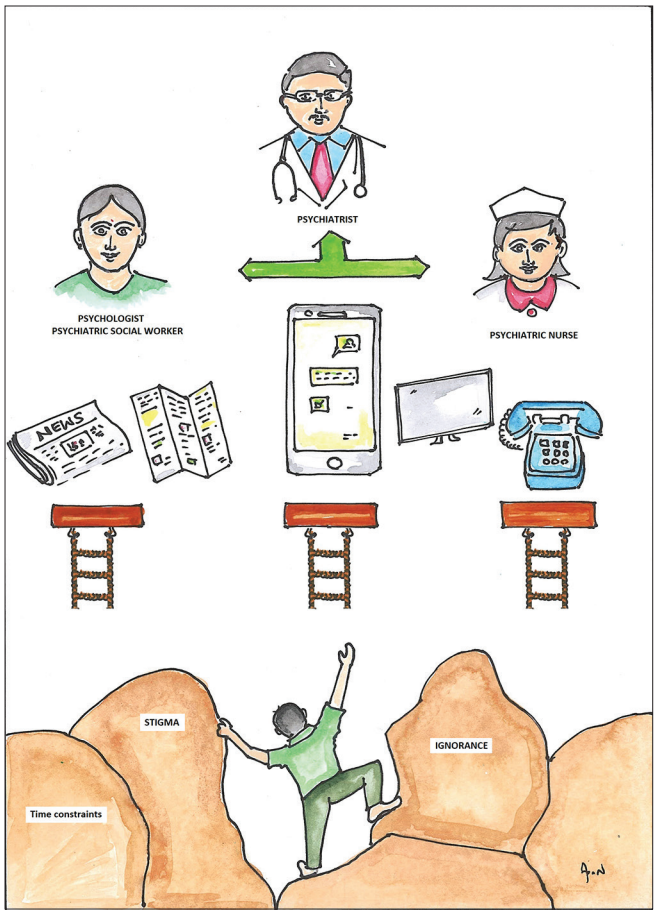
Reaching the Unreached: Insights on Psychological Interventions Beyond the Clinic–Walls

There is a strong body of evidence which points to the utility of psychological interventions in the field of mental health. Psychological interventions have been found to be efficacious in the treatment of various common mental disorders (CMDs), recommended as the first line of interventions and observed to have utility for improving adherence and lowering the rates of relapse and recurrence.[1-3] These observations broadly hold true despite some variability in the strength of evidence across type and severity of CMDs and type of psychological intervention[2] The paper aims at highlighting the need for psychological interventions beyond clinics and hospitals and provides a few illustrations from urban India. This is followed by a discussion of therapeutic elements in these interventions, challenges, limitations as well as sources of gratification for therapists engaging in such interventions.

ACCESS TO PSYCHOLOGICAL INTERVENTIONS

Notwithstanding the evidence on the effectiveness of psychological interventions, the available literature across the globe suggests that these interventions are not accessible to a large proportion of individuals who are likely to benefit from them[4,5] Need for multipronged approaches has been discussed to increase access to mental health services in general and psychological interventions in particular.[4-6] A recent review of evidence from 4 developed countries from 1990 to 2015 showed that despite a substantial increase in the provision of treatment (primarily in terms of pharmacotherapy), the prevalence of mood and anxiety disorders and symptoms had not decreased. There was limited evidence for an increase in psychological interventions during this period, and no significant masking of evidence for decreased prevalence due to increased exposure to risk factors was observed. This review highlighted the role of improving the quality of services for those in need and the necessity of enhanced and systematic focus on preventive interventions.[7]

A comprehensive approach to impacting public mental health would need to focus not merely on increasing the number of specialists and services, but making



professional services more accessible and use of strategies aimed at breaking mental and social barrier to services, increasing capacities for self-care and peer support in the communities as the first line of management for milder problems as well as enhancing focus on prevention and promotion.[8,9]

