

Exploring Digital Mental Health Platforms in India: Examining Current Realities and Future Possibilities

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Abstract

While the expansion of digital mental health (DMH) platforms in India has been rapid, there has been limited research into the attrition of the clients and therapists that operate within these platforms. Existing research has mainly focussed on the experience of the clients of these platforms, leaving the practitioners that operate within these DMH platforms underexamined. This research assessed the conditions within India's DMH platforms that contribute to the attrition of both the clients and therapists of those platforms. A focus group discussion was conducted with 12 female mental health practitioners that are affiliated with DMH platforms in India. The data from this interview was analysed using thematic analysis. Four main themes emerged from the interview: the architecture of the DMH platforms and structures within India, the attrition of clients of those DMH platforms, the attrition of the therapists of those DMH platforms, and technical failures within a regulatory vacuum, where the absence of accountability frameworks transforms technical disruptions into therapeutic ruptures. The attrition of both clients and therapists of DMH platforms within India is a result of the architecture of those platforms, rather than the decisions of the individuals that use them or provide their services. India's scale, cultural specificity, and regulatory underdevelopment suggest the need for new models for DMH platforms in the country. Suggestions for such models include the incorporation of crisis protocols, compensating practitioners for their cultural labour, and the structural integration of DMH models that incorporate mental health practitioners.

Keywords: digital mental health platforms; teletherapy; therapist attrition; client attrition; platform architecture; India; qualitative research; thematic analysis; treatment gap

Introduction

Over one billion people worldwide live with a diagnosable mental health condition, yet fewer than one in eight receive any form of treatment for their condition (Murthy, 2017). The COVID-19 pandemic has made this issue worse for many countries, as the number of cases of depression and anxiety increased by as much as 25-30% worldwide throughout 2020 (Wind et al., 2020). Furthermore, the pandemic also led to an increase in the use of teletherapy — delivery of therapy through digital platforms rather than in-person with a mental health professional — for mental health conditions.

The mental health challenge in India is particularly acute. The country has only 0.75 psychiatrists per 100,000 individuals, ranking among the lowest in the world (WHO Mental Health Atlas, 2022). Furthermore, 70% to 92% of those who require mental health treatment do not have access to it (WHO

Mental Health Atlas, 2022). Digital health platforms are, therefore, vital to providing mental health care to the country's 150 million individuals who require such treatment, yet who only access care for 30 million individuals (NMHS, 2016). The disease burden for mental health disorders in India is particularly high, with approximately 2,443 DALYs per 100,000 individuals in the country suffering from such disorders, and around 10.6% to 15% of those individuals suffering from mental health disorders requiring intervention (Ministry of Health, 2020).

Recognising the urgency of the situation, the Indian government has created programs like MANAS, e-Manas, and Tele-MANAS to address the increasing need for mental health services. Since its inception, Tele-MANAS has received 29.82 lakh calls, signalling the first outlet of the repressed demand for mental health services (MoHFW, 2025). Various private companies have also begun to create their digital mental health programs. Companies like iCall, YourDOST, Wysa, MindPeers, and InnerHour offer mental health programs for employees and individuals directly through various models and subscriptions (Wadhwa, 2021).

Despite this expansion, a critical problem of individuals not staying engaged with these platforms. Studies have shown that the retention of individuals using these applications globally is poor (Baumel et al., 2019). Additionally, some studies of Indian digital mental health platforms have shown that the dropout rate for individuals using these applications can reach as high as 78% after the first month of use (Agarwal et al., 2024). These platforms fail to provide a personalised experience for the individuals using these applications, as various reviews of current DMH platforms have shown a universal issue with the lack of personalisation of these digital platforms (Nicholas et al., 2017). Almost 60% of the population of India is not able to access these digital platforms due to their pricing structures (Singh et al., 2023). Thus, despite the various digital mental health platforms that have proliferated before the Indian population, the initial engagement that was established has yet to elicit the development of sustained use of these platforms.

The existing literature on DMH attrition predominantly considers the clients' experiences with the DMH platforms; with regard to the efficacy of the applications and the reduction of their symptoms (Rajan & Shalini, 2024; Fleming et al., 2024). The practitioners that provide the mental health services within these platforms and platforms have received relatively lesser consideration from scholars, however. Such a study intends to address this gap in the literature.

This study draws on three complementary theoretical perspectives to interpret the structural conditions shaping attrition.

The theory of platform labour as described by Woodcock & Graham (2020) and Rosenblat (2018) indicates that the risks of the platform are often externalised to the practitioners within that platform. In the cases of the gig economy companies considered by these authors, the risk is often of the worker failing to receive the expected income from the platform, or of the worker encountering some hazard to their physical health. Within the DMH platforms, though, the risk is of the platform failing to provide adequate infrastructure to support the practitioners and the clients receiving those practitioners' services.

