# SYLLABUS

PSY.D.
(CLINICAL PSYCHOLOGY)
**Norms, Regulations & Course Content**


## REHABILITATION COUNCIL OF INDIA

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# PSY.D. (CLINICAL PSYCHOLOGY)

## ***Preface***

*The field of psychology is so broad that those working towards a professional degree have several options, and choosing between Ph.D. (Doctor of Philosophy), and a Psy.D. (Doctor of Psychology) degree is one such option. Until recently the Ph.D. degree is most commonly pursued among the two choices, as Ph.D.is the oldest doctorate available. But, in the recent years the Psy.D. degree has seen a phenomenal rise in popularity, particularly after the Vail Conference of 1973, where Psy.D. was officially recognized as a professional doctorate, and American Psychological Association endorsing this recognition.*

*The Ph.D. is a more traditional, research-based professional degree, while the purpose of the Psy.D. is seen as placing greater focus on preparing the individual for professional practice, with less research training built into the curriculum. With this in mind, the decision to work towards either degree depends on what the individual plans on doing with his or her professional life. For a career in academia the Ph.D. is seen as more advantageous because of the research-based emphasis. However, if one plans on entering a career centered on applied, clinical practice, the Psy.D. is the choice.*

*The trend in India today is towards greater desire to work in a clinical setting-understanding, preventing, or treating psychologically-based disorders and ailments. Majority of the clinical psychologists prefers to be in clinical domain after the basic training. Following enactment of the RCI Act in 1993, the 2-year supervised clinical training, as outlined in M.Phil program, is officially recognized as a minimum qualification to work independently in the area of mental health as an expert and/or specialist with defined professional role and responsibilities. Since then, the clinical perspective to the field of psychology has increased by many folds keeping consistent with global trend.*

*The recognition of M.Phil though has been useful in giving the professionals an increased flexibility in various practitioner roles, current M.Phil program trains candidate in a generic manner and doesn't prepares the individual for a future career in specialty areas related to clinical psychology. That necessitates M.Phil trained candidates going in for an additional degree and/or specific skill training to become practitioner in sub-specialization. Also, some of the M.Phil qualified candidates feel alienated to work within medical/clinical setup without a Doctorate and thus feel obligated to acquire a doctoral degree.*

*Currently more than 60% of the M.Phil trained clinical psychologists are not in service sectors for which they were trained, as they tend to shift to university setup for pursuing their Ph.D. degree. Since, many university set up do not have enough number of qualified clinical research guides, the trained professionals tend to spend several not so useful years before they get a doctoral degree. These phenomena, in addition to several others, have contributed to a very high attrition in human resource in the area of clinical psychology. Therefore, it is thought an Applied Clinical Doctorate degree in clinical psychology like that exists in most universities abroad (known as Psy.D.) would alleviate the need for joining for an Academic Research Doctorate degree (Ph.D.) by otherwise qualified clinical psychologists who wants to focus on the practical skills of psychology and their clinical applications. In addition, it is thought a clinically focused degree such as Psy.D. would help overcome certain weaknesses hitherto present in the M.Phil program such as absence of an internship experience at the end of the training, absence of training in sub-specializations, lack of emphasis on leadership and consultative components during the course work etc.*

*The Psy.D. has been developed to reflect the current international trend in training and practice of clinical psychology, and to create supervisor level professionals to initiate and manage M.Phil and Diploma level training programs to build human resource in the field of clinical psychology. The Council takes immense pleasure in forwarding this document to all universities with a request to initiate the training and help the Council enhance human resource in the field.*

Rehabilitation Council of India
(A Statutory Body under the Ministry of Social Justice and Empowerment)

# Psy.D. in Clinical Psychology

## 1.0 INTRODUCTION

Psy.D. in Clinical Psychology is grounded in the practice-oriented practitioner-scholar model of professional psychology. Clinical training is central to Psy.D. The program is committed to assisting the trainee in developing the essential knowledge base, attitudes, and therapeutic skills necessary to function as a professional clinical psychologist and as a trainer.

The clinical training is expected to be of higher level and provide the trainees with experiences that ensure depth and breadth of clinical interventions, diversity of clients, the opportunity to develop therapeutic competencies that integrate their theoretical knowledge with direct client experience, and the development of several core competencies in professional psychology including;

* Professional Practice
* Interdisciplinary Integration
* Management and Advocacy
* Legal and Ethical Competence

Psy.D. program is of four years duration divided as Part I, II, III and IV. During the first three years, candidates in their clinical placements gain experience participating in a variety of service settings including out-patient, in-patient/residential, brief care, out-reach and community services. Supervision is provided by the qualified, doctoral level clinical psychologists on the faculty. Later in the program, they undertake a year-long fulltime rotation internship with the supervision by a professional clinical psychologist who may or may not be faculty member.

Concurrent with their supervised practicum, candidates participate in all teaching programs and competency exams (theory and clinical/practical) that are held periodically within the department for the purpose of reviewing the clinical practicum experience.

Candidates already registered with RCI as clinical psychologist following 2-year M.Phil clinical psychology degree, shall join Third Year (Part III) of Psy.D. program (hereafter referred to as ‘lateral entry’) and complete final two years of fulltime course work of Psy.D. i.e. advanced competency in two electives and one-year of rotation internship.

During the course of Psy.D. a trainee completes a minimum of 4,000 hours (over 3 yr.) of clinical training with direct client contact, including advanced competency in the elective areas, participates in academic programs such as seminar, journal review, case conference, psychotherapy meeting, clinical pedagogy, and obtains minimum expected grade in periodic assessments in theory and practicum. In addition, 2,000 hours of rotation internship experience in fourth year of the course culminate in the professional foundations for clinical psychology practice integrating various components of the program.

Lateral entry candidates joining third year of the course, completes minimum 1,350 hr. (1 year) of advanced competency training in the elective areas and 2,000 hr. (1 year) of rotation internship.

Although not designed to produce researchers, the Psy.D. program teaches candidates to be educated consumers of research. To reach this goal, they have both academic training and personal experience in advanced research methods and statistics.

Psy.D. graduates are eligible to gain employment as consultants in private practice, professional members in large and small academic organizations, leader-managers in human service organizations, faculty in higher education and principal investigator in research projects. The entry level appointment can be at Assistant Professor cadre in academic institutes.

## 2.0 AIM & OBJECTIVES

### 2.1 Aim

The aim of this program is to train and assist candidates in developing the knowledge base, attitudes, judgment, professionalism and technical skills essential to function as a consultant clinical psychologist and trainer, based on the principle of progressively increasing levels of responsibility in core areas and sub-specializations.

### 2.2 Objectives

The Psy.D. is applied clinical doctorate degree and its overall objective is to prepare candidates to practice at the doctoral level with flexibility to be useful in various different practitioner roles, make scholarly contributions to professional community,

and take leadership positions in the mental health field. To this end, the program strives to:

2.2.1 Foster personal growth in the trainee and to deepens his/her appreciation for the complexity, diversity and spirit of the human conditions. The objective is to broaden candidates' knowledge and sensitivity.

2.2.2 Promote maturation of conceptual and technical skills relevant to the delivery of clinical psychology services, and to provide the trainee with a well rounded understanding of multiple models of client change and techniques necessary to facilitate such change. The application of techniques to diverse clinical settings and various theoretical models in relation to client service.

2.2.3 Nurture a strong ethical base in the trainee, and to provide the trainee with a professional standard of conduct through classroom teaching and application of case materials, and to sensitize to dilemmas arising in professional work.

2.2.4 Teach multiple strategies for identifying, defining, studying and analyzing research data on clinical problems and foster a desire for systematic inquiry of clinical problems.

2.2.5 Assist the trainee to acquire advanced knowledge and proficiency in their areas of special interest (third year of program permits flexibility and offers a wide choice of sub-specialization, which are reviewed and revised periodically to reflect the contemporary needs).

2.2.6 Encourage professional exchange among the trainees by way of attending and presenting their idea/work at professional meetings, to publish and to involve in professional activities as deemed fit.

## 3.0 COMPETENCIES AND EXPECTED OUTCOMES

Upon completion of the program, the trainees are expected to have demonstrated competency in the following areas:

3.1 Case conceptualization and diagnoses through application of clinical strategies for problem analysis.

3.2 Addressing client problems through multiple psychotherapeutic strategies.

3.3 Sensitivity to gender, religious and socio-cultural diversity in clinical practice.

3.4 Understanding of transference and counter transference issues in the therapy processes.

3.5 Select, administer and analyze a wide range of assessment tools/techniques to facilitate problem understanding and recommendations.

3.6 Responding from an informed ethical base that demonstrates understanding of ethical code and professional conduct.

3.7 Development of relevant clinical research hypotheses and carrying out an empirical research inquiry.

3.8 Understanding of normal and atypical patterns of development and behavior across the life span of clientele, including children, adolescents, adults, elderly and clients with special needs like HIV/AIDS, terminally ill, traumatized, victims of abuse etc.

3.9 Understanding of psycho physiological, neuropsychological and psychopharmacological considerations in relation to diagnostic groups.

3.10 Understanding of human sexuality in relation to diversity of expression and treatment implications.

3.11 Understanding of social psychology principles that shape individual and group behavior.

3.12 Understanding of practice issues in the private sector.

3.13 Understanding legal and ethical obligations, and provide expert testimony in the court of law assuming different roles.

3.14 Understanding and developing strategies for client and professional advocacy through the organization and dissemination of clinical literature and data.

3.15 Understanding contemporary professional issues and taking leadership/ consultation/administrative/education/management/supervisor positions in the mental health field.

## 4.0 FUNCTIONS AT EACH LEVEL

The program provides considerable autonomy especially in the tasks already mastered in the previous years under faculty supervision. At each level of training, there is a set of competencies that the trainee is expected to master. As these are learned, greater independence is granted in the routine care of the patients at the discretion of the faculty who, at all times, remain responsible for all aspects of the care of the patients. Expected functions and responsibilities for each level (Year I to IV) are as given below.

## 4.1 First Year (Part – I)

The trainee is closely supervised by the faculty during the first year. Examples of tasks that are expected at this level include:

a) Clinical work up of clients with mental illness
b) Synthesize and integrate collateral information from multiple sources
c) Formulate problems within psychosocial models and arrive at diagnosis
d) Carry out psychological assessment as per clinical indications
e) Analyze psychological test/s results and communicate findings to the other members of the team involved in the care
f) Assess disability/dysfunction associated with the client's problem/s
g) Assess family and caregivers' burden
h) Obtain informed consent and make clear the ethical and legal issues involved
i) Communicate with patients and families about the illness, educate, address misinformation, if any, and outline the plan of care
j) Assist patients and family coping with symptoms and care-giving burden

Summary: The trainee is expected to exhibit a dedication to the principles of professional preparation that emphasizes primacy of the patient as the focus for care. The first year trainee must read selected subjects that promote personal and professional growth and be able to demonstrate successful use of the literature in dealing with patients. At all levels, the trainee is expected to demonstrate an understanding of the socioeconomic, cultural, and managerial factors inherent in providing cost effective care.