Innovations in the field of mental health directed at improving access to mental health services have tended to typically focus maximally on supply-side- barriers. These include innovative ways of improving the supply of mental health professionals offering a range of interventions, the supply of trained non-specialists offering basic psychological interventions, early identification and timely referrals in general/primary health services, and reducing structural and organisational barriers. In contrast, there has been

relatively less and inconsistent investment of resources in developing innovations for changing demand-side factors.[10] These demand-side factors that require to be addressed through access – innovations include complex factors such as meaning and interpretations of symptoms, perceived candidacy, eligibility for healthcare often jointly negotiated by initial interactions of individuals with healthcare systems as well as the dynamic process of individuals navigating their entry to health systems, circumventing ambivalences and other barriers.[10,11]

A closer examination of demand-side barriers can be a useful exercise for developing access- innovation, particularly for vulnerable sections of the population. Late adolescence and young adulthood are known to be a vulnerability period for the onset of various mental disorders, including CMDs.[12] In an ongoing Indian study on college youth, it was observed that those who were significantly distressed had higher perceived barriers to seeking professional help than their counterparts and were no more inclined than others to seek professional help (T.H. Noufal, personal communication, August 17 2018). This suggests that experience of distress in itself may not predict help-seeking inclination. Whether the experience of distress may also be linked to the perception of barriers and thus results in lower rates of actual help-seeking needs to be examined in further studies. In another study on urban Indian young adults, it was observed that only 29% of the sampled youth reported that a vignette which described moderate clinical depression in the background of a failure event was likely to be depicting a mental health problem. Moreover, about 51% of the youth were unsure if it was depicting a mental health problem and about 66% of the sample in this study indicated that they were unlikely to seek professional help if they were experiencing similar problems as depicted in the vignette.[13] Moreover, correct recognition of the vignette was not linked to higher self-efficacy for seeking professional help. In this study too, youth who had significant distress on a standardised measure were likely to report higher perceived barriers, and distress was unrelated to the inclination to seek professional help.[14]

REACHING THE UNREACHED- ILLUSTRATIONS

The above mentioned trends highlight the need for mental health professionals in general and clinical psychologists in particular to proactively reach out to people in need beyond the clinic walls and offer psychological interventions in various formats that may help in increasing the reach of such interventions, reducing access barriers, empowering communities to engage in self-help and peer support, as well as encouraging professional help-seeking, as and when appropriate. A few such initiatives and observations based on the same are now briefly discussed.

Extensive engagement with stakeholders, using surveys and focus group discussions, across 17 institutes of higher education in Bangalore, resulted in the development of a mental health promotive intervention program for youth named Feeling Good and Doing Well. This is a 20-hour, manualised, group-based universal intervention program. The results of a randomised controlled trial using this intervention indicated a beneficial impact on psychological well-being, positive affect, life satisfaction and distress, with gains being maintained at follow up.[15] Importantly, 31% of the youth who enrolled themselves in this program had significant levels of distress. There was a significant decline in distress post-program participation in the high distress group. These findings indicate the utility of a promotive intervention program of this nature to reach individuals in need and result in beneficial outcomes.

Such programs are well recognised as psychological 'interventions' and fall within the ambit of clinical psychology.[8,16] The therapeutic elements that are likely to have played a role in this intervention trial overlap to an extent with face to face psychotherapies for treatment of mental health conditions. These include a safe and non-threatening space, sense of connection to the facilitator and other participants, feeling empathised and validated through disclosure as well as discussion on common issues youth face, arousal of emotions and opportunities to reframe one's appraisals, sense of universality, vicarious learning from each other, reflection on life priorities, strengths, and weaknesses, development of individualised goal plan and education on emotion regulation strategies.

Compared to traditional face-to-face therapy, a promotive psychological intervention of this kind does have some constraints. There is little scope for individualised attention, along with limited opportunities for self-disclosure or discussion of individual-specific issues as well as dependency on the participants' ability to deduce personally relevant learning material and apply it in their day-to-day life.

