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APPLIED PSYCHOLOGY | RESEARCH ARTICLE

Mental health intervention at the workplace: A psychosocial care model

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Abstract: There are researches highlighting the importance of mental health of employees, which benefit the workplace and personal life. It is identified that the employee effectiveness depends on the mental health and well-being of the employees, and it contributes to the organizational productivity. However, there is a dearth of effective models of mental health interventions implemented and documented for organizations to follow and research on. This reflective paper based on a theoretical perspective discusses the Psychosocial Intervention Model developed by Mental Health Assistance Centre at Rajagiri College of Social Sciences for the Federal Bank Employees as part of the Employee Assistance Programme in the bank. This paper includes the basic processes, modalities, framework and two cases of intervention conducted as part of employee mental health well-being. This collaborative model progresses through various stages with different intervention strategies of Clinical Social Work, aligned to the mental health well-being of employees at the workplace. The major mental health issues of the employees identified are discussed with the outcome of the interventions.

Subjects: Social Sciences; Behavioral Sciences; Health and Social Care; Medicine, Dentistry, Nursing & Allied Health



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PUBLIC INTEREST STATEMENT

A healthy work environment is critical in contributing to mental and physical health of its employees, a prerequisite for efficiency and productivity. This article elaborates on trajectory of developing a comprehensive mental healthcare model for a human resource intense organization to address various psychosocial needs of its employees. This model strategically utilized the empathetic internal coordinators to increased mental health awareness and to enhance the coverage. This internal coordinator identifies the employees in need of psychosocial support and facilitate the professional intervention by liaising and linking them with mental health center. Individual-level curative complex interventions are designed based on a broad psychosocial care framework. Focus of group and organizational level preventive interventions are also part of this integrated model and aimed at employee welfare and development. This holistic workplace mental health intervention is economically viable, feasible and can be extrapolated to similar organizations.

Keywords: mental health of employees; psychosocial intervention in workplace; employee assistance; workplace intervention; employee mental health intervention model

1. Introduction

Mental health, though key factor in labor market, has been a long-neglected issue and now identified as one of the most imperative modifiers to performance and production (OECD, 2015). Work is generally a protective factor for individuals, but many a time unless addressed properly, it can become a risk factor, affecting the mental well-being of people (OECD, 2015; Quinodoz & Weller, 2018). Poor work-life balance, lack of opportunities for advancement, heavy workload, high expectations, and long hours are some of the risk factors for poor mental health outcomes (Tausig & Fenwick, 2011). Creating conducive environment is pivotal in maximizing employee performance (Pfeffer, 1998 as cited in Kang & Kang, 2016; Schaeff & Fassel, 1988, as cited by, Kang & Kang, 2016). Fragmented efforts focusing on organizational change and employee mental health support (Loretto, Platt, & Popham, 2010); employee wellness and mindfulness (Schulte & Verkuil, 2016); and integrated mental health support, stress reduction and social connectedness (Pattussi et al., 2016) are tried out in various organizations, but very few comprehensive management driven models of work place mental health models are implemented and tested, especially in the banking sector.

There is dearth of evidence-based comprehensive mental health intervention models tested in work place, and most of the existing workplace mental health intervention models address secondary and tertiary levels of prevention focusing on awareness raising against depression and anxiety, developing help-seeking behavior and skills, reducing negative and stigmatizing attitudes at workplace (LaMontagne, Keegel, Shann, & D'Souza, 2014) and job-stress interventions (LaMontagne et al., 2014). One of the interventions that focused on mental health literacy and leadership to create positive work environment, help seeking behavior in terms of crisis and job satisfaction interventions brings evidence of effectiveness in both organizational and individual levels (LaMontagne, 2017). The three-thread intervention, focused to prevent the harm, promote the positive and manage illness, is found to have positive evidences of improved mental health in employees (LaMontagne et al., 2014). There is a need for an integrated service delivery system which incorporates primary, secondary and tertiary levels of prevention (LaMontagne, 2017). The proposed workplace mental healthcare model integrates existing evidence-based models and elaborates on the processes of implementing the intervention program.

According to Zheng, Kashi, Fan, Molineux, and Ee (2016), "it would be appropriate for organizations to provide formal and informal counseling and training sessions aimed at developing those psychological coping skills, which should be embedded in ongoing employee professional development programmes." Multiple factors contribute to the mental illness, and some of them are job insecurity, work stress and conflict between work and life, relationship issues, family crisis, emotional ups and downs and unhealthy habits (Wang, Lesage, Schmitz, & Drapeau, 2008, as cited in Zheng et al., 2016). Counselling and therapeutic interventions are therefore effective in regaining the balance on performance and employee relations. According to Mayor (2001) (as cited in Joseph, 2012), in one of the studies, the counseling service to the employees made remarkable changes in their work-related symptoms, sickness absence and relationship issues. These published works evince that the counseling at workplace is an effective strategy; some researchers also advocate for legalizing such services in the organizational practices for better work-life balance (Zheng et al., 2016), which can enable individuals, organizations and society to function effectively. Counselling and psychosocial intervention support was aimed at addressing interpersonal conflicts, stress-related absence, inappropriate behavior with customers, problems related to disciplinary actions, work-related trauma, stress related to retirement, sexual harassment, workplace bullying and family or personal issues and unhealthy habits (Wang, Lesage, Schmitz, & Drapeau, 2008, as cited in Zheng et al., 2016). However, even though there are many claims on the effectiveness of workplace counseling, there are few effective models where the employee,

organizational and the professional collaboration includes all the ethical, confidential and organizational components into a productive intervention.

The recent transition focusing on expansion and diversification necessitated huge recruitment of manpower, and this subsequently resulted in change-related disequilibrium in the organizational culture. The challenge of living up to their vision without compromising institutional ethos was materialized by developing institutional systems and processes; employee assistance center was such an initiative. Customized holistic care package was the specialness of this center, and the emphasis was on productivity and efficiency (Gauche, De Beer, & Brink, 2017), through welfare and curative interventions in various levels: individual, group and entire organization. Objective of the Employee Counselling Service Centre was to develop evidence-based workplace mental health interventions. In this model, the Employee Counselling Service Centre was established to resolve problems in the workplace to enable employees to function effectively, both professionally and personally. Work-related issues, personal issues and family issues came under the purview of the intervention. The services were aimed at recognizing, accepting and dealing with issues that affect their well-being at work and improving their relationships with colleagues, managers and customers at work place.

