semicolon

the year that was

15th October 2020 - 15th October 2021

1ST ANNIVERSARY ISSUE

THE SYMBOL

The ';' mark is used by writers who could have ended the sentence but chose to continue it. Similarly, survivors made a choice - to continue life. The semicolon is symbolic of the survivor and is used in solidarity across the Mental Health community. It was popularised by Amy Bleuel.

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Opening Note

Today, October 15th, is special because it's my late grandfather's birthday. Shyam Sundar Goenka (or my 'Dadaji', as I fondly call him) left behind a legacy that is impossible to articulate, so instead, I'd like this to be a silent celebration in his honour. Exactly one year ago, on this date, Semicolon was born.

What a year it's been.

Semicolon went live in the middle of a global pandemic, and it created a community and platform I did not realise was possible. Over one thousand emails, countless Zoom calls, and connections that will last a lifetime with people from around the world - we have only just begun. Professors, researchers, writers, and therapists from several countries came forward and volunteered time to share their work with this growing family.

We explored several subjects in mental health together; virtual reality, canine therapy, self-compassion, criminal justice systems, and art therapy, to name a few. And we have an ever-evolving universe left to understand. As they sparked conversations, more people showed interest in learning about mental health and joined the journey.

Today, I am sharing the 1st-anniversary issue of Semicolon with you, a compilation of the year that was. As usual, this is completely free and accessible to all. Thank you for being curious, being open, and being brave.

It takes courage to ask for help, and so many have found that courage. So let's add to the voice, not the silence.

Read on, share widely, and stay safe!

With love,
Nupur

Un-demonising a beast: Electroconvulsive Therapy

DR. JAGADISHA THIRTHALLI

OCTOBER 15, 2020

Randle McMurphy (played by Jack Nicholson) is strapped to a gurney, surrounded by people in white coats, and is seemingly unaware of what is about to happen to him. They hold him down, forcibly insert a mouth guard and begin a procedure that looks nothing short of barbaric. A device is brought to each of Randle's temples and a knob on a machine is turned – it begins. His entire face contorts in pain as his body begins to convulse violently. They continue to hold him down and the convulsions continue, until mercifully, the scene comes to an end.

For many of us, this infamous scene from One Flew Over The Cuckoo's Nest (1975) imprinted what Electroconvulsive Therapy (ECT) looks like – a cruel procedure. Walking through the history of ECT with no bias, however, paints a strikingly different picture.

Let's go back to several centuries ago. It was a time when all Mental Illnesses were amalgamated into one word – 'insane'. People began to observe a strange relationship between seizures and a subsequent decrease in the level of insanity. When people experienced seizures, the severity of the symptoms of the mental illness seemed to come down almost immediately, sometimes to the point where the individual would become 'almost normal'. Soon enough, the scientific community began to wonder whether it is possible to induce a seizure to treat mental illnesses.

At first, they tried to induce seizures chemically with substances such as camphor and metrazol . This turned out to be a dead end; the onset of a seizure was unpredictable, and the patient often suffered from several side-

effects of these chemicals.

Psychiatrists in Italy stumbled on butchers, who used electricity to induce epileptic-comas in pigs before slaughter. It was a lightbulb moment (pardon the pun) in the history of psychiatry and by the late 1930s, the first session of 'convulsive therapy' was administered with electricity, and "Electroconvulsive therapy" was born. The use of electricity allowed the entire procedure to be much more focused and predictable unlike the earlier primitive attempts.

The first patient that it was administered on was an extreme case. He was incoherent, spoke gibberish, was unaware of his own identity, and seemed to neither eat nor bathe. After several sessions of Electroconvulsive Therapy, he showed an astonishing improvement! He regained composure, orientation, and even began to converse coherently. And so, it became the foundation for the practice that continues today.

By the mid-1940s, the standards of ECT had settled, and look similar to what it is today. Patients are given an anaesthetic and muscle relaxant prior to the procedure, and therefore, do not feel anything while it is happening. An electric current, equivalent to burning a 40-watt bulb for two seconds, is administered and the brain seizes. The electric circuit is closed in the brain itself and does not reach any other part of the body. The procedure, in fact, is safe enough to administer on women of near term pregnancy. Physiological symptoms such as an increase in heart rate and breathing during and immediately after the procedure are completely normal, similar to what would be experienced with a natural seizure. Short term memory-loss and disorientation are also common amongst patients; most regain their composure within 30 to 60 minutes after the procedure.

A strikingly different picture than what Randle McMurphy painted for all of us...

Electroconvulsive Therapy is not a cure, it is a temporary solution. In fact, if the patient does not receive either medication and other forms of psychological and therapeutic treatments after the procedure, they are very likely to relapse within a few days.

In many cases, ECT buys time for other interventions to help an individual discover their path to long-term recovery. It is used as a first-line treatment for patients who are perceived as high-risk for suicide or are completely catatonic for alleviating symptoms, and therefore, giving them the time and space they need with medication and other forms of therapies. ECT could also be used for individuals who have not improved with even high doses of medications and/or are unable to bear their side-effects.

> "World over, the practice of Electroconvulsive Therapy is declining. Far

> from common belief, however, this isn't because the procedure is inhumane or barbaric in any way. It is merely because we have started to get access to more sustainable alternatives.

Medications and therapeutic techniques for depression, bipolar disorders, schizophrenia, amongst others, are becoming more advanced and more effective. People are also beginning to seek treatment early and preventing the mental illness from reaching a point of severity where ECT can be considered effective. This does not imply, however, that the practice of Electroconvulsive Therapy needs to be banished, demonised, or dismissed.

At NIMHANS, we administer ECT to approximately 900 patients every year. This would amount to around 8000 sessions in total. Patients and their families are given all the information beforehand and always have the choice to opt for ECT or other alternatives, it is never a rigid prescription and different options do exist. ECT is never administered without an explicit written informed consenting process.

In a world that is already struggling to talk about mental illnesses, the demonisation rather than the knowledge of practices will only take us steps back; at a time when, more than ever before, all of us must leap forward.

WRITTEN BY

Dr. Jagadisha Thirthalli

Dr. Jagadisha Thirthalli is a professor in the Department of Psychiatry at NIMHANS (Faculty since 2002). He has 20 years of research and practical experience in ECT and other brain stimulation techniques. He's had several awards including Marfatia Award of the Indian Psychiatric Society and CV Raman Award from Government of Karnataka and has publications in Brain Stimulation, Schizophrenia Research, Journal of ECT, Journal of Affective Disorders amongst others.

This could get worse

MARK A. REINECKE

OCTOBER 15, 2020

In December 2019, a virus was detected in Southern China that unleashed a series of events and created a world that none of us have ever seen before. Within a matter of weeks, streets were left deserted and workplaces shuttered as people isolated themselves in their homes. Governments were forced to impose lockdowns to contain the virus spread which caused an unprecedented disruption of supply-chains and industries at a global scale. Unemployment rates spiked across the world, and continue to do so. Almost nine months into the pandemic, most of us are passive spectators, watching it unfold and waiting to see what the world will look like once it has run its course.

The future is always uncertain and we are all trying to adapt to a 'new normal'. However, there is a lot that our past can teach us to be better prepared for what's to come. For many decades, we have known there are strong associations between economic recessions and suicide rates. From the Great Depression of the 1930s, the Asian Economic Crisis of 1997-1998, to the economic downturn of 2008; each period has witnessed a surge in suicide incidents, particularly amongst men and young adults.

In a 2013 study conducted by Shu-Sen Chang and colleagues, they found that suicide rates in 54 countries were significantly correlated with levels of unemployment during the 2008 economic crisis. For those who lived through it, we remember them as difficult times. During the same year, the United States experienced the worst loss of jobs in six decades with unemployment rates rising to 7.2%. At its peak, approximately 600,000 people were filing for unemployment every week.

Today, the United States has recorded the highest number of Coronavirus cases in the world. With the ongoing COVID-19 epidemic, the loss of jobs the country has seen is far more severe than before. By July 2020, the US Bureau of Labor Statistics reported that 10.2% of adult Americans were unemployed. In India, recording the third highest number of Coronavirus cases, the Centre for Monitoring Indian Economy reported unemployment rates spiking to 23.5% in April and May 2020. As of August 2020, India witnessed over 18.9 million salaried jobs lost since the lockdown began in the country.

These are staggering statistics. And the impact on families and lives across the world will be profound. Unlike before, the potential impact will not be limited to adults. Individuals across all ages and walks of life are going through this pandemic, and we are all in its blast radius.

COVID-19 appears to have created a 'Perfect Storm'. Lockdowns and the resulting economic slump can trigger feelings of stress, hopelessness and helplessness in people. At the same time, we are witnessing a groundbreaking level of social isolation to contain the virus spread. Social alienation and a sense that the problems we are all facing are unendurable and unsolvable are all strong predictors of suicidal thoughts and tendencies. COVID-19 has created a miasmal fog of stress, uncertainty, hopelessness, and social isolation. Should this persist, the history is strong. Left unchecked, we could witness an increase in suicide rates over the next several months. This is unsettling, to say the least.

Can something be done?

Governments, around the world, need to first acknowledge this possible aftermath and create an actionable plan that we can all rally behind. Increasing the availability of unemployment insurance and interventions to limit lay-offs and furloughs can have a positive effect, if done well. We can also work to limit access to lethal means (guns, poison, etc.), control sales of narcotic medications, and restrict access to high risk locations (such as bridges or train tracks) as much as possible without causing disruptions.

Government action, however, can be slow. Perhaps the most important preventative steps begin at home. Family and community efforts to provide support to individuals who have struggled in coping with the challenges of these times has never been more essential.

The world is more connected than it has ever been before. Reach out to friends and neighbours who have lost their job or who are living alone. Be on-guard and for signs of depression or thoughts of suicide in people that are close to you. Listen to them, offer support, and take them seriously. Don't dismiss these as passing thoughts or feelings. Encourage them to seek out and accept help.

With teenagers, work to maintain a stable, supportive, and secure home environment. Encourage them to give a voice to their feelings and concerns. If they express thoughts of death or suicide, take them seriously and

offer support. Although no single approach has been found to prevent suicide, a combination of efforts can be very effective.

> Suicide *can* be prevented.

The next wave of the Coronavirus tsunami – suicide - is approaching, but the outcome is not inevitable. There are actionable steps we can take, individually, in our communities, as a nation, and as a global population, to help those most at risk. The outcome depends on the actions we take now. We should all prepare.

WRITTEN BY

Mark A. Reinecke

Mark A. Reinecke, Ph.D. is Professor Emeritus of Psychiatry and Behavioral Sciences and past Chief of the Division of Psychology at Northwestern University's Feinberg School of Medicine. He also served for 14 years as the Director of the Center for Cognitive Therapy in the Department of Psychiatry and Behavioral Neuroscience at the University of Chicago. He is a Distinguished Fellow and former president of the Academy of Cognitive Therapy, and a Diplomat of the American Board of Professional Psychology (ABPP) in Clinical Psychology and Clinical Child and Adolescent Psychology. Dr. Reinecke also is a Fellow of the American Psychological Association, the Association for Psychological Science, and the Association for Behavioral and Cognitive Therapies. He is the 2015 recipient of the Cynthia D. Belar Distinguished Service Award from the American Psychological Association. His research and clinical interests center on understanding and treating depression, suicide, and anxiety among children and adolescents. He has lectured internationally and has served as a visiting professor at institutions in Europe and Asia. Widely published, he has authored or edited eleven books, including Cognitive therapy across the lifespan, Comparative treatments of depression, Cognitive therapy with children and adolescents, Personality disorders in children and adolescents and Cognitive-behavioral therapy with adults. His first book for a general audience, Little ways to keep calm and carry on was published by New Harbinger and a new book, Landmark papers in psychiatry (Oxford University Press) was published earlier this year.

No longer criminals, but not equal citizens

MAHESH NATARAJAN

OCTOBER 15, 2020

In India, for 157 years (1861 – 2018), it was considered legal for only procreative sexual acts to take place between a man and a woman. Anything outside this was a crime. Peaceful protests have taken place across the country for several years against the infamous Article 377, calling for its reading down and the removal of its applicability to adults. Touted the 'victory of love', the reading down of Article 377 was an act of renouncing draconian laws rather than constructing ones that would lay a strong foundation for the community to be considered equal citizens. And while the decriminalization of homosexuality is a step in the right (or rather, obvious) direction, consistent oppression has left the community amongst the most vulnerable to mental health struggles.

Several other laws have continued this pattern of suppression. The Surrogacy Act (2019) rules out adoption and surrogacy for single parents, homosexuals and transgender individuals – taking away a large part of their right to build a family. At one point, the Trans Act (2019) considered it illegal to determine one's own gender – a clause which was removed but has exacerbated confusion in the community about its intent. The Act also forces a trans individual to live with their natal families, regardless of whether it is a physically and emotionally violent environment or not. The punishment for sexual violence against trans people is significantly less than the same against non-trans individuals; effectively condoning this behaviour. The discrimination is systemic, to say the least.

Psychological distress can quickly become an enormous problem when the stressors are intense and acute

(such as a physical assault or a sexually violent attack) or chronic and prolonged (such as poverty, discrimination, and neglect); our social systems have created a perfect recipe of both for the queer community. In many cases we have overlooked violence against the community from several individuals that claim to have a 'cure' for homosexuality. These are purely acts of cruelty packaged as 'therapy'. In the recent past, a young student in Kerala died by suicide after being subject to physical, mental, and medical torture by her family and by so-called 'conversion camps'. It is crushing to know that this is not the exception but the norm.

> Too often and for far too long, we have taken a problem that is created by society and its legal structure and unjustly converted that to a perceived flaw in a human being.

It is strange to consider how our social training can so easily prevent us from accepting something, purely because it is different. We have learnt how to equate 'dissimilarity' with 'immorality' and you can see this far beyond the queer community.

Our country's mental health system is not only strained but unequipped to handle the onslaught of struggles that this consistent oppression has created. We cannot possibly hope or expect individuals to live a great and full life when they're denied basic rights that most of us take for granted such as getting married, starting a family, and having the freedom to self-identify with our gender. We're at a nascent but important stage to not only support the queer community but to build a world where, at the very least, mental health can be taken for granted and not hurt by legal systems. A culture of affirmative care for people in minority groups doesn't exist today and we need to create it.

Over the last decade, our society has taken several steps in the right direction. Groups and bodies for the queer population are no longer scattered across the nation with little to no contact with one another. A sense of solidarity has been rapidly emerging. One can even have a sense of confidence that they have an entire community to rally behind them. Many people are coming together, connecting with each other, and working towards evaporating the feeling of isolation that has been deeply entrenched for so long.

Since the reading down of 377, several prominent people have come out about their sexuality and sexual identity without the fear of criminalization. These people have not only served as role models but have used their platforms to amplify voices of the community. Allyship has begun to germinate and grow with more people speaking out on social media and joining hands with the community for pride marches. The media has begun talking more openly about sexuality and gender as well.

Seeds have been sown, a few have even begun to take root, but we have a long way to go as a society. The community may not be criminals any longer, but we are far from being considered equal citizens in a country we call home.

Naturally, the predominance of mental health struggles in this group is staggering. Although a large part of society has been trying to leap forward against this oppression, they often find their mobility constrained by a variety of institutions. There is little doubt that introducing the true diversity of sexuality and sexual identity in early education will have its merits. But, lack of education and 'social class' are poorly related to ones acceptance of the queer community. Across society, there are enough families that are near impoverished and open their arms to the community, families that are incredibly wealthy who indulge in rejection, and vice versa. Perhaps, what we need is much more fundamental and deeply rooted in human nature than literacy. I wonder, can one teach another the art of basic love and compassion?

WRITTEN BY

Mahesh Natarajan

Mahesh Natarajan is a counsellor at www.innersight.in who works largely with adults and strives to provide an affirming and validating space for people of diverse genders, sexualities, races and social class/ caste, in which people can safely work on challenges they might have regarding identity, expression, personal and professional goals.

Is ignorance really bliss?

DR. SHIVA PRAKASH SRINIVASAN

OCTOBER 13, 2020

"Asatoma satgamaya, Tamasoma jyotirgamaya" – literally translated means 'take me from untruth to truth, take me from darkness to light'. These words are taken from the Brihadaranayaka Upanishad, one of the principle scriptures in Hinduism, and verbalise a plea from a student to a teacher (a guru). In India today, access to information is taken for granted with the prevalence of technology, but access to quality education remains a great concern. In 2018, gross secondary education enrolment in the country stood at 75.16%, while gross tertiary education (ages 18-22) enrolment was only 28.06% [1]. While these statistics are staggering, the teaching of mental health is insignificant in comparison; both in terms of outreach and quality. Perhaps taking a different approach to mental health education will help us make the right kind of difference.

There is great value in learning the theory of mental health and wellness, but perhaps even greater value in understanding its practical reality. The subject of mental health has remained in the shadows alongside people who have lived experiences and struggles with it; what if we bring them out of the darkness and introduce them to our youth?

> Through 'contact based education' we can allow students to see the wide spectrum of mental health and the positivity of seeking help by connecting with the living human rather than the imagined demon.

The lack of quality mental health education is particularly concerning in the younger age categories because we see a maximum number of issues emerge from this group. India has the greatest proportion of young people (below 24 years of age) in the world who account for approximately 45.27% of the total population. Several studies indicate about 50% of all mental health issues emerge prior to the age of 18 and up to 75% by the age of 25 [2]. Suicide is also the leading cause of death in the 15-29 age group and between 10-20% of children and adolescents suffer from mental health struggles. The motive to introduce the subject at an early age is well grounded in these numbers.

This demand creates an enormous strain on our mental healthcare professionals, and thus, most efforts are targeted towards addressing mental illnesses rather than preventing them from becoming worse in the first place. We can begin to alleviate this by introducing mental health literacy at an early stage and empowering young people with knowledge. This allows communities to reduce stigma, increase acceptance, and promote help-seeking behaviour. There is already a huge gap in mental health awareness amongst the youth. Several studies have shown that less than a third of school and college going individuals were able to identify mental illness and even fewer recognize where and when to seek help. To bridge this gap, it's important to understand how young people primarily learn about mental health today, why it's problematic, and how contact based education can build a strong foundation for future generations.

There are several movies that address mental health issues; 15 Park Avenue, Chicchore, Taxi Driver, As Good As It Gets, and Silver Linings Playbook come to mind. Social media is also rife with posts about mental health that are bite-sized and nested in visually appealing packages, making it easy to digest. Both approaches, however, have severe limitations. A movie tends to focus on the extreme ends of the spectrum by amplifying the more dramatic aspects of mental health, and social media runs the risk of providing partial information that is taken out of context. As a result, they can lead us down a dangerous path of deepening stigma and delaying help-seeking.

Contact based education finds an interesting balance between the full-meals of movies and the bite-sizes of social media. It can be a powerful medium that doesn't venture to the dramatic ends of the mental health spectrum yet introduces reality within its true context; all in a session that lasts less than the length of a school period. We invite people who have battled lived experiences with mental health to share their personal journeys and talk about how they sought help when they needed it. First, it's important to set the stage with a professional understanding of mental health issues so students know what to expect. This allows for a sense of empathy to take root and for the session to be much more powerful. A conversation takes place, and hopefully, a connection is formed. When a student is able to relate to another as a human being, it can have a profound impact on their perception about mental health. It allows them to develop more nuanced views

about their struggles and understand what real life progress looks like. The importance and positivity of help-seeking gets magnified.