Here are a few questions that emerge in hindsight that demand reflection. Is this a doorway to reach out to persons in need that we could use more frequently? Are we, as professionals, particularly in developing countries, under-utilizing such pathways rather than mainstreaming them? Do such findings reiterate the

overlapping nature of preventive and promotive efforts and efforts to reach out to distressed persons in the community? Does it have scope for scalability and potential to enhance mental health support to youth in the community? Review of relevant international and national published literature as well as field experience of the researcher suggests that perhaps all the answers to the above questions are in affirmative.[8,16-18] In addition to resource limitations in terms of trained workforce and limited public funding for programs of such nature, one of the important barriers to wider implementation has also to do with ambivalence or lack of sufficient clarity about the status of such programs as integral aspects of legitimate roles of mental health professionals.[16]

I now move on to illustrate two different kinds of digital pathways to increase access to psychological interventions for distressed non–treatment-seeking individuals. An initiative called Wellness Check (https://echargementalhealth.nimhans.ac.in/wellness-check/) comprises of a few standardised measures of distress and wellbeing that can be answered online (via a web browser or an app on the Play Store) and the respondent receives immediate, detailed online feedback, as well as suggestions to maintain/enhance wellbeing and links to mental health information and self-help resources. We began with the assumption that a broad conceptualisation of mental health (from distress to well-being) and ease of access on a digital platform can have the potential to engage distressed non-treatment-seeking adults in themes related to mental health. The findings of the pilot trial provided some support to this assumption when we examined the pilot data of individuals who accessed and used the website/app (N = 300). About 58% of the seekers of this initiative had significant distress, with 38% having scores in moderate to severe distress range. Moreover, about 70% of the users reported that they had no exposure to mental health services at any time in the past, and only about 12% were currently seeking mental health professional services. Out of the severely distressed sub-group, 76% reported that they were ambivalent or unlikely to seek professional mental health services in the subsequent three months. The resources on this site aim at enhancing self-awareness, self-help skills for enhancing well-being, as well as breaking motivational barriers to seeking help. Again, this highlights a digital approach that has the potential to reach out to the unreached.

Another digital intervention that I would like to use as an illustration is a digital self-help intervention for depression. The recently completed National Mental Health Survey reported that about 85% of individuals in India who are depressed are not receiving/seeking any professional help for the same.[19] This is despite the availability of empirically supported psychological interventions, as mentioned earlier. Empowering communities with structured self-help interventions has been discussed as an important first line strategy in addressing the treatment gap. Internet-based self-help interventions, particularly those with some level of human contact (guided self-help), have been found to be effective in several research trials across the globe.[20-22] However, there is a dearth of such studies from limited resource settings, including in India. A review of free apps on depression available for android phones for Indian users highlighted that most were limited to psychoeducation or self-monitoring tools. 33 interactive apps were identified in the review. Findings indicated that several did not clearly delineate the scope of the app/offered screening or provided any component aimed at breaking motivational barriers to professional help-seeking.[23]

An app named PUSH-D (Practice and Use Self-Help for Depression, https://echargementalhealth.nimhans.ac.in/pushd/) was developed to address some of the limitations of the reviewed apps in the Indian provides context. This is an interactive app which provide structured self-help modules and basic periodic telephonic-guidance for dealing with depressive symptoms. During the research trial, the typical seeker of PUSH-D was a young adult with an undergraduate level of education, mild to moderate severity of depressive symptoms amounting to major depression or dysthymia, and significantly impaired functioning. Most importantly, it was noted that 2/3rd were those who had never sought mental health professional help any time in the past, and 82% had not sought professional help for the current issues. Insufficient self-awareness, limited information on professional services, time constraints, stigma, and prior unsatisfying experiences with services emerged as some of the self-reported barriers to seeking professional help.[24]

On the other hand, ease of access, perception of problems as less severe, need for self-reliance, flexibility, and desire for self-empowerment to prevent further problems were reported as some of the factors that resulted in the appeal of PUSH-D.[25] The trial indicated statistically and clinically significant changes in depressive symptoms, functioning, well-being, and self-esteem in full as well as partial completers of PUSH-D modules. Qualitative feedback from users lent further support for its utility (e.g., 'availability of PUSH-D itself made me feel that there is something to help me,' 'it helped me to understand ways of fighting depression').[26]