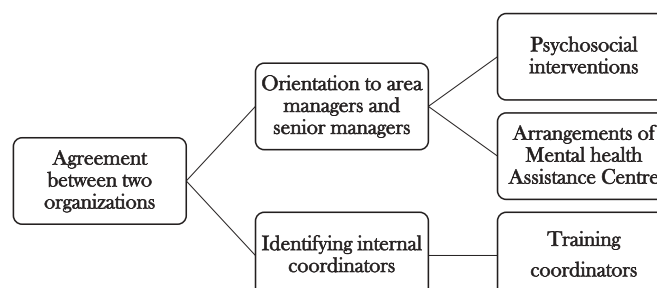
2. Methods

The Federal Bank has a credential of exhibiting great concern for its employees, and the awards they have won for their HR excellence show their commitment to strong HR practices (Federal Bank, 2015). Even though the employees care for each other largely as colleagues, solving some of their problems, the management has identified the requirement of expert assistance through their human resource management initiatives. An HR system they follow from the beginning “not just a job but a career” (Federal Bank, 2015, p. 16) is one such example. As an organization that lives up to the original vision, values and committed HR policies, the Federal Bank never believed in disciplinary and blaming model and, instead, trusted in a change model that led them to invest on establishing an employee assistance center called SMILES—“Spreading smiles, with care and concern” (Federal Bank, 2015), a psychosocial well-being program to provide professional help to its distressed employees, works in collaboration with trained a professional psychosocial intervention specialist (medical and psychiatric social workers). For this purpose, the bank has linked with professional organizations, and Rajagiri College of Social Sciences (RCSS) is the partner in providing professional support. Detailed description of the methodology of the process of intervention is described below (see Figure 1).

2.1. Initial discussion and agreement between two organizations

The bank officials recognized the need for the intervention and invited a team from RCSS (the service provider) for a negotiation session which lasted for 3 h. The discussion defined the systems and the processes of the employee-counseling model that the Federal Bank needs to follow with the professional support of RCSS. The particular patterns of service delivery that fit to the job and organizational conditions and implementation models were analyzed. The group decided to have a series of sessions, five 1.5 h sessions with top officials of the bank to orient them on the need of

Figure 1. Process of workplace intervention model.



mental-health-based management practices. The psychosocial interventions that enhance the well-being and performance of employees were included in the subsequent discussions.

2.2. Orienting area managers and senior managers

The cooperation and support of managers and senior officials is significant to implement employee's well-being and mental health initiatives. Implementing agency felt that the knowledge and positive attitude of decision makers on employees' mental health are a prerequisite for the success of interventions. "Managers" and coworkers' attitudes toward individuals with psychological disorders, judicial disinclination to view such disorders as worthy of accommodation and the stigma that tarnishes individuals with mental disorders exacerbate the difficulties that these workers encounter (Bernardin & Lee 2002, p. 15). "Many managers believe that 'if you cannot see it, you cannot measure it; if you cannot measure it, you cannot manage it' (Sutherland & Cooper, 2002)"; mental health issues in the work place is a reality that cannot be seen unless the managers train themselves to see. Therefore, the workplace intervention project started with orienting the area managers and senior managers on the need of mental health well-being of employees and the available interventions. In a 1-day orientation session, the basic psychosocial phenomenology and common symptomatology and its implications on day-to-day work life were deliberated, and vignettes were used to guide the discussion. The sessions helped to identify psychosocial needs of employees, and it also facilitated insights into the complexities of the mind. In turn, the session helped the mental health team to grasp the wide spectrum of issues of the managers in the specific work life context.

2.3. Identification of internal coordinators

As Sutherland and Cooper (2002) pointed out, certain problems arise because of job stress or due to poor work-life balance, but like love and electricity, they cannot be seen or measured. Most of the time people experience them, but they find it difficult to comprehend and communicate without an external support. It is essential to have individuals within the system to connect and link with the service providers of mental health well-being. In the second stage of the intervention, 20 senior employees were identified by the bank to coordinate the services within the organization. The distribution of employees cut across all the domains of banking sector. Representatives indicated two types of coordination, such as geographical coordination and functional coordination. Among 20 selected officers, 6 officers represented 6 zonal offices from within and outside Kerala and two senior employees represented Tamil Nadu and Karnataka. The functional departments were represented by senior employees from Credit Hubs, HR-Talent Development & Training, Legal department, SME Business Department, HR-Employee Relations & Operations, Marketing Department, Asset Recovery and Operations Department.

2.4. Training for the internal coordinators

One of the examples of negative organizational climate as described by Sutherland and Cooper (2002) is not considering something that cannot be seen or measured in the workplace or not giving due significance to something that is intangible. Mental health well-being of the employees is a significant resource that impacts the performance of the organization (Gold & Shuman, 2009). According to Gold and Shuman (2009), training can set a path to identifying the mental health needs of people in the workplace and giving primary support. Rajagiri team therefore conducted a 4-day training program to the 20-member Internal Coordination Team to equip them to do crisis intervention and provide their colleagues with psychological first aid. The themes discussed in the 4-day sessions were mental health needs of employees, occupational mental-health challenges and solutions, different approaches in counseling, customized assessment formats, counseling approaches in communicating with employees, steps and processes of counseling, different therapies, skills and techniques in counseling, identifying the challenges individuals face in the workplace. There were group activities to develop a mental healthcare plan: situation analyses of the bank employees and identifying and meeting leadership challenges in developing and implementing a healthcare plan. The team was also given training to develop a mental healthcare plan

using “Theory of Change model of developing complex intervention” to establish an integrated system of care for the bank employees.