Rather than passively listening to theoretical and didactic lectures, contact based education offers the 'practical' side of mental health education. This is no different from how we teach the sciences today; experiencing something has an impact that reading cannot replace. This is essential for schools and families to understand when concerns are raised about this style of teaching. However, we have realized that when schools recognize the importance of a subject and its method of delivery, it is rare for parents to object.

Almost half of India's population is statistically vulnerable to mental health issues, our healthcare has a huge deficit in meeting this demand, and our education system on the subject is weak at best. While our road ahead is long, and perhaps winding, we have an opportunity to use the power of lived experiences to create a breakthrough. With contact based education we can reduce stigma, increase knowledge, and encourage help-seeking, and perhaps, begin to address our system holistically.

If you are struggling with your mental health or know someone who is, please consider seeking out professional help. If you are an educator, consider the power of contact based education and introduce your students to a person with lived experiences with the support of mental health professionals first setting the stage. Help break the stigma. Beyond creating a sense of empathy, maybe it can also give young people the courage to step away from the shadows themselves. A courage that may slowly become the norm, and remove the need to rewrite these articles for our future generations.

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WRITTEN BY

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Misfit pieces in a puzzle: What textbooks might not tell you about depression

PANKHURI AGGARWAL

NOVEMBER 12, 2020

There are many different reasons as to why people around the world pursue a career in mental health. Some are fascinated by the mystery of the human brain, some have a zest for helping people with psychological struggles, and some aspire to shape the future of the field. Whatever the reason may be, most individuals begin their training with obtaining a formal education in psychiatry, psychology or other mental health allied fields. It is likely that their training in mental health will introduce them to diagnostic manuals such as the DSM (Diagnostic and Statistical Manual of Mental Disorders, authored by the American Psychological Association) and the ICD (International Classification of Diseases, authored by the World Health Organization). Although these diagnostic tools provide a helpful template for diagnosing different mental health disorders, over the past few decades, the universality of some of these categories has been questioned.

The DSM is currently in its fifth edition and provides literature, tools, and descriptions that allow healthcare professionals to diagnose mental health disorders accurately. In the 1950s, its content was heavily influenced to appropriately capture the clinical presentation of World War II veterans and service members. Given that normality was defined in terms of social deviance and infrequency, it is not surprising that homosexuality continued to be classified as a mental health disorder until 1987. Even then, studies included in the DSM were representative of a small section of the global population (i.e., those who lived in North America and Europe) with little to no research conducted in low and middle-income countries and with individuals with stigmatized identities. While the series of changes with every new edition of the DSM reflected the latest research

conducted in the field, it also began to question the stability of these diagnoses, especially across time and different cultural groups.

Specifically focusing on depression, the term depression itself has Latin roots, meaning "to press down" (Kress et al., 2005). In high-income countries, primarily in the West, individuals with depression may approach clinicians and report feeling 'blue' or 'down'. However, in many other cultures, people experiencing depression might not relate to this vocabulary, and may instead report feeling "empty" (Kleinman, 2004). When you use a questionnaire heavily based on language that is not a part of the inherent cultural experience, many respondents would not 'check' the box that asks if they're feeling 'down', as there is no other box that can effectively capture what they are experiencing. It is like someone trying to forcefully fit a puzzle piece in a spot where it does not belong...

In addition to differences in language, variations may also exist in the way depression is conceptualized across cultural groups. According to the DSM (American Psychological Association, 2013), depression can be best captured using three symptom clusters: affective symptoms (e.g., feeling low, crying), cognitive symptoms (e.g., lack of concentration, suicidal ideation), and somatic symptoms (e.g., fatigue, loss/gain of appetite). The DSM further states that these symptom clusters can lead to interpersonal and occupational difficulties, including social withdrawal, poor performance at work and so on. While such an explanation may hold true for individuals who define themselves *relatively independent from others*, more and more research studies are indicating that for individuals who define *themselves in relation to others*, interpersonal and occupational concerns might be primarily in the understanding of depression rather than secondary, as conceptualized in the DSM (Aggarwal et al., 2020; Chentsova-Dutton, Ryder, & Tsai, 2014; Koh et al., 2007).

> **If we don't consider these social, academic, and occupational impairments as primary markers of depression, not only do we run the risk of missing out on accurately diagnosing depression, but also jeopardize the chances of successfully treating it.**

In all, one must not forget to question the applicability of different concepts and phenomena to diverse contexts and not feel afraid of creating a system that truly acknowledges the cultural diversity we observe on a day-to-day basis. If we continue to force that piece of the puzzle to fit where it does not belong, we are likely to frustrate ourself or break the puzzle in the process, and neither of the options sounds good to a puzzle lover.

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WRITTEN BY

Pankhuri Aggarwal

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Healing with the power of art

NEESA SUNAR

NOVEMBER 19, 2020

I found myself in the throes of a psychotic episode in early 2011, most likely triggered by undue stress. I was working near-full-time as a classroom music teacher at an alternative private school in Brooklyn, utterly worked to the bone as I attempted to teach unruly children. I was simultaneously taking music education courses at a college in Queens, working towards earning certification to teach classroom music in public schools. I also had ten violin students, all of whom I taught individually on a weekly basis. It was far too much to manage.

I hit the breaking point when I attempted to do a standard homework assignment for college. As I wrote a paper on Beethoven's *Eroica Symphony*, my mind strongly told me I was in fact the reincarnation of Beethoven himself. This held monumental consequence, and I believed I was some pivotal person in human history not yet acknowledged.

I made phone calls, telling people I was Beethoven. The absurdity of the statement elicited non-judgmental laughter from some, processing it as a benign joke. Others told me I needed to see a psychiatrist, but I ignored this advice and attempted to continue with my life uninterrupted. But the obsession grew, and I could not hide it. While on a lunch break at the Brooklyn school, I confided to my boss that I was Beethoven, and her dramatic reaction elicited a hyperventilating panic attack within me.

It was in this frantic state when I arrived at the inpatient psychiatric unit at NYU Langone Hospital.

When I had my first breakfast in the small cafeteria with the other patients, I sat alone, buried in my Beethovian

thoughts while bearing a Beethovian scowl on my face, inner dialogue racing. When mealtime ended, a voice sounded from down the hall.

"Art therapy everyone! Art therapy!"

Not knowing what to expect, I followed others who walked into a smallish room, recent drawings hung on the walls. On the table, oblong pieces of tan paper and oil pastels were set up, ready for our use. I took a seat and sleepily blinked.

"Hello, I'm Abigail, the art therapist here. How is everyone feeling today?" She had a friendly and professional air about her. Others answered her benign question.

"I'm okay."

"Fine."

"Hrm." Someone grumbled, looking sleepy, a large hospital blanket wrapped around their shoulders.

"Good to hear."

She spoke at a slow and deliberate rate, with a non-threatening tone.

"So for this session, we're not going to do any project specifically. But... I have some magazines here. I encourage you all to find a picture that speaks to you. Take some time to look around. Then you can create something based on what you see in the picture you choose. Draw however you feel, and don't worry about what happens on the paper."

Her instructions were nonrestrictive.

"You don't want to use the magazines, that's fine too. There are no rules here. Are there any questions before we start?" There were none, but I appreciated that she offered the question.

She put on a recording of J.S. Bach's *Cello Suite No. 1 in G Major,* the famous opening prelude, at low volume. I flipped through the pages of a magazine and chose a portrait of a woman, some standard makeup ad. Taking a black oil pastel in my hand, drawing my first strident line...it had a satisfying grip on the paper. This was an expensive set of oil pastels with many colours to choose from. I realized that I wasn't working with depressing Elmer's glue and dried macaroni on paper plates like I had done at other hospitals.

As I formed the outline of the person's face, drew the flowing hair, filled in flesh colour for skin...it didn't look quite like the picture I copied from the magazine, but instead took a form of its own. The face conveyed a

personality and spirit as would a real person, and my hand was merely guided as I brought the woman to life. Memories spontaneously occurred to me, and I recalled how I had been teased for being ugly as a child, awkward as a teenager, how no one wanted to date me in college.

Recalling these memories allowed me to forget about my thoughts of Beethoven for a bit. My picture revealed a beautiful woman, and a powerful chord struck within me. I didn't need to be Beethoven in order to be great. I was good enough already.

I began to cry.

"What are you feeling right now?" The art therapist asked me.

"I...This is the best drawing I have ever done in my life. I didn't know I could draw this well."

"It is beautiful, I agree. What does it make you feel?"

"I don't know." There were private, wordless feelings within me that I could not describe.

"Keep going."

After sufficiently crafting the woman's face and hair, I worked on the space behind her head. I created a lovely shade of cerulean-teal, blending my favourite shades of bright blue and green together, crisscrossing strokes. These colours swept a wave over the picture, giving it movement, and the face now popped out.

The picture started to settle, and it eventually felt finished.

> I now felt a bond to what I had drawn, because it had been inspired by my difficult life experiences. While I felt ugly inside, the picture was not. I realized that I in fact wasn't ugly at all.

At the end of the session, Abigail facilitated a conversation where we each got to talk about what we created. One woman showed a crude picture she drew of a pack of cigarettes.

"I want to smoke. I've been here for three weeks."

Another person showed a simple picture of a star.

"It doesn't really mean anything."

Abigail stepped in.

"It looks great! I like the bright colours you used. Red, green and white. You also pressed very hard with the oil pastels, so the colours are vibrant."

"Yeah, I like colours."

Then it was my turn.

"I don't have much to say. But I like what I drew." My thoughts were very complicated, and I didn't want to share. And that was honoured.

NYU took their art therapy seriously. Groups were scheduled twice daily from Tuesdays through Fridays, and thrice on Saturdays. With each group, the art therapist facilitated different projects, giving us different media to work with. One day, we crumpled colourful tissue paper and slicked it on paper with Mod Podge, creating three-dimensional art pieces. We drew mandalas, and I drew an abstract rendition of Michael the Archangel. One time, an artist from the Museum of Modern Art (MoMA) visited and did a presentation, and then facilitated a project. The art supplies we used were all of high quality, and that improved my morale in groups, thus enhancing the therapeutic effect of art therapy groups.

After each session, I'd proudly take my new piece into my room at the hospital and tape it on the wall. After a few days, I had a little art gallery going on. Each piece I drew represented a part of me that was very personal, with no words to describe. During this time when I felt broken and distorted, my gallery gave me a view of myself that was positive and affirming.

The Benefits of Art Therapy in Mental Health Settings

Art therapy is a powerful modality that allows people to express emotions in a *nonverbal* way. When a person experiences complicated feelings that cannot be described in words, art therapy helps these feelings to emerge through visual means. While standard talk therapy employs logical thinking and rationalizing, art therapy accesses the subconscious mind and the power of intuition.

> Deep-seated feelings of fear, self-hatred or other difficult emotions find a voice as artwork is created, allowing for the release of distress. Artwork becomes a visible and tangible product that represents not only feelings but a process of personal transformation.

An art therapist must create a safe and non-judgmental environment in the studio. When people create art, they tap into something deep-seated and personal within themselves. They must not feel fearful of being judged for the artwork they create, because this can impede the therapeutic process. An art therapist never critiques a person's work based on its quality, and nothing is ever deemed "bad art." No previous skill or experience is needed to fully benefit from art therapy, and everyone is equally encouraged.

Before a person creates work, an art therapist will first facilitate a conversation, to help them focus on the artistic task that is to follow. They may guide them through a process of relaxation, encouraging them to breathe deeply and focus on relaxing the body. Or in my case, within a group therapy setting at the hospital, the therapist checked in with patients, asking how they were feeling, and also orienting them for the assignment for the session.

Art therapists are trained to understand the subconscious elements of the artistic process. They then apply this knowledge as they create assignments for patients. For example, with the mandala project that I created at the hospital, the therapist utilized the shape of a circle, where we drew inside of it. When drawing my feelings in the space of a circle, this specific shape served as a holding place that completely contained my emotions, encouraging me to feel safe.

As a person creates work, the therapist encourages them to "trust the process." The media they choose, the colours of paint selected, the way they brush strokes on the page, the ideas and feelings they have as they create...these are all personal decisions that a person makes for themself. Having this power of choice can help a person feel more in control, while also in a safe environment.

A therapist may or may not talk to a person as they create their work. If there is conversation, the therapist can ask a person how they are feeling as they create, or maybe ask why they chose a certain colour or brush. The process is very gentle, and the person remains in complete control.

When a piece is finished, the art therapist can facilitate a discussion for the patient(s) to talk about their work. In the case of my group session at the hospital, the discussion was brief, likely due to time constraints. Each of us said a small bit about our work, and this helped us wrap up the experience gleaned from the session.

When greater time is allowed, especially in a one-on-one session, the discussion can get more in-depth. The art therapist can guide a person as they evaluate the finished picture, perhaps asking the picture questions and intuitively gleaning answers from it. Using intuition accesses a deep-seated source of intelligence that normally goes unacknowledged. It allows the subconscious to speak through metaphors represented in the artwork, and this voices the needs and strengths of the person that were previously unknown.

Art therapy benefits mental wellbeing in additional ways. It creates a positive and affirming environment, which helps a person feel less anxious and more confident in expressing themself. Art becomes an outlet for releasing emotions, helping to alleviate stress. It also celebrates the strengths that a person already has within themselves, boosting confidence. Overall, the creative process invites mindfulness, where a person is focused on the here and now as they make choices in how they create artwork.

Frequently, art therapists work in mental health settings, such as inpatient psychiatric hospitals (as I experienced), outpatient clinics and community centres. They frequently work alongside other clinicians in treatment teams, where the entire team works together to comprehensively determine treatment plans for patients. Outside of the purely mental health realm, art therapists also work in schools, homeless shelters, senior centres, residential treatment centres and correctional facilities. They also can work in private practice.

Based on my own personal experience with art therapy as a patient, I believe it is a powerful modality. Art therapy allows me to express a part of myself that I normally need to hide in the real world. I lose the fear of rejection and judgment from others, and I am able to feel confident in myself for being a unique individual. In the art studio, I feel safe and supported, and hopeful that I will have a brighter future.

I encourage psychiatric facilities to strongly integrate art therapy in their services. Doing so can help address the needs of patients in a holistic way, which can complement the clinical services that they already receive. As it did for me, it can give patients greater hope and encouragement in their resilience and capacity to recover and be well.

Art Therapy in America

To become licensed in the United States, art therapists first need to earn a masters degree from a program approved by the American Art Therapy Association (AATA). To gain admission into graduate school, a student must have completed undergraduate courses in psychology and studio art. Relevant job experience and an art portfolio are also needed. When studying in graduate school, students learn about how to use the creative process to access the subconscious self. They also learn about the history and theory behind art therapy, assessment techniques within an art therapy framework, group facilitation, and working with different populations. Students also continue attending studio art classes, learning to use various media as would patients in art therapy sessions.

The Art Therapy Credentials Board (ATCB) is the organization that awards certification in the United States. In order to become credentialed, art therapists must first earn art therapy work experience under a qualified supervisor. Hours required differ depending on which state a person practices in. After finishing preliminary supervision hours, a person becomes a Registered Art Therapist (ATR). After a few more years of experience,

they can earn board certification (ATR-BC) by passing a national examination. This is the highest level of certification.

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The grief that does not speak

DR. STEPHEN HEAP

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There have been numerous reports in recent years about mother dolphins carrying the corpses of dead young [e.g. 1, 2, 3]. Such stories also bring to mind tales of elephants that visit graves of deceased Matriarchs [e.g. 1, 2, 3], or Jane Goodall's classic account of young chimpanzee Flint, who seemingly died from grief shortly after his mother's demise [1].

These tales suggest that grieving is not just for humans. It is part of life for many social creatures. The hallmarks of separation anxiety, grief and mourning have been reliably observed in species diverse as dogs, dolphins and ducks. These episodes are characterized by long-term changes in behaviour, often taking the organism far from their healthy state. This includes neglecting food and sleep, isolating from others, and expressing pain, anxiety or lethargy.

But what does it mean to grieve? Turns out, that's for us to decide.

The survival value of grief

The social dimension of life is a two-edged sword. To begin with, social animals derive huge evolutionary fitness advantages by coming together. They comfort and nurture each other, and they protect each other from threats. But no matter how strong and healthy a social bond can be, eventually, it must end. Companions die, disappear or disperse from our lives, and there's nothing that can be done but accept the new reality and adjust to it.

By observing how humans and animals respond to death and loss, scientists have proposed at least two

complementary evolutionary explanations for grieving. On the one hand, grieving can be seen as a healing process that accommodates the animal to the stress of its injury. For example, withdrawal can give them time to rest, learn and readjust. On the other hand, the suffering of grief can be the ultimate and unavoidable price of attachment. That is, animals exhibit feelings and behaviours that drive them to bond, but when a partner disappears, these compulsions can't ever be satisfied. For instance, animals can be attracted to closeness and touch; they can be motivated to help and reciprocate. But if there's nobody on the receiving end, then the result is stress to the body and mind. Thus, grief appears to be both a beneficial healing process and the ultimate cost of being close to someone.

But one thing is apparent under both explanations: the dynamic changes in psychology and behaviour that follow death are a personal means to continue living despite an irreparable loss. Engaging with the process reorients the bereaved to a new world in which their companion is gone, and helps them form a new reality around that void.

The abstract concept of grief

The clearest thing about animal grieving is the apparent pain. The painful part of grief comes down to something called 'affect', which is how the nervous system summarizes the overwhelming complexity of the body's activities and sensations. In essence, affect is the global sense of what the body is doing. It is experienced as feelings of high or low energy, which can take either a pleasant or unpleasant flavour. At least when it comes to mammals, the brain systems that generate affect are shared across all species, and they likely experience affect in similar ways.

By observing grieving events, it becomes clear that animals are suffering from a painful affect even if they can't use words to explain themselves. However, in one case, a zoo gorilla named Koko lost an adopted kitten under her care. This gorilla could communicate with sign language and told its human handlers that she felt 'bad-sad-bad' and 'frown-cry-frown-sad'. Even so, in most cases, we can't ask animals how they are feeling when they grieve.

This is important because humans don't just use language to relate their feelings of affect to one another. They are using language and a shared sense of meaning to *build upon* their feelings with complex and abstracted emotional concepts. These emotional concepts are used to put affect (e.g. 'I feel sick') into a subjective context ('because my friend died') and guide behavioural changes ('so I want to be alone').

Emotional concepts like grief are social constructs, installed into the brain with language and shared experience. We develop and build these concepts, teach them to our children and share them with our peers. So when humans talk about the emotional experience of 'grief', they are not referring to a specific state of

mind or body. There is no 'neural fingerprint' or 'circuit' for grief in the brain. Every experience of grief is a unique mental event. Rather, what these events have in common is their shared interpretation of feelings in relation to the loss of a loved one, and their shared goal in adjusting to the trauma.

The human concept of grief has been developed over many generations of human experience. It's a complex and abstract concept that relates the bereaved to existential issues of love and death in a self-reflective way. On one side, the concept relates to the irreversible and unavoidable nature of death. But on the other side, it's related to the love for a unique and irreplaceable individual. In short, human grief is more than a painful affect experienced in response to loss. Rather, it's a rich tapestry of meaning applied to the human experience of social bonding and the devastation that occurs when someone loved is lost.

