aaina

bapu Trust for Research on Mind and Discourse

a mental health advocacy newsletter
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Editorial

August 6th has passed us by once again this year. *Jan Manasik Arogya Abhiyan*, a people's campaign for human rights in mental health working from Maharashtra, has appealed that the Erwadi Day should be commemorated as a National human rights day for persons with psycho-social disabilities. News has poured in from various parts of the country and advocacy networks are flush with news about the continuing violations on people with psychosocial disabilities. A recent visitor to Erwadi writes about his experiences in this issue of *aaina*, giving a more grounded perspective. Poems have come in, some of which are published herein, which were disseminated in Maharashtra as posters and handbills in the week starting August 6th.

The *suo moto* action taken by the Supreme Court following Erwadi has ground to a stand still. The last judgment from the Court is that they will await the UN Convention on Rights of Persons with Disabilities, before making any further pronouncements. This is welcome to advocates who believe that the CRPD will change the ground level situation in mental health from one of deprivations and exclusions, to one of positive rights. However, the Government of India is yet to ratify the CRPD. We await this move with a high degree of expectancy. There is high drama in the disability sector, and awareness programs are being held on the Convention, while pressuring for ratification.

Meanwhile, the State Mental Health Authorities were called for a meeting by the Center, to explore their work and their engagement with the Mental Health Act. As readers of *aaina* will know, the MHA is the most prominent legal barrier to developing human rights compliant services in the country. A brief report of this significant meeting is found in this *aaina* issue. The meeting is significant as it shows some level of preparedness from the center to review and change the Mental Health Act

With these two initiatives coming from the central government, one on the CRPD and the other on the MHA, much is expected to happen on the policy and legal front in India on mental health. Appropriate and reasoned out responses to the problems plaguing the mental health sector will depend upon how well the different ministries involved (health, disability, legal) work together to clear the arena of legal and policy level barriers to human rights and good quality services in the mental health sector.

A high level of civil society mobilization is required on laws and policies, else, the center will work in an ad hoc manner to change the existing norms or create new ones.

This issue provides much information on healing alternatives, too, including studious ways of dropping psychiatric medications.

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aaina a mental health advocacy newsletter

Aaina is a mental health advocacy newsletter.

Aaina is an opinion-making and opinion-leading newsletter, with a consistent message of user empowerment, good practice, policy, legal and social reform in the mental health care sector in India.

Aaina covers issues in community mental health, the role of NGOs in mental health, self-help and healing, the use of non-medical alternatives in mental health, human rights issues in mental health, institutional reform, ethical dilemmas, policy discussions, and the mental health needs of special groups (young people, women, the poor, sexual minorities, persons with a disability, etc.).

Aaina covers themes related to disability caused by psychiatric drug use, and long term institutionalization. It has a great interest in how much money pharma companies are making by pushing hazardous drugs onto poorly informed communities.

Aaina provides a forum for users to express their problems and dialogues with the mental health service system, and their demands for change. It also addresses issues of social living for persons with a psychiatric disability, stigma, discrimination and deprivation of the right to life and liberty, especially of the poor and the homeless.

If you wish to make a donation to *aaina,* please make a DD or a cheque in favour of *"Bapu Trust for Research on Mind & Discourse, Pune"* and post it to our mailing address.

Maintaining therapeutic boundaries within the mental health profession

Gitika Talwar

When I first thought of writing this article, I remember visualizing it as an article to inform mental health service users about "things to keep in mind" when using a psychotherapeutic setting for medical or non-medical mental health work. As I began working, I remember being startled by how the gaze of the article gradually shifted to mental health service providers. I found myself speaking more to them, than to users.

I realize now that perhaps this was the best place to begin, because boundary crossings start with a therapist wanting to give more and get more than what is therapeutic for the client. As service provider and also as a user of mental health services, I think it is time to engage with the issue of boundary crossings and initiate a dialogue on what we need to do within ourselves to ensure that we keep therapeutic work at the optimal level.

A **boundary** is the edge of appropriate professional behavior, which is influenced by therapeutic ideology, contract, consent, and, most of all, context.

Boundary violations differ from boundary crossings. Boundary crossings are harmless deviations from traditional clinical practice, behavior, or demeanor. Examples of crossings include helping up a client who has fallen, giving a client an emergency taxi fare during a flood, or accepting an invitation to attend a wedding. Neither harm nor exploitation is involved.

Boundary violations, in contrast, are typically harmful and are usually exploitive of clients' needs—erotic, affiliative, financial, dependency, or authority. Examples include having sex or sexualized relations with clients, exploiting clients to perform menial services for the provider, exploiting clients for money or for financial demands beyond the fee, and generally using clients to feed the provider's narcissistic, dependent, pathologic, or sexual needs.

Boundary violation creates dual roles. Intentional breaches of boundaries clearly focus on exploiting the client, violators are often not aware that any exploitive action has occurred - for example, employing a student client, rationalized as helping the client with the cost of the therapy. However, this boundary violation creates dual roles, and thus confusion, in the relationship.

Clients are governed by no professional code; therefore, maintenance of boundaries is always the responsibility of the clinician. Thus if a client requests, demands, provokes, or initiates a boundary violation—as many do—the clinician must refuse to participate in that behavior and then must explore the underlying issues, aided by consultation as indicated.

Repeated demands to breach boundaries should prompt personal and consultative review about the viability of the treatment relationship, especially if the boundary issues become the only subject the client can discuss. As always, documentation in clinical notes of the client's refusal to discuss other subjects—coupled with the therapist's seeking consultation before, during, and after taking any action that impinges on boundaries—is the best protection against even inadvertent harm to the client and against liability resulting from one's interventions.

I take up my article about boundary crossings from here, with the fervent hope that you will engage with these issues as much as I[1].

Why this happens to service providers

Therapist's own life crises, a tendency to idealize a "special" client or an inability to set limits, and denial about the possibility of boundary problems. "This couldn't happen to me"—must also play a significant role in the persistence of the problem. Boundary issues arise in all therapies and for all clinicians, apparently irrespective of the number of years of experience, and even for those practicing only psychopharmacology. The relevant question is whether the difficulties can be successfully surmounted.

Repeated boundary challenges by a particular client should lead to a review of whether the treatment relationship is a wise one.

The dilemma: Oversensitivity to boundaries can promote technical therapeutic rigidity, excessive concerns with risk management, and suffocation of flexible innovation. Nonetheless, among the vast majority of practitioners, sensitivity to boundary issues remains an essential element of good clinical work that merits attention in training and practice.

This discussion of therapist factors that tend to lead to boundary violations, is accompanied by three caveats:

1. A therapist's personal problems do not mean a release from responsibility for setting and maintaining therapeutic boundaries; the therapist always bears the professional burden in this regard.

2. Discussions of boundary problems sometimes focus on the "bad apple" model: boundary problems and sexual misconduct occur only with a few bad apples, and the simple solution is to kick those persons out of the field. This simplistic view misses a central point of our discussion:

3. Therapists must learn to recognize the following trouble spots as risk factors for developing boundary difficulties.

Therapist factors that promote boundary violations

1) Life crises

Empirically, midlife and late-life crises in therapists' development appear repeatedly as common precipitants of boundary problems with clients, although early-career practitioners are not immune from boundary difficulties. For this last group, the challenges include difficulty establishing a practice; an excessive need to please clients, with filling empty hours in the schedule; and balancing the demands of family and professional life. For therapists in general, the effects of aging, career disappointments or unfulfilled hopes, marital conflict or disaffection, and similar common stress points are often associated with a therapist's turning to a client for solace, gratification, or excitement

2) Transitions

Retirement, job loss, job change—even promotion—or job transfer may produce predictable discomfort that makes a therapist susceptible to crossing the line with clients. Indeed, the authors' consultations with other clinicians suggest that some cases of financial exploitation outnumber the sexual ones.

3) Illness of the therapist

Death anxiety and fears of mortality

[1] Developed from 'This couldn't happen to me: Boundary Problems and Sexual Misconduct in the Psychotherapy Relationship', by Donna M. Norris, M.D., Thomas G. Gutheil, M.D. and Larry H. Strasburger, M.D.

play a role in a therapist's turning to a client for comfort.

4) Loneliness and the impulse to confide

A therapist encountering some life difficulty and seeking a "sympathetic" ear may struggle with the need to confide in a client about financial reversals, marital or sexual problems, professional setbacks, problems with his or her children, and the like. This lapse may precipitate a role reversal in which the client takes care of the therapist. **Self-disclosure,** one of the most controversial boundary issues, is an issue that often leads to confusion and uncertainty among therapists, ethics committees, and boards of registration. In the name of "honesty," therapists may slip into counter transference-based interventions, such as "When you say such things, I become sexually aroused; how we can understand that?" (*Gitika's note- It is essential to ask yourself 'how does this self disclosure help this client?')* Self-disclosure may cause no problems in the therapy, but even in response to seemingly innocent queries, it may intrude on the client's psychic space or replace a client's rich and clinically useful fantasy with dry fact, stripped of meaningful affect. To use a perhaps extreme example, a client who hears that a therapist is Catholic may have greater trouble or discomfort discussing her abortion. Similarly, "Are you married?" may stand in for "Are you gay? Are you available? Have you failed in past relationships?" The point here is that the therapist's inner awareness of longing to self-disclose to or confide in a particular client may serve as an alert to potential boundary difficulty to come.

