

**“.....I will turn their mourning into gladness;
I will give them comfort and joy instead of sorrow.”**

Jeremiah 31:13 New International Version (NIV)

Drishtikone means perspective or viewpoint in Hindi. The magazine seeks to provide a space in which Christians can share their perspectives and points of view on wholistic mission in India.

Our Vision is that **Drishtikone** will motivate change in readers. The experiences of development practitioners, theologians, grassroot workers and others demonstrating God's love in a practical way, will influence and encourage Christians to join the struggle for peace and justice in this country.

Drishtikone seeks to present a Biblical perspective on social issues and provide readers with information and models of engagement in wholistic concerns. It is a forum for evangelical reflection and dialogue on development issues in India.

Drishtikone is published three times a year by EFICOR to mobilise Christian reflection and action. Financial contributions from readers are welcome to support EFICOR in its efforts to influence the mind towards action.

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An EFICOR (The Evangelical Fellowship of India Commission on Relief) Publication.

For private circulation only.

Drishtikone is a magazine with many perspectives.

The views expressed are not necessarily those of EFICOR.

Layout and design by Houreilung Thaimai

EFICOR is registered under the Karnataka Societies Registration Act 1960 (Karnataka Act No. 17 of 1960) on 30th April, 1980. The Registration number is 70/80-81. EFICOR is also registered under the Foreign Contribution Regulation Act. 1976 and the registration number is 231650411.

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Contents

Letters to the Editor...



Dear Editor,

I am glad to have the opportunity to read Drishtikone magazine issue on "Transformational Education" which we have subscribed for our Library recently. I thank my colleague for introducing this publication to me. I wish every teacher would read this issue to understand the nobleness of their profession.

Appreciations and Best Wishes to the team!

*Dr. Jesudoss Manalan
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Dear Editor,

Thank you for sending Drishtikone magazine. The theme is great, having really good and interesting articles.

*Karsten Van Riezen
New Delhi.*

- 2 Editorial
- 3 Cover Story
Mental Health
Dr. Susheel K. Tharien
- 6 Response to the Cover Story - 1
Improving the Mental Health Care System
Dr. Jamila Koshy
- 8 Response to the Cover Story - 2
Are we Offering a Message of Hope
Dr. Monica Thomas Chandy
- 10 Christian Perspective on the theme
Christian Perspective on Mental Illness
Dr. Sony Lukos
- 12 Facts

1

Contents

- 15 Voice From The Grassroots
My Story: Living With Depression
 Ms. Senganglu Thaimai
- 17 Faith in Action
Mental Health Among the Poor
 Dr. Johann Ebenezer
- 18 Book Review
**Troubled Minds
 Side-Effects of Living
 Em and the Big Hoom**
- 20 Seeds of Transformation
Healthy Practice
- 21 My India
**Conversing with a Care
 Giver**
 Compiled by Mrs. Joan Lalromawi
- 23 Bible Study
**Mental Illness and Mental
 Health**
 Dr. Starlin Vijay Mythri
- 24 Ideas For Action



Editorial...

Mental illness can be defined as a health condition that changes a person's thinking, feelings or behaviour and that causes the person distress and difficulty in functioning. Just like any other disease, mental illness is severe in some cases and mild in others. Individuals who have a mental illness do not necessarily look like they are sick, especially if their illness is mild. Others may show more explicit symptoms such as confusion, agitation, hyperactivity or withdrawal. Mental illness alters a person's thoughts, feelings, and/or behaviours in distinct ways. This issue of Drishtikone is specifically concerned with mental health and it does not address other neurological diseases or brain disorders such as epilepsy, Parkinson's diseases, etc. which are often confused as mental illnesses.

Despite the fact that World Mental Health Day (10th October) has been observed for the last 27 years with the overall objective of raising awareness on mental health issues, many mentally affected individuals continue to experience discrimination, stigma and social ostracism. We often lack understanding of the causes of mental illness, lack awareness in regard to the symptoms of mental illness and lack empathy for individuals battling mental illness. Consequently, many suffer silently or are left behind closed doors. We fail to encourage those with mental illness to seek professional care and treatment. As a result their illness often remains undiagnosed for years.

In this issue, the writers highlight the need to reconsider our understanding and approach towards mental illness if we are to build a compassionate and responsible society. The Church, especially in India, needs to adopt an inclusive and compassionate response towards those with mental illness. Offering prayer to those with mental illness is appropriate and important, but we also need to be intentional in warmly including those with mental illnesses into our communities, and in offering emotional and practical support as needed. This issue of Drishtikone is an effort to present the state of mental health in India so that we become more aware of our role in supporting those are often marginalised and stigmatised due to their condition.

Mental Health

Dr. Susheel K. Tharien

The term 'Mental Health' or 'Mental Illness' is often greeted with mixed reactions - with a sense of perplexity, fear, shame, helplessness or sympathy. Somehow it does not seem as simple as physical or economic health. If we have a chest pain or high fever, we are ready to go to a doctor. But most people are reluctant to seek help for any mental health issue. Why do we shy away from speaking about mental disorders? Instead of encouraging people to seek help and supporting them, many of us prefer to judge, label and belittle people suffering from mental disorders. Why don't we behave in a similar fashion when it comes to physical health and wellbeing? Ignorance, stigma and lack of available resources are some of the reasons.

What is Mental Health?

Mental health refers to our cognitive, behavioural, and emotional wellbeing - in other words, it is all about how we think, feel, and

behave. Mental health can affect daily life, relationships, and even physical health. It also includes a person's ability to enjoy life - to attain a balance between life's activities, and to achieve a level of psychological resilience. It is the ability to be involved in productive activities, to have fulfilling relationships, the ability to adapt to change and to cope with adversity.

According to the World Health Organisation (WHO), mental health is: "... a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community." The WHO stresses that mental health, "is not just the absence of mental disorder." Mental health refers to a broad array of activities directly or indirectly related to mental well-being, prevention of mental disorders, and treatment and rehabilitation of people affected by mental disorders. As the first director-general of the WHO, Brock Chisholm declared in 1954, "Without mental health there can be no true physical health."

“According to a WHO report, India has one of the largest populations suffering from one form of mental illness or the other.”

Mental Illness

Mental illnesses are associated with distress and problems in functioning in social, work or family activities. Mental illness can affect anyone, regardless of one's age, gender, social status, ethnicity, religion, and background. While a serious mental illness may be obvious to others because of the gross abnormalities in speech or behaviour, the sufferer may not be aware of it at all. Conversely, sometimes a so called minor mental illness may cause significant distress to the person, but others may not notice it. Many early symptoms are often ignored due to lack of awareness and some symptoms are mistaken for plain laziness or hatred. Mental illnesses take many forms. Some are fairly mild and only interfere in limited ways with daily life, such as anxiety disorders or phobias. Other mental illnesses could be so severe as to necessitate hospital care.

Mental health disorders account for 15% of the total global burden of diseases. According to a WHO report, India has one of the largest populations suffering from one form of mental illness or the other. Mental health

and wellbeing are by far one of the most neglected areas in our country. According to a recent National Mental Health Survey in 2016,¹ approximately 150 million people in India need care for their mental health condition. 10.6% of adults in India have 'any mental disorder' (excluding tobacco use) and 2.7% have depressive disorders. The same survey also discovered that between 70% and 92% of these cases failed to receive treatment. The reasons include low awareness, inaccessible health care, costs, alternative remedies like religious/supernatural, as well as stigma, which is widespread, especially in Asia. In India, suicide was the most common cause of death in both the age groups of 15–29 years and 15–39 years.² Youth suicide in India is among the highest in the world, and the average suicide rate in India is 10.9 for every lakh people.

Though there are effective measures and treatments for the majority of mental health problems, there is an extreme

¹ National Mental Health Survey of India 2015-16, supported by the Ministry of Health and Family Welfare, Government of India and published by the National Institute of Mental Health and Neuro Sciences (NIMHANS), Bengaluru, P.30.

² Gender Differentials and State Variations in Suicide Deaths in India: The Global Burden of Disease Study 1990–2016, Lancet, 2018.

shortage of mental health workers like psychologists, psychiatrists and psychiatric nurses, and social workers. WHO reports that the mental health workforce in India (per 100,000

population) include psychiatrists (0.3), nurses (0.12), psychologists (0.07) and social workers (0.07). These are some staggeringly low numbers in a country where one in every six persons needs some sort of help with their mental wellbeing, according to the 2015-16 National Mental Health Survey (NMHS).

“More than 80% of people do not seek any professional help in India. The burden of mental disorders seen by the world is only the tip of the iceberg. Various studies have shown that the prevalence of mental disorders are high in females, elderly, disaster survivors, industrial workers, children, adolescents and those having chronic medical conditions.”

amongst these factors. We now know much more about how the human brain works and treatments are available to help people successfully manage mental illnesses. Treatment of

mental health disorders is of utmost importance. There is evidence to show that the earlier the treatment, the better the outcome. This is where awareness and early detection of mental disorders becomes important. Interventions

in the form of medicinal, psychological and social help can make a huge difference. But the availability of resources for this is currently limited. According to the Human Rights Watch, only 0.06 per cent of India's health budget is devoted to mental health and available data suggests that state spending in this regard is very low.

4 It is important to understand that there is a lacuna in how mental health is dealt with in our country. Lack of awareness about the issue, the stigma associated with it, lack of trained professionals, inadequate funding and the low priority given in the healthcare budget are the reasons why people coping with mental health issues fail to receive adequate and timely treatment.