The important distinction here is that grief can be broken down into two levels. The first is the embodied experience of a painful affect related to the loss of a close social partner. Many social mammals share this quality. However, humans build upon this layer with abstract concepts unique to their experience. They then use these concepts to explain their feelings to themselves and others. Thus, animals don't have the same perceptions of grief that humans do, even though they share the same underlying pains.

So, Koko could perceive her affective state and relate this to her human handlers. These handlers could then apply their concept of grief to Koko's experience. But could Koko perceive her own experience as grief? Could she perceive grief occurring in someone else? Probably not. This is not to discount Koko's experience, as she was clearly suffering. It's just to say that it's us humans who interpret her suffering as grief. Koko interprets it in her own way.

The work of grief

> Integrating and resolving grief is an active process, not a passive one. Mental health practitioners talk about the 'work of grief' that follows a massive loss. They recognize that coming to terms with the loss of close ones demands physical and emotional energy before health is restored. Apparently, this is true for animals as much as it is for humans.

The animals teach us that the painful affect of grief is part of basic functioning in social life. It's something uncomfortable, but discomfort is the prime motivator for action. By responding to painful feedback, animals are able to readjust themselves to a new environment that accounts for their loss. However, we still don't know how animals psychologically integrate pain and loss into their lives. We can only observe that they seem

capable of returning to normal following a period of chronic distress.

Cases of animal grieving also teach us humans that we are not alone in our pains. We can see that animals suffer in much the same way even if they perceive it differently. This recognition has important implications for animal rights and welfare. Denying animals their grief can produce similar kinds of psychological and physical distress that humans experience. For example, the systematic separation of milk-cows from their calves causes a pain that any parent could comprehend. Thus, as beings capable of perceiving grief, we are accountable for our actions that impose it on others.

But we are also accountable for how we conceive grief to ourselves. Grief, as humans perceive it, is a social construct that integrates inescapable realities of living within our minds. We not only have to deal with loss and its pains but relate these to our concepts of love and mortality in a self-reflective way. The way we choose to think and talk about grief has real-world consequences in whether it guides someone into a new life, or traps them in a painful emotional wasteland.

Animals teach us the survival value of grief, but it is our responsibility to encode that value into our abstract conceptions. If we forget the function of grief as a guide to continue living, we miss its purpose and dissolve its ultimate meaning. It puts us at risk of dulling the pains with drugs, denying realities by 'being tough', or subverting the process with a premature return to normalcy.

Death and loss is a universal reality of being alive, human or otherwise. The pains we experience in relation to loss are part of our animal lives. But how we make sense of those pains is how we shape our humanity. Do we choose to think of grief as an ending or as a beginning? Do we choose to think of it as an illness or as a survival guide? Either way, a full acknowledgement and appreciation of grief extends far beyond our experiences as individuals and even beyond our collective experience as humans. If we're not taking all this into account, we're kind of missing the point.

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India and alcohol: Beyond the tip of the iceberg

NUPUR GOENKA & DR. ABHIJIT NADKARNI

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India is a vast country with the second largest population in the world in which a relatively small proportion drink alcohol. However, the amount of alcohol consumed by this fraction of the population is so large that even spread out across 1.3 billion people to calculate per capita consumption, doesn't fail to reveal a grave and growing problem. It is one of the few countries where consumption per capita is actually on the rise. Where are we headed?

Let's start with a short history lesson, one that is several centuries old. It's a lesson that busts the myth of the 'abstinent Indian culture' and allows us to understand the truth about alcohol consumption in contemporary India. We will see how our perspective of alcohol has transformed through the passage of time; four horses, four directions, and an act of dismemberment that ends with the present reality of alcohol use in the country.

Several centuries ago, the consumption of alcohol was not only socially accepted but prevalent. Rules and behavioural expectations around alcohol use were codified to ensure that it was an enjoyable yet controlled activity (the kind of documentation, by the way, that does not exist in modern India today). Communities celebrated an open but socially regulated culture of drinking - the first horse.

Between the mid-eighteenth and the mid-nineteenth centuries, the British East India Company began to establish its supremacy until the British Raj planted its flag in the country. Amongst the many things the colonial rule overhauled, one was India's ancient relationship with alcohol. The production of alcohol and the act of drinking went from being a culturally regulated practice to a highly commercialised one - the second horse.

Before this could settle into the DNA of the country, we experienced another transformation during the independence struggle; the Gandhian Era and the dawn of a temperance movement that endorsed the moral superiority of abstinence.

The latter half of the 20th century was a time when the morality of consuming alcohol was deeply questioned. It threw cultures and practices that had lasted for several centuries into turmoil and with it, a large number of people into confusion - the third horse. All this while, however, borders were impervious, and globalisation hadn't taken the world by storm. By the early 90s, India finally opened its economy to the world, and we were yanked in yet another direction. Suddenly, availability of and accessibility to alcohol surged along with household incomes. The country was plastered with global marketing messages about the pleasures of drinking. This was a recipe for yet another major change in drinking behaviour - the fourth horse. As we stepped into the 21st century, all four horses had moved forward in different directions, and we began to see the results of the dismemberment.

In many countries, especially in the West, you would find a large proportion of the population consuming alcohol and a small percentage of that number displaying problems with alcohol. In India, it is the opposite. We have a smaller proportion of people who drink, but a large percentage of them have alcohol-related problems. Majority of people who consume alcohol are also males who primarily drink spirits, drink alone, and consume large amounts in short periods with the goal of getting intoxicated. Our history has fragmented our perception of alcohol, and we straddle between questioning its morality and exploiting its accessibility and pleasurable effects. We have not evolved into a culture of drinking as a socially enjoyable activity that is spread out over time without inebriation being the goal. As a result, you will witness problematic drinking patterns in bars littered across the country; a formula for immediate adverse events such as road accidents and physical brawls, and longer term poor health and social outcomes.

Let's now examine the spectrum of alcohol consumption patterns and the composition of drinking behaviours in India.

At its extreme, dependent drinking is not just psychological but physical as well. Alcohol withdrawals can involve experiencing shakes, nausea, vomiting, sometimes even hallucinations and seizures, and can be fatal.

Take a moment and imagine what comes to mind when you think about a person who drinks heavily? Perhaps you have pictured what most people do; an "alcoholic" man from a particular economic stratum, getting drunk alone every day, unable to find his way home and perhaps ends up sleeping on the road. In reality, this conjured image represents a tiny proportion of drinkers in the country. The very tip of the iceberg that is visible to all of us. But, the rest of the iceberg that we are blind to is what reveals the true picture on the ground. The larger problem is the significantly higher proportion of people who are managing to lead a semblance of productive and functional lives despite drinking problematically.

Herein lies the prevention paradox; do we focus on the large number of people who have a smaller risk or the small number of people with a much larger risk? Ironically, we have chosen to focus on the latter. We have invested heavily in programs that involve hospitalisation and detoxification but have barely broken the surface in making low-cost interventions available at scale to risky drinkers. We have geared up for this conjured image of the 'alcoholic' but we have not been able to effectively help the majority before they tip over into dependency.

> There is no single explanation for what causes and sustains addictive behaviour.

Similar to physical illnesses such as hypertension or diabetes, alcohol-related issues involve several things coming together. These include genetic predispositions as well as psychological and social factors. So, while a family history of alcohol problems doesn't destine you to the same fate, the lack of family history doesn't save you from it either.

Although the volume of alcohol ingestion can indicate risky drinking, it is critical not to ignore the pattern of consumption. Let's take an example; person A drinks one peg of whiskey every evening, and person B drinks five pegs only on one day of the week. Person B's behaviour is much more harmful as they are inflicting a lot more damage to their body by drinking a large amount of alcohol in a short amount of time.

By understanding these fundamentals, we can become more responsible, whether we drink or not. Importantly, it can also help us educate our loved ones and communities about alcohol consumption and get them early intervention from appropriate health professionals if that is the need. Small steps such as this can help us construct a healthier society.

It may (and it should) seem strange that our country doesn't have a consolidated alcohol policy that brings together various sectors which can potentially be involved in reducing alcohol related harms e.g. education, legal, and policing systems. Like our history, we're coping with fragments, and this is far from sustainable. We cannot move forward without recognition of where we stand today. Perhaps it is time we look beyond the tip of the iceberg to the reality of alcohol consumption in India – while there is no silver bullet, open discussion and education is always a great starting point.

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Solitude: What we think we know, and what ain't so

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If you look up readings on solitude, you are likely to find two types of articles: one type condemns its negative effects on mental health while the other defends its benefits for creativity, self-discovery, and relaxation. So, instead of adding to the debate about whether solitude is good or bad, I want to highlight one issue that isn't talked about enough: what exactly does solitude contribute to our daily, ordinary life and our mental health?

To answer this question, I will first clarify a few misconceptions that we often have about solitude. Then, I will try to resolve a few claims about it that continue to be re-enforced by popular culture despite lacking supporting empirical evidence. In closing, I will reveal the big finale that should not be a secret to anyone but somehow remains elusive in our conversations.

First, the misconceptions

In my review of the literature on solitude, I have observed that many of the apparent benefits are drawn from stories of extraordinary and exceptional people. Creative minds like Eugène Delacroix or Jane Austen often spoke about the contribution of solitude to their work. Mahatma Gandhi praised solitude as "a catalyst for innovation", and Albert Einstein credits many of his discoveries to time spent alone, which nurtured his maturity and offered space for self-reflection. Other less prominent figures, yet no less extraordinary, are Robert Kull, Christopher Knight, and Sara Maitland; they chronicled the years they voluntarily withdrew from society to seek wisdom-filled solitude in the wilderness. While these stories are inspiring, they paint a romanticised picture of solitude reserved for those with a phenomenal ability to benefit from extended periods of reclusive

existence.

Yet, solitude is a familiar experience in the life of an ordinary person. In a study conducted in the late 1990s, it was estimated that an average adult in the United States spends one-third of their waking hours alone [1]. This number is bound to increase if we look at the rising numbers of single-person households in many developed nations such as Germany, the Netherlands, the US, and the United Kingdom [2] [3]. On a typical week, it's rare to go several days without having a few moments of being alone. Some people spend time alone running errands and doing chores, some read, while others go out for a walk, or catch up on work and assignments. There are times in solitude when we sit in silence and reflect on our lives, think about plans for the evening and weekends, or reminisce about our past.

Despite how often solitude happens in our daily life, when people hear the word "solitude", it is usually associated with "loneliness" and "isolation". It's important to highlight the difference between the negative experiences that arise in unwanted solitude – periods of aloneness that we are forced into, such as when social plans are cancelled or when friends reject our invitation to hang out – from the positive experiences that come with chosen solitude. Many studies have shown that choice is an important ingredient of positive solitude [4]–[7].

Second, the claims without clear evidence

There are many flavours of solitude, and empirical research has only begun to explore key ingredients that determine its benefits and drawbacks. For example, people have found solitude enjoyable and positive when it contributes to their creativity, self-discovery, and inner peace [8]. In contrast, negative experiences in solitude are often associated with feeling lonely, judged, or excluded by other people [9]. It's important to understand that the majority of our insights about solitude are drawn from 'correlational studies', which restrict us from concluding that these experiences are caused by solitude [6]. We could argue that these positive and negative experiences could occur regardless of whether the person was alone or not.

For instance, let's talk about creativity. We have heard many tales of creative minds secluding themselves to pursue the arts. Correlational studies have shown that individuals with creative personalities have more positive outlooks toward solitude [8], [10]. But just because creative people like solitude does not mean that solitude is good for creativity. Even today, there is no clear evidence to show that creative people spend more time alone than the average person, nor that people become more creative when they spend time alone. At best, evidence from experimental studies have had mixed results. Some earlier work suggested that individuals produce more ideas when working alone [11], but more recent studies show that people generate more *creative* solutions when working in groups [12]. The many ways of assessing creativity may be the reason behind these polarities! The same limitation applies to literature that links solitude to self-discovery. There has

not been any published evidence to show that the activities and psychological processes activated during the time spent alone helps someone "discover" themselves better than the next person.

Finally, the obvious truth (with a few caveats)

Filtering out the signal from the noise, the only reliable claim we can make about the benefit of solitude so far is that it is a space for the mind to rest. In a survey of more than 18,000 people from 134 countries, a large percentage of people believe that being alone, or activities that are often done alone, are the most restful [13]. Studies have also shown that participants endorsed less 'emotionally charged' words related to arousing states such as excitement, enthusiasm, anger, or anxiety after sitting alone for only 15 minutes [4].

Imagine a day when you go from one meeting to another, deal with frustrated colleagues and difficult customers, on-and-on without a break. Then compare this to a long weekend at a friend's wedding celebration that goes from one ritual to another, bursting at the seams with spirit and constantly filled with high-energy interactions. Both of these are characteristic of high arousal states; the former usually leads to frustration and anxiety, while the latter stirs exhilaration and jubilation. It is obvious that in the first example, one would need an escape from all the negative feelings, but even in the second example, a few moments away from the crowd is treasured by many. This is what solitude can offer.

Yet, not all solitude is restful. It's an experience filled with caveats and individual differences that we can explore with curiosity. Some people are more predisposed to distress and negative thoughts than others, such as those with mental health risks who experience loneliness or emotional instability. For example, bulimic patients display more symptoms when alone at home [14], and lonely people tend to drink more when they crave another's presence [15]. Further, being alone can be difficult on certain days. For example, on days where the workload is high, people have found themselves unable to switch off after work [16]. This effect is likely to spill over to our solitary time. Finally, many people find unstructured solitude (empty time when a person is alone and unoccupied) challenging and unenjoyable [17]. Here, many people tend to fill this time with fruitless distractions, such as mindlessly scrolling through their devices, and are unable to engage in fulfilling activities.

> Solitude is best when it is chosen.

There are times when we need others, and there are times when we need time for ourselves. Knowing exactly what solitude does for our mental health allows us to experience, understand, and seek it out when the time and situation calls for it.

In a world that is getting more crowded and more connected with every breath we take, understanding (and not misunderstanding) solitude can give us the fresh air we so often seek.

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First a caller, then a volunteer

DR. PAULIUS SKRUIBIS

DECEMBER 17, 2020

My early teenage years were troubled and filled with distress. I was going through an intense turbulence myself when I realized that I wanted to reach out and help people who seemed to be unhappy like me. I was 16 when I began my training at Youth Line, an NGO-run suicide helpline service in Lithuania. Although I partly joined because I was trying to impress a girl I liked at the time (I'm sure you can relate), I really wanted to support people in their time of emotional need, the same way someone once did for me.

My first attempt to join Youth Line was unsuccessful and I was not selected after my training period. I admit, I did find it awfully strange that I was deemed unfit to help people when it seemed like there were so many in need of it. I accepted my disappointment and spent time working on myself instead. I went through my journey of therapy, self-discovery and self-understanding before I made a second attempt to volunteer at Youth Line and this time, I found my success. Once I got selected, I started to actively take calls from individuals in emotional distress who were seeking help and began a journey that would go on to define a large part of my life. I pursued my doctorate in Clinical Psychology to study the subject of suicide in more depth, became the Director of Youth Line, and experienced the process of training people like my 16 year old self to volunteer for the service.

People who volunteer for suicide helplines can come from a variety of backgrounds and may have no experience at all in the mental health field. We start them off with basic theory about mental health, suicide ideation, and emotional challenges, but focus a majority of the time on practical training; this is critical. Each

volunteer goes through role-playing exercises, so volunteers get a realistic idea of how to respond and react to a variety of situations. The volunteers then start to shadow real-life phone calls that the experienced volunteers answer. And after this, the volunteers begin taking calls themselves with the experienced volunteers listening in and on stand-by. The training methodology is a continually evolving process, and we keep learning how to improve ourselves.

> **However, we must continually stress on two critical practices and values that stand the test of time; listening with care and communicating with directness.**

I cannot understate the importance of listening to understand and sincerely care rather than to respond. It seems like such a simple thing to practice in everyday life, but an uncompromisable quality in a helpline worker. We must learn how to be very patient and hear out someone who is in emotional distress. One of the values of a helpline is to show, genuinely, that someone wants to spend time and understand your story. It can be a small but powerful motivation to seek help knowing that someone will pick up the phone in the middle of the night and care enough to listen to you and put you first.

It's equally important to address the subject of suicide directly and talk about it with openness and sensitivity at the same time. It's essential not to tiptoe around the topic, but to ask questions about thoughts, ideation, attempts, and planning of suicide and understand the mental state of the caller. All Youth Line volunteers are repeatedly trained to practice this when they are taking calls.

Even after several years of running the centre, it is difficult to understand how effective your work is and this can be an uncomfortable reality to confront. All calls that come into Youth Line are anonymous, so in reality, we don't know what happens after it has ended. We can't tell with certainty that we have managed to extend the help the person needs or not, however, there are a few things that we have tried to do. Immediately after the call has ended, we request the caller for feedback on how helpful they found the service. This doesn't guarantee complete or accurate feedback, but it is one method of evaluation. We also ask quality analysis staff and professionals from academic circles to assess the centre's effectiveness and provide us with inputs on areas of improvement. This allows us to have a non-biased judgment about our work as well.

Although my experience has been in Lithuania and different countries may have different ways of setting up and training volunteers to offer this kind of service, I have learnt that it is a process you have to keep learning and improving. There is no silver bullet of execution, but there are values that you cannot compromise on

when you genuinely want to help people who are struggling with their mental health.

It is both strange and enlightening to see the full circle of life during my time at Youth Line. When I was a teenager, I was a caller myself. I was in distress, and I reached out to Youth Line, and one of the calls was extremely helpful to me during my time of need. Over the years, I became the receiver of calls and extended my help to the community.

Looking back on my journey so far, I have seen so many like me; people who were in the midst of a violent emotional turbulence and called the service, and then moved on to became volunteers, extending help to those going through something they could empathise with. It makes one pause and wonder whether there really is a difference between the two roles, or whether what we are witnessing are the ebbs and flows of life.

WRITTEN BY

Dr. Paulius Skruibis

Dr. Paulius Skruibis is a psychologist, group psychotherapist and teaches at Vilnius University and the Institute of Humanistic and Existential Psychology. His main job is consulting and leading groups. He chose to study psychology after he started volunteering at the Youth Line. In this emotional support service, he learned to provide emotional support, and was a volunteer teacher, supervisor, and board member. In his studies in psychology, he was particularly interested in the topic of suicide, which later became the subject of his doctoral studies. He will continue his research on suicidal behaviour while working at the VU Suicidology Research Center.

He studied and continues to study psychotherapy at the Institute of Humanistic and Existential Psychology. He regularly discusses his psychotherapeutic work with the supervisor of the existential direction. Dr. Skruibis has membership in the Eastern European Existential Therapy Association, Society for Existential Analysis (UK), Lithuanian Psychological Union, Lithuanian Association of Trauma Psychology, International Association for Suicide Prevention.

'Red pill or blue pill': Virtual Reality for mental health

NUPUR GOENKA (BASED ON AN INTERVIEW WITH DR. LUCIA VALMAGGIA)

JANUARY 07, 2021

In the action/philosophical classic movie, 'The Matrix', Morpheus's words to Neo describe the world of Virtual Reality (VR) rather elegantly; "Your mind makes it real". Over the last three decades, the world of VR has taken several industries by storm. We have constructed simulated training programs for flight and space engineers to condition and prepare them before they risk their own and other's lives in the field. We have disrupted the gaming industry so individuals can interact with fantasy worlds as if they were really in them. The last five years has even seen VR technology become cheaper and more accessible leading to accelerated research. It's in this spirit that we consider the possibilities of Virtual Reality in mental health.

