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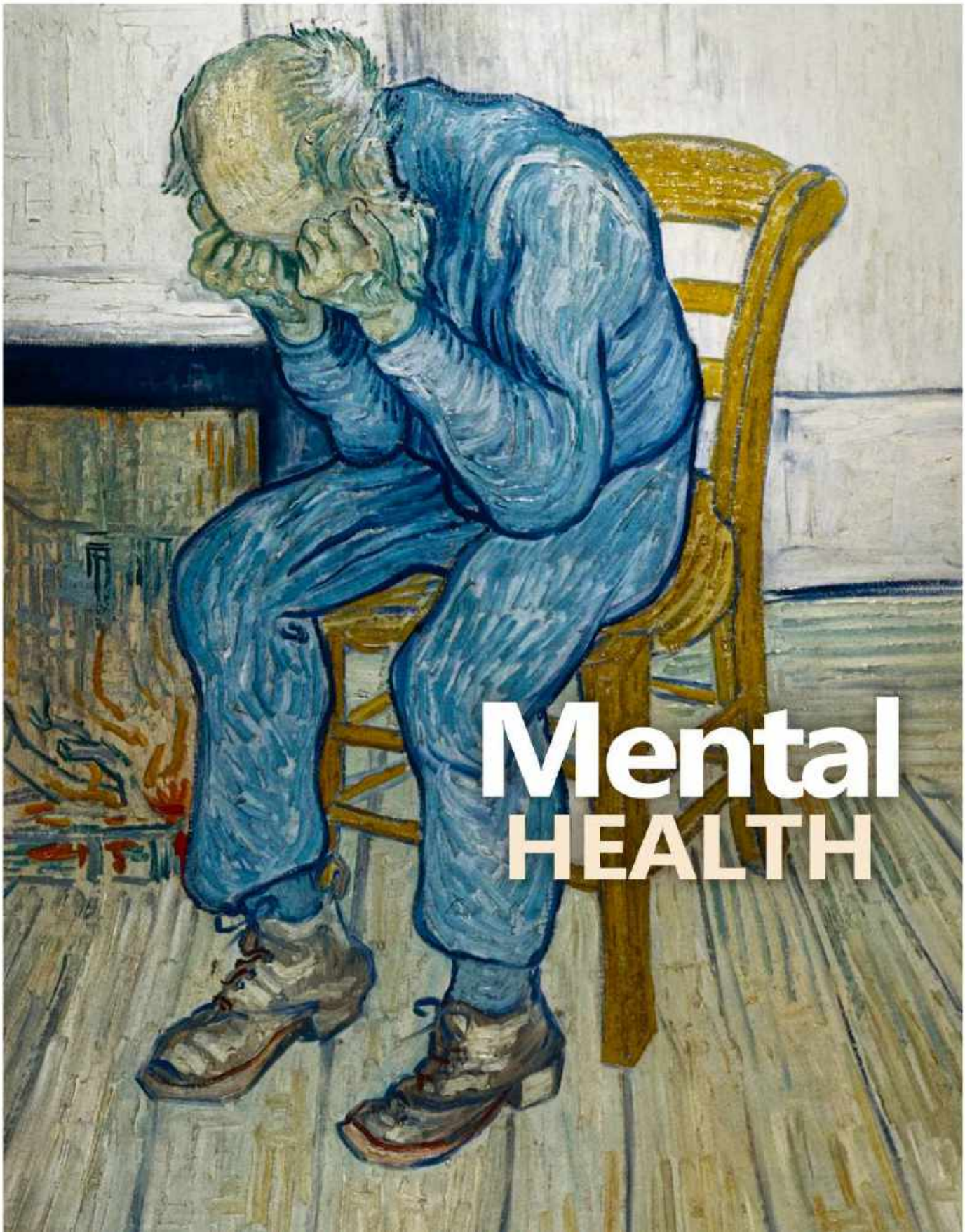
A Quest for Peace and Reconciliation



Mental HEALTH

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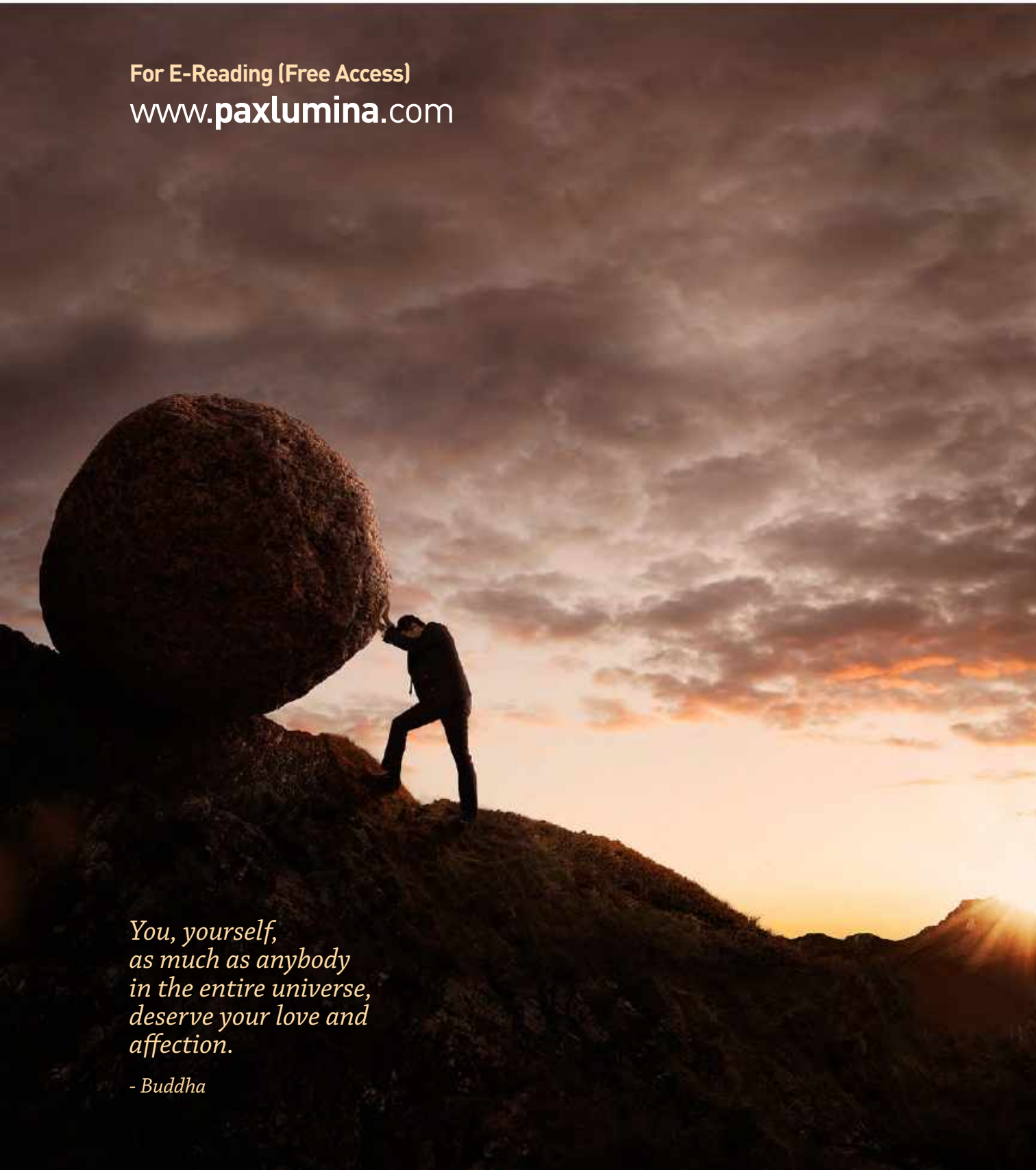

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You, yourself,
as much as anybody
in the entire universe,
deserve your love and
affection.

- Buddha

Vol. **3** | No. **6** | November 2022

Pax Lumina

A Quest for Peace and Reconciliation

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The Nodal Platform for Peace and Reconciliation Network of JCSA aims at fostering peace with a multi-pronged approach.

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Old Man in Sorrow (On the Threshold of Eternity) is emblematic of Vincent Van Gogh's suffering in his final months in Auvers-sur-Oise.

Contents

Vol. **3** | No. **6** | November 2022

Pax Lumina

A Quest for Peace and Reconciliation

What is MADNESS?

Editorial

What health means is not clearly understood. This is evident from the way different societies, cultures, and even individuals look at it and deal with it. And, when an additional and mostly ill-understood, and even misunderstood variable, namely the mind comes in, the matter becomes vague with serious consequences for society and the individual. In this issue of Pax Lumina, this is clearly illustrated by our writers from different countries and cultures. Also, the thinking on this subject varies substantially, amongst different intellectuals. Take the case of the modern French philosopher Michel Foucault. He held the view that rationality itself is a construct created by society to exclude, and even do away with those who think and act differently from the rest of the population, that is, those who question the dominant rationality and its mores. His famous book, 'The history of madness' explores and elucidates this thinking historically. The situation has improved somewhat, we can say, from the days of 'chaining the mad,' but the field of mental health is still clouded by superstition, ignorance, and most importantly, lack of empathy.

It is true that, as of now, institutionalisation is the only solution available for patients resorting to violent and aberrant behaviour, leading to injury to oneself and others. But here again, the lack of adequate infrastructure, trained personnel, and medical support essentially due to the absence of sufficient support from the government and other non-governmental agencies create problems. What is lacking is the empathetic involvement of the rest of society in understanding and accepting the difficulties faced by our fellow human beings. If societies can move positively in this direction, institution-centric treatment of the mentally challenged can be replaced by a family and community-centric approach. I think this is what Foucault had in mind when he painted the grim picture of the 'alienation of the mad' in his book.

But the problem is much more complex than the issue of the visibly mentally-challenged as our contributors clearly demonstrate. When, in this issue, one reads the story of the struggles of the Philippines-born Jesuit priest for

understanding and acceptance, a question arises: Aren't the stereotypes, cultural, racial, and biases based on a host of other irrationalities which have serious behavioural, social, institutional, and political consequences, forms of serious mental illness, an invisible lunacy which only compassion and tolerance can deal with?

In the last few years, an exacerbation of mental health situations has taken place globally because of the Covid pandemic. This has especially affected the young all over the world leading to depression, and, in some cases, suicide. Our authors have feelingly talked about this. I invite our readers for a compassionate reading of these experiential accounts so that these thoughts and feelings can be shared with those around us.

In the 'Art for Peace' column, post-card as a means of art communication is discussed. The great Dutch painter, Vincent Van Gogh, was a practitioner of this art form. Some of his postcards provide windows to his world of great art. Remember, Van Gogh was in an asylum when he did his great paintings. One look at his paintings (or even pictures of them) will convince anyone that he was a genius. But was he mad? No sane person can ask such a preposterous question.

I'm not suggesting all mentally challenged people are geniuses. All I say is that most of us jump to judgments very easily especially if these relate to others and their behaviour. So, let us try to go a little slow in this matter.

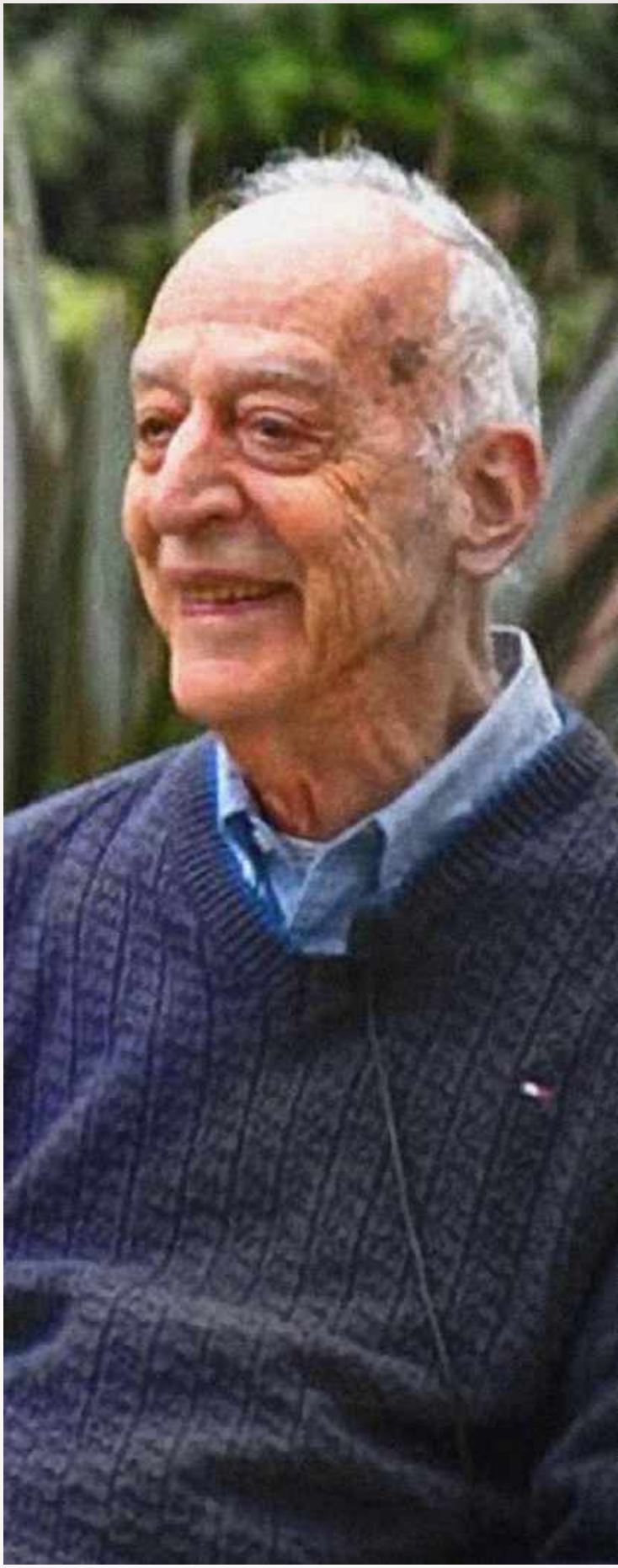
The lines of the great Russian poet, Yevgeny Yevtushenko (1933-2017), come up in my memory:

No people are uninteresting.
Their fate is like the chronicle of planets.
...and planet is dissimilar from planet.

Jacob Thomas

REMEMBERING **CARLOS EDUARDO VASCO URIBE** (1937-2022)

Pax Lumina 3(6) / 2022 / 08-09



Pax Lumina offers tribute to Carlos E. Vasco, a member of its Advisory Board, an eminent mathematician, scientist, philosopher, logician, and above all, a great well-wisher of the Peace and Reconciliation Network. We lost a great scholar, friend and guide when he passed away on 28 September 2022.

Carlos was born in Medellín, Colombia, on 12 October 1937. He had his primary and secondary education in Medellín, where he received the Bachelor's degree from Colegio de San Ignacio in1954. He completed his professional studies in humanities and philosophy at the Javeriana University in Bogotá, and his postgraduate studies in physics and mathematics at the University of Saint Louis in the State of Missouri, USA, where he obtained a Ph.D. (mathematics) in 1968.

He travelled to Germany to study theology, and was ordained a priest of the Society of Jesus in 1971. Upon his return to Colombia, he continued as a lay-scholar and devoted himself to research in mathematics and logic.

He was a professor at the Faculty of Sciences and the Department of Mathematics and Statistics of the National University from 1972 until his retirement as Professor Emeritus in 1995. He was also a professor in the Department of Mathematics at the Pontificia Universidad Javeriana, till 2006. Carlos was a special Professor of the Master's Program in Education of the Agreement CINDE-*Universidad Pedagógica de Bogotá-Universidad Nova de Fort Lauderdale* (Florida, USA) from 1977 to 1995.

He held several important positions in the field of educational administration. He was the Director of Department of Mathematics at the Pontificia Universidad Javeriana; Advisor to the Colombian Institute of Pedagogy ICOLPE; Member of the College Entrance Examination Board-CEEB of Princeton, New Jersey; Member of the ICFES Mathematics Working Group and the Coordinator of the COLCIENCIAS Research Group on the Social History of Science in Colombia.

