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Measuring Emotional Fitness Without Screening Anyone

Why clinical questionnaires are the wrong instrument for a workplace dashboard, and how rep counts, streaks and emotional-vocabulary breadth give HR real numbers with no clinical data inside them.

Dr Atul Aswani; Mumbai Psychiatrist and trained as a Results Coach
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01 Executive summary

At a 5 per cent workplace prevalence, a widely used nine-item depression questionnaire with sensitivity 0.88 and specificity 0.85 yields a positive predictive value of 24 per cent: three of every four people flagged are false positives. Rep metrics — count, streak, breadth (emotional vocabulary) and reach (people touched by connection reps) — give a wellbeing dashboard HR numbers it can act on, with no clinical data inside them.

The board asks a CHRO in Bengaluru for employee wellbeing metrics by the next quarterly meeting. The vendor deck offers the usual answer: send a clinical questionnaire to every employee and put the scores on a dashboard tile. That answer fails on three counts. First, community prevalence of current depressive disorders in India is 2.68 per cent; at that base rate the same instrument's positive predictive value falls to 14 per cent. Five per cent is already a generous assumption for an unselected workforce. Second, a questionnaire is not a neutral thermometer. Measurement-reactivity research shows that asking the items changes emotion, cognition and the numbers that follow. Third, individual symptom scores now sit in the HR system against named employees. That is a data class the employer should not hold. It is closer to a health record than to a participation count.

ISO 45003 metrics sit inside a management system, not a clinic. The 2021 guideline asks organisations to monitor psychosocial risk with leading and lagging indicators and to protect the confidentiality of personal information. Rep metrics meet that brief. They measure practice, not pathology. They aggregate only above a minimum group size. They leave clinical assessment where it belongs: off the HR dashboard. This paper sets out the evidence, the four metrics, the tiles, the privacy rules and a 90-day plan.

02 The problem in India

India does not lack concern. It lacks a number that HR can hold without also holding a health record. Three kinds of figure circulate in board packs, and they are not interchangeable. Population surveys estimate how common a condition is in adults. Employer surveys estimate how many staff say they have had a

difficult year. Employee-assistance pre-screens estimate how many people who already asked for help score above a cut-off. Mixing the three produces a dashboard that looks precise and is not.

What the population data actually say

The National Mental Health Survey of India, 2015–16, remains the last nationally representative field survey. Trained investigators completed 34,802 adult interviews across 12 states. Current depressive disorders were 2.68 per cent. Lifetime depressive disorders were 5.25 per cent. Current common mental disorders were 5.1 per cent. Current any mental morbidity was 10.6 per cent; lifetime prevalence was 13.7 per cent. Urban metro areas sat higher: current common mental disorders 8.11 per cent. The care gap for depressive disorders was 79.1 per cent. These are community figures. They are not employed-only figures. They are the correct denominator for any claim about how a questionnaire will behave if it is applied to a whole workforce.

The World Health Organization's mental-health-at-work fact sheet, updated in September 2026, estimates that 16 per cent of working-age adults worldwide had a mental disorder in 2023, and that 12 billion working days are lost each year to depression and anxiety, at a cost of US$1 trillion in lost productivity. That is a global labour-market estimate. It is not an Indian clinical rate, and it is not a licence to screen a floor of engineers with a nine-item form.

What employer surveys and help-seeker screens add — and what they do not

Deloitte India's 2022 workplace study, based on 3,995 employees surveyed between November 2021 and April 2022, estimated that poor mental health cost Indian employers about US$14 billion a year through absenteeism, presenteeism and attrition. Eighty per cent of those surveyed reported mental-health issues during the previous year. Forty-seven per cent named workplace-related stress as the largest factor. That is a COVID-period self-report survey. It is not a diagnostic interview and it is not a prevalence study.

1to1help's State of Emotional Wellbeing Report 2024 analysed more than 83,000 counselling sessions, 12,000 elective screenings and 42,000 assessments between January and November 2024. Among first-time users who had already elected counselling, more than 90 per cent of people under 35 screened positive for depression, anxiety or both. In the 31–35 band the depression-positive rate was 86 per cent; in the 36–45 band it was 80 per cent; above 45 it was 69 per cent. Those figures describe a selected help-seeking sample. They do not describe the workforce. Using them as a company-wide rate is a category error. A person who has already booked a session is not a random draw from payroll.