5) Idealization and the "special client"

Therapists must be alert for early harbingers of trouble in certain of their own counter transference attitudes toward clients. Typical views commonly associated with problems in maintaining boundaries include viewing the client as "special". Such feelings are an excellent stimulus to seeking consultation or supervision but not to terminating therapy with clients or abandoning them, as some clinicians seem to believe. Sexual feelings, hostile feelings, and boredom are all responses to clients that therapists must handle within the process of treatment unless these reactions become unmanageable or are unresponsive to supervision and consultation. Clues to these attitudes may lie in the therapist's tendency to treat the client as an exception to the usual rules of the therapist's practice: scheduling excessive or excessively long sessions, especially at the end of the day; giving permission to run up a high unpaid balance; making special allowances for the client; and having non emergency meetings outside the office. Therapists who find themselves in such a situation have been known to say "I don't usually do this with my clients, but in this case' when initiating the conversation about a boundary violation.

6) Pride, shame, and envy

Therapists with intact self-esteem systems are entitled to take pride in their work, but self-esteem—like all traits—can miscarry through excess and denial: "This couldn't happen to me." One would think that this problem is an especially common one for the younger, inexperienced therapist, and this is often the case. Seasoned practitioners may believe that, given their level of experience, they can take risks in this area: "I have good control and I know what I'm doing."

7) Problems with limit setting

Some clients—who cannot be blamed for the impulses—tend to press for boundary breaches for a variety of psychological reasons. The question then becomes, Can the therapist set appropriate limits on this intrusion? A common barrier to appropriate limit setting is the therapist's counter transference conflicts about aggression or sadism when the prospect of the client's expected distress, discomfort, or frustration at being told "No" is intolerable to the therapist. When caught in such conflicts, therapists often feel that they cannot refuse clients' requests to violate a boundary. These therapists report feeling pressed or intimidated by clients' unrestrained rage.

8) Small town issues

Closed communities pose another sort of boundary problem. They may be small towns; isolated institutions like schools, convents, and communes; or subcultures with a restricted social compass, such as some gay or lesbian subcultures in urban settings. In such cases, one cannot avoid the possibility of encountering clients outside the office in non professional settings. Such conditions require more circumspection and care about boundaries, not less.

9) Denial

Finally, denial about early problematic situations, which can lead to their evolving into full-fledged boundary disasters, is another common factor in clinical misadventures—particularly with more seasoned and experienced therapists. Evasion, externalization, and rationalization may be used by the therapist to help maintain the pretense that boundary problems are not serious, not harmful, or even not occurring at all. Here, consultation can be extremely useful in gaining perspective, but all too often the need for a consultation is also rationalized away.

Factors increasing client vulnerability

1) Enmeshment

Clients in psychotherapy may seek dependency rather than autonomy. With some clients, an intensely enmeshed, symbiotic relatedness may result, making it difficult for the client to break away or to report the matter.

2) Changing roles: from victim to actor

Initially a client comes to treatment seeking help and, in part through transference, imbues the therapist with healing powers and intent. The client may then seek a dependent position that does not question or challenge the therapist's decisions or actions.

3) Retraumatization

Some clients enter therapy to deal with the effects of previous, often childhood, trauma. The familiarity of the victim role may increase the likelihood of repetition, a condition described by one clinician as the sitting duck syndrome. (*Gitika's note: Clients may not even realize when they are falling into the mould of being exploited, since the territory is an extremely familiar one for them. One could imagine that past experiences could make one more sensitive to exploitation, however in some cases when past issues of exploitation have not been resolved, the personal factors that give greater benefit of doubt to perpetrators end up leading to clients giving greater than necessary benefit of doubt to therapists as well.)*

4) Shame and self-blame

Clients involved in boundary violations or sexual misconduct often struggle with self-blame, accusing themselves of failure to know better, failure to recognize abuse, having made foolish choices, and so on. Others fault themselves for causing the therapist to lose control or cross the line or for being "too seductive" or believe they bear full responsibility for the misconduct. None of these views, of course, captures the true picture.

5) True love

Though perhaps owing much of its force to the transference, intense feeling can develop in therapy, if only because of the inherent intimacy of the situation, especially if the client has few or no other relationships on which to draw. The relationship with the therapist may appear the only or the last chance for "true love" in the client's sphere. Indeed, a small percentage of clients enter treatment specifically to have an intense emotional experience in a relationship of some kind, even a paid one. In one legal case, a client tearfully told an expert witness that, although she knew that the misconduct was wrong and that she had been taken advantage of, she despaired of ever having such an exciting relationship again.

6) Dependency

Most boundary violations occur in the context of a helping relationship the client depends on. It is difficult for the therapist to discern what is help and what is overinvolvement, and it can be very difficult for the client to give up the relationship.

How to approach boundary problems

1) Opening up a discussion with the client

If there are frequent boundary challenges from a client (and none from the therapist), explore this with the client and try to arrive at the underyling issues. In some cases, it is possible that the client is not aware of the professional boundaries that are necessary in a mental health relationship despite the intimate nature of the work done. Psychoanalyst Peter Fleming, speaking on a panel on boundaries, noted that a long-term client who had entered a nursing home began to call him "honey" and "dear" rather than "Dr. Fleming" and to touch him a good deal when he got up to leave her room. He became concerned and raised his concern with her, which led to the client's sobbing that she had lost her memory and could not recall his name. Had he not dealt with this boundary change, he would not have discovered the problem.

2) Education

Psychodynamic theory, with its central discussion of the role of transference, can help trainees to enhance their understanding of the psycho-therapeutic relationship. A psychodynamically naive therapist who becomes the focus of idealization by a client or who is placed on the positive side of a good doctor-bad doctor split by a client with borderline personality disorder may feel that the client is experiencing true love—a situation that must be acted upon. Especially for younger clinicians and trainees, concerns are often expressed about the possible stifling of novel, innovative approaches to treatment of a client or treatment in general. In designing these new approaches, the clinician can avoid both the Scylla of too little attention to boundaries and the Charybdis of too rigid an approach to them by keeping in mind the critical issue of maintaining sensitivity without exploiting the client. Training techniques using films and videotapes and including presentations by victims and offending psychiatrists provide for more innovative approaches.

3) Supervision

Important aspects of the supervisory relationship are the

dynamic learning opportunities for all participants, both trainees and supervisors. In another case, a senior forensic psychiatrist was asked to consult about the dangerousness of a former client who was a possible stalker. Unraveled, the case proved to be one of a client who began to experience erotic feelings for his female therapist—feelings that she did not know how to handle. Two successive layers of senior supervisors could not deal with this issue either, and the therapist terminated the psychotherapy on their recommendation. In reality, the baffled client had taken to hanging about the clinic trying to get a straight answer about what had happened—hence, he was a "stalker." This vignette underscores the importance of having supervisory resources able to handle dynamic issues at different points in the course of treatment. Supervision provides the ideal setting for emphasizing and clarifying to the trainee how boundary issues inevitably arise in clinical work and how they may be managed successfully. Boundary questions commonly evoke countertransference issues, which may also be profitably explored in the protected supervisory context, as well as in the clinician's personal therapy. Supervisors' openness to seeking consultation presents another learning opportunity for trainees about the complexities of the work.

4) Consultation

In a grim paradox, consultation—which would often make possible the solution of a therapeutic boundary problem—is all too often slanted, for reasons deriving from the same therapeutic knot that first produced the boundary problem. As noted above, therapists should consistently maintain a low threshold for seeking consultation and should respond positively when a client requests it and welcome the occasion for both clinical and risk-management reasons. Therapists may refuse consultation because they "know" the consultant would urge them to stop treatment and get out of the relationship—an outcome they could not tolerate. Obviously, this is an inappropriate view of consultation. This individual problem is heightened by denial and resistance on the part of training institutions, especially when the boundary-violating practitioner is a senior clinician who may have trained many in the professional community

What guideposts can therapists employ to identify the need for consultation?

In addition to the therapist factors mentioned above, other signs of boundary problems may include:

1. The feeling of being solely responsible for the client's life;

2. The feeling of being unable to discuss the case with anyone because of guilt, shame, or the fear of having one's failings acknowledged.

3. The realization that one has let the client take over the management of his or her own case. Finally, noting that a client is provoking the therapist to cross boundaries would be an excellent trigger for consultation.

Gitika Talwar, clinical psychologist, who was with the Seher program, Mumbai, and assistant editor, Aaina, has moved on to do a Ph. D. in the US. She may be contacted at gitika.talwar@gmail.com

On finding a counsellor

Kunal Mithril

I think it was Erich Fromm who said something about a counsellor being a person who cheers from the sidelines, while the client helps sort him / herself out. I quite like that.

Counsellors are not popular in India, especially because there is a lot of misconception on what a counsellor is in the first place. In this country at least, you would never mention that you go to a counsellor, as people would look down upon you. So before I tell you how I think you can go about finding a good counsellor, I would first like to tell you that going to a counsellor does NOT mean that you are mad or dysfunctional or in any way more in need of help than anyone else.

There are many kinds of counsellors - there is the psychoanalyst, the behaviorist, the humanist and quite a few others. Some use confrontational techniques, others empathize, some suggest behavior modification techniques, each of which work differently with different people and different needs.

Regardless of techniques, the MOST important characteristic of a counsellor by far is his / her ability to listen to you without judging you or feeling sorry for you.

A few points that I think are vital in going to a counsellor and starting

the counselling process: It is better to go to a counsellor through a referral from a known and trusted doctor or someone from the mental health sector or at least someone who understands mental health. **DO NOT** look in the yellow pages or ask your local chemist where you can find one. Remember-it's your peace of mind we are talking about.

