

REVIEW ARTICLE

How do psychiatrists in India construct their professional identity? A critical literature review

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ABSTRACT

Psychiatric practice in India is marked by an increasing gulf between largely urban-based mental health professionals and a majority rural population. Based on the premise that any engagement is a mutually constructed humane process, an understanding of the culture of psychiatry including social process of local knowledge acquisition by trainee psychiatrists is critical. This paper reviews existing literature on training of psychiatrists in India, the cultural construction of their professional identities and autobiographical reflections. The results reveal a scarcity of research on how identities, knowledge, and values are constructed, contested, resisted, sustained, and operationalized through practice. This paper hypothesizes that psychiatric training and practice in India continues to operate chiefly in an instrumental fashion and bears a circular relationship between cultural, hierarchical training structures and patient–carer concerns. The absence of interpretative social science training generates a professional identity that predominantly focuses on the patient and his/her social world as the site of pathology. Infrequent and often superfluous critical cultural reflexivity gained through routine clinical practice further alienates professionals from patients, caregivers, and their own social landscapes. This results in a peculiar brand of theory and practice that is skewed toward a narrow understanding of what constitutes suffering. The authors argue that such omissions could be addressed through nuanced ethnographies on the professional development of psychiatrists during postgraduate training, including the political economies of their social institutions and local cultural landscapes. Further research will also help enhance culturally sensitive epistemology and shape locally responsive mental health training programs. This is critical for majority rural Indians who place their trust in State biomedical care.

Key words: Clinical ethnography, cultural identity, global mental health, India, local mental health, professional identity, psychiatric training

INTRODUCTION

“Indian Psychiatry is a child born to British parents and bred in Indian culture”

(Khan, 2004)

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India, like other highly populated low-income countries, faces the difficult challenge of meeting its population's mental health needs.^[1] Based on recent reports, an estimated 90% of people suffering from mental illness receive no form of treatment,^[2,3] despite a relatively high prevalence of serious and common mental illnesses such as schizophrenia and depression, 6.5% and 15.1%, respectively.^[4,5] This places a high burden on the society. The situation is aggravated by an acute shortage in India's mental health workforce.^[5] The complexity of this issue cannot be explained alone through the low number of available mental health professionals. Currently, whereas two-third of India's population live in rural areas,^[6] most psychiatrists reside and operate in major cities and towns including State-sponsored services and academic research facilities. Psychiatry in India is thus an "almost entirely urban phenomenon"^[7] in sporadic contact with the rural population. Taken together with their low numbers, this uneven distribution of mental health professionals significantly contribute to the current gross disparity between the mental health needs of the Indian population and available professional services.

In addition to resource scarcities, anthropological enquiries into clinical encounters between Indian psychiatrists and their patients have revealed a growing cultural chasm.^[8] Indeed, mental health concepts held by the majority of Indian population are often constructed on the basis of explanations predicated upon their own cultural identities and local concerns. In most instances, this comprises a pluralistic view of mental illness shaped by the available traditional and biomedical conceptions and treatment options within India's health-care system.^[9,10] On the other hand, Indian psychiatrists' practice and explanation of mental suffering and those of nonmedical mental health professionals are the outcome of a complex interplay between their own cultural and professional identities. The latter, including the "sets of beliefs, attitudes, and understanding about one's role,"^[11] are deeply influenced by the prevalent psychiatric culture^[12] and ultimately shape their day-to-day practice. For these reasons, the increasingly dominant biomedical nature of psychiatry's culture^[13] often prevails in clinical encounters. This frequently translates into an overemphasis on Eurocentric diagnostic categories and a tendency to rely more on pharmacological methods of treatment to address mental health suffering experienced by the community. Local and culturally rooted expressions of distress are therefore "slotted" into psychiatric diagnostic categories shaped by Euro-American academic discourses. This translates into treatment with chemical solutions, effectively stripping the people's narrative from its meaning as well as ignoring the crucial sociocultural causes of their suffering.^[14,15] Such a process of assessment, diagnosis, and management is not confined to the Indian subcontinent alone and has indeed been documented across cultures.^[16] As a result, therapeutic encounters may fail to mirror the actual needs and culture of the communities that mental

health professionals strive to serve, resulting in fragile engagement, superficial assessments of sociocultural factors, sketchy clinical management, and unsatisfactory patient outcomes.^[17-20] This issue has been echoed by various Indian scholars and clinicians who have argued "to look beyond symptoms and explore life events and other situational difficulties;"^[21,22] and for the development of "culturally oriented modules of nonpharmacological management" for the treatment of mental illness.^[23]

Just as patients' cultural identities shape their expressions of distress, professional identities are equally shaped by intersections of their own personal identities, including social class, gender, religion, and caste.^[24] In keeping with this enquiry of cross-cultural research, the published literature also suggests that cultural identity is not a homogeneous fixed and static category. It is relational, in that symptoms are the product of a dialog shaped by the identity of the patient and his/her clinician^[25,26] and the setting in which this discourse takes place. Over the past two decades, there have been a growing number of initiatives that address culturally sensitive care in clinical interventions, including the "cultural formulation" approach.^[27]