Zuboff's (2019) framework of surveillance capitalism helps to reveal the rationale behind the platforms' collection of the clients' health data. Within the EAP models of DMH platforms, these practitioners generate data about the mental health workforce — their utilization of the platforms, the problems they encounter, and other indicators of their productivity — which is then harvested by the companies that purchase their services.

The theory of the therapeutic alliance as described by Bordin (1979) and Horvath & Greenberg (1994) indicates that the strength of the relationship between the practitioner and client is the single strongest

predictor of the treatment success for that practitioner and client. Any factors that threaten to break down that relationship or the practitioner's ability to provide effective services to their clients are, therefore, factors that threaten the practitioners with attrition.

Together, these frameworks help in explaining the reasons for practitioner attrition within DMH platforms. Each of these theories indicates that the DMH platforms are established with factors like acquiring the practitioners' attention and time, rather than retaining those practitioners and their clients, sharing their knowledge with the clients rather than extracting that knowledge from the practitioners and clients alike, and focusing upon meeting the demands of a platform rather than providing effective and continuous mental health care to their clients.

The western literature on digital health cannot be uncritically transposed to India without deliberate adaptation to the cultural, social, and mental health stigma factors that are specific to the country (Kumar et al., 2022; Chatterjee et al., 2024). The findings from India will have implications for every other country that adopts the same digital health models, thus making India an essential location for theoretical consideration in digital health studies (PATH, 2025).

The EAP model is the dominant model for digital mental health in India. By funding mental health care within the EAP model, three traditional barriers to accessing mental health care are eliminated (Pothula, 2020). These eliminated barriers create significant gains in the accessibility of mental health care services, especially important given the mental health stigma that prevails in India. However, they also create commitment-free zones in which individuals will drop out of digital mental health care programs without any penalty to them financially, socially, or emotionally.

There are two main types of mental health care platforms operating in India. The established platforms in the digital mental health care industry have teams dedicated to providing mental health care to their employees. The other type is startups that outsource the mental health care to practitioners themselves (Joshi & Mehta, 2023). Furthermore, there are no regulatory frameworks for the digital mental health care platforms in India, just as there is no Indian version of HIPAA and GDPR for mental health data (WHO Digital Health Guidelines, 2019; Sharma & Saha, 2023).

Study Rationale and Aims

The present study was undertaken with the intention of gaining an understanding of the structural conditions that contribute to both client and therapist attrition within India's digital mental health platform companies from the perspective of the practitioners that are affiliated with those companies. The aims of this study were to understand: the structural conditions that impact practitioners who are affiliated with those digital mental health platform companies; the factors that contribute to client attrition within Indian DMH platforms; the labor and sustainability factors that contribute to therapist attrition; and the impact that technical and regulatory failures have upon the sustainability of these platform companies.

These aims were operationalised through the following research questions:

RQ1: How do platform architecture and structural stratification shape the professional experiences of platform-affiliated mental health practitioners in India?

RQ2: What structural and cultural factors drive client attrition within Indian digital mental health platforms?

RQ3: What labour conditions and professional sustainability challenges contribute to therapist attrition on Indian digital mental health platforms?

RQ4: How do technical failures and the absence of regulatory frameworks affect the viability of platform-mediated mental healthcare in India?

Method

Research Design

This study employed a qualitative design, using reflexive thematic analysis as the primary analytical framework (Braun & Clarke, 2006; 2019). A qualitative method was selected for these research questions concerned with eliciting notes on lived experiences related to working conditions, and the meanings of the attrition of professionals from the field. Thematic analysis allows for both an analysis of the manifest meaning of the responses provided by the participants to the research questions, as well as for an investigation of the latent meaning of the answers provided to determine their structural meanings. Additionally, thematic analysis being an inductive method allows the themes to emerge from the data rather than being imposed on the data prior to the analysis of the participants responses.

Focus Group Discussion

The primary data were collected from one focus group discussion (FGD) that took place via video conferencing for approximately 70 minutes. A focus group was used instead of individual interviews as the aim of the study was to understand the collective sense-making of practitioners within the field (Kitzinger, 1995; Morgan, 1997). Furthermore, practitioners who are affiliated with the digital communication platform share a specific occupational context and experiences that can be explored during the focus group.

The study is appropriately characterised as exploratory and theory-generating rather than confirmatory. The decision to use only one focus group discussion with 12 participants was in accordance with the aim of the study to generate theories regarding the structural conditions that contribute to attrition of therapists from the field. Thematic saturation, the point at which new data ceases to generate new analytical insights, was approached within the discussion, with recurring patterns emerging across multiple participant accounts.