Although qualifications are not everything, they still hold a great deal of value, the counsellor's qualifications and working field tells at the very least how qualified a counsellor is. This does not necessarily mean that a 'qualified' counsellor is the right one for you.

When you first call a counsellor, keep the message brief-mentioning your name and telephone number and that you would like to have an appointment with him / her. Please do not go into details about your problems, if it is a crisis situation, you could mention that you would like an appointment urgently. Usually counsellors get back within a day. But if a counsellor does not call back giving you an appointment within the week, please call another counsellor. Don't just give up on the idea of counselling.

The first session is a very very important as you and the counsellor are just getting to know each other. It is very necessary for you to look at your thoughts through the session and afterwards to find out whether you were truly comfortable with the counsellor, his methods and the settings.

The setting can sometimes be uncomfortable for you, either physically or psychologically. For example, the counsellor's office is too close to your neighborhood or if the patient coming in next can see you leave or if you feel that the counselling room is not soundproof enough. All this can play on your mind when you go to the counsellor. So please take them into account as well.

Please remember, all counselling sessions are necessarily CONFIDENTIAL.

The first session is also very important, because in this session the counsellor gets to begin to know what your problems / issues are. If you find that you are not comfortable revealing yourself to the counsellor, it would mean that you do not trust the counsellor and that the session and perhaps the whole process with this particular counsellor would be a waste. In my own case, I went to a counsellor who listened to my problems and was most probably feeling as overwhelmed as I was feeling. I constantly felt that in one of the sessions she was going to hug me. Now don't get me wrong, I like a hug as much as the next person, but the hug was not going to help me face my problems any better.

You are going to be bringing your problems to the counselling room and make yourself vulnerable in front of the counsellor, so your being comfortable, both physically and mentally is very very important for the process to begin and move forward.

The very process of revealing is a process of healing, so the utmost care has to be taken.

Lastly if you find that the counsellor is talking more than you are and also interrupts you frequently; then be sure that the counselling process is not going smoothly.

Another thing that should go without saying, but unfortunately needs to be stated anyhow, is that by and large the counsellor and the client do not have or make any physical contact. Sexual contact is a BIG BIG NO. So please do not even consider going into that area. It has nothing to do with counselling (Take my word for it. Freud was right in thinking that lots of things are connected to sex...even counsellors and counselling – but this is just for your reading and it is not a rule that counsellors and clients have to abide by).

Choosing a good counsellor like choosing a good Doctor is incredibly important because choosing the wrong doctor puts your life at risk at the worst and at the very least you continue with whatever problem you have.

Counselling is not a miracle drug that the counsellor possesses. The counsellor is more a person who by listening carefully helps you, the client, sort out the jumbled-up-ness of your thinking and emotions.

For this to begin, you have to find a counsellor whom you can trust (and if you have trust issues...then don't trust yourself in not trusting the counsellor. Also do tell the counsellor that you have trust issues and of course feel free to continue to not trust him/her), so that you can be frank about your situation.

So now that you have a few pointers, I wish you the very best in finding a good counsellor and in your journey of finding yourself.

All back issues of *aaina* can be freely downloaded from our website:

www.camhindia.org

National Consultation of State Mental Health Authorities: A Report

Amita Dhanda

The Ministry of health convened a meeting of all State Mental Health Authorities (SMHA) in the country on 25th and 26th of July 2007. The meeting was called in order to obtain a first hand understanding of the functioning of this statutory authority. The organizers also hoped that this sharing of data would promote mutual learning. The Authorities were primarily required to report on the establishment of the Authority, its primary activities, major difficulties and significant achievements. The meeting was also utilized as an opportunity to deliberate on the Mental Health Act 1987 and discuss from the perspective of various stake-holders the changes if any required in the law.

The ensuing reports showed that all the States had established SMHA. However whilst some States such as Goa, Himachal Pradesh, Karnataka, Kerala, Maharashtra, Manipur, Rajasthan and Uttar Pradesh had set up these authorities as early as 1994-1995, in most States the SMHA were set up after 2000. Even though the reports did not say so, it does seem that the special scrutiny by the Supreme Court of India on the functioning of the Mental Health Act after the Erwadi tragedy operated as a major catalytic factor in the establishment of the authorities. In fact, the intervention of the Supreme Court brought alive a number of Authorities, which prior to the interrogation by the court only existed for the records. The reports also showed that whilst some SMHAs namely the one in Andhra Pradesh, Delhi, Gujarat, Karnataka, Kerala, Maharashtra, Rajasthan, and Tamilnadu actively deliberated on the Mental Health Policy in their State; a majority of the State Authorities seemed to be doing no more than hold the mandatory statutory meeting. A number of States namely Delhi, Haryana, Kerala and UP reported that they have established links with the State Legal Services Authority in order to offset the baneful effects of institutionalization. And several authorities such as Andhra Pradesh, Maharashtra and Rajasthan were carrying on Information, Communication and Education (ICE) activities in order to address the problem of stigma.

The scope and extent of the licensing responsibility emerged as one issue of confusion and controversy. Whilst some States had not even established licensing authorities, others used the power only for exclusive in-patient psychiatric facilities while still others required a license to be obtained for all mental health services be they in-patient or out-patient and set up for care and treatment or rehabilitation. On a joint reading of the Mental Health Act, 1987 (MHA) and the Persons with Disabilities Act 1995 (PWDA) I put forth the following interpretation on licensing requirements in my presentation on the Mental Health Act.

Section 6 of the MHA prohibits any person to establish or maintain a psychiatric hospital or nursing home without obtaining a license. Section 2(q) of MHA defines a psychiatric hospital or nursing home to mean a hospital or nursing home established for the treatment and care of mentally ill persons and includes a convalescent home. However general hospitals and nursing homes established or maintained by the government which also provide psychiatric services have not been included. In accordance with this definition the license would need to be obtained for those hospitals and nursing homes which offer in-patient psychiatric services. Thus a medical service which only offers outpatient treatment and care would not be included in this definition because a medical facility without domiciliary services cannot qualify as a hospital or nursing home. A convalescent home is a place where persons go to recover health and strength gradually after sickness or weakness. This process cannot be confused with rehabilitation which can be understood as the process by which a person is helped to achieve the highest level of function, independence, and quality of life possible. Convalescence support may have to be provided before rehabilitation can be started but that linkage does not make convalescence equivalent to rehabilitation. The wide import of rehabilitation has been appreciated by the PWDA which defines rehabilitation as a "process aimed at enabling persons with disabilities to reach and maintain their optimal physical, sensory, intellectual, psychiatric or social functional levels".

This strict interpretation of the licensing provisions would be in

accord with the objective of introducing licensing in the MHA. The objective was to prevent the institutionalization and exploitation of persons with mental illness in substandard facilities; it was not to discourage the establishment of mental health services. Licensing could produce such an impact as it is a particularly rigorous form of regulation. The exclusion of these services from the licensing provision would not mean that they were being totally removed from the supervisory gaze. Both the SMHA and the CMHA have supervisory oversight over mental health services and these services have been broadly defined to include "in addition to psychiatric hospitals and nursing homes, observation wards, day care centres, in patient treatment in general hospitals, ambulatory treatment facilities and other facilities, convalescent homes and half way homes for mentally ill persons".

This restricted interpretation of the licensing provisions in MHA is also required if this legislation is to be read in harmony with the PWDA. Section 51 of the PWDA requires any person who wishes to establish or maintain an institution for persons with disabilities to do so in accordance with a certificate of registration from the competent authority. The authority to designate the competent authority has been conferred on the State Government. Section 2 (m) has defined institution for persons with disabilities to mean "an institution for the reception, care, protection, education, training, rehabilitation or any other service of persons with disabilities**".** Mental illness stands included in the definition of disability, thus on a harmonious interpretation of the two statutes it can be said that the non residential services for persons with mental illness may require registration under PWDA if an authority competent to provide such registration has been designated by the State government, however such services do not need to obtain a license under the MHA. In interpreting the licensing provisions both administrative and judicial authorities would need to balance between the need to prevent exploitation and abuse with the need to promote creation of innovative and quality services in the mental health sector. If total absence of regulation could result in the creation of sub-standard services, then much too rigorous a regulatory regime could thwart all initiative to provide services in the sector.

Guardianship; the amendments required in the MHA and its rules; the restructuring of the SMHA were the other issues which evoked concern and discussion in the two day meeting. On guardianship, the representatives of the parents group vociferously demanded a simple administrative procedure in line with the kind provided in the National Trust Act. Efforts to educate the parents on the deprivation caused by guardianship met with limited success. However the demand and its inconclusive discussion did bring home the need to deliberate on this question at multiple forums. Such discussion is more specially required in the face of the Convention on the Rights of Persons with Disabilities (CRPD) which recognizes the full legal capacity of all persons with disabilities, allows the seeking of support and clarifies that the obtaining of support in no way negates legal capacity. In the face of this endorsement of supported decision-making procedures of substituted decision-making such as guardianship need to be reexamined.

On the restructuring of SMHA it was suggested that the representation base of the Authority should be widened. It was proposed that the effectiveness of the SMHA would be enhanced if membership was accorded to user-survivors; family carers; members of civil society and the legal community. On the amendment front whilst suggestions for change were made in the main the consensus was to plug the deficits of the Act by imaginative interpretation and to address implementation difficulties by amending the Rules. However the procedure for making and amending rules itself required a reexamination. As it stands any amendment to the Rules by the State Government requires the approval of the Central Government. A number of states for example Goa, Tamilnadu and Kerala have amended their Rules but have still not obtained the approval of the Union Government.