One of the core strengths of VR technology is its ability to design, construct, maintain, and manipulate a world that is entirely under your control. You can create any setting (e.g., a pub, a kitchen, a park, etc.), add avatars or characters, and define their language, behaviour, dialogue, and background noise. There are several reasons the field of mental health can benefit from this; it gives you the ability to observe different people's reactions to the same situation, isolate social triggers, and even gradually expose a person to triggering scenarios. VR can do this within the mental safety of a world they know is virtual instead of setting off immediate trauma in someone by facing reality.

Consider an example of being in a pub where a person looks at you and then looks away – as simple as that. Based on your mental state, experiences, and history, the way you react to this might be completely different from someone else. Some may assume the person likes them, others may not give it a second thought, some

who have anxious tendencies may think the person is judging them, and yet others who fall in the spectrum of paranoia may feel threatened. The point is that we're all products of our unique life experiences so we may handle the same situation in so many different ways. By using VR technology, we can isolate and analyse the differences in these reactions.

When a person going through mental health difficulties experiences a social situation that is triggering, their threat system often gets activated. By being in this 'heightened' state, it is difficult to later remember the details of what happened. As accurate memory can be compromised, it may take a long time for the counsellor or therapist to understand the person's triggers to help them cope. With VR, we can expose them to various ambiguous settings (e.g. a pub) and observe how they are reacting to manipulations of parameters (e.g. the number of people they meet, background laughter, dialogue exchanged, and so on). This can potentially allow the therapist to get a better understanding of the specific triggers the person faces and plan their therapeutic journey accordingly.

Contrary to common belief, it is not easy for someone to calm their minds and bodies down when they are experiencing a panic attack. If it were that simple, they would have likely done it a long time ago, and the attack would not have occurred. In reality, it can take a while to relax your entire system down once it's triggered. When people face these situations, they tend to start avoiding them as much as possible (obviously). One of the things VR therapy systems can do is to put the person gently back in the setting (or a 'minimal version' of it) and help them learn how to deal with it rather than avoid it. We construct environments and situations that can 'incrementally' expose people to their triggers in a completely safe and controlled setting and, over time, work through their responses and reactions to them.

People who have more extreme reactions to social triggers can also benefit from VR therapy. In real-life, you are dealing with humans who you can't control, and this can be risky. Suppose a person reacts very negatively to a situation and behaves 'strangely', then, adverse reactions from other people in that setting can set off a vicious cycle for the individual getting triggered. The idea is to help them face those scenarios in real-life by restructuring thinking patterns and teaching them how to gradually calm their threat system down.

> A reason VR is growing in popularity is because it has an uncanny ability to 'fool' your mind into balancing mental safety with uncomfortable reality.

When you put VR goggles on, you respond to the simulation as if it were real, and at the same time, your mind

'knows' it's not real. Since you 'know' it's not real, it enables you to function on a level where you can still think coherently and try different strategies of coping that may not be possible for you otherwise.

One of our projects explores VR therapy for people who struggle with eating disorders such as anorexia nervosa and find it difficult to approaching places where food is prepared. We constructed a 'cartoon' kitchen where the individual can be gently introducted to the environment and even interact with food. We also created a 'likeable' little pink elephant in the kitchen so they could form a positive association with the setting. Over time, this allowed the person to expose themselves to an uncomfortable situation in a safe way. They gradually primed their minds and bodies to deal with things such as picking up and handling food to prepare for a journey of self-healing.

The VR industry has come a long way in the last 5-10 years. We're at a point where we can realistically imagine researching and benefiting untapped fields such as Mental Health. We can even think about scaling out the access of this technology to the healthcare community across the world.

Around five years ago, it cost approximately 60,000 GBP to set up a VR lab. Today, the headsets available in the market are significantly cheaper, much easier to set up and cost anywhere between 200-300 GBP. This price point continues to be too expensive for the majority of the world; however, the cost trend is an encouraging sign and has increased accessibility, accelerated experimentation and opened doors for the general population.

Even today, it can be costly and time-consuming to design, program, and maintain a virtual world, especially when you have limited funding in a research setting. To manage this, we have developed a library of environments to keep reusing based on the project. For example, we have a street, a school, a living room, and even have different avatars for characters that come alive in the simulation. Although you can buy ready-made avatars to cut your cost, they're usually created for the gaming world and are extremely far from resembling typical people. For this reason, we built a library of avatars that are more realistic and therefore, more useful.

Today, our project is only available to university labs, but eventually, we want to make it available to everybody in the mental health care community. We have also studied that our VR therapy is most impactful when you have a therapist guiding you through your journey. Therefore, to truly scale-out and make it accessible to people in their own homes, we have started exploring making the therapist a virtual character in the simulation itself.

There is little doubt that we can get even more creative with the applications of Virtual Reality in mental health. There is so much we can do to help those who face mental health struggles face triggering situations in real life.

Perhaps it can ease us out of our comfort zones without inflicting the mental trauma that too many of us deal with. It begs the question, can fooling your mind in a simulated world actually help you confront your own reality?

WRITTEN BY

Nupur Goenka (based on an interview with Dr. Lucia Valmaggia)

Dr Lucia Valmaggia works as Reader in Clinical Psychology and Digital Mental Health at the Institute of Psychiatry, Psychology and Neuroscience, King's College London where she leads the Virtual Reality Lab, and she is a Consultant Clinical Psychologist at the South London and Maudsley NHS Trust. In her career to date she has conducted research, which is clinically relevant and directly applicable to the delivery of clinical services. Her work has focused on the prevention and early detection of mental health problems, in particular psychosis.

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Headlines and copycats

PROFESSOR OM PRAKASH SINGH

JANUARY 14, 2021

The coverage of suicide with sensational headlines and repeated depictions of the body and method of suicide is known to cause undue distress. An increase in suicide attempts and incidents, particularly after a celebrity suicide, is known as the "Werther Effect". Despite this, there seems to be little awareness in media circles about suicide coverage.

By the end of 2019, it seemed like the Indian Psychiatric Society and the Press Council of India had begun to take some critical steps in the right direction. Both groups worked together and published guidelines about media coverage of mental health and suicide while referring to the World Health Organization (WHO) and the Mental Health Care Act (2017). Several organisations, such as the White Swan Foundation, NIMHANS, and Suicide Prevention India Foundation, issued their recommendations as well. While the last 10-15 years have shown improvements in media coverage of mental health, the publication of the guidelines marked a critical milestone for the country. It signified two associations joining hands after a long time. It also opened the door to using the power of mass media to break stigma, taboo, and misconceptions that have plagued the mental health space for as long as we can remember.

Unfortunately, the foundation that we tried to build has cracks. Over the last few months, the country witnessed a media tailspin that has all but silenced conversation about the importance of mental health. Several years of effort was reversed overnight, and coverage about high-profile incidents got published faster than anyone could keep up. Several things were published that were very stigmatising for the mentally ill. Less than a year after this milestone, we have managed to deepen taboo, add to the silence, and failed to protect the

vulnerability of many readers.

It is fruitless to underplay the influence that media has in our daily lives and our mental health. We are all more dependent on technology than ever before and are spending less and less time away from a screen. It is impractical to escape headlines, and it is impossible to know the mental state of the person who is reading the news. Scores of people who struggle with their mental health have consumed more misinformation about it in the last few months than they probably did in their entire lives. Print, digital, and social media have been swarming with articles that equate mental health and mental illnesses with financial loss, professional setbacks, and drug abuse. This falsehood has not only added to the confusion and panic amongst those who are at high risk themselves but amplify an already existing stigma about mental health across the general population.

A single spark set off a dangerous chain reaction across the country. News channels, print, and social media all went into a hyperdrive in sensationalising the story and defeating the whole purpose of the guidelines of suicide reporting. In India, an estimated 70-90% of individuals don't seek out help and treatment for psychiatric conditions. Amongst those that do, we have witnessed several people experiencing worsening symptoms and incidents of copycat behaviour over the last few months. We can only extrapolate what happens amongst those who don't seek out help.

> Copycat behaviour and suicides have been a well-known and predictable phenomenon for several decades. Almost every time a high-profile incident takes place, mental health front-liners face a sudden increase in patients who either mimic the incident or attempt to. And, although underreported, we have witnessed this across India in the recent past.
>
> Our intentions cannot be so far removed from its execution; we have a responsibility to do better, and we can.

Today, the Press Council of India is the only body that is empowered to enforce their guidelines in the media and journalism community. It is our duty to demand better, ethical, and more constructive coverage of mental health. We need to collectively acknowledge the responsibility we have and use mass media to break stigma and taboo, not strengthen it.

Psychiatrists and therapists alike should not take a stand to disengage with the media and worsen an already fragile situation but work towards reconstructing the foundation. The mental health community doesn't have

formal guidelines or training to help them engage with the media today. More often than not, this results in interviews and statements being given without understanding their possible repercussions. It's critical for us to educate this community and prepare them to work constructively with the media.

For readers; understand that you cannot assume everyone will read or watch the news with the same lens. Your history, your mental state, your background, and your knowledge is different. It is senseless to expect this or to place blame on people who consume it differently than you. While many of us are trying to take steps in the right direction, we have a very long way to go to talk about mental health openly. Considering the pervasive silence, we must all realise that it can be difficult for many around us to be outspoken about their struggles. The answers are unlikely to be simple, and it's essential to educate yourself, reach out to loved ones, be patient with them, and guide them to professional help without judgment if it's required.

Our country has started to take small steps forward, and it was a significant achievement for the Press Council of India to publish guidelines for the media fraternity. We have an opportunity to use this ethically and responsibly and realise that the impact of words can be far-reaching. We must work to build a foundation that doesn't crumble under high-profile incidents. Stigma and taboo around mental health are real and deeply entrenched across our society; it's our choice to take this as a setback or a chance to do better, together.

WRITTEN BY

Professor Om Prakash Singh

Professor Om Prakash Singh is the Hon. Editor of the Indian Journal of Psychiatry (IJP), the Hon. General Secretary of the Indian Association of Geriatric Mental Health (IAGMH) and the Immediate Past Hon. Editor of the Eastern Journal of Psychiatry (IPS, Eastern Zonal Branch). In the past, he was a Direct Council Member (2014-2017) of the Indian Psychiatric Association, Chairperson (2017-2018) of the IPS Biological Psychiatry Speciality Section, Co-Convenor (2008-2010) of the IPS CME Sub-Committee, and Chairman (2009-2013) of the IPSEZ CME Sub-Committee.

He has served as a Former Professor and Head at NRS Medical College (Kolkata, India), IPGME&R (Kolkata, India) and Burdwan Medical College (Burdwan, India).

The furry therapist

DR. CATERINA AMBROSI ZAIONTZ PHD

JANUARY 21,2021

Let's start with a story; there was a young woman (let's call her Christine) who had two children and had not left her house in over 14 years due to severe anxiety and panic attacks. She had tried various interventions, and nothing seemed to help. Soon enough, we decided to give 'Dog-Assisted Therapy' a chance. We planned sessions that lasted an hour each, spanned over six months, and had a focused goal of helping her leave the house without mental distress. During therapy, Christine developed a bond with the dog (whose name was Ariel) that seemed to keep strengthening as we worked through the sessions. She began interacting and playing with Ariel and slowly opened up about her memories and past trauma. As we started learning how to best deal with her mental distress, we also planned trips to leave the house along with Ariel in the backseat of the patient's car. Christine became more and more comfortable with Ariel by her side, and over time, she overcame her fears.

Today, it has been three years since we started Christine's journey with Ariel, and we see her filled with a confidence she never felt before. She not only leaves her house but drives for miles to other towns. A little help from our furry canine friends helped break a 14-year spell.

For many years, animal-assisted interventions were considered a 'soft therapy' done by volunteers and other practitioners who didn't require any formal qualifications. We are now starting to see this change. Italy is the first country to recognise Animal Therapy as an official form of clinical and rehabilitative intervention by the Ministry of Health. The Italian government's recognition of pet therapy has opened many doors. Not only can the general public benefit from these interventions, but the scientific community has been encouraged to

strengthen their research on the subject as well.

Italy's progress began with a set of guidelines published in 2015, which became the law in 2017 that all 21 regions of the country embraced. As a nation, we have been deepening our understanding of what animal-assisted therapy can do across several sectors. Apart from psychiatry, we have seen significant benefits also in the educational sector and prison systems. The law's rollout has helped break the stigma associated with animals being co-therapists and is comprehensive in determining the qualifications required for pet therapy professionals and animal welfare rights. It has surfaced possibilities for the field to rapidly develop and bring its potential benefits to many more people.

For several years, researchers have studied neurophysiological reactions when we have meaningful relationships with animals. For example, levels of oxytocin increase in humans and animals during interaction which benefits us in a deeply therapeutic and rehabilitative way. Pet therapy has even shown to help individuals struggling with anxiety, depression, and mental health conditions that accompany old age. This encourages the scientific community to continue publishing evidence-based literature and perhaps help the rest of the world embrace its untapped potential.

We have conducted a variety of projects that explore various benefits of animal-assisted therapy. One study looked at the impact of animals on individuals in a permanent vegetative state and recorded changes in their clinical parameters during a session. We've also used dog-assisted therapy in prison systems for male inmates to help them deal with mental trauma and allow for rehabilitation. And of course, we worked with patients in nursing homes who deal with mental distress because depression and social isolation have become growing concerns in these settings.

When institutions and clinics recognise dog or animal-assisted therapy (it is constructive, of course, when you have government support) as potentially beneficial, we help construct projects for patients to work with animals. One of the reasons behind animal-assisted therapy growing in popularity is because when a person interacts with another living being such as a dog, it can bring up emotions and patterns of memories that are difficult to elicit with other forms of conventional therapy. A study we conducted at a clinic showed us that some patients who suffer from clinical depression tend to be withdrawn, closed off, and often unable to communicate. However, their behaviour begins to change when an animal is introduced to the session. They opened up while physically interacting with the dog, talked about their memories and their trauma, and began a journey that could allow them to find their path to recovery. Pet Therapy can be also an excellent integrative intervention to psycho-pharmacological treatment in mood disorders, anxiety and eating disorders among others as shown by multiple scientific studies.

In animal therapy settings, the dog often becomes the vehicle for non-verbal communication through physical

interaction with the patient. In addition to petting and playing with the animal, one of the relationship's principal points is for the patient to receive love and affection back from the animal. The patient may slowly open up, and the therapist helps with cognitive and mental restructuring to address their past trauma and different sources of distress.

For all this to work well, we need an excellent canine co-therapist. The choice of the dog (not necessarily the breed) is of paramount importance because not all dogs will work well with all patients, and vice versa. Some dogs love working with kids, some enjoy older patients, and others love the challenge and energy of interacting with adolescents. If we don't respect the preferences that dogs clearly show us, we will benefit neither the animal nor the patient.




All this translates to a structured training program for therapy dogs.

> But, before you train a dog, you must select one. A good therapy dog must enjoy meeting new people and indulging in activities. This is incredibly wonderful because everyone is special to them, and they are capable of forging powerful and meaningful bonds with anyone.

In addition to high sociability, we also want the dog to be resilient and adaptive. It is likely for therapy dogs to interact with patients under distress who may express their suffering by acting out or screaming. As they are confronted with many different and unknown situations, it is vital for the dog to adapt while maintaining their composure without developing stress.

If a dog displays these characteristics (ideally, as puppies), we select them for training. The training is a combination of sociability (being exposed to social situations such as going to different locations, meeting other people, indulging in sports etc.), staying calm and technical steadiness (sitting and lying next to you for

prolonged periods without going into a state of distress), and obedience of basic commands (sitting, lying down, staying, etc.). It's also important for the dog to become indifferent to stimuli such as objects falling on the floor, which the dog may 'naturally' want to catch or eat, but could be lethal or dangerous (such as medication falling).

There are no breeds that are automatically 'excluded' from animal-assisted therapy. Of course, the privileged breeds are Golden Retrievers and Labrador Retrievers because of their inherent sociability. However, there are several meaningful studies on pet therapy with Pitbulls as well, and the Italian government considers it discriminatory to exclude any breeds a priori. Rescue dogs can also be used but they need to be assessed by Veterninary Surgeons and they cannot be employed in pet therapy unless they have received the proper rehabilitation therapy themselves. Otherwise, we would risk the dog getting afraid, uncomfortable, and potentially dangerous.

There is so much we don't know about animals and our interactions with them. There is a world to explore, and the benefits that we have observed so far are possibly just the tip of the iceberg. We have started the journey, and as we progress across the world together, perhaps we will unlock even more powerful interactions with our furry companions.

WRITTEN BY

Dr. Caterina Ambrosi Zaiontz PhD

Dr. Caterina Ambrosi Zaiontz PhD is a practising Clinical Psychologist-Psychotherapist from Italy. She is also a Chartered Psychologist with the British Psychological Society and has lectured at University College London at the Department of European Studies. She has been serving as a Senior University Lecturer and Researcher of Psychopathology and Transcultural Psychology IES Abroad Milan, Italy. Since 2010 she has been involved in Animal Assisted Therapy through evidence-based clinical interventions in the fields of Geriatrics, Psychiatry and the Prison System. She is a fully licensed Dog Trainer and Project Leader in Animal Assisted Therapy. She has published scientific studies and is the Scientific Director of Ministry approved Courses on Animal Assisted Therapy in Italy.

We can't 'copy-paste' mental health support across the globe

DR. ROSS WHITE

JANUARY 28, 2021

Over the last couple of decades, the field of Global Mental Health (GMH) has emerged as an area of study, practice, and research to address inequities in providing mental health support across the world. Historically, low- and middle-income countries (as classified by the World Bank's assessment of their economies) have struggled to establish and maintain the types of mental health services typically seen in high-income countries. This gave rise to concerns that the considerable burden caused by mental disorders [1] would go unchecked in low- and middle-income countries, which in turn prompted coordinated action aimed at building consensus about how best to respond.

In recent years, there has also been growing recognition of the important role that GMH can play in advancing progress in how people with a lived experience of mental health struggles in high-income countries (such as the US and the UK) can be better supported – particularly those who are marginalised and underserved by existing services. This is more befitting of the 'Global' ambition and scope that GMH ascribes to – rather than being restricted to certain parts of the world, it can have important impacts across the world. As such, 'GMH' is best understood as a diverse range of activities characterised by collaboration with local stakeholders to generate innovative, pragmatic, and context-sensitive approaches related to mental health and wellbeing in settings where resources are limited.

A myriad of initiatives (ranging from training community members to deliver forms of talking therapy, to reforming archaic mental health legislation) falls under the GMH ‘umbrella'. Furthermore, a plethora of various

actors contribute to GMH work, including people with lived experience of mental health difficulties, traditional healers, health professionals, government ministries, policymakers, researchers, non-governmental organisations, and international agencies (for example, the World Health Organization). As agendas, expertise, and ideas about the best ways forward can differ hugely, one may naturally wonder how coordination and consensus are established?

To answer this question, it is vitally important to understand how knowledge relating to mental health and well-being is shared, and how decisions about what knowledge is deemed credible are made. After all, what is considered a fact of life to people living in a particular part of the world, can seem like an absolute fantasy to those living elsewhere. It is important to recognise that there can be marked discrepancies in the power that different stakeholders have to shape the agenda for GMH. Care needs to be taken not to undermine the legitimacy and credibility of the knowledge and ideas that stakeholders bring when different worldviews meet because this can prove hugely detrimental to fruitful collaboration.

