MENTAL HEALTH TREATMENT APPROACHES IN THE GLOBAL SOUTH

A Review of the Evidence

PHOTO CREDIT: ICBF.

The Research Technical Assistance Center (RTAC) is made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of contract no. 7200AA18C00057. This brief was produced by Jenna Muller, Tara M. Powell, and Benjamin J. Lough. The contents are the sole responsibility of RTAC and NORC at the University of Chicago, and do not necessarily reflect the views of USAID or the United States Government.

September 2023

Key Takeaways

- ✔ International development actors often apply mental health approaches designed in the Global North to settings in the Global South. However, many of these are under-researched or lack evidence supporting their effectiveness in the Global South.
- ✔ There is debate on what "evidence" of the effectiveness of mental health treatment approaches means and critiques among some schools of thought that the current understanding of evidence-based practice is too narrow.
- ✔ Some well-researched mental health interventions developed in the Global North may not be appropriate for application in the Global South due to setting- and cultural-specific differences, including access to financial and infrastructural resources.
- ✔ Treatment approaches developed in the Global South may not have been well-researched according to Western standards or for applicability in settings other than where they originated.

Promising Approaches

When interventions shown to be effective in the Global North are considered for use in the Global South, carefully consider the cultural and social factors that may influence the effectiveness of a given intervention. Specific attention should be paid to:

- Barriers (i.e., factors that impede the implementation) and facilitators (i.e., factors that enable the implementation) of mental health intervention approaches: such factors may include the target population's willingness to participate with the proposed intervention, the extent to which the content of the intervention itself is appropriate for the cultural milieu, and the accessibility of the intervention in its target location.
- "Essential" or "Active" ingredients that influence symptom reduction in mental health treatment approaches that may differ based on social or cultural factors: these include exploring the elements (e.g., engagement, psychoeducation, cognitive coping) within a treatment and the dosage (i.e., number of sessions) related to symptom reduction.

Expansion on how "evidence" is defined should be considered. Explore different cultural ways of knowing and what may locally constitute knowledge.

- Recognize case study analyses, narrative-based data, participatory observation, and other forms of qualitative data as valid forms of evidence.

Increase support for research into locally accepted practices to treat mental health conditions. This may include integrating methods that rely on local knowledge and intuitive practice wisdom to deliver mental health services that take the cultural context into consideration.

Outreach, assessment, and adaptation of mental health services in different delivery settings are needed to adequately meet the needs of target populations. Areas of potential risk and harm to local communities should be carefully considered when implementing interventions and should be adapted to maintain safeguards against violations of human rights and ethics.

Introduction

Background

There is no one-size-fits-all approach to mental health treatment. What works best depends on many factors, including the specific mental health conditions, the cultural and social context, and the availability of resources.

In pursuit of this question, it is important to note that some mental health practitioners who adhere to a more traditional, "practice wisdom" approach strongly critique the movement towards evidence-based practice in mental health. One longstanding criticism is that too much emphasis is placed on strict adherence to the content, structure, and limited flexibility of evidence-based treatments and ignores the expertise and experience of practitioners—particularly in traditional and indigenous settings.[1] This criticism recognizes that research does not always adequately capture the complexity and uniqueness of individual cases and that the effectiveness of some treatment approaches, such as cognitive behavior therapy, are easier to measure than others, such as humanistic therapy.[2] Some practitioners also believe that evidence-based practice is too rigid and does not allow for flexibility in treatment. They argue that every individual is different and that a standardized "one-size-fits-all" approach to treatment is rarely effective.[1] These practitioners contend they must use their own judgement and experience to make decisions about treatment rather than relying solely on evidence and on a comparatively small set of easily measured methods.[3]

It is also possible that some mental health practitioners critique evidence-based practice because they are resistant to change, are comfortable with their traditional methods, or are not familiar with research in their field. Overall, it is important to recognize that both mental health approaches that are sufficiently evidence-based and those that rely on more intuitive practice wisdom have strengths and limitations.

