicine*, 59(9), 891–902.

26. Hiles, D., Ermk, I., & Chrz, V. (2017). Narrative Inquiry. In C. Willig & W. Rogers (Eds.), *The SAGE Handbook of Qualitative Research in Psychology* (pp. 157-175). SAGE Publication Ltd.

27. Hofstede Insights. (2010). Country comparison tool. Retrieved from *https://www.hofstede-insights.com/country-comparison-tool?countries=india%2Cunited+kingdom*

28. Hussain, M. (2021, August 27). We don't take mental health seriously here in India. *Times of India Blog.*

29. International Committee on Mental Hygiene. (1948). International Congress on Mental Health. *Lewis/Columbia University Press.*

30. Jaiswal, Y. S., & Williams, L. L. (2016). A glimpse of Ayurveda - The forgotten history and principles of Indian traditional medicine. *Journal of Traditional and Complementary Medicine*, 7(1), 50–53. https://doi.org/10.1016/j.jtcme.2016.02.002

31. Johns Hopkins Medicine. (n.d.). Ayurveda. *https://www.hopkinsmedicine.org/health/wellness-and-prevention/ayurveda*

32. Kennedy, M. (2010, August 10). India's mentally ill turn to faith, not medicine. *NPR.* *https://www.npr.org/templates/story/story.php?storyId=126143778*

33. Khandelwal, S. K., Jhingan, H. P., Ramesh, S., Gupta, R. K., & Srivastava, V. K. (2004). India mental health country profile. *International Review of Psychiatry*, 16, 126–141. https://doi.org/10.1080/09540260310001635177

34. King, N., & Hugh-Jones, S. (2019). Chapter 7: The interview in qualitative research. In C. Sullivan & M. A. Forrester (Eds.), *Doing qualitative research in psychology: A practical guide* (2nd ed., pp. 00-00). SAGE Publications.

35. Kumar, A., & Nayar, K. R. (2020). Covid 19 and its mental health consequences. *Journal of Mental Health*, 30(1), 1–2. https://doi.org/10.1080/09638237.2020.1757052

36. Lewis, N. D. (1974). American psychiatry from the beginning to World War II. In S. Arieti (Ed.), *American handbook of psychiatry* (2nd ed., pp. 28–43). Basic Books.

37. Magan, S. (2021, October 11). The Burari case is a reminder that mental health is not a "family secret" To hide. *Sri. ScoopWhoop.* *https://www.scoopwhoop.com/entertainment/the-burari-case-is-a-reminder-that-mental-health-is-not-a-family-secret-to-hide/*

38. Majumdar, P., Biswas, A., & Sahu, S. (2020). Covid-19 pandemic and lockdown: Cause of sleep disruption, depression, somatic pain, and increased screen exposure of office workers and students of India. *Chronobiology International, 37*(8), 1191–1200. https://doi.org/10.1080/07420528.2020.1786107

39. Mandell, W. (1995). *Origins of mental health*. Johns Hopkins Bloomberg School of Public Health. https://publichealth.jhu.edu/departments/mental-health/about/origins-of-mental-health

40. Markus, H., & Kitayama, S. (1991). Culture and the self: Implications for cognition, emotion, and motivation. *Psychological Review*, 98, 224–253.

41. Math, S., & Srinivasaraju, R. (2010). Indian psychiatric epidemiological studies: Learning from the past. *Indian Journal of Psychiatry*, 52(7), 95. https://doi.org/10.4103/0019-5545.69220

42. Matharu, S. (2023, July 5). Everyone's a therapist in India-influencers, dentists, homeopaths. it's the new epidemic. *ThePrint. https://theprint.in/ground-reports/everyones-a-therapist-in-india-influencers-dentists-homeopaths-its-the-new-epidemic/1655337/*

43. Maxwell, J. A. (2012). *Qualitative research design: An interactive approach*. Sage publications.

44. Mills, J. (2001). The history of modern psychiatry in India, 1858-1947. *History of Psychiatry*, 12(48), 431-458. doi:10.1177/0957154X0101204803