The meeting has inaugurated a useful dialogue between the SMHAs on their role under the MHA and inaugurated an initiative for informed legal reform. It is hoped that this meeting is not a flash in the pan and more wide ranging discussions on the Mental Health Act and its implementation are regularly organized by the Health Ministry.

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Ervadi: Six Years Later

Kevin M. Cremin[1]

Ervadi.[2] Since the sixth day of August 2001, the word has come to encompass a wide range of meanings. Chains. Neglect. Fire. Death. Turning Point. After visiting Ervadi, however, there are some additional words that Ervadi now brings to my mind. Community. Faith. Hope. Relief. Squandered Opportunities.

When I arrived in Ervadi, I was not sure what to expect. Although I had read many articles about Ervadi, none of them provided much more than basic information about the durgah, who visits it, the rituals performed, and how it is administered. Some of these questions were answered by the people I met at the durgah during the course of that March day.

The street leading to the durgah is lined by a number of hotels or guesthouses. Near the entrance to the durgah is a small building with a sign saying that it is the "Dargha Haqdhaar Management Committee, Ervadi Dargha, Out Police Station." Below the sign are the words "May I Help You," but the building was locked and remained locked for the entire day.

Near the entrance to the durgah is a large sign titled "Ervadi Durgah" that says: "It is the holy Place Where the body of 'Kuthbu Sultan Syed Ibrahim Hameed Oliyullah', 18th generation son of Lord Mohammed is laid. It is believed that Pyschiatric [sic] disorders are cured after a Sincere Prayer in the

Place. Pilgrims belong to all relegions [sic] visit the Durgah and Receive Blessings of 'Lord Allah'. Every Year Urus held in December – January." The durgah does not have doors; it is completely open to the public. Near the entrance is another sign, which sets forth the Dargha Haqdhaar Management Committee's rules.

The grounds of the durgah are covered with sand. On that day, there were approximately 100 people sitting on the sand, mostly in groups clustered around the trees or other shady areas. There were another 50 people sitting within the shade of the structure that houses the tomb of Kuthbu Sultan Syed Ibrahim Hameed Oliyullah. According to one of my

companions, in the women's prayer building there were approximately 35 women. Fifty men were praying in the mosque, which is located at the back of the grounds. In all, there were approximately 235 people at the durgah. Approximately 50% of them appeared to be in family groups.

On the grounds of the durgah, I observed two men tied loosely by rope to a fence that surrounded a stone memorial-type structure near where I was standing. One of the men was tied around his ankle. There were a number of people around him who appeared to be his relatives. The other man was on the opposite side of the structure, and he was tied with both hands behind his back. He was alone. I also noticed a person who was lying on the ground with his ankles chained together with a lock.

As I stood on the scalding hot sand of the durgah, I was approached by a number of different people. One of them was a young man in an orange striped shirt. In fluent English, he explained that he was a student from Kerala and that he was visiting the durgah with his parents. The purpose of their visit was to give thanks for his health. The student had spent two and a half months at the durgah during the prior year, and he had been cured of his illness. Later, he explained that he was ill because he was possessed by demons.

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[1] Kevin M. Cremin was an American India Foundation Services Corps Fellow at the Centre for Advocacy in Mental Health from September 2006 to June 2007. This essay is based on a March 2007 visit he made to Ervadi with Jordan Fletcher, who was a Service Corps Fellow at People's Watch Tamil Nadu, and Michele Host. Kevin can be reached by email at kevin_cremin@hotmail.com.

[2] This essay assumes the reader is aware that on August 6, 2001, a fire killed 28 people who were chained to pillars in makeshift mental asylum in Ervadi, Tamil Nadu.

Before visiting the durgah, the student's family had spent a lot of money on doctors and medicines. Unfortunately, the doctors and medicines did not help him. An elderly man who stays inside the mosque on the durgah grounds helped the student overcome his illness. This older man had come to the durgah thirty years ago as an orphan, and, because he is blessed by the spirit of Kuthbu Sultan Syed Ibrahim Hameed Oliyullah, he is able to help other people regain their health.

The student explained one of the ways a person may request assistance at the durgah. On a piece of paper, a person may write down his or her request. Then, after folding up the piece of paper, the person can put the request in a box near the inner sanctum with a small offering. He said that those who ask for assistance with a pure heart will receive it. Based on his experience, he is confident in the power of Kuthbu Sultan Syed Ibrahim Hameed Oliyullah's spirit.

At the nearby Ameer Abbas Minister durgah, there were approximately 50 people on the grounds of the shrine, and it seemed that additional people were resting in the small buildings that line the grounds. I had mentioned to the student from Kerala that one of my relatives has experienced mental health problems. The student explained this to the shrine-keeper, and the shrine-keeper invited one of my companions and I inside the shrine. He explained the ritual that he would perform and asked us for a 500R contribution. We explained that we did not have that much money, but that we could contribute a lesser amount. I was directed to put that amount in a box at the back of the shrine, and the shrine-keeper pushed it in with a knife. Then the ritual commenced.

The shrine-keeper took a folded cloth and raised it to our heads while reciting a prayer. Then the shrine-keeper directed us to go inside the gate that surrounded the tomb and unfold the cloth and place it on top of the tomb. He then directed us to lower our heads and kiss the cloth. We then were directed to circumambulate the inner sanctum before exiting. At this point, the shrine-keeper prepared a packet of materials for me to give to my relative. The packet included sandalwood powder, oil, and a piece of cloth. The shrine-keeper explained that I should give the packet to my relative and that my relative should apply the powder and oil for 45 days.

Next, the student took us to a small shrine that commemorates where Kuthbu Sultan Syed Ibrahim Hameed Oliyullah's ship arrived at Ervadi. On the day of my visit, dozens of small fishing boats were patrolling the nearby waters. The shrine is centered on a pole with the flag that Kuthbu Sultan Syed Ibrahim Hameed Oliyullah raised upon his arrival. There were one or two shrine-keepers and a few adults and children in this area. The student explained that the tradition is for people to tie a cloth to the pole if they are having problems conceiving a child.

After leaving this shrine, I asked the student to show us where the August 6, 2001 fire occurred. He said that there was nothing to see there anymore, because the area had been cleared and there are not any more makeshift shelters or asylums. This information was echoed by a number of other people throughout the day.

In addition to visitors, we also met with two individuals who are responsible for administering the durgah: Syed Rahamatullah, who is the Secretary of the Ervadi Dargha Management Committee; and MS. Ibragim, who is the Executive Officer of the Ervadi Dargha. Syed Rahamatullah explained that he wanted to start a not-for-profit and open a new mental health facility in Ervadi. He showed us a number of related documents, including "an approach paper on the proposed intervention to the visitors of Ervadi Dharga with problems of abnormal psychology" that was written in December 2001.

MS. Ibragim explained that most people come to the durgah for problems with black magic and nervous complaints and that no one is ever turned away. A logbook is maintained to register people as they arrive at the durgah. He explained that it lists the name, address, illness duration and diagnosis for those who visit the durgah. He also said that each person gets an identification card. There are over 1,000 people who visit the durgah. Both administrators stated that there were no longer any makeshift shelters or asylums in the town. They explained that rich people stay in nearby guesthouses and that poor people tend to stay on the grounds of the durgah. Some people have stayed at the durgah for up to 15 years.

Regarding the tragic August 6, 2001 fire, Syed Rahamatullah said that, two weeks before it occurred, they were told that there would be a fire. He said that they notified

the District Collector, but no action was taken. He said that he has documents to prove this. His words shocked me because, in the dozens of accounts of the fire, I had never seen any mention of this disturbing information.

MS. Ibragim has studied the practices of twelve hospitals in the region. He was impressed by one hospital he visited in Kerala that treats mental illness with a combination of medicine and faith. His hope is to join together three processes here at the durgah: nervous treatment, psychiatric treatment, and counseling. However, he explained that a lack of funding is preventing his vision from coming to fruition.

MS. Ibragim said that no families stay here, but that they bring the sick family member and then leave. Syed Rahamatullah disagreed and said that there are more than 100 families at the durgah. He acknowledged that some leave and, when they do, then the Management Committee helps take care of the person. For example, food is provided by the community.

During the interview, MS. Ibragim gestured out the window and said that there was a man tied to a tree. He said that he knows that it is the government's policy not to chain people, but that sometimes they have to use a chain or rope to reduce violence. He said that the durgah does not want to tie people up, but sometimes they feel as though they have no other choice. MS. Ibragim would like to start a treatment facility, but there are no resources. He said that a lot of money was given to not-for-profit organizations after the fire, but that he has not seen activities or results or resources in Ervadi.

Throughout the day, the administrators and a number of the visitors to the durgah mentioned the name of another American who had spent time at Ervadi: Craig Bagdasar. Mr. Bagdasar is an anthropologist who is interested in indigenous mental health treatment in South Asia. Mr. Bagdasar has studied: "the beliefs of patients and their families regarding the onset of disturbing behavioral and psychiatric symptoms and what they believed about healing, the process that they embarked on to regain normalcy, and how life progressed after their time at Ervadi." Part of his fieldwork included three censuses of individuals who were staying with family members in rooms or mental hostels around the Ervadi Durgah area. These were completed in 1993, 1996, and 2000. He has not yet published his findings.