Gallup's India workplace series, on a different instrument entirely, finds that 28 per cent of employees experienced a lot of stress the previous day on a three-year rolling measure to 2025. That is a daily-affect item. It is useful as a climate signal. It is not a clinical score and it should not be stored as one.

Table 1. Three kinds of number — do not mix the columns

Source	Who was counted	What was measured	Figure	What it is not
NMHS 2015–16	Adults, 12 states, n=34,802	Current depressive disorders	2.68%	Not a workplace score
NMHS 2015–16	Same sample	Current common mental disorders	5.1%	Not a help-seeker rate
NMHS 2015–16	Same sample	Current any mental morbidity	10.6%	Includes substance-use conditions
NMHS 2015–16	Urban metro adults	Current common mental disorders	8.11%	Not employed-only
WHO, 2026 fact sheet	Working-age adults, global	Mental disorder estimate, 2023	16%	Not India-specific
Deloitte India 2022	3,995 surveyed employees	Self-reported issues, past year	80%	COVID-period survey, not an interview
Deloitte India 2022	Same survey	Cost to Indian employers	US$14 bn / year	Modelled loss, not a headcount
Gallup India, to 2025	Employed adults, India	A lot of stress previous day	28%	Daily affect, not a screener
1to1help 2024	First-time counselling users	Under-35 screen-positive (dep. / anx. / both)	>90%	Help-seekers, not the workforce
1to1help 2024	Same help-seeker sample	Depression-positive, ages 31–35	86%	Selected sample

Sources listed in References. The 87 per cent figure sometimes attached to the 2024 1to1help report could not be verified against the primary PDF and is not used.

The practical problem follows. HR wants employee wellbeing metrics that a board will fund. Clinical questionnaires look like science. In a low-prevalence workforce they produce a long list of false positives, a short list of missed cases, and a file the organisation should not keep. The next section shows the arithmetic.

03 Why current approaches fail

Annual surveys measure opinion, not practice

The annual engagement or wellbeing survey is a lagging climate instrument. It is taken once. It is long. Response rates fall as the form grows. Results arrive weeks later, usually as a favourability percentage. Managers cannot tell whether a team practised anything the following Tuesday. ISO 45003:2021 is explicit that leading indicators, which predict future performance, should sit beside lagging indicators, which look backwards. An annual survey is only the second kind.

Surveys also collide with anonymity rules the moment a filter is applied. A team of eight with a gender split and a tenure split is already close to a named list. Vendors suppress cells below five or ten responses for this reason. That is good practice. It also means the annual survey cannot do what people analytics most wants: a live team tile.

Screening produces numbers HR cannot act on and should not hold

Clinical questionnaires were built to help a clinician decide whether a structured interview is worth the next twenty minutes. They were not built to populate a wellbeing dashboard HR. Applied to an unselected workforce they fail a basic test of usefulness: most of the people they flag do not have the condition the cut-off was validated against.

Levis, Benedetti and Thombs, in an individual-participant-data meta-analysis of 58 studies and 17,357 adults published in the BMJ in 2019, found that a nine-item depression questionnaire at the conventional cut-off of 10 maximised combined sensitivity and specificity against a semistructured interview: sensitivity 0.88 (95 per cent CI 0.83 to 0.92) and specificity 0.85 (0.82 to 0.88) in the semistructured stratum of 6,725 people. The authors themselves worked the implication: at the 14 per cent prevalence in that dataset, positive predictive value was 49 per cent. Half of the positive screens were false positives.

An updated individual-participant-data meta-analysis in 2021, covering 100 studies and 44,503 people, reported sensitivity 0.85 and specificity 0.85 at the same cut-off against semistructured interviews. Across theoretical prevalences of 5 to 25 per cent, positive predictive values ranged from 23 to 65 per cent. The floor of that nomogram is the number that matters for a workplace.

Plummer, Manea, Trepel and McMillan’s 2016 diagnostic meta-analysis of a seven-item anxiety questionnaire, 12 samples and 5,223 participants, found pooled sensitivity 0.83 (0.71 to 0.91) and specificity 0.84 (0.70 to 0.92) at a cut-off of 8. The paper does not report positive predictive value at low prevalence. The calculation is the same as for the depression instrument.

