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Psychotherapy in India

Past, Present and Future



Editors

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CHAPTER

How are We Treating the Suffering Children?

Vivek Agarwal, Chhitij Srivastava, Arundhati Gairola

ABSTRACT

The importance of psychotherapeutic approaches in India is on the rise due to the changing socio-cultural and economic structure of the society which has led to increasing stressors in modern life. This is especially relevant for children and adolescents because of concerns around safety of psychotropic medications. Various psychotherapeutic modalities are being practiced in India at limited places where trained manpower is available. Good evidence base for psychotherapy exists in the developed world but studies are limited in India and other low- and middle-income countries (LMICs). There is also huge variation in the practice of psychotherapy given the lack of standardized protocols. There are numerous other challenges in the practice of psychotherapy in India. This chapter will focus on the current evidence base of therapies in children, various challenges in the practice of psychotherapy in Indian population, and limitations of research.

Keywords: Psychotherapy, Children and adolescents, India, Evidence base

INTRODUCTION

Psychotherapeutic approaches play a vital role in addressing mental health issues. Their importance in India is on the rise due to the changing socio-cultural and economic structure of the society which has led to increasing stressors in modern life. As per the 2011 census, 40.69% of India's population is up to 19 years of age out of which about 12.5% suffer from diagnosable psychiatric disorders.[1] In children and adolescents (hereafter referred to as children unless specified), psychological interventions become especially important because of concerns around safety of psychotropic medications and paucity of research.

The western world has seen significant progress in the development of psychotherapies in children. Some of them are being practiced in India at limited places where trained manpower is available. This chapter will focus on evidence base of therapies in children, various challenges in practice of psychotherapy in Indian population, and limitations of research.

EVIDENCE BASE OF PSYCHOLOGICAL TREATMENTS

Problems of children can be broadly categorized as neurodevelopmental disorders like autism and learning disorders; externalizing disorders like oppositional defiant disorder; internalizing disorders like depression and

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anxiety disorders; severe psychiatric disorders like psychosis and bipolar disorders; substance use disorders, developing personality issues. Some adverse childhood experiences like child abuse and neglect deserve a special mention as they often play an extremely important part in the development of psychiatric disorders. Various psychotherapeutic interventions that have been found effective in these disorders using a parent or child approach have been summarized in **Table 1**.

TABLE 1: Summary of evidence-based psychological treatments for children and adolescents.

Psychiatric illness	***Psychological treatment***	***Reference***
Depression	• Cognitive-behavior therapy (CBT) • Interpersonal psychotherapy	• Asarnow et al. 2001[39] • Kaslow & Thompson 1998[40]
Anxiety disorders	• CBT • Systematic desensitization	• James et al. 2020[41] • Ollendick et al. 1998[42]
Obsessive compulsive disorder	CBT with ERP	Reid et al. 2021[8]
Oppositional/ conduct disorders	Parent management training (PMT)	Brestan & Eyberg 1998[43]
Autism spectrum disorder	• Applied behavior analysis (ABA) • Developmental models include DIR Floor time (The developmental, individual-differences and relationship-based model) and Naturalistic Developmental Behavioral Interventions (NDBIs) • Speech and language therapy (SALT) • Sensory integration therapy (SIT)	• Odom et al. 2010[44] • Solomon et al. 2014[45] • Schreibman et al. 2015[46] • Beukelman et al. 2005[47] • Case-Smith et al. 2015[48]
Attention-deficit/ hyperactivity disorder	PMT	Pelham et al. 1998[49]
Internet gaming disorder	CBT or multilevel counseling (MLC)	Chang et al. 2022[16]
Substance use disorder	Brief intervention including motivational interview	• Steele et al. 2020[50] • Li et al. 2015[51]
Tourettes syndrome	• Habit reversal training (HRT) • Behavior therapy including HRT and comprehensive behavioral • Intervention for tics	• Li et al. 2020[52] • McGuire et al. 2013[53]

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A recent meta-analysis of 447 studies on various psychotherapies including 30,431 children demonstrated a moderate pooled effect size (g = 0.46) across treatments. When treating anxiety disorders, pooled effect size was largest (0.61), which was preceded by conduct problems (0.46), attention deficit/hyperactivity disorder (ADHD) (0.34) and depression (0.29).[2]