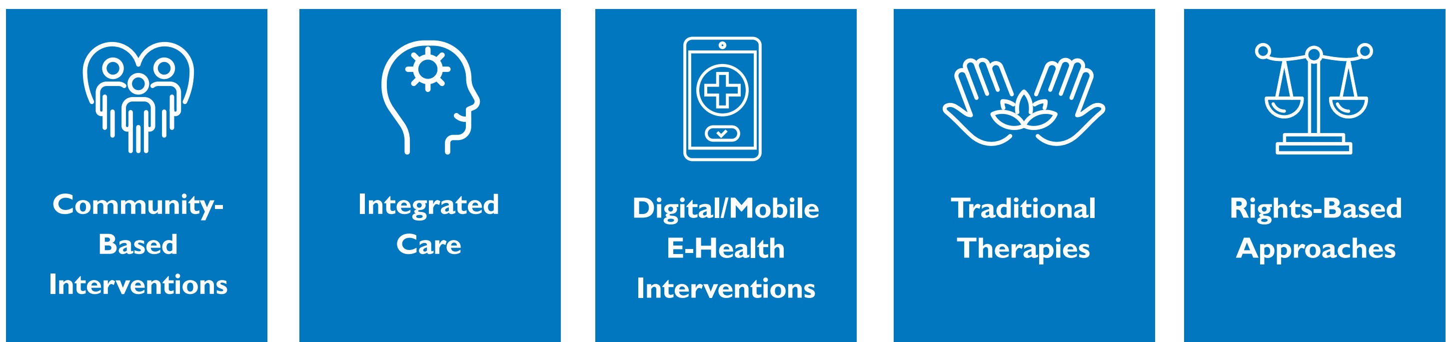
Search Strategy

A review of the literature was conducted across several databases, including SCOPUS, PsycINFO, EBSCO, and PubMed. Search terms included "treatment approaches LMICs," "digital or tele-mental health," "low-and middle-income countries (LMICs)," "evidence-based treatment," and "traditional therapies in (region)." Grey literature from the World Health Organization and other sources were also reviewed and included. The search yielded 25 resources whose primary authors hail from regions where USAID works including Ghana, Nigeria, Nepal, Jamaica, and Ethiopia. Articles published in French, Spanish, Arabic, and English were also included in this brief.

What promising mental health treatment approaches are not well-researched for use in international development, particularly in the Global South?

The literature review revealed a few mental health treatment and prevention approaches with great promise, but not yet well-researched in low- and middle-income countries. Figure 1 lists these intervention approaches.

Figure 1. Promising intervention approaches



Community-based interventions involve multi-sector partnerships with local stakeholders such as community members, non-profit organizations, mental health workers, and government agencies to deliver mental health programs and services. These interventions generally employ multi-level strategies to improve mental health such as individual education or counseling, peer support groups, and community mobilization.

Community-based interventions include methods such as task-sharing with community health workers or peer counselors to provide psychoeducation or counseling, community mobilization interventions to create support groups for people with mental health issues, psychological "first aid" provided by trained volunteers, and community-based rehabilitation such as vocational training or education and support to help people with mental health issues live independently. These interventions can be effective in reaching people who may lack access to more formal clinical services or who may be uncomfortable seeking care in a formal health facility. Community-based interventions have been sparsely researched in low- and middle-income countries but may be useful and more accessible in lower-income settings. A systematic review of community-based interventions in low- and middle-income countries found that interventions which train and utilize lay mental health workers (see task-shifting below) and use culturally adapted assessment tools had the strongest psychological outcomes.[4] Another review of 22 studies on youth in low- and middle-income countries also found strong evidence for the positive effects of community-based prevention interventions on mental health.[5] While the available evidence on community-based interventions gives reason for hope, a wide array of community-based models exist, and research in this area remains limited.

Integrated care is a life course approach, with individuals receiving a continuum of care ranging from health promotion to treatment of physical or mental health conditions based on their needs.[6] The incorporation of mental health into integrated care may improve access to care for those with mental health conditions and/or prevent mental health conditions for those at risk.[7] One study of integrated mental health care delivered in Ethiopia showed significant improvement in the severity of conditions experienced by patients.[8] Another study in Jordan examining an integrated non-communicable disease and mental health promotion intervention found significant reductions in mental health symptoms (i.e., depression) and cardiovascular disease risk factors such as body mass index and systolic and diastolic blood pressure.[9] Although the incorporation of mental health into integrated care is increasing, research is limited in the Global South. Expanded evidence on best practices of incorporating mental health promotion, prevention, and treatment approaches into healthcare settings is needed. Additionally, increased training in mental health and/or trauma-informed care among healthcare providers could expand efforts to integrate mental health into the health sector.