Addressing such cultural challenges within clinical practice demands an in-depth understanding of how beliefs, values, and practices of both patients and mental health professionals are acquired, deployed, and negotiated within the clinic space. In keeping with extensive accounts documenting cultural dimensions of Indian patients' illness explanation,^[28,29] an enquiry into the literature on how knowledge, practices, and attitudes of Indian psychiatrists are constructed to shape their professional identity is equally critical. Indeed, Western literature on psychiatric education has emphasized the importance of this period of professional socialization as the process through which students embody the "values, languages, behavioral patterns, and beliefs"^[30] disseminated by the culture of the psychiatric profession.^[31,32] This complex process is situated at the "interplay between individual and training institution"^[32] and involves various actors such as the State-prescribed curriculum, teachers, peers, pharmaceutical representatives, patients, and carers operating in an environment determined by more structural variables including organizations and related stakeholders, political ideologies, gender and social status, curriculum, and policy.^[33] More than a passive and normative exercise dictated by the institution, psychiatric training is thus inherently an active social process that requires students to engage with both formal and informal teaching of various socializing agents. Such engagement goes beyond simplistic acquisition of generic knowledge and skills and requires the construction of an exclusive cognitive identity.^[31,34] This ensures the establishment of a professional identity that reaffirms their developing role both to themselves and to the society. The former is particularly crucial as it intimately relates to notions of

professionalism, such as the development of strong moral values, empathy, and the adoption of an abiding code of ethics.^[35] The course of studies, socialization, and formation of psychiatrists' professional identity are therefore viewed as a complex and nonlinear process^[31] through which "certain aspects of a person's identity and life patterns are broken down (dissocialized) so that a new identity can be built up." This is often characterized as "violent" and/or "traumatic,"^[36] is indirect, unpredictable, and an interpretive and problematic process often characterized by conflict and resistance. Due to its flexible and contested nature, the possible multiple trajectories and outcomes of socialization offer potential for students to acquire complex and multilayered professional identities that may differ from the prototypical professional identity modeled by the psychiatric profession, their institutions, and symbolic heads worldwide. An examination of how the beliefs, values, and knowledge of Indian psychiatrists are constructed and dominate the clinical encounter must therefore involve a closer examination of the underlying structure of psychiatry training programs.

This paper aims to review the current literature of published studies on psychiatric education so far as it relates to the process of psychiatrists' professional identity formation in India. It analyzes and distills the published findings that demonstrate how the current knowledge, values, and attitudes imparted during undergraduate and postgraduate psychiatric education shape professionalization and professional identity development. Nuanced analyses of the key themes emerging from this literature review offer tentative conclusions and generate future research questions.

METHODS

A literature search was conducted by scanning the published biomedical and social science databases. These included MEDLINE (covering publications related to medical education and psychiatry education), Anthropology Index Online (covering publications on the anthropology of psychiatry and ethnographies of health-care systems), and Google Scholar. The following key words were used for the literature search: psychiatry training India, psychiatry education India, undergraduate training psychiatry India, postgraduate training psychiatry India, psychiatry identity India, psychiatry challenges India, biographies mental health India. The time frame for this search included articles and books published between 1947 (Indian Independence) and 2016. The search was further refined by applying two filters, divided into categories: "undergraduate" and "postgraduate." Medical psychiatric textbooks commonly used and recommended by training programs in India were also included as they are the primary learning material used by psychiatry trainees in India.^[37,38] Websites of the WHO, Indian Ministry of Health and Family Welfare, and Medical

Council of India were scanned for documents relevant to psychiatric training and policy. In addition, social media were perused for themes and personal accounts relevant to psychiatric training and professional cultural identity development in India.

RESULTS

A total of $N = 165$ hits were obtained from the initial search. These were subsequently narrowed down to $N = 66$ by applying key filters stated in the methods. Subsequently, those findings that best matched the search terms were thematically analyzed. The results have been summarized below under three separate headings: (I) undergraduate training in psychiatry, (II) postgraduate training in psychiatry, and (III) autobiographical accounts and personal experiences.

