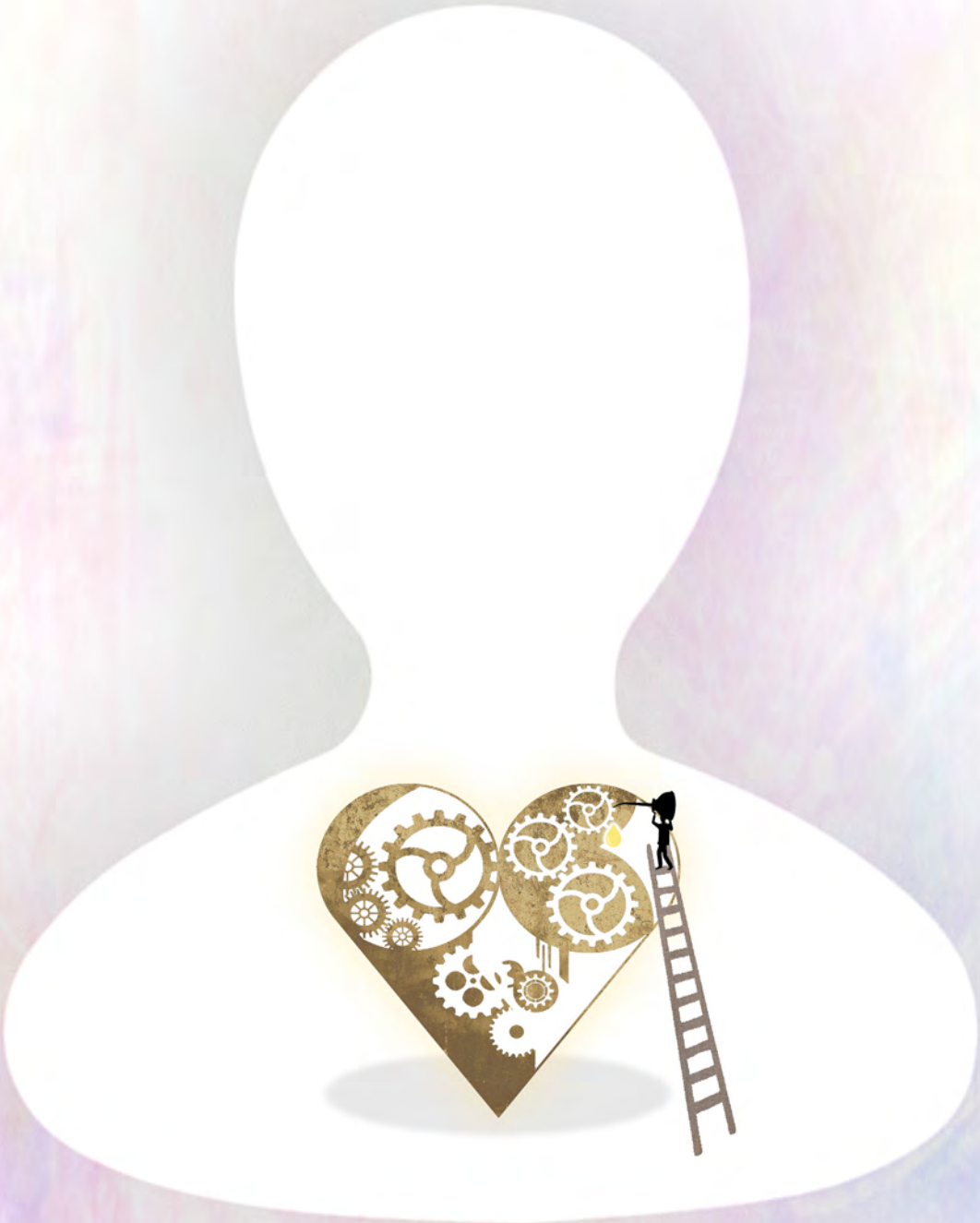
ARE YOU OK?

DISCUSSIONS ON MENTAL HEALTH, TRAUMA, AND FATIGUE IN ASIA



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This web-publication is a complete report of the Asian Cultural Dialogues session, *"Are you okay?": Discussions on Mental Health, Trauma, and Fatigue in Asia* held at the 6th Asia Future Conference on August 28, 2022.

We would like to thank the sponsors for making this roundtable possible.

