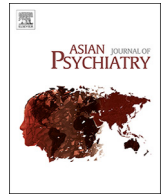




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Psychological interventions during COVID-19: Challenges for low and middle income countries



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ABSTRACT

At the start of 2020, the 2019 coronavirus disease (COVID-19), originating from China has spread to the world. There have been increasing numbers of confirmed cases and deaths around the globe. The COVID-19 pandemic has paved the way for considerable psychological and psychosocial morbidity among the general public and health care providers. An array of guidelines has been put forward by multiple agencies for combating mental health challenges. This paper addresses some of the mental health challenges faced by low and middle income countries (LMIC). It is worthwhile to note that these are challenges at the current stage of the pandemic and may change with the course of the pandemic itself.

1. Introduction

The COVID-19 pandemic has engulfed the globe and has caused far reaching physical and mental health implications worldwide. Although reports from China outlined some mental health issues (Liu et al., 2020), the effects of COVID-19 have been fairly similar for developed and developed nations considering mental health ramifications. Healthcare infrastructure, budgets and governance patterns differ between LMIC and the west and we look at specific issues that concern such nations while planning mental health interventions in the wake of this pandemic.

1.1. Challenge 1 – Paucity of resources and manpower

The population of many LMIC is huge and the available healthcare infrastructure and manpower for health in such situations is inadequate. While manpower for intensive care and medical care is itself less, there is a staggering paucity of mental health care personnel. In countries like India, according to reports from the Indian Union Ministry of Health and Family Welfare, the country needs around 15,000–17,000 psychiatrists in order to achieve an ideal ratio of psychiatrists to population which must be 1:6000 to 1:8000. Currently the situation is abysmal with only 6000 psychiatrists (one psychiatrist for over 1.25 lakh people) (Anon, 2020) and the World Mental Health Atlas puts the figure at 0.3 psychiatrists per 1, 00,000 population (World

Health Organization, 2015). Even if we keep the population growth rates and attrition rates of Psychiatrists at 0 %, we require 2700 new psychiatrists annually to fill in the gap in the next 10 years for India (Garg et al., 2019). Similar scenario, if not worse, exists in many South Asian and Latin American countries. In view of this pandemic and the resources we need, it is important to train primary care physicians, specialists in other medical services, psychologists, and paramedical team about the essentials of psychological/psychiatric interventions.

1.2. Challenge 2 – Accurate diagnosis of psychiatric disorders

It is vital when patients visit psychiatrists with psychological problems during COVID-19 we shall have to be vigilant and careful in the diagnosis we make and document. There may be many patients in an anxiety state related to the current situation or in a depressed state due to psychosocial factors and the lockdown or quarantine. We must be mindful whether we would want to diagnose them with a psychiatric disorder using DSM-5 (American Psychiatric Association, 2013), which will then become a label attached to them or whether we want to offer interventions first and keep diagnosis for a later date. There shall be many subclinical and minor anxieties and depressions that may warrant treatment but may not entail a psychiatric diagnosis. Basic management has to be offered at a family physician level prior to a referral to a psychiatrist/psychologist (Fricchione et al., 2012; Fava, 1999).

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1.3. Challenge 3 – Access to proper mental health care

Access to proper mental health care facility is a hurdle during a pandemic atmosphere. Most psychiatric facilities and outpatient departments will be non-functional and the curtailment of transport during 'lockdown' adds to the misery. Patients with psychiatric illness are often alone at home while their caregivers work through the day. There will be a change in this lifestyle as caregivers and the patient shall have to stay together locked in due to the enforced 'lockdowns' and many patients would get irritable and upset due to the lack of movement and freedom. There are chances of relapse or exacerbation of the illness during this period (Li et al., 2020).

Patients suffering from schizophrenia may experience delusions and hallucinations and they may develop new delusions that generate themselves around the themes of the current pandemic. Aggression and violent behavior may be exhibited by patients with schizophrenia with a considerable rise in their paranoia. Patients with obsessive compulsive disorder may show a relapse of symptoms and the current sanitization and cleanliness drive may serve to exacerbate their obsessions and compulsions in the form repeated sanitizer use, repeated hand washing and rigorous cleanliness. Patients with panic disorder may have a resurgence of their panic symptoms and panic attacks may occur. Mood may be depressed and depressive symptoms may worsen while some patients may also develop suicidal thoughts and feelings. Withdrawal symptoms may be seen in patients with substance abuse to alcohol and drugs. Withdrawal reactions and relapse of psychiatric symptoms may ensue due to the nonavailability of psychotropics during 'lockdown' period (Fiorillo and Gorwood, 2020).