Undergraduate training in Indian psychiatry

Undergraduate psychiatric training is often the first contact when medical students are exposed to psychiatry and has been the subject of central interest since the early 1960s.^[39-45] Due to the significant prevalence of mental health disorders encountered in primary care and shortage of specialists to treat these conditions, undergraduate psychiatric training is perceived as a critically important aspect for developing physicians' abilities to diagnose and manage such disorders within primary care.^[46] This period has also been considered an effective method to impart humanistic values such as empathy and good communication.^[47] The implementation of a 2-week compulsory clinical posting and 20 h of theory lectures in psychiatry for medical undergraduates was introduced by the Medical Council of India in 1997 as a way to increase students' psychiatric knowledge and exposure to the discipline. However, the nature of marking and time allocated to psychiatry training in comparison to other disciplines has since been extensively criticized. This is now considered grossly inadequate to meet its goals and objectives.^[47-59] Researchers have attempted to "identify lacunae in undergraduate psychiatry training as reported by undergraduate students, interns, and faculties at Medical college teaching hospital," but the results of such studies are not yet available in the public domain.^[60] Nevertheless, Indian Psychiatric Society (IPS) members have actively pursued efforts to integrate psychiatry as a full-fledged subject with appropriate examination at the undergraduate MBBS level with the hope that medical students may consider the discipline more seriously, by making recommendations to the Medical Council of India (MCI).^[61] Indeed, the MCI did suggest to the Ministry of Health and Family Welfare, Government of India, that these recommendations should be incorporated into the curriculum of psychiatry for undergraduate MBBS courses, coupled with innovations in the delivery of psychiatric training during undergraduate curriculum.^[62] These included increased teaching time and clinical placement, new marking and assessment scheme,

mandatory psychiatric posting during internship, and further integration with community medicine. However, most of these recommendations are yet to be accepted and implemented. The reasons for this remain unclear.^[47]

The sparse emphasis on undergraduate psychiatry training is reportedly due to the discipline's poor reputation among health-care personnel.^[46] Psychiatry is often ignored as a viable career option by medical students who harbor negative attitudes toward the discipline.^[63-65] Indeed, a majority of students seem to consider psychiatry as a specialty plagued with "scientific inaccuracies," regard psychiatrists as "poor role models,"^[66] and have a tendency to rate the quality of psychiatric teaching as "low."^[66] Furthermore, they perceived psychiatrists as being poorly regarded by doctors from other medical disciplines and as being "odd and eccentric."^[66] Their perceptions and attitudes toward psychiatric patients and illnesses are generally negative, often viewed as unlikely to ever get better,^[66] and as more emotionally demanding on doctors.^[64] Students also commonly reported experiencing negative emotions when interacting with psychiatric patients including fear,^[64] and more rarely, anger and even hatred.^[67] In addition, students' knowledge of the etiology of mental illnesses often did not encompass the "biopsychosocial" framework commonly taught in medical school.^[68] Interestingly, possible biological causes of mental disorders are marginalized by medical students in favor of sociocultural explanations relying on the local system of beliefs, such as excessive emotions, loneliness, and spiritual causation including past sins and evil/spirit possession.^[67,69] In contrast, students' opinions about the management of psychiatric patients and their illnesses however seem to deploy a more biomedical view.^[67] Taken together, these findings may explain psychiatry's poor image among undergraduate medical students, resulting in a relative lack of engagement with the discipline. Additional reasons for students' disinterest include viewing psychiatry as a difficult branch, familial pressure against pursuing psychiatry, and a fear of contracting psychiatric illness.^[67,70,71] An enhanced knowledge and exposure to psychiatry at the undergraduate level has indeed been suggested to improve students' attitudes toward the discipline and maximize their recruitment into postgraduate psychiatric careers.^[72] However, based on the literature search, there appears to be currently little agreement on whether or not undergraduate training positively influences medical students' attitudes toward psychiatry and psychiatric patients. Some studies show measurable change while others do not.^[73,74]

Postgraduate training in psychiatry

In contrast to the numerous studies on psychiatric training at the undergraduate level, few papers have addressed psychiatric training at the postgraduate level. Early research published between the 1970s and 1990s addressed the structure and assessment method of postgraduate training^[75] and queried the nature and quality of the different

centers in which postgraduate trainees were taught.^[76,77] Twenty years later, a paper by Kulhara and Chakraborti^[78] highlighted the expansion of psychiatric postgraduate training in India and echoed similar concerns. They noted the "lack of uniform standards, inadequate staffing, and wide variations in course content" with "the relative neglect of areas such as psychotherapy, subspecialty training, or research methodology."^[78,79] However, such lacunae appear paradoxical if one is to consider (a) the growing interest in psychological intervention such as cognitive behavioral therapy,^[80] and (b) the criticism of subspecialization on the grounds that "basic priorities are yet to be made."^[81] Similarly, concerns have been documented on the lack of multidisciplinary work,^[82] teaching of ethics,^[83] and a neglect of "psychological and social factors in the etiology, course, outcome, and treatment of various psychiatric disorders."^[84] These studies argue that while the quality of postgraduate psychiatric education in India can sometimes be "near world-class level," the standard of teaching for the majority of institutions remains "alarmingly low, disparate, and haphazard,"^[85] mostly due to the inability of local institutions to develop their own program and the lack of a well-defined nationally applied curriculum.^[85] Postgraduate psychiatric training in India also seems to growingly involve the methods of pedagogy developed by the Euro-American medical profession, including simulated interviews, role play to assess competence, and objective structured clinical examinations.^[86,87] More recently, the importance of appropriate supervision has been highlighted as "key aspects of the professional development of psychiatry trainees"^[88] through which professional values can be transmitted. Supervision in the training of psychiatry students in India was found to vary from informal in nature, or "supervision as usual,"^[89] to the more readily accepted "individual regular (protected time) supervision" in Western settings.^[89] Whenever the importance of power, dynamic, and identity in the process of supervision is mentioned,^[88,91] qualitative accounts of students' and teachers' experiences of supervision, including hurdles they may encounter and the perceived usefulness of the process, are scant.^[90] The singular exception is an extensive account by the Swiss psychiatrist Erna Hoch, who practiced in India.^[91] Hoch emphasized problems relating to counter-transference in the clinic and identified issues such as the "rigid attitude of trainees," "fear of contagion," "of losing their own control," while acknowledging the potential for greater personal growth that supervision provided.^[91] Hoch echoed Professor Surya's concerns about the need for psychiatrists to introspect on their identity as teaching is "one aspect of group interaction and hence needing psychotherapeutic insight."^[90]