There is growing recognition amongst those involved in GMH of the risk of what has been referred to as *epistemic injustice [2]* – put simply, this is the risk of people incorrectly believing that 'the way I understand things is the way that other people ought to understand things'. When working in cultural contexts that are different from our own, we need to hold our assumptions lightly, enter into dialogue and discussion with local partners, and be open to the shared learning that can happen in those spaces.

> **It's ultimately about respectful partnership, mutual learning, and pragmatic innovation to see what works on the ground. We need to ensure that we tailor support to the cultural context rather than copy-paste what has been shown to work in a different cultural context.**

There is growing evidence confirming that forms of support that have historically been viewed as *bona fide* treatments from a Western perspective (e.g. psychotherapies such as Cognitive Behavioural Therapy) can be helpful, provided these are adequately adapted for the cultural context in low- and middle-income countries. However, research has also indicated that existing forms of support in low- and middle-income countries (such as traditional healing practices) can have positive impacts on minor to moderate mental health difficulties in these settings [3]. Key questions to consider in evaluating the merits of different forms of support include: does it seem relevant and appropriate to the community, are people willing to access the support, does it uphold and protect people's human rights, does it show evidence of bringing about benefit for people, is there adequate resource to sustain the support, are there community members who can be trained to deliver the

intervention in a cost-effective way?

Some 'home-grown' interventions developed in the low- and middle-income countries have shown promise in supporting local populations' mental health and well-being. For example, in Zimbabwe, the 'Friendship Bench' [4] was developed as a form of support where community members were trained to deliver a problem-solving intervention during meetings on benches placed in local clinics' grounds. This has shown to be effective in treating symptoms of depression and anxiety. Similarly, in post-genocide Rwanda (where up to 1,000,000 people were killed in 1994), an approach called 'sociotherapy' or '*Mvura Nkuvure*' (heal me, I heal you) in the local Kinyarwanda language, has been developed and used extensively to reduce distress and facilitate community healing.

My colleagues and I at the University of Liverpool have been working in partnership with Community-Based Sociotherapy Rwanda [5] and researchers from the University of Rwanda (Kigala, Rwanda) and Makerere University (Kampala, Uganda) to explore adapting sociotherapy for the large number of Congolese refugees living in Rwanda and Uganda as part of the COSTAR project. Sociotherapy is delivered by two facilitators who are drawn from the local community and offered training. The intervention is delivered over 15 weekly sessions to groups of between 10 and 15 people and focuses on six phases of work: safety, trust, care, respect, new life directions, and memory. As a community-based approach, we hope that sociotherapy will help address the collective difficulties and shared sources of stress that affect refugees [6].

It is hugely important to recognise the enormous role that low- and middle-income countries play in generating knowledge relating to GMH. Too often in recent history, people living and working in the low- and middle-income countries have been narrowly viewed as recipients of knowledge. In particular, there are opportunities for stakeholders living in high-income countries to learn from the pragmatism and pluralism used in low- and middle-income countries. We must explore opportunities to promote more equitable knowledge flows that can improve mental health systems in high-income countries that fail to adequately meet people's needs, particularly for underserved populations such as Black, Asian and Minority Ethnic groups.

As GMH moves forward, it will be helpful to clarify its vision and ambition. As highlighted previously, a goal of GMH at its outset was to reduce inequities in the availability of services to address mental health difficulties across the globe. However, we must look beyond that to determine what the primary purpose of these mental health services actually is. If you ask mental health professionals, many will say it's to reduce the symptoms of mental health problems. On the other hand, politicians may wish to minimise the economic impact that mental health difficulties have on their nation's economy. But if you were to ask a person who has experienced mental health difficulties, and who may be enduring a poor quality of life even after their symptoms are alleviated, their perspective may be different again.

In recent years, there have been concerted efforts to consult with those who have a lived experience of mental health difficulties (a.k.a 'expert by experience') to ensure that their voices are heard in GMH initiatives [7]. This has coincided with a greater focus on important outcomes such as well-being and quality of life, which relate more to a person's ability to flourish and live a life that has vitality and meaning. Indeed, perhaps an enduring legacy of GMH can be its ability to refine processes and procedures that empower people and communities across the world to clearly articulate what living well and feeling fulfilled means to them.

So, to conclude, when considering mental health support across the globe it's better to make less haste with 'copy-paste', and instead, work collaboratively with local stakeholders to coproduce what will work best in that particular place.

1. https://www.mentalhealth.org.uk/statistics/mental-health-statistics-uk-and-worldwide
2. The term 'epistemic injustice' was coined by Miranda Fricker in her book *Epistemic Injustice: Power and the Ethics of Knowing* that was published by Oxford University Press in 2007.
3. https://pubmed.ncbi.nlm.nih.gov/26851329/
4. https://www.bbc.com/future/article/20181015-how-one-bench-and-a-team-of-grandmothers-can-beat-depression
5. https://cbsrwanda.org/
6. https://www.liverpool.ac.uk/costar/
7. The UPSIDES Project provides an example of efforts being made to involve experts by experience in efforts to build capacity for the provision of mental health support https://www.upsides.org/project/

WRITTEN BY

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Exploring the tech revolution for mental health

DR. NIDAL MOUKADDAM, M.D./PH.D & ASHUTOSH SABHARWAL

FEBRUARY 04,2021

We are living through an era of technological revolution. The number of smartphone users worldwide has been exponentially increasing over the last few years, especially in emerging economies such as India. This has opened up a world of opportunities across many commercial industries. However, applications aiming to improve mental health remain largely untapped. Here, technological innovations in smart medical devices and online platforms could improve access to mental health services, as well as identify warning signs and provide interventions. Thus, if we approach these technologies with responsibility, it could help us bring mental healthcare to people who need it most. Although data-driven services also carry concerns with privacy and confidentiality, emerging research indicates that these technologies are a useful supplement to traditional therapeutic practices. We have countless exciting opportunities waiting to be developed, and we have barely scratched the surface.

The first major asset that technology brings is the ability to provide treatment at scale. Traditional mental healthcare services remain out-of-reach for many, but online services and platforms could provide new delivery models that can reach significantly more people. Such platforms can offer similar styles of therapy provided by mental health practitioners while allowing patients to bypass social taboos or discomfort about visiting a therapist or psychiatrist in a physical location. These models can also improve education and validation of mental health goals among the population.

> Mental healthcare technologies could potentially open up opportunities to

detect the early onset of psychological symptoms. We have been developing increasingly intimate connections with our devices, allowing devices to examine individual activity patterns closely. This gives them the power to detect patterns that we are unaware of ourselves, and commercial industries use this information to sell commodities.

However, they may also detect and predict the onset of mental health issues early in their development, and alert people to take small steps in rectifying irregularities. These interventions can be personalised to the user, which overcomes the limitations of a generalised and un-relatable public education of mental health. Unfortunately, this potential remains mostly undeveloped and clinical research has yet to test any reliably effective techniques.

Researchers in *digital phenotyping* learn how data from technology users can detect, record, and predict health diagnoses. For example, the symptoms of depression often include changes in appetite, energy, sleep, and activity – a lot of which phones and wearable can directly detect. Our research has shown that we can use apps to track depression and anxiety levels (Curtis, Pai, Cao, Moukaddam, & Sabharwal, 2019) and the worsening of symptoms carries a specific digital "signature". Devices that detect significant variations in these patterns could conceivably trigger an alert to the user. This is taken further with the field of *digital therapeutics*, which aims to provide personalised, data-driven therapy to technology users and can include recommendations to change a routine, like exercising or mindfulness. Such apps could also help people become more aware of their mental state and understand how their symptoms relate to mental health.

Of course, the use of technology has its concerns; privacy and confidentiality being the most obvious ones. This is magnified when collected data is shared with other entities. We also don't have a physiological definition for 'normal usage of technology', so features such as comparing one's patterns to 'normal' or 'average' groups in aggregate and anonymised forms becomes problematic. Another concern about the use of technology is related to the underlying nature of mental health conditions. For instance, people that are depressed tend to lack motivation or energy to improve their state, so there is no guarantee that they will utilise their technology as prescribed. In other cases, constant alerts and recommendations may even worsen symptoms to the point where a person needs closer treatment. These are just two of several examples that indicate the need for clinical research to examine data-driven therapies with the same rigour that it tests and develops other modes of treatment.

Technology can help us identify and predict the early onset of symptoms and even provide personalised treatment. Digital phenotyping and digital therapeutics are intense areas of research with exciting and frequent

developments. Yet even with these possibilities, technology will always have its limits. With what we know today, digital phenotyping and therapeutics are best used to support a formal treatment plan. Here, feedback between the patient and their symptoms can increase the clarity of their diagnosis, their awareness of physical patterns and triggers, and treatment adherence. We have a chance to work with the mental health community, to experiment, to learn, and to use the power of technology to create breakthroughs that the field so desperately needs.

CO-WRITTEN BY

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Dr. Nidal Moukaddam, M.D./Ph.D., is an Associate Professor at Baylor College of Medicine where she is the Director of Psychiatry Outpatient Clinics at Ben Taub Hospital. She received her MD from the American University of Beirut and did both her PhD and residency at UTMB in clinical sciences. She is board certified in General Psychiatry & Addiction Medicine and specialises in challenging adult populations: she practices emergency psychiatry at Ben Taub Hospital, a level 1 trauma center in Houston, Texas, with a special focus on individuals afflicted with both psychosis and addiction. She is the Continuing Medical Education director for the National Arab-American Medical Association, and is passionate about normalising the conversation around mental wellness and culturally appropriate care. Moukaddam's research interests focus on how psychiatry can benefit from technological advances for detection, tracking, diagnosis and treatment of mental illness. She is the Harris Health site Investigator for The McNair Initiative for neuroscience Discovery (MIND-2), which uses a combination of biobehavioral sensing and functional imaging to enhance our ability to assess and quantify impulsivity in people with mood disorders and addiction. Moukaddam has supervised many students and residents, leading to numerous awards including Women of Excellence Award at Baylor College of Medicine (2020), the Faculty Mentorship & Teaching award for Baylor Psychiatry Department (2018), being selected for Houstonia magazine- Houston top 100 doctors selection (2017) and Baylor College of Medicine, Department of Psychiatry & Behavioral Sciences' Outstanding Mentor Award (2017). She is also the creator of a wellness curriculum for Baylor College of Medicine's Center of Excellence in Health Equity, Training and Research.

Ashutosh Sabharwal

Ashutosh Sabharwal received his B.Tech. from IIT Delhi, and MS, Ph.D. degrees from the Ohio State University. He is currently the Department Chair and Earnest D. Butcher Chaired Professor of Engineering in the Department of Electrical and Computer Engineering, Rice University, Houston, Texas. He research interests are in two areas. His first area of research is wireless. He is the founder of WARP project (warp.rice.edu), an open-source project which is now in use at more than 125 research groups worldwide, and have been used by more than 500 research articles. His inventions are part of both wireline and wireless networks. His second area of research is healthcare technologies. He is currently leading several NSF-funded center-scale projects, notably Rice RENEW (open-source massive MIMO) and "See below the skin" for non-invasive bio-imaging. He founded the Rice Scalable Health Labs (http://sh.rice.edu), which is developing a new engineering area called "bio-behavioral sensing." His research has led to four commercial spinoffs (one in wireless and

three in healthcare). He is a Fellow of IEEE, and received 2017 IEEE Jack Neubauer Memorial Award, 2018 IEEE Advances in Communications Award, 2019 ACM Test-of-time Award and 2019 ACM MobiCom Community Contribution Award.

The five misgivings people have about self-compassion

DR. STEVEN HICKMAN

FEBRUARY 18, 2021

Learning to treat yourself kindly when you struggle, fall short, and fail is not an easy thing. We are usually quite good at reaching out to our dear friends and family members when they face similar hardships, and we seem to know just the right thing to say or do, but when it comes to ourselves, it seems like we have a different standard. When a friend fails an important exam, you give them a hug and say "That must have been a tough exam. I know how disappointed you must feel right now. I'm here for you and we'll get through this together." But when you fail the same exam you might say to yourself "What's the matter with you? What a stupid thing to do! You are lazy and you didn't work hard enough. You don't even deserve to be in school!"

We know that 84% of people are kinder to their friends than they are to themselves, so if this describes you, you are not alone. But the problem is that we have trouble changing that inner narrative and being kinder to ourselves, even though we know that it might be good for us. There is a huge body of research (much of it done by Kristin Neff and her colleagues in the US) that shows that self-compassion is highly related to resilience, well-being, improved mood, and a number of other things.

The primary obstacle that people face to becoming more self-compassionate is actually themselves! People have beliefs, hesitations and misgivings that prevent them from actually trying the practice, and the sad truth is that these misgivings have been mainly disproven by research.

It is worth noting that self-compassion has two complementary aspects that are referred to as the yin and yang of self-compassion. The yin side is the one that is the comforting, soothing, and nurturing aspect to self-

compassion. However, self-compassion also has a more active strong side, a yang side, that is about protecting, providing, and motivating ourselves. Most people don't get this right away (especially men) and thus dismiss self-compassion as something weak or feminine or soft. But while it has a soft side, self-compassion is incredibly powerful, strong, and resilient.

"Self-compassion is really just a form of self-pity"

At first glance, some may come to the conclusion that self-compassion is an elaborate way of facilitating a "pity party" where you get to tell yourself "oh, poor me, I'm suffering" and basically wallow in your misfortune and become mired in your own victimhood. The fact is that research suggests that people who are more self-compassionate are actually much better than others at taking the perspective of *other people* and not over-focusing on their own distress.

Self-pity says, "poor me" and gives up or retreats. Self-compassion says, "this is hard, but this is how it feels when people struggle in situations like this" and takes stock of the situation and allows the person to assess what they need in this situation to navigate it wisely, even if it is very hard.

"Self-compassion is weak"

It is natural for us to be alert for where we are vulnerable and to protect against potential threats, so it's not surprising that some people might see self-compassion as weak. Our gut reaction is to tense up and brace for impact (emotionally OR physically) as a way of dealing with danger or threat, and anything that doesn't feel firm and solid can feel a bit disconcerting.

But think about what you *really* know about strength, or even more importantly, resilience, which is the quality that really makes us strong. As a human capacity, it refers to our ability to recover quickly from a difficulty. Resilience is not solid and rigid, but strong and flexible, and this is what self-compassion supports.

Self-compassion is a reliable and ever-present source of inner strength that confers courage and self-reliance for us to navigate difficult circumstances with purpose and resolve. Where weakness is passive or compliant to whatever comes along and says "I give up, you win", self-compassion says "I can meet this situation flexibly but firmly so that I can stay strong and present and keep my footing."

"Self-compassion is really just self-centred and narcissistic."

Similar to self-indulgence, the practice of self-compassion can seem to be rather self-centred and self-focused, as if we are prioritizing ourselves over all others. This goes against all the messages we get about helping others, putting others before ourselves, and generally focusing our compassion on those who have greater need.

> When you practice self-compassion, it isn't about directing compassion *only* to yourself, but simply *including* yourself in the circle of good will that you already cultivate so easily for others.

Why would you be any less deserving of compassion than any other human being? The research demonstrates that self-compassionate people actually tend to be more caring and supportive in romantic relationships, less jealous, and more likely to make compromises as needed in relationship conflicts.

Self-centeredness says, "I matter more than you and you need to take care of yourself," while self-compassion says, "You and I both matter and when we are both compassionate to ourselves, we are much better able to take care of each other too."

"I'll lose my edge if I'm more self-compassionate"

When I hear people say that they fear losing their edge or not reaching their full potential if they are self-compassionate, I suspect that they have achieved a certain success through self-criticism, perfectionism and putting aside their feelings when they come up. Think of the medical student who has relentlessly driven herself to achieve perfect grades and excellent test scores through relentless self-flagellation and withering self-criticism. It's hard to deny that these ways of being have helped get these people to the heights they've achieved, and one can understand why they would be reluctant to stop.

The sad thing is that while self-criticism can get us so far, self-compassion can take us much farther. A useful comparison is if you consider the motivational impact that a harsh, judgmental, punitive coach might have on your athletic performance, relative to a kind and supportive coach with high standards for you and a wish for you to achieve your highest performance. In reality, self-criticism turns out to undermine self-confidence and create a fear of failure instead.

Where self-criticism and perfectionism say, "Your best isn't good enough, because you're nothing if you don't win", self-compassion says "I know you have it in you to be the best. You're trying hard and I believe you have it in you to succeed."

I don't actually expect you to suddenly be a true believer in self-compassion now that I have laid out some of the common misgivings and the findings of science that refute those doubts. My hope is that you now have a richer and deeper appreciation for what self-compassion actually is and what it is not, and perhaps you will be a little bit more inclined to try it out for yourself. If you find that self-compassion works for you, brings you

more ease, less distress, and a more fulfilling and satisfying life, you will keep it up. You won't need me for that.

Look for a Mindful Self-Compassion course online or near you at the Center for Mindful Self-Compassion website (http://centerformsc.org).

WRITTEN BY

Dr. Steven Hickman

Dr. Steven Hickman is the Executive Director of the non-profit Center for Mindful Self-Compassion. He is a Clinical Psychologist and Retired Associate Clinical Professor in the University of California at San Diego School of Medicine, as well as the Founding Director of the UC San Diego Center for Mindfulness. Steve co-developed the Mindful Self-Compassion Teacher Training program and has participated in the training of over 900 MSC teachers around the world. Steve has co-taught the 8-week and intensive MSC program many times around the globe and is also a Certified teacher of Mindfulness-Based Stress Reduction (MBSR) and trains teachers of that program. He is married and has three young adult children, affording him ample opportunity to practice what he teaches!

Navigating the spectrum of Music Performance Anxiety

DR. TAWNYA D. SMITH

MARCH 11, 2021

Have you ever experienced stage fright? Most of us have, at least to some extent. Musicians and other performing artists generally deal with some level of stage fright that may vary in intensity based on the performance context or their state of mental wellbeing. Some musicians experience the 'butterflies' and an optimal level of hyperarousal that helps them perform their best. In contrast, others report disruptive and even debilitating symptoms that are more akin to Music Performance Anxiety (MPA) (Kenny, 2011). The range is wide, and it might help to think of an individuals reaction to performing as being somewhere along this spectrum. By considering their situation, it's possible to understand the types of practices and therapies that could help them manage both the long- and short-term causes of MPA symptoms. Although often dismissed under the umbrella term of 'stage fright', we can learn a lot about performers by dissecting MPA and maybe, realise how we can truly support those who dedicate their lives to the arts.

In the book "Performance Anxiety Strategies: A Musician's Guide to Managing Stage Fright" (McGrath et al., 2017), we provide an overview of various treatment approaches and therapies that have been used to treat MPA and help musicians work towards peak performance. For those who experience mild to moderate symptoms, several exercises can help identify elements of their history and current situation to determine the best way to cope. For example, some may benefit from physical health and wellness solutions when they experience symptoms due to their bodies being out of balance. However, others may find that mental health challenges or learned behaviours prevent them from coping with the stress of both preparing for and executing a performance. No matter the cause, at any given moment, different solutions or a combination of them might

be helpful to manage MPA symptoms for artists. It's important to be extremely mindful of your inner state and the context in which you are attempting to perform.