Digital or mobile e-health interventions are delivered through digital or mobile platforms, such as websites, apps, or SMS text messaging. E-mental health interventions may be particularly useful in low- and middle-income countries where there are often shortages of mental health professionals and limited access to mental health services. By providing mental health services remotely, using technology such as videoconferencing, teletherapy, and mobile-based applications, mental health interventions can reach people who live in remote or underserved areas. Although teletherapy shows great promise, the digital divide may limit access to some populations in the Global South (see below). Additionally, the quality and effectiveness of e-health interventions can vary, and rigorous safety standards and regulation is important to consider when delivering these types of services. There are some, albeit scant, studies on the use of apps to deliver mental health services in low- and middle-income country contexts. For example, a study in Jamaica reported that while the majority of people there have access to a smartphone, stigma was the largest logistical barrier to the use of mobile mental health apps.[10] Further study is needed to understand additional context-specific barriers and the effects of apps and teletherapy on mental health outcomes.

Traditional, ancestral, and holistic therapies may involve the use of local or ancestral healing practices native to a culture, such as herbal remedies, spiritual rituals, and holistic (i.e. integrated physical, emotional, and spiritual) remedies.[11] While these approaches are widely used in many low- and middle-income countries where USAID works, they have not been well-researched. Several promising treatments for mental health conditions have been identified, ranging from acupuncture to herbalism to prayer or ceremonial sessions with spiritual healers, but most clinical trials included in these systematic reviews have high methodological limitations by Western standards, and are thus often not perceived as legitimate mental health services in the context of humanitarian work or international development.[12,13]

Rights-based approaches to mental health care are framed on principles of autonomy, empowerment, non-discrimination, informed consent, and access to justice, among other human rights. These approaches prioritize the human right to health and wellness through the pursuit of equitable access to mental healthcare and power-based barriers to mental health that stem from people's surrounding environments.[14] Some rights-based strategies lie in opposition to much of the underlying philosophy of the biomedical model still dominant in mental health fields.[15] The biomedical model maintains that mental health issues are primarily biological in nature and can be treated with medical interventions, such as psychotropic medication or psychotherapy. It emphasizes diagnosis and treatment and relies heavily on standardized, evidence-based treatments. It has been criticized for being reductionist and ignoring the social and cultural factors that contribute to mental health conditions. A rights-based approach, in contrast, emphasizes the social determinants of mental health and prioritizes the participation of people with lived experience in decision-making, the value of traditional healing practices, and the community's role in mental health care. Rights-based methods are burgeoning but are still under-implemented and understudied in global contexts.

Although many of these approaches are backed by strong practice evidence, they have not been well-researched for use in global humanitarian and development settings. More research is needed to determine the effectiveness of these mental health approaches in different cultural and economic contexts, and to identify any potential barriers or facilitators to their implementation. Additional insights regarding approaches for addressing mental health can be found in a separate brief.

Are there evidence-based interventions from the Global North that have illustrated poor evidence in international context?

While certain mental health interventions may be evidence-based and shown to be effective in some contexts, in others they may not necessarily be effective and may even be counter-productive. Some mental health professionals have raised concerns about the potential of some interventions to cause harm by retraumatizing[A] those who have experienced traumatizing events. While this is a potential risk, there is very little research on the psychological harms of cross-cultural mental health interventions. Some individuals who use mental health services in low- and middle-income countries have reported feeling coerced to share their traumas and are stigmatized by mental health professionals upon disclosing their struggles.[16,17] One person quoted in a qualitative study of mental health service users with schizophrenia conducted in Nigeria said:

> *"If you begin to, you know, argue with the people that brought you here or with the medical personnel that is attending to you, it would be difficult, they will coerce you, but if you agree if you obey, if you begin to bear all whatever they say, or even make some little argument before you give in, they will not coerce. The only coercion will be just that of persuasion with words, not by whipping or chaining you."*[17]