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The 6th Asia Future Conference
Asian Cultural Dialogues

"Are you okay?": Discussions on Mental Health, Trauma, and Fatigue in Asia

Time August 28, 2022 (Sunday), 9:00-12:30 (Taiwan time)
Venue Online
Host Atsumi International Foundation Sekiguchi Global Research (SGRA)

Program Overview

9:00	Session Overview Dr. Sonja Dale
9:05	Presentation 1: Philippines Ma. Lourdes Rosanna E. de Guzman *Associate Professor, University of the Philippines – Manila and Philippine General Hospital*
9:30	Presentation 2: Indonesia Dr. Hari Setyowibowo *Lecturer, Universitas Padjadjaran*
9:55	Presentation 3: Japan Vickie Skorji *Lifeline Services Director, TELL Japan*
10:20	Q&A
10:30	Coffee Break
11:00	Roudtable Discussion and Comments *Commentators:* Carine Jaquet (Associate Researcher, Research Institute on Contemporary Southeast Asia) Dr. Ranjana Mukhopadhyaya (Professor, University of Delhi) Kritaya Sreesunpagit (Facilitator & trainer in personal transformation)
12:15	Tips for Survival - Meditation Practice led by Kritaya Sreesunpagit
12:30	Closing Remarks

Acknowledgments

The AFC6 Roundtable Organizing Committee would like to express its deepest appreciation to all those who contributed and made this AFC6 Asian Cultural Dialogues session a reality. We would like to especially thank Eiichi Tsunoda for his support and efforts in fostering this network over the years. Without his initiative this dialogue would not exist.

We would also like to acknowledge with much appreciation the presenters - Ma. Lourdes Rosanna E. de Guzman, Dr. Hari Setyowibowo and Vickie Skorji - and the commentators Carine Jaquet, Dr. Ranjana Mukhopadhyaya and Kritaya Sreesunpagit - for sharing their knowledge and valuable time. Thank you also to our SGRA and ACD network for assisting us in finding speakers for this event.

A special thanks also goes to the SGRA and AFC staff for ensuring that the event went smoothly despite the challenges brought about by online event hosting.

Last but not least, many thanks go to the sponsors for the support in making AFC6 a success. This event would not have been possible without the kind support and help of many individuals and organizations. We would like to extend our sincere thanks to all of them.

Purpose of the Roundtable

This is the fourth Asian Cultural Dialogues (formerly known as the Southeast Asia Inter-Cultural/Religious Dialogue) to be held at the Asia Future Conference. The first session was held at the 2016 conference (AFC 3) in Kita Kyushu, in which the impact of globalization on Southeast Asian countries and contemporary religious responses to the issue were discussed. The second session took place in 2018 in Seoul (AFC 4), and the focus was on peace and the role of religion in conflict and crisis resolution in Southeast Asia. The third Southeast Asia Inter-Cultural/Religious Dialogue looked ethical theory borne from religion (Christianity, Islam, Buddhism) and the economy. After three sessions focusing on Southeast Asia, we have decided to expand our lens to look at the wider context of Asia, and to focus on issues other than religion, although religion will continue to be a key part of our discussions. Owing to the turmoil of the past few years brought about by the COVID-19 pandemic, it seemed only fitting to choose this as our theme for the roundtable session this year.

The past two years have been eventful to say the least – a worldwide pandemic that we are still in the midst of natural disasters that have wrecked devastation on local populations, domestic and international conflicts in areas such as Myanmar and the war in Ukraine that have led to the loss of lives and displacement of millions. These events have not only affected the external conditions of how we live, but also permanently affected how we perceive the world and others, as well as left deep emotional imprints.

In this roundtable session we try and take stock of what has happened over the last few years and have a frank discussion about the side we often neglect to discuss – the emotional and individual, internal aspects of these issues. With presentations from Indonesia, the Philippines and Japan, this roundtable seeks to understand how recent events have impacted us mentally and emotionally, as well as the support systems and methods in place for people to cope with the reality we are now faced with. Through this discussion we hope to gain an understanding of some of the struggles that individuals in East and Southeast Asia are grappling with, as well as practical advice for dealing with the difficulties we experience in the new every day.

Presentation 1: Philippines

Reflections on Current Research and Directions for the Future on Youth Mental Health