## 4.2 Second Year (Part – II)

The trainee in the second year is expected to perform independently the duties learned in the first year. He/she may carryout clinical work up, psychological assessment, psycho-education of the patients and their families without direct (onsite) supervision. In addition, under the direct supervision of faculty;

a) Carry out specialized assessments required prior to start of the treatment, and set treatment goals
b) Develop management plan and carry out appropriate evidence-based interventions
c) Evaluate outcome and integrate alternative approaches depending on outcome
d) Maintain therapy record

e) Communicate other members of the team or referral source the treatment progress
f) Respond to consults in conjunction with the faculty member as senior trainee.

**Summary:** During II year as a senior trainee he/she should demonstrate continued sophistication in the acquisition of knowledge and skills in areas of clinical psychology and develop ability to function independently in evaluating problems and developing an intervention plan for patient care. He/she should be adept at the interpersonal skills needed to handle difficult situations and should be able to incorporate ethical concepts into patient care and discuss these with the patient, family, and other members of the team.

As senior trainee, he/she should take a leadership role in teaching I year trainees the practical aspects of patient care and be able to explain complex diagnostic and therapeutic procedures to patients and their families.

## 4.3 Third Year (Part – III)

The trainee in third year should be capable of managing patients with virtually any routine primary mental conditions, and be responsible for coordinating the care of multiple patients on the team assigned. A trainee in the third year may carry out all routine diagnostic and therapeutic procedures without direct (on-site) supervision.
The third year trainee be adept in supervising and guiding the first and second year trainees in their daily activities, as junior consultant.

While continuing to integrate the skills and knowledge acquired in the first two years, trainees in the third year are required to acquire advanced proficiency including full range of intervention skills, procedures and techniques in two sub-specialty areas from the list given in section 4.6 under the direct (on-site) supervision of the faculty in-charge of these specialties.

In the third year, trainees are also expected to begin to work on their empirical thesis which shall be related to one of their electives and by the end of the third year they are expected to have completed all processes involved in synopsis approval such as preliminary presentations at the departmental meeting and ethical committee clearance, permission from the concerned specialty unit/ department for data collection.

## 4.4 Fourth Year (Part – IV)

The fourth year is one of senior leadership and the trainee should be able to assume an increased level of responsibility as fellow/ associate consultant on selected services and can perform the full range of complex tasks expected under the supervision. Also, assume responsibility for organizing the service and supervising candidates on routine basis. The trainee should have mastery of the information contained in standard texts and be facile in using the literature to solve specific problems encountered in clinical practice.

The trainee gives formal presentations at scientific assemblies and assumes a leadership role in conducting various service activities and teaching on the services rendered. The mores and values of the profession should be highly developed, including the expected selfless dedication to patient care and commitment to continuous improvement of self and the practice of profession.

The trainee is required to complete one-year rotation internship assignment as outlined in section 4.7 and submit an empirical research thesis as specified in section 4.8 in fourth year.

## 4.5 All Years

Trainees at every level are expected to treat all colleagues and members of the health care team with respect and dignity, and recognize their contribution, direct and indirect, in the service activities. Religion, caste or gender slurs are serious violations and never acceptable. Trainees are to be identified exclusively as professionals-in-training and expected to conduct and act in a manner that displays the highest regard for human dignity and professional standard. Trainees are expected to demonstrate personal qualities that are required for psychologists. The professional behavior (ability to empathize with a wide diversity of clients and work in an effective manner with other professionals) is expected both in the service settings as well as at other relevant professional settings e.g., when conducting research, during internship etc. Any trainee found lacking in professional conduct shall be suspended or terminated from the program.

Trainees are expected to develop a personal program of reading. Besides the general reading in the specialty, trainees should do directed reading daily with regard to problems that they encounter in patient care. Trainees are responsible for reading prior to performing any interventions that he/she has not yet had the opportunity to perform and learn. Trainees are expected to attend all academic programs arranged at

the department. These programs are designed to provide a didactic forum to augment the trainees' reading and clinical experience. Trainees shall follow institute's policies and procedures and support the mission, vision and values of the service facility.

## 5.0 ADVANCED PROFICIENCY

In third year, all trainees must complete an advanced proficiency in two sub-specialization areas (hereafter referred to as "Elective – I" and "Elective – II") depending on his/her interest. The trainee can select any two sub-specializations from the list given in 5.1. Duration of the training in each elective is six months. At the completion of each elective posting, the trainee is expected to be skilled in various diagnostic and therapeutic procedures and their empirical basis, in addition to have synthesized the relevant concepts, theories, methods and recent knowledge, issues and challenges in the chosen specialty areas. By the end of third year trainees should be ready to assume clinical responsibility in these specialties and act as specialist on selected services and advice colleagues from other specialties in problems related to these specialties.

In case of inadequate facilities at the parent institute with respect to an elective area of trainees' interest, the center has the option of posting such trainees to center/facility outside its own for a maximum period of six months in the Third Year (three months in each electives, or six months to cover one elective entirely). In such instances, the center shall ensure training in the required area/s take place under the supervision of qualified professionals and the candidate's involvement, performance and competency are rated and certified.

### 5.1 Sub-specializations (Electives)

1. Applied Behavior Analysis
2. Behavior Therapy
3. Behavioral Medicine
4. Cardiac Rehabilitation
5. Clinical Child and Adolescent Psychology
6. Clinical Neuropsychology
7. Cognitive-Behavior Therapies
8. Community Mental Health
9. Crisis interventions

10. Forensic Clinical Psychology
11. Geriatric Psychology
12. Human Sexuality and Dysfunctions
13. Marital and Family therapy
14. Mental Retardation
15. Pain Management
16. Palliative Care
17. Psychoanalytic Therapies
18. Psycho-oncology
19. Rehabilitation of Mentally Ill
20. School Psychology
21. Substance Abuse

## 6.0 INTERNSHIP

The internship posting in the fourth year is for one year duration consists minimum 2000 hr. of supervised clinical experience under a professional clinical psychologist who may or may not be faculty member. The aim of the internship is to:

a) Apply knowledge and skills acquired during three years of studies to clinical practice and develop a realistic sense of competence in assessment and psychotherapy skills with a wide range of client populations through involvement in diversified inpatient and outpatient activities.

b) Round off studies/training with a strategic plan for the professional development drawing on the experience obtained from previously completed years.

c) Demonstrate mature, ethical, judgmental, clinical and administrative skills needed for independent clinical practice.

d) Understand the role of practitioner in mental health care delivery system and to be aware of the practical issues in mental health care management facing patients and professionals.

e) Develop leadership and consultative skills within a mental health setting, and function as part of a multi-disciplinary treatment team.

f) Collect specific data for empirical research thesis.

## 6.1 Placement

The department is responsible for finding placement for trainee's internship. If the trainee already has a service center fitting the requirements for internship; it can be carried on with the approval of the supervisor of the thesis and the head of the department. The completion report of the internship is due in a 10 days after completion of internship and should include description of the center where internship was carried out, aim and objectives of the internship, practical circumstances, precise description of the duties on daily basis, difficulties faced in work set up, what the trainee learned and accomplished, the effectiveness of doing the internship and an evaluation of the experience.

## 6.2 Rotation

The trainee completes four major rotations, each lasting three months, and typically consisting of assignment to adult and child mental health facilities. The major rotations sequence should focus on the development of basic clinical skills and providing opportunities for conducting assessments; participating in a multi-disciplinary treatment team; and providing group, family and/or individual psychotherapy. The trainee may explore specialty areas through minor rotations of two to three weeks' duration, with the permission of the concerned head of the facility and in outpatient work. Efforts shall be made by the concerned HOD to assign supervisors based on the trainee's interests with respect to therapeutic modality and patient population. From each posting the trainee has to obtain an evaluation report from concerned supervisor based on his/her performance and submits the same to the board of examiner on final exam along with an internship experience report and an empirical research thesis carried out during the internship period.

# 7.0 EMPRICAL RESEARCH THESIS

The empirical research thesis in fourth year is a scholarly undertaking in one of the elective areas the trainee has chosen to acquire advanced proficiency. The project

may be in the form of original research involving a clinical hypothesis, an evaluation of a technique/method/approach, developing norms, or standardizing a tool. In short, the thesis is meant to demonstrate the trainee's ability to think critically about the clinical issues and to make appropriate use of scientific knowledge and psychological research in professional practice.

The candidate initially develops a project proposal with consent of the Guide and presents during the departmental meeting. On approval by the faculty members and an ethical committee clearance he/she carries out the work as per the approved synopsis, under the guidance of a faculty member with Ph.D./Psy.D. having 5 years or more of post-doctoral clinical/research experience. If the research work is of interdisciplinary nature requiring input/supervision from another specialist, co-guide(s) from the related discipline may be appointed as deemed necessary.

It is desired that the trainee has already published some part of the data in peer-reviewed journal or being submitted or in the process of submitting for publication.

## 8.0 INFRASTRUCTURAL REQUIRMENTS

8.1 There shall be an independent Department of Clinical Psychology at the Institute/University.

8.2 The Department should have been involved routinely in one of the following activities for a minimum period of 3 years:

a) Rendering a wide variety of clinical services in mental health area
b) Involved in imparting clinical teaching
c) Conducting clinical research in core areas of clinical psychology

8.3 The Department should already be a recognized center for conducting M.Phil clinical psychology program (unless the existing infrastructure is exceptionally good and the doctoral program is justifiable).

8.4 There shall be at least two full-time permanent faculty members (RCI registered), one at the level of Additional Professor/Professor and the other at the level of Assistant Professor or above. The qualifications of the faculty members shall be as specified below.

Additional Professor /Professor: M.Phil + Ph.D. + 9 years of teaching experience, out of which 3 years as Associate Professor + 5 research publications in indexed journal as first/corresponding author.

Associate Professor: M.Phil + Ph.D. + 5 years of teaching experience either as Lecturer or as Assistant Professor + 3 research publications in indexed journal as first/corresponding author.

Assistant Professor: M.Phil + 2 years of teaching experience as lecturer or as clinical psychologist in department of clinical psychology conducting M.Phil program + 2 research publications in indexed journal as first/corresponding author (Ph.D. is desirable).