The National University of Colombia commissioned him as an Adviser to the Ministry of National Education for the preparation of the curricular programs of mathematics for Basic, Primary, and Secondary Education. He was Coordinating Commissioner of the Mission of Science, Education and Development, appointed by President César Gaviria Trujillo to design a navigation chart for the country, together with nine other scholars. He was also part of the commission appointed by the Minister of Education Cecilia María Vélez to encourage the process of creating the Second Ten-Year Education Plan 2006-2015.

Carlos was a lecturer, special guest, and visiting professor at countless international events in Universities in Colombia and abroad. In 2020, he delivered the convocation lecture during the valedictory session of CPJ-XLRI-LIPI Peace Studies Programme. He was a member of the Clavius Group of Mathematicians in the USA, named after the renowned Jesuit astronomer Christopher Clavius, for more than five decades. Being part of it, personally, I had the privilege of engaging in friendly and academic conversations with Carlos for the past ten years.

Carlos was a recipient of several awards which include IX National Education Award in the category "Exaltation of a Life Dedicated to Education" (2008) and the "Simón Bolívar" Award in the category "Orden Gran Maestro" of the Ministry of National Education of Colombia (2008) are a few among them. He has written or edited approximately thirty books and more than 100 articles on topics related to mathematics, logic, the history of mathematics, philosophy, the pedagogy and the didactics of mathematics in national and international scientific journals. Pax Lumina gratefully remembers his contribution to its May 2022 issue on "A Peace Manifesto on the US-EU-NATO Policy on the Ukrainian War."

Pax Lumina pays homage to this distiguished scholar and friend of the Peace and Reconcilation Network.

- Binoy Jacob, Pax Lunina

(Refer: https://accefyn.org.co/cv-carlos-eduardo-vasco-uribe/)

Christine Anyango
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Pax Lumina 3(6) / 2022 / 10-13

MENTAL HEALTH in AFRICA

Mental health is a more sensitive topic to me today than it was more than seven years ago. I had often heard of mental health but I never understood it in the sense that I do today.

This takes me to 2017. A close relative had an experience that took the entire family off balance. This was all so strange to us and at that moment we thought it could be anything else other than a mental health issue.

She was diagnosed with what the doctor referred to as bipolar disorder. In the days leading to the event, her hyperactive actions were considered to be anything but a mental health issue. This was the first time I heard of bipolar disorder. I realised mental illness is real. I also realised many people have no idea of what mental illness is and how to handle those suffering from it in its various forms and capacities.

Mental health is critical to every human person. It is important to be keen on our mental health as well as that of those around us. Caring for your mental health is important in avoiding or reducing mental illness and its effects.

In this article, I wish to take the discussion of mental health from an African perspective. I will discuss the cultural perspectives in understanding mental health and also more importantly, the gaps within the health systems in Africa in response to mental health issues.

According to the World Health Organisation (WHO), there is what is considered positive mental health. This means mental health can be negative. WHO defines mental health as 'a state of well-being in which an individual realises his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and can make a contribution to his/her community'.

Mental illness, on the other hand, is often characterised by abnormalities in thinking, feelings and behaviours. Mental health is conceptualised differently by different societies especially in discussing its nature as well as the causes and interventions that should be associated with it. Mental health has been considered to contribute to 14 percent of the global burden of disease. About 75 percent of those affected come from low-income countries.

Studies conducted in different African countries indicate that mental illness is often considered a taboo subject. This has often resulted in victims, caregivers or family members being stigmatised in their societies. This is because mental illness is often viewed as not culturally acceptable.

This kind of stigma has been linked to a lack of education, fear, religion, misconceived reasoning as well as general prejudice. Most people in the African context attribute mental illness to drug misuse, divine wrath and the will of God. Some have also seen mental illness as witchcraft or some form of spiritual possession.

Studies conducted in different African countries indicate that mental illness is often considered a taboo subject. This has often resulted in victims, caregivers or family members being stigmatised in their societies. **This is because mental illness is often viewed as not culturally acceptable.**

People do not put much consideration on genetics, family relationships or socio-economic triggers as being possible causes of mental health issues. Yet, this stands out to be a leading cause.

There has also been a breakdown of the traditional family structure and values. This has contributed to poor mental health among the different groups in African societies. Poverty is seen as a leading cause of mental illness. People in such situations are at increased vulnerability to being affected.

It is associated with difficult socio-economic conditions that tend to aggravate isolation and loneliness and the likelihood of depression. Rates of mental disorders have also been increasingly linked to wars and conflict situations. This is due to the impact such kinds of disasters have on the mental health and well-being of the people.

WHO estimates that a majority of refugees, because of the impact of the war and displacement from their homes, tend to have mental health problems. It ranges from post-traumatic stress to chronic mental illnesses.

Additionally, other natural disasters like death, chronic diseases, floods, drought and other epidemics have affected the mental health of people across African countries.

The stigma associated with mental health is seen in households with mentally ill persons. They keep such persons hidden, to escape the discrimination that can come if it is known. When it comes to marriage, girls who come from families where a member has a mental illness, become disadvantaged. This reduces their marriage prospects.

The consequence is the silence that is associated with mental illness. This, in turn, fails to nurture good mental health as a whole and the psychosocial well-being of the people. In addition to stigma, care of those with mental illness may cause financial pressures. In many countries across Africa, access to efficient critical care can sometimes become hard to come by.

There is a need to prioritise mental health to reduce the adverse effects of mental illness that may develop over time. Most developing countries are said to allocate less than two percent of government health budgets to mental healthcare.

n addition to stigma, care of those with mental illness may cause financial pressures. **In many countries across Africa, access to efficient critical care can sometimes become hard to come by.**

Mental health remains one of the most under-researched areas in public health in Africa. While mental health is attracting rising concern globally, in Africa, this is still weak. There are inefficient mental health policies set in place. This weakens the measures put in place to address it.

Mental health remains one of the most under-researched areas in public health in Africa. While mental health is attracting rising concern globally, in Africa, this is still weak. There are inefficient mental health policies set in place. This weakens the measures put in place to address it.

Recent research indicates that almost half of the African countries do not have an approved or updated mental health policy. Thus, they are not effectively able to assist the growing population with mental health problems.

The global recommendation is about the need to incorporate mental health as part of primary care settings. This is done by having it incorporated into basic primary medical care. There can be incentives to provide screening, assessment as well as treatment related to mental health.

Additionally, this would ensure the right treatment for those affected by mental illness and improve the care that is already being provided. There is also a lack of adequate national-level efforts as well as technology investments to address mental health and its impacts.

A lot of funds are allocated to check communicable diseases like HIV/AIDS, malaria and tuberculosis, among others. In conclusion, mental health is getting attention in the African space, but a lot more still needs to be done to bridge existing gaps.

Christine Anyango is Secretary at Hekima University College, A Constituent College of the Catholic University of Eastern Africa

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Pax Lumina 3(6) / 2022 / 14-17

SUPERSTITION and MENTAL HEALTH in AFRICA

n Africa, superstition still holds sway in the majority of the cultures and investment in modern medicine is still low. **Nevertheless, mental health awareness campaigns are on the rise.**

Superstition is a belief or practice resulting from ignorance, fear of the unknown, trust in magic or chance, or a false conception of causation. It is a notion maintained despite evidence to the contrary. Superstition has been with humanity since the days of the antecedents and so has been mental health challenges and illnesses.

Before the emergence of science and modern civilisation, superstition was a reference point in many cultures. It is the lens through which people choose to view events and developments, especially those which they do not have an understanding about.

Superstition has informed mental health perception and practices for a very long time. As such, it is not uncommon to hear phrases among some communities in Kenya such as, 'amerogwa', 'huyo ameharibiwa', or 'huyo amepagawa' to connote someone who has been subjected to witchcraft or demons to alter his/her normal mental functioning.

In Africa, superstition still holds sway in the majority of the cultures and investment in modern medicine is still low. Nevertheless, mental health awareness campaigns are on the rise. However, it is still unclear whether there are changing patterns of mental health perception and management as more sensitisation and information on evidence-based modern management methods become increasingly available to the population.

This paper explores the question: Are African people significantly abandoning their superstitions on mental health for evidence-based scientific treatment?

To explore this question, we first make reference to the assertion by Kwakye (2019) that cultural practices and traditional beliefs are an integral part of the African identity. Most of these practices are transgenerational, and preserved for different reasons among African tribes.

He further observes that the traditional African leadership hierarchy is complex. Attempting to change this is not only a near-impossible task, but may do far more harm than good. While this may be true in certain aspects, it is worth noting that colonisation and subsequently globalisation have significantly erased a lot of cultural aspects and superstition. Indeed, some of the traditional beliefs and superstitions are just shells of their former self.

In spite of these developments, the majority of Africans still subscribe to the dual worldview: the material and the spiritual. They believe the spiritual supersedes the material in all aspects (Claeys, 2016). Therefore, it is likely that superstition will still be part and parcel of the African cultural mind-set, and substantially inform how he/she views and interprets the world including mental health challenges.

People in Africa have always linked mental health challenges with events in the victim's life. For example, something the person or their family member(s) did, like a heinous crime or going against taboo. Sometimes, it is linked with spells cast by witches on persons for one reason or the other. Therefore, in most cultures, people with mental health illnesses were referred to traditional healers or witch doctors to undo the hex.

The practices still ensue today, albeit to a limited extent. Claeys (2016), for example, observed that in Ghana, there are cases in which the healer or witch doctor cannot ascertain spiritual

Majority of Africans still subscribe to the dual worldview: the material and the spiritual. They believe the spiritual supersedes the material in all aspects. **Therefore, it is likely that superstition will still be part and parcel of the African cultural mind-set and substantially inform how he/she views and interprets the world including mental health challenges.**

affliction. So, the mentally-ill individual is often referred to a local clinic or hospital. In the opposite direction, doctors and clinicians actually refer patients that they deem spiritually possessed to local healers.

Modern science, with its rigour, emerged in the latter half of the last millennium and rapidly advanced in the 20th century. The development of scientific theories and experimentation aided our understanding of phenomena including the biomedical characteristics of mental illnesses.

This knowledge has since been diffused all over the world and cutting across several cultures globally. However, the adoption rates of scientific methods in mental health management differ globally across different contexts. Modern medicine has increased over the decades in the continent. But the mental health component has not advanced in tandem with other medical practices.

There are fewer than two mental health workers per 100,000 people in the African Region, compared to a global average of 13 (Moeti, 2021). Even in countries considered developed such as South Africa, access to mental healthcare is still much lower than the set standards.

There are an estimated 1.52 psychiatrists per 100000 population (Moodley et al, 2022). Around 75 percent of South Africans living with mental health disorders have no access to mental health services (Lund et al., 2012). In Nigeria where 40-60 million people are estimated to be mentally ill, fewer than 10 percent have access to a psychiatrist or health worker, because there are only 130 psychiatrists in the country of 174 million people (WHO, 2018).

In Sierra Leone, it is estimated that 98 percent of people lack access to mental healthcare (Yoder et al., 2016). Access to mental healthcare in Kenya, like the rest of the continent, is also low. The country spends only about 0.05 percent of its health budget on mental health. There are only 80 psychiatrists and 30 clinical psychologists. This is much less than its 500 psychiatric nurses, with half the number working in mental health facilities (WHO, 2018).

The inability to access proper evidence-based mental health services means that for the majority of the population, traditional and faith healers still remain the only available option. As such, people will, of necessity, revert to the age-old mental health management practices informed by superstition rather than scientific evidence. Interestingly, however, there seems to be support for the symbiotic relationship between scientific mental health management practices and traditional methods in some instances in the continent as indicated by Claeys (2016).

Kwakye (2019) also seems to advocate for this fusion of traditional and evidence-based beliefs in his recommendations for breaking the cultural barrier to mental health treatment in the continent.

Conclusion

Currently, there are signs the times are changing. Unlike in the past, an increasing number of people in the continent are beginning to acknowledge

depression as a mental health disorder, though not necessarily as a disease.

They are beginning to seek evidence-based scientific treatment. In fact, according to a newspaper columnist in Kenya, depression is not regarded as a disease in African culture to the extent that, "no one has ever bothered to create a word for it."

This however, does not rule out spiritual interventions. Scores of patients now recognise the power of rehabilitation centres for their treatment and that of their relatives who have been diagnosed with substance abuse disorders.

However, superstitions about mental health still persist. Mental illnesses, like schizophrenia, are least understood. So, the people are stigmatised.

At the same time, those seeking bio-medical interventions will be encouraged to supplement the interventions with some cultural practices and taboos. But with more advocacy and increased healthcare spending on mental health, we may turn the curve on mental health illnesses and see a decrease in chaining 'mad' individuals as exorcism is carried out on them across the continent.

Stigmatisation and trivialisation of mental health disorders may also decrease as people embrace evidence-based mental health services in the continent, but a lot of sensitisation still needs to be done.

There are, however, those Kenyans who have come to understand mental illness and as such have embraced treatment services with even some insurance companies covering mental disorders in their medical schemes. The Kenya government has, in the last couple of years, made mental illness a part of its healthcare agenda, and this has helped to create awareness.

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Pax Lumina 3(6) / 2022 / 18-22

PROTECTIVE FACTORS for YOUTH in FAMILIES IMPACTED by INCARCERATION

While many studies have examined the negative impact and associations with paternal incarceration, **very few studies have investigated factors contributing to positive adjustment for children of fathers with a recent history of incarceration.**

Almost 1.5 million children in the United States have at least one parent in prison. Fathers are incarcerated at more than 11 times the rate of mothers. The incarceration of fathers, who are disproportionately Black and Latino, is associated with increased strain on the mothers.

They are often the sole breadwinners and primary caregivers for their children. It is also associated with poorer adjustment outcomes for their children, compared to the youth who have never had an incarcerated parent. While many studies have examined the negative impact and associations with paternal incarceration, very few studies have investigated factors contributing to positive adjustment for children of fathers with a recent history of incarceration.

A study conducted by the authors used data from the sixth wave of the Fragile Families and Child Wellbeing Study (3,146 participants) to examine the impact of recent (within the past five years) paternal incarceration on positive adolescent adjustment, measured by the Engagement, Perseverance, Optimism, Connectedness, and Happiness (EPOCH) scale.

The authors' study also examined the role of maternal parenting stress as a mechanism for change between recent paternal incarceration and adolescent adjustment. They found that mothers in families with a recently incarcerated father who was more stressed in their parenting role were more likely to have adolescent children with lower levels of positive adjustment. The study further looked at mother-adolescent closeness as a potential buffer against the negative effects of paternal incarceration.

The primary takeaway from this study is the verification that higher levels of maternal parenting stress are associated with lower levels of positive adolescent adjustment, and maternal parenting stress is a means through which recent paternal incarceration may impact youth adjustment.

A second key finding is that adolescents who report higher levels of closeness to their mother also have higher levels of positive adjustment, meaning that their closeness to their mother is an important counter-experience to adversity in their lives, including paternal incarceration. These results indicated partial support for the initial hypotheses, and are associated with clinical implications and policy recommendations, particularly related to interventions with families who have been impacted by incarceration.

What we can learn from these findings is that maternal parenting stress and a close mother-adolescent relationship are key targets for clinical and community intervention among families experiencing systematic oppression in the form of material hardship and paternal incarceration.

Given that recently incarcerated fathers in the study were largely non-residential, the results likely say less about paternal incarceration as a specific stressor within families or as a predictor of adolescent well-being than they do about the importance of parenting stress and the salience of supportive relationships with the family.

What we can learn from these findings is that maternal parenting stress and a close mother-adolescent relationship are key targets for clinical and community intervention among families experiencing systematic oppression in the form of material hardship and paternal incarceration.

These findings support what we know from scientific literature related to attachment and child well-being: that children with a secure attachment to their parental figures are more likely to experience healthy psychosocial adjustment, both in general and in the context of specific stressors, such as recent paternal incarceration.

For families impacted by recent paternal incarceration, the current findings suggest that although providing psychotherapy services to adolescents might be beneficial, it may be more important to provide support for their mothers. The study's results also indicate that interventions that help mothers manage their level of stress in their parenting role may help foster adolescent adjustment in the face of adversity.

Practically, these interventions could include clinicians prioritising parent-only sessions with mothers to help them navigate their stress levels while having parallel sessions with their children, offering support groups in community settings for mothers with incarcerated partners so that they may feel less alone in their parenting stress, and providing parenting psychoeducation sessions for mothers struggling to remain close to their children while simultaneously managing other stressors.