There is a lot of evidence for cognitive behavior therapy (CBT) in children. The effectiveness of CBT can vary depending on the actual process of therapy. For example, Whiteside et al., found larger effect sizes when in-session exposure and response prevention (ERP) had higher doses.[3,4] CBT has been successfully adapted to different disorders. Trauma focused cognitive-behavioral therapy (TF-CBT) for post-traumatic stress disorder (PTSD) is an excellent adaptation of CBT and had positive effects in trials conducted in various countries.[5-7] In the treatment of obsessive compulsive disorder (OCD), CBT with ERP had greater effectiveness than psychological placebo like psychoeducation (g = 1.13), and similar to CBT that focus largely on cognitive therapy (g = 0.05). Similarly, CBT with ERP had slight advantage over all forms of pharmacological treatment (g = 0.36).[8]

Meta-analyses of ADHD treatment trials have revealed mixed results, with behavior therapies showing most promising outcomes. However, in this group, the interventions are best provided through parents and teachers. Behavioral parent training and behavioral school-based interventions have pooled effect sizes of 0.70 and 0.66–0.72 respectively.[9] Miller & Lee's compiled 82 single subject experimental designs (SSEDs) studies comprising 168 participants with ADHD and concluded that functional analysis-guided interventions produced larger treatment effects.[10]

Psychotherapies for youth conduct problems yielded a pooled effect size of 0.82, according to Comer et al.[11] Aggression was found to have a significant overall small-to-medium effect size (d = 0.28) in multilevel meta-analysis. More effective interventions targeting the general population included behavioral practice and problem solving.[12]

Analysis of 44 randomized controlled trials (RCTs) reported dialectical behavioral therapies with reductions in self-harm (OR, 0.28) and suicidal ideation (Cohen d SMD, –0.71). Mentalization-based therapies were found effective in reducing self-harm (OR, 0.38) and suicidal ideation (Cohen d SMD, –1.22).[13] Studies that precisely evaluate treatments for nonepileptic seizures (NES) are scarce. It is not possible to draw a conclusion that one therapeutic technique was better than another from the existing literature, despite the fact that a variety of approaches have been used in managing conversion disorders with usually positive outcomes.[14]

According to recent research, psychosocial therapies like family-based therapy, CBT, and multicomponent approaches continue to be the most

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successful forms of treatment for adolescent substance use disorder.[15] A meta-analysis for treatment for Internet Addiction/Internet Gaming Disorder found that combining pharmacotherapy with CBT or multilevel counseling was the most effective treatment option.[16]

There is some evidence for efficacy of therapies done online. A meta-analysis of 37 RCTs on remote psychotherapies for youth on depression, anxiety, ADHD and conduct problems reported pooled effect size of 0.47 at post-treatment and 0.44 at follow-up that was comparable to results of meta-analyses of in-person youth psychotherapies.[17] However, the effect was significant for anxiety and conduct problems and not for depression and ADHD.

There is a wide range of sessions that are required for psychotherapy to be effective. The average number of sessions for youth psychotherapy examined in RCTs was 16, yet it was seen that young people only attend 1 to 4 sessions on average when receiving routine clinical care.[18,19] There were numerous RCTs evaluating single-session therapies as well. A meta-analysis of 50 RCTs of single-session therapy showed the average post-treatment impact size for all disorders was 0.32, with reasonable effects for anxiety (0.56) and behavior problems (0.54).[20] This study showed that it might be possible to do effective interventions in single session only.

EVIDENCE BASE IN LOW- AND MIDDLE-INCOME COUNTRIES

There is a huge gap when it comes to the evidence base of psychotherapies in low- and middle-income countries (LMICs). However, a recent meta-analysis with 43 treatment-control comparisons and 4,176 participants, showed pooled effects of youth psychotherapies in LMICs to be significantly larger than those in non-LMIC meta-analyses. However, the interventions that were culturally adapted from other nations had smaller effect sizes than those that were not. This probably means that in trying to adapt therapies to local cultures, there is a risk of altering the core therapy principles. An exception to this was evidence of successful application of culturally adapted DBT demonstrating that it is possible to adapt therapies effectively without modifying the fundamental principles.[21] However, there were high attrition rates in these trials as well as limited benefits of intervention by phone or by nonspecialist providers. Interventions delivered by the trained mental health professionals were more effective than lay persons. A systematic review of psychosocial interventions for self-harm in LMIC revealed that CBT and problem-solving therapy were the most extensively researched treatments.[22] Another meta-analysis targeting TF-CBT in LMIC showed it to be beneficial in addressing trauma-related symptoms and enhancing psychosocial functioning in children and adolescents.[23]