N.B.: Ph.D. shall mean earned research doctoral degree from UGC recognized university.

8.5 Sufficient clinical material/facilities shall be available at the department to meet the requirements outlined in the syllabus. A monthly turnover of 150 cases (old and new together) minimum per student of Psy.D. shall be required. The specified caseload for Psy.D. program is independent of that required for conducting any other program at the center and shall not under any circumstances “counted" toward caseload required for conducting another training program. Tele-counseling, e-counseling etc. that do not involve face-to-face interaction shall not be considered for computing the monthly turnover. Of the total turnover at least 50% of the cases shall be undergoing psychological treatment(s) of some form viz. psychotherapy, behavior therapy, biofeedback, hypnosis, counseling, marital therapy, group therapy, sex therapy etc. Clinical work-ups or psychological assessments alone without therapy interventions are considered suboptimal for professional training in clinical psychology.

8.6 Acceptable infrastructure in terms of adequately furnished rooms for every faculty members and trainees to carry out professional activities like working-up of cases, interviewing, counseling, therapies, testing etc. for indoor and outdoor cases shall be available at the department. Standard psychological tests, equipments/apparatus, questionnaires, scales, inventories, clinical rating scales related to all primary domains shall be available in sufficient quantity, and freely accessible to all concerned. Wherever possible the vernacular versions of the tests materials along with local norms shall be made available.

The minimum infrastructure required for an annual intake of TWO trainees for Psy.D. include but not necessarily limited to;

| | |
|---|---|
| i) Psychological tests: | 1 copy/set each of the core tests as given in section on "Practical – Psychological Assessments" |
| ii) Clinical rating scales: | For common conditions of childhood, adolescence and adult such as anxiety, mood, speech, language and thoughts, adjustment, personality, developmental, behavior, cognitive, pain, conduct, sexual disorders, and in specialty areas |
| iii) Behavior therapy apparatus: | 1 number |
| iv) Biofeedback: | 1 each, at least for 2 parameters |
| v) Classroom | 1 number with multimedia facilities for conducting in-house academic activities, on routine basis |
| vi) Computer | 1 with printer and internet facilities + statistical software packages |

**N.B.: The above facilities are in addition to what has been created for conducting other program/s at the center.**

8.7 Active liaison with department like Psychiatry, Medicine, Surgery, Neurology, Neurosurgery, Pediatrics, Social Work and such other allied specialties shall exist in addition to direct or self-referrals, so that exposure to a broad range of clinical problems shall be possible. Depending on the presence/ absence of facilities at the parent institute, the trainees may be posted to other centers as deemed necessary for an exposure in specialty areas such as child guidance, family therapy, addiction, neuro/cognitive rehabilitation, palliative/ hospice center, cancer and such other areas of expertise while training in core areas continues at the parent institute. In such events, the period of posting for extra-institutional learning shall not exceed three calendar months in I or II academic year, and shall not exceed six months in the III academic year for advanced

proficiency in sub-specializations (electives). In all years, the posting should happen under the appropriate on-site supervision of an expert in the area.

8.8 Adequate and updated library facilities with textbooks, reference books, important national and international journals (hard or soft copy), educational audio/video CDs, and access to Internet shall be easily available and accessible to all trainees. In addition, certain reference books, therapy manuals, index books etc. those required by the trainees for a quick reference during the service hours shall be stocked at the departmental library and shall be made accessible easily.

## 9.0 REGULATIONS OF THE COURSE

### 9.1 Number of Seats

The intake of candidates in an academic year shall not exceed the following ratio.

Additional Professor/Professor - 1 : 2

Associate Professor - 1 : 1

Part-time/temporary/superannuated/professional members crossed 62 years of age may render their input as deemed fit to enrich the program but they are ineligible to admit and guide students of Psy.D. Course.

### 9.2 Entry requirements

Requirements for admission shall be stringent.

#### 9.2.1 Direct Entry:

a) M.A./M.Sc. degree in Psychology from a university recognized by the UGC with a minimum of 65% marks in aggregate. For SC/ST/ OBC category, a minimum of 60% marks in aggregate is essential.

b) Should have completed Master’s Degree no more than five years prior to application.

c) Should have completed a research dissertation at the Master's level.

d) Two letters of recommendations from permanent faculty members from where Masters Degree has been completed should accompany the application. Of the two, at least one faculty member shall be with Ph.D.

### 9.2.2 Lateral Entry:

a) M.Phil Clinical Psychology degree from a RCI recognized centers with minimum 55% marks in aggregate.

b) Should have completed university exam of Part I and II in the first attempt.

c) Should have RCI registration under Clinical Psychologist category or the same must be in the process.

d) Two letters of recommendations from permanent faculty members from where M.Phil degree has been completed should accompany the application. Of the two, at least one faculty member shall be with Ph.D.

## 9.3 Admission Procedure

A selection committee that includes Head of the Department of Clinical Psychology shall make admission on the basis of an entrance examination consisting of an **objective-type exam** (to test the knowledge base in related branches of psychology), a **written test** (to test the writing skills essential to communicate among other clinicians/professionals), **group discussion** (to test the expressive skills), **practical** (to test the proficiency in administering and interpreting the basic psychological tests and conducting a problem-focused interview with a client) and an **interview** (to understand motivation and commitment to serve in the profession). It is desired that the selection committee take all of the above into consideration, assign weightage for each components and make final selection on the basis of the total score obtained. The entrance examination shall be held separately for direct and lateral entry applicants.

List of candidates so selected/admitted to the course should be sent to RCI within a month of admission formalities are completed. No changes shall be permitted once the list of admitted candidates for the academic year is sent to the council.

## 9.4 Duration

The training is for four years duration (divided as four parts) on fulltime basis and under the direct supervision of the qualified faculty members. Each year of clinical training involves supervised practicum with autonomy in the tasks already mastered in the previous years.

Lateral entry: The training for candidates with RCI recognized M.Phil Clinical Psychology degree is for two years duration. The candidates join Part – III of Psy.D. program and shall complete one year of advanced proficiency in two electives and a year-long rotation internship. Part - I and II are exempted for Post-M.Phil candidates.

## 9.5 Attendance

9.5.1 Part – I to IV of the course must, unless special exemption is obtained, continuously be pursued. Any interruption in a trainee's attendance during the course of training, due to illness or other extraordinary circumstances must be notified to the Head of the Institution/concerned authority and permission should be obtained.

9.5.2 A minimum attendance of 80% (in each Part of the training) shall be necessary for taking the respective year-end university examination. More than four weeks of absence in an academic year will make the trainee ineligible to appear for the respective annual examination, irrespective of circumstances/reasons.

9.5.3 A maximum of 15 days of casual leave per academic year shall be permitted during the four-year course period.

## 9.6 Content of the Course

**Part - I (I - Year)**

Group "A"

Paper - I : Psychosocial Foundations of Behavior

Paper - II : Biological Foundations of Behavior

Paper - III : Psychopathology

Paper - IV : Psychiatry

Practical : Psychological Assessment and Diagnosis (including Viva Voce)

Group "B"

Submission : Ten full-length Psychodiagnostic Records, out of which two records should be related to child and two related to neuropsychological assessment. The records should include a summary of the clinical history organized under relevant headings, and a discussion on a) rationale for testing/assessment, b) areas to be investigated, c) tests administered and their rationale, d) test findings and e) impression

**Part - II (II - Year)**
**Group "A"**

Paper - I : Psychotherapy and Counseling

Paper - II : Behavioral Medicine

Paper - III : Evidence Based Practice and Clinical Research Issues

Paper - IV : Statistics and Research Methodology

Practical : Psychological Therapies (including Viva Voce)

Group "B"

Submission : Ten fully worked-out Psychotherapy Records, out of which two should be child therapy records. The records should include a summary of the clinical history organized under relevant headings, and a discussion on a) reasons for intervention(s), b) areas to be focused including short- and long-term objectives, c) type and technique of intervention(s) employed and rationale d) therapy processes, e) changes in therapy or objectives, if any, and the reasons for the same, f) outcome, g) prevention strategies, f) future plans

**Part - III (III - Year)**
**Group "A"**

Paper - I: Theory and application issues as related to Elective - I

Paper - II: Theory and application issues as related to Elective - II

Practical -I: Intervention skills as related to Elective – I and viva voce

Practical-II: Intervention skills as related to Elective – II and viva voce

**Group "B"**

Submission – I: Five video recording of treatment sessions related to Elective – I along with printed records as described below.

Submission – II: Five video recording of treatment sessions related to Elective – II along with printed records as described below.

**Description of the Records**:

1) Current diagnostic formulation: In this section the trainee reviews the current ICD diagnostic impression of the client, describes the client's personality, strengths weaknesses, diversity issues, legal and ethical issues in the case and theory about what is causing the ICD condition(s).

2) Conceptualization of the intervention plan: In this section, the trainee reviews literature that supports the treatment model that is being employed with the client and his/her conceptualization of the intervention plan and comments on the prognosis, difficulties that may be encountered in the successful completion of the planned intervention and ways to mitigate them.

3) Description of the video recorded session: This section would include elements such as; the session number, goal for the session, session content, the value of the session within the overall treatment plan, process comment, transference and counter

transference involved in the case, and the trainee's thinking on the success of the session.

**Part - IV (IV Year – Internship and Empirical Research)**

Group "A"

Internship: Rotation Internship as described in Section 6.0

Group "B"

Empirical Research: A thesis based on empirical research as described in Section 7.0 under the guidance of a faculty member having minimum five years of post-doctoral clinical/research experience.

## 9.7 Minimum prescribed clinical work

| | Number of Cases | | |
|---|---|---|---|
| | Part - I | Part – II | By the end of Part - III * |
| 1) Detail case workups | 100 | 150 | 250 |
| 2) Psychodaignostics | 100 | 150 | 200 |
| 3) Neuropsychological Assessment | 20 | 30 | 40 |
| 4) Therapies | | | |
| i) Psychological Therapies | 100 cases totaling not less than 1000 hr. of intervention by the end of Part - III | | |
| ii) Behavior Therapies | 100 cases totaling not less than 1000 hr. of intervention by the end of Part - III | | |

9.7.1 Therapies should be not less than 500 hr. of work in each of the Electives in the third year, and not less than 250 hr. of work in each of the following areas up to third year:

a) Therapies with children/adolescents
b) Individual therapies with adults
c) Family/marital/group/sex therapy
d) Psychological and/or neuropsychological rehabilitation

9.7.2 A logbook of the clinical work carried out under the supervision during each year of the training, with sufficient details such as particulars of the client, diagnosis, duration and nature of intervention(s), number of sessions held etc. should be maintained by all trainees and must be submitted to the board of examiners at the time of year-end final examinations.