Many of the risk factors that contribute to paternal incarceration overlap with the factors that impact maternal parenting stress and positive adolescent adjustment. As such, clinicians ought to work collaboratively with other providers and systems involved in these families' lives, including social services, case managers, schools, and medical or other healthcare providers, to educate them on the cumulative risk and trauma experienced in these communities, and collaborate on partnering with the family to address their concerns.

To alleviate some of the mothers' financial stress, policies and legislation should address providing more resources, including a stipend to supplement their income, free childcare, food security, and subsidised mental healthcare.

These interventions will increase mothers' bandwidth to spend more time with their children and create a more secure attachment to them, thereby increasing their positive adjustment. Additionally, programmes to help fathers stay connected to their children while they are incarcerated, such as letter-writing programmes, weekly fatherhood support groups, and special visitation programmes designed to foster their connection, could result in less maternal parenting stress and more positive adolescent psychosocial adjustment.

Yael Levin, M.S., is a clinical psychology doctoral candidate at Loyola University Maryland and doctoral intern at WestCoast Children's Clinic in Oakland, Calif. Her clinical and research interests focus on treating and understanding protective factors when working with youth and families who have experienced historical, intergenerational, and interpersonal trauma.

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EPOCH Scale (Adolescent Adjustment

EPOCH Subscale	Survey Item
Engagement	1. When I do an activity, I enjoy it so much that I lose track of time. 2. I get completely absorbed in what I am doing 3. I get so involved in activities that I forget about everything else. 4. When I am learning something new, I lose track of how much time has passed.
Perseverance	1. I finish whatever I begin. 2. I keep at my schoolwork until I am done with it. 3. Once I make a plan to get something done, I stick to it. 4. I am a hard worker.
Optimism	1. I am optimistic about my future. 2. In uncertain times, I expect the best. 3. I think good things are going to happen to me. 4. I believe that things will work out, no matter how difficult they seem.
Connectedness	1. When something good happens to me, I have people who like to share the good news with. 2. When I have a problem, I have someone who will be there for me. 3. There are people in my life who really care about me. 4. I have friends that I really care about.
Happiness	1. I feel happy. 2. I have a lot of fun. 3. I love life. 4. I am a cheerful person.

NB: Items were originally scored on a scale of 1-4, with 1 = "Strongly Agree," 2 = "Somewhat Agree," 3 = "Somewhat Disagree," and 4 = "Strongly Disagree." Items were reversed scored in the present study.

Aggravation in Parenting Scale (Maternal Parenting Stress)

	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
1. Being a parent is harder than I thought it would be.	1	2	3	4
2. I feel trapped in my responsibilities as a parent.	1	2	3	4
3. I find that taking care of my child(ren) is much more work than pleasure.	1	2	3	4
4. I often feel tired, worn out, or exhausted from raising a family.	1	2	3	4

NB: Items were reversed scored in the present study.

Caregiver-Child Closeness Scale (Mother-Adolescent Relationship Closeness)

	Extremely Close	Quite Close	Fairly Close	Not Very Close
How close do you feel to your mom? Would you say...	1	2	3	4

	Extremely Well	Quite Well	Fairly Well	Not Very Well
How well do you and your mom share ideas or talk about things that really matter? Would you say...	1	2	3	4

NB: Items were reversed scored in the present study.

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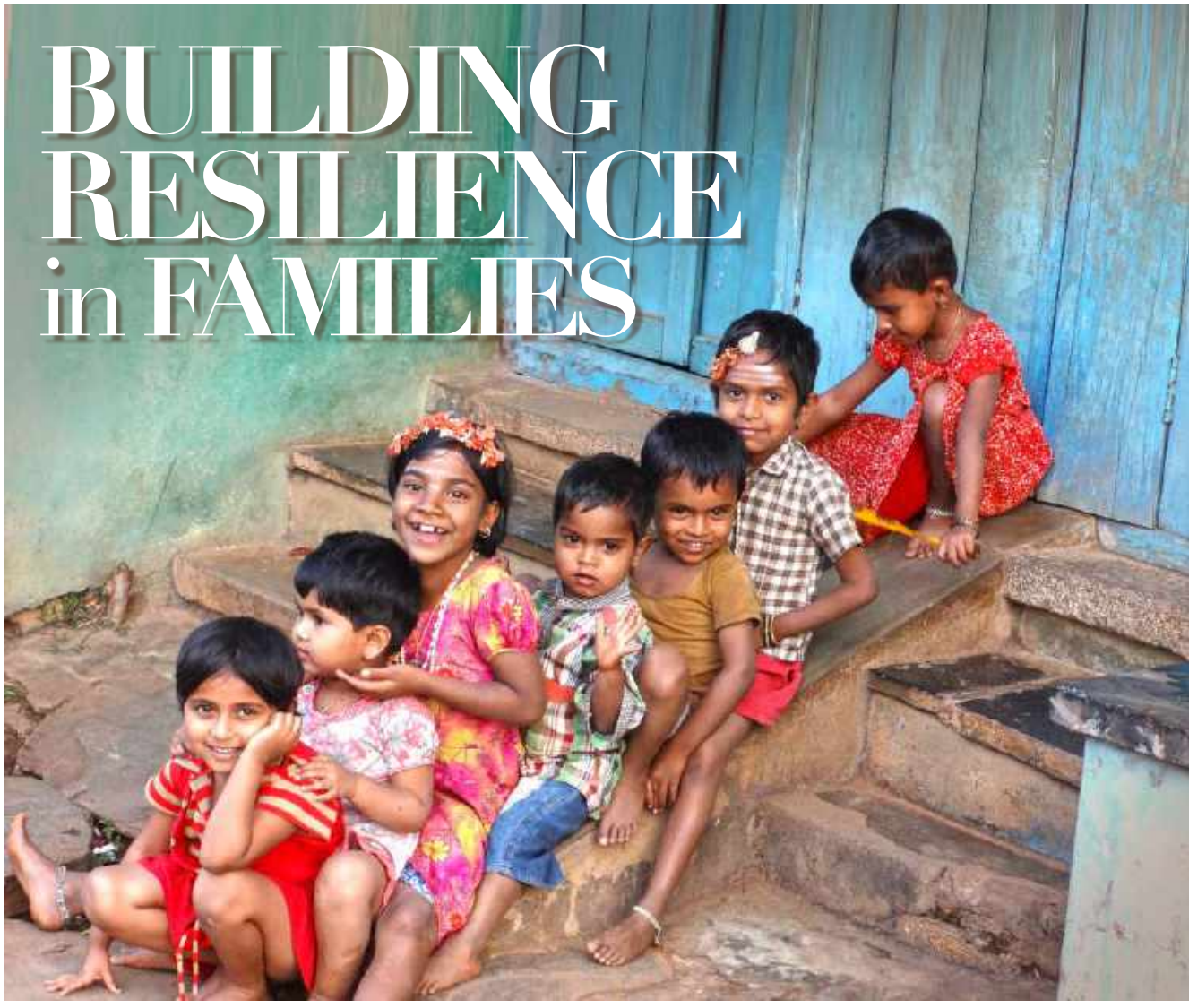
BUILDING RESILIENCE in FAMILIES



In the midst of the ongoing COVID-19 crisis across the world, it has become more apparent the dire need to publicly and institutionally recognise the impact of mental health and well-being on a society's overall functioning.

Across the world, an increased emphasis on caring for the mental well-being of oneself and others has been emphasised and prioritised in public discourse. However, institutional, structural, and societal barriers still exist across the world and negatively impact overall engagement with accessing mental health resources.

Structural racism, casteism, colourism, elitism, and economic barriers persist. It continues to impede access to mental health resources and information to the most marginalised sections. Within families, children are the most vulnerable to the negative impact of poor mental health on family units and individual members.

Despite the sizable challenges in acknowledging the impact of mental well-being on a society's ability to function and maintain engagement within the workforce during unprecedented moments of crisis, research is increasingly focusing on ways of boosting resilience within families and in societies.

Boosting resilience can be an accessible and easy way of incorporating discussions on mental well-being in societies and may also positively impact the well-being of the most marginalised and underrepresented communities.

Resilience, or the ability to thrive and succeed in the face of adversity, comprises individual, family, and community factors to combat the negative effects of poor mental functioning, cumulative stress build-up, and the impact of trauma.

Black, Indigenous groups, and other groups of colour (BIPOC individuals, including South Asians), as well as groups of a lower socio-economic status and class and those living in poverty are disproportionately impacted by the negative effects of trauma and stress. These groups rely heavily on family and community sources of support to boost resilience and promote positive mental well-being.

Boosting familial resilience can be an important way of promoting resilience in Indian families. It helps to offset the harmful impact of trauma and mental illness on family units. Notably, the family is essential to develop resilience within South Asian households and among children.

The collective family cohesion within nuclear and joint families is an important source of strength for families to cope with stressors. Specifically, the maintenance of cultural, spiritual, and communal values has been associated with increased psychosocial and health benefits for Indian families.

Familial and individual perception of risks and adversities faced by families also determines the overall resilience of the family. If a family perceives the societal and individual challenges they experience as manageable, they are likely to cope better than families who do not perceive them as manageable.

Families may assist in boosting a child's resilience by encouraging curiosity about learning, promoting reading to boost empathy, limiting screen time, **and supporting responsive and supportive relationships in a child's life. Notably, when familial cohesion is low, children are negatively impacted.**

By shifting dialogues regarding mental health from the current deficit-based model (linked to illness) to an empowering, strength-based resilience model, **Indian families could be encouraged to prioritise their mental well-being and tap into their internal family resources to combat the negative effects of stress and mental illness.**

Familial cohesion and strong caregiver-child relationships also assist in increasing resilience factors. Boosting individual members' self-esteem and encouraging autonomy within families may also help in boosting individual members' perceptions of being able to cope with adversity.

In Indian families, the familial support provided to individual members provides safety nets for exploring ideas, and feelings, and encourages communal living over prioritising individual interests alone. Additionally, for Indian children, education is an important driver of resilience. The presence of a supportive school environment and fostering of positive feelings regarding education moderate behaviour problems and low academic achievement.

Families may assist in boosting a child's resilience by encouraging curiosity about learning, promoting reading to boost empathy, limiting screen time, and supporting responsive and supportive relationships in a child's life. Notably, when familial cohesion is low, children are negatively impacted.

However, the presence of at least one supportive and responsive adult in a child's life boosts resilience by a large amount. Cultivation of curiosity about a child's interests and encouraging developmentally appropriate play are additional impactful ways of utilising familial relationships to increase a child's sense of self and boost resilience.

Additionally, reducing as many sources of stress as possible is important in creating more stability within family units to boost overall resilience. Sharing and delegating tasks to various members can help reduce sources of stress. Also, encouraging engagement with religious and spiritual practices, as well as involvement with the wider community can help support families and boost their levels of support and resilience.

Overall, although discussions of mental health within the Indian diaspora tend to focus on stigma and lack of access to mental health resources, conversations about resilience provide some hope for the future of mental health discourse in India.

There is an untapped source of strength within Indian families for combating the negative effects of poor mental health, stress, and trauma. Boosting familial resilience and encouraging appropriate socialisation and engagement within the community may provide families and children with additional and more accessible tools to boost their resilience and overall mental well-being.

By shifting dialogues regarding mental health from the current deficit-based model (linked to illness) to an empowering, strength-based resilience model, Indian families could be encouraged to prioritise their mental well-being and tap into their internal family resources to combat the negative effects of stress and mental illness.

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COMMUNICATING without HARM in COLOMBIA

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The psychological consequences of the population that has suffered armed conflict have been extensively studied. Depression, anxiety, post-traumatic stress disorder, emotional reactiveness, aggressiveness and behavioural problems are some of them. **However, an armed conflict also destroys community infrastructure, deteriorates the sense of belonging and weakens institutions.**

In 2017, Colombians witnessed an event that ten years earlier was unthinkable. The oldest guerrilla in Latin America handed in over seven thousand weapons in a village in the municipality of Mesetas, Meta.

Surrendering arms was one of the first steps for the implementation of the Peace Agreement signed between the national government and the Revolutionary Armed Forces of Colombia—People's Army guerrillas the previous year.

A large banner that read 'Our only weapon will be words' was displayed on the stage where the ceremony took place. The same message was printed on the shirts of ex-combatants, who received their national identification cards, and female ex-guerrilla members who, in the middle of the act, released hundreds of yellow butterflies.

And whilst the disarmament scenario was being flooded with butterflies, social networks were being filled with insults and messages of deep pessimism regarding this historic event.

Two days later, several polls showed that over half of their respondents believed that the peace agreements were on the wrong track. They showed that, while the weariness of war was a shared feeling by the majority, paradoxically, scepticism, despair and refusal to participate in a reconciliation process were abundant in a wide section of the population.

The psychological consequences of the population that has suffered armed conflict have been extensively studied. Depression, anxiety, post-traumatic stress disorder, emotional reactiveness, aggressiveness and behavioural problems are some of them. However, an armed conflict also destroys community infrastructure, deteriorates the sense of belonging and weakens institutions.

Therefore, rebuilding society implies going beyond individual needs. It is necessary to heal the innumerable wounds that affect mental well-being, trust, community life and the ability to come together. We have inherited from decades of armed conflict, immense difficulties in communication, reaching consensus and managing our conflicts in a peaceful and democratic manner. The dynamics of violence have exerted intangible and incalculable damage to the value of words.

A historical moment like this requires thinking of new forms of social interaction and building narratives. It allows us to unlearn and distort the language of war. Giving way to argumentative debate and democratic dialogue that is respectful of differences is not an easy task. It takes effort, creativity and commitment to begin to listen to each other, understand each other and reach a consensus. Only then, can we obtain the individual and collective well-being that has been diluted as a result of violence.

The enormous communication challenge that we have as citizens and as an interdisciplinary team is to pose this question. How to promote ways of communication that encourage national

Giving way to argumentative debate and democratic dialogue that is respectful of differences is not an easy task. It takes effort, creativity and commitment to begin to listen to each other, **understand each other and reach a consensus. Only then can we obtain the individual and collective well-being that has been diluted as a result of violence.**

reconciliation and favour the mental health of Colombians?

To answer it, multiple voices and perspectives were required. Numerous professionals in psychiatry, social communication, philosophy, anthropology, political science and psychology shared their ideas and nurtured them with those of a large group of journalists. They were experts in conflict and peace. They were joined by more than forty regional communicators who spoke about the type of communication that we should do as citizens of reconciliation.

This dialogue of knowledge, professional trajectories and life experiences was compiled into the book entitled 'Comunicarnos sin daño: Convivencia y salud mental' (Communicating without harm: coexistence and mental health).

It contains reflections and practical recommendations on how to communicate from a psychosocial perspective. It focuses on differential and developmental action without harm, in the light of communicative ethics, social responsibility and common interest.

This book is a call to understand communication as an ethical and political system and to reflect on its impact on the mental health of citizens. The success of reconciliation will depend, to a large extent, on individual and collective mental health. Hence, the fomenting of psychological, social, cultural, economic and political conditions is encouraged as well as policies that enable the integral well-being of people and society.

The analyses and reflections of this initiative, in which the Faculty of Medicine and the Faculty of Communication and Language of the *Pontificia Universidad Javeriana de Bogotá,* Colombia worked hand in hand, shed light on other aspects of life in society in which the narratives and languages inherited from the war have strong influence and become obstacles to reconciliation processes.

This is how the project addresses recommendations to communicate without harm in peace processes and reconstruction of memory, social protest situations, gender issues, migrations, public

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emergencies, and digital environments, among others.

Communicating without harm is presented as a way to heal wounds, settle divisions, promote reconciliation and improve the mental health of those who have directly or indirectly lived amongst different forms of violence. That is why this initiative has been nationally disseminated through different media, social networks and community, school, work and academic environments, to reach as many people as possible. Everyone, as citizens, is called to think about the power of information, language and words on mental health, the peaceful resolution of conflicts and reconciliation.

Each voice, each pen, each communicative piece, and each pedagogical action for harmless communication can be a true beacon in a society in need of light and motives to heal its wounds, to believe in its capacities for union and resilience and in its enormous potential to build a different country.

