PROPOSAL FOR A SCREENING INTERVENTION OF MENTAL HEALTH

Summary of the proposal

Depression and stress are the leading cause of morbidity and disability. According to a WHO study, India tops the list of countries for the incidence of depression.

Depression and stress are the maximum morbidities in young professionals. Both of these go undiagnosed and untreated.

By taking the awareness of depression and stress to the doorstep of the sufferer, we can increase the chances of early detection, diagnosis and treatment facilitating quicker recovery and low suffering.

The human resource departments in most organizations are taken up with the task of recruitment, appraisals and facilitation of administrative structures. Even though trained in understanding the psychology of the employees and armed with the knowledge and resources of online psychological testing and information, the HR personnel fall woefully short of the required help. And the clinical medical aspect of the intervention gets lost in this process.

This team proposes a multi-pronged approach of psychological testing, psychiatric interview, psychotherapy, follow up psychological tests, lectures and group interactions to facilitate a screening and treatment intervention for the participants.

The expected outcome is to provide mental health help to those who might have masked suffering.

The organization can achieve their goal of mental health for their employees and students alike.

The Problem of Depression in India

She didn't speak for four years. Four grim years, when she lost all. Her friends disappeared. Her PhD was cancelled. Her writing and her music stopped. Doctors came and went, befuddling everyone with conflicting opinions. Tough medicines with unpronounceable names filled up the home: some medicines made her sleep like the dead, some played terrifying tricks with her mind and body. Could she interpret sensations, reason or feel the full range of emotions? No one knows. She just clung to her bed: gaunt, silent, vacant. She had just turned 30.

Does the nation know her? She is one out of every four women, and every 10 men, the nation loses to depression. Yet another wasted life, stripped of personality, struck down in the most productive years. They navigate through jagged decades of health and work, tormented by troubled moods and disturbed brains, alternating between full-blown agitation and wakeful lucidity, causing heartbreak to their loved ones and challenges to their doctors.

Wake-up call

It's a wake-up call for the land of happy. India routinely scores high on happiness surveys. In the 2014 Happy Planet Index, it ranks fourth out of 151 countries for delivering long and happy lives to its citizens. The economy is looking up: balance of payments is improving, current account and fiscal deficits are shrinking and inflation is coming down. Over 64 per cent Indians are happy with their jobs and work-life balance, reports a 2014 Monster Salary Index.

Yet the upbeat nation hides a terrible secret: the malady of melancholy, that happens for no apparent reason, hijacks the brain, eats away at personality and snuffs out lives. **Depression, the common psychological disorder, affects about 121 million people worldwide.** World Health Organization (WHO) states that depression is the **leading cause of disability as measured by Years Lived with Disability (YLDs) and the fourth leading contributor to the global burden of disease**. By the year 2020, depression is projected to reach second place in the ranking of Disability Adjusted Life Years (DALY) calculated for all ages. Today, depression already is the second cause of DALYs in the age category 15-44 years.

The WHO study, based on interviews with nearly 90,000 subjects across 18 countries with different income levels, said that the average lifetime rates of depression were found to be 14.6 percent in 10 high-income countries, and 11.1 percent in eight low and middle-income countries.

The study, released late July, said while around nine percent of people in India reported having an extended period of depression within their lifetime**, incidents of major depressive episodes (MDE) were highest among Indians at 35.9 percent**. China, a comparable large country, recorded the lowest with 12 percent.

A study conducted in 2009 by the Bangalore-based National Institute of Mental Health and Neuro- Sciences placed the **average age of the depressed Indian at 31 years**.

Such statistics give credence to estimates that put the number of Indians who suffer from depression around 10 million.

An estimated 3-4% of India's 100 crore plus population suffers from major mental disorders and about 7-10% of the population suffers from minor depressive disorders.

The above shows that disability due to depression exceeds disability due to all forms of cancer and diabetes mellitus combined, as well as exceeding the disability due to strokes and hypertensive heart diseases.

The National Crimes Records Bureau states that of the 127,151 recorded suicides in 2009, 8,469 were linked to serious mental illness. Indian union health ministry estimates state that 120,000 people commit suicide every year in India. Also over 400,000 people attempt suicide. A significant percentage of people who commit suicide in India (37.8%) are below 30 years of age. Ministry officials state that majority of those committing suicide suffer from depression or mental disorders.