Interventions in the form of medicine, psychological and social help can make a huge difference. More than 80% of people do not seek any professional help in India. The burden of mental disorders seen by the world is only the tip of the iceberg. Various studies have shown that the prevalence of mental disorders are high in females, elderly, disaster survivors, industrial workers, children, adolescents and those with chronic medical conditions.

Determinants of mental health

Mental health, like other aspects of health, can be affected by a range of socioeconomic factors. Mental illness needs to be dealt with using comprehensive strategies focusing on promotion, prevention, treatment and recovery. Determinants of mental health and mental disorders include not only individual attributes, such as specific psychological, personality and genetic factors, but also social, cultural, economic, political and environmental factors such as national policies, social protection, living standards, working conditions and community social support. Poverty and low educational levels are the key

Role of the church

Many individuals turn to their church and their faith for spiritual guidance in times of emotional distress. Unfortunately, there is still a stigma attached to mental illness in many Christian churches. The prevailing culture of silence along with misguided attitudes and erroneous expectations often cause suffering believers to feel shamed, blamed and very unsupported. Thus, many suffer in silence. Suicide, depression, schizophrenia and substance abuse are just some of the mental illness-related topics many Christians find hard to talk about.

Spirituality is an important aspect of mental health. St. Augustine prayed, "O God, thou created us in thy image and our hearts will be restless until they find their rest in Thee." Though Sigmund Freud looked upon religion as an illusion and neurosis, Carl Jung considered the psyche as a carrier of truth, powerfully rooted in the unconscious mind.

Recent research strongly suggests that for many patients, religion and spirituality are resources that help them cope with the stresses in life, including those of their illness. Many psychiatrists now believe that religion and spirituality are important in the life of their patients. The importance of

spirituality in mental health is now widely accepted.

Lack of spirituality can interfere with interpersonal relationships, which can contribute to the genesis of psychiatric disturbance. Psychiatric symptoms can also have a religious content. For example, the loss of interest in religious activities is a common symptom of depression. Too much and distorted religious practices are common in major mental illnesses like schizophrenia. It is well recognised that some spiritual experiences are misdiagnosed as symptoms of psychiatric illness, for example visions and possession states. The spiritual background of the patient will help in the diagnosis of psychiatric disturbance. According to the former Professor of Psychiatry in CMC Vellore, Dr. Abraham Verghese, spirituality is important in the treatment of psychiatric disturbance because spiritual matters can be profitably incorporated in psychotherapy. Spirituality is important in the prognosis of psychiatric conditions. In the spiritual perspective, a differentiation must be made between cure and healing. Cure is the removal of symptoms. Healing is healing of the whole person. Adversity often produces maturity. Hence, in psychotherapy and counselling, the person must be helped to accept the handicap and transform the handicap to a life of usefulness, says Dr. Abraham Verghese.

Patients with mental illness continually fail to receive adequate or timely treatment. Among other reasons, stigma against and misunderstandings of mental illness prevent millions of people from promptly seeking appropriate medical attention, thereby distressing not only those affected, but also their families and communities. Recent research on attitudes toward mental illness among Christian leaders and members of the Christian community has demonstrated that knowledge regarding causation and applicable treatment remains limited among Christians, and that negative views toward mental illness are widespread.

One study showed that a vast majority of Christians surveyed believe that prayer alone is the standard treatment for mental illness, meaning that some Christians are liable to refuse clinical intervention and psychotropic medications as primary treatment approaches. Such neglect can delay additional treatment and further increase the morbidity, mortality, and possibility of life-threatening consequences among mentally ill Christians.

Some of the myths and misconceptions about mental illness prevailing among many Christians include the following:

- Mental illness is a sign of weakness: Instead of being recognised for the legitimate, clinical condition that it is, mental health problems like depression might be viewed as a personal flaw, character weakness, or caused by a lack of faith, self-discipline or willpower.
- Prayer is the only solution: We may not say this for cancer

or heart disease or diabetes, even though we will certainly offer prayer and believe that God is the ultimate healer. As a famous surgeon said, “I cut; God heals”. By offering shallow, overly simplistic solutions we may heap more shame onto what is already an overwhelming and painful experience.

- Mental illness is a punishment from God: When Jesus was faced with the question regarding the cause of blindness in a man he said, “Neither this man nor his parents sinned, but this happened, so that the work of God might be displayed in his life.”
- Mental illness is the result of possession by evil spirit: Though the Bible records instances of possession by evil spirits resulting in abnormal behaviour, the Bible also records cases of people with deafness, blindness and muteness from whom Jesus drove out evil spirits. Christians hardly ever think of spirit possession on seeing a blind man, but tend to think of it on seeing a mentally ill person! We cannot automatically attribute everything which we do not understand to the devil.
- We are letting God down and the church if we suffer from mental illness: Even mature Christians, including many contemporary faith leaders as well as the prophets, Apostles, and Jesus himself, experienced sorrow, sadness and grief.

The Bible includes several examples of people who have struggled with emotional problems and perhaps debilitating mental health conditions (not necessarily psychiatric disorders), including Moses, Elijah, Jeremiah, Job and David. Moreover, it is notable how God responded to their conditions: with love, patience, and kindness. The Christian community ought to have the same attitude.

Many look to the church for help in times of their emotional stress or for help for their loved ones. Often church leaders do not know how to help. It is time that the church realises the need for counsellors, even lay counsellors. Even if not trained, anyone with a willing heart to listen and care can help many. We need to recognise that people with mental illness are people created in the image of God, loved and valuable. We can pray for them. We can show by our love that we are with them. This could be by small acts of kindness, especially to the close relatives who are the caregivers and often carry a heavy burden. Psychiatrists and mental health providers can also play a pivotal role in educating Christian patients and their relatives on mental illness and its interaction with faith and spiritual practices.

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Improving the Mental Health Care System

Dr. Jamila Koshy

Dr. Susheel Tharien has ably described the burden of mental health issues and the urgent need to take mental illnesses, their prevention and the enabling of mental well-being more seriously at the national and local level. He has brought out various issues related to the understanding of mental health within the country at large and the Christian community in particular. We read about the necessity of understanding mental health as a vital component of overall health, the separation and stigma faced by people with mental health issues, and he has given us a good summary of the factors involved in mental illness, from genetics and the functioning of the brain to psycho-social stress factors like poverty and education.

6 He described for us some faulty ideas held by religious people about mental illness and how these have worked to slow down, obfuscate and sometimes prevent proper treatment of mental illness, and has pointed out how religion and spirituality should actually work in a positive way to reduce the burden of mental illnesses for the patients, families and community.

These truths can only be agreed to and reiterated.

Mental illnesses are illnesses. They relate to the body, primarily the brain, which houses the mind, just like heart illnesses involve poor functioning of primarily the heart and blood vessels. And just like heart diseases may be precipitated and worsened by other factors such as smoking cigarettes, coffee, stress, so diseases of the brain can also be precipitated by factors such as drugs – including coffee!! – and stress. Just like heart diseases would require prompt treatment by qualified doctors, so mental illnesses, too, should be treated promptly, by qualified doctors. Just as the stress part of a heart disease could be handled with psychological support, prayer and counselling, in addition to the medical treatment, so do mental illnesses benefit from psychological support, prayer and counselling.

The mistake we make is to often think that psychological support, prayer and counselling alone can sort out mental illnesses. We would never do this, as Dr. Tharien points out, to patients with heart illnesses, or the blind and deaf, but this is done routinely to patients with mental illnesses. This has unnecessarily delayed treatment of mental illnesses, in some

patients' cases, for decades. This must stop, if we truly wish for the patients' welfare.

It is sometimes debated that the point at which a person can be said to have a mental illness is not fixed. So how does one know there is a problem? Is it okay to lose your temper once a month? Once a week? Daily? Five or six times a day? At what point should one consult a doctor? Why can't I fix it myself, with prayer? Other religious folk often want to try yoga, or reiki. Others would like to try 'mild' systems like homeopathy.

The same question, however, can be said about dysfunction of any bodily system. At what point should I consult a physician? When climbing six flights of stairs makes me breathless? Four flights? Or two? One? Can't I heal it myself with prayer? Can't I try yoga, or some diet, or homeopathy?

The answer to both is that there is no rule, but one would probably go to a doctor depending on how careful one is of one's health. The extremely careful person may go to a physician at the first sign of breathlessness. She may be prescribed only some care with her diet, to lose a couple of kilos, or to cut down on a rushed lifestyle or re-examine priorities. Similarly, a person with anger or anxiety may note them early and wonder what is wrong, or be told by an anxious spouse that something is wrong, and he may go to a doctor. The psychiatrist may tell him the problem is mild, but he needs help. He may be told to meet a pastor, therapist or counsellor, re-examine and modify his thoughts and emotions through some form of therapy, and to exercise more regularly.

This may suffice for some. Others however, may still, despite attempts at prevention or early treatment, go on to develop heart disease, or to more severe forms of mood or anxiety disorders. They may require medication as well as therapy, pastoral counsel, or lifestyle modification.

The point therefore is that, while accepting the role of prayer, or cognitive and behavioural methods of counselling, the biological part of mental illnesses should not be neglected. All too often it is, however, totally neglected. It is as if taking medication or other treatments for mental disorders is not acceptable, and to be avoided at all costs.