2.5. Operational arrangements of the Mental Health Assistance Centre (RCSS)

A systematic way of looking at employee needs and a value-based service was quite a big task and the responsibility of the employer to ensure employee well-being (Thomas & Murphy, 2002). Therefore, the operational arrangements at RCSS have been made to encompass the specific nature of work, specific nature of the services each employee may require and specific socio-cultural context of the employee. It was always a priority of the Mental Health Assistance Centre at RCSS to adhere to the values and principles of mental health assistance services and social casework such as dignity and worth of the individual, acceptance, person in situation, configuration, confidentiality, empathy and service users’ self-determination. The discussions with the managers and the other selected employees helped to design the operation style of the mental health service center. The strategies and modalities were devised to match with the expectations of the workplace. The author of this paper provided telephonic service and face-to-face services from 5 pm to 9 pm on all working days without any prior appointment. Employee assistance by the author through personal visits to the assistance center was made available on all Sundays from 10 am to 5 pm at the premises of RCSS, Kalamassery, Ernakulam, Kerala, India. Employees who required personal visits intimate the same through the dedicated telephone number or register the same with one of the internal co-coordinators at Federal Bank—latest by 5 pm on preceding Saturday.

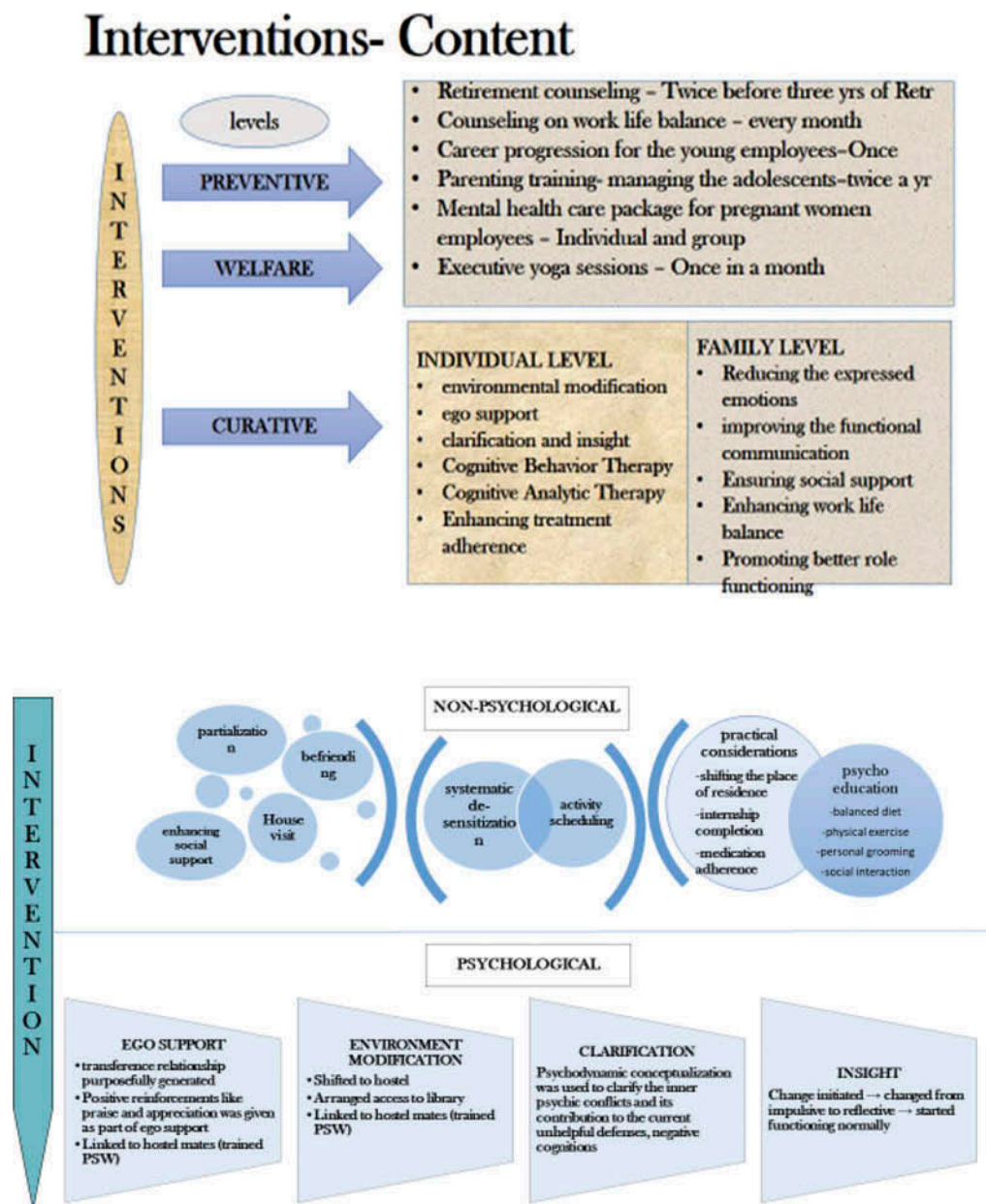
Therapist has encouraged the face-to-face interactions at least for the first visit to develop therapeutic relationship. The trained employee coordinators (those who received training from the Mental Health Service Centre) were also given responsibility to facilitate the conduct of the program by linking the employees with the center and coordinating their visits to RCSS. Confidentiality was ensured. Appropriate feedback was provided to HR department or internal counseling cell co-ordinators, after obtaining permission from concerned client, in instances where the clients get preferential treatment and support from the work place.

Mental health services were started with individual counseling but later expanded to six additional services. Life course approach was used to develop various additional services. Preventive, welfare and curative services were envisaged to make this intervention holistic and encompassing. The additional services were the mental health package for pregnant employees, career progression workshops for the young employees, parenting training to manage their adolescent children, counseling on work-life balance, retirement counseling to plan the retirement life of employees (retirement age is 58 years in this organization) to lead a productive postretirement life and executive yoga sessions to reduce the ill effects of sedentary-lifestyle-related physical complications. These services were evolved and designed based on the felt needs of the employees and to ensure well-being of all the employees. The entire model has developed over a period of 4 years, and it is still evolving. The content of the intervention is displayed in Figure 2.