1.4. Challenge 4 – Availability of psychopharmacological and other treatments

One of the major challenges that will be faced shall be the availability of psychiatric medications and supply of them if manufactured locally. Procuring medications may be difficult in a lockdown due to short supply and relapses in psychiatric illness may occur due to this shortage and a lack of compliance with medication as a result. We may also have to change our prescribing practices in such situations. Many stable ambulatory patients with schizophrenia may be prescribed long acting injectable antipsychotics to maintain antipsychotic levels and reduce withdrawal psychosis as may be seen with abrupt stoppage of antipsychotic drugs. Patients on benzodiazepines may develop withdrawal symptoms causing rebound anxiety and panic with a lack of sleep. The short supply of antidepressants can cause sudden dips in mood due to withdrawal and rebound depression may occur. There would also be instances where patients suffering from bipolar disorder on antiepileptics as a mood stabilizer may get a seizure due to abrupt withdrawal and shifting them to longer acting once a day preparation will be needed. The same holds true for patients of epilepsy on regular treatment (Duan and Zhu, 2020).

1.5. Challenge 5 – Public private partnerships and role of non-government organizations

There will be a need in LMIC for looking at the economic and social development and the needs of people with psychiatric disorders. The regional development banks, national development agencies, foundations, non-governmental organizations, global business community and public private partnerships should all participate in addressing the challenges (Collins et al., 2011). In a world which is globally connected, we all recognize the pandemic effects and have an idea of the suffering, death, losses, grief, anxiety, uncertainty, distress and psychological morbidity that develops. Public private partnerships and non-governmental organizations shall serve as a means of communication for psychological assistance and support, and can help LMIC to build on existing resources (Raphael and Ma, 2011). The need of the hour is the

solidarity and co-operation of all mental health professional organizations, government and non-government agencies, public-private partnerships and the financial inputs from corporate and other philanthropic agencies.

1.6. Challenge 6 – Catering to the needs of special populations

A major effect of the lockdown and COVID-19 will be on special populations that are vulnerable to mental health problems (children and adolescents, geriatric populations, children with developmental disabilities, pregnant women and patients with existing medical illnesses). Many children and adolescents with existing psychiatric conditions may worsen and there may be exacerbation of attention issues and lack of medication may worsen these issues. Schools need to take the initiative and carry out positive mental health interventions using digital media for children and adolescents who may be worried about multiple issues and they can be addressed in simple and lucid language for them to understand (Newman et al., 2014). Many older adults may face a problem as they stay alone and away from their children. Older adults with existent psychiatric issues may worsen and patients with dementia may show deteriorating cognitive and behavioral symptoms due to the lockdown. The physical and mental health of the elderly will need to be addressed and many issues related to death, the pandemic and recovery may upset them that may need to be addressed via online counseling. The lack of use of digital means in the elderly may affect their access to mental health care and young adults shall have to take the lead and help them (Yang et al., 2020; Johnson et al., 2015).

1.7. Challenge 7 – Consideration of various psychosocial factors

Multiple psychosocial factors shall determine one's response to a pandemic. The pandemic and the enforced lockdown would cause financial stress to all professions and bring economic stress on the common man. The pandemic affects most the daily wage worker and those that have small businesses and shops that earn on a daily basis. The longer the pandemic lasts, the greater the stress and this would lead to depression, anxiety, uncertainty about the future and days ahead which would cause panic and further anxiousness. There would be a huge surge in mental health issues and psychiatric problems more so after the pandemic ends considering the losses suffered and burden on the people. In LMIC, there are many other factors like small houses, family structure (nuclear families as well as huge joint families), family interpersonal factors and income, salary cuts, loans to be paid, being told to vacate rental premises, excluded from societies and living complexes if having COVID symptoms, that aggravate stress. The psychosocial dynamics is multifold and play a huge role when it comes to planning mental health interventions they need to be taken into consideration (Sood, 2020; Gist and Lubin, 2013).