A Bayes worked example on 1,000 employees

Positive predictive value is (sensitivity × prevalence) ÷ [(sensitivity × prevalence) + ((1 − specificity) × (1 − prevalence))]. Take the 2019 figures, sensitivity 0.88 and specificity 0.85, and an unselected workforce of 1,000.

At 5 per cent prevalence — already above the national current-depressive-disorder rate of 2.68 per cent, and close to the urban-metro lifetime figure of 5.25 per cent — there are 50 true cases and 950 people without the condition. The instrument finds 44 of the 50 (true positives) and misses 6. It also flags 143 of the 950 who do not have the condition (false positives). The dashboard lights up for 187 people. Only 44 of them are true cases. Positive predictive value is 23.6 per cent, about 24 per cent. Three of every four flags are false positives.

At 8 per cent prevalence the same arithmetic gives a positive predictive value of 33.8 per cent. Two of every three flags are still false positives. At the NMHS current-depressive-disorder rate of 2.68 per cent, positive predictive value falls to 14 per cent. About six of every seven flags are false positives. The 2021 nomogram's 23 per cent floor at 5 per cent prevalence matches the same calculation with sensitivity 0.85 and specificity 0.85.

For the seven-item anxiety questionnaire at Plummer's cut-off of 8, the same 1,000-person floor at 5 per cent prevalence gives a positive predictive value of 21.4 per cent. About 79 of every 100 flags are false positives.

Table 2. What a screen-positive list actually contains

Assumption	True cases / 1,000	True positives	False positives	PPV
Depression instrument, 2.68% (NMHS current DD)	27	24	146	14%
Depression instrument, 5% workplace	50	44	143	24%
Depression instrument, 8% workplace	80	70	138	34%
Depression instrument, 14% (Levis dataset)	140	123	129	49%
Anxiety instrument, 5% workplace	50	42	152	21%

Depression instrument: sensitivity 0.88, specificity 0.85 (Levis 2019). Anxiety instrument: sensitivity 0.83, specificity 0.84 (Plummer 2016). Figures rounded to the nearest person. PPV rounded to the nearest percentage point.

A list that is three-quarters wrong is not an action list. It is a liability list. A manager who receives it will treat colleagues as cases. A regulator who receives it will ask why the employer is processing health-condition data. A lawyer who receives it will ask who consented, where it is stored, and who can see it. None of those questions has a good answer if the original brief was "give us a wellbeing number."

Measurement changes the people being measured

French and Sutton defined measurement reactivity as present "where measurement results in changes in the people being measured." Their 2010 review in the British Journal of Health Psychology found effects on cognition, emotion and behaviour of up to medium size. Completing questionnaires about personally salient illness can raise reported anxiety. The later MERIT project (French and colleagues, 2021) restated the point for trials: measuring people changes behaviour, emotions and the data they then provide. Randomised studies show that completing questionnaires about the consequences of illness produces higher anxiety than no-questionnaire controls.

A clinical form on a workplace dashboard is therefore not a thermometer. It is an intervention the organisation did not set out to run. First-time scores tend to sit higher than later scores (initial elevation bias). Teams that are asked the items more often will look worse for reasons that have nothing to do with the work. Rep counts do not ask symptom items. They record that a practice was completed. They do not trigger the same reactivity.

The legal boundary

EmotionApp is a non-clinical coaching platform. It does not collect clinical data and does not offer diagnosis, treatment or therapy. That sentence is the product boundary and the legal boundary. A questionnaire score stored against an employee identity is a health-adjacent record. Under the Digital Personal Data Protection Act, 2023, employers may process personal data for employment purposes as a legitimate use, but necessity and proportionality still apply. Holding symptom scores in an HR system is hard to defend as necessary for running a coaching programme. Holding a count of completed practices is not.

ISO 45003:2021, clause 9.1, asks the organisation to monitor and measure activities related to managing psychosocial risk, to provide data on those activities, and to recognise the confidentiality of personal information. It also asks for leading and lagging indicators. A dashboard of clinical cut-offs meets none of those tests cleanly. A dashboard of rep metrics does.