2.6. Framework of the model (intervention model)

The curative individual level services were designed to suit both the organizations. Psychosocial Intervention was designed to match the employee preference and time specifications. As shown in Figure 3, the intervention had two modalities of delivery: (1) one-to-one session and (2) group session. In the one-to-one session, the employees who required psychosocial support directly meet the social caseworker at RCSS as per the confirmed appointment. The professional meets the employee, and they mutually decide on intervention modalities and procedures after a detailed assessment. The one-to-one also was provided telephonically in situations where the commutation was impossible. Social casework intervention was based on symptomatology, phenomenology, behavioral manifestations and contextual factors, but certain components were made mandatory for each category to standardize the package. Table 1 shows the intervention

Figure 2. Content of intervention.



modalities adopted for each category of employees screened based on the Mayer Gross format of psychiatric assessment and Mental Status Examination. Table 2 describe the demographic details of severely ill patients and table 3 demonstrate the changes overtime from baseline to post six month follow up.

Group sessions were aimed at improving the overall mental health of employees. This was conducted both in small or larger groups.

2.7. Content of the intervention

Intervention was started with assessment, and its focus was on identifying the stressors, current coping methods and available untapped coping resources and social support both from family and society. The intervention was tailor-made based on “Theory of Change model” of developing

Figure 3. Framework of intervention model.

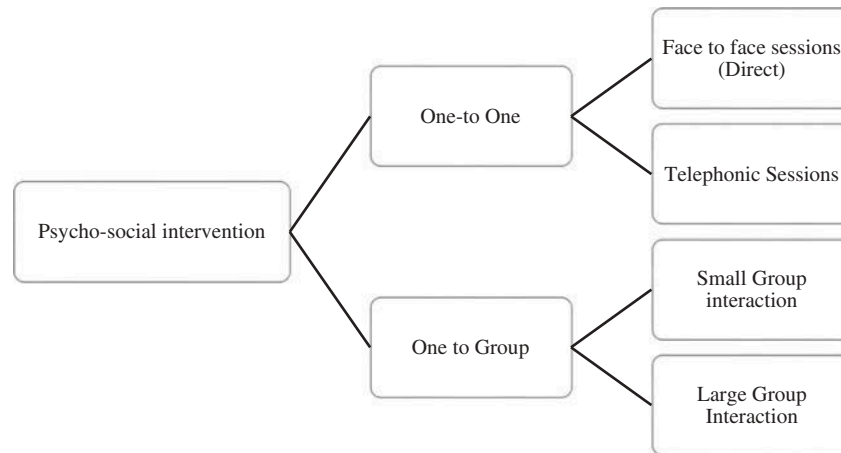


Table 1. Intervention modalities adopted for each category

Category	Interventions
Mild	Jacobson's progressive relaxation therapy, cognitive behavior therapy, family therapy
Moderate	Jacobson's progressive relaxation therapy, cognitive behavior therapy, psychodynamic psychotherapy, family therapy
Severe	Jacobson's progressive relaxation therapy, cognitive behavior therapy, cognitive analytic therapy, family therapy

Table 2. Demographics of severely ill patients (n = 15)

Variables	Statistics
Age Mean	27.87 ± 9.724
Gender	
Male	9 (60%)
Female	6 (40%)
Diagnosis	
Major depression	6 (40%)
Schizophrenia	3 (20%)
Minor depression	2 (13.3%)
Anxiety	1 (6.7%)
Bipolar disorder	3 (20%)

complex interventions which looked into the pathway of change in a scientific manner, formulating the mission statement, setting objectives, identifying various domains of intervention, activities with clear indicators of its output and outcome (Schierhout et al., 2013; De Silva et al., 2014; Walker, 2015). The pathway of change was elaborated using various theoretical foundations and perspectives. Social casework intervention included ego support, environmental modification, clarification and insight. Transference-related anger was also maintained to stimulate action on the options and solutions. The social worker also guided the anger reactions in a positive direction to brainstorm multiple options and adopt the best suited options to cope up with their stress. Family members were helped to facilitate environment modification, thus act as a buffer system to absorb intense psychological pain due to various stressors. Family intervention was aimed at reducing the expressed emotions, improving the functional communication, work-life balance and better role functioning (roles as—employee, father/mother, son/daughter, as member of

Table 3. Changes overtime from baseline to post-6 month follow-up

Outcome measures	Preintervention-mean (SD)	Postintervention mean (SD)	Mean difference (SD)	95% Confidence interval of the difference		T value	Sig.
				Lower	Upper		
Caseness	19.07 (2.865)	7.67 (3.309)	11.400 (3.699)	9.351	13.449	11.935	0.000
Neuroticism	16.40 (4.867)	12.33 (3.904)	4.067 (3.173)	2.310	5.824	4.964	0.000
Psychoticism	7.60 (2.64)	3.80 (1.146)	3.800 (2.242)	2.558	5.042	6.563	0.000
Ambiversion	13.73 (3.327)	12.07 (4.590)	1.667 (3.958)	-.525	3.859	1.631	0.125

various social, cultural, religious groups etc.). Cognitive behavioral therapeutic paradigm was used for cases with cognitive distortions and cognitive dysfunctions. Antecedent-behavior-consequences (ABC) model was used to identify the patterns of behaviors of the client. Behaviors were analyzed using “FINDS”—frequency, intensity, number of times, duration and situation in which the behavior is exhibited. This models helped to identify the negative behaviors and to weaken them if it was unhelpful, strengthen when it was weak (should be there but not strong enough), introduced the new positive behaviors (not at all present, but should be there). Cognitive analytic paradigm (Ryle & Kerr, 2002) was used for clients with severe psychiatric conditions to make the assessment and interventions. Psychotherapy file that consists of traps, dilemmas and snags, personality assessment tools and repertory grid helped to analyze the personality and cognitive patterns of the clients. This paradigm was used to formulate, clarify, reformulate and facilitate insight in the clients. Strategies of cognitive analytic therapies such as formulation letter, reformulation letter, no sent letter, activity scheduling, behavior reactivation techniques, partialization and other behavioral techniques were accurately used in conjunction with the identified needs. Whenever the clients were referred to psychiatrists, medical compliance and treatment adherence was ensured.