Depression is associated with more impairment in occupational and interpersonal functioning in comparison to several common medical illnesses. The cost of depression, particularly the cost in lost work days, is as great as or greater than the cost of many other common medical illnesses.

The outcome of depression can be significantly improved by early detection. A wide range of highly effective treatments including antidepressant medications (at a cheaper cost), somatic therapies and psychotherapeutic interventions is available for the treatment of depression. Antidepressant medications and supportive psychological interventions are effective in about 80% of patients.

Less than 25% of those affected (in some estimates less than 10%) by depression receive treatment.

According to WHO, countries like India allocate less than one percent of their health budget to mental health activities compared to some western countries which give 10 to 18 percent.

Work-related stress depression and anxiety is defined as a harmful reaction people have to undue pressures and demands placed on them at work. By its very nature, stress is difficult to measure

The main work activities suggested as causing work-related stress depression or anxiety reported are

1. Workload pressures including scheduling, shift work and other organizational factors;

2. Interpersonal relationships including difficulties with superiors and bullying or harassment; and

3. Changes at work including reduction of resource or staff and additional responsibilities.

Age and Gender distribution

Female prevalence and incidence rates have remained statistically significantly higher than corresponding male rates over time.

The **45-54 age group** had the highest incidence rate for all persons, and this rate was statistically significantly higher than the average for all persons. This was also the case for females in the 45-54 age group.

Size of Workplace

Small workplaces (<50 employees) had the lowest prevalence rate of stress, followed by medium workplaces and the highest rate was amongst large workplaces (250+ employees).

The self-employed on own or with partners but no employees consistently show a statistically significantly lower prevalence rate of stress compared to the average across all persons.

In 2013/14, small businesses lost, on average, 0.27 days per worker due to stress in the workplace. Medium and large workplaces had statistically significantly higher number of working days lost per worker compared to small businesses with 0.46 and 0.56 average days lost per worker, respectively.

The Problem of Depression in Corporate India

Akhil Mehta, better known as the brain behind a popular Twitter handle committed suicide. He was 27. Known for his witty & sarcastic humor and the manner in which he questioned our society's (frequently illogical) beliefs, the news of his death sent shock waves across the social media.

Despite having over 50,000 followers, fans and friends, none could help him deal with his condition and prevent him from taking this extreme step. While some attributed it to the backlash he was getting from the powerful lobby that he had ridiculed through his posts, most fans probably had no clue about the depression that was gnawing him up from the inside.

This isn't an isolated case.

MBA jobs are among the most stressful. The stress starts with MBA applications, extends to the job hunting phase and continues till retirement.

While doing research on statistics related to depression in India, a study published a few weeks back by The Associated Chambers of Commerce & Industry of India (ASSOCHAM) had startling revelations.

Out of every 10 Indian professionals surveyed across the metropolitan cities, 4 suffered from general anxiety disorder or depression.

If the results of the survey are to be extrapolated, a *huge* number of Indian workers put on a smiling mask to hide their pain as they head to work each day.

In the list of the top diseases that affect corporate executives, **depression (42%) ranks at the top**, followed by obesity (23%), high blood pressure (9%) and diabetes (8%).

Roughly half the respondents admitted to feeling exhausted too often, over a quarter said that headaches were a common feature of their working lives.

What's more worrying is the age distribution of the respondents. Over half (55% to be precise) were under the age of 30 and a quarter were between 30 and 40 years.

Most international MBA aspirants from India are under 30 years. They are ambitious and competitive. They want the best from their careers in their most productive years.

There's a difference between being occasionally feeling low, and chronic depression. But for most, it's difficult to differentiate between the symptoms. The earlier you do, the easier it would be to control the damage.

Stress and Depression amongst students in India

Stress and depression can both be caused by life events and medical conditions. The one difference is that stress can be caused by pleasant events such as a promotion or marriage, while depression is associated with unwelcome events like financial difficulties or death. Life for many young people is a painful tug of war filled with mixed messages and conflicting demands from parents, teachers, coaches, employers, friends and oneself.

Stress among college students can be very difficult for some people. Many times they get home sick and want to isolate themselves. They have to get into a new routine of going to college, and change can be very difficult. It is definitely hard to get into the swing of college. They have to navigate through classes in a new format while living away from all the comforts of parents. A college student's life usually consists of attending classes, long hours of studying, and having a social life.