Prior to the fire at Ervadi, Mr. Bagdasar and several other people had planned to build a small mental health facility near the durgah that would "utiliz[e] the successful indigenous methods of treatment as well as Western psychiatric modalities for the treatment of those with psychotic disturbances." The facility would have housed approximately 40 patients. After the fire, however, people were more interested in starting a much larger facility for approximately 1,500 patients. Mr. Bagdasar was not interested in being part of such a large mental institution.

After speaking to the administrators, we went back outside. At night, the durgah was transformed. There were approximately 1,000 people there, mostly in family groups. The most notable difference was that there was a large stream of people circling the main shrine building in a clockwise fashion. Many children were also playing on the grounds of the durgah. Before leaving, I met the parents of the student from Kerala. They were sitting peacefully on a blanket with their beloved son.

In the discussions about how to regulate traditional healing centres, the government and courts do not appear to be considering the experiences of the people I met at the Ervadi Durgah. Whether good, bad, or indifferent, the experiences of users of traditional healing centres should be taken into account. Academic studies, like the one completed by Craig Bagdasar, are another rich potential resource. Similarly, the experiences, ideas, and points of view of administrators and faith healers themselves should be considered.

By spending one day at Ervadi, and meeting users, family members, healers, and administrators, it became clearer to me how little I know about the complex subject of traditional healing. A similar lesson in humility seems to be in order for those who are considering how to regulate traditional healing centres. As a report issued by faculty members at Harvard Medical School has recommended: "Planning for the application of current psychiatric knowledge in local communities in societies in Asia, Africa, and Latin America should first strive to 'do no harm' – that is, to enhance existing local strengths rather than to eliminate what might be viewed as irrational or traditional from the perspective of contemporary biomedicine."[3]

[3] Robert Desjarlais et al. (Department of Social Medicine, Harvard Medical School), World Mental Health: Problems and Priorities in Low-Income Countries (Oxford University Press, Inc. 1995)

Media News from a Mental Health Resource Center

Stress Management

Newspapers nowadays have become an important part of our daily routine. At the Center for Advocacy in Mental Health, Pune, we have been regularly documenting daily newspaper cuttings related to mental health for the last 7 years. The significance of newspaper articles is that they are smaller in text and still give an understanding, or birds' eye-view of the subject on which heavy books are written. Also, the language used is very simple, and understandable to the community. Articles written by scholars in their respective fields having plenty of useful experience can guide us to our own positive mental health. Experiences of people and some positive stories of resilience and struggle, teach us problem solving techniques; infuse courage, and hope inside us, and show us how one can overcome all adversities in life. Let us utilize this rich source of knowledge for our own positive mental health. This article is about understanding stress and how to manage it. To present the subject in an effective way, we have compiled abstracts from select news listed at the end.

In the midst of a tight daily schedule, list of responsibilities, list of uncompleted tasks, other goals to be achieved in life, meeting the demands and expectations from others and self, we keep on working or rather forced to work continuously and in the course, we overlook the harmful and undue stress we are bearing. At some stage when this stress exceeds limits, we are forced to attend to it, as it shows up as symptoms of harm, damage, and disorder. In this article, let's understand the signs and symptoms of undue stress. If we feel some of them are present in us, then let us learn and implement any of the suitable stress relieving techniques mentioned herein or any thing else you know about.

A very important thought I would like to share with you before starting the article. The media can give us only information. After all it is up to us to utilize the information to increase our awareness, understanding, inculcate it, implement it and be healthy. So it will be very nice, if after reading the article one is able to de-stress oneself by practicing any one of the stress relieving techniques.

About stress

Stress is the change in condition of the emotional world and the body, when it faces an unmanageable circumstance. The circumstance might not be objectively unmanageable, but the mind feels it to be unmanageable and gets stressed.

Stress is the inability to cope with a real or imaginary threat to one's mental, physical, emotional and spiritual well-being, which results in a series of physiological responses and adaptations.

Stress can be of less duration and severity, like being late for a dinner. Some kinds of stress are repetitive periodically, like examination. These kinds of stresses remain for some time and vanish. They are known stresses. Some kinds of stress are long-term, like marital, relationship related stress, official stress, diabetes related etc. These are somewhat difficult to handle.

The ability to deal with stress varies from person to person. Stress also affects the same person differently on different occasions.

Positives about stress

In small doses, stress can actually be beneficial to us. Stressors can help to give us increased energy and alertness, even helping to keep us focused on the problem at hand. This type of stress is good.

If handled well, stress can increase motivation and stimulate.

Stress can work for you or against you, just like a car tyre. When the pressure in the tyre is right, you can drive smoothly along the road: If it is too low, you feel all the bumps and the controls feel sluggish. If it is too high, you bounce over potholes, and easily swing out of control.

Everyone has an ideal level of stress, but it differs from person to person. Basically, if there is not enough stress, then performance may suffer, due to lack of motivation or boredom.

Pressure is inevitable. Pressure can be the stimuli we need to enjoy our lives and learn new skills, experience excitement and get things done. It can also cause depression and anxiety, and make us fail to complete tasks, miss deadlines, break relationships and become seriously ill. In other words, pressure can either help to raise performance or it can cause stress. The way we react to pressure, combined with our adaptability, governs the outcome of the stress process. So we must learn to manage pressure.

We must learn to monitor our own stress levels, firstly to identify our

own optimum level of stress and secondly to learn when to intervene to increase or decrease the level of stress. This way stress works for each of us.

Signs and symptoms of stress

Fatigue and irritation are the early symptoms of stress. Poor work performance is the next level of stress symptom. If not controlled at this stage, it can lead to symptoms of various disorders.

You know that you are suffering from stress if you experience. . .

- Difficulty in communicating thoughts
- Difficulty in sleeping
- Difficulty in maintaining balance
- Easily frustrated
- Increased use of drugs / alcohol
- Limited attention span
- Headaches / stomach problems
- Tunnel vision / muffled hearing
- Colds or flu-like symptoms
- Disorientation or confusion
- Difficulty in concentrating
- Reluctance to leave home
- Depression, sadness
- Feelings of hopelessness
- Mood-swings
- Crying easily
- Overwhelming guilt and self-doubt

Fear of crowds, strangers, or being alone

Ill effects of stress

We have seen the psychological ill effects of stress in signs and symptoms. Read on to find out the price our bodies pay for stress.

Stress begins in the brain, with a surge of hormones causing intense alertness. We can't relax or sleep. The hormone surge and exhaustion cause tension, headaches, irritability, inability to concentrate and memory loss.

Stress curbs the production of the hormones that energize us and make us feel joyful.

Stress causes indigestion, diarrhea, constipation, incontinence and colon spasms. Stress increases acid production, aggravating ulcers. It is also linked to colitis and irritable bowel syndrome, painful and sometimes debilitating digestive disorders.

One of the first things we do when we feel stressed is hyperventilate. Those quick breaths can cause dizziness and sharp pains in the diaphragm. Severe stress can aggravate asthma and other dangerous respiratory conditions.

The surging hormones induced by stress improve our hearing to help us react to danger. Studies have shown that this better hearing can be more dangerous to the body as even moderate noise elevates heart-damaging stress hormones.

Stress triggers eye ticks because eye muscles become fatigued. Eyes may bulge if stress over-stimulates the thyroid gland.

Dry mouth, bad breath and difficulty in swallowing occur when stress makes us take short, shallow breaths. Under constant stress, some people clench their jaws or grind their teeth.

A body under stress burns nutrients, like the vitamin selenium, and that can lead to dull hair and premature graying. Chronic stress can trigger the autoimmune system to attack hair follicles, causing hair to fall out completely or in clumps.

A heart under stress pumps fast and hard. Blood pressure rises, can lead to heart palpitations and chest pain.

Extreme and constant stress lowers our white blood cell count, making us more susceptible to disease and hampering our body's ability to heal itself. One recent study showed that the pneumonia vaccine was less effective in people under constant stress.

Stress causes hormones to be released that make acne, rashes and itchy patches worse. Some people blush, while others go pale when the small blood cells in the skin contract. Under extreme stress people can become covered in hives.

Chronic stress can aggravate rheumatoid arthritis, cause sore muscles and make us prone to sprains. Women who suffered chronic stress had lower bone density.

Stress can halt menstruation, inhibit ovulation and cause premature birth and loss of libido. Doctors speculate stress-related infertility is the body's way of keeping us from becoming pregnant and giving birth under dangerous conditions. Stress hormones released by a pregnant woman can make her baby more prone to stress and the accompanying risk of heart attack.

A recent study by the Harvard University School of Public Health, in Boston, found that a stressful job can be as harmful to a woman's heart as smoking.

Another, by Swedish researchers, concluded that the women with marital stress are significantly more likely to suffer heart disease.

Unchecked stress can also trigger depression, which strikes twice as many women as men.

If we suppress the stress or emotions behind that for long time, it can lead to extreme reactions like extreme depression, violent anger, thoughts of suicide, addiction.

Stressors

A stressor is that which causes stress. (Stressors can be divided into two categories, external and internal. External stressors are things happening around us and internal stressors are characteristics and habits of our body and mind.) Here are some of the common stressors, some of which we hardly notice or identify as stressors.

1. Traffic
2. Taxes
3. A looming deadline at work
4. Crying babies
5. Failed relationships
6. Social and financial problems
7. Medical illness
8. Lack of social support
9. Family history
10. Rising job insecurity
11. Lack of job satisfaction
12. Overwork
13. Compromise on one's social and personal life
14. Bad time management
15. Trauma
16. Managing both office and home
17. Fears about the future. (How? What? When? Where?)