A more recent paper highlighting developments in postgraduate psychiatry training in the Indian context acknowledges that "psychiatrists have played a prominent role in shaping the mental health program and providing

mental health care to patients in every country (...). However, their influence is in part a by-product of their own professional preparation."^[93] This absence of evidence to evaluate the quality of postgraduate student professional training is highlighted by Thirunavukarasu and Thirunavukarasu^[5] and Sharma.^[93] The latter extends an invitation for "continuous retrospective introspection" to assess "how satisfactory is the training in the changing social, economic, and technological environment, which is an area that needs constant evaluation and improvement."^[93,95] This is in keeping with numerous concerns raised regarding the growing medical orientation of postgraduate psychiatry training programs in India.^[94,96] As a result, psychiatry trainees are reported to be poorly trained in psychotherapeutic techniques and overly reliant on psychopharmacology.^[97]

These concerns are validated in autobiographical accounts of some of India's most prominent psychiatrists and from the relatively few ethnographies on the practices of Indian psychiatrists.

Autobiographical account psychiatry training, identity, and practices

The earliest reflections made on the professional identity of Indian psychiatrists could be attributed to Professor Surya, who expressed concern that "the present-day Indian psychiatrist is still a product of Western training,"^[90] hinting at the possible conflicting dimensions of Indian psychiatrists' identity who "remains Indian in his daily life, but adopts Western anticipations and values as soon as the setting becomes professional psychiatry."^[90] Summing up this argument through the lens of his own experience, Surya laments his initial inability to deal with Indian patients due to being "completely out of tune as I was applying totally different value systems, alien both to myself as to the patient."^[98] At the core of this disjuncture, Surya notably called for a reflection concerning the use of English language in the therapeutic encounter. For him, it was essential to consider "the question of language" as for "the psychiatrist himself, the English words he uses have more often, only a dedicated, cognitive significance, and more often a prestige value," whereas "for the patient, these have very little interactional significance."^[90] For him, a failure to assess this aspect of psychiatrists' professional identity in India would lead to them becoming "ineffectual caricatures of Western psychiatric thoughts and either fail in psychotherapeutic theory and practice or succeed in reducing our living patients into a set of prestige-loaded foreign jargon."^[90]

Chakraborty,^[99] one of India's foremost and arguably radical psychiatrists, in her memoir expressed concern regarding the increased reliance on psychopharmacology. She stated that: "This success of pharmacology has led to pernicious

attempts to solve all human ills through medications. It is this overmedicalized model of psychiatry that I am against. (183)."^[99] Identifying mainstream Indian psychiatric position as "organic or biological,"^[99] Chakraborty provides a rare insight on the nature of psychiatric training in India: "Academic psychiatry is now too 'biological' and medically oriented; training of psychiatrists is almost devoid of social and human dimensions."^[99] In her extensive analysis, she reaffirms the initial concerns of Professor Surya and attributes the predominance of this type of psychiatric training to "accepting with open arms Western expertise and know-how"^[99] where "our uncritical acceptance of Western psychological thoughts, ideas, and problems as our own has hampered our own growth and lack of development."^[99]

It is however worth noting that the biomedical model of psychiatry had not established itself as the dominant paradigm in India prior to Chakraborty's writing. In a rare but extremely insightful collection of introspective essays on the history of psychiatric training in India, various authors have emphasized the early influence of psychoanalysis on the curriculum.^[100] Some authors extolled their UK- and US-trained teachers as true "guru" and "role models," whose teaching methods helped them both in their professional and private development.^[101] In contrast, others stressed the importance that was placed on the subjective experience of the patient and the doctor's role in "understanding the patient more and more in the context of their relationship"^[102] so as to generate more psycho-dynamic formulations. Already reliant on Western textbooks, the profession seemed to have been predominantly occupied with questions such as "what (psychodynamic) school was best suited for the Indian need."^[103] Describing the decade spanning the seventies to the eighties as a "transition phase,"^[103] one of the authors reaffirms Chakraborty's analysis of the profession:

"In our present day, all these things have changed (...). For the modern psychiatrist who is all the time looking for solid evidence, paying attention to the subjective experience of patients is unfashionable! (...). The profession is too preoccupied about various rigid diagnostic criteria, algorithms and so on! Diagnostic manuals convey an impression that by just following them strictly, clinical practice would be hassle-free! (...). Today it's like the entire profession is getting medicalized, and is going back completely to the 'predynamic era' (...). Doctors in general keep away from mundane day-to-day concerns of their patients, because during their medical education, they did not learn a 'theory' to explain those kinds of things (...). It is the identity of psychiatrists, among medical profession that is threatened today. It is as though the profession is losing its very moorings!"^[102]

This position is corroborated in more recent writings by other psychiatrists in India. These accounts have vocalized discontent over training and criticized the overemphasis of Western concepts of psychiatry. Significantly, they allude to the lack of cultural, social, and human dimensions in their education, as well as the increasing prominence of pharmacological therapies as a way to address mental illness:

“I sometimes wonder what is our concept or training in psychiatry? I have started believing that we have become slaves or replica of the so-called American brand of psychiatry. Our training is completely confined to their textbooks, Diagnostic and Statistical Manual of Mental Disorders, and Stephen Stahl” (Psychiatrist A, posting on social media, 2014).

“We are trained to prescribe medicines. We follow a simple motto-pill for every ill. We work in clinics and hospitals and we presume anyone and everyone coming for our help is a patient and needs drugs. We often fail to distinguish a life problem/issue from an illness” (Psychiatrist B, posting on social media, 2014).

“Our PGs and consultants have turned blind followers with very limited thoughts of their own and most of us have stopped looking at our patients’ problems and their solutions with our own social and cultural perspective and have started treating psychiatric disorders just like other medical or surgical disorders” (Psychiatrist A, posting on social media, 2014).

“For many of us, it is as though the only important objective is to attain a kind of parity with all others and become part of ‘mainstream’ medicine! For many, their only goal is to function in the grand ambience of a high-end general hospital. Ordering sophisticated tests, investigations, and looking for causes based on biology for every disease is the way to become successful (...). We have among us many who even want to give up the traditional name of their speciality, Psychiatry. They are keen to be known as neuro-psychiatrists. It is as though they want to show the whole world that everything they do by way of their clinical practice is based on biological concepts!”^[96]

Similar observations are also reflected in various ethnographies concerned with psychiatric practices in India. Addlakha^[104] remarks that “psychiatric training for the Indian doctor is a double socialization, i.e., into psychiatric diagnostic systems and treatment regimens and into the culture of biomedicine.” This emphasis on the

biomedical aspects of psychiatry during training results in students being taught “according to a putatively universal approach to the psyche that assumes an individual self,”^[105] which may lack cultural relevance in the Indian context. The professional socialization of trainee psychiatrists is thus noted to “at times blunt this (cultural) sensitivity and render the practitioner partially impervious to the culturally coded messages being communicated by her clients.”^[106] The lack of “attention to cultural factors” in the training curricula of psychiatrists in India has also been seen to impair the formation of the “counseling component” of their professional identity.^[106] Perhaps more interestingly, the work of Nunley^[107] provides vital insights into the social nature of psychiatry training and its effect on professional identity development. The “biological view of disorders”^[107] dominating psychiatry training, “where all forms of psychotherapy are de-emphasized,”^[107] is explained by the authors “as an association with the modern (...) encouraging the public to make use of their service”^[107] and as a primary means by which psychiatrists defend themselves against the psychiatrist’s professional identity (...) in regards to society, family members, and other professionals who often understand psychiatry to be “unscientific” and a discipline “most often given to students who are not at the very top of their classes.”^[107] During their professional socialization, trainees are “dealt with like someone who has experience enough to be left on his/or her own (...) he is barely ‘taught,’ ‘corrected,’ or ‘trained’ and he/she is not taken through an organized academic schedule.”^[108] While this apparent neglect of the “formal curriculum”^[109] is inconsistent across institutions, a clear reliance on the “hidden curriculum”^[110] appears to be frequent. Students are thus observed to learn psychiatric knowledge and practices “mostly through the practical knowledge that he or she has received from an older brother or sister.”^[107] This so-called “brother–sister system”^[107] situates senior residents and more senior trainees as key socializing agents. This seems to be to the detriment of consultants, who consider residents as “more or less out of their control.”^[107] Such reliance on the knowledge of more experienced practitioners reflects the existing gap “between the training and practice of psychiatry” in India where “the nosological understanding has to be complemented by a cultural understanding based on patient’s experiences and beliefs.”^[108] This “cultural understanding” is acquired by psychiatrists in India over several years and is based on the needs of their patients, but remains glaringly absent from the teaching curriculum and culture-free “evidence-based” practices that are promoted in Western countries.^[111] As a result, this crucial lacuna could engender frustration among psychiatry trainees who may find it “difficult to understand and accept the ways of functioning of a senior practitioners” as they may feel that they are “wrong on many counts and that (their) practice is all about doing things wrong.”^[108]