Communication as a daily exercise of reconciliation can open new spaces for coexistence and citizen interaction, weave trust and solidarity networks, build new images, tell untold stories, denature discriminatory speeches, renew relationships, senses and meanings, recover strength from Community of The Word, encourage the ability to understand each other, and, above all, inspire different possibilities for the future.

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MENTAL HEALTH and COVID-19

Increased online behaviour during the pandemic also may have contributed to poor mental health. Social comparison resulting from social media use, **online addiction, and exposure to online hate is known to harm mental health.**

According to the Global Burden of Disease Project, mental health issues affect more than one in ten of the world population. However, there is no scientific consensus on factors that contribute to poor mental health. Multiple factors seem causal: heredity, childhood experience, traumatic life experiences, nutrition, exercise, drug abuse, social connections, and pollution. Then, there was the deleterious effect of Covid-19 on mental health.

Covid-19 did not affect physical health alone. Studies document the effects of the pandemic on mental health. There has been an overall decrease in the psychological well-being of the population. A large number of people experienced psychological distress and loneliness. There has been an increase in the cases of depression, anxiety, substance abuse, eating disorders, sleeping problems, post-traumatic stress, obsessive-compulsive disorder, suicidal ideation and deliberate self-harm. Indeed, instances of severe depression and anxiety were twice as high during the pandemic as they were before.

Various factors in the pandemic may have contributed to deteriorating mental health – uncertainty, crises, tragedies, social isolation, and family conflicts. During the first phase, uncertainty was high. Hospitals were overcrowded, and oxygen cylinders were unavailable. The media spoke of the pandemic all day and telecasted visuals of infected people gasping for breath and worn-out health workers.

Crises and tragedies struck individuals and families. The death of near and dear ones, the fear of being infected and infecting vulnerable relatives, job loss, financial crisis, bankruptcy from paying hospital bills, and worries about the future of the economy.

There was social isolation in the form of lockdowns, physical distancing, travel restrictions, closure of schools and colleges, and lack of access to social support services, in addition to an overall sedentary behaviour pattern. All this led to acute loneliness. Family conflicts increased as the changed working conditions such as working from home resulted in increased parental stress and the shelter-at-home order led to exhausting interactions with family members.

Increased online behaviour during the pandemic also may have contributed to poor mental health. Social comparison resulting from social media use, online addiction, and exposure to online hate is known to harm mental health.

People increasingly relied on social media to overcome social isolation from the pandemic. However, excessive use of social media can lead to social comparison — feeling oneself as inferior in comparison to others perceived as possessing desirable traits and having a better life. Among adolescents and young adults, social comparison often leads to weight stigmatising and body dissatisfaction.

Online addiction (such as gaming addiction), in addition to leading to a neglect of important things in life, has serious mental health consequences. Research shows that the more time people spend in virtual environments, the more depressed or anxious they become.

Though people seek out human connections, social media consists of hate messages directed

at individuals and groups. Surveys show that 42 percent to 67 percent of social media users see hate messages online and 21 percent have been the target of online hate (cyberbullying).

Perpetrators target any characteristic for cyberbullying — race, ethnicity, sex, religion, gender, sexual orientation, immigrant status, and political affiliation. Online hate appears as incriminating write-ups, abusive or insulting comments, altered images, trolls, posting recorded private conversations, and revenge porn.

Online hate, both seeing and being a victim, has negative consequences for mental health. Online hate can cause depression, social anxiety, self-doubt, lack of confidence, disappointment, and loneliness.

Mental health issues affected everyone, but the impact was more among adolescents and youth in the age group of around 12-25. During the pandemic, adolescents and youth were socially isolated and lonely. They lost important life moments and age-specific celebrations. These pandemic-specific lifestyle changes led to a deprivation of interrelationships and sociality.

Adolescents and youth require a complex network of social relations for their healthy development. They need to form interlinks of communication and interaction with parents, relatives, teachers, other adults, classmates, and other peers of their age. Overall, for adolescents and youth, the pandemic altered their rhythm of life, led to major lifestyle changes, and deprived them of social connections crucial for their formation. These changes augmented the impact of the pandemic on the mental health of adolescents and young adults.

Active mental health promotion and intervention programmes should be implemented to counter the negative impact of the pandemic. Perhaps, we might think, as time goes on and we get used to the challenges of the pandemic, mental health issues may decrease.

This might be wishful thinking. Studies, tracking the evolution of mental health issues, show a decrease in cases of anxiety and depression. However, anxiety and depression had the highest increase. In some cases, it was a 100 percent increase. In addition, there was no change in most mental health issues like PTSD, psychological distress, suicidal ideations, loneliness, and substance abuse.

In Latin America and Europe, overall psychological distress and insomnia are on the increase. Thus, parents, schools, and other institutions need to seek out active interventions.

Mental health promotion should aim for a restructuring of the life of the young. Many changes brought about by the pandemic are here to stay. An example is the evolved online behaviour.

Many have migrated online for studies, social connections, news, self-expression, and for business. These patterns of behaviour are less likely to subside. Another example is substance abuse. Awareness programmes should continually bring to the table topics such as responsible online behaviour and the ill effects of substance abuse.

Adolescents and youth require a complex network of social relations for their healthy development. **They need to form interlinks of communication and interaction with parents, relatives, teachers, other adults, classmates, and other peers of their age.**

In addition to disrupting the dysfunctional behaviour, the school and parents will need to take steps to better schedule and structure the daily routine of the young. **The young will require time for learning new skills, exercise, relaxation, spirituality, and critical thinking, all of these contribute positively to mental health.**

In addition to disrupting the dysfunctional behaviour, the school and parents will need to take steps to better schedule and structure the daily routine of the young. The young will require time for learning new skills, exercise, relaxation, spirituality, and critical thinking, all of these contribute positively to mental health.

Finally, adolescents and youth would require opportunities for creatively contributing to society. Many young people coped with the pandemic by reaching out to society. Some took the initiative to set up networks of supportive family and friends. Others were engaged in mitigating the social impacts of the pandemic. They engaged in food distribution, providing information online on vacant hospital beds, helping migrant workers walk back home, helping to teach poor students, and sheltering stray animals. We should encourage and create opportunities for our young people to be involved in society.

An other-centred attitude is a key to hope, resilience, and mental health.

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A New Paradigm for MENTAL HEALTHCARE in INDIA

A recent pan-India study conducted by India State-Level Disease Burden Initiative Mental Disorders Collaborators indicated that 14.3 percent, or approximately 1 in every 7 Indians has a mental disorder.

These numbers are roughly commensurate with those from the nationwide survey by the Bengaluru-based National Institute of Mental Health and Neuro Sciences (NIMHANS). The latter survey of 34,802 people gathered from 12 States found the lifetime prevalence of mental disorders in India to be 13.7 percent.

In India, a nation with 1.38 billion people, the impact of mental illness may be particularly acute because more than 80 percent of those affected are not able to access care for these problems. Despite such a strong mental health need, there is a critical shortage of trained mental health professionals in India, with only two mental health clinicians per 100,000 people.

According to the World Health Organisation's recent World Mental Health Atlas, India has 0.29 psychiatrists, 0.80 mental health nurses, 0.07 psychologists and 0.06 social workers for every 10,000 people in its population. This disparity between need and availability has led to severe consequences such as enormous disease burden, stigma, discrimination and socio-economic inequalities.

Many factors influence people's willingness to seek help for mental illness. Several such factors are internal to the individual (stigma, mental health literacy, social exclusion), while others are more concrete (prohibitive costs, treatment availability) or systemic (organisation of healthcare services).

In recent years, the Indian State has recognised mental health as a paramount requirement for the well-being of its people. This recognition has enabled policymakers, professionals, and communities in India to engage critically with the mental health needs of the community.

The Mental Healthcare Act 2017 aims to safeguard the rights of people with mental illness, along with access to healthcare and treatment without discrimination.

However, just as with basic needs like food and primary healthcare, there are several challenges associated with mental health that India has historically been struggling with.

India has tried to address one of its greatest challenges, the shortage of primary physical healthcare workers, by turning to community health worker (CHW) programmes. This is in line with the global trend advocated by the WHO in 2016.

A CHW Programme is a needs-oriented system. In it, a cadre of workers from the local community, who share common characteristics like ethnicity, culture, race, and language are selected and trained to cater to the healthcare needs of the residents.

CHW programmes are receiving extensive consideration universally as mechanisms to help surmount health worker scarcities, retain health workers in underserved areas, and deliver culturally appropriate primary healthcare. Responding to this need, India was one of the first countries to launch an extensive community health worker mission called the Accredited Social Health Activists (ASHAs), in 2005-06.

In recent years, the Indian State has recognised mental health as a paramount requirement for the well-being of its people. **This recognition has enabled policymakers, professionals, and communities in India to engage critically with the mental health needs of the community.**

Originally initiated to address the heightened infant mortality rates, the ASHA programme has grown significantly. Currently, there are almost a million activists in the ASHA cadre. They have made considerable enhancements in primary physical healthcare delivery in India. However, this model has generally not been extended to mental healthcare delivery.

A systematic review by researchers of efforts to involve CHWs in delivering evidence-based mental health interventions to under-served communities in the United States and low and middle-income countries shows that the CHWs were able to deliver mental health interventions. As a result, they were able to address various clinical disorders ranging from depression, anxiety, and psychological trauma, besides disruptive behaviour disorders.

Among the major advantages of CHW-based mental health service delivery were positive mental health outcomes, catering to underserved populations, cost-effective care in low-resourced communities, privileged access to traditionally under-served communities by building trust and navigating challenges, reducing stigma related to mental disorders, and recognising and responding to the needs of mental health issues in the community.

In India, the role and functioning of ASHAs, the largest of the three CHWs (the other two being auxiliary nurse midwives, and Anganwadi [childcare centre] workers, is still evolving.

As originally conceptualised in 2005, one woman per village would be selected (approximately 1 per 1000 population) to receive a 23-day training on basic health topics.

First, they were expected to serve as a link between the community members and health services by finding and referring cases to higher health facilities.

Second, they could mobilise the community around issues such as water, sanitation, nutrition, and health.

Third, they could offer primary medical care including basic first aid and supplies, health education on sanitation, hygiene, antenatal and postnatal care, immunise children and accompany expectant mothers to the hospital for safe delivery.

The role of ASHAs has expanded over the two decades of their existence. The diversification of ASHA's roles was demonstrated in the recent global pandemic when they joined forces with the governments. They have been involved in conducting house-to-house visits, reporting

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Mental health knowledge must be a significant part of the ASHAs training programme to prepare them to be more comfortable and **equipped in dealing with persons with mental illness, particularly those with severe mental illness.**

symptomatic cases, carrying out contact tracing, maintaining documentation, monitoring, helping enforce quarantine, and creating awareness about COVID-19 in the community.

There are significant factors that encourage the use of ASHAs as link workers. With the organised nature of their service and extensive presence across the country, ASHAs are more likely to reach groups that are typically left out of the formal healthcare system. They often share a common culture, ethnicity, economic status, language, and life experiences with the communities they serve.

Additionally, familiarity with the health system and different work experiences, even in the context of stigma and discrimination, is a solid foundation for the ASHAs to be less stigmatising towards persons with mental illness.

For the same reason, ASHAs are more likely to endorse the efficacy of treatment interventions for the mentally ill. In a meta-analytic study, a group of researchers conducted a statistical analysis called probabilistic sensitivity analysis and concluded that ASHAs can be very cost-effective. They would continue to be cost-effective even when their financial incentives are increased by 10 times.

There are some general challenges as well to employing ASHAs as link workers for mental health services, such as community resistance, social, economic, and political power structures, traditional gender stereotypes, and poor remuneration and incentivisation.

Moreover, there are societal views on mental illness that are shaded by stigma, prejudice, and discrimination that tend to associate mental illness with danger and violence. The governmental healthcare system that the ASHA is trying to work within often lacks supplies and services. Her role is often not sufficiently respected, either within the healthcare system or by the community. This is a problem further compounded at times by her caste and class location.

Despite these challenges, there is a heightened need for mental health services. ASHAs are a very important resource available at the ground level for this purpose. They may be envisaged as the primary link workers who would identify common mental illnesses in the community and provide basic psychoeducation about the nature of the illness. The aim is to destigmatise and provide appropriate referral to psychiatric and psychological services available.

To employ ASHAs as link workers, there are a few steps to be implemented. Proper studies must be carried out to assess their attitudes towards knowledge of and comfort level in dealing with mental illness.

Mental health knowledge must be a significant part of the ASHAs training programme to prepare them to be more comfortable and equipped in dealing with persons with mental illness, particularly those with severe mental illness.

ASHAs have to be financially compensated for these additional services. In a scenario of a dire dearth of health professionals, it may be argued that the services of paraprofessionals like ASHAs are inevitable in linking the community to primary care providers.

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Did I FORGET Something?

A man who has been an expert in handling all sorts of gadgets suddenly forgets how to use a mobile phone. A man who went to buy two kgs of mutton, a practice for many years, returns with half a kilo of fish. Little did George Varghese's family know that their beloved one was heading towards dementia. It is one of the most challenging health issues India will be facing very soon.

Dementia is a gradual and progressive decline in cognitive function. It is severe enough to impair a person's ability to carry out his or her daily activities. It is irreversible in that there is an impairment of higher mental functions like memory, thinking, orientation and a comprehensive learning capacity of language and judgement.

Dementia is a gradual and progressive decline in cognitive function. It is severe enough to impair a person's ability to carry out his or her daily activities. **It is irreversible in that there is an impairment of higher mental functions like memory, thinking, orientation and a comprehensive learning capacity of language and judgement.**

About 5 percent of persons above 65 years of age are affected by it. Coming to the Indian context, the ageing population is the most significant emerging demographic. According to a study on 'Ageing in India by 2050' by Prof. S. Siva Raju, the chairperson of the Centre for Development Studies at the Tata Institute of Social Sciences, Mumbai, the proportion of older persons 60 years and above is projected to rise to 21.1 percent. This will be one billion in number.

At 53 percent, Asia has the largest number of the world's elderly, followed by Europe (25 percent). This pressure of increasing numbers of the elderly will intensify in the next 50 years. By 2050, 82 percent of the world's elderly will be in the developing regions of Asia, Africa, Latin America and the Caribbean while only 16 percent will reside in the developed regions of Europe and North America. In 2010, India had an elderly population of 91.6 million but that population is expected to reach 158.7 million by 2025.

Elderly people suffering from cognitive disorders like dementia and Alzheimer's disease need more care as compared to others. In dementia, the cognitive functioning of the individuals deteriorates. It becomes extremely difficult for individuals to do their daily routine as they do not have the appropriate memory of the routine. They become entirely dependent on others, mainly family members for their well-being.

Institutional care of the elderly is one of the current forms of care for the elderly. This care is designed to meet the functional, medical, personal, social and housing needs of individuals who are suffering from physical, mental or behavioural disorders.

Established in 1999, the Chaitanya Institute for Mental Health (CIMH) is one of the leading residential psychiatric care centres for the acute management and community-based psychosocial rehabilitation of the mentally ill. It provides residential care facilities for patients suffering from various psychiatric disorders such as schizophrenia, mood disorder, personality

disorders, substance-related disorders and geriatric disorders, especially dementia and Alzheimer's disease. Currently, it has branches in Kerala, Goa, Maharashtra and Nepal.

GOALS AND OBJECTIVES

The CIMH's ultimate goal is to reintegrate chronically mentally-ill persons back into their families and society. Towards this goal, Chaitanya works on specific objectives like:

1) Providing psychosocial rehabilitation services to individuals suffering from mental illness.
2) Offering psychological and social support to the families of the mentally ill.
3) Promoting mental health and creating awareness about mental illness in the community.
4) Networking with other organisations working in the field of mental health.

SERVICES PROVIDED

Chaitanya has specialised facilities and activities for specific groups such as a psychiatric rehabilitation care unit, de-addiction unit, geriatric and dementia care unit and vocational training and daycare centre.

The services provided are based on the biopsychosocial model. This includes understanding the specific needs of the individuals who are availing of the treatment at the centre. This covers the physical, psychological and social aspects.