There are several things you can do as an artist to support a healthy level of stress. One of them is to take an honest inventory of your history with performing and preparing for performances. What does this look like? Some may discover that they have learned unhealthy coping strategies and thought patterns from childhood caregivers, teachers, or coaches. It's difficult to learn healthy habits as a child if we are surrounded by those who do not gracefully manage stress or are abusive or neglectful.

It is also possible that some people with severe MPA may have a personal or family history of trauma, substance abuse, or mental illness. Children who have been raised by caregivers with frequent or more serious mental health conditions may be more at risk to internalise negative coping patterns. If a person does have such a history, its important to consider seeking therapy to address childhood wounds and negative thought patterns. And in cases where a person is recovering from PTSD or extreme childhood abuse and neglect, imbalances in their brain or nervous systems must be confronted (Herman, 1992; van der Kolk, 2014). Many people who are well into trauma recovery or who have experienced less serious harm in their lives may find help in talk therapies such as cognitive behavioural therapy, somatic therapies (such as expressive or arts therapies), and yoga (van der Kolk, 2014). The intention is simple; first, to understand and acknowledge the possible causes for your symptoms and then realise there is a path to recovery without dismissing your experience as 'normal stage fright'.

While childhood and family history is important to recognise, it may not be the cause of MPA symptoms. Many people have negative experiences with performing that disrupt their ability to build experiences of mastery needed to develop self-efficacy (Hendricks, 2014). When young performers are pressured to perform before they are adequately prepared or in conditions that are not emotionally or physically safe, they can have unsuccessful performances. And when a person holds such experiences in their memories, it can be hard to shake. Some performers use negative memories to motivate themselves to prepare; others find that this strategy sets up a stress response that cripples their performance. In other words, if you practice using fear as a motivation, you are reinforcing the fear, which is likely to carry into your performance. So if you are an artist or performer who is plagued by negative memories, it's crucial to consider building mastery over time and engaging in low-stress performances where success is likely.

Fortunately, it is possible for us to reconstruct our memories with a healthier perspective. Our memories are linked to our emotions, so it may be easier for us to recall incidents that cause emotional distress. However, we may sit and work with the negative memory and possibly identify neutral or even positive details about a bad experience. If you can engage with your memory at this level, perhaps you can recreate your story. You can

add details so that a more honest and less emotionally damaging version of the memory can be recalled instead.

All this is obviously easier said than done. While it may not always be possible to recall positive aspects of an event, it is usually possible to at least reposition the meaning of the story from one of victimisation to one of power. In this case, you can identify what you have learned from the experience and then make a conscious choice to see the event as one that helped you grow or become more aware. Choosing to reinterpret the meaning of a memory is powerful and can slowly help build your confidence again. And, of course, you can always intentionally recall positive performances as well. In fact, we recommend that artists create a 'backstage book' that includes written reflections of positive performances and the feedback and encouragement they received from others (McGrath et al., 2017).

> **While its important to manage your thoughts, emotions, and physical well being, its equally important to acknowledge if you are in a negative performance environment. If you assess your surroundings and discover that you are in an abusive relationship or in a competitive environment where peers undermine your success, you may need to consider changing where, how, or with whom you work.**

Working in hostile environments can rapidly chip away a person's resilience and magnify even minor mental health challenges. If this is the case, it's critical to reassess your journey forward; look for positive opporunitites, try to manage your exposure to toxic individuals as much as possible, and begin to reclaim your sense of safety. Being self-aware of your potentially harmful tendencies is equally important, so you don't contribute negatively to relationships with others. In an environment that may already be hostile, the lack of this self-awareness can continue to add toxicity and create a vicious cycle for the entire community.

Most of us go through life enjoying the performing arts and connecting with them in our own ways, oblivious to the experiences of the artists themselves. However, to truly move forward and support the creative community, we must not only understand the wide spectrum of Music Performance Anxiety but acknowledge that it's not necessary for unhealthy 'stage fright' to be normalized or dismissed. Perhaps we can even encourage an environment where artists enjoy their preparation and performance as much as the audience loves the final show.

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WRITTEN BY

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Dr. Smith teaches graduate courses in research, curriculum, arts integration, and undergraduate courses on the topic of creating healthy classrooms, and arts and the environment. She is an integrative researcher who explores expressive arts principles to promote holistic learning. Her background in music education has led her to experiment with free improvisation and multi-modal art response as a means for learners to explore the self in community settings. Her recent work focuses upon arts integration and social justice.

Could music be an antidote to loneliness?

NUPUR GOENKA & DR. CHARLOTTE BRAND

MARCH 18, 2021

The stereotypical image of a heartbroken teenager listening to "dark" music alone in their bedroom is a cliché for mental health campaigns and doesn't often evoke compassionate responses. Some cultures mock teenagers for being overly emotional and dressing in clothes that accompany sombre lyrics, but is this apparent preference for negative imagery just a phase that we grow out of? Recent studies have found that the proportion of negative lyrics in songs seems to be growing, and has been increasing since 1965 [1]. Analysing the increase of negative and decrease of positive lyrics over the last few decades may stir curiosity about its potential correlation to mental health. We may wonder, have we begun to propagate sadness even more than we did before? Or, are we learning to use music and other art forms to help people heal by feeling less isolated?

The scientific analysis of emotional trends over time is becoming more possible with the proliferation of large, openly accessible datasets such as Musixmatch [2]. A group of researchers specialising in the study of 'cultural evolution', including changes in behaviours, tools, and cultural artefacts over time, decided to investigate the apparent growth of negative lyrics in a dataset of over 150,000 songs between 1965 and 2010. In line with 'The Pollyanna Principle' in linguistics, the corpus of lyrics contained more words associated with positive emotions than negative emotions *overall* [3]. However, the *proportion* of negative lyrics has been increasing since 1965, whereas the proportion of positive lyrics has been decreasing.

When looking at the data, the use of the word "love" roughly halved in 50 years, plummeting from 400 times per year in 1965 to 200 times in 2010. The word "hate", on the other hand, has skyrocketed to being used

20-30 times per year after not being mentioned at all in the 'Top 100' songs during the 90s.

Researchers tried to investigate what was driving this trend and its possible correlations to the theory of cultural evolution [4]. In this field, behaviours are transmitted through populations via copying, often by preferentially imitating those who are most successful or most prestigious in the group. Similarly, cultural artefacts may evolve and may be selected for being more appealing or functional based on particular societal or psychological preferences. This theory echoes Darwinian principles but applies them to learned cultural behaviour rather than genetic evolution.

To test these ideas, the researchers ran statistical models that tried to tell if song lyrics were influenced by the success of previous songs or by prestigious artists. However, they didn't find much evidence to support either of these hypotheses. On the other hand, the researchers did find that songs that had more negative content tended to do better in the charts, i.e. they were more likely to achieve a 'Top Ten Hit' status. This pattern held regardless of genre and was not driven by an increase in the popularity of HipHop/Rap in recent years, as some unfairly and incorrectly intuit. So, what can explain these trends?

The apparent preference for negative content and the increase in it over time might seem upsetting and bring up the question, is society plummeting into despair? However, if we dig a little deeper, there may be a more hopeful and uplifting message behind the data. An alternative, encouraging theory is that the selection of more negative songs can be driven by the fact that, at times, they provide a more useful function than their positive counterparts. Cast your mind back to your most recent heartbreak or period of grief. Would you have been comforted by the sound of someone singing about how in love they are? Or would it have been a solace to hear someone sharing feelings and experiences that mirror your own?

> The idea that we seek comfort in art and that it can serve the function of healing, connection, and relatability, is not ground-breaking. In fact, research suggests people reliably underestimate the prevalence of others' negative emotions, and this underestimation exacerbates their loneliness [5]. Perhaps the popularity of negative song lyrics is an antidote to this loneliness. Hearing others sing and share their negative experiences tells us that we are not alone and show us through music that others have felt and feel something very similar to us.

The spectrum of mental health is non-binary; the world is not divided into people who are 'mentally healthy' and those who are not. The spectrum has a place for every person and for every phase of life and diversity of experiences that they go through. While we still have a long way to go in normalising open discussion about mental health, we have walked quite a distance compared to where we were just a few years ago. In many cases, the stereotypical dark image of the teenager listening to music continues to be 'symbolic' of mental health conditions in many communities and cultures. If one were to look at this data at the surface level, it might even appear to corroborate this imagery. However, perhaps if we dig a little deeper, we can further study, analyse, and understand the correlations these trends have with our human tendency to find solace and liberation in art. Perhaps, rather than plummeting into despair, our society has been finding ways to promote healing and emotional catharsis through music, adding to how we can all, in our own ways, find remedies for our pain.

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Mental health in the criminal justice system: Punishment vis-a-vis rehabilitation

DR. CHARLIE BROOKER

APRIL 09, 2021

The prevalence of mental health conditions in prison populations is much higher than in the general community; however, access to mental health services is significantly lower. Such a relationship holds constant across the globe. In England and Wales, efforts have been made to understand the prevalence of mental health conditions amongst offenders, the types of currently available treatments, the shortfall, and the possible path forward. While the relationship between the treatment of mental health disorders and reoffending is unclear, there is an opportunity for us to use the criminal justice system not purely as a means to punish but as an aid in recovery. This has been termed 'equivalence'; that is, offenders incarcerated in prisons are entitled to the same mental health treatment as anybody else in the population.

Various ideologies exist in treating offenders and criminals; some tend to one extreme of severe punishment, whereas others believe in rehabilitation and recovery. And while there is no 'absolute' blanket ideology that will apply to offenders of all backgrounds, genders, ages, and criminal histories, it's important to consider the majority who have committed relatively 'minor' offences. Can our lack of focus on mental health rehabilitation put us at risk of perpetuating a vicious cycle of reoffending behaviour and prevent us from helping the same individuals contribute positively to society in the longer term?

We must first consider why the prevalence of mental health disorders in prison systems are so high. Everything from environmental factors and substance abuse to disruptions in neurological functioning may lead to risky behaviour. While none of these schools of thoughts is 'incorrect', we cannot consider them in isolation as the

'causes' of criminal behaviour. However, mental health conditions in prisons across England and Wales co-occur with a high prevalence of childhood physical or sexual trauma, PTSD, substance abuse, and the manifestation of psychosis [1]. We can also look at the conditions of prisons and prison culture. Naturally, they are not environments that have been constructed to deliver care and can often be anti-therapeutic in themselves. Therefore, the experience and pain of imprisonment can often exacerbate and trigger mental health issues in prisoners who did not enter with a diagnosis. In this context, suicide is a major concern.

The provision of mental health treatment for offenders generally poses many challenges in mainstream community settings. People serve probation orders and face stigma amongst mental healthcare professionals themselves, many of whom equate offending with risk. Often the call is to refer such individuals to forensic services. Mental healthcare in the general population is already in a state where the demand significantly outweighs the supply, so one may wonder why we should focus time and resources on individuals in the criminal justice system. While you are in prison, however, a mental health referral could be triggered in several ways and is usually catered to by an 'in-reach team'. Prison Officers may notice behavioural patterns in inmates, prisoners could proactively ask for interventions from their primary care staff, and self-harm, suicide attempts, or violent instigation can also prompt intervention. If an offender undergoes mental health treatment in prison, many rooms are designed to balance the inmate and the mental health professional's safety. The rooms are usually equipped with a 'panic button' in case there are any emergencies.

Another primary concern with pushing the need for access forward is the lack of education and resources for prison-based programs that already exist.

> **There are several ongoing debates about the culture of control and punishment instead of recovery and therapy and what it would mean for prison staff to deal with offenders in a 'trauma-informed way' (acknowledging the trauma someone has experienced and interacting with compassion on a day-to-day basis).**

This would require the recruitment and training of a prison's operational staff and those who interact with inmates daily. In England and Wales, while it is necessary for prison officers to have formal training in mental health awareness, they generally report too many daily stressors and a lack of support [2]. Also, resources available to conduct formal therapy are scarce (in-reach teams in England are often small) and are usually available to prisoners only when they are extremely unwell. The levels of distress leading to self-harm or suicide in prison are high, so it's important to acknowledge the workforce's insufficiency across the criminal

justice system.

Advocates of rehabilitation may ask for equivalence in access to mental health care regardless of whether you're an offender in prison or an individual in the community serving a probation order. The argument here is that this access to appropriate services can help offenders with recovery and promote better mental and physical health, which would lead to a reduction in risky behaviour, violence, self-harm, and possibly their reoffending. However, when we assess the prevalence of mental health conditions in prison systems, we see that 'equivalence' is perhaps not what we are truly seeking. There is not only a high prevalence of mental health issues but more than 1 in 10 cases where the individual has 4-5 co-existing mental disorders [3]. If you look to general society, the likelihood of such co-existence is minimal, if at all. And this begs the question, are we seeking equivalence of care? Or should we try to understand the specific situation and gaps in prison systems and create relevant models to address these individuals in the community appropriately?

Let's now re-look at the spectrum of punishment and rehabilitation. Whenever a crime, any crime, is committed, most people tend to the former end of the spectrum and believe that the individual should be punished for their offence and locked up due to the pain and grief they have caused. We also consider society's safety in general, so people who are likely to inflict harm on others are kept away from communities. However, we must look to the nature of the crime and understand the punishment not only in terms of tenure of imprisonment but to the background of the individual, the possibilities of rehabilitation and recovery, and access to physical and mental health care. Perhaps, for the vast majority who commit significantly minor offences, we can create systems and models that encourage and build understanding and compassion, hopefully ending the vicious cycle in the criminal justice system rather than perpetuating it.

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Dr. Charlie Brooker has been a researcher and academic for over thirty years. His main interest was in psychosocial approaches for the care of people with serious mental health problems up until 1995 when he was professor of mental health both in Sheffield and Manchester. Since then, he has almost exclusively researched aspects of the Criminal Justice system and mental health. This work has taken him into police stations, prisons, courts, sexual assault referral centres, and, in the last 10-15 years, probation services.

In 2010 he retired formally from University life but was awarded an honorary chair at Royal Holloway, University of

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Loneliness and teenagers amidst a global pandemic

DR. MARIA LOADES & LUCIE SMITH

MAY 14,2021

Often, we think of loneliness as spending lots of time alone or lacking social interaction or connections. This can be true; a person you see sitting on their own may feel isolated and lonely. However, loneliness is more complex. People can also feel lonely when surrounded by a group of people, including their family and closest friends.

So, loneliness is not just about being alone. It's a feeling we experience when there is a gap between our ideal social contact and our actual social contact. This gap can be in the quantity or quality of our relationships or both. Even amongst a crowd, we can feel lonely if we do not have a sense of close connection with them. Loneliness may also have a broader negative impact on other aspects of mental health and wellbeing, such as our self-esteem.

This means that loneliness can be hard to spot as it is an internal experience. It can also include a myriad of difficult emotions, including anger, pain, and frustration, making it challenging for those closest to us to identify the signs of loneliness or consider it a potential underlying cause of distress.

Most importantly, loneliness is normal. Almost everyone will experience it at some point during their lives [1].

Why loneliness is particularly common in teens

The teenage years are a time of rapid growth and development as we transition from childhood to becoming independent adults. For younger, primary school-aged children, family relationships are the primary influence

in their development. However, for teens, the peer group becomes increasingly important, and sharing experiences with people outside their family unit helps them develop their identities and provides a sense of belonging. It allows teens to experience ways of doing things that are different from their normal family life.

Teen loneliness and the COVID-19 pandemic

The COVID-19 pandemic has required us to enforce social distancing measures globally to tackle the spread of the virus.

> For most teenagers, this has meant prolonged school closures, cessation of hobbies and extra-curricular activities, and has limited in-person interactions with their family unit. The closure of schools also means there has been less access to support, including mental health services.

At the outset of the pandemic, psychologists predicted that social distancing could make loneliness worse, which might negatively affect mental health for everyone, including teens. Our team conducted a rapid review of the existing literature and found 63 relevant studies that included a total of 51,576 school or university students. The evidence from these studies showed us that loneliness is associated with increased long-term risks of depression and anxiety symptoms up to 9 years later. Although many studies have not covered it extensively, the evidence suggests that the duration of loneliness could be more problematic to mental health outcomes than the intensity of loneliness [2].

Studies that have looked at loneliness in the pandemic context have found that teens have reported increased feelings of loneliness due to social distancing measures [3, 4]. This may be because of the developmental importance of peer relationships at this life stage, which have been severely limited by reduced in-person social interactions.

Increased loneliness may be one factor contributing to a rise in mental health difficulties in this context, although we do not yet know for sure [5]. There are many other pandemic related stresses that teens are facing. For each person, a combination of different stressors is likely to be relevant, of which loneliness may be one. For example, a teen may have worries about the health of themselves and family members, threats to family income, changes to their education, and the perceived changes to their future [6]. School closures have meant that teens have missed out on important milestones of their formative years, such as taking examinations or school graduations.

Although we might assume that teens are well skilled in technology and social media to stay in touch with friends virtually, it is not the same as in-person interactions [6].

So, what can we do?

Social distancing does not have to lead to disconnection. The way we talk about and approach loneliness can make a big difference to teens and help them become resilient in the face of loneliness. We need to validate their feelings, encourage them to be open about their experiences, and promote social interaction once allowed by local authorities. Here are some guidelines for parents/caregivers and adults working with teens.

- Foster a climate of trust and connection

Talk openly about the challenging times everyone is going through. We can convert a difficult experience into something we have overcome. Celebrating what we have been able to get through and the resilience we have built can help support a positive mental framework about the situation.

Regularly check in with each other as to how we are feeling and help recognise and validate the feelings of others. This provides the space to connect and communicate, which can help to diminish feelings of loneliness.

- Be open about loneliness

Talk openly about loneliness with teens by providing a safe space for them to open up about the difficult emotions they might be experiencing. Do not dismiss or neglect their feelings. Validating their experience also promotes social connection and helps them make sense of what they are going through.

Moreover, talk about what loneliness means, and the different ways loneliness can present itself. Normalising the experience and explaining that it is something that most people go through can make a big difference to help reduce feelings of isolation and disconnection.

- Provide space and time to build or rebuild social connections

Some teens may find it difficult to re-integrate back into 'normal' life after being isolated and kept away from regular in-person social interactions for a long time. We need to provide opportunities for them to re-learn dynamics with friends and be part of social groups.

While academic catchup is important, we also need to allow space and time for teens to catch up socially and emotionally.

The pandemic has been an unprecedented time for all of us, and no parent or caregiver would have been forewarned or trained on how best to handle a child's mental health during long periods of social distancing and isolation. And while there is no formula, it's essential first to acknowledge that we can do something about

this. It starts with normalising conversation around mental health and loneliness. Just like any other feeling, loneliness is something we all experience at some point in our lives. Ironically, during the pandemic, too many of us collectively felt all alone. Perhaps, we can all come together to talk about it too?

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Why should we make room for art and design in clinical spaces?

NEESHA GOBIN

MAY 21,2021

Imagine you enter a hospital. You walk through the doors and find yourself looking for directions. It's a busy area, and there's a lot of signage, but you manage to find your way to the correct department. The lobby lights are bright, and the receptionist greets you. You take a seat in the waiting room and look at the small television broadcasting the news on mute. Not the most uplifting content, you think. The chair is cold and hard, practical, but not comfortable. You look around the room for a distraction, and your eyes land on medical posters with warning signs that incite worry and fear. You hear the doctor call out your name, and walk in for your consultation. The entire area looks sterile, each bay identical to the other. The decor is dull at best, and the lighting is fluorescent and stark. There is a smell of disinfectant in the air to accompany the sound of medical equipment. How do you feel?