Moreover, this social process of practical knowledge acquisition appears to take precedence over the more formal

teaching of theoretical aspects of psychiatry. The latter, taught to students through Western textbooks and scientific publications, only begins to gain importance to trainees as they approach examinations. A practical approach of “getting the work done” thus seems to dominate psychiatry training in India. As Nunley eloquently states: “Training in psychiatry often consists fundamentally of learning, first to diagnose as quickly as possible and second, to associate particular diagnoses with the standard drug regimen.”^[107] Portrayed as both as strength and a consequence of the working conditions in which trainees must learn, this simplistic description of the nature of psychiatry training must be viewed in contrast to this remark made by a consultant interviewed by the same author:

“In the 1st year, they think they know everything, and they believe all psychiatric illness is biological. In the 2nd year, they start finding contradictions in the literature. About 2 months before they start the 3rd year, everything is confusing. As senior residents, they develop more tolerance for other types of healing. They begin to believe others can sometimes do some good.”^[107]

Such comments thus hint at the training program’s “heavy demand on one’s emotional resource,”^[110] where students appear to find themselves trapped in a circle of deconstructing and reforming identities while simultaneously grappling with the uncertainties of balancing the evidence of their books with the practicalities of their day-to-day practices. Indeed, the socializing aspect of training is further described by Sinclair^[112] as an active process of “impression management”^[113] on the part of trainees who must learn to juggle their newly forming professional identities with other primary identities such as their own social class, gender, religion, caste, and regional geographical characteristic.

Furthermore, the affective ramifications of developing alternative forms of professional identity to those supported by the psychiatric profession in India and its associated training institutions require further exploration. What happens when psychiatry trainees decide to practice psychiatry in a way that differs from the biomedical model? The following exchange between a senior Indian psychiatrist with the second author of this paper hint at the consequences:

“Will you believe me that to be exiled within your own country is so much harder than being exiled abroad! I am almost a leper within the psychiatric community in my own country just because I do things differently from others, do not walk on the often-treaded path. (...) which is not only an institution which I guided for a while but which was my own alma mater-never invites me. My own students do not involve me in any of (...) programmes. People are invited from other far off places to give endowed lectures but I am

not. (...). I cannot be a total nonentity because I find people giving respect to my views when I go to other countries. So what is it? Does it say something about me? Does it say something about our country?”

The apparent ostracization reported in the above extract begs the question: What is the impact that alternative forms of cultural, professional identity, and epistemological resistance to dominant discourses have on students and professionals alike? These issues were briefly discussed in the first autobiographical account written by an Indian psychiatrist who examined issues related to marginalized identities.^[114] Other authors have noted that the “cultural roots” of trainee psychiatrists were often neglected by teachers, who found themselves unable to perceive “the way in which the changing cultural values and the concurrent professional development influence their (students) development as individuals.”^[108] Nonetheless, these reflections remain unacknowledged in more recent debates on psychiatric training in India.

DISCUSSION

The authors hypothesize that by “fitting into the mould” and adopting “Western” professional norms, the cultural sensitivity of Indian psychiatry trainees is sanitized. This leads to developing a professional identity that is rather impervious to the culturally grounded narratives of suffering and illness communicated by their patients and carers.^[115] This peculiar process of socialization during training may well impair future Indian psychiatrists’ abilities to intuitively understand and engage with their patients on the basis of their own cultural (in) sensitivity. It may re-configure the traditional “assumptive system that psychiatrists as cultural actors share in common with their patients and other members of society.”^[104] Yet, the practices of psychiatrists in India have sometimes been shown to be “simultaneously mediated by both professional and local cultural categories” as psychiatrists engage “in negotiate(ing) their own common sense understanding with allegedly objective and universal discourse of the biomedicine model.”^[104] Indeed, uncritical transplantation of biomedical psychiatry into another culture “undergoes multiple transformations in its epistemologies and methodology, acquiring a local or indigenous gloss in response to the demands of the situation.”^[104] How doctors use “(their) professional knowledge as psychiatrist and (their) cultural knowledge as social actor”^[104] to acquire and generate locally relevant practices is scarcely documented.^[116]

This critical review reveals an absence of studies on the process of professional identity formation and socialization during psychiatry training in India. The paper demonstrates a lacuna of knowledge concerning the nature and outcomes of such social processes and limits our overall understanding of the changes taking place during their

professionalization. This is surprising, considering the large body of literature addressing such issues in the West. For example, published ethnographic accounts of psychiatric training in Western settings have been instrumental to our understanding of the process leading to the identity formation of psychiatrists. In “becoming psychiatrists,”^[36] the medical sociologist Donald Light demonstrated through the observation of students in psychiatric residency “what kinds of people choose to become psychiatrists, how their training experience alters their sense of illness, treatment, and responsibility, and how they overcome the uncertainties of their work.” Such studies provide important theoretical contributions to our grasp of how the “underlying structure of professional training programs affects the behavior and attitudes of future practitioners.”^[36] Similarly, in “of two minds,”^[31] Tanya Luhrmann provides a detailed account of the theory and practice conveyed to students attending psychiatry residency training in the United States through 4 years of ethnographic fieldwork. Her work provides compelling evidence of the existing competing models of illness and treatment being taught in psychiatry (biomedical and psychodynamic) and the tension this generates among residents who consider them incompatible, representing different ideals or “different moral sensibilities, different fundamental commitments.”^[31] In the UK, this split between psychiatry and psychoanalysis led to the birth of different training institutions, together with extensive documentation of their training curricula. Although it focuses on the training of psychoanalysts, “The making of psychotherapists: an anthropological analysis”^[32] is an excellent account of how an ethnographic study can reveal the power of institutional devices in transforming trainee practitioners’ identities and practices into professional images.