This is unacceptable, because many mental illnesses respond well to medical treatment and denying treatment to the patients is causing them to undergo quite unnecessary pain and anguish. And as Dr. Tharien pointed out, the sooner things are treated, the better they respond. This again, has a parallel in most illnesses. No one would neglect heart conditions for years, trying to fix it with tinctures or lifestyle modification alone. No one would ignore a lump or unexplained pain, hoping it would go away by prayer. If delayed, treatment may come too late. Similarly, this neglect of early treatment of mental illness causes morbidity and discomfort to a great number of patients, and also leads to spill-over effects like the disruption of marriages and families, or problems at the workplace severe enough for job loss. Ignoring mental illness carries a very heavy cost.

Changes needed in the mental health scenario of the country:

1. We urgently need more medically trained personnel. As pointed out by Dr. Tharien, India has a severe shortage of psychiatrists, and psychiatric nurses, while having a very high burden of untreated mental illnesses, which are causing marriages to break up, neighbours to fight with each other, drug use to flourish, psychotic people to enthrall the gullible public with grandiose nonsense. Christians could encourage young doctors to consider specialising in mental health. Nurses could opt for training in handling psychiatric patients. But that is not enough! Trained persons need to consider or be deliberately challenged to stay back in India and work here as a calling and commitment to this huge and needy nation, while fully aware that they would get paid much better in some hospital in the USA.

2. We need other mental health practitioners working with people and their problems - psychologists, pastoral counsellors, social workers - to work closely with psychiatrists, having a good understanding of mental illnesses and checking in with psychiatrists early and regularly, to see that treatable illnesses are not being missed, and other treatment options besides counselling/therapy are not being missed, for even mild illnesses. Checking in early is key, rather than referring to a doctor after months and years of struggle. This would require a paradigm shift for many counsellors. Rather than the psychiatrist being the last resort referred to when marital therapy has failed, or the person has become suicidal, people working with disturbed people should discuss cases early and often with a psychiatrist co-worker, and work alongside.

3. All practitioners need to increase awareness in the community about mental illnesses and encourage

people to seek medical help early, while continuing cooperatively with pastoral help, prayer, counselling. They can do a great deal to reduce the stigma of seeing a psychiatrist, if it is discussed matter-of-factly and positively.

4. All practitioners need to discourage patients and their families from seeing mental dysfunction primarily as either a sign of weakness, immaturity or as sin – any of which may of course be present in any patient without being the primary cause for the illness. Neither should they encourage hasty ‘diagnoses’ of demon possession. This is a huge problem in India across religions and delays getting the patient the help s/he desperately needs. This would apply to illnesses across the spectrum including depression (often seen as laziness and immaturity), anxiety disorders (too often branded as a lack of trust in God), schizophrenia (many patients would have been to an exorcist of some religion, including our own, before reaching a doctor many months later), alcohol and drug dependence (seen as rebelliousness, sin, etc), conversion disorders or possession syndromes (almost always branded as demon possession), etc.

5. People, including mental health practitioners, are sometimes confused when asked by a disturbed person or their relatives who they should consult for the first visit. Should it be one’s pastor, a faith healer, a counsellor, psychologist or psychiatrist? It actually doesn’t matter as long as whoever is consulted is aware about the need for screening for mental illness, and ensures that it is done, as early as possible and repeated as required.

6. Many serious disorders such as schizophrenia, bipolar disorder or drug dependence initially present with mild symptoms but left untreated, they go on to ruin the lives of patients and families. Treatment also is long term, and not always easy. All mental health practitioners should defer to doctors in the treatment of these disorders, and play the supporting role of encouragement, counsel, caring for the caregivers, and so on which can make all the difference in the life of the affected family. What should not happen, but sadly, sometimes does, is pastoral counsellors advising patients to stop all the medication, pronounce that they are healed and so on. This interference does not happen often in any other branch of medicine, but is a daily occurrence in the field of mental illness.

Let us hope and pray that the terrible burden of mental illness in India can be reduced by caring and committed Christians and others, working together.

(Dr. Jamily Koshy is a Christian Psychiatrist currently living and working in Chennai. She can be reached at jamilakoshy@gmail.com)

Are We Offering a Message of Hope?

Dr. Monica Thomas Chandy

The opening lines of Dr. Tharien's article sums up the dilemma, the ambiguity, the genuine puzzlement of society at large, and Christians in particular; mental health is complex, with layers of genetic predilection, psychosocial determinants, and spiritual overlay. There is a scientific neurobiological basis, and yet, one must guard against soulless reductionism - it is clearly a proposition different to the removal of an appendix or clearing the blockage of a heart vessel. It would be good for the church, the medical community and society to work in concert, and provide for early recognition, and a non-judgemental support structure. To borrow from Twila Paris' song, "Every heart that is breaking tonight," we need to get our message right to the myriad presentations of mental illness.

8

***"To the hallucinating fearful son
trapped in the terrifying
bedlam of voices in his head,
to the tortured desperate student
struggling with the maelstrom
of competing chemicals in his head
and an indifferent world outside
to the deeply depressed young woman
in her dark and colourless world
to the tricky manipulative patient
difficult to pin down
to the shame stricken alcoholic
slipped after ten years
to the inattentive impulsive teen"***

To millions of those across the puzzling spectrum of mental health, we must get our message right of hope and healing, "He sees you, He knows you, He loves you." We need to reassure patients and their families of the eminently treatable nature of mental illness, and that the majority of mental health patients can lead normal lives. The message of hope has to be delivered on a platform of sound clinical reasoning, compassion, and a lens that is not cluttered by one's own individual philosophical paradigm. So often, Christian health workers and church leaders are conflicted between the thundering wrath of



Photo: www.pixabay.com

God and the image of Jesus carrying the lost sheep. It is in avoidance of the binary, that the solution might lie, where we decry a judgemental attitude, make a sensible medical diagnosis, and manage the individual with medication, psychotherapy, family support and counselling. All these measures must be integrated within the context of a supportive, loving community, which will have to be carefully built up across the country, based on best practices and customised for our particular setting. The communities must also build mental health services, which would have the advantage of easy access, better acceptability, ongoing contact, trusted local providers, closer family involvement and definite economic benefits.¹ In view of the serious shortage of mental health professionals, it makes sense to have digital networking for training, mentoring, follow up as well as dispensing of medicines. As the model of care gets deinstitutionalised, we need more half way facilities where high functioning patients can find a place to reside and go out to work. It is also important to recognise that the individual should not be put back prematurely into the same set of circumstances and family dynamics that contributed to his mental illness in the first place. Therefore, the need for safe spaces, which could be an extension of the school, college, or church.

¹ Brandon A. Kohrt, et. al, (2018) The Role of Communities in Mental Health Care in Low- and Middle-Income Countries: A Meta-Review of Components and Competencies, International Journal of Environmental Research and Public Health, 15(6), 1279. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6025474/>

“ It is a terrifying fact that suicide is the second leading cause of death in the age group of 10 to 24 years.³ As a society, and even more as a church, we have to pull out all the stops - sensitising the congregation, training pastors, using social media, creating safe havens and shelters for those who are mentally afflicted and are in need of help.”

About 14% of the global burden of disease has been attributed to neuropsychiatric disorders, mostly due to the chronically disabling nature of depression and other common mental disorders, alcohol-use and substance-use disorders, and psychoses.² And, yet, the shame and stigma attached to mental health has pushed it further into the shadows. We need educational campaigns and awareness programmes to mainstream the issue of mental health, to shed light in the darkness, and encourage individuals and families to access help before the loss of a precious life. It is a terrifying fact that suicide is the second leading cause of death in the age group of 10 to 24 years.³ As a society, and even more as a church, we have to pull out all the stops - sensitising the congregation, training pastors, using social media, creating safe havens and shelters for those who are mentally afflicted and are in need of help. We need to grow out of our narrow moralistic approach, and look at the way that the Lord communicated with the woman at the well, and the non-scandalised even tones when he refers to her numerous marriages and her current live-in relationships. There is some speculation whether the Samaritan woman was suffering from a borderline personality disorder.⁴ Be that as it may, the Lord's masterful communication is a great example for us to imitate.

Another distressing aspect of mental health is its criminalisation! David Simpson, a psychiatric patient advocate has written that 70% of youth admitted in the juvenile justice system have a mental health illness. This

is an extremely difficult matter to unravel, as it straddles neurobiology, psychosocial contributors, human rights, matters of law and criminal justice, but this is exactly the time when the church must speak up, and take the lead in galvanising a nation-wide response.

Dr. Tharien makes several strong recommendations for the church, namely, getting right the theology of disease, creating a safety net, and mechanisms for therapy. The last part of his article resonates with the lyrics of a Casting

Crowns' song - “And we are the body of Christ; but if we are the body, why aren't His arms reaching? Why aren't His hands healing?”



Photo: www.pixabay.com

(Dr. Monica Thomas Chandy is a Neurophysician with an interest in mental health.

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² [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(07\)61238-0/fulltext?code=lancet-site](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(07)61238-0/fulltext?code=lancet-site)

³ World Health Organisation, 2 September, 2019. Suicide. <https://www.who.int/news-room/fact-sheets/detail/suicide>

⁴ People with borderline personality disorder may experience mood swings and display uncertainty about how they see themselves and their role in the world. As a result, their interests and values can change quickly.