Review meetings with the management: The joint review meetings were conducted once in 6 months to assess the impact of the program. The internal coordinators also participated through video conferencing. Review was of two types: one was routine periodic review to ensure smooth functioning and second was for crisis intervention. In routine reviews, the utilization of services, barriers and practical issues to carry out the program was analyzed. Crisis intervention was required in cases that were beyond the purview of memorandum of understanding between the bank and service provider. For instance, in the case of an employee suffering from severe depressive stupor due to suicide of her only son, home visit was only way to proceed with the case, but it was not part of the Memorandum of Understanding signed between two organizations. Mental health professional contacted the General Manager (HR), and it was sorted out in favour of the employee immediately. Reviews always helped to enhance the quality of services, publicize the program among employees and officers and expand and diversify the services.

3. Results

Mayer Gross format of psychiatric assessment and Mental Status Examination format were used to assess the clients. International Classification of Disorders—10 (ICD 10) was used to make the diagnosis and based on the severity of the disorders the 112 clients were categorized into mild 59 (53%), moderate 37 (33%) and severe 15 (14%). Total number of service users in the year 2016 was 112 and out of which 11 were to make enquiries about the project and the rest were with very specific reasons requiring intervention. The total number of sessions (face-to-face and telephonic) with each employee ranged from one to nine. In certain cases, house visits were necessary as part of intervention. The bank has provided special assistance to employees who required practical support. For example, one client had come from Hyderabad (almost central part of India) to Kerala (the southernmost state of India) specifically to get the services. His stay was arranged in the Corporate Training Center, Aluva, and he could attend the sessions with the therapist. Duration of the telephonic sessions was of average 90 min, and the face-to-face interaction was longer due to assessment and intervention. Average time spent in face-to-face sessions was 150 min for clients who came with family members and 120 min with the employees who came alone. Majority (88%) of the clients used to come with their family members, and each of them were assessed to understand the complexity of the problems. Among the severe cases, three of them were referred to the psychiatrists based on the clinical indicators of disturbed sleep, appetite, irritability, work and adjustment difficulties. Among the three employees referred to psychiatrists, one of them was from Hyderabad with the diagnosis of bipolar affective disorder (BPAD) with predominant manic episode. The psychiatrist and the social caseworker managed the client and the client had face-to-face (4 sessions) and subsequent telephonic

sessions (12) with the social case worker. The second case from the south of Tamil Nadu was diagnosed as severe depression and suicidal ideation; the client was unable to travel and was referred to a psychiatrist in that area, and telephonic services (10 sessions) was also provided to the client. The third case was diagnosed with BPAD with depressive episode from Kozhikode and was referred to a psychiatrist and combination of biopsychosocial care given by the mental health team had significant positive outcomes. These three clients recovered from their psychiatric conditions and resumed their normal duties and responsibilities in the bank, after being granted medical leave.

Figure 2 explains the basic demographic details of the people with severe mental illness, and Figure 3 explains the results of the basic difference in the outcome variables before and after intervention. Caseness, neuroticism, psychoticism and ambiversion were taken as the basic outcome measures to measure the impact of the intervention. Results of paired-sample *t* test found significant difference in caseness, neuroticism and psychoticism between pre and postintervention indicating the significant improvement due to intervention.

Various psychosocial issues identified among the employees during the tenure include family issues, domestic violence, adjustment issues, work stress, marital issues, parenting-related issues, relationship problems and harassment issues, and the psychiatric disorders identified were general anxiety disorders, performance anxiety, depression, panic attacks, BPADs and depressive stupor (Figure 4). Two case examples mentioned below describe the process of individual-level intervention in two different issues, crisis intervention and long-term intervention for people with psychosis.

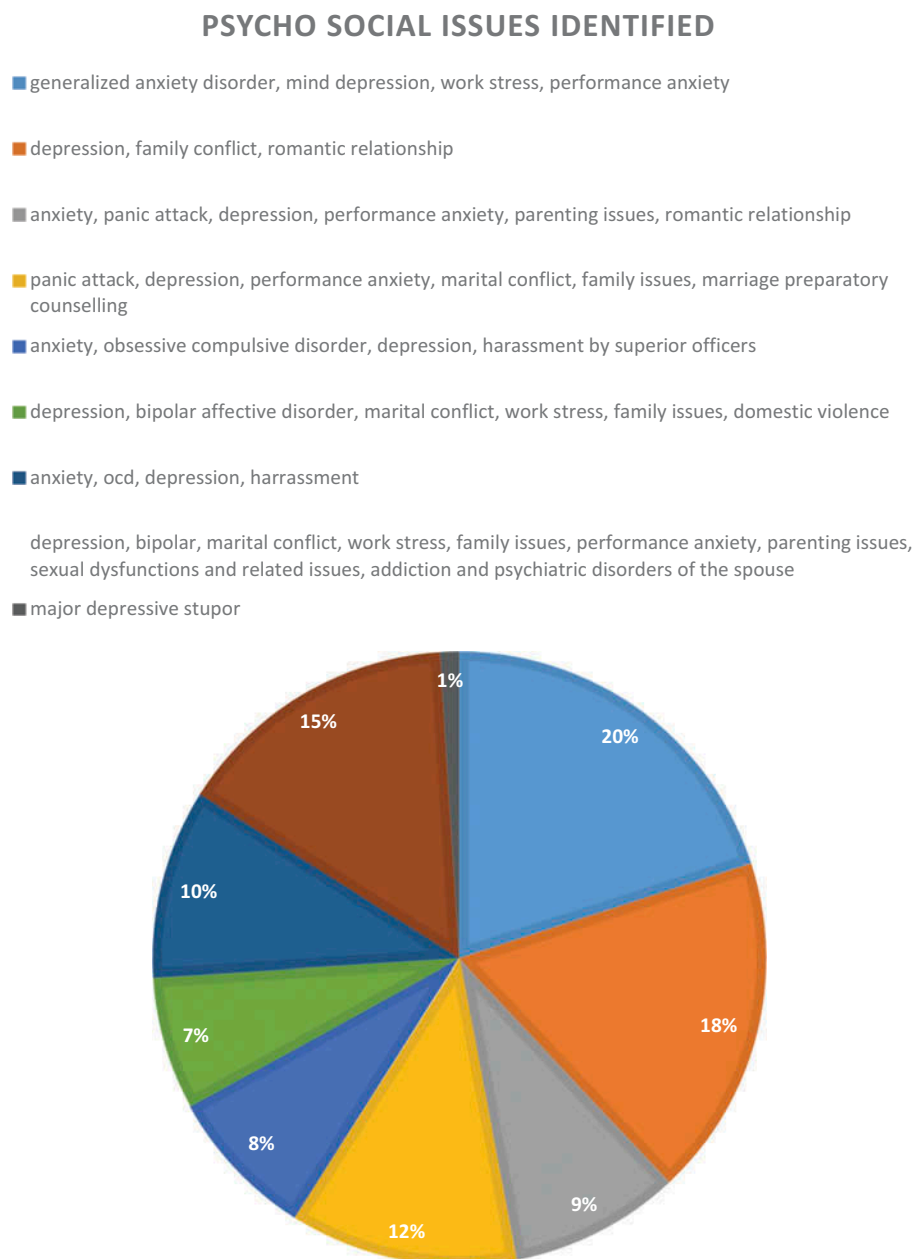
3.1. Case-1—example of crisis intervention