One example of an evidence-based approach that may not work as effectively or require considerable adaptations in low- and middle-income countries is cognitive behavioral therapy. While the therapy has been shown to be effective in treating a wide range of mental health issues in high-income countries, it may need significant adaptations in low- and middle-income countries, to address cultural and social factors. For example, research has suggested that cognitive behavioral therapy content and activities may need to be adapted in cultures that emphasize social relationships and collectivism, as opposed to individualism.[18] Other standardized evidence-based interventions that use Western diagnostic criteria (e.g. the Diagnostic and Statistical Manual of Mental Disorders or the International Classification of Diseases) focus on individual outcomes and often fail to address household or community-level factors, which play significant roles in mental health.[19] Interventions that address broader social and environmental factors may be more effective in many settings. However, research on the effectiveness of alternative community-based interventions in low- and middle-income countries is limited.

[A] Re-traumatization refers to the resurfacing of symptoms previously experienced as a result of a trauma. Re-traumatization can happen through conscious or unconscious reminders of the original trauma such as lights, smells, spaces, or images that resemble the previous traumatic event.

Likewise, many mental health interventions that have been developed and tested in high-income countries may not be feasible in low- and middle-income countries, due to differences in resources and infrastructure. A few examples, shown in the table below, include intensive outpatient programs, virtual reality therapy, teletherapy, and psychotropic medications. Further study of the effectiveness of these interventions is needed to understand whether they can be applied in Global South settings as is, adapted to be more feasible, or discarded in favor of more accessible approaches.

Table 1. Strengths and Limitations to a Selection of Evidence Supported Approaches

INTERVENTION	DESCRIPTION	SUCCESSES	LIMITATIONS
Intensive outpatient treatment programs	Typically involve multiple sessions per week with a mental health professional, and may include individual therapy, group therapy, and/or medication management.	Can be effective in treating mental health conditions. [20,21]	May not be feasible in low- and middle-income countries due to a lack of trained mental health professionals and inadequate infrastructure to support these types of programs.
Virtual reality therapy	Uses virtual reality technology to create immersive experiences for therapeutic purposes.	This approach has been growing and has shown solid promise in high-income countries. [22]	May not be feasible in low- and middle-income countries due to the cost and availability of virtual reality technology. Other technology-based approaches may also not be feasible. Research in this area in low- and middle-income countries is lacking.
Teletherapy	Provides mental health services remotely using technology such as videoconferencing.	May be an effective way to reach people who live in remote or underserved areas. Some research shows promising efficacy of teletherapy for mental health in global contexts.[23]	May not be feasible in countries with limited internet connectivity or a lack of access to technology.
Psychotropic medications	Use of well-evidenced mental health medications (e.g., antidepressants, antipsychotics, anxiolytics, or mood stabilizers).	Effective treatments for some mental health conditions.[24]	May not be available in rural clinics or may be too expensive for use in low- and middle-income countries. Limited access can make it difficult to implement certain evidence-based treatment approaches in these contexts. There may also be differences in cultural acceptability of psychotropic medication use for mental health conditions.[24]

Muller, Jenna, Tara M. Powell, and Benjamin J. Lough. "Mental Health Treatment Approaches in the Global South: A Review of the Evidence." Evidence Brief. Research Technical Assistance Center: Washington, DC, 2023.

The Research Technical Assistance Center is a network of academic researchers generating timely research for USAID to promote evidence-based policies and programs. The project is led by NORC at the University of Chicago in partnership with Arizona State University, Centro de Investigación de la Universidad del Pacifico (Lima, Peru), Davis Management Group, the Duke Center for International Development at Duke University, Forum One, the Institute of International Education, the University of Notre Dame Pulte Institute for Global Development, Population Reference Bureau, the Resilient Africa Network at Makerere University (Kampala, Uganda), the United Negro College Fund, the University of Chicago, and the University of Illinois at Chicago.

REFERENCES

[1]Martin, Prerna, Laura K Murray, Doyanne Darnell, and Shannon Dorsey. "Transdiagnostic Treatment Approaches for Greater Public Health Impact: Implementing Principles of Evidence-based Mental Health Interventions." *Clinical Psychology: Science and Practice* 25, no. 4 (December 2018): e12270. https://doi.org/10.1111/cpsp.12270.