<https://www.nlm.nih.gov/health/topics/borderline-personality-disorder/index.shtml>

Christian Perspective on Mental Illness

Dr. Sony Lukos

I had just entered my consultation room after lunch when I noticed a familiar face. Sister Georgia* an old staff member at my hospital had been anxiously awaiting my arrival as she had brought a patient. John* had been on treatment at our hospital for the past several years but had stopped treatment 6 months ago when a certain pastor had told him that God would heal him and so he need not depend on medications. John had never been eager to take his medications and so he happily stopped, until his problems began to recur over the past month. He was sleeping less, becoming increasingly violent and abusive towards his wife and had stopped working 10 days ago. John suffers from 'schizophrenia' which is a severe mental illness and requires regular medications. However, the overly zealous and rather uninformed pastor had created a crisis which was avoidable. And John had relapsed to his previous state.

10

Sadly, this is not an isolated incident. It would perhaps be an understatement to say that Christians struggle with understanding how to respond to people with mental health issues. It is definitely a problem we cannot choose to ignore, as the burden of mental illness is only increasing. The situation is further worsened with a poor understanding of the Bible as well as the underlying medical nature of mental illnesses.

Let me make one thing clear at the outset. I'm not saying that God can't heal a person with a mental illness. Neither am I saying that there is absolutely no spiritual cause for mental illnesses. All illnesses, physical and mental, are rooted in Adam's sin. Some illnesses may even be specific to a person's sinful behaviour and perhaps also an attack by an evil spirit. But patients with mental health problems are not dealt with in the same way by many people as they deal with diabetes, hypertension or any other physical illnesses. And there lies my concern.

I sincerely believe that all truth is God's truth. And so there is wisdom in looking outside the Bible for certain matters. That is why every Christian couple desires their



Photo: www.pixabay.com

children to be sent to schools and colleges to teach and equip them to live in this world. Interestingly even the Bible, both in the Old Testament and the New Testament, quotes pagan sources in context to prove a point. So it would do all of us a great deal of good to open our minds to the truths around us. Yes we must test and check the authenticity of any matter. The Bible only encourages that.

So what are mental illnesses? It must be clear to all that good health does not limit itself to the body but also the mind. However, sometimes the mind is not well which is revealed by abnormal thoughts, emotions and behaviours. I'm referring here to a persistent pattern of abnormality and not our day to day fluctuations. This abnormal fluctuation can be compared to a tsunami wave as opposed to the gentle or occasionally rough waves we see normally at the seaside which would be our day to day emotional fluctuations. These

tsunami like changes in the mind do not just affect the particular person but also the people they are in immediate contact with. There are different types of mental illnesses. Among the common mental illnesses are psychotic disorders where there is an abnormality in the mind leading to a disturbance in the person's perception of reality. This can lead to sometimes violent behaviours or in some cases, an excessive fearfulness and withdrawal.

The other common types of mental illness are the disorders that occur in the person's mood state. There can be an abnormal level of sadness accompanied by negative thoughts, lack of energy and disturbed sleep patterns which is referred to as 'Depression'. The opposite of this is the state where the person is overly energetic and confident along with extreme happiness, unrealistic planning and excess activity. This is referred to as 'Mania'. Some people even tend to have both of these conditions occurring at different times. Then there are the illnesses where the person is seen to be excessively worrying, sometimes over trivial matters. Though these persons would be aware of their condition they are often unable to deal with it. To cope with their condition, they depend on substances for relief, gradually becoming dependent and addicted to those harmful substances. The abuse and dependence of various substances and activities are referred to as addictions. The substances can be alcohol, tobacco, glue, sedative tablets, etc. Activities could be gambling, use of social media, pornography use, etc. The preoccupation and concern with the use of these substances or being involved with such activities can be very distressing and limit the person's day to day functioning. Certain people have what is referred to as 'Personality disorders'. This refers to people with extreme patterns of thinking and behaving which makes them inflexible in their interactions with people and maladaptive in their patterns of behaviour.

So why do mental illnesses occur? There are a variety of reasons for this. Sometimes the same illness can be triggered or caused by different reasons in different persons. It can be a combination of various reasons too. They can be broadly explained by the following reasons:

1. Genetic – Several genes have been found to be associated with certain mental illnesses. In fact certain families have multiple generations of people affected by mental illnesses.

2. Biological – It is now commonly understood that certain brain chemicals are abnormally active in the brain which tends to affect the mind of the person. Sometimes these can occur due to the presence of other medical conditions too leading to changes in the brain.
3. Psychological – Stress is becoming an increasingly obvious factor in the development of mental illnesses

with people finding it difficult to cope with the various challenges that they encounter in various spheres of life.

4. Social – The nurturing of a person too plays a very important role in the presence or absence of mental illnesses. Parental conflicts and physical, sexual

or emotional neglect can lead to an increased risk of mental illnesses.

So, what does mental illness have to do with spiritual attacks or demon possession? The answer is that there is not a consistent direct relationship. A careful study of the Bible shows that people from whom demons were cast out did not always exhibit signs of mental illnesses. Some had chiefly physical manifestations like deaf, mute, bent over, seizures, etc. Based on my study of the Bible and medicine I understand the relationship to lie in a spectrum.

1. Mental illness as a disease
2. Mental illness mimicking a demon possession
3. Mental illness as a result of unconfessed sin
4. Mental illness as a spiritual attack.

But I must make a clear exception here. Children of God who are sealed with the spirit of God CANNOT be possessed. They can be spiritually afflicted or oppressed but not possessed. Christians too can have mental illnesses, the same way in which they can also suffer from physical illnesses. Charles Spurgeon, the famous preacher was known to have bouts of depression. He once said, "I think it would have been less painful to have been burned alive at the stake than to have passed through those horrors and depressions of spirit."

Mental illnesses are treatable with different modes of treatment. Many benefit from medications, some may require medication for a short duration while others may require them to be taken for several years. Some may benefit from counselling or what is formally referred to as psychotherapy to help them cope better with various

“Mental illnesses are treatable with different modes of treatment. Many benefit from medications, some may require medication for a short duration while others may require them to be taken for several years.”

FACTS

“Mental illness and disorders are among the leading causes of ill-health and disability worldwide. These include 1210 lakhs with depression, 240 lakhs with schizophrenia and 370 lakhs with dementia.”



Common mental illnesses as listed by National Mental Health Survey 2016:

1. Tobacco addiction - **13.1%**
2. Alcohol addiction - **4.6%**
3. Mental issues due to substance use - **5%**
4. Stress related disorders - **3.5%**
5. Depression - **2.7%**
6. Suicide - **0.9%**
7. Bipolar disorder - **0.3%**
8. Schizophrenia - **0.4%**
9. Any mental illness - **10.6%**
10. Mood disorders (including Depression) - **2.8%**

List of Organisations

ASSAM Sarathi 104, 104, 24x7

CHANDIGARH
Asha Helpline
+91 172 2735436, +91 172 2735446,
Monday to Saturday: 8am to 7pm

CHHATTISGARH
Arogya Seva: Health Care and
Health Counselling Centre, 104, 24x7

DELHI
Sumaitri
+91 011 23389090
Mon-Fri 2pm to 10pm and Sat-Sun 10am & to 10pm

Snehi
+91 011 65978181 Daily: 2pm to 6pm

Sanjeevani
011 24311918, 011 24318883 (Mon-Fri)
26862222, 26864488, 40769002 (Mon-Sat)
Timings: 10 a.m. to 5.30 p.m.

Fortis Stress Helpline
+918376804102, 24x7

Cooj Mental Health Foundation: 098322252525
(3pm to 7pm on Weekdays): +918322252525.

Live Jam
They organise campaigns that aim to kill depression and suicide among urban youth in India with the message of HOPE.
Address: 1, Bhai Vir Singh Marg,
New Delhi – 110001. Mob.: 9821006603
Website - <https://www.livejam.org/>, www.killit.in,
<https://www.iamheretohear.org/>,
Email: contact@livejam.org

GOA
COOJ Mental Health Foundation
+91 8322252525, +91 98225 62522,
Weekdays: 3pm to 7pm

GUJARAT
Saath
+91 79 26305544, +91 79 26300222,
Daily: 1pm to 7pm
Jeevan Aastha helpline, 1800 233 3330, 24x7

JAMMU AND KASHMIR
Kashmir Lifeline, 1800 180 7020
Sunday to Thursday: 10am to 5pm

Srinagar
The Sara
+91-9697-606060, Daily: 10am to 5pm, Jammu Tawi

offering help and their Helpline numbers in different parts of India:

JHARKHAND

Chikitsa Salah: Health Information Helpline
104, 24x7

Jeevan Suicide Prevention Helpline
+91 0657 6453841, +91 0657 6555555
Daily: 10am to 6pm

KARNATAKA

Parivarthan Counseling Helpline Services
+91 7676 602 602
04:00 PM to 10:00 PM | Monday to Friday

Sahai
+91 080 25497777, 9886444075
Monday to Saturday: 10 AM to 8 PM

Sa-Mudra Yuva Helpline
+91 9880396331

Arogya Sahayavani 104

KERALA

Thanal Suicide Prevention centre
+91 0495 2760000, Daily: 10am to 6pm

Kozhikode, Maithri Kochi
+91 484 2540530, Daily: 10am to 7pm
Kochi

Pratheeksha
+91 0484 2448830, Daily: 10am to 6pm
3N Paravur

Prathyasa
+91 480 2820091. Irinjalakuda

Sanjeevani
+91 0471 2533900
Monday to Saturday: 1pm to 5pm

Thiruvananthapuram
Disha, 1056, 24x7

MADHYA PRADESH

Spandan
+91 9630899002, +91 7389366696, 24x7

Sanjivani
1253, +91 0761-2626622

Jeevan Aadhar - Adolescent Helpline
1800-233-1250
Daily: 9am to 5pm (Except National Holidays)