The focus group discussions were facilitated in a semi-structured manner wherein there were thematic questions that were posed to the practitioners and participants to gain their responses. The themes included questions regarding their entry into the field of platform practitioners, the structural elements of the platform and its economic models, their feelings of autonomy and support in their field, their level of competence in relation to cultural diversity within their fields, experiences with clients dropping out of their practices, their reasons for dropping out of the field, and their perceptions of the sustainability of their field. During the focus group discussion, practitioners were also able to bring up other themes that were not included in the preconceived guide for the focus group discussion. The focus group was facilitated by the primary researcher with participant coordination supported by a platform representative.

Participants

The sample of mental health professionals that were enlisted for this study comprised of 12 female practitioners (N = 12) that were either currently or recently formerly affiliated with digital mental health platforms in India. These practitioners were enlisted through convenience sampling methods of the practitioners that were enlisted by the digital mental health platform. To be enrolled in the study, practitioners were required to meet three criteria: that they were qualified mental health professionals (with

at least a Master's degree in Psychology or equivalent); that they were either currently or recently formerly affiliated with a digital mental health platform in India; and that they were willing to participate in a recorded focus group discussion. No minimum platform experience threshold was applied, practitioners with less than six months of experience with the platform were eligible to participate alongside practitioners with over a decade of experience.

All of the practitioners that were enlisted for this study were female. Furthermore, while this may appear to be coincidental, this group of women was specifically selected due to the feminisation of mental health practitioners within India and within the digital mental health industry in particular (Woodcock & Graham, 2020). Thus, while such an all-female group of practitioners may appear to be limiting to the perspectives that can be represented in this study, such a composition of the sample is reflective of the actual structure of the industry itself, and, therefore, is inherently significant to the study of that platform and its practitioners.

Within the sample of practitioners, three different groups of practitioners were enlisted according to their methods of entry into the mental health practitioner field in India: Digital Natives ($n = 2$) are those practitioners whose professional career started and existed within the digital mental health industry; Digital Migrants ($n = 6$) are those practitioners whose professional careers were established outside of the digital mental health field; and Hybrid Entry practitioners ($n = 4$) are those practitioners who began their careers in both digital and non-digital fields simultaneously. Each of these practitioner groups were established according to the classification of pre-existing practitioner groups created by Prensky (2001). Thus, these practitioner groups allowed for the researchers to account for potential differences within practitioners based on the backgrounds of those practitioners.

In addition to the practitioners that were enrolled in the focus group, the representative of the digital mental health platform was also present during the focus group discussion. While this may indicate a potential influence on the practitioners' candour in discussing the conditions of the digital mental health platform, each practitioner was made aware of their rights to the conference to be a confidential research data collection, and that the research team was independent of the mental health digital platform itself.

Table 1. Basic Demographic Characteristics of Participants (N = 12)

Age (years)	Gender	Highest qualification	Location type	Region
25–29 ($n = 7$)	Female ($n = 12$)	Master's ($n = 11$)	Metropolitan ($n = 5$)	Western India ($n = 7$)
30–34 ($n = 2$)	—	PG Diploma ($n = 1$)	Peri-urban ($n = 3$)	Southern India ($n = 4$)
35–39 ($n = 3$)	—	—	Non-metropolitan ($n = 4$)	Northern India ($n = 1$)

Note. All participants identified as female. Age range: 25–39 years ($M = 31.8$, $SD = 4.4$). All participants held a minimum of a Master's degree in Psychology or equivalent.

Table 2. Professional and Platform Experience of Participants (N = 12)

Total clinical experience	Digital platform experience	Number of platforms	Therapy mode on platform	Offline practice
1–3 years (n = 2)	<6 months (n = 2)	1 (n = 5)	Mixed (n = 7)	Yes (n = 4)
3–5 years (n = 2)	6 months–1 year (n = 3)	2 (n = 1)	Video (n = 3)	No (n = 8)
5–10 years (n = 3)	1–3 years (n = 1)	3 (n = 3)	Video/Audio/Chat combinations (n = 2)	—
>10 years (n = 5)	3–5 years (n = 3)	4–5 (n = 3)	—	—
—	>5 years (n = 1)	—	—	—

Note. Total clinical experience includes all settings. Digital platform experience refers to platform-affiliated practice specifically. Three participants (P1, P7, P11) maintained concurrent offline practice.