[2]Hoffman, Louis. "Existential–Humanistic Therapy and Disaster Response: Lessons From the COVID-19 Pandemic." *Journal of Humanistic Psychology* 61, no. 1 (January 2021): 33–54. https://doi.org/10.1177/0022167820931987.

[3]Kirmayer, Laurence J. "Cultural Competence and Evidence-Based Practice in Mental Health: Epistemic Communities and the Politics of Pluralism." *Social Science & Medicine* 75, no. 2 (July 2012): 249–56. https://doi.org/10.1016/j.socscimed.2012.03.018.

[4]Al-Tamimi, Saleh Adel G. A., and Gerard Leavey. "Community-Based Interventions for the Treatment and Management of Conflict-Related Trauma in Low-Middle Income, Conflict-Affected Countries: A Realist Review." *Journal of Child & Adolescent Trauma* 15, no. 2 (June 2022): 441–50. https://doi.org/10.1007/s40653-021-00373-x.

[5]Barry, Margaret M, Aleisha M Clarke, Rachel Jenkins, and Vikram Patel. "A Systematic Review of the Effectiveness of Mental Health Promotion Interventions for Young People in Low and Middle Income Countries." *BMC Public Health* 13, no. 1 (December 2013): 835. https://doi.org/10.1186/1471-2458-13-835.

[6]Thornicroft, Graham, Nisha Mehta, Sarah Clement, Sara Evans-Lacko, Mary Doherty, Diana Rose, Mirja Koschorke, Rahul Shidhaye, Claire O'Reilly, and Claire Henderson. "Evidence for Effective Interventions to Reduce Mental-Health-Related Stigma and Discrimination." *The Lancet* 387, no. 10023 (March 2016): 1123–32. https://doi.org/10.1016/S0140-6736(15)00298-6.

[7]Gureje, Oye, Jibril Abdulmalik, Lola Kola, Emmanuel Musa, Mohammad Taghi Yasamy, and Kazeem Adebayo. "Integrating Mental Health into Primary Care in Nigeria: Report of a Demonstration Project Using the Mental Health Gap Action Programme Intervention Guide." *BMC Health Services Research* 15, no. 1 (December 2015): 242. https://doi.org/10.1186/s12913-015-0911-3.

[8]Hanlon, Charlotte, Girmay Medhin, Medhin Selamu, Rahel Birhane, Michael Dewey, Kebede Tirfessa, Emily Garman, et al. "Impact of Integrated District Level Mental Health Care on Clinical and Social Outcomes of People with Severe Mental Illness in Rural Ethiopia: An Intervention Cohort Study." *Epidemiology and Psychiatric Sciences* 29 (2020): e45. https://doi.org/10.1017/S2045796019000398.

[9]Powell, Tara M., Shang-Ju Li, Yuan Hsiao, Michelle Thompson, Aseel Farraj, Mariam Abdoh, and Rami Farraj. "An Integrated Physical and Mental Health Awareness Education Intervention to Reduce Non-Communicable Diseases among Syrian Refugees and Jordanians in Host Communities: A Natural Experiment Study." *Preventive Medicine Reports* 21 (March 2021): 101310. https://doi.org/10.1016/j.pmedr.2021.101310.

[10]Maloney, Catherine A., Wendel D. Abel, and Hamish J. McLeod. "Jamaican Adolescents' Receptiveness to Digital Mental Health Services: A Cross-Sectional Survey from Rural and Urban Communities." *Internet Interventions* 21 (September 2020): 100325. https://doi.org/10.1016/j.invent.2020.100325.

[11]Dein, Simon. "Traditional Healers and Global Mental Health." In *Innovations in Global Mental Health*, edited by Samuel O. Okpaku, 1–11. Cham: Springer International Publishing, 2020. https://doi.org/10.1007/978-3-319-70134-9_132-1.