This can be divided into three levels

Individual Level:

Residential care incorporating the following modes of treatment

a. Structured and supervised daily schedule.
b. Activity scheduling.
c. Supervised pharmacological interventions.
d. Individual-oriented interventions and psychotherapies.
e. Group therapies.
f. Recreational therapy.
g. Behavioural modification therapies.
h. Yoga therapy.
i. Therapeutic community meetings.
j. Music therapy/ Art therapy.
k. Reminiscence therapy.
l. Mediation.
m. Aversion therapy.
n. Relaxation techniques.
o. Movement therapy.

Dementia and Alzheimer's disease, once a hidden burden on families, is now a major public health concern. **The vanishing joint family system, one of the main sources of caregiving for the elderly in Indian societies, urban nuclear families, and women's employment have emerged as major problems in providing care for the elderly within the family.**

Family Level

The treatment at the family level includes various interventions:

a. Psychoeducation
b. Supportive therapy
c. Family therapy
d. Group therapy
e. Self-help groups

The CIMH recognises and encourages the needs of the family in the process of rehabilitation. Families are free to meet their wards, counsellors and other professionals on specified days to know the well-being of the person who is undergoing treatment. Families can talk to the concerned counsellors over the phone regularly (2 pm-5.30 pm) too. Counsellors send progress reports to the concerned families every month.

Community Level

The services at the community level include:

a. Referral services.
b. Awareness programmes.
c. Workshops/Seminars.
d. Placement services.
e. Liaisoning with other agencies.

The CIMH has been actively involved in various outreach and public awareness programmes, like the distribution of literature containing information on mental illness and related issues, organising exhibitions, workshops, public awareness rallies, and street plays to sensitise the community and fight the stigma attached to mental illness and those affected by it.

The CIMH has been offering residential-care facilities for persons with dementia and Alzheimer's since 2012. Dementia and Alzheimer's disease, once a hidden burden on families, is now a major public health concern. The vanishing joint family system, one of the main sources of caregiving for the elderly in Indian societies, urban nuclear families, and women's employment have emerged as major problems in providing care for the elderly within the family.

As Alzheimer's disease or dementia is not a natural part of the ageing process it requires special care. While caring for a loved one, caregivers frequently suffer a decline in their health as a result of the strain and pressure or simply lack time to attend to their own needs. There is frequently a high rate of caregiver burnout, particularly towards the end of the illness, when the patient begins to lose the memory of their loved ones.

Institutions like CIMH play a major role in providing care to the elderly, especially for persons with dementia, although staying at such residential care facilities are helpful for better care for the patient. It should not be seen as getting rid of a burden. It should rather be seen as specific need-oriented, compassionate and professional care. It helps a person with dementia to live in a conducive environment and having a structured routine to follow so that their remaining life becomes more meaningful.

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Mental Health and Its Relation to POVERTY and THE POOR

News reports suggest that mental disorders are now among the leading causes of health burden worldwide, with no evidence of global reduction since 1990. In 2017, an estimation of the burden of mental health conditions for the States across India revealed that as many as 197.3 million people need treatment for mental health.

This included around 45.7 million people with depressive disorders and 44.9 million people with anxiety disorders. The situation has been exacerbated by the Covid-19 pandemic, making it a serious concern the world over (Indian Express, February 11, 2022).

Mental health is the integral, holistic health of a person and is the foundation for the well-being and effective functioning of individuals. It includes mental well-being, prevention of mental disorders, treatment and rehabilitation. It affects how we as individuals and members of society think, feel, and behave. It reflects our decision-making processes, our approach to stress, and our relationships with others and work. Mental health is important at every stage of human development and functioning.

Our deliberation is focused and limited to the aspect of mental health and its relation and impact on people on the margins in India. Mental illness affects all sorts of people and yet its consequences and impact are different for different people and their families. It is not the same for the poor and the not-so-poor.

The World Health Organisation (2007) reported that 'mental disorders occur in persons of all genders, ages, and backgrounds. No group is immune to mental disorders, but the risk is higher among the poor, homeless, the unemployed and persons with low education'.

There is enough evidence to show a close link between poverty and mental health. An article 'Mental illness, poverty and stigma in India' (Trani *et al*., 2015) suggested that public stigma and multi-dimensional poverty linked to Severe Mental Illness (SMI) are pervasive and intertwined.

Mental illness and poverty create a self-fortifying cycle of certain groups that emerge more vulnerable than others. Social hierarchies of gender, sexual orientation, economic status, ability, and caste often result in exclusion, discrimination and marginalisation of certain individuals and groups.

A case-control study conducted in Delhi from November 2011 to June 2012 found that the intensity of multidimensional poverty increases for persons with severe mental illnesses (PSMI) compared to the rest of the population. Those marginalised groups that hold lower positions of power within these social hierarchies experience greater intensity of mental distress than those who are advantageous and enjoy higher positions (India Development Review (2020).

There is another aspect, namely, the social and economic inequalities and disparities often caused by the 'haves' contribute to the creation of poverty. The very same poor then have to

Mental illness affects all sorts of people and yet its consequences and impact are different for different people and their families. **It is not the same for the poor and the not-so-poor.**

Poverty is both a cause of mental health problems and a consequence. The mental health of individuals is shaped by the social, environmental and economic conditions in which they are born, grow, work and age. **Poverty and deprivation are key determinants of children's social and behavioural development and adult mental health**

provide care to some of these 'haves' who in some way are responsible for their poor status in society.

One may ask how and when?

Hospitals and clinics have support staff largely from the marginalised communities who clean these places, maintain cleanliness, and hygiene and clean the toilets people use. There are households and hospitals in which severely affected mental health personnel require personal assistance to clean and dispose of faeces and urine. Often, it is not the family members, but members of the community from the margins who are hired to come to their aid. The members of vulnerable communities often do not have access and cannot afford the education needed to qualify to be healthcare givers at a higher level.

Poverty is both a cause of mental health problems and a consequence. The mental health of individuals is shaped by the social, environmental and economic conditions in which they are born, grow, work and age. Poverty and deprivation are key determinants of children's social and behavioural development and adult mental health (Knifton L, Inglis G. 2020). It is found that 'poverty and common mental disorders in India are inseparable twins' (International Journal of Community Medicine and Public Health).

What is the poverty of the poor?

Some have conceptual knowledge of poverty but have not seen it, leave alone experienced it. Poverty is a state or condition in which an individual or a group lacks the financial means and necessities for a basic level of living. Poverty occurs when one's earnings from work are insufficient to meet fundamental human requirements. Poverty-stricken individuals and families may be deprived of adequate housing, safe drinking water, nutritious food, and medical care.

An exclusion from employment linked to negative attitudes and a lack of income are the highest contributors to multidimensional poverty; it increases the burden for the family.

The WHO-Global Health Expenditure Database showed that India's Out of Pocket (OOP) health expenditure was 54.8 percent in 2019. This is a significant barrier to healthcare utilisation. The total health expenditure of the government was 3.2 percent of the GDP in 2018, the lowest since 2004-05.

The vicious cycle of mental illness and poverty means borrowing money, selling household assets, and contributions from friends and relatives. Inadequate wages of many in our country such as tribals, Dalits, traditional fisherfolk, single mothers, members of the third gender, sex workers, and migrants, to name a few, do not have the OOP to take care of their health, leave alone a prolonged severe mental illness of any one of their dear ones.

Obsessive guilt and suicide are related to mental health. Suicide is the leading cause of death among those aged 15–29 in India. There are many causes leading to suicide but poverty, debt, and stigma are not uncommon.

The Ayushman Bharat (Healthy India) initiative launched in 2018 aims to provide comprehensive primary healthcare and health insurance coverage

for non-communicable diseases including mental disorders, which could contribute to reducing the adverse effects of mental disorders. However, what is on paper and how it is translated on the ground needs to be measured.

Let me conclude by stating that addressing mental health care in India requires holistic medical healthcare. It will have to address the stigma related to mental health.

A person's mental health and many mental disorders are shaped by various social, economic, and physical environments but the poor and disadvantaged suffer disproportionately.

Policies, fund allocation and implementation are required to improve the conditions of everyday life, beginning before birth and progressing into early childhood, late childhood and adolescence, during family building and working age, and finally to old age.

India's President Ram Nath Kovind, in a speech in December 2017, warned of a potential mental health epidemic in India, with 10 percent of its 1.3 billion-strong population having suffered from one or more mental health problems. He observed that the shortage of mental health professionals was another major gap that the country has to address. The President said there were 5,000 psychiatrists and less than 2,000 clinical psychologists in the country. We hope the government has time to take the warning seriously amid its political electoral agenda.

Finally, promoting Good Health and Well-being (Sustainable Development Goal 3) for all at all ages is expected of us and more so from the government. The political choice we make in electing responsible and responsive governments is an important step in improving the mental and holistic health of India.

The political choice we make in electing responsible and responsive governments is an important step in improving the mental and holistic health of India.

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THE SECULARISATION OF SUICIDE

Suicide has emerged as a response to unbearable suffering, injustice, discrimination and despair. There are rape victims and students who fail exams committing suicide. Other reasons include failure in marital life, loneliness, chronic sickness and depression.

Self-destruction and self-erasure or what is popularly known today as suicide existed in most societies with somewhat different cultural meanings attached to such acts. In European Christianity, the prototypical case of suicide is that of Judas Iscariot, the disciple of Jesus who betrayed him and hung himself. This act branded suicide as a sin accompanied by guilt and punishment.

Early studies on suicide in Europe treated suicide as 'Moral Statistics'. However, secularisation and relegation of religion to the private sphere have minimised the quantum of sin, guilt and punishment regarding suicide. As also causes of suicide have gone beyond Judas's despair in secularised societies.

Suicide may be a sin in most cultures but the concept of sin may not be the same. Specifically speaking, in societies of South Asia there are ways of self-erasure such as voluntary renunciation of the body for reasons that could be personal, collective or even secular. Such deaths are admired for serene courage, the ability to face death, and complete mastery of one's body and mind with the assumption that a good life must end with a good death.

Calmly inviting death through 'Santhara' among Jains, 'Atmabali' - a warrior's self-sacrifice, self-immolation among Hindus, or even Gandhi's satyagraha conveys suicidal heroism for higher causes. Sati or widow-burning on the funeral pyre of the husband had religious sanction. Suicide bombing in some countries has recently become popular which derives religious meaning and justification.

The multidimensionality of suicide shows that suicide cannot be studied merely as a psychological phenomenon or mental health issue. **Psycho-analysis, psychiatry and counselling alone may not handle suicides. One may have to do psycho-social autopsies.**

The classic study of suicides by Emile Durkheim in 1897 in French and its English version in 1951 was exclusively based on European data, classifying it as altruistic, egoistic, anomic, and fatalistic. The rapid changes brought about in European society after colonisation, industrialisation, and urbanisation brought about such suicides in large numbers.

However, it is a hidden fact that continuously for twenty years suicide data on Bombay city was begun by Rheatsek, a Hungarian, who lived in the city and thereafter by others from the year 1886-1907. This data is according to communities, age, gender, weather, time, occupation and modes of suicide (Shah and Lobo 2018). These statistics do not elaborately deal with the reasons and causes behind suicides as contemporary suicidologists do.

However, even in South Asia, the concept of suicide has undergone secularisation. Suicide has emerged as a response to unbearable suffering, injustice, discrimination, and despair. There are rape victims and students who fail exams committing suicide. Other reasons include failure in marital life, loneliness, chronic sickness and depression.

The domain of despair is expanding in India with farmer suicides and has become a politically live issue for newspapers. The latest National Crime Records Bureau (NCRB) data shows that large number of daily labourers have committed suicides. Covid-19 brought misery on them and they were economically bankrupt. They trudged miles on foot with their families to reach their natal villages from their destination in cities.

Finland is the happiest country. The parameters include Gross Domestic Product, life expectancy, social support, freedom, low corruption, democracy, judiciary, emotions, income, welfare, individual autonomy, safety, excellent governance, socially progressive ideas and model work culture.

Safety, security, consumerism and pleasure are the primary triggers of behaviour. Yet it has one of the highest rates of mental health problems among European countries. Materially prosperous persons and countries may appear happy on the surface but their mental and social support system appears to have given way.

In India, the recent data on suicides published by the NCRB is a case in point. The report shows that 1,64,033 people lost their lives due to suicide in 2021, which is 7.2 per cent more than in 2020. This means around 450 persons die by suicide each day in India.

The modes of suicide with modern technology have provided more ways to commit suicide: hanging, drowning, poisoning, throwing oneself from heights, suicides with drugs, pesticides and suicide in garages, etc. It is said one of the most popular books in France is Edouard Levé's 'Suicide', who himself committed suicide at the age of 42!

Despair in secularised and modernised society claims an expanding number of people taking to suicide. In contemporary society, suicides are classified as sympathy suicide, revenge suicide, escape suicide, and repentance suicide. Suicide as a means of achieving sympathy; suicide as a means of getting revenge; suicide as a means of escaping an unbearable situation; and suicide as self-punishment to show repentance for the wrongdoing.

Subsequently, motivations for suicides can be grouped (Crichton-Miller 1931) into the following:

1. Physical pain and frustration.
2. Mental depression.
3. Social suffering and fears including remorse for wrongdoings and avoidance of social humiliation.
4. Doubts and dread about life hereafter.

While we rely much on psychiatrists to handle mental health and **suicides one needs not only psychiatrists but also social scientists to engage in uncovering the causes of mental health and subsequently of suicide in each society and culture.**

The multidimensionality of suicide shows that suicide cannot be studied merely as a psychological phenomenon or mental health issue. Psycho-analysis, psychiatry and counselling alone may not handle suicides. One may have to do psycho-social autopsies.

An autopsy is a medical term that enhances our understanding of diseases and how we die and provides evidence for legal action. Most of us link autopsies with homicide cases but this concept can be applied to study suicides. Autopsies can be beneficial for compensation, a way to seek reassurance and peace of mind for a family after the demise of a person.

Psychological autopsy is well known. However, a psychosocial autopsy may not be so well known (Bharati, Lobo and Shah 2021).

What are the psychological determinants and sociological determinants of suicide?

One must identify the social conditions and issues that compel a person to suicide. Why is it that under similar conditions, some end one's life and others do not? How can we identify individuals and groups with high suicidal tendencies? Is there a link between individual personality, social circumstances and acts of suicide? How do social forces and processes in terms of crucial events build up inner mental stresses and turmoil and prompt a person to end one's life to escape from such anxieties.

Those who contemplate and those who attempt suicide, but do not succeed, may have to teach us much about mental health.

In modern society where suicide has become secularised diminishing religious sanctions, one finds a greater incidence of suicide in most societies. Apart from despair, aspirations and individualism have risen.

While we rely much on psychiatrists to handle mental health and suicides one needs not only psychiatrists but also social scientists to engage in uncovering the causes of mental health and subsequently of suicide in each society and culture.

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Mental Health of CHILDREN and YOUTH in INDIA

Only recently people have been concerned about mental health issues, especially in the context of Covid-19 where many experience lots of stress and anxiety. Mental health is understood as the emotional, psychological, and social well-being of people. It affects how we think, feel, and behave in our environment. It also helps determine how we handle stress, relate to others, and make healthy choices in life. Good mental health helps one to cope with the most difficult situations in one's life and grow into an integrated, healthy adult.

As the Chairman of the Child Welfare Committee (CWC) of the Government of Kerala, India and as the Convener of the CHILDLINE Nodal Agency, at Loyola Extension Services in Thiruvananthapuram for six years, I had the experience of encountering multiple cases of children with psychological problems.

CHILDLINE focuses on the relief and rehabilitation of children in distress. Any child in distress or anyone aware of the distressing situation of a child in the district can avail of the free service round the clock (day and night) by calling the toll-free number 1098.

It is important to have trained counsellors and mental health professionals in all our schools and colleges to help the students with their psycho-social needs. **In addition to it, the public must be aware of the legislation signed in by the Govt. of India to protect the rights of children.**

It is a project of the Ministry of Women and Child Development of the Government of India in partnership with the State Government, NGOs, and corporate sectors. Street children, child labourers, children who have been abused, child victims of the flesh trade, disabled children, child drug addicts, children affected by HIV/AIDS, conflict or disasters and children whose families are in crisis are the ones who come within the ambit of its services.

We notice that young people with mental health disorders are more likely to be unhappy at school or college, and backward in their studies. Their learning is negatively impacted because of poor concentration, distractions of life, distorted peer relationships, and aggressive behaviour.