Again, it is worth examining the potential therapeutic qualities in this digital self-help intervention. These include the provision of a structured framework to deal with depressive symptoms, education, motivation-enhancement, tools for self-learning and application, cultivation of hope and sense of self efficacy as well as awareness of therapeutic support in the background. These factors partially overlap with the therapeutic mechanisms in face to face psychotherapies. The app incorporated empirically supported therapeutic strategies such as behavioural activation, cognitive restructuring, self-soothing, decreasing self-criticality and increasing self-compassion, enhancing a sense of mastery and mobilising support in a self-help format, in addition to improving awareness on when to step up to higher intensity intervention. Unlike face-to-face psychotherapies, some of the limitations of PUSH-D include insufficient scope for consistently working through the medium of a therapeutic relationship in a narrative/conversational format, focusing on past issues, processing of difficult emotions in safe space and 'real' therapist presence, or corrective emotional experiences. Despite these limitations, the study findings on the whole indicated openness of urban Indian adults to use psychological intervention strategies in a digital format for self- help and potential to reach out to depressed individuals in the community who are otherwise not availing any professional help.

Our recent review of studies on smartphone-based psychological interventions highlighted that though such interventions are found to be efficacious, there is a dearth of implementation studies, field reports of deployment, and studies on factors related to user uptake and engagement in diverse cultures and low resource settings.[25] This reiterates the viewpoint that digital pathways have significant potential to reach out to the unreached. Unfortunately, most of the researched apps are not freely accessible to the public, and the reverse is also true that most of the apps freely available in the public domain have not gone through empirical testing.[27]

REACHING THE UNREACHED: CHALLENGES AND SOURCES OF GRATIFICATION IN TAKING PSYCHOLOGICAL INTERVENTIONS BEYOND THE CLINIC-WALLS

There are several challenges that therapists may need to negotiate when they intend/attempt to reach out to those in distress by going beyond the clinic walls. Inadequacy of apps in handling complex issues and non-contextualised, non-individualised solutions that are typical of most parts of unguided/guided self-help interventions can be sources of dissatisfaction in clinicians.[21] Not having sufficient information on how the app-content is being assimilated could emerge as another cause of concern for professionals. Offering app-based interventions could also give rise to apprehensions that clients may become complacent and not step up to higher intensity interventions when that is required. Some of these challenges could be at least partially addressed by providing some scope for customisation built into the apps and supplementary telephonic contact and/or online communication or the use of a blended approach that combines face to face and digital interventions as per need. Above all these aspects, clinicians may experience a sense of not offering the 'best of themselves as therapists' to their clients when they deploy self-help/guided self-help or blended interventions that combine face-to-face and Internet-based interventions.

Notwithstanding the challenges, reaching beyond clinic walls and offering psychological interventions can be gratifying in several ways. First of all, psychological interventions offered in varied formats, though typically low in intensity, can increase access to the same to those who otherwise may not be seeking any form of routine mental health care. The possibility that such access innovations can trigger a therapeutic change process and also provide an opportunity to decrease motivational barriers to seeking face to face professional help can serve as a major source of gratification for therapists.

On the whole, there are several factors that can help the 'therapist-self' in a clinician to invest efforts in innovative approaches to reaching out to distressed persons and increasing access to psychological interventions, though these may not always be seen by the professional community as one's core clinical responsibility. This stance requires courage to deviate from the routine and bear with the question on the legitimacy of such interventions. Integrating components in such interventions that encourage and facilitate face-to-face professional help-seeking as well as strengthening evidence-base for the same, particularly in developing nations, require attention.

To sum up, these reflections raise the following distinct possibilities: a) Interventions aimed at enhancing one or more components of well-being (i.e., promotive interventions) may also be of relevance to non-treatment seeking distressed individuals b) Openness in mental health practitioners to judiciously explore novel pathways, including digital tools, can improve the practice-research feedback loops, c) Psychological interventions delivered beyond the traditional clinical settings may serve not just as useful low-intensity

interventions but also as gateways to seek mainstream mental health services. All these possibilities merit attention and examination in view of the fact that a broadened attention to the entire continuum of mental healthcare has been recognised as important for reducing the treatment gap. Stepping out beyond the clinic walls more often than what we do, with more conviction, more consistency and in a systematic manner, by a larger number of mental health professionals in India, including therapists, is likely to be an exercise worth undertaking.

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