This is what most of us have experienced when visiting a hospital or clinic – bland, sterile, and institutionalised. We have only recently started paying attention to studies that show how our immediate environment can directly affect mood and mental health, which can either help or inhibit our recovery and impact staff morale as well.

All over the United Kingdom, art strategies are now included as standard practice for new healthcare buildings. A significant change in the NHS design policy recognises that the mental wellbeing of patients, staff, visitors, and stakeholders are better supported in environments that include visual art, music, and well-designed interiors. We find that care is more compassionate, there is a reduction in painkillers, and patients

are even discharged sooner.

So how do we go about making these changes to support mental health in everyday clinical settings? What is 'good design' when it comes to hospitals? A good place to start is with our senses, what we see, hear, touch, and smell.

Choice of colour can impact people both psychologically and physiologically. Bright colours and vibrant, engaging artwork can help create a positive and welcoming space for children. Anxious adults may benefit from calmer and more muted colours. Bold contrasting colours are favourable in dementia care environments where they can help differentiate surfaces and locations. Using colour wisely can be beneficial in recovery, help positively impact mental wellbeing, and play a crucial role in allowing patients to navigate the space well.

In addition to colour, it is well documented that access and proximity to nature can aid recovery. Although exposure to daylight, fresh air, and nature significantly reduce anxiety and alleviates symptoms of depression, these elements are either scarce or entirely missed in healthcare settings. The same positive impact can be achieved by 'biophilic design' that focuses on replicating the natural world in a constructed environment. We can accomplish this using raw materials such as wood, incorporating organic shapes within furniture design, lightboxes placed in ceilings to mimic skylights, soundscapes featuring birdsong, and mounted artwork of nature on display.

All this is also true of lighting. Our exposure to light can play a significant role in supporting our healing process. When used well, warmer tones can create a calm ambient atmosphere, and sensory lights such as coloured or twinkling lights can be a positive distraction in labour wards and children's waiting areas. Light even helps control our internal body clock, which synchronises many physiological and psychological functions on a 24-hour cycle known as our circadian rhythm. Our circadian rhythm helps regulate our daily sleep pattern, and the inability to do so can lead to several physical and mental health issues. So, hospitals with unnatural, bright, and harsh fluorescent lights can inhibit the normal cycle of rest and activity and have a detrimental effect on the patient's wellbeing.

Digital artwork is also on the rise, often used as a distraction in waiting rooms or treatment areas for children. Chelsea and Westminster Hospital commissioned the creation of the ‘digital zoo’. The ‘digital zoo' features digital moving portraits of 60 different animals ranging from gorillas to goldfish installed within the Children's Accident and Emergency Department. Results showed 79% reported improvement in their patient's perceived pain, and 67% reported progress on the time taken to complete a basic procedure. These are statistics that trickle up to not only lowering the strain on the child's wellbeing but alleviating parental anxiety to a large extent.

Alongside visual arts, we can also consider participatory arts within healthcare settings. Participatory arts can work across all art forms such as dance, music, film, visual arts, poetry, and crafts. Working with cultural organisations, activities in community and hospitals provide opportunities for people to engage with each other through their creativity which directly improves their sense of mental wellbeing. The arts can reduce stress and increase social engagement as well as provide opportunities for self-expression.

During my time at The Royal London Hospital, we invited the London Symphony Orchestra to play in the neonatal ward. As the musicians sang lullabies and played music to the babies, the nurses noticed that heart rates lowered and oxygen levels increased for some. This was not only beneficial for the babies, but the parents felt much happier and relaxed. According to the recent *All-Party Parliamentary Group (APPG) on Arts, Health and Wellbeing 2017,* engaging in participatory art workshops can dramatically improve physical and mental health. Singing has shown to alleviate chronic respiratory conditions and cystic fibrosis. Studies have found listening to music has beneficial effects on people with cardiovascular disease. There is also evidence that art therapies diminish the physical and psychological suffering of cancer and the side effects of treatment.

> **Over time, we have gotten used to bland and sterile clinical spaces, and we must change this. The idea that mental wellbeing is deeply related to physical wellbeing and recovery is not new, nor is their relationship with our immediate environment.**

The quality of artwork and design in a space also subconsciously impacts the patient's perception of care and therefore experience, making it either a positive or negative one from the moment they walk through the door.

While we work towards acknowledging and learning more about the relationship between our physical and psychological health, there is so much we can already do to improve our spaces. We have taken some strides forward in the United Kingdom along with policy changes but there is so much scope for improvement and progress across the world. Perhaps we can start by making a conscious effort to enhance clinical settings with art and beauty and allow its positive impact on our mental health to speed up our physical recovery.

WRITTEN BY

Neesha Gobin

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Neesha trained at Chelsea College of Art UAL and went on to gain her BA (Hons) at Leeds University. She has worked at a variety of contemporary art organisations and has specialised in Arts in Health. She also featured in a book of Healthcare Heroes – celebrating people working with passion, purpose and determination to improve people's lives all over the world.

AFK, trying to unpack mental health in video games

NUPUR GOENKA (BASED ON AN INTERVIEW WITH DR. RACHEL KOWERT)

JUNE 24, 2021

The rapidly growing gamer community has millions of people worldwide with diversity across age, race, gender, sexual orientation, and backgrounds. It begs the question, what will we find if we unpack the mental health narrative in this space?

I sat down with Dr. Rachel Kowert to discuss the recent trends in research around mental health and video games. Dr. Kowert is a research psychologist, Research Director of *Take This*, and science content creator Psychgeist (www.youtube.com/psychgeist). Here are some insights from the conversation.

Sensationalised media and myths about gamer violence

Over the past 50 years, video games have become a sensationalised scapegoat for individuals exhibiting violent behaviour and are often conflated with mental health conditions, sexism, addiction, and toxic culture. Even today, concerns about the impact of violent video games on long term mental health issues and aggression continue, especially since younger generations have begun to join the gaming world. However, to put it simply: there is no scientific evidence linking violent video games with aggression and violent crime. Several other myths have been debunked many times over as well. There is a gap between reality and perception at a time when, more than ever before, we need to look at mental health in the gaming world and have a much more nuanced discussion.

Death Race was one of the earliest games that sparked controversy and incited general moral panic after its

release in 1976. The game was a driving simulator where players could earn points using their on-screen cars to 'run over and kill' gremlins. There was an immediate controversy that Death Race made players use their cars as 'weapons' to run people over. A few years later, the release of Mortal Kombat kept the debate going. The game became particularly famous for its gory fatality endings that included beheadings and disembowelments. And of course, we have to mention Grand Theft Auto. This video game continues to create controversy and outrage even today as players participate in a wide range of criminal behaviour.

Hundreds of scientific studies have evaluated the relationship between violent video game play and aggression. Of these, many have reported small, short-term increases in aggression following exposure to violent video games. While this may sound like a reason to sound the alarm, it is important to note that these increases are typically measured only within the first few minutes following violent video game play. There is also no evidence to suggest that these short-term rises have any long-term impact on a player's level of aggression or mental health.

Mental Health in game design

Let's also consider that video games can provide interactive and enriching opportunities to learn about mental health and well-being, especially since independent games have become even more prevalent and are a dominant media form with millions of players across the globe. While several games have come under scrutiny for either misrepresenting mental health or conflating mental illness with violence, the community has recently seen several games that show a positive development in their considerations for game design. For example, just within the last year, games like Celeste, Gris, and Sea of Solitude tell mental health stories in nuanced and accurate ways. Hellblade: Senua's Sacrifice is also lauded for its mental health storytelling and portrayal of Schizophrenia. Many people who have played this game have reported that it gave them a new perspective on what this mental health condition is like for those living with it, increasing the ability to empathise rather than stigmatise.

> The discussion about the portrayal of mental health in games is unique compared to other mass media because apart from characters and stories, it's also about game mechanics and in-game decisions where people are actively involved in play. By being immersed in an interactive world, players find themselves in an 'active learning' situation rather than passively retaining information. And this can be a potent tool if used well.

For designers, it's crucial to avoid tropes and stereotypes. How mental health is portrayed within media matters and games are no exception. Setting a game in an "insane asylum" to make people scared further reinforces negative stereotypes about mental illness and those suffering from mental health challenges. We have seen that misrepresentation of mental health in games can increase stereotyping, deepen stigma, and even reduce help-seeking behaviour.

Gamer culture, toxic behaviour, and dark participation

While we consider the design and construct of games, it is equally important to understand and discuss the cultural movement of gamers. As it has evolved over time, gamer culture is now often cited as 'toxic'. It describes a movement based on exclusion rather than inclusion with players hiding behind anonymous gamer identities. Dark participation is an umbrella term that encapsulates "deviant" online behaviours in games - what others often call toxicity or toxic behaviour. The behaviours that fall under this umbrella, such as trash-talking, harassment, griefing, hate raiding, and doxxing, can have a detrimental impact on a players mental well-being for both the short (increased distress) and long-term (PTSD). This culture refers to the perpetuation and normalisation of these behaviours within gaming communities.

Games are meant to be fun and playful activities for everyone. However, dark participation and toxic gamer culture fuelled by verbal and behavioural abuse within these communities have created a space that is the opposite of welcoming. A study by the ADL in 2019 found that 1 in 10 players reported depressive or suicidal thoughts resulting from harassment in online multiplayer games. While these statistics are shocking, and it can be challenging to change group norms once established, it is still a solvable problem if we work both top-down and bottom-up.

One way to combat this toxic culture is for the video game industry to make reporting tools much more effective to increase accountability. We must also have stronger community guidelines to create a safe space for everyone and encourage better industry collaboration between researchers to collectively understand and combat toxic behaviour. Even then, we have to do our part as a community as gamers. It's important to stand up to harassment when you see it rather than ignore verbal abuse or add to the toxicity with similar comments. We must be the active ally; if you see something, say something.

And, finally...

The world of gamers and gaming culture is complex and constantly evolving. Unfortunately, many people who aren't in this movement tend to view it through biased eyes because of stereotyping in pop culture and sensationalised media. However, if we look closely, we can find many opportunities to create a stronger narrative for mental health in the community. We need to look past the stigma and myths to stop perpetuating

and normalising misleading reports. We have to get creative with game design and leverage their interactive nature to make powerful stories and learning opportunities. And finally, we cannot sit back and accept toxic culture when there is something we can do about it. This is a global community with millions of people connected to each other, and the opportunity we have before us is massive.

WRITTEN BY

Nupur Goenka (based on an interview with Dr. Rachel Kowert)

Rachel Kowert, Ph.D is the research director of *Take This* (www.takethis.org) and science content creator Psychgeist (www.youtube.com/psychgeist). She is an internationally recognized speaker and author on a range of topics relating to the uses and effects of digital games, including its impact on physical, social, and psychological well-being. She has published several books and scientific articles relating to the psychology of games and, more recently, the relationship between games and mental health specifically. One of her most recent books, *A Parent's Guide to Video Games*, won an INDIES award in the science category. For more information about Rachel and her work, visit her website at www.rkowert.com.

Rain Man and the lessons of autistic portrayals in film and TV

PROFESSOR ANDERS NORDAHL-HANSEN

JULY 01, 2021

"I know all about autism, I've seen that film" is a quote from the movie Snowcake. A woman confidently tells Alan Rickman's character that the idiosyncratic behaviours displayed by Sigourney Weaver's character, who is autistic, needs no explanation. The line alludes to the Oscar-winning Rain Man where Dustin Hoffman played Raymond Babbitt and is often considered detrimental to the cultural canon of fictional autism portrayals. However, following the film's release in 1988, the world saw a gradual rise in autistic characters in the entertainment industry. It marked the starting point of an impactful increase in the awareness of ASD (Conn & Bhugra, 2012).

I have been working with autistic individuals for about 20 years. I started as an assistant to autistic children, pursued studies in special education, and researched a range of topics related to autism, mainly from a developmental perspective. Over the last two decades, I have noticed something that almost always comes up about my work in social gatherings; autistic portrayals in major films and TV shows. This piqued my curiosity, and along with my colleagues, I decided to delve deeper into this topic.

We believe this line of research is important because of how pervasive and accessible the entertainment industry has become to the general public. The reach of autism-related content on-screen is significantly higher and more potent on public perception than other sources such as publications I produce 'hidden away' in scientific journals (which, perhaps, can be quite dull for non-academics). After several years of research, we believe that autistic portrayals on-screen have pros and cons in influencing the audience's perception,

including autistic individuals and their families. It's a double-edged sword, raising awareness and acceptance on one side and a potential source of emphasizing stereotypes and increasing stigma on the other.

Awareness and stereotypes

The accuracy of autistic narratives is central to this distinction between beneficial and detrimental representations in popular culture. It remains a matter of intense debate, especially for autistic people and their families. In one of our studies, we used the DSM-5 diagnostic manual to investigate whether the behaviours and traits displayed by fictional autistic characters lined up with the symptom criteria (Nordahl-Hansen, Tøndevold, & Fletcher-Watson, 2018). In a sample size of 26, 22 films and 4 TV shows were highly popular and included characters linked to the autism spectrum (e.g. Rain Man, My Name is Khan, Community, The Big Bang Theory, The Bridge, Alphas). We found that a majority of character portrayals were in very close alignment with the diagnostic criteria for an autism spectrum diagnosis as described in DSM-5.

Now, one might think this is a good thing, but we must tread with caution. A problem here is that it is too "perfect", and characters become textbook and homogenous representations of a highly complex and heterogeneous condition. As the saying goes, *"if you have met one autistic person, you have met one autistic person".* Thus, while portrayals of autistic characters might positively raise awareness, they may also reinforce stereotypes (Nordahl-Hansen et al., 2018).

"Super-skills"

'Savantism' is usually a topic of high interest for producers in the film and TV industry. It refers to a person's exceptional abilities within one specific area, such as having calculus, spatial, artistic, or musical skills. It's easy to acknowledge why savant skills are fascinating and just as easy to understand that screenwriters tend to "give" these features to their characters, perhaps hoping to make them more interesting (Nordahl-Hansen et al., 2018). However, this has led to the incorrect impression that Savantism is something that most people with ASD have. While it is true that it's more common in autistic individuals than in those without a diagnosis, the prevalence of Savantism in media does not match its reality. It's also not mentioned in the diagnostic criteria for Autism Spectrum Disorder (APA, 2013). All in all, it's probably not sensible to approach autistic persons or families of autistic people by asking them what special skills the individual has.

The current state of research

Publications on the topic of 'autistic characters in film and TV' can be found in scholarly journals across various disciplines, including American Studies, Asian Diaspora, Education, Emergency Medicine, English, Film, Mass Communication, Journalism, Psychology, Psychiatry, Sociology, and Spanish (Dean & Nordahl-Hansen, 2021). While there is growing diversity in the current research base, in comparison to other psychiatric

conditions on-screen such as schizophrenia, split personality disorder, anxiety, and depression, to name a few, studies on autistic portrayals are in their infancy. We need to do a lot more.

Portrayals of autistic characters moving forward

In our latest systematic review (Dean & Nordahl-Hansen, 2021), we argue that there is some distance to go for the film and TV industry in focusing on marginalized groups within the autistic spectrum. Paying attention to this may spur a broader understanding of the richness and complexity of the condition. Some examples of underrepresentation include the non-white, LGBTQIA+, older adult, and female communities who sometimes appear as 'incidental characters' rather than in lead roles.

Possibilities for the future

Film and television can highlight various aspects of living with ASD. Recurring themes include family life and dynamics, consequences of hypersensitivity to environmental stimuli, problems in school, struggles with academic success, and severe bullying, to name a few. Difficulties in dating, sex, and relationships are also frequently depicted. We also see more overarching existential issues and general difficulties with social communication that lead to feelings of social ostracism. Nevertheless, many argue against the over-representation of middle-class white males, either as teenagers or young adults, who are so-called "high functioning" (Nordahl-Hansen & Øien, 2018).

> To give the general audience a nuanced view of the heterogeneity that lies within the autism spectrum, we need variety in on-screen portrayals to take steps in the right direction. One character in a film or TV show cannot capture the complexity of the entire spectrum, nor do justice to the diversity in autistic lived experience (Nordahl-Hansen, 2017).

While there certainly are some fictional films and TV series that depict autistic characters with this variety, many of these don't reach as wide an audience as mainstream 'Hollywood' productions.

In addition to the increased portrayal of autistic characters who have higher needs of everyday support, it would be welcoming also to see non or minimally verbal or display self-injurious behaviours. The Swedish/Danish TV Series called 'The Bridge' is one of few examples that have female characters with ASD, and we need more. Portrayals of autism and ageing are almost entirely missing as well. Overall, while we have seen progress, there are still many gaps we need to fill. Character portrayals can never fully capture real life, and it is important to make use of insights from autistic people themselves to strengthen representations

and truly help spread awareness.

The entertainment industry is growing in reach across the world and in diversity in a way we have not seen before. Several communities continue to be underrepresented and misrepresented, and there is a vast opportunity to learn how we can navigate our way to progress and be more inclusive. It's in our best interest to diversify while we create, listen to communities while we produce, and use the massive power of film and television to encourage open conversations rather than strengthen stigma.

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WRITTEN BY

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Between the devil and the deep sea, there lies moral injury

PROFESSOR NEIL GREENBERG

JULY 22,2021

The COVID-19 pandemic has pushed our global healthcare systems and workers to their limits. Clinical infrastructure around the world crumbled as waves of the virus swept across countries. Many doctors and nurses have had to make seemingly impossible decisions, including distributing limited resources, choosing which patients to give oxygen to, and which medicines to try, amongst others. Our healthcare front-liners have been in morally ambiguous situations with no 'correct' answers, but decisions still had to be made. By studying past traumatic events, we know that we can expect substantial mental healthcare repercussions in this community due to moral injury unless we act today. It's worth spending a few minutes understanding the history of moral injury, what it means for healthcare workers in the pandemic, and how we can build resilience.

The concept of moral injury has been around for centuries but was highlighted in military contexts during the Vietnam War. American troops found themselves in morally unclear events and were tired, exhausted, and traumatised but, on many occasions, had to act without sufficient information to enable them to properly assess the situation. When they returned home, they experienced psychological distress symptoms linked to events beyond the death and trauma of war, and we observed 'moral injuries'. Many of them who identified as 'family oriented' and 'good, loving parents' began to feel disappointed in themselves for what they had done and wondered whether they could ever be forgiven. They felt betrayed and let down by people who sent them to war and felt they should never have been in that situation in the first place.

The cycle of mental distress that comes with moral injury was never explicitly considered, even though we had witnessed it before, for example, during the two World Wars. Once we realised that it's not only the death

and trauma of war that can cause long term mental health conditions but also moral injuries, we began to look beyond the military. We started understanding the implications of moral injury on mental health in various other professions such as media, policymakers, and healthcare workers.

Unfortunately, moral injury in a situation is often only recognised after it already happens, just like how we found ourselves in the middle of a pandemic. Although healthcare workers regularly deal with uncertainty and ambiguity, the last 15 months have very much changed their meaning. As the volume and intensity of the COVID-19 virus increased, healthcare workers were required to make more judgements in much greater uncertainty without relying on experience. The virus had its own unknowns; its ability to spawn variants, its contagiousness, the efficacy of a vaccine, and much more. The lack of access to manpower, equipment, medicines, and information increased the strain on front-liners to a breaking point. While continuing to exercise judgment with massive uncertainty, many healthcare workers began to feel the distress of moral injury.