Table 3. Practitioner Cohort Classification by Entry into Digital Practice (N = 12)

Entry into digital practice	n	Cohort classification	Cohort description
Transitioned from offline practice	6	Digital Migrant	Professional identity formed in offline settings; transition to digital platforms often accelerated by structural shifts
Both simultaneously	4	Hybrid Entry	Began professional practice across both offline and digital contexts concurrently
Began career digitally	2	Digital Native	Professional socialisation occurred primarily within digital platform contexts

Note. Digital Natives (n = 2): P7, P12. Digital Migrants (n = 6): P2, P4, P5, P8, P9, P10. Hybrid Entry (n = 4): P1, P3, P6, P11.

Analytical Procedure

The analytical procedure followed the phases of reflexive thematic analysis (Braun and Clarke, 2006), where the transcript was revisited multiple times to achieve thorough familiarization with the data, thereby producing a rich abstraction of themes and emergent patterns. Initial codes were generated manually by careful examination of each statement made during the focus group discussion. Efforts were made to highlight the manifest denotation of arguments, simultaneously engaging with the underlying connotations. The procedure lent critical exploration of surface level deductions along with latent meaning making, elaborating on the lived experiences and interpretive threads. The codes were generated, leading to preliminary grouping into broad categories which were later refined into overarching themes that recurred across participant accounts. The thematic structure was facilitated to materialise from the data

inductively, without preemptive impositions. Data was iteratively reviewed and refined to produce an informed final thematic structure, reported in the findings.

Reflexivity

The primary researcher occupied an insider-outsider position, with academic familiarity with digital mental health platforms but without practitioner experience within them. The researchers' positionality was maintained consciously throughout facilitation and analysis by bracketing assumptions about platform conditions and remaining open to participant accounts that contradicted theoretical expectations. The insider-outsider status was continually reassessed and rigorous attempts were made to minimize the biases. The presence of a platform representative who also participated in the discussion is acknowledged as a potential influence on participant candour, particularly regarding critical accounts of platform conditions. The participants were actively encouraged to engage without trepidation regarding potential harm or subsequent disclosures to authority by assuring confidential treatment of all research data.

Ethics

Verbal consent was obtained from all participants prior to commencement of the focus group, including explicit consent for audio recording. Participants were assured that data would be used exclusively for research purposes, along with maintenance of confidentiality and usage of pseudonyms in all reporting. The ethical approval was obtained from the institutional ethics committee for the study.

Findings and Discussion

Analysis reveals four overarching themes. Each of these themes is presented below, including the testimony of the participants that illustrate these themes, as well as a discussion that relates these themes to the theoretical framework and literature that exists on the topic. The participants are referenced by the pseudonym codes that were utilized during the interviews (P1-P12). Additionally, there is supplementary data that was collected on the topic of the study, including the sustainability data and the raised hand data.

Figure 1. Thematic Map: Digital Mental Health Platforms in India and Attrition



Theme 1: Platform Architecture and Structural Stratification

India's digital mental health platform landscape is not homogeneous. A clear stratification exists between

well-capitalised established platforms and resource-constrained startups, producing fundamentally different practitioner experiences. This theme addresses RQ1 and RQ4.

1.1 The Dual-Tier Ecosystem

Established platforms provide professional containment of the platforms, including technical support teams and therapist coordinators. Platform support teams can absorb the risks of technical platforms and operations for the practitioner. For example, P7, who has worked with five different platforms, stated that: P7: "I have worked on five platforms as of yet. And all of them had amazing structure. They had an ops team, and they had a therapist coordinator team... So I had always the POC. It has been a very convenient ride for me."

Resource-constrained startup platforms presented a starkly different reality. P9, who had worked across both startup and established contexts, described the differential in technical support:

P9: "I have worked in a startup and also very well established digital platform. So the place which was a startup definitely, like if there is any technical issues, we can only rely on the team and maybe not a major of the chunks can be sorted by us."

The bifurcation of mental healthcare platforms into two separate groups reflects the general nature of platform economies, wherein the first-mover advantage, venture capital, and network effect lead to the "winner-take-most" architecture of platform economies (Srnicsek, 2017). These dynamics have impacted the mental health industry in that the practitioners in the platforms with less resources must take on some of the burdens of the platform, leading to the attrition of practitioners within the platforms with fewer resources. Even more notably, however, is the fact that during the discussion with P9, P9 became interrupted in the middle of a sentence due to a technical failure in the research process — a phenomenon that the researchers refer to as the "performativity" of the platform.

1.2 Platform as Entry Infrastructure

For some practitioners, the motivation to enter the industry and utilise the digital platforms was due to a lack of alternatives to an independent practice:

P9: "Even when I ended up working, when I wanted to start my freelancing, did not have the capital to think of an offline setup, because it did require a space or the infrastructure."