Attention Deficit Hyperactivity Disorder, anxiety problems, behavioural problems, and depression are the most commonly diagnosed mental disorders in young people. Multiple studies have found a strong link between addiction to social media and an increased risk for depression, anxiety, loneliness, self-harm, and even suicidal thoughts. Social media promotes negative experiences to increase the risk of low self-esteem, long-term bullying and being the victim of violence, such as physical or sexual abuse.

Childhood abuse, trauma, neglect, social isolation, loneliness, experiencing discrimination and stigma, social disadvantage, the disparity between the rich and the poor, racism, poverty, bereavement (losing someone close), long-term stress, and physical sickness are the major causes of mental health problems.

During my tenure as the CWC Chairman, I dealt with over 4500 child abuse cases. Among them, 143 were sexual abuse cases. In most of those cases, it was necessary to get professional help for children for their mental well-being. Unfortunately, such help was not available then and the situation has not improved to date.

It is important to have trained counsellors and mental health professionals in all our schools and colleges to help the students with their psycho-social needs. In addition to it, the public must be aware of the legislation signed in by the Govt. of India to protect the rights of children.

These include The Child Labour Prevention Act, Prevention of Child Marriage Act, Right to Education Act, Juvenile Justice Act, and the Protection of Children from Sexual Offence Act.

Government and other institutions must make sure of things that can help keep children and young people mentally healthy which include being in good physical health, eating a balanced diet, getting regular exercise and having meaningful interpersonal relations.

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SPIRITUAL DIRECTION or PSYCHOTHERAPY?

In 2010, the American psychotherapist Pilar Jennings published a volume – part memoir, part academic reflection – called 'Mixing Minds: The Power of Relationship in Psychoanalysis and Buddhism'. In the pages of this work, the author, a therapist and a practising Tibetan Buddhist, points out, not without irony, how her professional colleagues and her fellow Buddhist practitioners struggled to understand her 'dual commitment' to psychological work and meditation.

Surely, other therapists and psychologists tell her, if she were really serious about working on her psychological issues in therapy, she would not need Buddhist practice at all. At the same time, quite a few Buddhist practitioners are convinced that if she has to see a therapist at all, she is not taking her meditation practice seriously enough either.

In response to these criticisms, the author passionately argues that religious practice and psychotherapy are complementary, as they address different stages or aspects of the person's psycho-spiritual development. Therapy engages the individual's struggles and unresolved issues that must be addressed before embarking on an ambitious programme of spiritual practice.

Doing the latter when one has yet to resolve inner psychological struggles can be not just fruitless, but dangerous. A simile that Jennings does not use, but appears fitting, is that of an individual with a broken leg who wishes to train for a marathon. This person needs to work with a physical therapist until the normal functioning of one's organs is restored. Only at that point will it be possible to start training for a marathon.

Historically, Catholics' attitude to psychotherapy has not been without challenges. Sigmund Freud (1856-1939), the father of psychoanalysis, was famously critical of Christianity, and indeed, of all religions. He viewed a religious commitment as a symptom of a failure to mature or achieve psychological adulthood.

Carl Jung (1875-1961) did not share Freud's dismissive attitude towards religion. This was one of the chief reasons for the break between the two. At the same time, Jung's understanding of Christianity was highly controversial. He envisaged the classical articulation of religious beliefs transmitted to us from the past as a culturally conditioned articulation of archetypes inscribed in the collective unconscious, rather than analogical descriptions of metaphysical, supernatural realities.

In response to these criticisms, the author passionately argues that religious practice and psychotherapy are complementary, as they address different stages or aspects of the person's psycho-spiritual development. **Therapy engages the individual's struggles and unresolved issues that must be addressed before embarking on an ambitious programme of spiritual practice.**

For decades, it seemed that an unbridgeable chasm existed between psychoanalysis and those committed to traditional Christian practice. **Alas, this also meant that spiritual directors were sometimes asked to work with individuals struggling with psychological problems that they had neither the resources nor the ability to address them.**

For decades, it seemed that an unbridgeable chasm existed between psychoanalysis and those committed to traditional Christian practice. Alas, this also meant that spiritual directors were sometimes asked to work with individuals struggling with psychological problems that they had neither the resources nor the ability to address them. Rather than engaging one's issues, the latter were swept away or repressed, leading often to more severe challenges at a later stage.

One school of psychotherapy that developed in English-speaking countries was Cognitive Behavioral Therapy (CBT). This was promoted by Albert Ellis (1913-2007) under the name of Rational Emotive Behavioral Therapy.

This approach emphasised the centrality of mental health in the relationship between cognition and behaviour, where the two shape and influence each other. Often unwittingly, individuals enter into a behavioural pattern where thoughts and conviction shape their behavioural choices, which, in turn, reinforce one's mental habits in a chain that is as strong as difficult to discern.

Mental images, in particular, can reinforce this mechanism. This is something even more crucial in a society like ours that is utterly saturated by visual stimuli. Dependence and addiction feed on this inner dynamic that is often accompanied by strongly-held beliefs about one's inability to break out of self-destructive modes of behaviour.

If an individual in the grip of any kind of addiction, such as substance dependence or compulsive use of pornography, were to be advised to sit on a cushion and meditate, or engage in 'lectio divina' (divine reading) and mental prayer, the results would most likely be disastrous. The person would be flooded with thoughts and mental images connected with one's addiction, and the inability to meditate or pray would convince them of their worthlessness and the hopelessness of their situation.

The use of CBT would help the individual come to a realisation of one's mental and behavioural processes, which often unfold below one's level of awareness, and work towards gradual change. A modified version of CBT known as Dialectical-Behavioural Therapy (DBT) builds on CBT's achievements but integrates them with an emphasis on the relationship between the patient and the therapist.

This relationship, which must be based on mutual trust, becomes the framework for helping the individual to achieve a new inner equilibrium.

Anyone familiar with early Christian literature may recall what Evagrius Ponticus (345-95 AD) taught about the role of inner spiritual work in the life of the monk. A mind agitated by passion cannot turn to God in prayer and thus has first to achieve a condition of tranquillity.

Discernment of spirits ('diakrisis ton pneumaton') helps the individual distinguish between demonic and angelic thoughts. Habits of thought lead to habits of behaviour, and therefore intellectual

discernment leads to behavioural transformation.

The condition of 'apatheia' (dispassion, or tranquillity) is not one of detached contempt for the world, but one where the fading away of attachments or ignorance enables one to engage ever more intensively in the pursuit of prayer or the practice of the virtues.

In this perspective, the first stage of spiritual practice is one where one has to reconfigure one's own inner life since pure prayer ('kathara proseuche') is not possible if one's thoughts and behaviour are still controlled by the passions. It is important to remember that Evagrios ascribed great importance to the role of the elder, who would guide their disciples on the road to 'apatheia'. Indeed, it was deemed dangerous to embark on a hermit's life if one had not gone through this process beforehand.

The kind of 'via purgativa' recommended to monastics by Evagrios is functionally analogous to a kind of DBT practice, informed, of course, by scriptural principles and by the example of Christ's life that is always presented as the paradigm of integrated practice.

This is the work that could be carried out by a Christian psychotherapist seeking to help an individual who is struggling with dependency or addiction. The 'via illuminativa' and eventually the 'via unitiva' that follow the achievement of an inner equilibrium could then be entrusted to the care of a spiritual director. Of course, whenever the latter also has the required training, the same individual could accompany the patient through both phases, but this is always likely to be the exception rather than the rule.

In the third decade of the twenty-first century, the Catholic Church is called to do its part in responding to the global crisis in mental health. Psychology can offer tools to address this challenge. At the same time, even within the Church's tradition, one can find resources that mirror and complement the insights of contemporary psychology.

Greater awareness of the different goals and purposes of therapy and spiritual direction, but also of the very great potential that can come from their cooperation, will help Catholics gain a better appreciation of the role that an authentic Catholic psychotherapy can play in the life of the church.

In the third decade of the twenty-first century, the Catholic Church is called to do its part in responding to the global crisis in mental health. **Psychology can offer tools to address this challenge. At the same time, even within the Church's tradition, one can find resources that mirror and complement the insights of contemporary psychology.**

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LITTLE BROWN BROTHER

Negotiating One's Cultural Identity is a Crucial Factor in Mental Health

In this write-up, Gerdenio Manuel reflects on his experience of holding diverse identity factors and navigating life, work and ministry in the US, a cultural potboiler. This is a great example of the life and work of many psychologists and other health professionals who strive to carve a niche for themselves holding a unique cultural identity among a wide array of cultures from around the globe.

Although I am a West Coast Jesuit, I am a native New Yorker, born at St. Luke's Hospital in Manhattan. I attended kindergarten at PS 22 and grade school at St. Michael's in Flushing. Growing up in the 1950s in Whitestone and Flushing in the borough of Queens, I remember New York as a warm and welcoming city.

Like the Vietnamese who would later also be identified with an unforgettable war, Filipino-Americans still struggle with the myth and reality of World War II and US colonisation. **They continue to fight for the veterans' rights and benefits that the US government had promised its 'little brown brothers and sisters.'**

Our neighbourhood was mostly Jewish, Italian and Irish American. We were the only Filipinos and the only Asians. But it didn't seem to matter. I didn't recognise anything different about myself or my family other than all of us were noticeably shorter than everyone else.

Being short or small did not hold any of us back. After work, my father went to night school to complete the undergraduate and graduate degrees that enabled him to pursue a lifetime career in the Philippine Foreign Service. At St. Michael's, my sister once was the May Queen, and I was class president for several years running.

Adolescence and later life experience would complicate my naive understanding of race, religion, culture, faith and community. One of my earliest memories of what it meant to be Filipino was the boast I heard repeatedly from middle school classmates that General MacArthur and the United States saved the Philippines. In their minds, this established the superiority of the United States and the American people over the Philippines and Filipino people. This made me in their words, a 'little brown brother'.

At home, former U.S. Army doctors, who, along with my mother, a Filipina US Army nurse, were World War II prisoners of war and survivors of the Bataan Death March. They talked instead about the shared suffering, surviving together, serving one another, and extraordinary acts of kindness and generosity they had experienced. Being small and Filipino mattered in different ways to different people. It was beginning to matter to me.

Like the Vietnamese who would later also be identified with an unforgettable war, Filipino-Americans still struggle with the myth and reality of World War II and US colonisation. They continue to fight for the veterans' rights and benefits that the US government had promised its 'little brown brothers and sisters.' Within American popular culture and society, we aim to establish our identity as a unique ethnic group with a distinctive cultural history as well as a contemporary set of political concerns.

In over 30 years as a Jesuit, I can recall several experiences that helped me understand how Jesuits and others failed to appreciate the extent to which my cultural context and self-understanding determine how I live my life, my ministry and my priesthood in the Society.

Sometimes, there were 'innocent' insults rooted in ignorance or mistaken attributions. I have never forgotten a famous interchange following a university lecture on missiology by historian Fr. Horacio De la Costa, a former Philippine provincial and at the time, one of the general assistants of Fr. Pedro Arrupe, the former Superior General of the Society of Jesus.

With some impatience, a priest commented in a thick Irish brogue, "Tell me, Father, until the arrival of our Christian missionaries, weren't Filipinos pagan after all?"

To which Fr. De la Costa replied, "No, Father, they were animists. They worshipped the god of the trees, the god of the rivers, the god of the lakes, just like the Irish."

In the years to come, the grace and wit of his reply helped me respond kindly or at least silently when greeting people at the church doors, I would be met with "Father, welcome to St. Theresa's, it must be Mission Sunday," or "Thank you, Father, it was a lovely Mass and you speak such beautiful English," or "We just love the islands!"

In the Jesuit dining room at Santa Clara University during my early years as a faculty member, I was walking by one of the tables at lunch when a guest snapped his fingers at me, signalling me to clear the table and bus his dishes.

Neither educational achievement, living in a religious community, nor holy orders made me immune from the stereotyping, entitlement, and rudeness that our kitchen and household help sometimes experience from our guests or even from ourselves.

After all, not too long ago California law prohibited Filipinos from marrying whites, and in my college years, I can recall a good friend awkwardly informing me that her Sicilian parents preferred that their daughter find another date for the freshman dance.

I would like to believe that we have come a long way from those days, especially in the Society, but sometimes I wonder. When I was the California Province's formation director and for a time also vocation director, many in our province were delighted with the growing diversity of our scholastics.

Others would ask, "How many speak English?" or "Are you sure they are prepared for our course of studies?" or, believe it or not, "Not counting the minorities, how many vocations do we have?"

Neither educational achievement, living in a religious community, nor holy orders made me immune from **the stereotyping, entitlement, and rudeness that our kitchen and household help sometimes experience from our guests or even from ourselves.**

I would have to convince some administrators in prolonged and intense conversations that our scholastics of colour were as capable as their peers of meeting ordinary teaching and pastoral responsibilities. "And what about their accents, what's being done about that?" I've frequently wondered why European accents are considered charming while Asian or Hispanic ones are not.

I have often been questioned about my credentials, experience, and training, right down to where I studied and when I received my degrees. When visiting other Jesuit communities across the country, I found that some Jesuits were surprised and incredulous that I was California's formation director, a clinical psychologist, and a tenured university professor. More subtly, in group settings, I've sometimes observed that Jesuits of colour are neglected in conversation, albeit unconsciously to the extent that some Jesuits even fail to make eye contact with us.

While some experiences in the Society have challenged and even hurt me, I remain grateful and proud to be a Jesuit. I have experienced the profound depth of community life and the transforming power of our ministry. As a Filipino who highly values and needs companionship, I have always felt the presence and support of the Society in times of personal crisis and pain.

And when each of my parents died, a close Jesuit friend travelled with me to the Philippines and helped me bury them and care for my extended family. In these and numerous other instances of faithful and compassionate support, the Society's love has been unwavering and unconditional beyond what I had ever thought possible.

With the same power and grace, Jesuit life and ministry have allowed me to deepen my love for others and my appreciation for the diversity of our world. The witness of my Jesuit brothers through the years, especially concerning the preferential option for the poor, has challenged me to travel where I would never have had the courage to travel alone. I was able to stretch my own cultural and class boundaries to discover the breadth and range of God's concern for all peoples and nations, whether in the barrios of Manila, the campo of El Salvador, the favelas of Brazil, or the inner cities of our country.

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STATISTICAL METHODS in MENTAL HEALTH RESEARCH

A mental health researcher is usually confronted with enormous amounts of data. Statistics helps researchers to organise this large amount of information to get an overview and to observe patterns and trends in a comprehensible manner. Statistics can also be used to describe as well as to infer from data. Inferential statistical tools help researchers to establish the difference across groups or assessments or to establish the association or relationship between variables.

Mental health researchers are often interested in understanding how the changes in one variable impact another variable. For example, stress and coping. Is there a relationship between them? How strong is the relationship? Can one be predicted from the other? Regression analyses that allow researchers to quantify the relationship between one or more predictor variables and a dependent variable would answer these questions.

Regression analysis is a predictive modelling technique that analyses the relation between the dependent variable and the predictor variable in a dataset. Linear regression and logistic regression analyses are the most commonly used techniques of regression.

However, there are many other regression models and their applications depend upon the nature of the data. Some of the regression models are explained concerning the type of dependent variable and recent applications of the model also have been explained.

1. Dependent variable - Numerical

The Linear regression analysis is employed for modelling the relationship between a numerical dependent variable (Y) and a predictor variable (X) that are linearly related. The model is referred to as a multiple linear regression model if there are multiple predictors.

A mental health researcher is usually confronted with enormous amounts of data. **Statistics helps researchers to organise this large amount of information to get an overview and to observe patterns and trends in a comprehensible manner.**

The Ordinary Least Squares (OLS) method is used to estimate the regression coefficients. If the data shows a linear relationship between two variables, the line that best fits this linear relationship is known as a least-squares regression line, which minimises the vertical distance from the data points to the regression line. The term 'least squares' is used because it is the smallest sum of squares of errors.

There are some important assumptions associated with a linear regression model.

LINEARITY: The relationship between X and the mean of Y is linear.

HOMOSCEDASTICITY: The variance of residual is the same for any value of X.

INDEPENDENCE/LITTLE OR NO MULTICOLLINEARITY: Observations are independent of each other.