04 The emotional-fitness model applied

PULL QUOTE

Across 93 mental-health apps, median 30-day retention was 3.3 per cent. Opens are not practice.

Emotional fitness, as used here, is the capacity to practise a small set of positive-psychology techniques often enough that they are available under load. EmotionApp delivers those techniques as countable daily reps of about ninety seconds. The public site currently lists 21 techniques, taught with evidence notes, in a language stack that is live in English and Hindi and designed for 23 Indian languages. The operating line on the technique pages is “counts, never confessions.” That line is the measurement philosophy of this paper.

The four rep metrics

Count is the number of completed reps in a period. A rep is a defined practice with a start and an end: a named emotion logged at a stated granularity, a thank-you delivered, a good-news response matched, a scheduled positive deposit completed. Count is a leading indicator of practice volume. It is not a mood score.

Streak is the number of consecutive days, or working days, on which at least one rep was completed. Streaks measure regularity, not intensity. A three-day streak of ninety-second reps is a different signal from a single long session. Baumel, Muench, Edan and Kane's 2019 panel study of 93 mental-health apps found a median daily open rate of 4.0 per cent and a median 30-day retention of 3.3 per cent. Opens are a weak engagement metric. Streaks of completed practices are a stronger one, because they record that the technique was done, not that the icon was tapped.

Breadth is the size of the active emotional vocabulary: distinct emotion words used, and the granularity of those words, over a period. EmotionApp's "Name It to Frame It" practice counts emotions named and a granularity score. The working claim, stated on the technique page, is that a precisely named feeling becomes a registered event, and that a finer vocabulary travels with steadier self-regulation. Breadth is not a distress score. A team whose vocabulary widens is practising a skill. A team whose vocabulary stays at "fine" and "stressed" is not.

Reach is the number of other people touched by connection reps. Two current practices generate reach: a delivered thank-you, and a matched response to someone else's good news. Reach is a network metric, not a sentiment metric. It tells HR whether the programme is staying inside the individual's head or moving into the working relationships the organisation actually depends on.

Leading versus lagging

ISO 45003 asks for both. In this model the leading indicators are count per active user per week, streak length, vocabulary breadth, reach per 100 employees, and participation rate. They move in days. The lagging indicators that may sit on the same dashboard, if the organisation already collects them for other reasons, are unplanned absence, regretted attrition, and EAP utilisation rate. Those lagging numbers must not be linked back to an individual's rep history. They are organisational outcomes. They are not a grade for a person's inner life.

Minimum group sizes

No Indian statute sets a cell size for a wellbeing dashboard. k-anonymity, as defined by Sweeney in 2002, requires that each released record be indistinguishable from at least k – 1 others on the quasi-identifiers in play. Employee-survey vendors commonly suppress cells below five responses; some use ten. For emotional-fitness tiles the conservative design rule is $k \geq 10$ at team level. Where a manager can see the roster and apply two filters (for example gender and tenure), suppress any cell that would fall below 10. Do not release individual scores to the employer. Do not put open-text reflections

on the HR view. Ten is a policy choice, not a clause of ISO 45003. It is the choice this paper recommends because team plus gender plus tenure re-identifies quickly.

Table 3. What each metric is for

Metric	Definition	Leading or lagging	Privacy rule
Count	Completed reps in the period	Leading	Aggregate only; k ≥ 10
Streak	Consecutive days with ≥1 rep	Leading	Distribution, not named streaks
Breadth	Distinct emotion words + granularity	Leading	Team vocabulary size, not word lists tied to names
Reach	People touched by connection reps	Leading	Counts of acts, not identities of recipients
Participation	Active users ÷ eligible users	Leading	Team rate only; k ≥ 10
Absence / attrition / EAP use	Existing HR outcomes	Lagging	Never joined to an individual's rep file

05 The dashboard specification

Every tile below can be built from event logs of completed practices. None of them requires a symptom item. The data source is the coaching platform. The employer sees the tile. The employer does not see the underlying utterance, the emotion word attached to a person, or any message content.