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Parent/caregiver-mediated therapies make up the majority of autism intervention in LMIC (N = 8; 44%). Evidence suggests early intervention (ages 1–7) has beneficial effects on development.[24,25] However, the level of the evidence base is limited, with just a few successful replication studies.[26] In these studies, peer-mediated, parent-sibling-mediated as well as parent-teacher-mediated interventions were included. The periods ranged from 3 weeks to 6 months, with a wide range of the frequency of sessions (daily to weekly). There is some evidence that children with autism can benefit from interventions administered by nonspecialists in a variety of ways, particularly well-suited for LMICs.[27]

INDIAN RESEARCH

With respect to India, there is limited literature available on the effectiveness of psychotherapy in children. A review of interventions in ADHD of Indian studies reported efficacy of behavioral interventions in children.[28] Similarly, a study found manual-based parent skills training intervention for families having children with ADHD effective in reducing inattention, hyperactivity/impulsivity and conduct problems.[29] A computer-assisted CBT (Smartteen) in depression was noticeably more effective than TAU in improving depressive symptoms and functioning.[30] Another study reported efficacy of mindfulness-based cognitive therapy on children (MBCT-C) with anxiety.[31] Despite the paucity of data in India, the potential of therapy, along with its feasibility and acceptance, raises optimism for more research in this expanding field.

CHALLENGES IN PSYCHOTHERAPY PRACTICE

Providing psychotherapy to children in India presents a unique set of challenges that are influenced by cultural, social, and economic factors. Therapies which are being done are largely eclectic which involves exploration of stress, providing psychological support and possible resolution of stress or improving the coping skills. Therapies are usually not done as per manual. There are also numerous logistic challenges making it difficult to provide mental health services to those in need.

- *Lack of awareness and stigma:* In many parts of India, there is limited awareness about mental health issues as well as about the benefits of psychotherapy as a treatment option, leading to delayed or inadequate interventions. Stigma surrounding mental health issues remains prevalent in India, making it difficult for parents and caregivers to seek help for their children. Traditional cultural beliefs often attribute mental health issues to destiny or supernatural causes, which can deter families from seeking professional help. There is also a fear of negative social judgment and discrimination. Even when there is an acceptance of psychiatric illnesses,

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many Indian families especially from rural areas fail to see talking therapies as treatment modalities and seek medications instead.

- *Limited access to mental health services:* There is lack of availability of child psychiatric services in most parts of our country. Even if services of psychiatrist are available then clinical psychologist are not available so, the entire burden falls on the psychiatrist. As people come from distant places, it is not feasible for them to come frequently for therapy. Also, therapies are expensive other than the government sector and people find it difficult to afford. In government sector, therapists are few, leading to long waiting time or frequently missed appointments.
- *Training issues:* The therapy standards even in trained professionals can be very variable especially when it comes to the pediatric population. Most training institutes in psychiatry and psychology do not have a dedicated unit for the younger population which is a serious limiting factor. Besides, training in psychotherapy is also not very standardized with different institutes following different protocols. For example, in recent years, CBT has gained popularity in India as a valuable tool for addressing the emotional and psychological needs of children and adolescents. A recent review highlighted a number of pitfalls in the way CBT is being practiced in India.[32] These include incorrect interpretation of core CBT principles, using non-CBT techniques, side-lining cognitive aspect of CBT, etc. Some institutes are trying to adapt CBT to Indian context which alters the core CBT principles.

COMORBIDITY OF PSYCHIATRIC DISORDERS

There is a mismatch between the efficacy in clinical trials and effectiveness of therapy in community settings owing to the severe, comorbid conditions encountered in clinical practice. The rates of comorbidity are extremely high with around 40% of patients reporting more than one diagnosis comorbidity are extremely high with around 40% of patients reporting more than one diagnosis.[33] The high comorbidity rates probably do not represent true comorbidity but probably a shared common etiology between the reported comorbid disorders.[34,35] Current understanding shows that diagnostic boundaries are more fluid than previously believed and that it is important to focus on similarities between different disorders rather than focusing just on differences. Transdiagnostic treatments focus on shared common grounds between different diagnoses rather than the actual diagnosis and can address several comorbidities simultaneously. For example, a young person's eating disorder may be linked to her OCD symptoms. Rather than treating her eating disorder and OCD separately, they can be brought under one formulation based on the similarities and sometimes causal links and treatments can be designed to target both diagnoses simultaneously.[36] This has led to

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the development of Transdiagnostic CBT (TCBT) approaches to address symptoms and shared mechanisms across disorders. A recent Indian study found that such an approach can be successfully applied in our population.[37] Further it had the benefits of lowering costs and therapist time as it was targeting more than one disorder in a group setting. Another such approach termed "The PRIDE programme" is being piloted to develop transdiagnostic, low-intensity, stepped care psychological interventions addressing a wide range of emotional and behavioral problems among adolescents attending Government run secondary schools in India.[38] This is an exciting area in the practice of psychotherapy and is both an opportunity and a challenge in our population.