Client X1, aged 46, female, bank employee with 10 years of service, with two children, a daughter and a son. Husband passed away when the son was only 5 years old. Client was living with her son as daughter was married. Her son was working in a private company as the accountant at the time of his clueless suicide. Her assistant manager referred the case and she approached the mental health assistance center at RCSS. After the incident of her son's suicide, she exhibited the symptoms of immobility, mutism, refusal to eat, sleeplessness, acute social withdrawal and decline in personal hygiene.

Assessment: The social worker visited the house after intimating the Human Resource Department of the bank on a Friday. The social worker had a face-to-face interaction with the client at client's residence. Mayer Gross assessment and Mental Status Examination elicited the data that fulfilled the criteria for severe depressive stupor. Cognitive assessment indicated that she had severe negative triad to self, others and to future as she felt severe guilt and shame, negative emotions of anger, fear and depression; she felt others looked down upon her and also experienced paranoid schizoid thought patterns about others; she also had severe helplessness and hopelessness, and consequently, she felt that her future is doomed. She also had depressive and placation traps. She had severe dilemma to self and others. Her intense negative thoughts activated by the suicide of her son led to acute negative emotions and disabling behavioral dysfunctions and subsequently to symptoms of depressive stupor. Social, cultural and religious stigma was unbearable, and she was progressing to disintegration and fragmentation that resulted in the stupor.

Intervention: Transference relationship was the major task of the therapist. Accurate empathy, nonjudgmental attitude and genuineness of the therapist led to the development of rapport with the client. Active listening and paraphrasing helped to align emotional systems of the client and the therapist. Debriefing techniques were extensively used to take on to denial. She gradually moved from denial and anger to bargaining and subsequently to depression and acceptance. Once her cognitive processes were manageable, the therapist moved to behavior activation, started with simple-to-complex tasks progressively at the same time to raise the level of anxiety to its optimum level. ABC model was used to identify the current behavior of the client. The consequent behaviors

Figure 4. The various psychosocial issues identified.



were analyzed based on FINDS in which the behavior is exhibited. Various behavior modification strategies were used to reactivate the client. Systematic desensitization was required to remove her acute shame and guilt. Gradually the therapist helped her to convert her shame and guilt into anxiety and resulting anger. Skill of the therapist helped her to maintain a particular level of anger to push her to overcome her own self-defeating apathy and anhedonia. Various ego support strategies were used to negotiate her primitive ego defences of regression, repression and denial. Various verbal and active nonverbal strategies were used to shift her from depressive position to paranoid schizoid position which instilled in her defences of displacement and projection. Her attachment behaviors were triggered by enhancing the relationships with her daughter, her extended family members and specifically with her own elder sister with whom she had secure attachment. Understanding her religious sentiments, the therapist helped her to make a visit to

the temple in the evening with her daughter and immediate relatives. As a part of cognitive restructuring, the therapist also suggested few prayers and offerings in the temple. The therapist, a priest himself, also assured his prayer support to help her for cognitive reformulations. Environment was modified by helping her to move to her sisters' house to avoid the environmental triggers. As a normalization process, the therapist negotiated with the company to facilitate her gradual reintegration into the workplace. Negotiation was also done with the client to start visiting the office for a short duration of 2 h; transportation was organized with the help of the family members. The bank manager and other employees were instructed to enhance their support and scaffold her until the client function normally and optimally. Untapped coping resources like her own daughter and her family, elder sister and her family, neighbours, office staff senior officers etc. were identified and underutilized resources were focused as relapse prevention strategy. Enhancing the social capital was also part of improving the mental capability of the client. This brief intervention led her to premorbid level of functioning. She returned to her previous position in the bank after 40 days; the period of absence being considered a medical leave, hence she was paid her full salary during the period of her mental illness.

3.2. Case two—long-term psychosocial care

Client X2, aged 24, female, B.Com graduate, preparing for chartered accountancy examination. The client's father, 53 year old, is a senior officer in the bank. Client's mother, 50 years of age, is a homemaker. She has a younger brother who has completed B.Com, staying away from the home and does not maintain emotional connect with the client. The client resides with her parents. Initially, she had severe apprehension about her capacity to clear the chartered accountancy exams, as she had difficulty in attention and concentration. The client gradually started to avoid studies and engaged in watching movies and reading novels and developed physiological symptoms of headache, feeling of excessive pressure in the head. She started locking herself in her room and become aggressive with her parents, and she attempted to kill them.