## 9.8 Requirement/Submission

9.8.1 Two months prior to Part - I examination the trainees are required to submit ten full-length Psychodiagnostic Reports as outlined under Section 9.6

9.8.2 Two months prior to Part - II examination the trainees are required to submit ten Psychotherapy Records as outlined under Section 9.6.

9.8.3 Two months prior to Part - III examination the trainees are required to submit five video recording of a treatment session related to each Elective area along with a printed report as outlined under Section 9.6.

9.8.4 Two months prior to completion of Part – IV the trainees are required to submit, an empirical research thesis carried out under the guidance of a clinical psychology faculty member as specified under Section 7.0 and successful completion of one-year rotation internship certificates.

9.8.5 The application for appearing in each Part of the examination should be accompanied by a certificate issued by Head of the Department that the trainee has carried out the specified minimum clinical work as outlined under Section 9.7 and submitted all records. A competency certificate stating that the trainee has attained the required competence in core-tests

(refer Section 10.0 (Part –I) "Practical - Psychological Assessments" for the list of core-tests) shall be required, in addition to the above, to appear in Part – I of the examination.

## 9.9 Internal Assessment

Thirty percent marks will be determined on the basis of internal examinations in each subject of Group "A" (theory and practical) in Part I and II, and in each subject of Group "A" and "B" (theory, practical and submissions) in Part III. These marks will be added to the marks allocated to the respective subjects in the final examinations and results declared on the basis of the total so obtained. The guidelines for allotting the internal marks may be prepared by the concerned department which shall include at least two theory and practical/clinical exams.

## 9.10 Final Examination

9.10.1 As a final evaluation at the end of each part, theory and practical exams are held. Trainees must pass the respective exams before he/she is allowed to take the exams connected to the next part. The purpose of the final exam is to ensure that the trainee has developed the requisite skills in each professional domain successfully before taking the next level of competency exam. Completion of all course requirements as specified for each part is mandatory for appearing at the final exams.

9.10.2 A trainee who has not appeared or failed in final examination of Part I or II may be allowed to continue the training, and be allowed to take the supplementary examination of the respective year.

9.10.3 A trainee will not be allowed to take the Part – II exam unless he/she has passed the Part – I exam, similarly he/she will not be allowed to take Part – III exam unless he/she has passed the Part – II exam.

9.10.4 A trainee will not be allowed to begin internship unless he/she has passed all the exams of Part – III.

9.10.5 A trainee will not be allowed to start the data collection prior to having passed the Part – III (Elective – I and II) exams.

## 9.11 Examination Fee

The prescribed examination fee as laid down from time to time by the concerned university to appear in each of the examination should be paid as per the regulations.

## 9.12 Scheme of Examination

**Part – I (I Year)**

| Paper | Title | Exam Duration | Marks: Internal Assessment (Maximum) | Marks: Final Examination (Maximum) | Total |
|---|---|---|---|---|---|
| Group "A" | | | | | |
| Paper I: | Psychosocial Foundations of Behavior | 3 hr. | 30 | 70 | 100 |
| Paper II: | Biological Foundations of Behavior | 3 hr. | 30 | 70 | 100 |
| Paper III: | Psychopathology | 3 hr. | 30 | 70 | 100 |
| Paper IV: | Psychiatry | 3 hr. | 30 | 70 | 100 |
| Practical: | Psychological Assessments and Viva Voce | | 30 | 70 | 100 |
| Group "B" | | | | | |
| Submission: | Ten cases of full-length Psychodiagnostics Report | | 100 | - | 100 |
| | | | | | 600 |

**Part – II (II Year)**

| Paper | Title | Exam Duration | Marks: Internal Assessment (Maximum) | Marks: Final Examination (Maximum) | Total |
|---|---|---|---|---|---|
| Group "A" | | | | | |
| Paper I: | Psychotherapy and Counseling | 3 hr. | 30 | 70 | 100 |
| Paper II: | Behavioral Medicine | 3 hr. | 30 | 70 | 100 |
| Paper III: | Evidence Based Practice and Clinical Research Issues | 3 hr. | 30 | 70 | 100 |
| Paper IV: | Statistics and Research Methodology | 3 hr. | 30 | 70 | 100 |
| Practical: | Psychological Therapies & Viva Voce | | 30 | 70 | 100 |
| Group "B" | | | | | |
| Submission: | Ten fully worked-out Psychotherapy Records | | 100 | - | 100 |
| | | | | | 600 |

**Part – III (III Year)**

| Paper | Title | Exam Duration | Marks: Internal Assessment (Maximum) | Marks: Final Examination (Maximum) | Total |
|---|---|---|---|---|---|
| **Group "A"** | | | | | |
| Paper I: | Elective – I | 3 hr. | 30 | 70 | 100 |
| Paper II: | Elective – II | 3 hr. | 30 | 70 | 100 |
| Practical -I: | Interventions related to Elective – II including Viva Voce | | 30 | 70 | 100 |
| Practical-II: | Interventions related to Elective – II including Viva Voce | | 30 | 70 | 100 |
| **Group "B"** | | | | | |
| Submission - I: | Five video recording of one of the treatment sessions related to Elective – I along with therapy report | | 30 | 70 | 100 |
| Submission - II: | Five video recording of one of the treatment sessions related to Elective – II along with therapy report | | 30 | 70 | 100 |
| | | | | | ----- 600 |

## Part - IV (IV Year – Internship & Thesis)

### Group "A"

Satisfactory completion of a year-long rotation Internship as described in Section 4.7.

The supervisor responsible for each of the rotation postings will grade the trainee based on his/her performance during the posting in the following domains.

### Grading:

1 Very weak
2 Weak
3 Adequate
4 Strong
5 Very strong

### Domains:

- Assessment skills _____
- Working alliance with the client/family _____
- Clinical conceptualization of the case _____
- Intervention skills _____
- Documentation skills _____
- Ability to integrate research with practice _____
- Understanding of ethical guidelines _____
- Professional conduct and alliance with team members _____

### Evaluation: *Satisfactory / Not Satisfactory*

Grade less than 3, in three or more domains is considered "Not Satisfactory". The trainee has to repeat the posting in which he/she has been graded "not satisfactory" for the same duration and obtain satisfactory grades before he/she is declared to have successfully completed the rotation internship.

### Group "B"

Submission of Research Thesis under the guidance of a Clinical Psychology faculty member as outline in Section 4.8.

**Evaluation:** ***Accepted / Non-Accepted***

Upon completion of the work and approval by the guide the trainee submit required number of copies (usually four) two months prior to exam and makes a final presentation to the board of examiners on the day of exam. The thesis should be "Accepted" at least by two out of three examiners before the trainee is declared to have passed this component of the training. In case of non-acceptance by two or more, the trainee has to comply with the shortcomings pointed out by the examiners and/or discussed at the time of oral presentation, and resubmit the revised thesis or rework on the problem, as case may be, and reappear in the next exam.

## 9.13 Board of Examination

The Board of Examination (BOE) consists of three doctoral level clinical psychology faculty members. The Chairman BOE shall be the Head of the Department of Clinical Psychology who will also be an internal examiner. The other two examiners are chosen externally from an academic institute/center.

All the examiners, one internal and two external, shall evaluate each of the theory paper, submissions and will conduct the practical/clinical and vivo-voce examination. The external examiners shall assist the Chairman – BOE in paper setting, evaluation of the submissions and thesis, as deemed necessary.

## 9.14 Minimum for Pass

A trainee shall be declared to have passed the year-end final examination of Part – I, II or III if he/she obtains not less than 60% of the marks (average among the examiners) in each of the theory paper, practical including viva voce, and submission (where it applicable). All three examiners will evaluate each of the theory papers, submission and performance in practical independently and fill out a statement of marks. In Part – IV, Pass/Fail is declared based on grade assigned, as outlined in Section 9.12.

A trainee who obtains 75% and above marks in the aggregate of Part – I, II and III shall be declared to have passed Psy.D. with Distinction.

## 9.15 Appearance for each examination

Trainees shall appear for all the groups when appearing for the first time and reappear upon failing only for the group in which he/she has failed. A trainee has to complete the course including internship successfully within a period of six years from the year of admission to the course in case of direct entry, and within a period of four years from the year of admission in case of lateral entry. No trainee shall be permitted to appear Part – I, II, III and IV examination more than three times.

## 10.0 SUBJECT WISE SYLLABUS OF PART I AND II

The syllabus for each of the paper of Part-I and II is as appended below. It is desired that each units of theory papers be covered employing effective instructional methods such as didactic lectures, seminars, tutorials, guided discussion, critical review of existing literature, clinical pedagogy as deemed fit depending on the content, nature and objective of each units, and the learners' style and the level of learning that they must attain. Attention shall be given, however, to see that each method of teaching shall not exceed 20% of the required teaching input.

**Part – I (Year – I)**

**PAPER – I: Psychosocial Foundations of Behavior**

Unit - I: Introduction: Overview of the profession and practice; history and growth; professional role and functions; current issues and trends; areas of specialization; ethical and legal issues; code of conduct.

Unit - II: Mental health and illness: Mental health care – past and present; stigma and attitude towards mental illness; concept of mental health and illness; perspectives – psychodynamic, behavioral, cognitive, humanistic, existential and biological models of mental health/illness;

Unit-III: Epidemiology: Studies in Indian context; tools available/standardized for epidemiological surveys; socio-cultural correlates of mental illness; religion and mental health; psychological well-being and quality of life – measures and factors influencing.

Unit-IV: Self and relationships: Self-concept, self-image, self-perception and self-regulations in mental health and illness; learned helplessness and attribution theories; social skill model; interpersonal and communication models of mental illness; stress diathesis model, resilience, coping and social support.

Unit - V: Family influences: Early deprivation and trauma; neglect and abuse; attachment; separation; inadequate parenting styles; marital discord and divorce; maladaptive peer relationships; communication style; family burden; emotional adaptation; expressed emotions and relapse

Unit - VI: Societal influences: Discrimination in race and gender; social class and structure, poverty and unemployment; prejudice, social change and uncertainty; crime and delinquency; social tension & violence; urban stressors; torture & terrorism; culture shock; migration; religion & gender related issues with reference to India.

Unit – VII: Cultural Influences: Culture specific perspectives of normal/abnormal behavior as against universal stances, cultural idioms of distress, mental illness in different cultural contexts, influence of culture on expression of symptoms, impact of mental illness, the meaning of mental illness, cultural adaptations of treatment.

Unit - VIII: Disability: Definition and classification of disability; psychosocial models of disability; impact, needs and problems; issues related to assessment/ certification of disability – areas and measures.