Table 4. Tiles, definitions, sources, privacy rules

Tile	Definition	Data source	Privacy rule
Participation rate	Share of eligible employees with ≥1 rep in the last 7 days	Platform event log	Team and above; suppress n < 10
Reps per active user	Mean completed reps among actives, last 7 days	Event log	No individual column on the HR view
Median streak	Median consecutive active days among actives	Event log	Show the median and the share with streak ≥3; never a named list
Vocabulary breadth	Mean distinct emotion words per active user, last 28 days	Name-it events, aggregated	No raw word-by-person table
Granularity index	Share of named emotions that are more specific than a six-word core list	Name-it events, aggregated	Team index only
Reach per 100	Connection reps that named or messaged another person, per 100 eligible	Thank-you and firecracker events	Count of acts; recipient identity never on the HR view
Language coverage	Share of active users practising in a scheduled Indian language	Locale of the session	Fine; not sensitive

Tile	Definition	Data source	Privacy rule
Coach hand-off rate	Share of actives who opened a human-coach path in 28 days	Hand-off events	Rate only; no reason codes on the HR view
Team heat on participation	Participation rate by team, last 7 days	Event log × org tree	k ≥ 10; no drill-through to a person
Leading–lagging strip	Participation and reps beside absence and regretted attrition	Platform + HRIS, organisational grain	Joined only at unit grain ≥ 50, never at person grain

Two tiles that must not appear: a team "risk score" derived from symptom items, and any distribution of questionnaire totals. Those tiles re-introduce the false-positive list from section 3 and the data class the employer should not hold.

WhatsApp-first delivery does not change the specification. The channel is how the rep is prompted and logged. The dashboard still sees only the event. Message text stays on the employee's device or in the platform's India-resident store under the employee's control. It does not land in the HR data warehouse.

06 Measurement — a dashboard that holds no clinical data

What the employer sees

The employer sees participation, volume, regularity, vocabulary breadth, reach and hand-off rate, at team grain and above, after the k ≥ 10 rule. The employer may see those leading indicators next to lagging operational numbers it already holds: unplanned absence, regretted attrition, EAP utilisation. The join happens at organisational grain, not at person grain. The employer sees language coverage, because a 23-language product that is only used in English is a design failure, not a health finding.

What the employer never sees

The employer never sees an individual's emotion words, journal text, coach-chat transcript, questionnaire total, cut-off flag, or any field that could be read as a health-condition label. The employer never sees who thanked whom. The employer never sees a ranked list of "most distressed" people. The platform may use those signals inside a coaching relationship, with the employee as the data principal. That is a different processing purpose. It is not an HR report.

This split is how the organisation measures employee mental health without surveys in the clinical sense. The phrase is easy to abuse. Here it means: do not put a validated clinical questionnaire on the HR dashboard; do put countable practice on it. The first creates liability. The second creates a number a people-analytics team can defend.

ISO 45003 metrics without a screen

ISO 45003:2021 is a guideline for managing psychosocial risk inside an ISO 45001 occupational-health-and-safety system. It is not itself a certifiable requirements standard. What it does ask, in the performance-evaluation clause, is a systematic approach to monitoring and measurement; data on activities related to psychological health and safety; recognition that personal information is confidential; and key performance indicators that include leading and lagging measures. A rep-metrics dashboard is an activity measure. It is leading. It can be collected without storing a health record. That is the fit.

What ISO 45003 does not ask is a company-wide screen. Organisations that add one often believe they are being thorough. They are importing a clinical instrument into a management system that was written to manage work factors — workload, control, support, role, relationships, change — not to classify staff. The work factors remain the organisation's job. The questionnaire does not do that job.

07 Implementation — a 90-day plan

The plan below assumes a single legal entity in India, an existing EAP or coach path for people who want one, and a CHRO who will sign the no-screener rule before the first tile is switched on. Owners are roles, not vendors: when a tile goes wrong, the people-analytics lead answers, not the vendor's account manager.