45. Ministry of Finance, Government of India. (2021). Union Budget [2021]. URL: *https://www.indiabudget.gov.in*

46. Ministry of Health and Family Welfare, Government of India. (2016). National Mental Health Survey of India. Retrieved from *http://www.indianmhs.nimhans.ac.in/Docs/Summary.pdf*

47. Mishra, A., & Galhotra, A. (2018). Mental healthcare Act 2017: Need to wait and watch. *International Journal of Applied and Basic Medical Research*, 8(2), 67.

48. Moses, A. (2021). How to get an RCI license?. *Manokosh.* *https://www.manokosh.com/post/how-to-get-an-rci-license-6148be9d00eed.html*

49. Mullatti, L. (1995). Families in India: Beliefs and realities. *Journal of Comparative Family Studies*, 26, 11–25.

50. Naraharisetty, R. (2021, October 11). How patriarchy drives mental illness, superstition to end lives in "House of Secrets." *The Swaddle.*

https://theswaddle.com/how-patriarchy-uses-mental-illness-superstition-to-end-lives-in-house-of-secrets/

51. Nawab, N. (2022, October 7). *Mental health care analysis*. Times of India Blog. https://timesofindia.indiatimes.com/blogs/voices/mental-health-care-analysis/

52. Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic Analysis: Striving to Meet the Trustworthiness Criteria. *International Journal of Qualitative Methods*, 16(1).

53. Patel, V., & Saxena, S. (2014). Transforming lives, enhancing communities – Innovations in global mental health. *New England Journal of Medicine*, 370, 498–501.

54. Pathak, V., Jena, B., & Kalra, S. (2013). Qualitative research. *Perspectives in Clinical Research*, 4(3), 192. https://doi.org/10.4103/2229-3485.115389

55. Psychologs Magazine. (2023). Mental health help in India is not as accessible as it seems. Retrieved from https://www.psychologs.com/mental-health-help-in-india-is-not-as-accessible-as-it-seems/

56. Rana, R. (2021, September 22). *The Mental Health Epidemic: About 56 million Indians suffer from depression*. The Logical Indian. https://thelogicalindian.com/mentalhealth/mental-health-indians-30811

57. Roy, S. (2021, March 1). Why a lack of space & privacy in Indian households is actively hampering my mental health. *iDiva. https://www.idiva.com/health-wellness/mental-health/lack-of-space-and-privacy-in-indian-households-affects-mental-health/18017929/*

58. Sehgal, C., & Kapoor, H. (2021, November 3). How India can make mental healthcare affordable and accessible to all. *Business Today. https://www.businesstoday.in/opinion/columns/story/how-india-can-make-mental-healthcare-affordable-and-accessible-to-all-311224-2021-11-03*

59. Sharma, S., & Chadda, R. K. (1996). Recommendations of WHO workshop on "Future role on mental hospitals in mental health care." In *Mental Hospitals in India: Current Status and Role in Mental Health Care*. Institute of Human Behaviour and Allied Sciences, Delhi.

60. Shaw, B. (1946). *Man and Superman: A comedy and philosophy*. Penguin Books.

61. Shetty, R. (2023, January 24). Breaking the stigma: Addressing mental health in India. *Times of India Blog. https://timesofindia.indiatimes.com/readersblog/myamusings/breaking-the-stigma-addressing-mental-health-in-india-49561/#*

62. Shidhaye, R., & Kermode, M. (2013). Stigma and discrimination as a barrier to mental health service utilization in India. *International Health*, 5(1), 6–8. https://doi.org/10.1093/inthealth/ihs011

63. Srivastav, S. (2023). Mental health and how its portrayal has changed in Bollywood. *English Jagran. https://english.jagran.com/entertainment/mental-health-and-how-its-portrayal-has-changed-in-bollywood-10072731*

64. Stephan, S. H., Weist, M., Kataoka, S., Adelsheim, S., & Mills, C. (2007). Transformation of children's mental health services: The role of school mental health. *Psychiatric Services*, 58, 1330-1338.