Unit-IX: Rehabilitation: Approaches to rehabilitation; interventions in the rehabilitation processes; models of adaptation to disability; family and caregivers issues; rights of mentally ill; empowerment issues; support to recovery.

Unit - X: Policies and Acts: Rehabilitation Policies and Acts; assistance, concessions, social benefits and support from government and voluntary organizations; contemporary challenges; rehabilitation ethics and professional code of conduct.

Essential References:


An Introduction to Social Psychology, 2nd ed. Kuppuswamy, B. Konark Publishers: New Delhi

Culture, Socialization and human development, Saraswathi, T.S (1999). Sage publications: Delhi

Asian perspectives in Psychology, Vol. 19. Rao, H.S.R & Sinha D. (1997). Sage publications: Delhi

Indian Social Problems, Vol.1 & 2, Madan G.R (2003). Allied Publishers Pvt. Ltd., New Delhi.

Elements of ancient Indian Psychology, 1st ed. Kuppuswamy, B. (1990) Konark Publishers: Delhi.

Handbook of Social Psychology, Vol.1 & 5. Lindzey, G., & Aronson, E. (1975). Amerind Publishing: New Delhi

Family Theories – an Introduction, Klein, D.M. & White, J.M. (1996). Sage Publications: Delhi

Personality & Social Psychology: towards a synthesis, Krahe, Sage Publications: New Delhi

Making sense of illness: the social psychology of health and disease. Radley, A. (1994). Sage publications: New Delhi

The sociology of mental illness. 3rd ed. Irallagher, B. J. (1995). Prentice hall: USA

Abnormal Psychology, 13th ed, Carson, R.C, Butcher, T.N, Mureka, S. & Hooley, J.M. (2007). Dorling Kindersley Pvt Ltd: India

## PAPER – II: Biological Foundations of Behavior

## Part – A (Anatomy, Physiology and Biochemistry of CNS)

Unit – I: Anatomy of the brain: Major anatomical sub-divisions of the human brain; the surface anatomy and interior structures of cortical and sub-cortical regions; anatomical connectivity among the various regions; blood supply to brain and the CSF system; cytoarchitecture and modular organization in the brain.

Unit – II: Structure and functions of cells: Cells of the nervous system (neurons, supporting cells, blood-brain barrier); communication within a neuron (membrane potential, action potential); communication between neurons (neurotransmitters, neuromodulators and hormones).

Unit – III: Biochemistry of the brain: Biochemical and metabolic aspects of Brain; medical genetics; structure and function of chromosomes; molecular methods in genetics; genetic variation; population genetics; single-gene inheritance; cytogenetic abnormalities; multifactorial inheritance; biochemistry of genetic diseases.

Unit – IV: Neurobiology of sensory/motor systems and behavior: Organization of sensory system in terms of receptors, relay neurons, thalamus and cortical processing of different sensations; principle motor mechanisms of the periphery (muscle spindle), thalamus, basal ganglia, brain stem, cerebellum and cerebral cortex, neuronal aspects of drives, motivation, hunger, thirst, sex, emotions, learning and memory

Unit – V: Regulation of internal environment: Role of limbic, autonomic and the neuroendocrine system in regulating the internal environment; reticular formation and other important neural substrates regulating the state of sleep/wakefulness.

Unit – VI: Psychopharmacology: Principles of psychopharmacology (pharmaco-kinetics, drug effectiveness, effect of repeated administration); sites of drug action (effects on production, storage, release, receptors, reuptake and destruction); neurotransmitters and neuromodulators (acetylcholine, monoamines, amino acids, peptides, lipids).

**Part – B (Neuropsychology)**

Unit - VII: Introduction: Relationship between structure and function of the brain; the rise of neuropsychology as a distinct discipline, logic of cerebral organization; localization and lateralization of functions; approaches and methodologies of clinical and cognitive neuropsycholoigsts, functional human brain mapping (QEEG, EP & ERP, PET, SPECT, fMRI)

Unit- VIII: Frontal lobe syndrome: Disturbances of regulatory functions; attentional processes; emotions; memory and intellectual activity; language and motor functions.

Unit-IX: Temporal lobe syndrome: Special senses – hearing, vestibular functions and integrative functions; disturbances in learning and memory functions; language, emotions, time perception and consciousness.

Unit – X: Parietal and occipital lobe syndromes: Disturbances in sensory functions and body schema perception; agnosias and apraxias; disturbances in visual space perception; color perception; writing and reading ability.

Unit –XI: Neuropsychological profile of various neurological and psychiatric conditions: Huntington's disease, Parkinson's disease, progressive supranuclear palsy, thalamic degenerative disease, multiple sclerosis, cortical and subcortical dementias, Alzheimer's dementia, AIDS dementia complex etc., and principal psychiatric syndromes such as psychosis, mood disorders, suicide, anxiety disorders, and other emotional and behavioral syndromes.

Unit – XII: Neuropsychological assessment: Introduction, principles, relevance, scope and indications for neuropsychological assessment and issues involved in neuropsychological assessment of children.

Unit – XIII: Neuropsychological rehabilitation: Principles, objectives and methods of neuro-rehabilitation of traumatic brain injury and brain disease; scope of computer-based retraining, neurofeedback, cognitive aids etc.

## Essential References:


Clinical Neuroanatomy for Medical Students, Snell, R.S. (1992), Little Brown & Co.: Boston.

Neuropsychology, a clinical approach, Walsh K. (1994), Churchill Livingstone: Edinburgh.

Textbook of Medical Physiology, Guyton, A.C. Saunders Company: Philadelphia.

Behavioral Neurology, Kirshner H.S, (1986). Churchill Livingstone: NY.

Principles of neural science, Kandel, E. R, & Schwartz, J. H (1985). Elsevier: NY

Foundations of physiological psychology, 6th ed., Carlson, N.R. (2005). Pearson Edn. Inc

Essential psychopharmacology, Stahl, S.M. (1998). Cambridge University Press: UK

Textbook of physiology, Vol 2, Jain, A.K (2005). Avichal Publishing Company: New Delhi.

Handbook of clinical neurology, Vols, 2, 4, 45 and 46, Vinken, P J, & Bruyn, G W, (1969). North Holland Publishing Co.: Amsterdam

Fundamentals of human neuropsychology, Kolb, B.I. Freeman & Company: NY

Neuropsychology, a Clinical approach, 4th ed., Walsh, K (2003). Churchill Livingstone: Edinburgh

Handbook of Cognitive Neuroscience, Gazaaniga, M. S. (1984). Plenum Press: NY

Handbook of clinical neurology, Vols, 2, 4, and 45, Vinken, PJ, & Bruyn, GW, (1969). North Holland Publishing Co.: Amsterdam

Neuropsychological assessment of neuropsychiatric disorders, 2nd ed., Grant, I. & Adams, K.M. (1996). Oxford University Press: NY.

Neuropsychology, a clinical approach, Walsh K. (1994), Churchill Livingstone: Edinburgh.

Diagnosis & Rehab. in clin. neuropsychology, Golden, CJ, Charles, C.T. (1981). Spring Field: USA

Principles of Neuropsychological Rehabilitation, Prigatano, G.P. (1999). Oxford University Press:

Event Related brain potentials – Basic issues & applications, Rohrbaugh, J W (1990). Oxford University Press: NY.

Neuropsychological assessment, Lezak, M.D. (1995), Oxford Univ. Press: NY

Neuropsychological assessment of neuropsychiatric disorders, 2nd ed., Grant, I. & Adams, K.M. (1996), Oxford University Press: NY.

Comprehensive clinical psychology- Assessment, Vol 4, Bellack A.S. & Hersen M. (1998). Elsiever Science Ltd.: Great Britain

## PAPER – III: Psychopathology

Unit – I: Introduction: Definition, concepts of normality and abnormality; clinical criteria of abnormality, continuity (dimensional) versus discontinuity (categorical), and prototype models of psychopathology; classification and taxonomies – reliability and utility, principles of classification, problem of classification and diagnosis, methodological issues in clinical diagnosis, classificatory systems currently in use and their advantages and limitations.

Unit – II: Developmental Psychopathology: Lifespan developmental approach, problems and limitation of prediction, risk and protective factors, stability and change across the lifespan, intergenerational issues, vulnerability and resilience.

Unit – III: Culture, Ethnicity and Psychopathology: Influence of culture on the expression of psychopathology, meaning of mental illness, impact of diagnosis and treatment, research in cross-cultural psychopathology, culture-bound syndrome.

Unit – IV: Psychobiological theories: Brain abnormality in psychopathology, inferences from psychiatric drug effects, imaging studies, developmental antecedents of neurological disorders, development of biological treatment and its consequences,

Unit – V: Genetic Theories: Genetic contribution to psychopathology, nature of genes, development in the study of genes and behavior, interaction of genetic and environmental effects, nongenomic inheritance of behavior, neuroscience and its contributions, psychosocial influences on brain structure and function, intervention of psychosocial factors with brain structure and function

Unit – VI: Psychological theories: Psychodynamic; behavioral; cognitive; humanistic; interpersonal; psychosocial; integrative approach and other prominent theories/models of principal clinical disorders and problems, viz. anxiety, somatoform, adjustment, behavioral, sexual, substance use, personality, suicide, childhood and adolescence, psychotic and mood disorders

Unit – VII: Signs and symptoms: Disorders of consciousness, attention, motor behavior, orientation, experience of self, speech, thought, perception, emotion, and memory.

Unit – VIII: Indian thoughts: Concept of mental health and illness; nosology and taxonomy of mental illness; social identity and stratification (Varnashrama Vyawastha); concept of – cognition, emotion, personality, motivation and their disorders.

**Essential References**:


Oxford Textbook of Psychopathology, Millon, T., Blaney, P.H. & Davis, R.D. (1999). Oxford University Press: NY

Developmental Psychopathology, Achenback T.M. (1974). Ronald Press Co.: NY

Fish's Clinical Psychopathology, Fish, F, & Hamilton, M (1979). John Wright & Sons: Bristol.
Psychopathology in the aged, Cole, J.O. & Barrett, J.E. (1980). Raven Press: NY

Abnormal Child Psychology, Mash, E.J & Wolfe, D.A. (1999). Wadsworth Publishing: U.S.A

Handbook of Clinical Child Psychology, 3rd ed. Walker, C.E & Roberts, M.C. (2001). John Wiley & Sons: Canada.