Some common stressors for college students include the transition to college, academic concerns (difficulty with material, lack of motivation), time pressures, financial concerns, family difficulties (conflict with parents), social (loneliness), or developmental tasks of early adulthood.

External stressors are the demand or pressures from job or college, demands of family or friends, physical or environmental factors (noise etc.), looking for a job, moving, looking for accommodation, holidays, and so forth.

Internal sources of stress result from our reactions to these demands. For example, if you feel there are many demands, and not enough resources to handle them, you may feel stressed. Our own wants, feelings and attitudes can also create stress.

We spend a lot of time relating to other people, which can at times be satisfying or stressful.

Most important to note is that stress is not only due to the circumstances but mainly due to thoughts and attitude related to those circumstances.

Telling someone that their problem is no big deal, even with the intention of encouraging them, might deepen and intensify their experience of stress.

Those who felt they were being unfairly treated by their employers, family or society are twice as likely to suffer serious heart diseases as those who perceived the world as fair.

Researchers say that even thinking stressfully raises blood pressure.

And a Swedish study concluded that stressful romantic relationships were more damaging to a woman's heart than work related stress.

Martin Seligman, renowned for his research into the psychology of hope, expresses concern about what he calls "big 'I' and small 'we'" - a distended self-centeredness and an increasingly attenuated sense of connection with others. This tendency must be confronted if we are to prevent our lives from growing even more stressful.

From one perspective, core sources of stress can be traced to our contemporary ideas about the nature of the self.

Stressors differ from person to person as characteristics, traits, mindset and surroundings changes from person to person. Everybody can find his own stressors by his / her own rational thinking or taking help from a mental health professional. If you study the root cause of stress, most of the times you will find it in our own mind only, in the form of wrong belief, defective attitude, negative thinking / imagination, and related negative emotion.

How to cope with stress?

First of all it is needed to go to the root cause of the stress and stressors. If diagnosis is done correctly then we can take more precise corrective actions. Knowing the root cause of stress is the first step in de-stressing. It can be achieved if we think quietly without an impact of our emotions.

The good thing is that as soon as we feel calmer, our bodies begin to repair the problems caused by short-term stress. Just thinking about something relaxing releases hormones that make us feel better. And a few simple things – a shared laugh, a couple of deep breaths – can counter the effects of stress.

Talk with someone about your feelings – anger, sorrow, and other emotions even though it may be difficult. It is important for us all to have someone we can share and talk with on an intimate level. Talking can help in getting to know the different solutions to stress.

Relationships can provide great support to help us deal with the stress in our lives. Try to work on building good relationships with people.

(Relaxation is a great stress buster. For that we can use techniques like Shavasana.)

Make sure that you get enough sleep. There are many good effects of a sound sleep, mentioned in various news.

Set aside fifteen or twenty minutes a day for meditation or prayer. It is a well-established fact that people who do this have significantly lower cortisol (a major stress hormone) levels.

Consider learning some simple Yoga exercises. Yoga is an outstanding stress buster.

Breathe! It is more calming, relaxing and healthy to breathe fully into our abdomen using the diaphragm.

When working, writing, studying, typing on the computer, or any other focused activity, take a break for at least 1 minute per 1 hour of activity. Allow the body a change of pace and recovery time.

Exercising our brain produces and activates the hormonal substance endorphine which has a sedating, calming, euphoric effect on body and mind creating a mental state of a natural high and feeling "up with life".

A balanced diet allows the body to be consistently fulled and nourished. Get plenty of green vegetables, and whole grains. These foods act as 'stress buffers' cleansing, toning, and balancing the body.

Have a time for leisure, rest and rejuvenation. A balanced lifestyle includes activities to enhance, harmonise, relax, and integrate mentally, emotionally, spiritually, and physically.

Have a creative outlet: A hobby, some activity that does not have to generate income like painting, drawing, sewing, fishing, crafts, reading, writing journal keeping, writing poetry, or perhaps meeting with friends for a philosophical conversation.

Laughter is still the best medicine. There are clinics and cancer therapies that include it in their treatment. Laugh at yourself, laugh with others.

Writing the thoughts freely into the diary also reduces stress.

Time table planning and assigning proper time for required work reduces stress.

There are always some small small things happening around us filled with happiness, which we overlook in our fast paced life. If we consciously find happiness in those things it will ease the stress.

One nice prayer is there which helps us cope with stress. "God, give me the tranquility to accept the circumstance which I can not change. Give me the courage to change the circumstance, which I can. And, give me the understanding to know the difference between these two." In Mukatangan De-addiction Center, they pray this daily.

External stressors are not directly under our control but we can certainly control our internal stressors and thereby reduce the intensity, ill effects of stress and prevent future stress in advance.

Actually, there are so many nice articles on stress management, but it is not possible to present them all here. It is better to read them in original. You will find each point explained properly and more influencing.

Newspapers

TH = The Hindu

TOI = Times of India

IE = Indian Express

Lok = Loksatta (Marathi)

Sakal = Sakal (Marathi)

News referred

*TH - 2.3.03 - Mapping your stress points

*TOI–18.5.07–Getting worked up at office can raise heart attack risk

*TOI – 26.01.07 – Release the Universal Human Capacity for Empathy

*0IE – 20.11.06 – Health Wise

*TOI – 4.11.06 – Transform Your Life With Stress Management

*TOI – 11.7.04 – Stress Can Cause Acne

*TOI – 5.12.04 – How to Ease Stress

*TOI – 5.10.05 – What's stress?

*TOI – 11.6.04 – Job pressures lay youngsters low

*TOI – 21.10.03 – Students in distress

*Lok – 16.9.03 – Tan Olakhava Kasa?

*Lok Chatura – May07 – Tan-Tanavanshi Samana

*Lok – 14.9.03 – Tanachi Vyakhya

I think it is better to forget the ill effects of stress in details because mind can visualize them in a more stressful manner. It is better to only know that the stress is 'harmful'. If we focus on de-stressing or positive habits instead of stress level and its bad effects, we will lead ourselves to the healthy life more easily. If you observe you will find that our mind is like a magnifying glass, enlarging all that which it focuses on; meditates on; thinks of. So why to focus on negative only all the time?

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Taper Safely, Inc.
There is a Path To Freedom from SSRIs...

Lynn Michaels

TAPER

After 8 years of searching for a safe way to taper off SSRIs [Selective Serotonin Reuptake Inhibitors, including antide-pressants such as Paxil, Prozac, etc.] repeatedly ending up in terrifying and seemingly unending withdrawal and finding no credible help, Lynn had to surrender to making this her full-time job. She could no longer continue in an active life or work full-time - these drugs were draining the life force out of her and she was completely miserable. Additionally, she continued to suffer many undesirable side-effects from them.

Because there are no detox facilities in the US or UK [or anywhere?] that would take Lynn off an SSRI, Lynn needed help and had no idea where to turn. She was 'up against a wall', and could not afford to lose any more time. This plight was already taking too much of her life and now, she felt that she'd have no future unless she freed herself – and that time had to be 'now'.

At 47 and divorced [yes, the constant withdrawal is quite trying on a relationship especially when the pharmaceutical companies continue to spend countless amounts of money to hide how dangerous these drugs are], Lynn turned to her mother for help.

Lynn quit her full-time job as an Interior Designer at one of the top architectural firms in the US, released her New York City apartment, put her belongings in storage and went to stay with her mother. She was determined to get off the 75mgs of Zoloft and 20mgs of Lexapro, no matter what it took. The surprise was that it didn't take that long!

Lynn Michaels

PROTOCOL

Taper Safely is a multi-step holistic approach to tapering off an antidepressant under the guidance of a team of professional practitioners.

Ultimately, we are all our own inner physicians and no one person/practitioner has every answer. This is why it is CRITICAL to have a team, consisting of:

1. an Alternative MD
2. a Naturopath
3. a Nutritionist
4. a Therapist or Counselor
5. and a Partner or Companion

It is also essential to be on a core regimen of nutritional supplementation and absolutely critical that *diagnostic medical testing - blood and neurotransmitters* - be performed to identify any underlying medical conditions and to treat them. There is a reason that one started on an antidepressant in the first place, and it is very important to go back to the beginning and find out why.

Most importantly, under no circumstances should you abruptly stop taking an SSRI for this can be extremely dangerous. The time when dosing is adjusted - up or down - is the time when most SSRI-induced suicides and homicides occur. Careful steps must be taken to assure your safe arrival off an Antidepressant.

LYNN'S "FAST TAPER"

Core Nutritional Supplementation

Lynn began by finding research directing her to research indicating the importance of consuming an organic, pharmaceutical grade Omega-3 Fish Oil. For those tapering off an SSRI, the suggested dose appears to be 3000mg 2x/day in the morning and early afternoon for a total of 6000mg/day.

There is much research on the efficacy of fish oils as a treatment for depression and mood disorders, especially as compared to SSRIs!

The second supplement was a glutathione building product called, "Immunocal", manufactured by Immunotec, a Canadian Company. Immunocal is very well established product and is listed in the Physician's Desk Reference – a US handbook for physicians. There is much research on the importance of building glutathione, known as "GSH". "GSH" is essential for healing the body as a whole and cannot be taken in capsule form but rather it must be derived from a whole food or whey protein. The

body must do the assimilating and manufacturing of the GSH. This is why one needs the Immunocal.

Immunocal may be bought through any number of distributors and supplemented with a whole-food multi-vitamin rich in B-Vitamins. **Taper Safely** has arranged to be able to offer this product at wholesale or 40% discount for a 1 month's supply, to those seeking to integrate it into their protocol. For additional information, please email: info@tapersafely.com or go to: http://immunotec.com/tapersafely .