1.8. Challenge 8 – Combating the stigma of psychiatric illness

A psychiatric diagnosis is one that comes with a stigma and label that often affects the care a patient receives in other medical departments as a lot of the symptoms the patient experiences may always be attributed to psychopathology rather than physical causes. There is a need for us to be open to patients with psychiatric illness that may visit emergency medicine departments during this period and also be open to the level of care that they may need. The need to sensitize all specialties to the same is a must (Qiu et al., 2020). There may also be cases where patients with psychiatric illness may need treatment if they suffer from COVID symptoms and may not always be cooperative to treatment and care. They must be attended to and their medical needs must be handled if required. The media in LMIC also plays a central role in both perpetuating and fighting stigma and discrimination. Negative media stereotypes of people with mental illness, their families and mental health care professionals are common and hurtful to see. Such

portrayals should be protested and correct scientific portrayals must be promoted (Abbey et al., 2011). Stigma against being diagnosed as having a psychiatric illness and receiving treatment for the same is one of the biggest challenges for LMIC during this period.

1.9. Challenge 9 – Faith healing and cultural considerations

There are a number of factors that cause delay in getting the right at the first instance for psychiatric problems and these include socio-cultural profiles, level of education, the attitude of family/society toward mental illnesses, the perceptions, myths, beliefs, stigmas attached with psychiatric disorder and the availability/accessibility of psychiatric services along with referral patterns and religious views including approach to faith healers (van der Watt et al., 2018). In LMIC, there is the problem of age old cultural myths, demonic and supernatural explanations of psychiatric disorders and the need to visit faith healers and places of worship seeking a cure for mental illness. Faith healers are the first care providers for a majority of psychiatric patients and they are rarely referred for psychiatric care. There are instances where care seekers might visit faith healers and may simultaneously seek help from modern and traditional methods of therapy. Direct access to psychiatric services after the onset of illness is not a prominent pathway in LMIC. The reason for the same is magico-religious model of causation of psychiatric disorders and faith in black magic and exorcism (Trivedi and Jilani, 2011). Traditional and religious leaders (not all) may impart wrong impressions about the Covid19, offer diverse therapeutic methods, and ignore social distancing. Combating these blind beliefs is another challenge faced during the pandemic in LMIC.

1.10. Challenge 10 – Rural and urban divide in mental health

In LMIC, most of its population lives in rural areas while the major healthcare facilities and infrastructure is in urban areas. Mental health policy is an important component of scale up of services in rural areas although it is not in itself sufficient. There appears to be a disconnect in most governments regarding expressed interest and support for mental health services and the lack of tangible expressions manifested by resource availability and policy implementation (Eaton et al., 2011). The gap between rural and urban mental health services in LMIC will only be merged when the poor knowledge and stigmatizing beliefs among the general population are identified; their willingness to seek help is intensified and during the pandemic healthcare workers must include strategies to change attitudes and help seeking behavior. This can only be achieved by the involvement of people using mental health services and their families along with the community. There shall also be a need to target respected leaders such as village elders, panchayat heads, district health officers and traditional health-care providers along with religious heads in rural areas. The availability of psychiatrists in many rural areas is also a challenge and there is a need to train local doctors there to rise up to the challenge (Hoefl et al., 2018; Maulik et al., 2017).

1.11. Challenge 11 – Consultation liaison psychiatry

Many psychiatrists feel that the current pandemic has made psychiatry a non-essential field. Hospitals and many centers have allowed that their non-essential staff stays home which include basic sciences and psychiatry in some quarters but the question of essentiality and non-essential is a personal one that we have to answer. We cannot shy away as we are doctors first and psychiatrists later (De Sousa, 2020). Psychiatrists have to be there for everyone who has fear and uncertainty related to the pandemic, even if they are not infected with COVID. These patients may come to emergency departments and may present with psychiatric symptoms. There may also be admitted inpatients worried about their existing medical problems worsening and can even be admitted psychiatric patients rattled by the current pandemic (Grover, 2011). Consultation-liaison psychiatrists usually

traverse through the hospital and multiple specialties system and will be on the frontline in this pandemic. This shall be another challenge for LMIC hospitals to have a large number of psychiatrists in the frontline of healthcare during this pandemic (Greenberg et al., 2020; Tandon, 2020).