Some students work at a job or study harder than others, but they are all trying to get degrees so maybe one day they will have meaningful and significant lives. It is a constant struggle for everyone who is trying desperately to make him or herself into a success. And every college student wants to be involved with something in order to further their education, or just have fun. The struggle consists of demands on time, financial pressures, parental pressure and conflicts, interpersonal conflicts, managing freedom, peer and academic pressure and the transitional period to a new academic environment. All of these factors combined can cause emotional disturbances and one of the most common is stress.

For most students, college is the first experience living away from home, family and friends. When things become difficult, their support system (including family and friends) may be miles away and their surroundings unfamiliar. This may bring feelings of homesickness, loneliness and isolation. Many students find college more academically demanding than they anticipated and feel stressed or anxious about not performing well. Like any new life change, such as starting a job, college students have to negotiate an entirely new social network.

Teenagers spend years negotiating and establishing a social network in middle school and high school. All of a sudden, they are forced to do that all over again. The added pressure of greater exposure to drugs and alcohol can also play a role. For someone who is at risk for or already depressed, substance use may serve to exacerbate risk or symptoms and serve as a means to self-medicate and avoid his/her personal problems. Stress and depression share some similar behavioral symptoms, including social isolation, increased or decreased eating, sleep disturbances and potential drug abuse.

Facing repeated stress and the negative mindset of depression can result in feelings of helplessness. **Struggling with unrelenting stress increases the potential for depression**. On the flip side, depression lowers the ability to cope, and any small daily challenge may trigger unusually high stress. Ongoing stress results in continuously elevated levels of biochemicals, and that leads to medical conditions, including depression. It is not known

for sure if stress affects men and women differently. Generally, as the two genders often operate in different social contexts, both tend to develop different emotional dispositions and personality traits. Accordingly, their responses and coping mechanisms to stress situations vary.

The Proposed Intervention and Rationale for the Intervention

People suffering from stress and depression access mental health services only when the suffering has increased beyond their coping capacities leading to prolonged and painful treatment. The absence of preventive mental health and the lack of qualified mental health professionals leads to undiagnosed and untreated mental health problems. India has 3.5 psychiatrists per million people. A 2010 report by the Stanley Medical College (SMC) in Chennai titled ‘Training and National Deficit of Psychiatrists in India’ said: “With 6.5 percent prevalence of serious mental disorder, the average **national deficit of psychiatrists in India is estimated to be 77** percent and that more than one-third of the population had a 90 percent deficit of psychiatrists.”

It would be quite useful if awareness of these maladies and how it affects them was presented to these people right at their doorstep. **A multi-pronged approach would be able to capture the nascent problem and enable the sufferer to nip the development of the mental health problem in the very early stage**. Understanding the problem within a group allows the participant to feel one with the others and not feel isolated or abandoned. Approaching the problem from various angles allows the participants to understand various facets of mental health problems as most of the problems can be masked.

We propose using various tools to bring the preventive mental health interventions close to the people who may most need it. The approach consists of the following interventions:

1. Psychometric tests and psychological tests/questionnaires
2. Psychiatric Diagnostic Interviews
3. Psychotherapy
4. Awareness through lectures
5. Group Discussions
6. Regular follow up activities

These interventions keep the connection between the mental health professionals and the participants going on throughout the year. This enables the sufferer to seek help at his/her doorstep and remove stigma. Crisis intervention becomes more accessible thereby reducing suffering by early intervention.

We propose the following detailed interventions described above as a screening intervention.

Psychological tests

A psychological test is an instrument designed to measure unobserved constructs, also known as latent variables. Psychological tests can strongly resemble questionnaires, which are also designed to measure unobserved constructs, but differ in that psychological tests ask for a respondent's maximum performance whereas a questionnaire asks for the respondent's typical performance.

1. **Emotional assessment scale** – The EAS is 24 item instrument designed to measure immediate emotional responses to a full range of emotions at the same time. It is a very useful instrument for measuring momentary levels and changes in emotions. It measures anger, anxiety, disgust, fear, guilt, happiness, sadness and surprise.

2. **Self Esteem Rating Scale** – The SERS is a 40 item instrument that provides a clinical measure of self-esteem that can indicate not only problems in self-esteem but also positive or non-problematic levels. The items tap into a range of areas of self-evaluation including overall self-worth, social competence, problem-solving ability, intellectual ability, self-competence and worth relative to other people. The SERS is a very useful instrument for measuring both positive and negative aspects of self-esteem in clinical practice.