NORMALITY: For any fixed value of X, Y is normally distributed.

The Ridge regression analysis, a subset of linear regression, can be used to predict a numerical dependent variable when the predictors are highly correlated among themselves (i.e., multicollinearity is present).

Regression analysis is a predictive modelling technique that analyses the relation between the dependent variable and the predictor variable in a dataset. **Linear regression and logistic regression analyses are the most commonly used techniques of regression.**

It can also be used when the number of input variables is larger than the number of observations, as in the case of microarray data analysis, and environmental pollution studies. With many predictors, fitting the full model without penalisation will result in large prediction intervals, and the LS regression estimator may not uniquely exist in such situations. Ridge regression analysis was recently used to predict bipolar disorder using mRNA expression levels in the N-methyl-D-aspartate receptor genes by Eugene *et. al.* (2022).

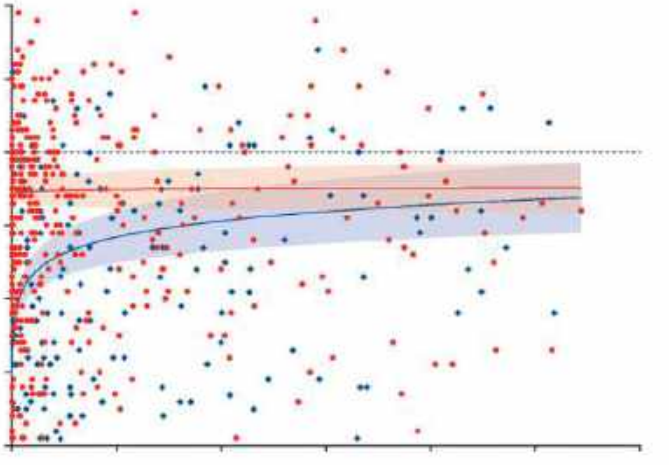
The Quantile regression analysis is also a subset of the linear regression technique. It is employed to predict a numerical dependent variable when the linear regression requirements are not met when the data contains outliers. Quantile regression provides greater flexibility than other regression methods to identify differing relationships at different parts of the distribution of the dependent variable (Lê Cook & Manning, 2013).

The QR model has the advantage of being much more robust to outliers than ordinary least squares regression, avoiding the assumption of parameter distributions in the error process and being a powerful tool for estimating the conditional distribution of outcomes (Yu, Xiang & Wang, 2021).

2. Dependent variable Discrete - Categorical

Binary logistic regression models: the most popular of the logistic models are used to predict a dichotomous dependent variable, while multinomial and ordinal logistic regression models are extensions of the binary logistic regression model.

Multinomial logistic regression is applicable when the dependent variable is nominal and has three or more categories. A nominal variable refers to a variable with no intrinsic ordering. Ordinal logistic regression is used, as the name suggests, when the dependent variable is ordinal and has three or more categories.



Recent applications of Ordinary Logistic Regression were to find the factors associated with the Socioeconomic Status of Households in Southwest Ethiopia (Lelisho, Wogi & Tareke, 2022), to identify the factors associated with the Mental Health of Undergraduate Students in Nigeria (Nwakuya & Mmaduka, 2019).

3. Dependent variable Discrete – Count

Count data is common in many disciplines. Most often in mental health research, the dependent variable would be the count of occurrences of an event, like the number of relapses in de-addiction programmes.

The distribution of counts is discrete, not continuous, and is limited to non-negative values. An ordinary linear regression model of the count data would create some issues. The distribution of count data is usually positively skewed with many zeros. A large number of zeros might prevent the transformation of a skewed data distribution to a normal one. Also, the regression model could produce logically impossible predicted values which are negative.

The most commonly used count models are Poisson and negative binomial. The simplest regression model for count data is the Poisson regression model. Negative Binomial Regression, Zero-Inflated Count Models, Zero-Truncated Count Models, and Hurdle Models are other commonly used count regression models. They can be used in the presence of over-dispersion or extra zeros to predict count data.

For example, penalised count regression models have been employed to find out factors associated with the number of re-hospitalisations among patients with schizophrenia disorder (Arayeshgari et al, 2022).

Karazsia & van Dulmen (2008) gave a very lucid practical demonstration of regression models recommended for count data using longitudinal predictors of unintentional injuries of children.

Conclusion

A regression model provides a function that describes the relationship between one or more predictor variables and an outcome, response, dependent, or target variable. The type of regression model to be adopted in a study would be decided by the types of data.

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SCIENCE & PEACE
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HUMAN EVOLUTION
The 'Re'search of Prof. SVANTE PÄÄBO

Prof. Svante Pääbo is a geneticist at the Max Planck Institute for Evolutionary Anthropology in Leipzig, Germany. He single-handedly won the Nobel prize in Physiology or Medicine in 2022 for 'his discoveries concerning the genomes of extinct hominins and human evolution.'

The research on human evolution by Prof. Pääbo and his team takes us to the notion of searching who we are, where we come from, whether we still have ancient DNA and what could be the usefulness of it.

The work earned extraordinary attention, as they focused on bringing light into the genome of an extinct, but closer relative of present-time humans, the Neanderthals. The study also attained a remarkable finding on the existence of Denisova, an unidentified and extinct hominin.

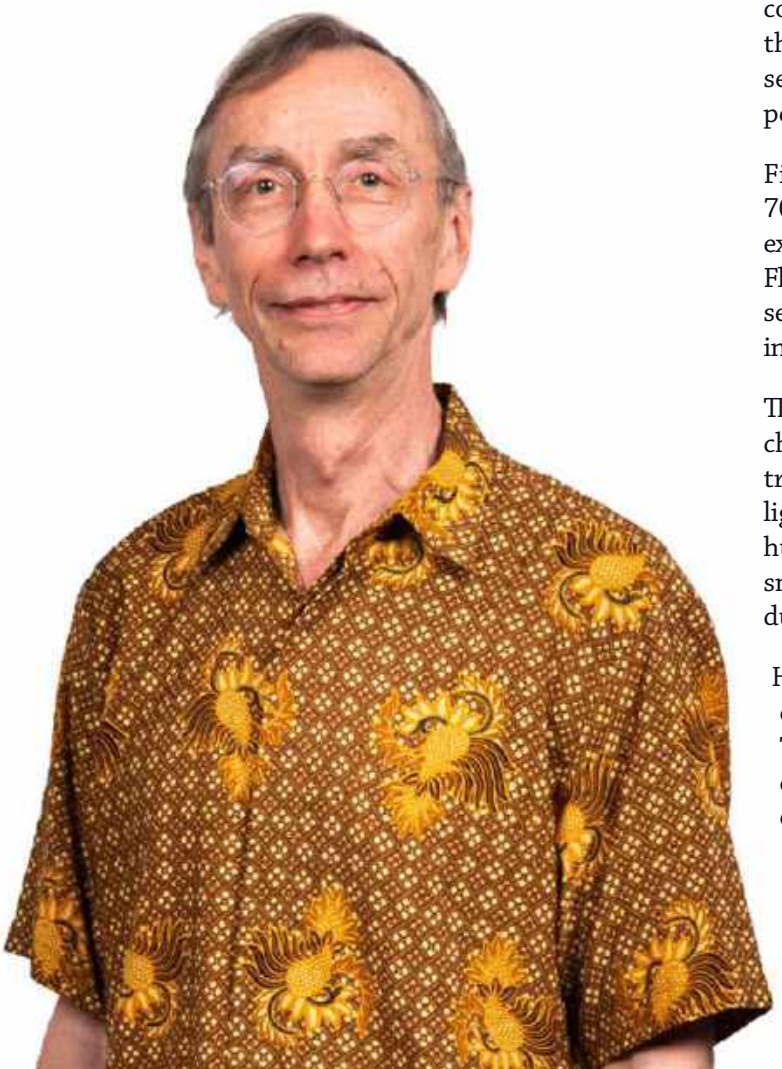
As a molecular evolutionary geneticist trained in cell biology, Prof. Pääbo's research on human evolution started from the idea of DNA extraction followed by gene cloning from ancient Egyptian mummies. This was considered impossible.

The work earned extraordinary attention, as they focused on bringing light into the genome of an extinct, but closer relative of present-time humans, the Neanderthals. **The study also attained a remarkable finding on the existence of Denisova, an unidentified and extinct hominin.**

DNA is the genetic book of an organism with its complete history. Hence, if we want to study the entire history of the human being, it is indispensable to develop an efficient method for DNA extraction from any sample, for example, from archaeological samples, museum specimens, or mummies. Prof. Pääbo succeeded in attempting the DNA extraction from various such samples and demonstrated that it is possible to clone and sequence such old and damaged DNA.

Cloning is the method of relooking the targeted piece of DNA, using the standard approach, to know the structure and function of the gene of interest. And sequencing is one of the techniques in molecular biology currently ruling the entire biological science world with its advancement and applications.

In general terms, DNA sequencing is the code reading of the DNA as a whole (book) of any species, where the four codes are represented as 'A, T, G, C' (Adenine, Thymine, Guanine, Cytosine). Even though there are challenges in decoding the DNA sequence, the application of the outcome is diverse.



This is a clear message for evolutionary genomics research. **The continuous works on old and living human samples by Prof. Pääbo made a colossal contribution to palaeontology and archaeology.**

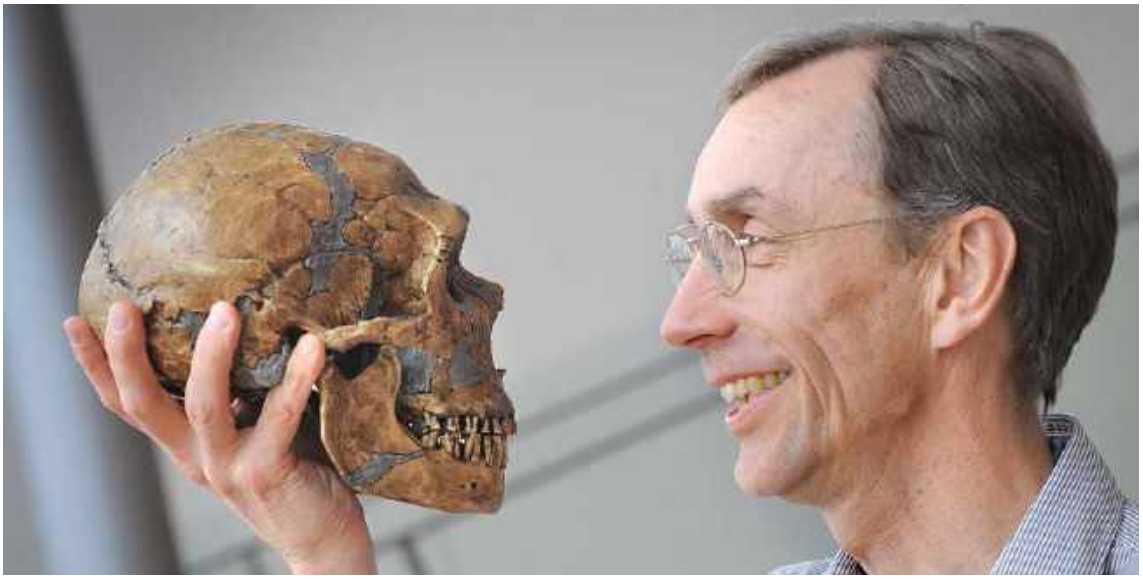
Once Prof. Pääbo succeeded in the sample collection, DNA extraction and sequencing of the archaeological samples, he unlocked the secrets of human evolution, and changed our perspectives of our origin and evolution.

First, he took the mitochondrial DNA from a 7000-year-old human brain from an individual excavated from Little Salt Spring in Southwestern Florida. He got a very informative anthropological sequence and reported three maternal lineages in the prehistoric colonisation of the New World.

Then, he got the idea of sampling the tribes by choosing 63 individuals from an Amerindian tribe and discovered 28 lineages, which shed light on their origin. It predates the entry of humans into the Americas, and scientifically smashed the concept of dramatic founder effect during the peopling of the Americas.

He did similar studies about the independent origins of New Zealand Moas and Kiwis, and Tyrolean Alps, which also contributed to changing the scientific scenario of human evolution and migration.

In 1995, he and his team corrected the report on the relationship between the dinosaur and human DNA sequences by stating that 'a



sequence from an ancient specimen that is not identical to any hitherto determined sequence cannot be taken as an indication for the ancient origin of that sequence'.

This is a clear message for evolutionary genomics research. The continuous works on old and living human samples by Prof. Pääbo made a colossal contribution to palaeontology and archaeology. These disciplines deal with the reconstruction of human origin and history and mainly reported that the variation of the human gene pool originated in Africa within the last 200,000 years.

With his continuous effort in methodology development in DNA sequencing, in 1997, his team studied the Neanderthal-type specimen, found in 1856 in Western Germany and stated that Neanderthals went extinct without contributing to modern humans.

The study, with the samples of 224 individuals across the Nile River Valley, answered how human migration happened at the molecular level and concluded that the migration from North to South was earlier in the extent of gene flow than the migration from South to North.

In his continuation of research on human population genomics by targeting various samples, the excavation of a bone in 2008 from Denisova cave, Altai Mountains, Southern Siberia, led to the discovery of an unknown type of hominin that shares a common ancestor with anatomically modern humans and Neanderthal, about 1.0 million years ago.

The study also suggested that the Denisova hominin lived close in time and space with Neanderthals and modern humans. Further study on the Neanderthals showed that they interbred with modern human ancestors some 120,000 years ago, leaving traces of Neanderthal DNA in contemporary humans. This outcome opened many more questions on the immunity and adaptation of modern humans and the search for possible answers.

Beyond human evolutionary studies, his research focused on comparative studies with two African apes. Mainly, the investigation focused on finding the relationship between the

The study enhanced the understanding of the population history and selective events that affected the apes and the reasons behind the phenotypic similarities between humans and apes.

Prof. Pääbo has cracked the code of human evolution, migration, and mutation by **using old and living samples with the support of thriving molecular tools and techniques.**

bonobo genome with chimpanzees and humans. Surprisingly, the result showed that more than three per cent of the human genome is more closely related to the bonobo, a chimpanzee, than to each other.

The study enhanced the understanding of the population history and selective events that affected the apes and the reasons behind the phenotypic similarities between humans and apes. Generating molecular data for various species created the question of whether interbreeding happened between humans and Neanderthals.

Consequently, Prof. Pääbo's team in 2012 figured out that interbreeding between them occurred when modern humans carrying the upper palaeolithic technologies encountered Neanderthals as they expanded out of Africa.

Modern sequencing technology has driven his research to another phase. He has started collaborating with various research groups worldwide. One of the research projects is about the genetic history of Ice Age Europe by analysing 51 Eurasians dating from 45000 to 7000 years ago.

Interestingly, the research found no evidence of the earliest modern humans in Europe contributing to present-day Europeans' genetic composition. And given the overview of how population turnover and migration have been recurring themes of European prehistory.

The comprehensive look at human evolution raised the question of whether we got the genetic risk factor from Neanderthals when the pandemic paralysed the world, and he answered it. The study showed that a genomic segment that confers the risk is inherited from Neanderthals and is carried by around 50 percent of the people in South Asia and approximately 16 percent of people in Europe.

To wrap things up, Prof. Pääbo has cracked the code of human evolution, migration, and mutation by using old and living samples with the support of thriving molecular tools and techniques. As of October 2022, he has published 351 papers and obtained two patents related to population genomics. He has touched not only humans and related species study, but also other species (bats, rats, reindeer, maize). Over and above, the breakthroughs have also opened new research areas in human immunogenetics and medical applications.