65. Szasz, T. S. (1960). The Myth of Mental Illness. *American Psychologist*, 15, 113–118.

66. Sutton, J., & Austin, Z. (2015). Qualitative research: Data collection, analysis, and management. *The Canadian Journal of Hospital Pharmacy*, 68(3), 226–231. https://doi.org/10.4212/cjhp.v68i3.1456

67. The Economic Times. (2022). Monsoon rain widens cracks in Joshimath, five families shifted to relief camps. *The Economic Times.*

https://economictimes.indiatimes.com/news/india/monsoon-rain-widens-cracks-in-joshimath-five-families-shifted-to-relief-camps/articleshow/102731554.cms

68. Times of India. (2022). *Post Covid, more people seek help for Mental Health: Mumbai News - Times of India*. The Times of India. https://timesofindia.indiatimes.com/city/mumbai/post-covid-more-people-seek-help-for-mental-health/articleshow/94733688.cms

69. Thorne, S. (2000). Data analysis in qualitative research. *Evidence Based Nursing*, 3, 68–70. doi:10.1136/ebn.3.3.68

70. Tripathi, S. (2023, May 21). *Bw sunday special: May means making mental health a priority*. BW Businessworld. https://www.businessworld.in/article/Bw-Sunday-Special-May-Means-Making-Mental-Health-A-Priority-/21-05-2023-477368/

71. Van Ginneken, N., Jain, S., Patel, V., & Berridge, V. (2014). The development of mental health services within primary care in India: learning from oral history. *International Journal of Mental Health Systems*, 8(1), 1-14.

72. Weiss, M. G. (1986). History of Psychiatry in India. *Samiksa*, 11, 31–45.

73. Whorton, K. (2016). *Qualitative interview pros and cons*. ASAE. https://www.asaecenter.org/resources/articles/an_plus/2016/january/qualitative-interview-pros-and-cons

74. Willig, C. (2017). Interpretation in qualitative research. In C. Willig & W. Rogers (Eds.), *The SAGE Handbook of Qualitative Research in Psychology* (pp. 274-288). SAGE Publications Ltd.

75. Wig, N. (1999). Mental health and spiritual values. A view from the East. *International Review of Psychiatry*, 11, 92–96.

76. Wig, N. N., & Murthy, S. R. (2015). The birth of national mental health program for India. *Indian Journal of Psychiatry*, 57(3), 315.

77. WebMD. (2021). *Types of psychotherapy for mental illnesses*. WebMD. https://www.webmd.com/mental-health/mental-health-psychotherapy

78. Welle, D. (2022, October 29). India fails to address growing mental health problem. *Hindustan Times*. https://www.hindustantimes.com/lifestyle/health/india-fails-to-address-growing-mental-health-problem-101667038300362.html

79. World Health Organization. (2001). The World Health Report 2001 - Mental health: new understanding, new hope. Geneva: *World Health Organization.*

80. World Health Organization. (2022). Mental health: Strengthening our response. Fact sheet. *https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response*

6. Appendix

Appendix 1. Interview Questions

Good morning/afternoon/evening,

My name is [redacted], and I will be interviewing you for my dissertation today. I hope you are doing well today and whenever you feel comfortable, we can start:

Ice-breaker questions:

- How long have you been practicing as a therapist?
- Did you always want to be a therapist?
- What is your favourite part of being in the field of psychology?
- What difference do you feel when you practice therapy online versus offline?

Professional career:

- What are some challenges that you have faced as a practicing therapist in India?
- How do you think India can improve the credibility of their psychologists?
- It may be difficult to generalise, but what are some common issues faced by clients in India?
- Is there a specific demographic coming for therapy?
- Can you discuss a few future prospects of psychology as a career in India?
- Does the society support your career as a psychologist? Also, please share if you faced any challenges in the beginning of your career? Please define the demographic you would refer to as "society" when answering the question.