ODISHA

Health Helpline, 104, 24x7

MAHARASHTRA

Hitguj help number, +91 022 24131212

Aasra
022-27546669 or 27546667, 24x7,
Languages - English and Hindi,
Email: aasrahelpline@yahoo.com, Navi Mumbai
Nagpur Suicide Prevention Helpline
8888817666, Nagpur

Connecting...NGO
1800 843 4353 (Toll-Free)/+919922001122
Emails: distressmailsconnecting@gmail.com
Daily: 12 PM to 8 PM
Pune

Vandrevala Foundation for Mental Health
1860 266 2345, 1800 233 3330
Email: help@vandrevalafoundation.com
24x7

Tata Institute of Social Sciences - icall
022 25521111
Monday to Saturday: 8 AM to 10 PM, Mumbai

The Samaritans Mumbai
+91 84229 84528 / +91 84229 84529 /+91 84229 84530
Daily: 3 PM to 9 PM

Maitra Helpline
+91 022 25385447
Monday to Saturday: 9am to 9pm and
Sunday: 9am to 1pm
Thane

Shushrusha Counseling, Guidance and Training Institute
+91 9422627571, +91 8275038382, 24x7, Islampur

PONDICHERRY

Maitreyi
+91 0413 2339999, Daily: 2pm to 8pm

PUNJAB

Medical Consultation – Health
104, 24x7

Hope Helpline for Students
+91 0744 2333666 , +91 0744 2414141
24x7, Kota

RAJASTHAN

Medical Advice and Helpline
104, 24x7

SIKKIM

Suicide Prevention Helpline
221152, 18003453225
24x7
Gangtok

TAMIL NADU

Sneha India Foundation, Chennai
+91 044-24640050 | 24 Hours |
Monday to Sunday +91 044-24640060 |
08:00 AM - 10:00 PM | Monday to Sunday
You can even write to them anonymously at
help@snehaindia.org.
Helpline number is +914424640050.

Jeevan Suicide Prevention Hotline
+91 044 2656 4444
24x7
Chennai

TELANGANA

Roshni Trust
+91 40 6620 2000, +91 40 6620 2001
Monday to Saturday: 11am to 9pm

SECUNDERABAD

One Life
+91 7893078930
24x7

HYDERABAD

Darshika
+91 040 27755506, +91 040 27755505
Secunderabad

**Makro Foundation -
Suicide Prevention Helpdesk**

+91 040 46004600
Monday to Friday: 10:00 am to 7:00 pm
Hyderabad

WEST BENGAL

Lifeline Foundation
+91 033 24637401, +91 033 24637432
Monday to Sunday: 10:00 AM to 06:00 PM
Kolkata

NIBS Helpline

+91 98364 01234, +91 033 2286 5603
Monday to Friday: 6 pm and 10 pm
Kolkata.



My Story: Living with Depression

Ms. Senganglu Thaimai

I am a born again Christian, I serve in a church, and I have suffered depression.

I was often told in my early days that I was a sensitive child who got easily affected by the sight of suffering or pain. Relatives and friends attributed it to my pampered and protective upbringing. During my university education in Delhi, the city offered its glitter as much as its muck - ranging from its dazzling attractiveness to its dingy cold darkness, steep intellectual challenges to dull mediocrity. Each day was a race one ran on the sharp edges for survival and self-respect. It had its moments of unbridled liberty, but abject rejection was never too far away. In this city, I grew from a sensitive child into an adult.

I was introduced to authors and thinkers whose works exploded my mind with stimulating discussions and employed my questioning mind. Along with my academic growth, I was nurtured by the kind mentoring of mature Christians. I sought for a confluence of my intellectual life and my faith. This led me to decide for a career in Delhi University, and I married a young pastor who shared my goal of serving in North India. My testimony thus far was of a young, enthusiastic believer of Christ whose life was relatively sorted, goals set, and on fire for the Kingdom, except that it wasn't going to be any longer.

Three months after my wedding, my 30 year old brother passed away, leaving behind his young widow and a three month old baby. I prayed for strength, and with the confidence that God's will was still the best; I stood by my devastated parents, and my grieving sister-in-law. Little did I realise that by disallowing myself to mourn for my loss, I was letting my foot slip.

Grief came in waves, and deep sorrow became more recurrent. I combatted sadness thinking it was an attack from the enemy, I prayed harder, and read the Bible more. Sometimes there were longer spans of general happiness, disrupted by short periods of despair. I tried to figure out how to avoid these ripples of sorrow, but over time, they became bigger and lasted longer. There were times when I would break down and weep uncontrollably, confused as to why my brother had to go away so early. I talked to myself, consoled myself with encouraging Bible verses, and

reminded myself that God had willed it, and death was just a sleep, only to wake up eternally. These self-consolations became less convincing by the day. Eventually they gave way to an understanding that the reason for his passing was a mystery that would be revealed later, perhaps, when I finally get to heaven. Even at this time, I still put on a brave face, and I continued to attempt to remain "strong" by saying all the right things to myself and to others.

However, my sorrow started to affect me physically. I began to have bad headaches, and I found temporary relief by taking headache pills. I became extremely lethargic and struggled to get up in the morning. Insomnia was the order of my nights, and there were some nights I did not sleep a wink, which made my days difficult and unproductive. This sleep disorder would go on for weeks at a stretch. Still, I was managing relatively alright up to this point, despite bouts of weeping and my constant struggle with low energy.

Meanwhile, at work my two year position as the Head of Department coincided with this phase of my life. Every day was a struggle with mismanaged administration; clash of egos among colleagues, conflict of principles and politics occupied my already fevered mind. There were moments of moral victory over certain issues in difficult departmental meetings that elated me, but crushing defeats closely lurked behind. There were instances of good progress made in bringing justice to the corrupt and unjust practices in the university, but at the end of each day, my life seemed to slowly drain away from me, leaving me empty and hollow. The elevated idea of the University I had in my idealistic youth crumbled and all I saw was a messy heap of pettiness and insecurities among the supposedly high-minded intellectuals. An increasing sense of futility to fight for justice, and the guilt of my inability to perform as I should have, added to the tide of sorrow that was swelling in my head.

While the storm brewed in my mind, and dark clouds churned with personal tragedy at home and utter disappointment in professional space, I finally faced the eye of the hurricane in midst of the community of believers. Church was and still is where I and my husband love to be, and we have never doubted our call to serve God's people. We were sufficiently mentored by wise people early on for

conflict resolution, hostility, and criticisms both serious and trivial within the community. We were armed with numerous trainings on marriage and family life. However, none of them included the alternative circumstance of childlessness.

5 years had passed since we lost our brother, which also meant that we had been married for the same number of years. Light hearted teasing as to when we were giving the “good news” of a new arrival quickly turned to serious concern from everyone around us. We had shared prayer requests in the church and other fellow believers in this regard, and they had prayed earnestly, for which we are still grateful. It intensified as no answer was heard for months, stretching on to a few more years thereafter. Advice of all kinds, suggestions of successful fertility doctors to Christian healers poured in on a daily basis. At this point, allow me to clarify that I do not condemn or hold resentment against them in any way, for I know every single one of them came with good intentions and out of genuine love and concern. There came a time, however, when the flood gates opened, and I was drowning in the violent gush of good intentions. The news of my barren womb spread much beyond the walls of my immediate church, friends and family. I started getting calls and messages from people I had not met or heard from in a long time, recommending healers or sharing what God told them about us. My patience ran out, annoyance progressed to anger as instances of insensitive comments increased and would affect me for days.

16

I started to dread seeing people. The thought of starting a conversation that would eventually take a turn towards the dreaded subject was my biggest fear. I have always loved long stimulating conversations with fellow believers and talk of what God would do in our generation excites me to no end. Coming from a non-Christian background, I genuinely consider the people of God as my own family. However, I was encountering a new season in my life when I felt that I had been defined by a lack, an incomplete state of being. My identity was of a barren woman and nothing more.

I felt utterly exhausted and isolated, but the worst part was that I began to slowly believe what I heard about myself from others. I spiralled down the vortex into a deep abyss of despair and misery. Just getting basic daily chores done was a struggle. Days slipped into nights without having achieved anything, recreations I used to love became a drag, distractions and attempts to escape from misery only weighed down on me and exhausted me further. My personal prayers were long battles, full of bitter complaints, anger, and guilt, mishmashed with wretchedness. Since everything social drained me, I sought comfort in being left alone, not talked to, and not being seen by anyone. The assurance of being God’s precious child with a clear calling both in Christian ministry and at the university grew faint, as my mind was preoccupied with acute sense of emptiness,

anguish and meaninglessness.

I NEEDED HELP!

My husband and my cousin were my biggest support, their unflinching love and patience helped me get by each day. There were times they too felt completely helpless, but they did not give up being by my side, listening to me, and holding me up as I took one step at a time. I took leave from work; risked being misunderstood or judged, left my initial apprehensions, and stepped down from my leadership role in church.