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ART & PEACE
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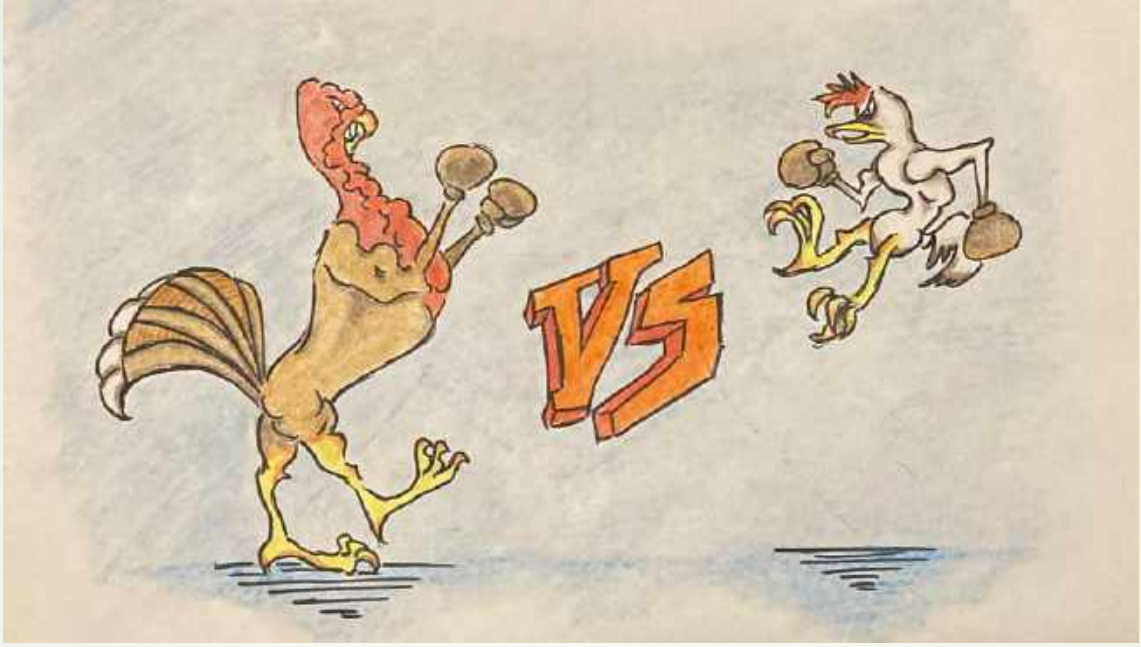
The Glories of **MAIL ART**

Communication began in the form of pictorial depictions in the prehistoric era. It has gone through a lot of advancements since then. The postal media is a form of communication which was rapid in the last century and is still being used in an age of instant communication.

Postal messages are a simple way to remind others that you are thinking of them. The post reminds one of the beauty and simplicity of an age when communication was precious because of the constraints of space and time.

The dissemination of messages through postcards was short, crisp and sweet. Children would draw and write these letters to their friends and family. People also fondly used to buy picture postcards from various tourist places to send as souvenirs to their dear ones. There was a sweetness in these postal communications which is now foreign to the younger generation of this digital age. Even our mythologies make a



mention of the then form of mail art where princes or princesses were sent portraits of prospective life partners through messengers like the modern-day posts.

In the early 20th century when sending messages through the post was one of the main forms of communication, artists started sending each other their artworks through the mail. Though it is believed that French painter Marcel Duchamp initiated the concept of mail art in 1916, American artist Ray Johnson (1927-1995) is considered to be the one who pioneered it.

He began mailing and receiving original postal art to his network of artists. This grew and flourished internationally. The postal system helped in the transit of the art and the network of people with a new creative connection who likely had never interacted with each other made it unique and special.

This beautiful way of propagating art was an equaliser. Anyone with any level of art skills could participate in this form. Artists from any part of the world could participate in this by sending drawings, paintings, postcards, photocopies, collages and prints. It is not just an experimental art but also expressionist and edutainment too.

When the entries of artists reach in a second through emails the physical mails take days and weeks to reach their destination. After all that wait, when one receives the anticipated or unanticipated mail, with all those marks caused by the transfer such as postal stamps and seals, the experience is fascinating.

The value of the art is enriched by those marks and it becomes more personal. Some of the interesting components can be handmade decorative envelopes or unique stamps. These unique artistic stamps are often referred to as 'artistamps'. These are also known as pseudo-stamp or Cinderella Stamp.

Some mail artists also design and create their postage and just stick that on envelopes and postcards. Although these stamps have no postage value, they allow the artist to put their stamp on the artwork. There may even be small photographs of

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the artists or abstract colour patches. In the 1950s, American artist Yves Klein created a series of stamps in his signature blue with the stipulated postal regulation size for the invitation cards for his exhibition.

Postal art can also be used as a form of education and entertainment amongst children and elders. The seals provide philatelic and historic information. Each bit of the mail tells us some interesting information about its journey, subject, and culture.

The famous artist Vincent Van Gogh's letters posted to his brother, Theo, are also special because of the sketches he added to them. These sketches were meant to give Theo an idea about what he was working on.

Information about the life and works of Van Gogh is obtained from his letters including those which have been instrumental in art forensics about his works. Today the artist's letters with sketches are displayed in the Van Gogh Museum in Amsterdam.

Postal art can also be used as a form of education and entertainment amongst children and elders. **The seals provide philatelic and historic information. Each bit of the mail tells us some interesting information about its journey, subject, and culture.**

Yet nothing can replace the surprise, intimacy and preciousness of having a tangible object which flowed **through a noticeably larger period and through multiple restrictions to reach the receiver.**

In this century, the transmission of art through the digital medium has overtaken its old method of transmission through analogue methods. With the development in quality, storage and speed the transmission of images has reached a different level. So, a simple way of propagating art through mail art might look inconspicuous in the deluge of art available on digital platforms.

Yet, nothing can replace the surprise, intimacy and preciousness of having a tangible object which flowed through a noticeably larger period and through multiple restrictions to reach the receiver.

Anyone can exhibit mail art. Occasions such as the World Postcard Day on October 1, World Post Day on October 9, National Postal Day of India on October 10, and Philately Week can be utilised to celebrate mail art along with the importance of various aspects related to postal services and posts.

Mail art exhibitions can be conducted to make people interested in this art style. This can be used for edutainment. During the pandemic, this art style had seen a surge along with digital art and digital exhibitions due to financial upheavals and mobility constraints.

The strength of postal art is that since postal services are available even in remote locations where networks necessary for digital transmissions are unreliable, the post remains a reliable mode of communication. Hence, by using it, art can be propagated despite the constraints of place, financial stringency, skill or equipment.

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Reference link: https://Awww.vangoghmuseum.n1/en/art-and-stories/stories/van-goghs-letters

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BOOK REVIEW

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DIFFERENTIATING REAL CONSCIENCE and SUPEREGO

Fulfilment Using Real Conscience:
Practical Guide for Psychological and Spiritual Wellness

Author: Dr. N. S. Xavier, M.D.
Published by: AuthorHouse, Bloomington, 2009

The book titled 'Fulfilment Using Real Conscience,' by Dr. N. S. Xavier, M.D. shares the idea that life can be made beautiful by the proper use of one's real conscience. It is based on his research experience as a practising psychiatrist in Alabama, USA, for well over three decades. Very often, we are in utter confusion to understand the difference between real conscience and superego. The core insight of the book is how to differentiate both.

Superego is socially programmed. It is formed by the value system that we acquire from our childhood such as family and society. It has got an ethical framework which is legal and ritualistic. Whereas, real conscience is moulded by reason and the Golden Rule that is upheld by all religions: 'treat others as you would like to be treated.'

Faith without fundamentalism, power without authority, self-respect without pride, rules without rigidity, relations without hatred, judgement without prejudice, and decisions without selfishness spring from the real conscience.

Unfortunately, religions and their ideologies, which are supposed to foster real conscience, reinforce the 'superego' of divisive communalism and fanaticism.

The superego is superfluous, whereas, the real conscience is deep-rooted and is inscribed in the heart. Love, mercy, empathy, ethics and a sense of justice belong to the domain of real conscience. Socrates, Cicero, Mahatma Gandhi and Martin Luther King lived according to the real conscience. The teachings of Mahabharata, Manusmriti, Buddhism and Jainism are, indeed, of the same sphere.

The author mentions four ways to live according to conscience. The first way is awareness. It is a conviction on the consequences of the decision to be accomplished.

The second is decision. It means, to analyse the various options that are useful for oneself and others. To do this, one has to utilise the data and the information gathered during the stage of awareness from family, religion, media, and education.

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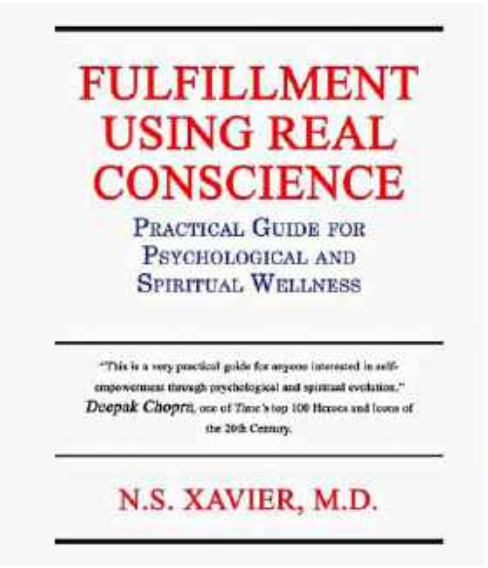


The third is action. Action should always be based on a decision. To put any decision into action, discipline is required. Self-control, self-confidence, wisdom and insight will come to one's help at this stage.

The fourth one is reassessment. This is the process of evaluating our decisions and actions. The findings and morals we get from the evaluation help us to make future decisions. Real conscience is the inner force that convinces our mind whether a thing is right or wrong before and after it is done. Desire is the root cause of most of the problems of human beings. According to the author, there are alternative and sublime methods to accomplish the physical-mental-intellectual-spiritual needs.

To many a person approaching him in the clinic, he shows the alternative path of hope through the proper utilisation of their true conscience. Among them are patients from broken families with wounded minds, the drug-addicted, those who suffer isolation in their old age, and mental patients. This book is divided into 13 chapters with an appendix consisting of meditation techniques. It is conversational in style and lives up to its name as a 'guide', providing lists, acronyms, quotations, clinical anecdotes, and literary stories.

To some, it may feel that the book lacks academic rigour, but the author intends to transform ordinary people who struggle to lead healthy and meaningful lives. I would strongly recommend this book to mental health professionals, counsellors, patients, teachers, the youth and children.

This splendid work is an adequate means to promote peace and well-being in individuals, communities and countries as we live in a world of violence and conflicts.

Besides the present book, Dr. N.S. Xavier has authored other books, such as, "The Two Faces of Religion: 'A Psychiatrist's View' (1987), 'The Holy Region: A Wonder of World Religions in Harmony' (2003), and 'Fulfilling Heart and Soul: Meeting Psychological and Spiritual Needs' (2006).

Dr.K.M.Mathew is a former Professor of Commerce at Kerala University of Fisheries and Oceanic Studies, Kochi.

LETTERS TO THE EDITOR

Dear Editor,

Thank you for the PAX LUMINA issue of September 2022 on Global Food Crisis and Food Justice with my contribution. Thank you also for the distinguished design for my article. It is my honour and pleasure to collaborate with your mission and wish you all the Best for all your efforts.

Best regards,

***Siham Rizkallah,** Lebanon*

Dear Editor,

Congratulations once again for the wonderful issue of PAX LUMINA on Food Security with insights from across the globe, especially from Ukraine. The interview of Vandana Shiva was enriching. All the other articles were well written.

Best wishes,

***Denzil Fernandes,** Delhi*

Dear Editor,

Thank you for the November 2022 issue of Pax Lumina.

As far as the food crisis and food justice in India is concerned…. some facts and thoughts!

The Indian constitution guarantees some basic human rights under Part III Fundamental Rights (Justiciable) and Part IV Directive Principles of State Policy (Non-justiciable) respectively. Notably Articles 21, 39 (a), 47 and 32 sent into motion the rights and the remedies available. These rights also get echoed in UDHR 1948 (Art. 25) and its corresponding reflection in Art. 11(2) of the ICESCR 1976, to which India is a signatory.

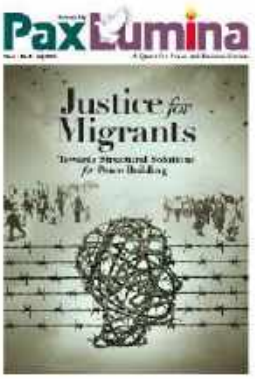
And yet, as for food justice, the efforts continue. The honorable Supreme Court of India judicially established these rights in the case of Chameli Singh v. Union of India; CESC v. Shubhash Chandra Bosh and Peerless General Finance v. R.B.I. Even CEDAW in 1979 and CRC in 1989 reaffirmed this right to food as an essential human right. Yet the war on hunger continues, as it becomes a problem of distribution and equity in a country where the levers of control on resources were unequally located and the socio-economic engineering mandated through Constitutional provisions were far from achieving their goals.

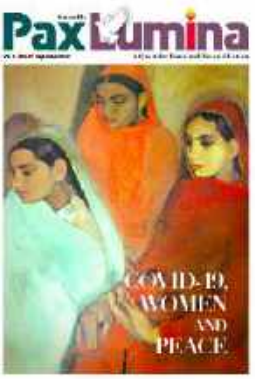
And then came the 2001 PUCL case, where the Supreme Court reiterated its previous jural ratio in clearly declaring that "the right to food" is an extension to the fundamental right to life guaranteed under Art.21 of the Indian Constitution. Despite this it took a long time to have legislation on the subject…. The National Food Security Act came into effect on 5th July 2013.

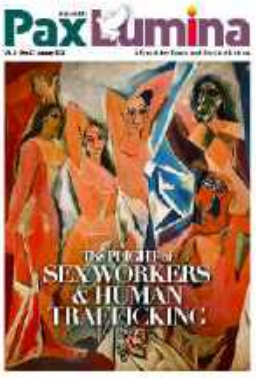
The question then to ponder is about adequacy of Constitutional mandate, Statutory protections, and the judgements of the Apex Court on the one hand and the inadequate Institutional structures of State on the other hand The Annapoorna Yojana, Antyodya Anna Yojna, and the Mid-Day Meal Scheme on the one hand and the actual accommodation of the beneficiaries on the other hand… there are many challenges to overcome.

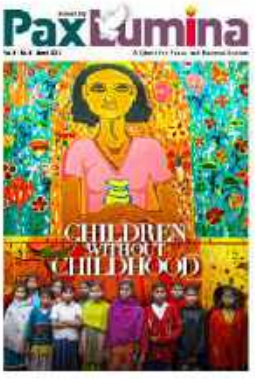
Regards,

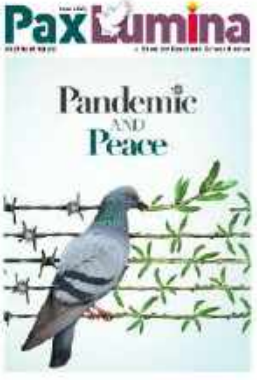
***Paramjyot Singh,** XLRI Jamshedpur*

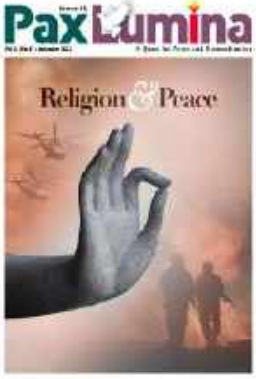


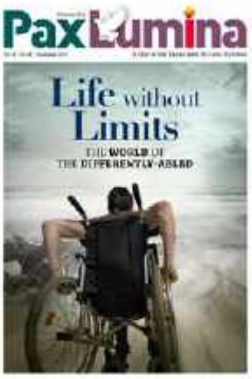


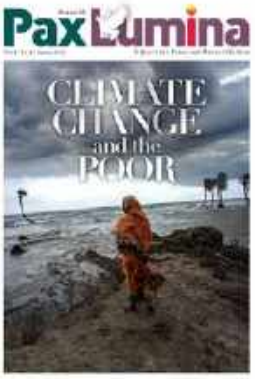


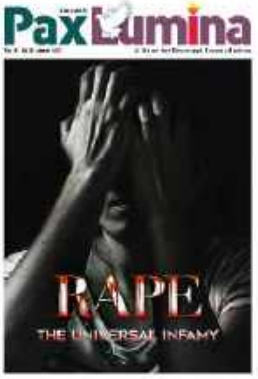


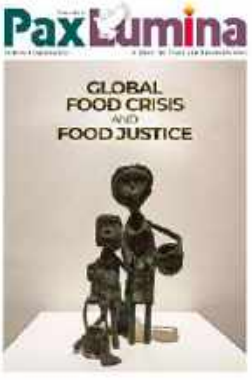












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