[12]Thirthalli, Jagadisha, Liang Zhou, Kishore Kumar, Jie Gao, Henna Vaid, Huiming Liu, Alex Hankey, et al. "Traditional, Complementary, and Alternative Medicine Approaches to Mental Health Care and Psychological Wellbeing in India and China." *The Lancet Psychiatry* 3, no. 7 (July 2016): 660–72. https://doi.org/10.1016/S2215-0366(16)30025-6.

[13]Nortje, Gareth, Bibilola Oladeji, Oye Gureje, and Soraya Seedat. "Effectiveness of Traditional Healers in Treating Mental Disorders: A Systematic Review." *The Lancet Psychiatry* 3, no. 2 (February 2016): 154–70. https://doi.org/10.1016/S2215-0366(15)00515-5.

[14]Cosgrove, Lisa, Zenobia Morrill, Justin M. Karter, Evan Valdes, and Chia-Po Cheng. "The Cultural Politics of Mental Illness: Toward a Rights-Based Approach to Global Mental Health." *Community Mental Health Journal* 57, no. 1 (January 2021): 3–9. https://doi.org/10.1007/s10597-020-00720-6.

[15]World Health Organization. Guidance on community mental health services: Promoting person-centred and rights-based approaches. 2021. https://www.who.int/publications-detail-redirect/9789240025707

[16]Kaiser, Bonnie N., Saiba Varma, Elizabeth Carpenter-Song, Rebecca Sareff, Sauharda Rai, and Brandon A. Kohrt. "Eliciting Recovery Narratives in Global Mental Health: Benefits and Potential Harms in Service User Participation." *Psychiatric Rehabilitation Journal* 43, no. 2 (June 2020): 111–20. https://doi.org/10.1037/prj0000384.

[17]Aluh, Deborah Oyine, Olaniyi Ayilara, Justus Uchenna Onu, Ugn Grigait , Barbara Pedrosa, Margarida Santos-Dias, Graça Cardoso, and José Miguel Caldas-de-Almeida. "Experiences and Perceptions of Coercive Practices in Mental Health Care among Service Users in Nigeria: A Qualitative Study." *International Journal of Mental Health Systems* 16, no. 1 (November 23, 2022): 54. https://doi.org/10.1186/s13033-022-00565-4.

[18]Guo, Feng, and Terry Hanley. "Adapting Cognitive Behavioral Therapy to Meet the Needs of C Hinese Clients: Opportunities and Challenges." *PsyCh Journal* 4, no. 2 (June 2015): 55–65. https://doi.org/10.1002/pchj.75.

[19]De Jong, Joop T.V. M. "Challenges of Creating Synergy between Global Mental Health and Cultural Psychiatry." *Transcultural Psychiatry* 51, no. 6 (December 2014): 806–28. https://doi.org/10.1177/1363461514557995.

[20]Warlick, Craig A., Jonathan Poquiz, Jonathan M. Huffman, Leslie DeLong, Kelsey Moffitt-Carney, Julia Leonard, Brynne Schellenger, and Juliet Nelson. "Effectiveness of a Brief Dialectical Behavior Therapy Intensive-Outpatient Community Health Program." *Psychotherapy* 59, no. 1 (March 2022): 125–32. https://doi.org/10.1037/pst0000388.

[21]Emmelkamp, Paul M.G., and Katharina Meyerbröker. "Virtual Reality Therapy in Mental Health." *Annual Review of Clinical Psychology* 17, no. 1 (May 7, 2021): 495–519. https://doi.org/10.1146/annurev-clinpsy-081219-115923.

[22]Acharibasam, Jeremiah W., and Rolf Wynn. "Telemental Health in Low- and Middle-Income Countries: A Systematic Review." *International Journal of Telemedicine and Applications* 2018 (November 1, 2018): 1–10. https://doi.org/10.1155/2018/9602821.

[23]Zhang, Xiaolong, Shôn Lewis, Joseph Firth, Xu Chen, and Sandra Bucci. "Digital Mental Health in China: A Systematic Review." *Psychological Medicine* 51, no. 15 (November 2021): 2552–70. https://doi.org/10.1017/S0033291721003731.

[24]World Health Organization and Fundação Calouste Gulbenkian. *Improving Access to and Appropriate Use of Medicines for Mental Disorders.* Geneva: World Health Organization, 2017. https://apps.who.int/iris/handle/10665/254794.