Meanwhile, I saw a Christian professional counsellor. The Pastoral Team in my church supported me without any hue and cry. It has still not really been told to me how all the elements that disturbed me ceased in the church, but the community’s expressions regarding my childlessness were somehow silenced. A few much matured members extended their friendship without me realising that they were actually helping me with careful intentionality. I was too unwell to gather everything that was going on during the time. But looking back, what helped me perhaps was these loved ones valuing me for who I was instead of devaluing me for what I was not. The church surely prayed, but behind the closed doors of their homes. The counsellor taught me meditation of the Word of God all over again. He led me out from the path of guilt of not trying hard enough, towards complete dependence on God’s strength. The road to recovery was slow but praise be to God I got back on my feet.

It’s been more than 5 years that I am back serving in church. I returned to my job with renewed strength and clearer vision, and I have been able to complete my research program as well. One thing depression has given me, above everything else, is empathy and real compassion for people who are suffering. Even as I was recovering, my prayer rose from the deepest recesses of my being that God would lead me to the broken and the wounded, and that He would use my experience to bring healing to them. God has since then heard my humble cry and brought several people into my life, who I have been able to walk alongside through the eye of their storms. I have been actively involved in counselling and mentoring not as a strong, sorted individual, but as a fellow sufferer, a broken jar of clay, from the cracks of which the light of the Lord shines forth.

He stilled the storm to a whisper; the waves of the sea were hushed. They were glad when it grew calm, and He guided them to their desired haven. (Psalm 107: 29-30)

(Ms. Senganglu Thamei teaches in Miranda House, University of Delhi. She can be reached at sengmei64@gmail.com)

Mental Health Among the Poor

Dr. Johann Ebenezer

Jesus Christ's earthly ministry was characterised by three pillars - teaching, preaching and healing. Throughout the gospel accounts he seems to have given equal importance to all three. This is the model he wanted his disciples and the church to follow. The church has at various times in history and in various places excelled in one or more of these areas; and in some wonderful times and places it has excelled in all.

Jesus' ministry of healing, in particular, has been an inspirational focal point for much Christian mission work in India. Mission hospitals started by Christians of various backgrounds exist throughout the country, even in the most remote areas, and have served local populations for decades. One of the areas of healthcare that has, until recently, been neglected even by these hospitals, is mental health. Fortunately, this is now changing, in a big way.

Padhar Hospital is a rural Lutheran mission hospital that has been serving a predominantly tribal area in Betul District of Madhya Pradesh for over 60 years. It is a unit of the Evangelical Lutheran Church in Madhya Pradesh, and has been providing a variety of medical, surgical, pediatric, gynecological, orthopedic and cancer services, as well as numerous community-based initiatives and projects. When the hospital started providing mental health services in 2014, it was the only regular mental health service in a radius of 200 km. In the initial months, most patients who came for a check-up were from urban areas only. Hardly any came from the surrounding nearby tribal villages. This prompted the hospital to take a radically different approach: to take the interventions to the tribal communities and homes. Thus was born 'Project Shifa' - Padhar Hospital's Community Mental Health project.

Rural India's mentally ill live in a strange world of perpetual darkness. People in these communities look at mental illnesses and epilepsy with terror as well as awe - patients are either feared as demon-possessed or are worshipped as gods. Many rites and rituals are performed to exorcise these 'demons' - ranging from local herbal remedies to harsh beatings or branding with hot iron rods, often at great financial cost to the families. Patients and their families are looked down upon by others in the community, and may often be excluded from public functions.



Photo: Dr. Johann Ebenezer

The team of Project Shifa consists of one Psychiatrist, one coordinator, ten community field workers who are recruited by the hospital from the surrounding rural areas, and nursing students from the attached college of nursing at Padhar. The team conducted door-to-door screening using a specially designed screening tool. The team, including the psychiatrist, made regular outreach visits at various village locations and made home visits to those who were too sick. They provided medications to patients in the villages who suffer from severe disorders like schizophrenia, bipolar disorder and epilepsy, while those with common mental disorders like depression or anxiety disorders were referred to the psychiatry OPD at Padhar for interventions including counseling and psychotherapy, as well as medications if required. More recently, the team has also started community-based alcohol detox camps in some villages to deal with addiction. Group counseling sessions were held in various village settings for patients and families with severe illnesses who were receiving regular treatment. More than 540 patients have so far been registered under this project; about 200 received treatment at their homes and about 100 patients who need long term medications are still on regular follow up in the community. About 80% of those with severe mental disorders and epilepsy have improved and started working at home, in the fields or have got jobs elsewhere.

The church's work through the Project Shifa in Padhar Hospital has brought about remarkable healing and change in perceptions regarding mental illness among the rural poor in this part of the country.

(Dr. Johann Ebenezer is a psychiatrist. He worked at Padhar Hospital in Madhya Pradesh from 2014 to 2017. He can be reached at johann.ebenezer@cmcdistedu.org)

Books on our Desk

Troubled Minds: Mental illness and the Church's Mission

by Amy Simpson

Published by Inter-Varsity Press, US, 2013, Pages 222

Ms. Joylin Niruba

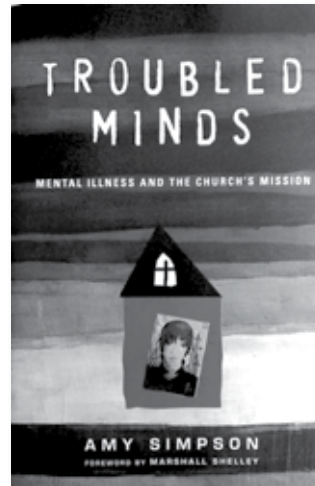
This is a book which touches a less-celebrated topic in the church over the ages. It looks at how the church has responded to the issue of mental illness. Drawing from her personal experience, Amy Simpson takes the reader through the emotional journey of growing up around a schizophrenic mother. She hits the spot on the coldness or oblivious silence of the church in breaking the so called 'church-created' taboos and myths surrounding mental illness. She highlights the biblical mandate of the church to be inclusive and its evident failure to do so. Throughout the book she includes quotes from others who have been affected by mental illness, as well as their families, which adds to the content.

18

The initial chapters of the book show that although mental illness is increasingly common, families with a mentally ill member often experience significant loneliness due to society's fear and the stigma it attaches to mental illness. This chapter also includes an educational section on major mental illness like anxiety disorders, ADHD, ASD, eating disorders, personality disorders, psychotic disorders etc. Those that suffer the most from this illness are the family members. Amy's compassion is contagious as she writes about the ways in which they suffered and the feelings and emotions they experienced, such as shame, confusion, grief and loss, instability and maladjustment, as they navigated through hard and inconspicuous support systems. She also describes the not-so-healthy but inevitable coping mechanisms that sufferers use.

She gives a full, 360 degree analysis of how the church has responded to mental illness. She stresses the fact that to these mentally ill people and their families, the church represents God and when they feel rejected or ignored by the church, they feel rejected or ignored by God himself. In the next chapter, the challenges of ministering to the mentally ill, including inappropriate behaviour, spiritual confusion, family denial, are thoroughly and fairly elaborated. She concludes the chapter by talking about why the church matters in this scenario; it is empowered by the Holy Spirit to pour out love on people especially those who are oppressed and suffering.

Amy also reasons as to why there is persistent stigma around



mental illness, even with modern medicines and successful treatment. She cites adverts, movies, misinformation, and the misinterpretation of the Bible as explanations for the continuing stigma attached to mental illness by society and the church. However, some of these reasons cited may be controversial among the church community itself as it contradicts certain doctrines of some churches.

The last few chapters focus on actions and recommendations on what we can do as a church and as individuals. Citing examples of churches that are doing well in serving the mentally ill and their families, she gives rather simple and practical steps such as starting support groups, creating awareness among other church communities, walking through the journey with those who are broken, and equipping people in the church to specifically meet the needs of those struggling with mental illness in the church.

In conclusion, she navigates the struggles of the church in, as she crisply puts it, "accepting psychosis in a world poisoned by sin and death." She looks forward to the future, to the hope of eternal life, "when we will see each other as God sees us" and, mentally ill or not, we will worship God together. She also reiterates the hope in the "current redemptive work of God and the future and eternal fulfilment of his promise of life without the burden of sin." The book ends with a celebratory note on Redemption!

Although quite a long read with tiresome data on certain aspects, in a nutshell this book is a wakeup call for today's church and a must read especially for Christian leaders and clergy if we are to reach the fullness of the God-given mission of the church.

(Ms. Joylin Niruba works with EFICOR in the Programmes Department.

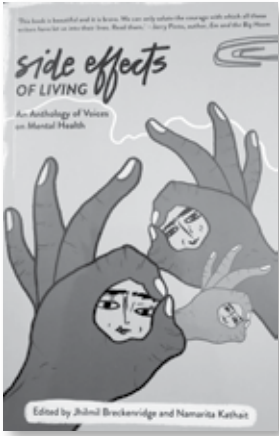
She can be reached at joylin@eficor.org)

Side-effects of Living

By Jhilmil Breckenridge & Namarita Kathiat

Speaking Tiger Publishing Pvt Ltd & Women Unlimited (10 April 2019), Pages 224

Dr. Ashok Chacko



It was wonderful to review this anthology of real stories of people, who are suffering or have faced mental illness in their family situations. It is refreshing to read and understand their struggles which they have openly shared or ventilated. The book brings together first-person life experiences, moving poetry and a bit of art in an attempt to provide a few answers and help destigmatise mental health distress. The key is to realise that no one

is 'normal' - it is a social construct

with cultural indicators. 'To be human is to be open to pain!'