Clinical Child Psychology, Pfeiffer, S.I. (1985). Grune & Stratton: USA

Mental Health of Indian Children, Kapur, (1995). Sage publications: New Delhi

The Inner world: a psychoanalytic study of childhood and society in India, Kakar, S (1981). Oxford University press: New Delhi

Applied Cross cultural psychology, Brislin, R. W. (1990). Sage publications: New Delhi

Psychopathology, Buss A.H. (1966). John Wiley and sons: NY

Alessandra Lemma (1997) 'Introduction to psychopathology' Sage publications Inc, New York, New Delhi.

Frank Andrasik Michel Hersen and Jay c. Thomas (2006) 'comprehensive handbook of Personality and psychopathology – Adult Psychopathology' volume 2, John Wiley & sons, inc., Hoboken, New Jersey.

Henry E. Adams and Patricia B. Sutker (2002) 'Comprehensive handbook of psychopathology', 3rd edition, Kluwer Academic Publishers, NY

James E. Maddux and Barbara A. Winstead (2008) 'Psychopathology foundations for a contemporary understanding' 2nd edition, Taylor and Francis group, LLC, New York.

Jay c. Thomas and Daniel L. Segal (2006) 'comprehensive handbook Of Personality and psychopathology- personality and every day functioning' volume 1, John Wiley & sons, inc., Hoboken, New Jersey.

Leslie Atkinson and Susan Goldberg (2004) 'Attachment issues in psychopathology and intervention' Lawrence Erlbaum associates, Publishers Mahwah, New Jersey London.

Linda Wilmshurst (2005) 'Essentials of Child Psychopathology' John Wiley & Sons, Inc.Hoboken, New Jersey

Michael Alan Taylor and Nutan Atre Vaidya, (2009) Descriptive Psychopathology 'The Signs and Symptoms of Behavioral Disorders' Cambridge University Press, New York.

Patricia Casey and Brendan Kelly (1967) 'Fish's clinical psychopathology – signs and symptoms in psychiatry' 3rd edition, Ireland.

Stephen Strack (2005) 'Hand book of personology and psychopathology' John Wiley & Sons, Inc.Hoboken, New Jersey.

## PAPER – IV: Psychiatry

Unit - I: Introduction: Approach to clinical interviewing and diagnosis; case history; mental status examination; organization and presentation of psychiatric information; diagnostic formulation; classificatory system in use.

Unit - II: Psychoses: Schizophrenia, affective disorders, delusional disorders and other forms of psychotic disorders – types, clinical features, etiology and management.

Unit - III: Neurotic, stress-related and somatoform disorders: types, clinical features, etiology and management.

Unit - IV: Disorders of personality and behavior: Specific personality disorders; mental & behavioral disorders due to psychoactive substance use; habit and impulse disorders; sexual disorders and dysfunctions – types, clinical features, etiology and management.

Unit - V: Organic mental disorders: Dementia, delirium and other related conditions with neuralgic and systemic disorders – types, clinical features, etiology and management.

Unit - VI: Behavioral, emotional and developmental disorders (including mental retardation) of childhood and adolescence: types, clinical features, etiology and management

Unit - VII: Neurobiology of mental disorders: Neurobiological theories of psychosis, mood disorders, suicide, anxiety disorders, substance use disorders and other emotional and behavioral syndromes.

Unit - VIII: Therapeutic approaches: Drugs, ECT, psychosurgery, psychotherapy, and behavior therapy, preventive and rehabilitative strategies – half-way home, sheltered workshop, daycare, and institutionalization.

Unit - IX: Special populations/Specialties: Geriatric, terminally ill, HIV/AIDS, suicidal, abused, violent and non-cooperative patients; psychiatric services in community, and following disaster/calamity, Consultation-liaison psychiatry and services in general hospital and other primary care settings

Unit - X: Mental health policies and legislation: Mental Health Act of 1987, National Mental Health Program 1982, the Persons With Disabilities (equal opportunities, protection of rights and full participation) Act 1995; Rehabilitation Council of India (RCI) Act of 1993, National Trust for Mental Retardation, CP and Autistic Children 1999, Juvenile Justice Act of 1986; ethical and forensic issues in psychiatry practice.

## Essential References:


Comprehensive Textbook of Psychiatry, 6th ed., Vol. 1 & 2, Kaplan & Sadock, (1995). William & Wilkins: London

Oxford Textbook of psychiatry, 2nd ed., Gelder, Gath & Mayon, (1989). Oxford University Press: NY

Symptoms in mind: Introduction to descriptive psychopathology, Sims A, Bailliere T, (1988)

Textbook of postgraduate psychiatry, 2nd ed. Vol 1 & 2, Vyas, J.N. & Ahuja, N. (1999). Jaypee brothers: New Delhi.

Child and Adolescent Psychiatry: Modern approaches, 3rd ed., Rutter, M. & Herson, L (1994) Blackwell Scientific Publications: London

Textbook of postgraduate psychiatry, 2nd ed., Vol 1 & 2, Vyas, J.N. & Ahuja, N (1999). Jaypee brothers: New Delhi.

## PRACTICAL – Psychological Assessments

Unit - I: Introduction: Case history; mental status examination; rationale of psychological assessment; behavioral observations, response recording, and syntheses of information from different sources; formats of report writing.

Unit - II: Tests of cognitive functions: Bender gestalt test; Wechsler memory scale; PGI memory scale; Wilcoxen cord sorting test, Bhatia's battery of performance tests of intelligence; Binet's test of intelligence (locally standardized); Raven's progressive matrices (all versions); Wechsler adult intelligence scale – Indian adaptation (WAPIS – Ramalingaswamy's), WAIS-R.

Unit - III: Tests for diagnostic clarification: A) Rorschach psychodiagnostics, B) Tests for thought disorders – color form sorting test, object sorting test, proverbs test, C) Minnesota multiphasic personality inventory; multiphasic questionnaire, clinical analysis questionnaire, IPDE, D) screening instruments such as GHQ, hospital anxiety/depression scale etc. to detect psychopathology.

Unit - IV: Tests for adjustment and personality assessment: A) Questionnaires and inventories – 16 personality factor questionnaire, NEO-5 personality inventory, temperament and character inventory, Eyesenk's personality inventory, Eysenck's personality questionnaire, self-concept and self esteem scales, Rottor's locus of control scale, Bell's adjustment inventory (students' and adults'), subjective well-being questionnaires, QOL , B) projective tests – sentence completion test, picture frustration test, draw-a-person test; TAT – Murray's and Uma Chowdhary's.

Unit - V: Rating scales: Self-rated and observer-rated scales of different clinical conditions such as anxiety, depression, mania, OCD, phobia, panic disorder etc. (including Leyton's obsessional inventory, Y-BOCS, BDI, STAI, HADS, HARS, SANS, SAPS, PANSS, BPRS), issues related to clinical applications and recent developments.

Unit - VI: Psychological assessment of children: A) Developmental psychopathology check list, CBCL, B) Administration, scoring and interpretation of tests of intelligence scale for children such as SFB, C-

RPM, Malin's WISC, Binet's tests, and developmental schedules (Gesell's, Illingworth's and other) Vineland social maturity scale, AMD adaptation scale for mental retardation, BASIC-MR, developmental screening test (Bharatraj's), C) Tests of scholastic abilities, tests of attention, reading, writing, arithmetic, visuo-motor gestalt, and integration, D) Projective tests – Raven's controlled projection test, draw-a-person test, children's apperception test, E) Clinical rating scales such as for autism, ADHD etc.

Unit - VII: Tests for people with disabilities: WAIS-R, WISC-R (for visual handicapped), blind learning aptitude test, and other interest and aptitude tests, Kauffman's assessment battery and such other tests/scales for physically handicapped individuals.

Unit - VIII: Neuropsychological assessment: LNNB, Halstead-Reitan battery, PGI-BBD, NIMHANS and other batteries of neuropsychological tests in current use.

**Core Tests:**

1. Stanford Binet's test of intelligence (any vernacular version)
2. Raven's test of intelligence (all forms)
3. Bhatia's battery of intelligence tests
4. Wechsler adult performance intelligence scale
5. Malin's intelligence scale for children
6. Gesell's developmental schedule
7. Wechsler memory scale
8. PGI memory scale
9. 16 personality factor questionnaire
10. NEO-5 personality inventory
11. Temperament and character inventory
12. Children personality questionnaire
13. Clinical analysis questionnaire
14. Multiphasic questionnaire
15. Object sorting/classification test
16. Sentence completion test
17. Thematic apperception test
18. Children' apperception test
19. Rorschach psychodiagnostics
20. Neuropsychological battery of tests (any standard version)

A certificate by the head of the department that the candidate has attained the required competence in all of the above tests shall be necessary for appearing in the university examinations of Part – I. However, if the center opts to test and certify the competency in neuropsychological tests as part of the requirements for appearing in the university examinations of Part - II (i.e. excluding it from Part - I), it could be done so. In such case, the Practical/Clinical examinations of Part – II shall include practical examination in Neuropsychological Assessment, in addition to examination in Psychological Therapies.

**Essential References:**


Theory and practice of psychological testing, Freeman, F.S. (1965). Oxford and IHBN: New Delhi.

Comprehensive handbook of psychological assessment, Vol 1 & 2, Hersen, M, Segal, D. L, Hilsenroth, M.J. (2004). John Wiley & Sons: USA

Comprehensive Clinical Psychology: Assessment, Vol. 4, Bellack, A.S. & Hersen, M (1998). Elsiever Science Ltd.: Great Britain

The Rorschach – A Comprehensive System, Vol 1, 4th ed., Exner, J.E. John Wiley and sons: NY.

The Thematic Apperception Test manual, Murray H.A. (1971), Harvard University Press.

An Indian modification of the Thematic Apperception Test, Choudhary, U. Shree Saraswathi Press: Calcutta

## Part - II (Year - II)

## PAPER - I: Psychotherapy and Counseling

Unit - I: Introduction to Psychotherapy: Definitions, objectives, issues related to training professional therapists; ethical and legal issues involved in therapy work; rights and responsibilities in psychotherapy; issues related to consent (assent in case of minors); planning and recording of therapy sessions; structuring and setting goals; pre- and post-assessment; practice of evidence-based therapies.

Unit - II: Therapeutic Relationship: Client and therapist characteristics; illness, technique and other factors influencing the relationship.

Unit - III: Interviewing: Objectives of interview, interviewing techniques, types of interview, characteristics of structured and unstructured interview, interviewing skills (micro skills), open-ended questions, clarification, reflection, facilitation and confrontation, silences in interviews, verbal and non-verbal components.

Unit - IV: Affective psychotherapies: Origin, basis, formulation, procedures, techniques, stages, process, outcome, indications, and research & current status with respect to psychodynamic, brief psychotherapy, humanistic, existential, gestalt, person-centered, Adlerian, transactional analysis, reality therapy, supportive, clinical hypnotherapy, play therapy, psychodrama, and oriental approaches such as yoga, meditation, shavasana, pranic healing, reiki, tai chi etc.