3. **Symptom Questionnaire** – This 92 item instrument measures four aspects of psycho-pathology – depression, anxiety, somatization and anger-hostility. It also measures subscales of well-being namely relaxed, contented, somatic well-being and friendliness.

4. **Perceived Stress scale** – The PSS is a 10-item instrument designed to measure the degree to which situations in one's life are appraised as stressful. The PSS assesses global perceptions of stress with a rationale that stressful events can increase the risk of health problems when they are appraised as threatening or otherwise demanding. The PSS provides information about the processes through which stressful events influence pathology. The scale also can be used to investigate the role of overall stress appraisal and situations in which the objective sources of stress are difficult to measure. The PSS also can be viewed as an outcome measure examining the experienced level of stress as a function of objective stressful events, coping processes and personality factors.

5. **Stressful situations questionnaire** – This 40 item questionnaire measures the level of reported apprehensions or concerns in various social situations. The situations are those believed to involve a loss of self-esteem.

Psychiatric Interview

The purpose of a psychiatric diagnostic interview is to gather information that will enable the examiner to make a diagnosis. Having established a diagnosis, the clinician can then make predictions about the future course of a disorder and the likely response to treatment. As with all areas of medicine, treatment decisions are guided by diagnosis. Unlike most disciplines of physical medicine, however, psychiatry has no external validating criteria, no laboratory tests to confirm or refute diagnostic impressions.

Consequently the diagnosis is wholly a product of the skills and knowledge of the individual psychiatrist and can never be better than the judgment made by individual clinicians.

Medical Model and Psychodynamic Formulation

The medical model has become the dominant mode of psychiatry. In this model psychiatrists are seen as physicians who specialize in the treatment of psychiatric disorders.

In contrast, the adaptational model sees psychiatrists as specialists in behavior and adaptation whose expertise can benefit people whether or not they have a diagnosable psychiatric disorder. A psychoanalytic interview is less concerned with establishing a diagnosis than with surveying psychological functions as they have evolved over an individual's lifetime.

A psychodynamic formulation draws from the principles of psychoanalytic theory. It describes personality structure in terms of ego strengths (including principal defense mechanisms, regulation of drives, relationships with other people, and reality testing), principal psychological conflicts, and developmental history, with particular emphasis on early childhood. The psychodynamic formulation is not intended to produce a diagnosis but rather to describe an array of psychological and adaptive capacities. These descriptions allow the analytic psychiatrist to formulate a theoretical model that explains current symptomatic behavior and interpersonal or functional limitations. It serves as the template for the conduct of a psychoanalytic therapy by anticipating unconscious intrapsychic conflicts and unacknowledged developmental arrests or delays.

The psychodynamic formulation differs from a diagnostic interview using the medical model in several significant aspects. It is more concerned with the unique characteristics of the particular individual than with commonalties of a diagnostic class.

In clinical practice psychiatric assessments are likely to draw from both analytic and medical models and are shaped by the unique circumstances of individual patients. There are patients for whom a psychodynamic formulation is relatively more important and will thus take up a greater portion of the interview. Among these are persons being considered for a psychodynamic therapy or those with a constellation of complaints not subsumed in a conventional categorical diagnosis. There are also persons for whom a psychodynamic formulation may be of negligible importance, for example, an individual with a diagnosis of

obsessive-compulsive disorder or simple phobia in which the planned therapies are pharmacological and behavioral rather than psychodynamic. However, even in these circumstances many psychiatrists prefer to have some sense of a person's psychological makeup and developmental history to avoid focusing on symptom relief to the exclusion of other areas of potential concern and to deal with resistances to therapy as they arise. The principles of psychoanalytic theory may offer a workable model for organizing and using these concepts.

The psychiatrist wants not only to ask the questions necessary for formulating a differential diagnosis, but also to establish rapport and create an atmosphere of confidence and trust. Relaxed and trustful patients are more likely to provide useful information than those who are nervous or on guard.

The initial psychiatric assessment usually lasts 90 minutes, with the length of time agreed upon in advance. Sometimes additional time is necessary to complete the evaluation, in which case it is better to schedule an additional session.