I enjoyed the illustrations by Sonakshi Iyengar titled 'I'm NOT OK' as it graphically described the feelings of a person who is suffering from mental illness. Many of the stories describe emotions and pain of a person experiencing suffering, including the pain inflicted from the family and the feeling of shame from interacting with outsiders. In 'Bipolar Sunshine' the author ends her story with, "I don't expect my condition to ever go away permanently - I am fine with that. I am learning to live with it, manage it and accept that I will always be different. Life ultimately is a gift and I choose to take the good, discard the bad and be thankful for the support structure of immediate family and friends".

Garima Plawat describes her condition in "Monologue"-
'Every day I feel as if I am invited to a luncheon part of anxiety and panic attacks.....The orchestra of my insecurities presents new musical notes of my inner guilt in varying tones of nervousness.'

The time to be human is now. The book is for people who have felt alone, experienced trauma or struggled with a mental illness. It is for caregivers and families, for people left behind when a loved one commits suicide. Read it to change your image of mental health and to help you empathise with the sufferers and the caregivers.

(Dr. Ashok Chacko is Director of the Biblical Counseling Trust of India, based in New Delhi.

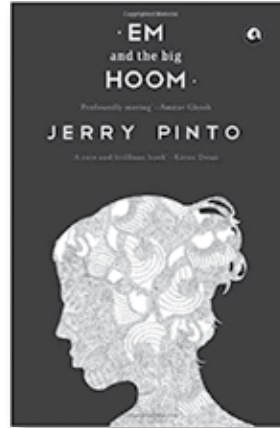
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Em and the Big Hoom

By Jerry Pinto

Aleph Book Co. 2019, Pages 240

Mrs. Joan Lalromawi



This interesting book by Jerry Pinto reveals the story of his family, who lived in a small apartment in Mumbai's Mahim area. The author presents this work in a fascinating, interview-like conversation style, often combined with recollections, anecdotes, short scenes, letters and diary entries of his parents, whom he and his sister, Susan, addressed as Em (the mother) and the Big Hoom (the father). His mother's ancestors migrated from Myanmar to Bengal and then to Goa.

One is intrigued by how the family members, especially his father - the Big Hoom, lovingly took care of their mother, despite her condition. She suffered from a mental illness, known as schizophrenia, bipolar disorder or manic depressive disorder. The family often felt they were on an emotional roller coaster, especially after Em's attempts at committing suicide which would cause them all to rush to Ward 33, Psychiatric ward, at JJ Hospital, Mumbai every now and then. Her manic episodes of schizophrenia and depression manifested itself time and again - with her constant obsession with smoking beedi, her imaginings that someone was wanting to kill her, and living in constant fear. She openly discussed many taboo subjects with her young children which can be noted in their series of conversations mentioned in the book. The author presents this narrative without any hint of uneasiness over his mother's mental illness. He opens our eyes to how family members might experience caring for a loved one with a mental illness. He cited how miserable he felt when other children at his school referred to him as the son of a mad woman. In the last chapters of the book, Pinto wrote about how he experienced grief over the death of his mother, Em.

The narrative creates awareness of the challenges faced by the displaced, the rituals or way of life of the Catholic Goans, of people living in Mumbai and the state of mental institutions in India. The author has truly presented a humane way of dealing with mental illness which is something we can all learn from.

(Mrs. Joan Lalromawi works with EFICOR.

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HEALTHY PRACTICE

A cadre of married women trained in emergency health management in Assam's Dhemaji district brings down morbidity and mortality rate in post-flood situation.

If you go to any flood devastated village in Assam's Dhemaji district, there is a high possibility that you would spot a community health volunteer (CHV) busy preparing people to fight post-disaster health risks. During disasters like a flood, you would find them equipped with medical instruments and medicines, ready to treat immediate health needs. There are 160 CHVs in Sissiborgaon and Jonai Development Blocks of the district rendering preventive and curative health services to 400 flood affected remote villages on a regular basis. To a large extent, their efforts have reduced morbidity rate as well as mortality rate from waterborne and vector borne diseases in the flood stricken villages.



community-based and self-sustaining health volunteers network. This was to make sure that the flood vulnerable and affected people of Brahmaputra river basin have access to emergency health services before, during and post floods. In 2004, the process started with training of 30 Community Health Volunteers (CHVs) from 30 remote villages of Sissiborgaon Development Block of Dhemaji. The CHVs are selected by the community through a village meeting to ensure that they remain accountable to the community on providing services.

The selected volunteers are given intensive in-house training for 15 days by experienced health personnel working on preventive and social health medicine. They are trained on preventive health for a range of water and vector borne diseases, maternal and child health, reproductive health, STI and HIV/AIDS. The CHVs are also trained to check blood pressure, measure temperature and read the pulse. If the CHVs come across any serious patients, they refer them to health centres in RVC premise or to the nearest hospital. On successful completion of the training, the CHVs are provided with a medicine-box containing various kinds of essential medicines for common ailments and manuals explaining key symptoms, preventive and curative measures for each disease.

The medicines are provided as one-time assistance along with a rate chart at which the CHV can provide medicine to the community. Realising the absence of a proper supply chain for essential medicines, RVC has set up a mini-medicine depot in its premise to ensure uninterrupted supply of essential medicines to the CHVs. The CHVs have to keep a record of their medicine stock and update their requirements to RVC staff on a monthly basis. The CHVs are now well-organised and they registered themselves in 2007 as an apex body called Gramya Swasthya Sewa Samiti (GSSS) and in 2008, they registered under the Trust Registration Act. They have been actively functioning and are able to help the communities.

20

DHEMAJI'S HEALTH BURDEN

Dhemaji district is the most flood affected district in the state. Flooding has been a regular occurrence for the last three decades. During floods access to proper health care is a major concern. Even when there is no flooding access to health care has been a pressing concern. An analysis of the health scenario in Assam places it in the 14th rank amongst the 15 low performing states in terms of Human Development Index (HDI). The HDI value for Assam is 0.407 and the same for Dhemaji is 0.277. Further, zeroing on health index indicates that while for entire Assam the figure stands at 0.343, for Dhemaji district it is 0.186. The situation becomes more alarming during floods when the dilapidated surface communication system results in even the barest minimum health services from reaching the people.

An independent study supported by Rural Volunteers Centre (RVC) in the flood plains of Dhemaji found a high rate of morbidity and mortality due to waterborne and vector borne diseases. As per a study, it was found that there were 3422 morbidity cases (jaundice/diarrhea/viral fever/severe cough/skin disease), out of which 80% were children. 28 mortality cases were found in 11 villages of which 18 were children.

THE COMMUNITY CADRE

To ensure achievements of the Millennium Development Goals (No. 4 and 5), RVC initiated the process of setting up

(Adapted from the book 'Turning the Tide: Good Practices in Community Based Disaster Risk Reduction', published by EFICOR and Sphere India, 2010, pp. 88-89)

Conversing with a Care Giver

For centuries, families in different cultures around the world have provided care and support to each other during times of illness, sorrow or grief. The responsibility of caring for mentally afflicted individuals rests on family members who provide the necessary support. Institutional or medical care in hospital settings provides some degree of help but real care-giving has always been done by the family members. Despite the chronic and long-term nature of some mental illnesses, with proper treatment and care they can lead productive lives and contribute to society. Over 80% of people with schizophrenia can be free of relapses after one year of treatment with antipsychotic drugs combined with family intervention. Up to 60% of people with depression can recover with a proper combination of antidepressant drugs and psychotherapy. Up to 70% of people with epilepsy can be seizure free when treated with simple, inexpensive anticonvulsants.¹

It is tragic that some families do not care for, and even may neglect, their own mentally afflicted family members. Societal stigma is one of the biggest social challenges that affects families as they care for patients with mental problems. This article is an effort to highlight the experiences of a strong and loving caregiver who patiently takes care of her husband suffering from a Bipolar Personality Disorder.

1. Can you share about your family? You have been a great support to your husband, please share more about your experiences in caring for him. To what extent is he fully dependent on you and your family members in his day to day life?

My husband and I have been married for more than 30 years. In the initial years of our marriage, he was healthy and led an active, happy life. We have a son and a daughter, and grandchildren now.

As far back as I can recollect, he had been living with his depressive illness for a long time but we were not aware that we needed to go to a doctor for this. I remember the times when he would feel happy and would buy new things for us. On other days, he would have mood swings and sometimes it turned violent. Due to this erratic behaviour, it became a challenge for him to keep friends. His behaviour

pattern became more unpredictable and it was difficult to cope with his demands. Finally, we went to a Psychiatrist who noticed symptoms of depression. We went from one doctor to another for consultation. It was eventually confirmed that he was suffering from severe depression and had a Bipolar Personality Disorder.

We were referred therapies to improve his condition. These have somehow helped improve. But, at present, he is more or less dependent on me even for little things. His expectations are high which makes me feel, 'I can never reach, and I am a failure in my role.' Due to his short term memory, he leaves things just anywhere and everywhere. We need to search for the misplaced item, and till the time it is found, he gets anxious. According to the doctor, we cannot leave him alone nor can he go out alone anywhere due to this.

2. What aspects of caring for your husband have made you happy and satisfied? You may also share some of the challenges that you have faced while caring for him.

I know my marriage is in the plan and purpose of God. It covers everything. In the past few years, my husband never seems to be pleased with what I do for him, in taking care of him. He seems to be lost in his own world - stuck in a bubble most of the time, uninterested in social life nor enjoying the company of his friends. Of late, he said, "thank you" when I served him food. This is a huge milestone for him and I am really thankful to God for opening his mind and heart.