Unit – V: Behavior therapies: Origin, foundations, principles & methodologies, problems and criticisms, empirical status, behavioral assessment, formulations and treatment goals, Desensitization - (imaginal, in-vivo, enriched, assisted), Extinction - (graded exposure, flooding and response prevention, implosion, covert extinction, negative practice, stimulus satiation), Skill training - (assertiveness training, modeling, behavioral rehearsal), Operant procedures - (token economy, contingency management), Aversion - (faradic aversion therapy, covert sensitization, aversion relief procedure, anxiety relief procedure and avoidance conditioning), Self-control procedures - (thought stop, paradoxical intention, stimulus satiation), Biofeedback – (EMG, GSR, EEG, Temp.,

EKG), Behavioral counseling, Group behavioral approaches, Behavioral family/marital therapies.

Unit - VI: Cognitive therapies: Cognitive model, principles and assumptions, techniques, indications and current status of rational emotive behavior therapy, cognitive behavior therapy, cognitive analytic therapy, dialectical behavior therapy, problem-solving therapy, mindfulness based cognitive therapy, schema focused therapy, cognitive restructuring, and other principal models of cognitive therapies.

Unit – VII: Systemic therapies: Origin, theoretical models, formulation, procedures, techniques, stages, process, outcome, indications, and research & current status with respect to family therapy, marital therapy, group therapy, sex therapy, interpersonal therapy and other prominent therapies.

Unit – VIII: Physiological therapies: Origin, basis, formulation, procedures, techniques, stages, process, outcome, indications, and current status with respect to progressive muscular relaxation, autogenic training, biofeedback, eye-movement desensitization and reprocessing, and other forms of evidence-based therapies.

Unit – IX: Counseling: Definition and goals, techniques, behavioral, cognitive and humanistic approaches, process, counseling theory and procedures to specific domains of counseling.

Unit - X: Therapy in special conditions: Therapies and techniques in the management of deliberate self harm, bereavement, traumatic, victims of man-made or natural disasters, in crisis, personality disorders, chronic mental illness, substance use, HIV/AIDS, learning disabilities, mental retardation, and such other conditions where integrative/eclectic approach is the basis of clinical intervention.

Unit - XI: Therapy with children: Introduction to different approaches, psychoanalytic therapies (Ana Freud, Melanie Klein, Donald Winnicott); special techniques (behavioral and play) for developmental internalizing and externalizing disorders; therapy in special conditions such as psycho-physiological and chronic physical illness; parent and family counseling; therapy with adolescents.

Unit – XII: Psychoeducation (therapeutic education): Information and emotional support for family members and caregivers, models of therapeutic education, family counseling for a collaborative effort towards recovery, relapse-prevention and successful rehabilitation with regard to various debilitating mental disorders.

Unit – XIII: Psychosocial rehabilitation: Rehabilitation services, resources, medical and psychosocial aspects of disability, assessment, group therapy, supportive therapy and other forms of empirically supported psychotherapies for core and peripheral members.

Unit - XIV: Psychotherapy in the Indian Context: Historical perspective in psychological healing practices from the Vedic period and the systems of Ayurveda and Yoga, contemporary perspectives; socio-cultural issues in the Indian context in practice of psychotherapy; ongoing research related to process and outcome.

**Essential References:**


An introduction to the psychotherapies, 3rd ed., Bloch, S (2000). Oxford Medical Publications: NY

Encyclopedia of Psychotherapy, Vol 1 & 2, Hersen M & Sledge W. (2002). Academic Press: USA

The techniques of psychotherapy, 4th ed., Parts 1 & 2, Wolberg, L.R. Grune & Stratton: NY

Theories of Psychotherapy & Counseling, 2nd ed., Sharf, R.S. (2000). Brooks/Cole: USA

Handbook of Psychotherapy & Behavior change – An empirical analysis, Bergin, A.G. & Garfield, S. L. (1978). John Wiley & Sons: NY

Comprehensive Clinical Psychology, Vol 6, Bellack, A.S. & Hersen, M., (1998). Elsiever Science Ltd: Great Britain

Handbook of Individual Therapy, 4th ed., Dryden, W. (2002). Sage Publications: New Delhi.

Psychotherapy: an eclectic integrative approach, 2nd ed. Garfield, S. L. (1995). John Wiley and sons

International handbook of behavior modification and therapy, Bellack, A.S., Hersen, M and Kazdin, A.E. (1985). Plenum Press: NY

Behavior therapy: Techniques and empirical findings, Rimm D.C. & Masters J.C. (1979). Academic Press: NY.

Handbook of Clinical Behavior therapy, Turner, S.M., Calhown K.S and Adams H.E. (1992). Wiley Interscience: NY

Dictionary of Behavior Therapy, Bellack, H. Pergamon Press: NY

Comprehensive Handbook of cognitive therapy, Freeman, A., Simon, K.M., Beutler L.E. & Arkowitz, M. (1988), Plenum Press: NY

Cognitive Behavior Therapy for psychiatric problems: A practical guide, Hawton, K. Salkovskis, P.M., Kirk, J. and Clark, D.M. (1989). Oxford University Press: NY

Rational Emotive Behaviour Therapy, Dryden, W. (1995). Sage publications: New Delhi

Cognitive Therapy: an Introduction, 2nd ed, Sanders, D & Wills, F. (2005). Sage Publications: New

Advances in Cognitive Behavior therapy, Dobson, K S and Craig, K D. (1996). Sage publications:

Science and Practice of CBT, Clark, D M and Fairburn, C. G. (2001). Oxford University press: Great Britain.

Counseling and Psychotherapy: theories and interventions. 3rd ed. Capuzzi, D and Gross D. R. (2003). Merrill Prentice Hall: New Jersey

Handbook of psychotherapy case formulation. 2nd ed. Eells, T.D (2007). Guilford press: USA

Psychoanalytic techniques, a handbook for practicing psychoanalyst, Wolman BB Basic Book: NY

The Technique and Practice of psychoanalysis Vol. 1, Greenson, R.R. (1967). International Universities Press: USA.

Psychotherapy: The analytic approach, Aronson, M. J and Scharfman, M.A. (1992). Jason Aronson Inc: USA

New Approach of Interpersonal Psychotherapy, Klerman, G. L., Weissman, M. M (1993). American Psychiatric press: Washington

Handbook of clinical child psychology, 3rd ed., Walker, C.E. & Roberts, MC (2001). John Wiley and Sons: Canada.

Abnormal child psychology, Mash, E.J & Wolfe, D.A. (1999). Wadsworth Publishing: USA

Clinical Practice of cognitive therapy with children and adolescents, Friedberg R.D. & McClure, J.M. Guilford Press, NY

CBT for children and families, 2nd ed., Graham, P.J. (1998). Cambridge University Press: UK

Handbook of clinical behavior therapy, Turner, S.M, Calhour, K.S. & Adams, H.E.(1992). Wiley Interscience: NY

Basic family therapy, Baker, P, (1992). Blackwell Scientific Pub.: New Delhi

Handbook of family and marital therapy, Wolman, B.B. & Stricker, G, (1983). Plenum: NY

Introduction to Counseling and Guidance, 6th ed., Gibson, R.L. & Mitchell M.H. (2006), Pearson, New Delhi

## PAPER - II: Behavioral Medicine

Unit – I: Introduction: Definition, boundary, psychological and behavioral influences on health and illness, neuroendocrine, neurotransmitter and neuroimmune responses to stress, negative affectivity, behavioral patterns, and coping styles, psychophysiological models of disease, theoretical models of health behavior, scope and application of psychological principles in health, illness and health care.

Unit – II: Central nervous system: Cognitive, personality, behavioral, emotional disturbances in major CNS diseases like cerebrovascular (stroke, vascular dementia etc.), developmental (cerebral palsy), degenerative (Parkinson's etc.), trauma (traumatic brain and spinal cord injury), convulsive (epilepsy), and infectious (AIDS dementia), assessment and methods for psychological intervention and rehabilitation with such patients.

Unit – III: Cardiovascular system: Psychosocial, personality, lifestyle, and health practice issues, psychobehavioral responses including coping with illness and functional loss in hypertension, MI, following CABG and other cardiovascular conditions, salient issues with regard to quality-of-life and well-being, empirically proven methods of psychological management of CVS diseases.

Unit – IV: Respiratory system: precipitants, such as emotional arousal, and other external stimuli, exacerbants such as anxiety and panic symptoms, effects, such as secondary gain, low self-esteem in asthma and other airway diseases, psychological, behavioral and biofeedback strategies as adjunct in the management.

Unit – V: Gastrointestinal system: Evaluation of psychological factors including personality characteristics and stress/coping style in functional GI disorders such as irritable bowel syndrome, inflammatory bowel disease, peptic ulcer disease, esophageal disorder etc., role of psychotherapy, behavior modification, cognitive restructuring, biofeedback and relaxation training.

Unit – VI: Genitourinary/renal/reproductive system: Psychosocial issues in male/female sexual dysfunctions, micturition and voiding problems including primary/secondary enuresis, end-stage renal disease, dialysis

treatment, primary and secondary infertility, empirically validated psychological and behavioral interventions in these conditions.

Unit – VII: Dermatology: Role of stress and anxiety in psychodermatological conditions such as psoriasis, chronic urticaria, dermatitis, alopecia and the impact of these on self-esteem, body image and mood, role of psychological interventions such as relaxation, stress management, counseling and biofeedback strategies.

Unit – VIII: Oncology: Psychosocial issues associated with cancer - quality of life, denial, grief reaction to bodily changes, fear of treatment, side effects, abandonment, recurrence, resilience, assessment tools, and goals of interventions for individual and family, and therapy techniques.

Unit – IX: HIV/AIDS: Model of HIV disease service program in India, pre- and post-test counseling, psychosocial issues and their resolutions during HIV progress, psychological assessment and interventions in infected adults and children, and family members/caregivers, highly active anti-retroviral treatments (HAART), neuropsychological findings at different stages of infection, issues related to prevention/spreading awareness and interventions in at risk populations.

Unit – X: Pain: Physiological and psychological processes involved in pain experience and behavior, assessment tools for acute and chronic pain intensity, behavior, and dysfunctions/disability related to pain, psychological interventions such as cognitive, behavioral, biofeedback and hypnotic therapies.