Alternative Medical Doctor

The next step was for Lynn to replace her drug-dealing psychiatrist with a Medical Doctor specializing in Alternative Medicine. Quite ironically, Lynn found a wonderful doctor who was located about 2 minutes from where she was staying with her mother. Lynn's MD prescribed amino acid therapy, homeopathic remedies, performed neurotransmitter tests and instructed her to drop from 75mg to 50mg of Zoloft Lynn returned to her doctor in 3 weeks to review the neurotransmitter test results and added natural support for her adrenal glands. At a following appointment the doctor added natural support for Lynn's pituitary and hypothalamus glands.

Naturopath

Also during this period, Lynn had a number of visits with a Doctor of Naturopathic Medicine. The Naturopath prescribed a different type of homeopathy, prescribing pellets that were incredibly effective for her. It was a vital part of her successful taper. The Naturopath also worked with Lynn on sleep issues, adding an herb and amino acid to her regimen.

Nutritional Counseling

One of the most wonderful additions to Lynn's experience with tapering was her move to a raw food diet listed on her **Taper Safely** site at: http://tapersafely.org/cleansing_diet. From Lynn's experience, she found that it was necessary to eliminate wheat, dairy, sugar and caffeine [except for green tea] and to eat only foods listed on the "Cleansing Diet" given to her.

Therapy, Counseling or Group Work

It is very important to have emotional support during one's taper off an SSRI. A qualified practitioner can be an invaluable resource of encouragement and understanding, especially on a topic such as this, which is so hidden from the public eye. Lynn sought all types of help from professionals that could support her, including taking a 6-week course entitled "Healing Brain Chemistry without Medications". Lynn also had multiple private sessions with the instructor of this class who, herself, had been in and out of mental hospitals for 35 years, had been labeled and suffered from symptoms of autism, went through numerous episodes of shock therapy, died 9 times AND, at 55 years old, is completely healed and in vibrant health with a demanding work schedule. Very inspiring to say the least!

Alternative Modalities & Exercise

It is also very important to spend time in the quiet of nature – be it walking, sitting still, stretching or doing yoga poses. Massage is wonderful! Tai-chi is wonderful! Chiropractic is wonderful! Have a colonic! Anything you find healing and/or relaxing is wonderful. Always add JOY to the mix! Do whatever you need to, to laugh! Lynn resumed playing tennis during her taper, a sport she was unable to participate in for so long due to disequilibrium caused by the drugs. Additionally, she went for regular massages and signed up to go through a Yoga Teacher Training Program in New York City beginning in October of 2007 and completing in May of 2008. She looks forward to guiding others with Yoga while they **Taper Safely** off SSRIs.

Recovery

Be kind to yourself and know that you have just come off a very lethal drug and that your body and mind need time to heal. SSRIs are fat-soluble drugs and take weeks or months to eliminate from the body.

There is little research or documentation on this subject of any kind so please be forewarned that it is critical that you continue to work closely with your health care practitioners after you stop taking an SSRI. Lynn's MD added supplements during the weeks after she stopped her last dose of Lexapro as her body began to adjust to its new "life" without antidepressants. More has been written on this subject of prolonged or "Protracted Withdrawal" which can be found on the web at: http://tapersafely.org/protracted_withdrawal .

If you follow the **Taper Safely** protocol, it is not necessary to experience debilitating withdrawal during your taper or afterward. However, it is very important not to "cut corners". Do not stop taking your supplements or seeing your practitioners no matter how well you are feeling!

Purification [or Detoxification]

After a number of months off an SSRI, one will want to go through a Purification or Detoxification process to rid the body of lingering toxins and chemicals. This should be done through the guidance of a skilled and knowledgeable health care practitioner.

SUMMARY

By following the **Taper Safely** protocol, Lynn was able to taper off 75 mg Zoloft and 20mg Lexapro - an equivalent dose of 70mgs Prozac or Paxil -in 47 days or 7 weeks without experiencing a drawn-out, debilitating withdrawal. The symptom she incurred was an increased need for sleep.

Had she endured a "slow taper" at a 10% reduction from the original dose weekly, it would have taken her 154 days or 22 weeks. Some promote a "slow taper" to be a 10% reduction from the dosing bi-weekly + 2 weeks with no adjustments when starting a new drug taper. This would have taken Lynn 518 days or 74 weeks - an excruciatingly long time with no guarantee that there would be any relief at the end of the taper.

Most importantly was that as Lynn's body began to heal from nutritional support and natural medicine, her energy 'kicked in' and she actually enjoyed the experience of tapering and beginning to reclaim her life.

If Lynn can get off these drugs quickly and without debilitating withdrawal, she believes that anyone can.

Getting off an SSRI can be a very positive, life-enhancing journey.

You now have a choice to walk the path to freedom from SSRIs.

"Nature's Nature is to Heal"

Taper Safely, Inc. is currently filing for nonprofit, tax-exempt status, as a Section 501(c) (3) charitable organization.

Lynn Michaels can be contacted at lmichaels02@yahoo.com

Erwadi Memorial Day: A national human rights day for persons with psycho-social disabilities

August 1st, 2007

On March 30th, 2007, India signed the United Nations' Convention on the Rights of Persons with Disabilities [CRPD]. People with psychosocial disabilities from around the world played a major role in the enactment of this Convention. The CRPD sets up a comprehensive regime of positive rights for persons with mental illness.

What we have experienced in Maharashtra, reflective of the situation in India, are the extreme exclusion and violation of the rights of persons with mental illness. On August 6th, 2001, 28 people labelled as 'mentally ill' in the Badhusa mental home in Erwadi, Ramanathapuram, Madurai District, Tamil Nadu, perished in a fire. The tragedy highlighted the dire conditions under which many persons with psycho-social disabilities are treated in our country till today.

The *Jan Manasik Arogya Abhiyan*, a people's mental health campaign in Maharashtra, comprising of approximately 50 organisations and individuals, has dedicated August 6th as a "Memorial Day for persons with psycho-social disabilities" and runs campaigns and events around this time every year in Pune & Mumbai.

This year, this campaign was extended to ALL OF INDIA, and appeals were made to one and all to express solidarity against the apathy of the mental health system in ensuring the rights of people with psychosocial disabilities.

The JMAA appeals to all mental health actors to dedicate a minute, an hour, a day or a week every year around the August 6th. Keep up your advocacy with governance for the human rights reform of the mental health system.

Posters dedicated to JMAA – Erwadi Day, 2007 can be downloaded for free from www.camhindia.org

For more information contact,

info@camhindia.org / Baputrust.Mumbai@gmail.com

JMAA Convenor (2005-2007):

Bapu Trust for Research on Mind & Discourse,

Survey No. 50,
Gulmohar Apartments,
Ground Floor,
Kondhwa Khurd,
Pune 411 048,
Maharashtra, India.
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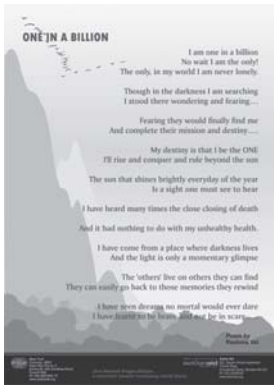
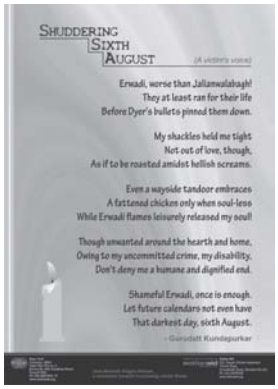
www.camhindia.org





Shuddering Sixth August

Erwadi, worse than Jalianwalabagh!

They at least ran for their life,

Before Dyer's bullets pinned them down.

My shackles held me tight,

Not out of love, though,

As if to be roasted amidst hellish screams.

Even a wayside tandoor embraces

A fattened chicken only when soul-less

While Erwadi flames leisurely released my soul!

Though unwanted around the hearth and home,

Owing to my uncommitted crime, my disability,

Don't deny me a humane and dignified end.

Shameful Erwadi, once is enough.

Let future calendars not even have

That darkest day, sixth August.

Gurudatta Kundapurkar

Interview with Tripura Kashyap - Dance Therapist

Tripura Kashyap, an Ashoka Fellow, is a Dance Therapist and Choreographer based in Bangalore. Apart from classical dance and Martial arts, she trained in Dance/Movement Therapy at Hancock Center of Movement arts & therapies in U.S.A and holds an M.A degree in Psychology. She worked for about 10 years with varied groups like children with Celebral Palsy, mentally challenged children with Baldwin's Opportunity School, adults with schizophrenia at Atmashakti in Bangalore, children with hearing impairment, visual disabilities and Down's syndrome. She founded Apoorva Dance Theatre and has worked collaboratively with filmmakers, visual artists and musicians on cross-art projects. Most recently she has started an organization called Rainbow Inc through which she conducts and organizes workshops on various arts across 8 cities in India and in Kathmandu, Nepal.

What is Dance therapy?

Tripura: Dance and movement therapy is a way of helping people to express themselves, their thoughts, feelings, and emotions. The idea is to get people in touch with themselves and express what they feel at a particular point in time. All of us are born with movements. As we get into adulthood, the movement is much lesser than before. In fact the movement is getting reduced to just remotes, keyboards and just using fingers more and more. In that sense people have got alienated from themselves because there is a lack of movement. The idea of doing dance therapy is helping people to move, developing a personal movement language and helping them to express themselves through this movement.