PRACTICAL PROBLEMS IN IMPARTING PSYCHOTHERAPY

Conditions in clinical trials are different from community settings with extensive pre-therapy training, close supervision on protocol adherence, and a small caseload of homogeneous clients. These ensure much better compliance than that can be seen in routine clinical practice. Even where trained personnel are available, it is difficult to ensure compliance to treatment protocols. Attrition rates are high as Indian families often look for quick results which psychotherapy does not provide. This means that therapies are often terminated midway with poor follow-up. A lot of therapies especially CBT involve home assignments that some children and their families are often reluctant to complete. Therapies are not always done in closed clinic rooms. However, most therapists do not extend therapy to outside clinic rooms because of workload, time constraints, traditional thinking about therapy. There are various other practical issues in providing therapy as explained below:

- *Communication barriers:* Communication with children poses its own set of challenges as children may not have the vocabulary or emotional awareness to express their feelings. Therapists need proper training to be able to communicate effectively with them using age-appropriate measures like play, stories, art, etc. A significant proportion of adolescents who are brought by their parents for help do not recognize any problem with their behavior. They do not see the need to seek help and therefore are reluctant to engage in therapy. Parents often resort to forcing them into the therapeutic process which makes the child–parent relationship worse. As expected, it leads to premature termination of therapy.
- *Child rights, consent and confidentiality:* Consent and confidentiality issues can arise when working with children, especially in cases where parents have differing opinions on the child's treatment. Often in Indian context, parents do not understand these issues and feel entitled to be made aware of all discussions that a young person has with the therapist.

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This, therefore, makes it difficult for the young person to be able to trust the therapist and they become reluctant to share sensitive information with them often resulting in the failure of therapeutic process.

- *Family dynamics:* Traditional Indian families are joint families with multiple people in parenting role. While this is often an advantage, it also interferes with the therapeutic process with the young person who sometimes gets conflicting messages from different adults in the family. Family members also often hesitate to openly discuss relevant family dynamics which may be relevant to the therapeutic process. They may often also blame the child thus making it difficult for the therapist to come to a proper formulation and deliver effective therapy. Indian families also put a lot of emphasis on academic achievement of their children. While the focus on academics is a healthy thing, it can become excessive and almost feel like a burden that the child has to bear. Parents evaluate the outcome of therapy in context of academics.

LIMITATIONS OF RESEARCH IN PSYCHOLOGICAL TREATMENTS

Research in psychological treatments has not been able to provide moderators of treatment effects like characteristics of child or parents or culture, technique or effect of time. Similarly, it is not clear how the psychological treatments work. Studies have not been able to provide a consistent biological basis of effect of psychological treatments. Also, the treatments are largely focused on symptom reduction then overall recovery in different areas of impairment in the youth. Studies need to focus on these issues besides including children who are more similar to clinical settings to generalize the effects of therapies.

CONCLUSION

There is substantial evidence of efficacy of large number of psychological interventions in different disorders in youth. However, database in India is almost negligible. Reasons could be lack of mental health professionals, funding for research and overburdened professional with clinical care. The way forward may be use of technologies like app-based treatments, telemedicine as well as supervised treatment provided by trained lay persons. However, there is need to develop data base of effectiveness of interventions in Indian population to cater to the needs of huge population of youth.

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Psychotherapy in India
Past, Present and Future

This book focuses on psychotherapy in the Indian context. The book begins with the history of psychotherapy in India, tracing the path of its journey in India both in practice and growth as a sociality. The book has two sections. Section 1, "Inquiring Voices from the Region", has chapters on training in psychotherapy in India for psychiatrists, psychotherapy with special populations of children, persons from low literacy and socio-economic backgrounds and the current state of psychoanalytic practice in India. The last chapter in this section addresses psychological therapies in India in the Global context. Section 2, "Helpful Echoes from the Indian Diaspora," has chapters on the journey of the psychiatrist in becoming a medical psychotherapist, placing India in their psychotherapeutic work. Chapters focusing on yoga and mindfulness in cognitive psychotherapy and psychotherapy in Bhagavad Gita are included in the second section. The last chapter concludes the main findings and provides recommendations for the growth of psychotherapy. This book gives an overview of the past, present, and future of psychotherapy in India.

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