1.12. Challenge 12 – Telepsychiatry in the current situation

For those who would not be able to reach a mental health professional, consultations would happen over the phone and in India, telepsychiatry as a modality is yet to gain popularity and impetus. Psychiatric assessments and mental status examinations are best done face to face a video call may not suffice always for the same. Many agencies (private and government) in LMIC have started telepsychiatry services offering free mental health services during the COVID-19 pandemic. While services are available, there is no stringent regulatory authority to monitor the quality of these services and whether ethical standards are maintained. It is prudent that professionals offering telepsychiatry services well qualified and trained to do the same. The judicious use of telepsychiatry, its maintenance and the appropriate idea of when to refer to a hospital is another challenge faced by LMIC (Corruble, 2020; Knopf, 2020; Rangaswamy Thara, 2013). Legal aspects of telepsychiatry vary nation to nation and the same holds true for prescribing via email or online.

1.13. Challenge 13 – Sensitive handling of the media of psychological issues

The general portrayal of psychiatry in the news, print and entertainment media as well as social media is usually negative. People are made to believe that psychiatry deals with insanity and has no effective treatment techniques. The media has often conveyed a negative picture of psychiatric hospitals and psychiatrists. Reports on ECT have been frequently negative and biased and the relationship between psychiatry and the industry has been blown out of proportion (Sartorius et al., 2010). Guidelines on sensitive reporting of mental health issues like depression, suicide; ECT, child abuse etc. have been produced for the media though they are rarely followed. There is challenge faced by LMIC countries to increase the sensitivity of all forms of media with regard to COVID reporting to reduce anxiety and also to have sensitivity when reporting mental health problems in the eye of the pandemic and lockdowns (Nesseler, 2011).

1.14. Challenge 14 – Ethical concerns and research

Ethical issues are an important consideration when training, preparing for and responding to pandemics like the one we are in. This is more so if research has to be carried out in the pandemic setting and that too interventional research. Legal and ethical issues are related to each other but are distinct and the domains in which they both develop are often different. The first question would arise on how one would get ethical clearance for their research proposals when most hospitals are battling the pandemics and research committees are probably not meeting. The accountability regarding the safety of the subjects in the study, the nature and protocol and type of intervention as well qualitative data if collected, and research in vulnerable population during a pandemic would then be an ethical dilemma. Ethical guidelines should be modified while conducting research during pandemic settings (Flynn and Speier, 2014; Call et al., 2012).

1.15. Challenge 15 – Mental health of frontline healthcare personnel

The healthcare personnel looking after COVID patients and working in hospitals and isolation wards also need to have their mental health managed. The stress of the work they are doing shall get to them and it will be difficult for them to deal with situations once cases escalate. Regular mental health care for these doctors, nurses and ancillary staff

is very important for us to have a stable healthcare infrastructure to combat COVID. There is also a need for training these staff in communication skills and building their resilience for the tough times that they shall face ahead. The mental health of them as well as their family members shall have to be looked into. This shall be combined with the need for group interventions and counseling sessions for them on a regular basis (Adams and Walls, 2020). Organizations should undertake awareness as well as interventional strategies to minimize the stress and behavioral burden during pandemic scare (Matsuishi et al., 2012).

1.16. Challenge 16 – Pandemic preparedness

The limited scientific understanding of covid19 pandemic and technical 'know how' of interventions make the pandemic preparedness in a perplexed state (Fineberg, 2014). COVID pandemics do not occur yearly and neither are the trends identifiable that one can assess and plan in advance. No one can predict with confidence how the COVID infection would affect human health and to what degree. We need a deeper biologic and epidemiologic understanding to help us in pandemic preparedness. Pandemics will continue to challenge policy makers and public health leaders as well as mental health professionals with stress and uncertainty. Pandemics will challenge national authorities and the WHO to function more efficiently and effectively with insufficient resources and also plan mental health interventions in such trying situations. All we can do is learn from one pandemic and use this learning to counter the next when it happens (Hanvoravongchai et al., 2010).

2. Conclusions

The present review posits multiple challenges in carrying out psychological interventions in LMIC during the current COVID pandemic. We may not have solutions for all the challenges but can plan to combat some of them. We also need to realize that challenges may increase and change from time to time based on the course of the pandemic and we shall be in a better position to deal with the pandemic only when we are sure about its course and mortality as well as multiple other factors. One thing we know for sure is that mental health interventions shall play a huge role in this pandemic and we shall be able to help people deal with the current situation via planned and progressive psychological interventions.

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