The authors of this paper argue that a re-engagement with qualitative research, and more particularly, with ethnographic approaches is essential to advance the quality and outcomes of psychiatry training in India. Such research methodologies may further our understanding of the political economy of India’s medical institutions and the social framework within which the construction of professional identity takes place. Through an in-depth analysis of the day-to-day life of India’s medical schools and students, such methodologies may also potentially address some of the concerns raised in recent literature regarding the role of ethics, corruption, the influence of pharmaceutical companies, and the “effect of continuing privatization of health education”^[117-119] on the training of psychiatrists. Moreover, it may help identify the social agents that play an important role in socializing Indian psychiatry trainees, which may reasonably be assumed to differ from their Western counterparts. For example, the central position of the family in the Indian culture as a cohesive social unit with great continuity^[120] might influence the socialization process in a greater way than what has been observed in European studies of professional socialization. Similarly,

culture-specific kinship structures might be replicated in medical institutions, influencing the relations that medical students have with themselves and other socializing agents. The “brother–sister” supervision system documented by Nunley^[107] is a case in point. Finally, the important influence of patients^[7,121,122] and pharmaceutical companies in shaping both government and private psychiatric practices^[123] in India needs to be researched in the context of professional socialization and professional identity development.^[124]

Investigations into the nature of the social interactions that take place during the professional socialization of psychiatry trainees may also help unpack the sociocultural learning process and dynamics at play during psychiatry residency. This, in turn, could lead to key recommendations regarding pedagogic practices and teaching methods. For instance, it would be necessary to re-examine the influence of cultural historical constructs such as the “Guru–Chela” relationship. This understanding may shed light on the ability of psychiatry trainees to challenge received knowledge, and in the process, develop a reflexive self that bears upon their own knowledge and practice.^[125-127] In addition, students’ relation to authority warrants exploration in view of accounts situating hierarchy and humiliation as a central framework for social interaction in both medical training^[128,129] and Indian society.^[130,131] By adopting passive positions in relation to authority, Indian psychiatry trainees might thus be more prone to conform to the norms, beliefs, and practice set by the institutions, thus differentiating them from Western students who have been shown to be active and critical actors within their socialization.^[112] In this process, and for fear of symbolic castration of “disciples” by their “Gurus” in keeping with dominant Hindu mythic templates, their imagination and creativity may be stifled.^[127] Similarly, such passivity might also increase the emotional burden Indian psychiatry trainees are likely to bear as a result of not infrequent humiliations inherent to medical training. In line with Professor Raguram’s arguments regarding the emotional impact that psychiatrists must bear during their practice, a similar enquiry is needed to understand the nature and influence of the cultural affective landscape of psychiatry training.^[132]

Such an approach may also give weight to how the identity capital of Indian psychiatry trainees, which includes broader social constructs such as caste, gender, language, ethnicity, and social class, influences their education and the formation of their professional identity. First-hand discussion between the second author and psychiatrists in India suggests that both caste and gender operate in explicit and implicit forms, often resulting in social exclusion by their peers, poor performance, and suicide.^[133] Women psychiatrists in India notably have to begin balancing their professional identity and its demand with those of their private life as early as their postgraduate training, sometimes to the detriment of their career.^[134-136] This may in turn provide critical insight into the process of adult identity formation

in the Indian culture, a domain of enquiry that so far remains neglected, to the exception of few psychoanalytic writings.^[137-139] Socialization in Western societal systems and institutions privilege and produce forms of identity characterized by values favored by Western culture, such as autonomy, privacy, self-actualization, initiative, and independence. Consequently, it can be assumed that the identities constructed as a result of socialization into Indian social systems and institutions will vary from those documented in the Western literature by giving preference to values upheld within the Indian culture, such as mutual dependence, connections, and community.

In the context of a more applied clinical setting, there is a rich literature on the relationship between identity and “cultural countertransference.” This has been discussed as an “obstacle” if unaddressed,^[141,142] yet both “facilitators”^[143] and of “relevance and validity”^[24] for “cultural competent practice.”^[140] These papers highlight culture as integral to the process of transference-countertransference,^[144] making explicit the role of sociocultural dimensions embodied in professional and patient histories. In contrast, there is a surprisingly significant absence of literature in India, to the exception of Hoch’s analysis of supervision among psychiatry trainees in India^[91] and Neki’s canonical although dated analysis of the Guru–Chela relationship.^[125,126] An exception to this is a more recent account of inter-cultural dimensions in psychotherapy within an intra-cultural South Indian mental health setting.^[140] A further enquiry into how trainees’ identity shape the process of cultural transference/counter-transference, both in their training and clinical practice, is critical. This is particularly relevant in the context where contemporary market forces have intensified Indian society’s attempts to reconcile tradition with modernity^[145,146] and have led to a drastic reconfiguration of family structures and functions.

