Psychological treatments for the world: Lessons from low- and middle-income countries

This review describes how and which psychological treatments for common mental disorders in adults are delivered by non-specialists in low-resource settings. It helps to inform the design, delivery and scale-up of such treatments in low- and middle-income countries in order to reduce treatment gaps in highly-burdened populations.

Why was this research needed?

Populations affected by natural and man-made disasters, which primarily occur in low- and middle-income countries (LMIC) show high rates of depression, anxiety, and posttraumatic stress disorder – which account for more than 40% of the burden of all mental and substance use disorders.

However, psychological treatments or ‘talk therapies’ are often not accessible due to the limited number of mental health professionals, interventions focused on single disorders, and stigma. As a result, up to 93% of people in need remain untreated.

A promising strategy to address these issues is to use non-specialist providers and treatment approaches targeting a range of mental health problems at the same time. Nevertheless, there is a need to identify the common elements among successful interventions and how, by whom, and where they are implemented.

Key Messages

1. Interventions can be broken down into key elements and techniques. The successful ones can be selected to develop optimal interventions for a specific context. These include nonspecific approaches to engage patients, specific psychological mechanisms, and in-session techniques.

2. The delivery of existing combinations of these elements by trained and supervised non-specialists successfully reduces the burden of common mental disorders, compared to usual care in low-resource settings.

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What Works

→ **WHAT** – Psychological treatments in this review share a number of key elements and implementation techniques. The researchers analysed the number of elements and techniques in each trial and how frequently each technique was used.

→ **WHO** – Using local, affordable non-specialists with good language, communication, and interpersonal skills, as well as appropriate training in psychological treatments and supervision, is more effective than usual care in LMICs. Two-thirds of all non-specialist treatments were delivered only by women and for women.

→ **HOW**: There were different training, supervision, and treatment delivery methods. On average, there were 10 days of face-to-face training mixed with a practice phase. Supervision was mostly done on a weekly basis, either in groups or individually with a range of techniques such as in-person and phone or online communication.

→ **WHERE**: The interventions were delivered where it was most convenient for the participant. Use of public spaces required modification of confidentiality practices in some cases.

→ **HOW WELL**: Most trials targeted depression or PTSD with moderate-to-strong effects.¹

Recommendations for Researchers

→ Explore which combinations of elements are most effective in psychological treatments for specific mental disorders.

→ Address barriers to training and supervision, possibly using technology platforms and other incentives.

→ Evaluate treatment interventions in younger populations.

→ Explore opportunities for more non-specialist psychological treatments delivered by and for men.

→ Collect data more systematically, eg. by using a checklist of key implementation processes.²

Authors’ Conclusions

Psychological treatments delivered by non-specialist providers that share a number of key treatment components are more effective than usual care in low- and middle-income countries. There is potential for scaling up such treatments globally.

¹ Standardized mean differences from meta-analyses: All primary outcomes 0.49 (95% CI = 0.36-0.62); depression 0.46 (95% CI = 0.33-0.59); trauma 0.47 (95% CI = 0.17-0.76); mixed anxiety/depression 0.65 (95% CI = 0.31-0.99); anxiety 0.24 (95% CI = 0.09-0.39).

² Checklist available at [www.mhinnovation.net/resources/mhin-summary-psychological-treatments-world](http://www.mhinnovation.net/resources/mhin-summary-psychological-treatments-world)

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1 What did the treatments consist of?

**Nonspecific elements**
- Family involvement
- Active listening
- Empathy
- Normalisation of illness
- Collaboration

**In-session techniques**
- Goal setting
- Assigning homework
- Psychoeducation
- Direct suggestions
- Giving praise

**Specific elements**

**INTERPERSONAL**
- Assessing relationships
- Eliciting social support

**EMOTIONAL**
- Emotional regulation
- Linking affect to events
- Eliciting affect

**BEHAVIOURAL**
- Relaxation
- Problem-solving

**COGNITIVE**
- Distraction
- Mindfulness
- Restructuring thoughts

**Activation**
- Self-monitoring

2 Who delivered the treatments?

**Non-specialist providers**
- Community health workers
- Peers from same community
  - Nurses
  - Midwives

**Mental health specialists in diverse roles**
- Evaluating treatments
- Supervision
- Assuring safety
- Building competency

3 Where were these treatments delivered?

- **50%**
  - Schools
  - Outdoors
  - Community meetings

- **38%**
  - Primary care centres

- **27%**
  - Homes

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