3. How do your other relatives help you in caring for him?

Ours is a big family - his siblings, our children and grandchildren. I used to think that our family members do not seem to understand us. This bothered me a lot earlier. However, some of them are sympathetic, they encouraged and comforted me. I also feel that my efforts in taking care of him are futile at times as there is no acknowledgement of anything that I do for him. Now I have got used to it and carry on - taking care of him. And as I said, he has recently begun saying "thank you" whenever I give him food or help him. This has also motivated me that all the therapies and treatments are worth it, after all.

¹ https://www.who.int/whr/2001/media_centre/press_release/en/

4. What are the attitudes and views of the people around you concerning caring for a person with mental problems?

Many don't know that it is a medical problem which needs special care. Many don't acknowledge that these kinds of problems are medical issues, hence, they do not seek medical help, fearing society. I feel that we should not be scared of what people will say because of our mental condition. I have seen people isolating their mentally afflicted family member whereas there are also those who come forward and seek medical advice or help. I have also taken a few people to doctors upon request and I am glad that I could guide them.

5. What are the attitudes of your church members to you and your family? Do you feel any stigma or social ostracisation? You may also mention any positive support that you receive.

From my church community, there has been no specific support as such, and many are not aware of our problems. There are a few who know about our struggles and they stand with me. I appreciate their emotional support. Even some of them would have noticed the odd behaviour of my husband at times but no one made it an issue. I am thankful that we do not face any kind of social ostracisation by our church community.

6. What are the formal and informal support systems that you rely on to help you deal with your husband's mental health problems?

Since it is a medical issue, we consulted a Psychiatrist, who is very supportive. She prescribes medicines, therapies, etc. My husband is also quite comfortable with the doctor and he always abides by what she says. So taking medicine was never a problem for him.

At times, I reach out to our children for support. They understand him and he too listens to them. That's a big comfort. I enjoy being in the company of people and our network of friends. They come over, they call us up and stay with us sometimes. I am grateful that I have a strong support system, besides the medical treatment plans.

7. What are the other coping mechanisms that you use to deal with such problems? Eg. prayer.

In order not to cause undue stress, I avoid telling him about controversial issues - family, church matters or extended family troubles. I do not make any comment about anyone's negative matters before him. I try not to cross his thinking. At times, I disagree with him silently, and only if I feel like it, do I bring up an issue for him to think over.

I pray and commit our efforts to God. I reach out to the doctor and get advice but I put my trust in God, that He will bless all our efforts, medications and therapies too.

8. What suggestions and advice would you give to families who are going through similar issues to what your family has experienced?

I truly understand those who are undergoing similar problems like us. I would like to remind them that it is a medical issue, so seek medical help. It is important to have a mentor or friend to whom you can confide, without tarnishing the patient's image. Cry out to the Lord in secret. Trust the Lord. He will enable you to float above troubles...

9. Mental illnesses often carry social stigma. What has been your experience and your family members' experience in regard to the stigma associated with mental illness?

In India, the family members of the mentally afflicted persons face a lot of social stigma. This becomes a great problem especially while seeking marriage alliances. People avoid associating or getting marriage alliances with another person just because he/she has a family member who is mentally afflicted. People also wrongfully label those with mental health disorders like bipolar disorders as 'mad,' I know my husband is not 'mad.' Another misconception with bipolar disorder is that people with this disorder are not functional in society - and that they rapidly shift between depressed and manic state. They are quick to understand people and will immediately offer help if they have any issues. They are also genuine people - genuine to the core. Yes is yes and no is no.

10. What recommendations do you have to help the caregivers or family members of persons with mental illness in the community?

People should understand it as a medical problem. Instead of avoiding them, offer friendship and listen to their stories, you will be surprised that you will enjoy their company. To understand the caregiver is important. Giving the patient a change of environment is helpful. Friends and extended family can help depending on the situation. An offer of help to the caregiver by asking him/her to take a break or have some personal time by volunteering your time to care for the mentally afflicted person will do wonders for the caregiver. Play some indoor games with the patient and walk with him regularly. It is my prayer that God will take care of the mentally afflicted and that He will abundantly bless their caregivers.

(These responses have been narrated by a caregiver and compiled by a Psychiatrist and Joan)

Mental Illness and Mental Health

Dr. Starlin Vijay Mythri

Read & Reflect

A Biblical view of suffering is by far the most comprehensive view compared to other worldviews. It doesn't simplistically espouse that illness (in present case, mental illness) is only or always due to sinful behavior or lack of faith. Along with accepting that illness might be sometimes due to personal sin (John 5:1-14), it allows that at other times illness causation is beyond our understanding and has specific divine purposes like reminding us of human frailty and mortality (Luke 13:1-5), and ultimately about God's sovereign plan to glorify Himself (Book of Job and John 9).

Mental illness is a complex state where many things intersect such as - inherited genes, brain dysfunction, personal loss, the feeling of being unwanted, fears, guilt, consequences of personal choice, and sometimes as a result of demonic influence etc.

Severe mental illnesses: Schizophrenia, Bipolar Disorder, Psychotic or biological depression, Dementia, Intellectual disability and Autism. These can be chronic and more disabling than the 'common mental illnesses'. People who suffer, lose their awareness of being ill and live in their illness-constructed dark and fearful world. There is a high chance of genetic deficits or brain dysfunction in this group. Persons with mental illness along with their relatives bear the brunt of the illness. Add to that the specter of societal stigma, which complicates the problem by looking at these victims of the illness and their families either as cursed, unfortunate or sinful.

Common mental illnesses: Depression, Anxiety disorder, Obsessive Compulsive Disorder and Personality disorders. Though these are less severe and more common, they can be disabling too. They interfere with a person's work performance, inter-personal relationships and mental peace. Most of us might go through these states at some point in our life.

The contemporary church, I believe, is ill equipped to delve into the Thesean labyrinth of suffering especially of mental illness. This might be due to the current trend of individualised worship as well as the health and wealth

gospel. Mental illness within the church and in the wider society challenges contemporary Christian understandings of human suffering and its correlates. To care for persons with mental illness we need to look at the following aspects of the Bible -

Sovereignty of God: The benevolent God of the Bible is in control over everything and it is impossible for him to lose control. He works through the evil intentions of those who bother us and turns them around (Genesis 50:20) and he controls and directs people who are over us (Proverbs 21:1).

Human Dependence and Weakness: We have to give up the secular view of wanting to be in control and do away with the terms 'self-confidence' and 'self-reliance'. We are taught to deeply understand ourselves as jars of clay, ordinary and fragile (2 Corinthians 4:7), to jettison an individualist and isolated existence and live as parts of a larger body, the church, reflecting God's truth (1 Timothy 3.15). We are called to accept our weakness, indeed boast of it, like Paul (II Corinthians 11:30; 12:9-10).

Church and the Mentally Ill: Why does God bring persons with mental illness to church? How should we look at intellectually disabled children and adults? How should the church respond if someone or some family in the church faces mental illness? How should the church respond to suicide? These are some questions we as Christians have to answer. Therefore, we are also called to love and care for the mentally afflicted who are in need of care, instead of stigmatizing or labelling them.

The church as both individuals and an organism should reflect honestly about our misconceptions, indifference and superficiality when confronting the complex chasms of mental suffering. Clergy and believers should learn about the Biblical counsel regarding the reasons for suffering and help people within and outside the church to care for persons with mental illness. May the God of healing use us, the church, as his instrument of healing in the lives of people with mental illness!

*(Dr. Starlin Vijay Mythri is a Psychiatrist, living in Hyderabad, Telangana.
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IDEAS FOR ACTION

AS AN INDIVIDUAL

- It is important to understand that mental illness is a complex condition that requires treatment. Stop blaming yourself, your family or others for your condition.
- Educate communities to curb the stigmatisation of mentally affected individuals and their families. Encourage people to stop labelling or judging people with mental illness. Never use names such as mad, retard or dumb to refer to a mentally affected person.
- Don't be hesitant to seek medical treatment. If you know someone has a problem, talk to them and ask them to get help from a mental health professional. Trust your mental health professional and comply with the process of treatment.
- As a mental health professional, ensure quality care and treatment is easily available and accessible to all.
- Give support to families of mentally affected persons. Caring for a mentally affected person can be difficult for the family, often necessitating one family member dropping out of work to provide care. Offering emotional support to the family can be a helpful way to contribute.

AS A CHURCH

- As a church, be open and willing to talk about mental illness. Let your congregation members know that they are welcome to come forward to seek support for any mental health related issues. In cases when people come for help, maintain confidentiality and be supportive to them - counsel them or guide them to get help from organisations or doctors dealing with these issues.
- Encourage members from your church to visit and give emotional support to those who are in distress, in grief or are traumatised.
- Be open to support or even initiating drop-in centres, schools, day-care programmes, and residential homes that benefit those with mental illness. Half-way homes for destitutes or the recovering mentally ill, de-addiction centres, and schools for children with learning disabilities, are difficult to finance and expensive to run. Your church could provide much needed support. You could mobilise other churches to come together and start homes or schools at subsidised rates for the welfare of the mentally affected children in your area.
- The elderly have a high percentage of people with neuro-psychiatric problems. Caring for them at home is extremely difficult for their children, often necessitating one or the other dropping out of work and finding it difficult to make both ends meet. Churches can help by thinking of starting day-care programmes or residential places for the elderly and those with such problems.

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