Finally, such methods of inquiry may help “historicize”^[147,148] the nature of Indian psychiatrists’ professional identity by shedding light on how colonization, culture, and identity continue to impact on identity formation and its changing configuration. Indeed, the current dominance of Western epistemologies in teaching curricula evokes a “cultural invasion”^[149] of the traditional Indian ways of dealing with mental illness by a largely Western-dominated biomedical psychiatric culture. At the center of this “invasion,” educational and medical institutions can be viewed as instrumental vehicles through which colonialism “colonizes minds in addition to bodies and releases forces within colonized societies to alter their cultural priorities once and for all,”^[149] leading in turn to a “postcolonial paralysis” of the Indian psyche.^[150] The role of such “cultural invasions” in discrediting the foundation of the “native” knowledge and identities might therefore explain (a) the fact that most Indian psychiatrists still perceive Western psychiatry as a superior form of culture that confers social status to

their professional identities,^[151] and (b) the critiques and ostracization that a handful of psychiatrists faced from their peers in attempting to resist and reappraise their discipline on the basis of its origins and validity shortly after independence.^[90,125,152] For these reasons, it is possible to posit that the professional identity of psychiatrists in India dominates their personal identity “in one’s pursuit of the upwardly mobile, elitist culture exemplified by their peers in the Western world.”^[106] Those wishing to develop a professional identity that deviates from and resists norms dictated by the official institution of psychiatry may thus find themselves stigmatized by their peers. Faced with such social and professional isolation, one could expect the professional identity of Indian psychiatrists to remain dominated by the Western psychiatric epistemologies first brought to India by the British and to be maintained by the rising place of psychiatry in the discourse of biomedical power that has appeared in the wake of globalization. As such, these attempts frequently fail to critically appraise or apply the philosophical and cultural relevance of acquired knowledge to their own practice. In short, the theory of psychiatry in India does not match local clinical challenges.

CONCLUSION

In this paper, the authors argue that student psychiatrists form their professional identities in a manner that has yet to be fully documented in India. Despite the recent and welcome publication of a collection of essays written by psychiatry students^[108,153] on their perspectives regarding their education, such accounts so far fail to provide the “thick description” that other anthropological enquiries of the subject have provided in a Western setting. Several important questions require further research: does identity develop in a linear manner that Freire cites as a passive “empty vessel” which simply “receives, memorizes, and stores” the imported Western narrative^[149]? What is the nature and site, of resistance to this received wisdom? Confronted with demands to adapt to a rapidly shifting culture, how do trainees become fluent in the “local tongue” of such changing cultures^[31]? What impact does this have on changing the prism through which they interpret local vernacular idioms of suffering and relevant constructions of illness? How trainee psychiatrists’ “other” identities are operationalized during their training, and what may be the emotional cost of doing so? The authors suggest further qualitative ethnographic research to unpack these challenging and vital questions. Such approaches hold potential to provide crucial insight into the ways of improving the outcome and experience of psychiatry training in India, while also helping to develop locally rooted epistemologies and practices. Furthermore, situating such enquiries within a postcolonial framework may shed light on how trainee psychiatrists in India shape the complex relationship between colonialism, modernity, globalization, and their newly found professional identity through

repudiation of their own cultural identity. In this regard, consideration should be given to the growing influence of social movements including “global mental health,” which, operating under the umbrella of international development, have been critiqued for serving to reproduce similar colonial dynamics by being a simple “deployment of Western biomedical models of mental disorders” through various national and international institutions.^[154-156] A critical reflection using postcolonial theory on the globalization of medical education and the “export of Western curricula, educational approaches, and teaching technologies” within the Indian context is essential.^[157] Indeed, attempts to address some of these issues have been documented in more recent publications.^[158] Finally, this paper proposes that such modes of inter-disciplinary enquiries will kick start a vital yet strikingly absent dialog that would allow for a cross-fertilization of theory between the social sciences and mental health in India to enhance locally responsive clinical training and practice.^[159,160]

Although this paper interrogates and critiques the professional identities of psychiatrists in India, this in no way belies the dedication and sincerity of those involved in conceptualizing, operationalizing, and delivering mental health services in India. It is crucial to note that the personal, clinical, and anthropological expertise of the authors (C.B, S.D, and S.J) situate them in a unique position. Indeed, the luxury of writing a critique from an intellectual position glaringly contrasts with the day-to-day struggle of those in positions of implementing services for a largely rural Indian population under complex and extremely challenging circumstances. The authors consider both positions useful, relevant, and complimentary.

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