Intensive Short-Term Dynamic Psychotherapy (ISTDP)

ISTDP is a unique form of psychodynamic treatment that **facilitates the rapid resolution of a broad spectrum of emotional disorders**. It is an **evidence-based psychotherapy** that is strongly supported by current clinical research studies. ISTDP interventions are specifically designed to resolve anxiety, depression, somatization and personality disorders, as well as, to alleviate a variety of self-defeating behaviours, many of which derive from unstable or troubled early life attachments.

Philosophy of ISTDP

ISTDP has common roots with classical psychoanalysis aimed at treating patients with psychoneurosis (environmentally acquired mental illness). Both treatments focus on unconscious mental processes (perceptions, past events, feelings about events, and distorted beliefs) as the cause of neurotic disorders. What distinguishes practitioners of ISTDP is that we believe that psychological treatment should be both comprehensive and efficient to

- **Remove symptoms**
- **Change character traits when necessary**

Findings of clinical improvement confirmed by scientifically designed studies demonstrate that the above changes occur and that they are long lasting, and finally, that **treated patients continue to improve even after termination.**

To accomplish the above goals, the ISTDP therapist is an **active advocate of change** rather than a neutral observer as in traditional analysis. The attitude of the ISTDP therapist is that the patient's time is irreplaceable and comprehensive change is possible in a reasonable, cost-effective time frame.

In ISTDP, **experience of core emotion from the past is seen as the transformative vehicle** and the therapist relies on non-interpretive techniques: encouragement to feel; challenge to take responsibility to change; and confrontation of resistance to change.

Protocol of interventions:

We propose the following protocol for the screening interventions:

- A battery of **five psychological questionnaires** as outlined above will be administered in the first phase. The total time taken for the administration of these questionnaires would be around 1 hour. We would need one week to score these questionnaires and prepare the report. The reports would be mailed to each individual or given in printed form to each person.
- In the next meeting held with all the participants who have participated in this intervention, the test results are discussed generally. This would take place a week after the administration of the questionnaires and after all the participants have their test reports. The discussion includes the purpose of each questionnaire, the norms and the cut-off limits. The participants who have scored beyond the norms are encouraged to avail the clinical psychiatric diagnostic interview. The individual reports are kept confidential.
- After the first two meetings, the participants are offered a **clinical psychiatric diagnostic interview** if they wish to avail of it. This consists of discussion of the individual test results, the factors responsible for the abnormal scores and a full clinical interview as described above. A follow up interview can be scheduled if needed. The participants who have abnormal scores are encouraged via e-mail and telephonic call to avail of the diagnostic interview.
- After the diagnostic interview, some participants who have been diagnosed with clinical problems are offered **5 to 10 sessions of ISTDP**. Further sessions can be planned if needed.
- A **follow up each month** is scheduled for all the participants. It would entail administration of a psychological test and discussion of the topic in the test. Participants who score beyond the norms may avail of the diagnostic interview as described above. (Tests are outlined in Appendix 1)
- A **lecture** by a well-known faculty on the clinical manifestations of mental health problems is scheduled once a month. (Topics are outlined in Appendix 2)
- An optional **group interaction** once a month can be started for the interested participants.

Cost of the interventions

To be discussed

Expected Outcome:

With the above mentioned interventions, the team expects to help the participants explore their mental health status. They would be able to test, diagnose and treat the people suffering from depression and stress. They would be able to create a mental health cell within the organization to help the participants access mental health at a very early stage.

Appendix 1

Psychological tests

1. Competitiveness Scale
2. Life Distress Inventory
3. Index of marital satisfaction
4. Index of family relations
5. Parenting scale
6. Achievement anxiety scale
7. Aggression inventory
8. Ascription of Responsibility Questionnaire
9. Belief in Personal control scale
10. Defense style Questionnaire
11. Indecisiveness Scale
12. Index of clinical stress
13. Interpersonal Dependency Inventory
14. Life Satisfaction Index
15. Irrational Values Scale
16. Rational behavior inventory
17. Index of Job satisfaction
18. Index of self esteem
19. Verbal aggressiveness scale

Appendix 2

Topics for lectures

1. Depression
2. Anxiety
3. Substance abuse - Alcohol, cannabis and others
4. Sexual problems
5. Personality problems
6. Attention and Attention deficit disorders
7. Memory and ways to improve memory
8. Emotions
9. Motivation
10. Stress and its effects
11. Eating disorders
12. Sleep disorders
13. Somatic Symptoms
14. Suicide
15. Psychiatric medicines – an understanding
16. Psychotherapies – an understanding