There are three ways in which we experience moral injury; (1) acts of commission (things you or other people have done), (2) acts of omission (things you or other people could not or did not do), and (3) betrayal (being let down by people you thought you could trust or who should have been looking out for your welfare). During the first wave in the UK, we surveyed 25,000 healthcare workers and unearthed some interesting data. We found that the most significant impact of moral injury was betrayal. The experience of betrayal in nurses usually manifested in feeling let down by their teams and managers, and for doctors, it manifested as disappointment in society and healthcare systems. So many felt let down that they were doing their best in the worst circumstances. Still, society continued to socialise, refused to wear masks, and indulged freely in concerts, weddings, and other events.

> **While we see the light at the end of the tunnel, we are still in the middle of a very challenging situation. Therefore, we need to cautiously think about the recovery of ourselves and our healthcare workers.**

Examining traumas more generally, we find that there are three stages; pre-trauma, trauma, and post-trauma. The risk of developing long term psychological distress can vary from person to person based on who they were (socioeconomic status, history of mental illness, social support, poor education etc.) in the pre-trauma stage and the intensity of the trauma itself. However, we find that the strongest predictor of mental health repercussions comes from the experience during the post-trauma stage. People who have strong social support, lower exposure to stress, and exhibit help-seeking behaviour early, are much more likely to have a positive outcome than those who don't. This period we are in right now and how we handle it will be the

strongest predictor in how our healthcare workers recover from the mental shock of the pandemic. If we can build solid mental health support systems, we may reduce the number of people who have long term mental health conditions while maximising the experience of post-traumatic growth, which describes increases in personal and group resilience as a result of being exposed to adversity.

With healthcare workers likely to be amongst the most impacted, organisations and governments are asking themselves how to prepare for a resilience-building recovery process. First, we need to help people make sense of what has happened so the experience of moral injury doesn't fester. And while there may be a need to increase access to professional support, it's essential to acknowledge that many solutions lie within the individual's team and immediate social circle.

One of the biggest misconceptions of moral injury is to believe it's an illness that only psychiatrists and psychologists can help solve. However, since healthcare is a very team-based profession, we can find many answers within the healthcare community in which the person works. To begin with, individuals mustn't wait for their distress to deepen and intensify before they seek help. This is dangerous for the individual and creates a complex situation for any therapist, who, perhaps, could have intervened more successfully at a much earlier stage. We have observed three things that make a big difference in alleviating moral injury in healthcare teams:

- Ensuring all supervisors are confident in speaking about mental health and having 'psychologically savvy' conversations to encourage early help-seeking behaviour. We have found that giving a simple one-hour training course on asking the right questions leads to almost a doubling in the proportion of supervisors who feel confident to speak about mental health with their staff.
- Ensuring that some individuals within the team receive evidence-based peer support training, which allows them to formally check on colleagues who have been exposed to trauma or morally challenging situations. This will enable them to identify if they need support or if they do not recover, whether they have mental health symptoms that may require attention.
- Practising 'reflection' where the team gets together to try and make sense of the situation they are in and build meaningful narratives so everyone can benefit.

While professional support may be necessary for an important minority of staff, building these three things into healthcare teams can be extremely powerful to reduce the number of people who develop long term illnesses.

There is no doubt that we are living through a global situation which we have not experienced in recent history. We are in the middle of an ongoing and complex traumatic event, and society must decide how to foster post-traumatic growth whilst minimising the chance that healthcare staff will develop mental health disorders. Mass and social media constantly report huge spikes in mental health distress for healthcare front-

liners and those who work in critical care, with a large number experiencing symptoms that appear to resemble PTSD. We may have a substantial problem on our hands if we assume that most staff will become unwell and need formal mental healthcare; this is unlikely to be true. By examining past traumatic events, we realise that it is natural to experience many symptoms of distress during the trauma. However, there can be no doubt that as the situation improves, as it hopefully will, most people will recover even with no formal intervention, but we must remain cognizant of the important minority who develop a mental health disorder. Therefore, while we ensure we don't misinterpret conclusions from media reports, we must prepare and educate ourselves and support one another at work and home. We need to encourage people to seek help early when the solutions to the problem are simpler, and they still have their self-esteem, relationships and work to help sustain them through their recovery.

WRITTEN BY

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Professor Neil Greenberg is a consultant academic, occupational and forensic psychiatrist based at King's College London. Neil served in the United Kingdom Armed Forces for more than 23 years and has deployed, as a psychiatrist and researcher, to a number of hostile environments including Afghanistan and Iraq. At King's Neil leads on a number of military mental health projects and is a principal investigator within a nationally funded Health Protection Research unit. He also chairs the Royal College of Psychiatrists (RCP) Special Interest Group in Occupational Psychiatry. Neil has published more than 300 scientific papers and book chapters and has been the Secretary of the European Society for Traumatic Stress Studies, the President of the UK Psychological Trauma Society and Specialist Advisor to the House of Commons Defence Select Committee. During the COVID19 pandemic, Neil has worked closely with NHSEI, PHE and has published widely on psychological support for healthcare, and other key workers.

Five common myths about hypnosis

STEVEN N GOLD, PHD & MICHAEL A QUIÑONES, PHD

AUGUST 05, 2021

We are both psychotherapists in the U.S. who specialize in treating individuals with serious psychological problems, including severe and constant anxiety, insomnia, impaired concentration, terrifying nightmares, drug addiction, and suicidal depression. Although we do not see it as appropriate for *everyone* we treat or for *all* the difficulties we try to help people overcome, in many instances, we find hypnosis to be an invaluable asset. But, unfortunately, despite the tremendous impact hypnosis can provide in addressing many of the most daunting challenges our therapy clients bring to us, there is a great deal of skepticism and wariness due to a lack of familiarity with the science behind it.

Many people view hypnosis from one of two extremes: they either see it as something that doesn't really exist or as being so powerful that it can be dangerous. For this reason, when the two of us use hypnosis in therapy, we first take our time explaining to the person we're working with what it is and how it works. Then, once they understand it better, they're usually much more open to including it in their treatment. So here we address five common misconceptions about hypnosis.

1. "Hypnosis is nothing more than a fancy term for imagination."

The history of hypnosis in modern science dates back almost 200 years. However, even among professionals who are trained in and make use of hypnosis, there was little agreement about how to define it. With the availability of fMRI (Functional Magnetic Resonance Imagery) equipment that measures brain activity, we now

have solid scientific confirmation that there are specific patterns when someone is in a hypnotic state. Compared to the brain activity present in our everyday waking state of consciousness, hypnosis promotes variations in activity across the brain's constituent structures.

Changes in patterns of brain activity depend on the type of hypnotic phenomena cultivated during hypnosis. Deepening bodily relaxation, fostering alterations in attention and self-awareness, reducing awareness of the external environment, and increasing absorption with internal imagery, sensations, and emotions correspond to specific brain activity changes. For example, hypnotically cultivated relaxation can reduce situational awareness and facilitate increased internal awareness of images and sensations. This corresponds to reduced activity in the prefrontal (areas related to focus and attention) and sensorimotor (areas related to bodily movement and coordination) regions of the brain and increased activity in the occipital (visual area of the brain) and midbrain (experiencing sensations and emotions) regions. Therefore, hypnotic states change activity patterns in the brain that correspond to specific alterations in consciousness.

Hypnosis is a state of mind in which the conscious and logical mental activity we are mostly aware of (literally residing in the front of the brain, the prefrontal cortex) reduces in intensity. This shift makes way for the more intuitive and fundamental brain activity of which we are largely unaware. Although always active, it is obscured by conscious activity in the front of the brain, which tends to be more salient.

Hypnosis is also a naturally occurring state of mind that everyone has experienced at one time or another. Examples of a hypnotic state include periods when you are unaware of the stretch of road for 10 minutes while driving long distances or when you are so absorbed in watching a TV program that you don't hear someone in the same room talking to you. These examples reflect that hypnosis is commonplace and naturally occurring mode of experience that individuals may encounter routinely without conscious awareness of them . The primary difference with formal hypnosis, whether self-induced or guided by someone who is trained in hypnosis, is that these examples occur spontaneously, while hypnosis is the *intentional* evocation of this mental state.

2. "Being hypnotized involves letting the person doing the hypnosis control your mind."

This is one of the most common and troublesome misunderstandings about hypnosis. One of the main sources of this misconception is the dramatic and misleading ways in which it is depicted in movies and television. No one controls your mind but you. The psychotherapist or medical professional leading the hypnosis simply guides you toward experiencing the state of hypnosis, usually by talking to you in a way that reduces the activity of the front of the mind and un-obscuring what is occurring in "the back of the mind."

Experiences and behaviors under the direction of the front of the mind *feel* under our control. However, those

executed in the back of the mind are also under our control, but they *feel* as if they are occurring "by themselves". If we assume that *someone* must be in charge of our experience and behavior, and it does not feel as if it is us, we are prone to believe that it must be the person guiding us into the hypnotic state who is in control. But this is not the case any more than thinking someone else is in charge of our breathing or heartbeat.

It is well established in the research literature that someone in a hypnotic state cannot be directed to do anything they would not do in a standard waking state. Our way of thinking about hypnosis is that it is a joint effort. Guiding a client into a hypnotic state is most effective when we, to some degree, enter that state ourselves. Our state of mind, then, becomes discernable to the person we are working with and helps them "follow" us into a hypnotic disposition. Although we use hypnosis to achieve treatment goals during therapy sessions, our ultimate aim is to teach the client how to experience hypnosis on their own, outside of our meetings, so that it becomes a tool they can use independently of us.

3. "Hypnosis is amusing when demonstrated at parties or nightclub performances, but it is of no practical value."

We often use hypnosis in our psychotherapy practice because it helps people accomplish things that cannot be done as easily or, in many cases, cannot be done at all in a standard waking state of consciousness. In other words, it allows access to mental abilities and capacities that lie outside the logical and conscious awareness that corresponds to activity in the frontal area of the brain.

For example, it is not unusual for people to learn how to lower their blood pressure under hypnosis. That is a function "behind" the conscious, front part of the brain. Some individuals who are especially adept hypnotic responders can turn off the experience of physical pain to the extent that they can undergo major surgery without a chemical anesthetic. Again, this is a process that resides in the areas situated behind the front part of the brain. We are in the habit of assuming that if we don't consciously decide and choose to do something, it will not happen. But, our heartbeat is controlled by the brain. Awareness of physical pain is controlled by the brain. And these are just some of the activities constantly occurring outside of the prefrontal region of conscious awareness.

Scientific research supports the utilization and efficacy of therapeutic hypnosis to promote improvements in managing stress, chronic pain, and its application in medical settings. Recent neuroscience research validates that hypnosis is associated with modulation of activity in the areas of the brain related to bodily awareness, sensations, and mental perceptions of pain. This suggests that while reducing a sense of effortful control typically associated with the front of the brain, hypnosis can improve an individual's capacity to promote beneficial changes in activities related to other regions of the brain.

> A person in a hypnotic state, therefore, has access to functions outside of conscious awareness. There is nothing magical about this as it is the nature of the human brain and corresponding human abilities and experiences.

4. "Hypnosis is dangerous."

Many things have the potential to be dangerous if not properly used; a kitchen knife, a match, or medication. Like these, hypnosis can be tremendously valuable in the right hands but useless or even dangerous if used by someone unfamiliar with the subject. As alluded to in our answer to question 3), hypnosis can be a powerful asset in treating a range of psychological and medical problems. Various health professionals have effectively applied its use in many fields, including medicine, dentistry, and mental health. However, some people aren't trained in the medical or helping professions but purport to use hypnosis to help solve people's psychological or even medical ailments. These people not only lack training in the helping professions but they also often lack organized and structured training in hypnosis itself. In the hands of such people, hypnosis can be detrimental. It is never a good idea to seek treatment from someone who is not a fully trained and licensed professional, with or without hypnosis. Professionals should only perform hypnosis with formal training in both the specialty they are licensed in and also in the use of hypnosis as an adjunct to their professional expertise.

5. "Hypnotic treatment only takes one session."

One of the more common misconceptions about hypnosis is that it resolves difficulties in a single visit. Self-described "hypnotists" without professional training and licenses have been known to advertise that they can help people lose weight, overcome cigarette smoking and other addictions, or even cure medical illnesses in just one session. Whether they are capable of being helpful is questionable, but it is extremely unlikely that these claims of single-session "cures" are accurate. However, many people in our psychological practice with whom we use hypnosis can achieve a clinically beneficial level of responsiveness the first time we work with them hypnotically. For some, this accomplishment alone takes several sessions of practice. Building on the hypnotic state to work on problem-solving usually takes additional visits. Thus, promises of single-session resolution of difficulties are generally a clear sign that the person making those claims is not to be trusted.

We've reviewed some of the common myths attributed to hypnosis. Dispelling these myths has provided an opportunity to describe the various ways hypnosis can benefit and improve quality of life. As described earlier, substantial research and case studies on the practical applications of hypnosis continue to support its relevance as a treatment for a wide range of psychological, behavioral, and health-related challenges.

Recent trends in neuroscience also support that hypnosis is a discrete state of consciousness with potential benefits accompanied by various changes in brain activity. Although discretion is highly recommended when seeking therapeutic hypnosis, empirical and clinical research provides a solid foundation for the healing potential of hypnosis and its' holistic benefits for the body, brain, and mind.

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Relationships: A matter of life and death?

DR. SUZANNE MIDORI HANNA

OCTOBER 07, 2021

I became a family therapist because I wanted to "help" people. I believed that family relationships provided the background to understand someone's distress and to leverage resources for healing. Back then, I didn't use the word, healing. We called it treatment. But spending decades across many settings have led me to see the power of attachment and how attachment wounds can be a common denominator that plays-out in personal, interpersonal, cultural and global affairs. Here, I make the bold claim that attachment quality is a matter of life and death.

To this end, family therapy became a twentieth-century profession, licensed in each U.S. state. Originally, psychiatry moved from Freud in 1900 to an array of psychotherapeutic modalities by the 1970s. Within these innovations, maverick practitioners left medicine, psychology, social work, and clergy to develop an interpersonal view of problems that became known as marriage and family therapy. In this view, the family and social environment was the unit of focus to understand a person's experience and engaged members of these social systems in problem-solving. Thus, symptoms and behaviors were not reduced to diagnoses; they were expanded to be problems for the social environment to address.

In the most traditional sense, therapy might be for couples or families. In the most innovative sense, multifamily psychoeducational groups actually help those with schizophrenia to improve their functioning. Groups of 6-8 families receive education and help for problem-solving and conflict resolution. In the process, each group becomes a "tribe" of support for members and a "community frontal lobe" in which all members participate in brainstorming and problem-solving, functions the brain often lacks during schizophrenia. This doesn't look like

"therapy" or act like "therapy," but these communities of healing get therapeutic results.

Inspired by these projects, I refer to my own practice as ecosystemic practice. Social ecology examines the interpersonal and cultural world that surrounds a person, similar to a biological ecosystem. But one may ask, what about genetic predispositions? This concept is quickly shrinking in importance as genetic studies accumulate large databases that show the power of environmental factors. This leads to a rethinking of many serious health and mental health conditions such as substance abuse, post-traumatic stress, obesity, depression and bipolar disorder, to name a few. This new information shows how attachment can be a matter of life and death.

Although the American mental health establishment is financially and conceptually dependent on psychiatric diagnoses, in practice, family therapists quickly move beyond diagnoses to the context within broader interpersonal and social realms. Symptoms without this context provide a narrow range of possible solutions. Instead, we ask, "how does this behavior make sense?" We look at the intersection of cultural factors such as institutional racism, social class, gender, and attachment quality in the intergenerational family. Behavior is multidetermined, and resources for healing should draw from multiple layers of development. Once the behavior makes sense in context, we can learn about the root intention of the behavior and negotiate safer attachments that foster a sense of identity and belonging.

My father's story illustrates some of these concepts. As a boy and young adult, he was the brunt of cruel racism toward Japanese Americans before, during, and after WWII. Raised in Albuquerque by parents from Japan and Kentucky who could hardly read or write, he looked outside his family to find the American dream. Hired and trusted by some wonderful Hispanic grocers at the corner market, he gained the skills to open his own store as a self-made man. This was a great blessing to our family, but it didn't help him heal deep humiliation. When I learned more about his violent father, I was able to see that his hypervigilance was the heroism of a young boy trying to protect younger siblings who were victims. Then, his first wife's parents paid for an abortion because they didn't want a Japanese child. Basically, he never felt good enough.

Looking back, in family conflicts, he needed to show that he was better and smarter than "they" thought, whether this was family or friends. We were merely stand-ins for the early perpetrators of micro-aggressions in his youth. His conversational style was an animated effort to prove himself. His parenting style rewarded respect and punished any egalitarian discussion. Upon spending a day with him, one of my friends deemed him "narcissistic." I believe this is an overused concept. I had come to understand that he was really having an imaginary conversation with those who had devalued him. His unspoken intent was, "I'll show them." In adulthood, these were the "ghosts of humiliations past" left with no first aid. They looked like bravado, but instead of a diagnosis, dad really needed compassion, empathy, safety and affirmation.

Dad's social environment became a healing resource as he aged. Besides his wonderful Hispanic mentors, he joined the Masons. When his family was judgmental, he had the customers at his store who loved the special orders for gourmet foods they could place through him. He found solace outside our family with his coffee buddies. In his generation of WWII veterans, he found "real men" and validation. In retirement, a niece and nephew were more attentive than his own children. His strict morning and afternoon coffee schedule assembled a surrogate family of "regulars" and waitresses who spoke at his funeral. Despite a tragic childhood and young adulthood, his social network was a matter of life and death, and he found secure attachments. He lived to be 95.

> In family therapy, no one is blamed or criticized. Instead, behaviors stem from relational dilemmas that are the real culprit. They may lead to wounds, and those may be stumbling blocks that slow us down.

Regardless, the beginning of healing will need large doses of systemic empathy and sympathy (how does this behavior make sense?). If a person acquires the label of narcissistic or sociopathic personality disorder, I will ask, how were empathy and sympathy not available to this person? Empathy is understanding interpersonal dilemmas. Sympathy is validation from family or friends of a loss or wound. In this way, relationships become the medicine. Injustices can turn to challenges, and those with wounds can be acknowledged as unsung heroes. These lead to important levels of love, safety and belonging. Without sufficient doses of these, our health and mental health are at stake. Yes, relationships are a matter of life and death.

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WRITTEN BY

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Closing Note

Mental Health doesn't have to be an uncomfortable topic. There is so little that is understood about it, and so much more that is misunderstood.

For those of us who have experienced battles with Mental Health, we have often found the silence around us deafening. We understand the sense of isolation that can come with this quiet. We have realized the importance of speaking up, even if we fall short in our attempt to articulate.

You shouldn't have to experience your own battle to have a conversation.

Semicolon seeks to bring together a community of contributors, researchers, experts, and writers from around the world to unbox the culture, art, science, and evolution in the Mental Health space. We will try to explore creative ways to disseminate knowledge by drawing on topics ranging from psychopathology and neuroscience to social issues and therapeutic innovations with the hope that it will inspire discussion.

Let's add to the voice, not the silence.