When you do things with the body at a movement level it also affects the way you think. One of the principles of dance therapy is that the body and the mind are continuums of each other. When you do some tai chi exercise for example, which consists of breathing and movement, it really helps to calm down and reduce stress.

Each group has their needs and issues, and you have to study those needs and issues and based on that you come up with your goals – short-term and long-term. Again based on that you chose activities that you think will help them deal with the problem.

When I was working with Atmashakti I saw that bonding happens very easily through movement. Communication is happening at a completely different level. People are touching, holding hands, working with each other, and using props. I feel that sometimes, verbal communication also inhibits people coming together.

People were freer with the way they express themselves after they go through the emotional expression exercises. People realize that emotions are actually our friends and guides. There is nothing like a negative emotion. Every emotion is positive, including anger or disgust because it saves us from certain situations.

What role do you see of dance therapy in the recovery process of especially very severe disorders?

Tripura: At Atmashakti, it was not just dance therapy but they also had psychotherapy in groups, they had music, yoga. What they were looking at was a holistic development. The feedback I got from the psychotherapist was that those who were part of the dance therapy sessions, were working and sharing at a different level. A dance therapy session does not remain limited to just dance. There is verbal processing of each activity. For example, if we do an activity like mirroring or shadowing, immediately after the activity we have something called review questions that we ask to the group about what their feelings were, what was their experience and whether they were comfortable doing it. Instantly, there is a feedback and processing that happens. You get to know what the client is going through. Sometimes I feel that you can also work the other way round, like starting at a movement area. Not everyone might want to talk. There might be severely distressed populations. What works with them is art

therapy, where they draw things or drama therapy or dance. I found that non-verbal communication was much stronger and powerful for them. I found that rhythm was the one thing that caught their attention and brought them to the here-and-now, which was a very important thing for them.

What are the differences that you see in individual and group therapies? In what cases, is one more effective than the other?


Tripura

Tripura: When you're working with children with autism, you might have a very specific goal in your head. There is just one goal to take care of in one session. Individual sessions work beautifully because your entire concentration is on one person. The goals are very specific. But I also find that the dynamism of the group is great. I find a lot of joy in that. People's energies affect each other. When one person is sharing something personal, the other persons also want to immediately come out with it. Some people are very passive with their body but when they see that the energy level of the group is high, they automatically try to match themselves with that. I feel more effective as a therapist in a group rather than one-to-one. It's always a time-bound program. Within that time frame I try to achieve my goals, be it individual or group sessions.

What are the values and principles that guide the therapy process?

Tripura: The whole idea of trust and the client being central to the therapy. Another very important principle is that the mind and body are interconnected. Also being non-judgmental and listening skills of the therapist are important. Picking up movement cues from the group that you work with, for example if you're doing warm up and one child is doing something completely different, you don't judge whether someone is right or wrong, but you're looking at the uniqueness of the expression that comes out. You say that what you're doing is interesting and can we use it. It increases the self-esteem of the children in the group and you acknowledge that each person is special. You build on the patterns of movements that already exist.

One of the issues that we're trying to grapple with related to alternative therapeutics, especially in group situations is this compulsion to share your feelings and emotions. Sometimes people might not be willing to share or might be uncomfortable doing it, especially in a group situation. Can you comment on that?

Tripura: The whole idea of doing these therapies is that we're trying to help people sort out their issues or problems. Sharing is not the end of it. For example, if a person has problems related to being assertive in a family set up and unless that person shares it with you, you may not know how to deal with that problem. Though there should be no compulsion to share. But we must also remember that if sharing does not happen then therapy also does not happen and it remains a dance class or a drama class. The whole idea of sharing helps people to work towards the problem. Its not compulsory but one should be careful of leading into the sharing rather than asking the person to share in the first session which they won't. Some people might require more time and space to begin sharing. The therapist's job is to ask what the individual is feeling or experiencing during an activity. Because neither can a therapist not ask that. But if the group does not want to respond or some people might not yet be comfortable doing it, its perfectly fine. But as they get confident that they can share, people do share and the therapist needs to give space for that. When you are compelled to share something, you might also lose trust in the therapist.

How has your experiences with collaborations with other AMH practices been?

Tripura: While working in Sadhana Village, I worked with Zubin Balsara (Drum Circle Therapy) and Aanand Chabukswar (Drama Therapy). We all have worked from different angles for the same issues. We drew up a plan so we knew what were the needs and issues of the group. We came up with certain heads and goals and worked towards that using dance, drama and music. It was very exciting to see the kinds of changes that were happening. The collaboration was very fruitful because at the end of it Sadhana Village also had a sense of taking it forward. But for me collaboration is when these arts come into the same session, using all the arts at the same time.

Do you feel that such a linkage could enhance the process more?

Tripura: Probably. I don't know. Some individuals are more receptive to drawing. Not everyone wants to do drama or movement. Maybe they want to sketch. In that

sense, it might be more exciting to see how in a single session the response is to different mediums. I did this in Argentina when I worked with some of the artists there. It was very interesting there. Many of the artists, suppose it's a drama person, he or she already knows all the other arts. For example if I start with gestures, then a visual artist would get us to sketch the gestures and then we would sketch it on a paper on a wall and then the music person would say that that looks interesting, can we put it to music. So each person would contribute to the same exercise and make it much more enriched and broader. There are different methods that can be used to bring the arts together. At the same time you as a therapist also grow as it also enriches what you already know.

Starting with your training in dance therapy in the US and then working with individuals and groups and now setting up Rainbow Inc, how has this entire journey been?

Tripura: It's been a very exciting journey. There are new experiences happening all the time. I have also experienced a lot of body-oriented therapies and all these experiences have fed into my growth not only as a dancer but also as a person. I found that there was a lot of opportunity for work but it wasn't possible for just one person to do that. That's when I came with this idea to train people who are already working with people with disabilities who are there with the group all the time anyway. The use of movement was very limited and most of the work is mind-oriented. That's why I decided to train people to use movement activities with the children or adults that they work with. The confidence to set-up Rainbow has come from my experience. I have seen the responses to my workshops and I felt the need to set up an organization that caters to art therapies and various forms of arts.

Green Walking Beats The Blues, New Study Recommends Ecotherapy For Depression

Medical News Today, 14 May 2007

Going for a green walk in a park or countryside where one is surrounded by nature reduces depression whereas walking in a shopping centre or urban setting increases depression.

This is the message of Mind, a leading UK mental health charity that is launching a new "green agenda" for mental health based on the concept of "ecotherapy". Mind is calling for ecotherapy to be recognized as a "clinically-valid frontline treatment for mental health problems".

Other countries are already prescribing ecotherapy as a treatment for mental distress. For instance in the Netherlands and Norway, GPs can prescribe their patients a stay in a care farm. The Netherlands has 600 care farms and Norway 400 care farms.

Ecotherapy is about getting out of doors and becoming active in a green environment as a way of boosting mental health, say Mind. This includes taking regular walks in the countryside or the park, flying a kite, or taking part in a gardening therapy project.

The campaign is backed by two studies commissioned from the University of Essex. One study looked at the effect of "green" exercise such as walking, gardening and conservation work on mental health, and the other compared the impact of outdoor versus indoor exercise on mental well being.

In the first study of its kind to examine the effects of green exercise on people with mental health problems, the researchers examined 20 members of local Mind groups who took part in two walks, one in a country

park and one in an indoor shopping centre, to test the impact on self-esteem, mood and enjoyment.

The results showed that:

- 71 per cent reported decreased levels of depression after the green walk.
- 22 per cent felt their depression increased after walking through an indoor shopping centre and only 45 per cent experienced a decrease in depression.
- 71 per cent said they felt less tense after the green walk.
- 50 per cent said they felt more tense after the shopping centre walk.
- 90 per cent said their self-esteem increased after the country walk.
- 44 per cent reported decreased self-esteem after window-shopping in the shopping centre.
- 88 per cent of people reported improved mood after the green walk.
- 44.5 per cent of people reported feeling in a worse mood after the shopping centre walk, 11 per cent reported no change and 44.5 per cent said their mood improved.
- 71 per cent of people said they felt less fatigued after the green walk and 53 per cent said they felt more vigorous.

The report says there are four main reasons why people enjoy green exercise:

1. Natural and social connections: For example watching wildlife, evoking memories of happier earlier times such as special outings and spiritual feelings.

2. Sensory stimulation: colours and sounds, fresh air, excitement, fun, escape from pollution, contrasts with urban life, being exposed to the weather.

3. Activity: learning manual skills, physically challenging activities such as digging, cycling.

4. Escape from modern life: time to think and reflect, clear the head, get away from pressures and stress.

Useful links

The website

http://www.mentalhealth.org.uk/publications/

has a wide range of interesting studies and publications, which can be freely downloaded, including: Pathways to Policy Toolkit; The Impact of Spirituality on Mental Health; Investigation into Auricular Acupuncture; Investigation into Massage; Dancing for Living Report, and Exercise and Depression. The website will be useful for looking at evidence and building work on alternative mental health, among other policy areas.

Sourced by Kevin Cremin, American India Fellow, 2006.

Aaina, a networking and opinion sharing newsletter in mental health, is for private circulation only. It is sponsored by Bapu Trust for Research on Mind & Discourse, an organisation committed to mental health literacy and advocacy. The views expressed in the newsletter are however not those of the organization. We are not endorsing the practice of any healer through this newsletter.

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