India's Stance:

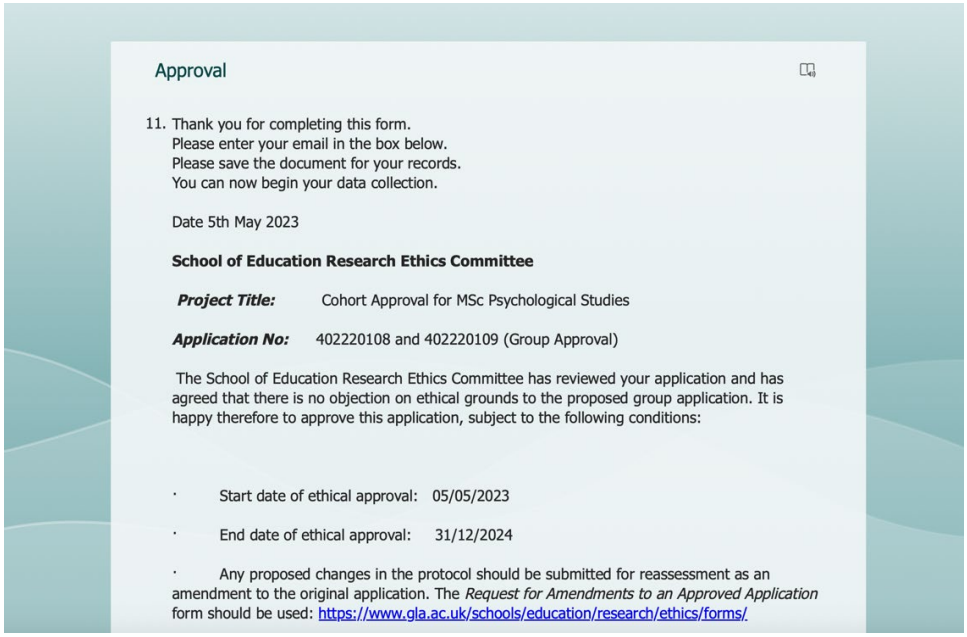
- What do you think is the point of view of India on mental health?
- Do people still hesitate and believe in the stereotypes attached to mental health in India? If yes, why do you think that is?
- Who do you think are the most dominant demographic when it comes to being stereotypical towards mental health in India? And what can be the reason for it?
- What are some common stereotypical notions you get to hear? How does it affect your professional career?
- Do you think political, economic, or cultural factors might affect India's stance on mental health?

Future of India (Conclusion):

- What do you think is the future of India's stance on mental health?
- Do you see potential in the upcoming youth spreading awareness of mental health in India? If yes, then how?
- What is some advice or tip you would like to give other psychologists or people planning to pursue a career in psychology in India?
- If possible, is there anything you would demand from the Indian government to create a better and safer space for the mental health of Indians?

Lastly, if you have a few experiences or thoughts to share on this topic. Please do not hesitate. Any input is welcomed and encouraged. Thank you so much for your time and effort.

Appendix 2. Ethics Approval



Approval

11. Thank you for completing this form.
Please enter your email in the box below.
Please save the document for your records.
You can now begin your data collection.