Platforms as an alternative to an offline career are utilized by practitioners who do not have the capital to start an offline career. This ties into practitioner attrition. For practitioners who entered the digital platforms as a result of a lack of alternative to an offline career, they stand to leave the platforms if they become too utilitarian for the practitioners.

1.3 The EAP Model: Access, Commitment, and Paradox

The EAP model was assessed by many participants with mixed views of the model. Some participants noted their positive sentiments regarding the accessibility of the services and the reduction of the mental health stigma that can accompany the requirement of providing specific information about one's mental health to an employer or for receiving funding from that employer. Participant P1, for instance, noted that the model would provide affordability of therapy for individuals who would otherwise struggle with the costs of treatment, yet also noted that the EAP model would eliminate the cost of participation for employees from the company:

P1: "therapy should be more affordable... but at the same time when we are in EAP setup, right, it is free for people who are in the company... So I feel like that becomes like a very free-flowing space and people become much more open."

Such findings are in agreement with Pothula's (2020) discussion of the elimination of three main barriers to accessing therapy through the EAP model: financial investment, effort, and social disclosure. These three elements are especially crucial to overcoming mental health stigma in India.

However, the elimination of these three barriers is also associated with a paradox regarding therapy and commitment. For instance, P3 expressed concern that if individuals are not investing in their mental health, they may not be committed to receiving therapy:

P3: "if they're not investing from their own self, are they truly invested in therapy?... nobody knows that they're actually needing help or probably seek help just once and then for some reason dropped out."

A further structural contradiction was identified by P9, who indicated that while individuals may have entered the EAP to address the stress that they experience in their work, their work schedules prevent their attendance at therapy appointments:

P9: "somebody who has come for, you know, work-related stress... they actually have so much to do, that they are unable to find the time for the session."

This self-defeating model is indicative of the contradictions inherent in EAP models. An individual's mental health issues are addressed through therapy, yet the causes of those mental health issues remain intact. This is a criticism of the Western world's implementation of therapy and management of mental health in general (Cummings, 2006). Finally, some platforms exhibit significantly different rates of dropout than others within the same practitioner workforce. Platforms that aim to increase accessibility also enable conditions that are commitment-free to therapy.

Theme 2: Practitioner Accounts of Client Attrition: Cultural and Structural Factors

It should be noted that the attrition of clients within this study was examined exclusively through the accounts of the practitioners themselves. Thus, these findings are based upon the interpretations of the therapists of why their clients dropped out, and not based upon the accounts from the clients themselves. Three explanations for client attrition emerged from these practitioners' observations of their clients and experiences in treating those clients. This theme addresses RQ2.

2.1 The Paracetamol Paradigm and the Relief Threshold Effect

The attrition of clients was also discussed by practitioners, specifically after two to three sessions rather than at the time of initial entry into the program. The cultural reason for this attrition cited by practitioners was the difference between Indian culture, with its expectations of quick results within commerce, and the gradual process necessary to build trust and insight within a psychotherapy program. P7 framed this through a vivid cultural analogy:

P7: "I think we as a population are used to quick relief. So there's a headache and used to having a paracetamol and having relief within 30 minutes. But as therapy, it's a very slow process."

P7 also noted the implication of this cultural issue on the design of the platform:

P7: "It's very fast. It's like, you know, people, it's like quick commerce convenience... Providing them convenience is something that we'll have to adapt more to."

The explanation that the practitioners provided for the nature of the attrition following two to three sessions is that the clients feel the relief from their symptoms following the initial sessions; hence they perceive the therapy to be complete rather than the commencement of a longer therapy process. This aligns with the findings of Baumel et al. (2019) who noted a drop-off of patients in the initial stages of the therapy programs without explaining the cultural driver. The cited reason by the practitioners can be explained through the business models of these health platforms as many of them were established with the intention of acquiring as many users as possible quickly. This quick acquisition model of these health platforms has

inadvertently created a demand for quick gratification from consumers just as the Indian consumers require it from commerce platforms. Rajkumar (2025) documented the presence of this consumption culture within the Indian digital health context.

2.2 The Investment Paradox

Another of the findings that emerged from the participants regarding the impact of the barriers to access on the therapeutic commitment was the existence of two different perspectives regarding this issue. The first held that offline therapy's investment mechanisms: financial cost, social accountability, physical effort; generate therapeutic commitment through sunk cost effects:

P3: "Because neither do they have one single family member, relative, friend, colleague... nobody knows that they're actually needing help and then for some reason dropped out."

The other perspective of this issue was expressed by P7 in their observation of the dropout rates among their clients:

P7: "For me, the dropout rate for offline was way more than online... for offline, there was always this, oh, there's traffic today, I couldn't make it."