Table 5. Ninety days

Week	Owner	Action	Metric
1–2	CHRO and legal	Write the no-screener rule. Record the processing purpose: coaching practice, not health classification. Confirm India-resident storage and the DPDP notice.	Signed policy note
3–4	People analytics	Agree the tile set in Table 4. Set k ≥ 10. Map the org tree. Name the two or three lagging indicators that may sit beside the tiles.	Tile dictionary signed
5–6	IT and vendor	Stand up WhatsApp-first prompts in the pilot languages. Sign the data-processing terms. Test that no symptom field can be exported to the HRIS.	Export test: zero clinical fields
7–8	Comms and HRBPs	Invite two or three functions. Opt-in. Explain that the dashboard counts practice, not distress. Point to Tele-MANAS 14416 and to the existing EAP.	Invite reach ≥ 80% of pilot headcount
9–10	Pilot group	Run the reps. HRBPs look only at team tiles that clear k ≥ 10.	Weekly participation; reps per active user
11–12	People analytics and CHRO	Review leading indicators. Check suppression. Compare, at unit grain only, with absence and EAP use. Decide whether to scale.	Pilot memo; go / no-go
13	CHRO	If go: extend language cover, publish the dashboard charter, schedule a 180-day review.	Charter published

The week-5 export test is the load-bearing control. An IT engineer runs a trial export to the HRIS and opens the file. If a symptom field, a cut-off flag or a free-text reflection can be pulled through, the project has failed, however healthy participation looks. Rebuild the interface before inviting anyone else.

08 One-page checklist the reader can run this week

- Write one sentence: this organisation will not place a clinical questionnaire on an HR dashboard. Date it. Put it on the people-analytics charter.
- List every wellbeing number currently shown to managers. Mark each as leading or lagging, and as practice or pathology. Remove any pathology tile.
- Confirm with legal whether any vendor file contains questionnaire totals against employee identifiers. If yes, stop the feed and record the purpose limitation.
- Set the cell-size rule at $k \geq 10$ for team tiles. Test it on the smallest team in the pilot.
- Name the four rep metrics you will accept: count, streak, breadth, reach. Do not add a fifth that is a score.
- Name the lagging indicators you already hold and will view only at unit grain: absence, regretted attrition, EAP use.
- Draft the DPDP notice in plain language: what is counted, what is never shown to the employer, how to withdraw.
- Put Tele-MANAS 14416 and the EAP number in every launch note. A coaching dashboard is not a crisis path.
- Run the export test: can a cut-off flag leave the platform? If it can, do not launch.
- Book the 90-day review before the pilot starts. Without a date, the dashboard turns into a Monday league table of teams.

09 FAQ

Q1 Can we put a depression questionnaire on the HR dashboard if we only show team averages?

No. At a 5 per cent prevalence the instrument's positive predictive value is 24 per cent. Averaging false positives does not make them true. It also keeps a health-adjacent field in the pipeline. Count completed practices instead. A team average of reps is a number. A team average of cut-off flags is still a screen.

Q2 What number should I take to the board this quarter?

Participation rate and reps per active user, at company grain, with the k ≥ 10 rule applied underneath. Add reach per 100 if connection practices are live. Do not take a prevalence estimate derived from a help-seeker sample. The 1to1help under-35 figure of more than 90 per cent describes people who already asked for help, not your payroll.

Q3 How small can a team be before we hide the tile?

Hide any tile built on fewer than 10 people. Employee-survey vendors often use 5. Ten is the conservative rule for emotional-fitness data because team, gender and tenure together re-identify. If two filters would drop a cell below 10, suppress the cell. Do not make the manager guess.

Q4 Does this replace our employee-assistance programme?

No. Rep metrics measure practice across the workforce. An assistance programme serves the people who ask for a conversation. In the 2024 1to1help file, mental-health concerns were 15 per cent of counselling sessions. Keep the programme. Do not turn it into a company-wide screen. The two systems should not share individual files.

Q5 **What does ISO 45003 actually require us to put on a dashboard?**

It is a guideline, not a certifiable standard. Clause 9.1 asks for monitoring of psychosocial-risk activities, confidentiality of personal information, and leading as well as lagging indicators. It does not ask for a clinical cut-off. Four leading tiles — count, streak, breadth, reach — plus participation meet the brief without creating a health record.

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HOW TO CITE

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NOTE

EmotionApp is a non-clinical emotional-fitness coaching platform. This paper describes practices, techniques and coaching. It is not therapy, treatment, diagnosis or medical advice.

SAFETY NOTE

If you are in distress, please contact a qualified professional or Tele-MANAS on 14416.