Assessment: The mode of onset of the illness was acute and the precipitating factor was the demanding academic requirements. The client had the complaints of feeling of excessive pressure on the head, diminished ability to think or concentrate, decline in academic performance, crying spells, feeling of worthlessness and repeated thoughts of death, aggression to others and physical violence to parents. The client started her chartered accountancy studies with high expectations but has experienced difficulty to cope with the academic requirements of this exam. She had anxious avoidant attachment where she was obsessively preoccupied with her relationships - and had problems with trust in others. She was physically and verbally abusive and had attempted self-harm in various ways: by cutting the veins, banging her head against the walls and jumping from top of the building. She had multiple cuts and bruises on her wrist and had ankle fracture. She was under psychiatric outpatient department and was under medication. Client was clinically diagnosed with BPAD with manic episodes, i.e. mania with psychotic symptoms (ICD 10, F30.2). Social caseworker assessed the family as dysfunctional due to high expressed emotions of critical comments, hostility and over involvement. Parental conflict and role reversals made the family situation further vulnerable; father was weak and ineffective, and mother unyielding and lacking in expressive and integrative role functioning which resulted in family dysfunction. Faulty communications of double bind, undercutting and rubber fencing of mother confused the client and affected her emotional stability. Mother's over expectation triggered anxiety in the mother, and mother expressed it indirectly through nonverbal communications and telephonic conversations with her immediate relatives that in turn increased the anxiety, guilt and shame in the client. Her early-life events caused distorted perception on self and others, especially about her mother who failed to play maternal roles effectively. Maternal BPAD genetically predisposed the client, and social pressures, academic challenges and familial factors triggered the disorder. Early preverbal pathological communications and parental attitudes contributed to her current pathological patterns of thinking and behavior. Tremendous stress resulted from unrealistic parental expectations and unachievable parental targets contributed to the vulnerability for reduced frustration tolerance, increased tension, arousal and inadequate containment. Too much of continuous tension

about highly competitive exam coupled with too little containment overwhelming with mental system led to breakdown in the feeling of coherence and the ability to function in an organized manner (Foa & Andrews, 2006). She had dilemmas to self and others which required clarification and clear directions. She constantly struggled to get rid of her paranoid anxiety by projecting it into her mother (Breggin, 2014), and it was exhibited through her verbal abuse and aggressive behavior. From childhood, the mother failed to contribute to intersubjective space with emotional modulations, adaptation and challenges (Foa & Andrews, 2006) due to faulty mother child interactions especially during childhood.

Intervention: Nonpsychological aspect of the patient was focused in the initial stage to equip the patient to analyze the psychotic aspects. Family, social and academic aspects had been given priority in the initial sessions of intervention. Psychoeducation could reduce the maternal anxiety. Three house visits helped the therapist to understand the pathological patterns of the family. The family interaction patterns and communications were found to be highly negative and triggers negative energy so environmental modification was suggested as an intervention, and as part of it, she was helped to shift to hostel accommodation that facilitated her studies; the therapist also arranged access to the nearby college library. It had two advantages: the change of environment and interaction with peers which helped to share and ventilate. The client was also linked to the hostel mates, and two of the hostellers (who were trained in psychiatric social work) were trained to befriend her. And it was found effective. Problem-solving strategies of “partialization” were used to reduce academic stress by identifying the simple to complex subjects and topics and was encouraged to start with the simplest and progress to complex, which enhanced her self-confidence. Systematic desensitization was effective to reduce exam performance anxiety. The activity scheduling helped the client to reactivate and keep the track of the daily events and achieve the optimum. Mood check was made part of routine homework to understand the antecedents to negative mood. Psychological intervention was planned focusing on the integration of affect and meaning through support and interpretation (Bateman, Ryle, Fonagy, & Kerr, 2007). Therapist used psychologic where the therapist helped the patient to weave painful and fragmented, isolated, not understood perceptions, apperceptions and attachment experiences into a more coherent and bearable self-awareness and self-understanding (Bateman et al., 2007). Therapist also helped to clarify how this early childhood experiences and disturbed perceptions in the patients’ mind can be understood differently with nuances and with other emotional associations. The four major elements of social casework were ego support, environmental modification, clarification and insight was practiced with the client with the help of the transference relationship purposefully generated. Practical considerations including getting an internship completion certification from the employer, shifting the place of residence to a hostel near to an arts and science college, suggestions regarding balanced and nutritious diet, personal grooming, physical exercises, and social interaction helped the client to reduce the stress and anxiety and enhanced functioning and improved self-esteem. Positive reinforcements like praise and appreciation were given as part of ego support. Psychodynamic conceptualization was used to clarify the inner psychic conflicts and its contribution to the current unhelpful defenses, negative cognitions. Clarification further leads to the generation of insight, which triggered guilt, shame and anger in her. Anger was positively diverted to initiate change. Shame and guilt were continuously guided to convert it into anger and controlled anger was used to change the life positions from paranoid schizoid position to depressive position (Breggin, 2014), where she started to reflect and act instead of being impulsive. Client started to function normally after the medication was reduced tapered off by the psychiatrist.

4. Discussion

The intervention model developed by RCSS for the Federal Bank was an effective strategy to intervene with the mental health needs of people at workplace. As it is evidenced by many authors, the mental health well-being of employees directly impact the performance of the organization (Gauche et al., 2017; Kang & Kang, 2016; OECD, 2015; Quinodoz & Weller, 2018), and this employee assistance model suggests an effective intervention strategy to enhance employee well-being at workplace. Many interlinked aspects played a crucial role in this feasible model. The model is

a collaborative venture, wherein the employer, mental health service center, employees (the service users), coworkers and subsequent systems of both agencies are the stakeholders.