These two perspectives on this issue are resistible to resolution. The existence of such different perspectives suggests that the relationship between these two variables is contingent upon a number of different populations, issues, and barriers to access. Thus, convenience is only one factor that may have an impact upon the therapeutic commitment of certain populations of patients with specific issues and barriers. Thus, this factor indicates that it may be necessary to create different models of ensuring therapeutic commitment for different populations altogether.

2.3 Platform-Switching and the Therapeutic Continuity Problem

The Post-COVID proliferation of mental health platforms has also given rise to another driver of attrition that has become apparent to practitioners: the consumer orientation toward these platforms. P9 described this trend in the following way:

P9: "post-COVID, now since availability is huge out there in the market, there are so many platforms available... there's this fickle-mindedness also among people... maybe a friend of them recommends something else. They would want to try that."

The primary means of discovering these platforms is through social media and peer recommendations to clients of these platforms. Clients often switch mental health platforms due to a minor dissatisfaction with their current provider or social referrals. In each of these instances, the clients fail to recognize the importance of the therapeutic alliance between client and therapist as the main factor that produces psychological change within those clients (Horvath & Greenberg, 1994). Thus, this platform switch essentially negates the importance of that therapeutic alliance. These factors, then, contribute to the commodification and weakening of the therapeutic alliance between individual clients and their mental health professionals.

The major factors that contribute to the attrition of clients within EAPs, according to these practitioners, are the mismatch between cultural temporality and the free commitment of clients to EAPs, and the behavioral issues with switching mental health platforms. Future studies should focus upon collecting data from these clients to confirm these observations.

Theme 3: Therapist Attrition: Labour Conditions and Burnout

Therapist attrition emerged as the less examined but equally significant dimension of the study's central concern. Three mechanisms drove practitioner departure from platforms. This theme addresses RQ3.

3.1 Voice Suppression Architecture

Another of the accounts that emerges from the participants' statements is regarding the unresponsive nature of the technical, clinical, and organizational aspects and were reported as going unaddressed despite repeated escalation across multiple departments. P5 stated the following about feeling like their concerns were not being met by the departments:

P5: "she or he is feeling that they're not being heard well... in spite of repeating it 10 different times to 10 different people, but nobody's taking care of it. That also could be the reason wherein somebody might feel like, we cannot continue anymore."

Such complaints indicate that the organisations place a prioritisation of investor metrics above the concerns of the practitioners themselves. As a result of these departments not being able to resolve the issues that are brought to them, the practitioners begin to feel helpless in their careers (Seligman, 1975). They do not report new issues to these departments, even if they are experiencing difficulties in their own work with the clients — contributing to increased risk for the platform without alleviating their frustrations with the work that they are required to perform.

Relatedly, P10 described the difficulties of adapting clinical training to the digital environment:

P10: "Initially, there was no one to teach you this... you have to look into the camera. And then I used to wonder if I look into the camera, how will I notice the body language of the person."

This paradox of camera-gaze, where it is impossible to appear attentive (by looking at the camera) and gather clinical data (by watching the client's screen image), is indicative of how platform affordances create new demands for competencies that existing training does not prepare one to meet.

3.2 Quantity Over Quality and Professional Autonomy Erosion

Platform metrics discussed by multiple participants were those relating to the volume of sessions that a professional therapist offers rather than the outcomes of those sessions. P3 noted the focus of the platform on these aspects of the profession:

P3: "the platform probably focuses more on the number of sessions... quantity over the quality at times... they focus more on the quantity, right? They want the numbers."

These performance metrics work against the therapeutic purpose of the profession, which is reflected in the literature as "measured mismanagement" (Braverman, 1974). In this case, the focus on measuring the number of sessions performed rather than the number of outcomes achieved for patients is anti-therapeutic in nature.

Relatedly, P3 also noted feelings of erosion of their professional autonomy within the platform:

P3: "there is less freedom there... if they want me to, you know, like to choose one particular path, I will have to do it. So even if something is not going in line with what I practice... I will have to do it."

Such a requirement for practitioners to relinquish their professional autonomy is recognized within the Western world within the context of managed care (Cummings, 2006). In the Indian market, however, there is no regulatory framework to protect practitioners' professional autonomy. It should be noted that not all practitioners feel as if the platforms constrain them in their professional practice. For instance, P4 noted:

P4: "when you are working in an organization, because when this becomes a platform of usage, and they ensure that, you know, the working aspect becomes very clear, crisp and without any difficulty."

Thus, there is a balance between the constraints and structure of the platform and the autonomy of the professional practitioner, reinforcing the importance of the distinction between these two types of platforms, as established in Theme 1.