Date 5th May 2023

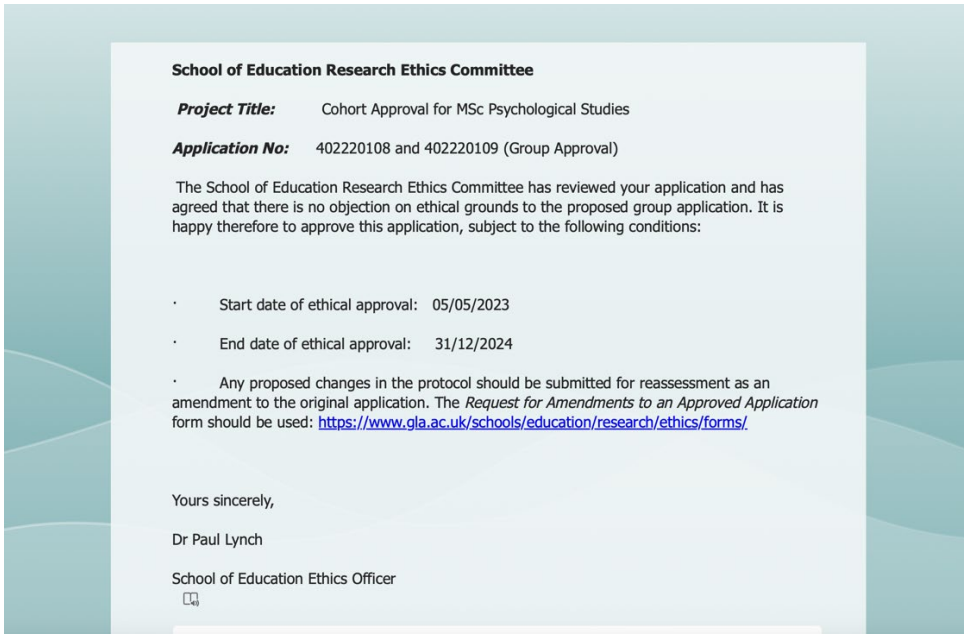
School of Education Research Ethics Committee

Project Title: Cohort Approval for MSc Psychological Studies

Application No: 402220108 and 402220109 (Group Approval)

The School of Education Research Ethics Committee has reviewed your application and has agreed that there is no objection on ethical grounds to the proposed group application. It is happy therefore to approve this application, subject to the following conditions:

- Start date of ethical approval: 05/05/2023
- End date of ethical approval: 31/12/2024
- Any proposed changes in the protocol should be submitted for reassessment as an amendment to the original application. The *Request for Amendments to an Approved Application* form should be used: https://www.gla.ac.uk/schools/education/research/ethics/forms/



School of Education Research Ethics Committee

Project Title: Cohort Approval for MSc Psychological Studies

Application No: 402220108 and 402220109 (Group Approval)

The School of Education Research Ethics Committee has reviewed your application and has agreed that there is no objection on ethical grounds to the proposed group application. It is happy therefore to approve this application, subject to the following conditions:

- Start date of ethical approval: 05/05/2023
- End date of ethical approval: 31/12/2024
- Any proposed changes in the protocol should be submitted for reassessment as an amendment to the original application. The *Request for Amendments to an Approved Application* form should be used: https://www.gla.ac.uk/schools/education/research/ethics/forms/

Yours sincerely,

Dr Paul Lynch

School of Education Ethics Officer

Appendix 3. Consent Form

University of Glasgow | School of Education

Consent Form

Title of Project: Practitioner's reflection on mental health in India

Name of Researcher: [redacted]

Name of Supervisor: Chris Hand

Please tick as appropriate

Yes ☑ No ☐ I confirm that I have read and understood the Participant Information for the above study and have had the opportunity to ask questions.

Yes ☑ No ☐ I acknowledge the provision of a Privacy Notice in relation to this research project.

Yes ☑ No ☐ I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

Yes ☑ No ☐ I consent to interviews being audio-recorded

Yes ☑ No ☐ I acknowledge that participants will be referred to by pseudonym.

I agree that:

Yes ☑ No ☐ All names and other material likely to identify individuals will be anonymised.

Yes ☑ No ☐ The material will be treated as confidential and kept in secure storage at all times.

Yes ☑ No ☐ Other authenticated researchers will have access to this data only if they agree to preserve the confidentiality of the information as requested in this form.

I agree to take part in this research study ☑

I do not agree to take part in this research study ☐

Name of Participant [redacted] gnature ... [redacted]

Date 30th July, 2023

Name of Researcher [redacted] Signature [redacted]

Date 30th July, 2023

Choose sidebar display

..... End of consent form .....