Orientation and training program: The successful implementation of a psychosocial intervention model in a workplace depends on the way the senior managers and heads of departments are oriented to the needs and issues of the matter of fact (Bernardin & Lee, 2002; Sutherland & Cooper, 2002). In this model, the bank, the employer, was determined to provide all support to the employee in need (policy decision), and the orientation and training program unified the managers' attitude and knowledge about the mental health well-being needs of the employees to build a performing organization. This orientation by the trained professionals from the service providing agency paved the platform for further progress of the intervention.

Internal coordinators: The trained internal coordinators were the catalysts within the organization. Their basic personality characteristics were commitment to their organization, ability to express accurate empathy, genuineness, authenticity and moreover their listening and discerning skills. HR department has taken efforts to identify them. The service delivery team had trained them and management had encouraged and acknowledged them. Intervention had two paths: one path was the internal coordinators making the initial assessment then if necessary refer the client to the counseling service center. Second path was the distressed employee contact the counseling service center directly. This facilitated the peer support in the case of mild stresses and professional intervention for the moderate-to-severe cases. This mechanism of peer counseling reduced the need for referral to the counseling center. The second important achievement was better awareness of mental health and mental health issues within the organization, which subsequently helped to develop employee friendly policies and programs, e.g. retirement counseling and executive yoga.

The service providers—the selection of the agencies—are very critical for the success of the program. The professional therapist/practitioner need to be trained in dealing with psychosocial aspects of the service user and a postgraduate degree in social work, with adequate amount of fieldwork experience and practice experience is an essential element to manage the employee assistance program in this manner. In this model, all the therapists/counselors and trainers were authorized by the service provider (RCSS) and additional training was imparted to the members to work in the specific model. The authorization need to be renewed every year to ensure the ethical compliance. The service provider also organized monthly case conference to ensure that the service is managed effectively. The external service provider has an edge in this type of models, as it is ideal in order to protect the confidentiality and to ensure a neutral environment that facilitates the openness and protection of the rights of the employees.

Modality of services—face-to-face v/s telephonic: First meeting is very crucial, where the client and therapist develop an empathetic understanding of the issues, establish rapport and the transference relationship. Consequently, the subsequent telephonic sessions will have similar therapeutic effect. Frequent face-to-face interactions can be reduced and thus save the time and money of the employees. But at the same time, face-to-face interaction is needed after 6 months to maintain the therapeutic relationship in more complex cases.

Referral: The social caseworkers, based on the indicators identified during their initial interviews or assessments, take the referral decisions. Both the agencies need to have link with the referral systems (psychiatrists). The doctors could be part of the case conference to explain the biological and physical aspect of the clients. Among 112 cases reported during the reporting period, only 3 of them had to be referred to the psychiatrists. It is indicative of the quality of the recruitment system followed in the bank. Second, the counseling services could prevent the distressed employees from psychiatric medication dependency, reduce stigma, enhance work efficiency and result in higher quality of life.

Intervention: The individual cases are related to general anxiety disorders, performance anxiety, depression, panic attacks, BPADs, family issues, domestic violence, adjustment issues, work stress, marital issues, parenting-related issues, relationship problems, harassment issues and major depressive stupor. Social work method of working with individual in clinical setting suits very well, and all the employees who received the assistance displayed improved workplace performance during the evaluations conducted after 3 months. As mentioned above, out of 112 cases handled, only 3 were referred to psychiatrists, and the rest were effectively intervened by the social casework practitioners.

5. Lessons learnt

The success of the program depends on the goodwill of the vision driven management joining hand with professionally competent service provider, capable of integrating different levels of services: in developmental, preventive and curative domains. Group-level interventions are meant for developmental and preventive and individual level interventions are meant for curative purposes. Well thought out individual level interventions can transform the life of employees, who are troubled, distressed, disturbed and disordered with various issues. The success of these complex interventions largely depends on the skills and competencies of the service providers, and due to complexity of human mind, the standardization of package of care is not completely possible but developing broad assessment, diagnosis, and psychosocial intervention outline is used in this model. This helps to develop an intervention frame work. Equipping the internal coordinators is part of task shifting and task sharing strategy where the basic assessments is done by them, and they facilitate referrals and act as a link between the higher ups in the bank and service providing agency. A 4-day training program to the internal coordination team to equip them to do crisis intervention and provide their distressed colleagues with psychological first aid was also an important reason for the success of this model. System and processes, pattern of referral, feedback systems, monthly reporting and half yearly appraisals help in better coordination and timely improvements in the system. This process itself helps to develop an empathetic attitude in the top management which is percolated to entire organization, contributes to more and more steps for positive mental health initiatives. Next step of this project is to introduce randomized control trial to measure effectiveness of the intervention in overall improvement of the organizational climate, second, to develop more structured complex intervention package based on “Theory of Change model” and Medical Research Councils Guidelines for people working in similar environment.

6. Recommendations for future practice

This unique model that emerged gradually is an economically viable and theoretically sound intervention which can be extrapolated, improvized and customized for similar settings. As the program at present has impacted the organization in a positive way in better awareness of mental health problems and mental health interventions, this paves way for further continuation of the program in the setting incorporating advances in mental health strategies. The present intervention can be tailored to suit any workplace and can be replicated to resolve mental health issues in workplace.

7. Conclusion

This specific model of psychosocial intervention in the workplace is unique and distinct. The unique human resource model practiced in the Federal Bank ensures the profitability and viability without compromising the competency of its employees. This initiative proves that the welfare approach has predominance over the disciplinary approach in reducing the employee attrition, increased satisfaction, enhanced commitment and dedication of the employees. This article on the Psychosocial Care Model has provided evidences for its effectiveness in reducing negative mental health outcomes, enhance quality of life and improve productivity. The setting reduces the stigma which is a great barrier for mental health service coverage. Intervention reduced psychiatric medication dependency; it prevented clients from progressing from mild to moderate and

moderate to severe. This experience suggests that psychosocial and environmental factors are important target of interventions to ensure mental health in work place. Further randomized trials are required to formalize the work place intervention packages of care.

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