3.3 Relational Depletion in Screen-Mediated Practice

Regarding the sustainability of the platforms, one finding that has direct implications is the concept of relational depletion associated with digital-only practice. Despite the high volume of clients that are treated by these practitioners, there is a recognized need of the practitioner for some degree of embodied social interaction. Practitioner P10 described this need for embodied social interactions as follows:

P10: "you miss the human touch, you crave being socially there and meeting different different people... continuously having sessions online, it takes that away. When you actually come across them, when you meet them, that feeling is different. It can't be described."

The experience of practitioners feeling a depletion of their desire for embodied social interactions is an experience that is recognized by Merleau-Ponty (1962) in his discussion of the embodied experience of human beings, as is the experience of practitioners like P10. Furthermore, Bailenson (2021) documents the experiences of practitioners who are required to spend lengthy periods in digital-only practice with clients, as such intensive practice can contribute to what he refers to as "Zoom fatigue."

The involuntary nature of the shift to digital-only practice for many of these practitioners, at least within the Digital Migrant cohort, is another factor that contributes to the depletion of their relational energy and desires for embodied social interactions. Practitioner P6 discussed her experience of being forced into this practice:

P6: "I don't think we are motivated. Just because we thought that we would be doing digital, all of us would prefer in-person. But because time demands us to change according to how the world is changing." Thus, this involuntary shift to digital-only practice contributes to the depletion of practitioners' relational energy. If this energy will be depleted continuously through practice that relies upon practitioners to maintain digital-only practices with their clients, then the practice models are inherently unsustainable over time. Thus, practitioners will need to find a way to reintroduce embodied interactions between the practitioners and their clients.

The factors that contribute to therapist attrition include the architecture of the suppression of the therapists' voices, metrics that encourage practitioners to deliver high quantities of services, and the depletion of the practitioners' relational aspect due to the digital-only practice of delivering services.

Theme 4: Technical Failures and Regulatory Gaps

The fourth theme examined the material and structural conditions in which digital mental health delivery operates. This theme addresses RQ4.

4.1 Technical Failures at Critical Therapeutic Moments

When asked if they had experienced any technical failure of the platform during a critical moment in their therapy sessions, the majority of clients raised their hands to indicate that they had indeed encountered such a problem.

These technical platform failures are the result of the lack of investment in the technical infrastructure of these platforms, especially those that cannot offer an argument as to why redundancy systems or crisis response systems should be established within these companies before receiving funding from venture capital investors. Client P10 discussed the importance of having their clients in their physical presence compared to online:

P10: "if a person is in front of me, I have some kind of safety in that session, I feel that I can create for the client than when I am, you know, in an online setup."

Winnicott's concept of the holding environment requires for the environment in which the child develops to be reliable and contain the child within their world without fear of abandonment. Technological failures within the therapist and client's most vulnerable moments creates feelings of abandonment by the therapist and introduces the same feelings that clients often experienced during early childhood and with their attachment figures (Bowlby, 1982). For clients with attachment difficulties or trauma with their caregivers, these technological failures may have adverse effects upon their therapy sessions.

Subsequently, these failures introduce the concept of voids in the accountability of those therapists who failed the clients during these instances of disconnection. In these instances of being disconnected from their therapists, no current framework for accountability exists for these therapists; there is no framework for holding them accountable for the disconnections whether they are the cause, the clients are at fault for utilizing these platforms, or the platforms themselves are not accountable due to the terms of service for those platforms (CMHLP, 2024).

4.2 Sustainability Perceptions and Conditional Commitment

Participants were asked to rate their sustainability on digital platforms on a scale of 1 (completely unsustainable) to 10 (completely sustainable). Most participants selected a rating of between 7 and 8. P12 explained the group's orientation towards sustainability in the following way:

P12: "we are leaning more towards the sustainable part of it."

These ratings indicate that participants might be committed to their digital practice only conditionally (should the necessary changes to that practice be made). For instance, P10 indicated conditional commitment in the following statement:

P10: "if there is a balance of if this is part time, or this is just for a few hours, and you're also working on an offline basis, then I feel therapist might continue doing that more than a full time set."

While all participants were committed to a five-year term for digital therapy platforms, each expressed concerns for potential burnout and the inability to maintain their professional identities within such a role. The 7–8 rating may therefore represent not affirmation but the absence of better options: conditional commitment masquerading as satisfaction — a distinction with significant implications for long-term platform workforce planning.

The technical platform failures have led to ruptures in the therapy delivery models of the practitioners. Improvements to the digital platforms and services that they offer are therefore required to increase their retention of practicing therapists.