Unit – XI: Terminally ill: Medical, religious and spiritual definition of death and dying, psychology of dying and bereaved family, strategies of breaking bad news, bereavement and grief counseling, management of pain and other physical symptoms associated with end-of-life distress in patients with cancer, AIDS, and other terminal illness, professional issues related to working in hospice including working through one's own death anxiety, euthanasia – types, arguments for and against.

Unit – XII: Other general clinical conditions: Application of psychological techniques and their rationale in the clinical care of patients in general medical settings where psychological services appears to affect the outcome of medical management positively, for example in diabetes,

sleep disorders, obesity, dental anxiety, burns injury, pre- and post-surgery, preparing for amputation, evaluation of organ donors/recipient, pre- and post-transplantation, organ replacement, hemophiliacs, sensory impairment, rheumatic diseases, abnormal illness behavior, health anxiety etc.

Unit – XIII: Contemporary Issues: Research and developments in health psychology, psychophysiology, psychoneuroimmunology, psychobiology, socio-biology and their implications, and effects of psychotherapy on the biology of brain.

## Essential References:


International handbook of behavior modification and therapy, Bellack, A.S., Hersen, M and Kazdin, A.E. (1985). Plenum Press: NY

Behavior therapy: Techniques and empirical findings, Rimm D.C. & Masters J.C. (1979). Academic Press: NY.

Handbook of Clinical Behavior therapy, Turner, S.M., Calhown, K.S and Adams, H.E. (1992). Wiley Interscience: NY

Dictionary of Behavior Therapy, Bellack

Handbook of clinical psychology in medical settings, Sweet, J.J, Rozensky, R.H. & Tovian, S.M. (1991), Plenum Press: NY.

Health Psychology, Dimatteo, M R and Martin, L.R. (2002). Pearson, New Delhi

Biofeedback – Principles and practice for clinicians, Basmajian J.V. (1979). Williams & Wilkins Company: Baltimore

Handbook of Psychotherapy and behaviour change, 5th ed., Lambert, M.J (2004). John Wiley and Sons: USA

Behavioral Medicine: Concepts & Procedures, Tunks, E & Bellismo, A. (1991). Pergamon Press: USA

Health Psychology, Vol 1 to Vol 4, Weinman, J, Johnston, M & Molloy, G (2006). Sage publications: Great Britain

## PAPER – III: Evidence-Based Practice and Clinical Research Issues

Unit – I: Introduction: Evidence-based practice - definition, criteria for levels of empirical support, treatment manuals and clinical practice guidelines for each clinical conditions, training opportunities for empirically supported treatments, utility of empirically supported treatment and the need for the same, cost effectiveness, concept of managed care

Unit – II: Practice Perspective: Uses and misuses of evidence, managed care, treatment guidelines, and outcomes measurement in professional practice, cultural variation in the therapeutic relationship, Evidence-Based Practice (EBP) for a diverse society, individual diversity, the need to consider individual variables, engaging patients in shared decision-making, measuring patient preferences and acquisition of clinical skills to perform Empirically Supported Treatment/s (ESTs), developing cogent rationale for clinical strategies

Unit – III: Research Perspective: Research findings on the effects of psychotherapy and their implications for practice, assessment and evaluation in clinical practice, using and testing evidence-based psychotherapies in clinical care settings

Unit – IV: Training and Policy: Training the future clinicians, employing a scientist-practioner model with an emphasis on connecting theory with empirically supported therapies, methodological realism at the interface between science and practice, evidence-based practice and public policy, issue of gold standard in evidence-based practice, controversies and evidences for EBP.

Unit – V: Training in Clinical Research: Training in different types of research evidence in support of efficacy, clinical observation, methodology related to clinical trial, qualitative research, systematic case studies, single-case experimental designs, public ethnographic research, process-outcome studies, effectiveness research in naturalistic settings, randomized-controlled trails and their logical equivalents, meta-analysis, search strategies and reporting systematic reviews

Unit – VI: Empirically supported techniques: ESTs in the practice of counseling and psychotherapy – therapist-client relationship skills, contextual and collaborative assessment, diagnosis and conceptualization, counseling

theories and techniques, psychodynamic theory and techniques, interpersonal therapy, systemic therapy, humanistic theories and techniques, behavioral theory and techniques, cognitive-behavior therapy and techniques, dialectical-behavior therapy and other third generation cognitive-behavior therapies, assessment and intervention in emergency situations including crisis, suicide, and violence assessment

Unit - VII: Contemporary issues: Issues related implementing evidence-based practices in routine mental health service settings, managed care, and research related to process and outcome.

## Essential References:


Evidence-Based Practice in Infant and Early Childhood Psychology 2009 John Wiley & Sons, Inc.

Practitioner's Guide to Evidence-Based Psychotherapy Jane E. Fisher and William T. O'Donohue, 2006 Springer.

Handbook of Evidence-based Psychotherapies A Guide for Research and Practice, Chris Freeman and Mick Power, 2007 John Wiley & Sons Ltd.

Textbook of Psychotherapeutic Treatments, Edited by Glen O. Gabbard, M.D, 2009 American Psychiatric Publishing, Inc.

Handbook of Evidence-Based Psychodynamic Psychotherapy, Raymond A. Levy, 2009 Humana Press, a part of Springer Science Business Media, LLC.

Principles of Counseling and Psychotherapy, Gerald J. Mozdzierz, 2009 by Taylor & Francis Group, LLC.

Alan E. Kazdin PhD and John R. Weisz(2003) Evidence-Based Psychotherapies for Children and Adolescents, the Guilford press, New York.

Chris Freeman and Mick Power (2007), Handbook of Evidence-based Psychotherapies: A Guide for Research and Practice John Wiley and Sons L.td. England.

David Sue, Diane M. Sue(2008), Foundations of Counseling and Psychotherapy: Evidence-Based Practices for a Diverse Society, John Wiley and Sons, England

Jane E.Fisher & William,T.O,Donohue (2006) Practitioner's guide to Evidence-Based Psychotherapy Springer Science + Business Media, LLC.

John R. Weisz and Alan E. Kazdin(2010) Evidence-Based Psychotherapies for Children and Adolescents, Second Edition, the Guilford press, New York.

Raymond Levy, Stuart J. Ablon and G.O. Gabbard (2010), Handbook of Evidence-Based Psychodynamic Psychotherapy: Bridging the Gap Between Science and Practice (Current Clinical Psychiatry), Human press, a part of Springer Science

## PAPER - IV: Statistics and Research Methodology

Unit - I: Introduction: Various methods to ascertain knowledge, scientific method and its features; problems in measurement in behavioral sciences; levels of measurement of psychological variables - nominal, ordinal, interval and ratio scales; test construction - item analysis, concept and methods of establishing reliability, validity and norms.

Unit - II: Sampling: Probability and non-probability; various methods of sampling - simple random, stratified, systematic, cluster and multistage sampling; sampling and non-sampling errors and methods of minimizing these errors.

Unit - III: Concept of probability: Probability distribution - normal, poisson, binomial; descriptive statistics - central tendency, dispersion, skewness and kurtosis.

Unit - IV: Hypothesis testing: Formulation and types; null hypothesis, alternate hypothesis, type I and type II errors, level of significance, power of the test, p-value. Concept of standard error and confidence interval.

Unit - V: Tests of significance - Parametric tests: Requirements, "t" test, normal z-test, and "F" test including post-hoc tests, one-way and two-way analysis of variance, analysis of covariance, repeated measures analysis of variance, simple linear correlation and regression.

Unit – VI: Tests of significance - Non-parametric tests: Requirements, one-sample tests – sign test, sign rank test, median test, Mc Nemer test; two-sample test – Mann Whitney U test, Wilcoxon rank sum test, Kolmogorov-Smirnov test, normal scores test, chi-square test; k-sample tests - Kruskal Wallies test, and Friedman test, Anderson darling test, Cramer-von Mises test.

Unit - VII: Experimental design: Randomization, replication, completely randomized design, randomized block design, factorial design, crossover design, single subject design, non-experimental design.

Unit - VIII: Epidemiological studies: Prospective and retrospective studies, case control and cohort studies, rates, sensitivity, specificity, predictive values, Kappa statistics, odds ratio, relative risk, population

attributable risk, Mantel Haenzel test, prevalence, and incidence. Age specific, disease specific and adjusted rates, standardization of rates. Tests of association, 2 x 2 and row x column contingency tables.

Unit - IX: Multivariate analysis: Introduction, Multiple regression, logistic regression, factor analysis, cluster analysis, discriminant function analysis, path analysis, MANOVA, Canonical correlation, and Multidimensional scaling.

Unit - X: Sample size estimation: Sample size determination for estimation of mean, estimation of proportion, comparing two means and comparing two proportions.

Unit - XI: Qualitative analysis of data: Content analysis, qualitative methods of psychosocial research.

**Essential References:**


Research Methodology, Kothari, C. R. (2003). Wishwa Prakshan: New Delhi

Foundations of Behavioral Research, Kerlinger, F.N. (1995). Holt, Rinehart & Winston: USA

Understanding Biostatistics, Hassart, T.H. (1991). Mosby Year Book

Biostatistics: a foundation for analysis in health sciences, 8th ed, Daniel, W.W. (2005). John Wiley and sons: USA

Multivariate analysis: Methods & Applications, Dillon, W.R. & Goldstein, M. (1984), John Wiley & Sons: USA

Non-parametric statistics for the behavioral sciences, Siegal, S & Castellan, N.J. (1988). McGraw Hill: New Delhi

Qualitative Research: Methods for the social sciences, 6th ed, Berg, B.L. (2007). Pearson Education, USA

**Part - III (Year - III)**

**Advanced Proficiency in Sub-Specialization (Elective - I and II)**

The objective of advanced proficiency in sub-specializations is to create discipline-specific experts and is guided by the concept of Professional Praxis – ethically-responsible, theoretically-informed and research-based effective practice. Discipline-specific expertise thus demands a thorough understanding of elements such as; a) discipline area knowledge, b) historical development, c) major core concepts, d) relevant theories, e) models, f) methods and application, g) recent advances, h) newer knowledge, i) critical appraisal of existing literature, j) evidence-based practice and k) legal/ethical issues involved in management of clients with clinical issues.

Keeping in mind the comprehensive nature of the advanced proficiency training and the level of competency that the trainees must attain, it is the responsibility of the concerned discipline experts at the center, to create appropriate and relevant learning environments, instructional activities and practical experience to the trainees. The advanced course should also give the trainees knowledge and skill in formulating research questions and hypotheses, planning a study, and choosing appropriate tools of evaluation.

Final evaluation in the elective areas may consist of long and short essays targeted at testing students' theory as well as applied knowledge domains, and practical examination involving working-up and assessing cases with varying clinical issues, for assessing a trainee's professional praxis and ethical sensitivity.

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