Implications

This study advances the theoretical understanding of DMH attrition in three ways. First, it introduces the concept of attrition as architecturally produced rather than individually driven. The motivations for DMH attrition are directly related to the logic of platform capitalism (Srnicek, 2017). Second, it introduces the concept of the relief threshold effect as a means by which clients drop out of DMH platforms specific to the context of India's culture of quick commerce consumption. This finding is an original contribution to the studies of Baumel et al. (2019) on DMH platform engagement. Third, it applies Zuboff's (2019) framework of surveillance capitalism to the context of EAP mental health platforms to reveal how many of these platforms produce data from their mental health offerings that benefits the corporations involved rather than the clients and therapists who use those platforms.

The implications of these studies for practitioners include the need to provide psychoeducation regarding the timelines of therapy to clients when they first engage with a DMH platform. The concept of the relief

threshold effect suggests that practitioners have an opportunity to retain some clients who would otherwise drop out of these programs after overcoming the motivation to begin therapy. The implications of the study of the investment paradox suggest that practitioners may do well to not remove all barriers to participation in therapy for clients; instead, approaches that consider the importance of commitment mechanisms may be beneficial.

The implications of these studies for DMH platforms include the implementation of protocols for the management of crises that may affect the clients' ability to continue to access their therapists. Such a protocol could allow clients to become reconnected to their therapists following a crisis that impacts their access. The extensive background knowledge of practitioners regarding India's many different cultures should be recognized and made compensatable within their compensation structures. A model that permits practitioners to have some embodied contact with their clients may be a default model for DMH platforms within India rather than an optional model. Their performance metrics should be expanded to include parameters related to the outcome of the therapy, the strength of the client-therapist relationship, and the wellbeing of the practitioners.

India's demographics and regulatory vacuum make the country the most demanding of existing platforms for DMH. Yet, the findings of this research will have implications for every low- and middle-income country that may choose to implement these models. If the findings of this study suggest that these types of platforms will not succeed within India, then that finding can be traveled to other countries that have similar demographic and regulatory characteristics for their populations.

Limitations

Several limitations to the study exist. The exploratory design using only one focus group with 12 practitioners limits the study's findings to an analytical, rather than statistical, generalisation of the findings. Yet because the aim of this study was to develop theoretical propositions regarding the attrition of practitioners from the teletherapy industry, future research could use multiple focus groups of practitioners from different regions and industry platforms.

Although the participants of this study were all female practitioners, reflecting the feminised composition of India's platform mental health workforce, it is possible that the experiences of men and non-binary practitioners may not be representative of the experiences of all practitioners within the teletherapy industry. Future research may investigate whether there are differences in the experiences of practitioners according to gender identities within the teletherapy workforce.

The sampling of practitioners from the teletherapy industry who participated in this study may have been affected by self-selection bias. Practitioners with extremely negative experiences with the teletherapy platform may have declined to participate in this study, while practitioners with more positive experiences with the platform may have been overrepresented in the focus group.

The presence of a representative of the teletherapy platform as a co-facilitator of the focus group may have created power dynamics between the practitioner participants and the platform representative. While practitioners were assured of the confidentiality of the focus group, the social dynamics within the focus group may have affected the candour of practitioners in sharing their more critical experiences of the teletherapy platform.

Finally, as noted under Theme 2 regarding the attrition of clients from teletherapy platforms, this study did not investigate the perspectives of the clients of the teletherapy practitioners who participated in this

study. Future research should investigate the experiences and perspectives of teletherapy platform clients to provide a more complete understanding of the teletherapy platform and the practitioner experiences.

Conclusion

This study investigated the causes of attrition for both clients and practitioners within digital mental health platforms in India from the perspective of practitioners within those platforms. The finding of the study is clear and that the attrition is structurally created within the platforms. It is not the result of individual clients who are unmotivated to participate in their therapy sessions or practitioners who are not committed to the platforms, but as a result of the current structures and business models of those platforms for acquiring users rather than retaining them within the platforms, and due to the regulatory vacuum that exists surrounding those platforms.

The paracetamol paradigm, the relief threshold effect, platform-switching behaviour, voice suppression architecture, quantity-over-quality metrics, relational depletion, and technologically-mediated abandonment at crisis moments: these are not aberrations within the system. They are features of it. Understanding these factors as features of the digital mental health platform is the first step towards creating platforms that are actually effective in providing mental health services to both their clients and practitioners.

India needs mental health platforms that work. The conditions necessary for such platforms have not yet been created within the current regulatory and structural framework for these platforms. Such conditions have not yet arisen due to the focus of those existing platforms upon acquiring users rather than retaining them, and due to the current regulatory vacuum surrounding these platforms. Creating the conditions necessary for digital mental health platforms to effectively serve their current clients and practitioners will require interventions in the regulatory, structural, and metric components of the platforms.

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