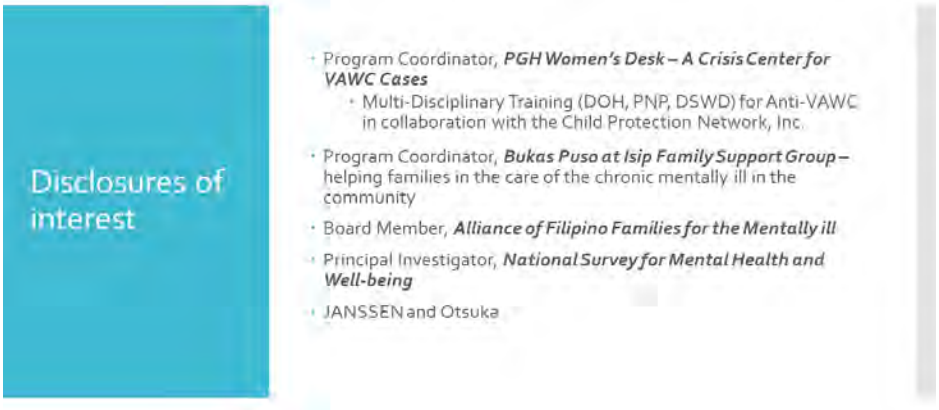
Ma. Lourdes Rosanna E. de Guzman

Abstract

The health sector reform in the Philippines has been accelerated with the passage of the Mental Health Act of 2018 and the Universal Health Care Law of 2019, both of which are landmark legislation bills that seeks to recognize the need for health care services by making it widely accessible, positively responsive and equitably distributed for ALL FILIPINOS. Having just concluded the nationwide survey on the National Survey of Mental Health and Well -being, this will assist policy makers as well as different stakeholders to provide the necessary direction for a resilient, unified and skilled set of individuals and communities. By intervening early with evidence-based universal or targeted programs and fit-for-purpose youth mental health services, we will have the potential to strengthen the mental health of Filipino children and young people considering the novel living conditions the youth find themselves in the aftermath of the COVID -19 pandemic, which continues to linger on.

Good morning, ladies and gentlemen! First of all , I would like to sincerely express my gratitude to the main organizers of this conference, Atsumi International Foundation Sekiguchi Global Research Association (SGRA) and wish them success in their endeavors.

I will start by disclosing any potential conflict of interest.



This year, millions of Filipino children went back to school after 2 years of online learning due to the lockdown. With the goal to "flatten the curve," everyone had to cope with unfamiliar new surroundings. The entire country has slowly started to open up, with standardization of safety and health protocols at all education levels given the introduction of the COVID-19 vaccines. This was necessary to help us get back on our feet and enable the country to recover. The virus, however, remains a threat to our well-being. There is a need to explore ways in which the COVID-19 pandemic might adjust, shape or reorder our lives across multiple dimensions.

In this presentation, I will discuss the following issues:

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- Where we are now?
- Prevalence and Causes: the what, why and how?
- Interventions for youth mental health
- Looking ahead: Future Directions for Youth Mental Health Research
- Moving Forward

The COVID-19 pandemic drastically affected all aspects of society globally from economic and social upheaval, public health dilemmas, food shortage, unemployment, and mental health problems among others. Education has not escaped the damage brought about by COVID-19. Due to the widespread lock-downs and constant shifting and adaptation within the online learning spaces, students and teachers in the health professions face mental health concerns. These concerns include the risk of experiencing violence in abusive homes, unemployment due to enrollment uncertainties, and child labor, restriction of movement, quarantine and lockdowns have disrupted lives of people, Online instruction required adjustments on both students and teachers. The pandemic triggered a wide array of psychological distress to everyone including students. In the health sciences, students and teachers experienced social isolation, and health and well-being vulnerabilities during the pandemic (Rabe et al. 2020).

In the recently concluded Child and Adolescent Survey for Mental Health of 2021, the impact of COVID-19 was also looked at. A total of 4,275 children and adolescents were interviewed from 6 regions, representative of the entire Philippines. The disorders that were most common and had the greatest impact on children and adolescents were assessed.

These were:

- Attention-Deficit/Hyperactivity Disorder (ADHD)
- Conduct disorder.
- Major depressive disorder
- Suicidality
- Generalized anxiety disorder

In the last two and a half years, both the Guidance Counseling Program of

the Office of Student Affairs (OSA) and the Department of Psychiatry of the Philippine General Hospital experienced an 80 per cent increase in the number of student referrals for psychosocial support, from 183 pre-pandemic to 953 from the entire UP System all over the country. During the period of the 2021-2022 academic year, a total of 953 students were evaluated by the Health Service, 8.7% of whom were assessed to have mild to severe depression.

The mental health of students is one of the primary concerns of the University of the Philippines Manila. To address this, the university created the Psychosocial Wellness Network (PSWN), a collaborative work between Office of Student Affairs and the different colleges. Its aim was to work collectively to foster a healthy campus climate through the implementation of strategic programs. All students were required to have an annual physical examination and mental health evaluation prior to the start of face-to-face classes. A mobile app, LiftUP, was created to offer online counseling. An online mental health survey, spearheaded by the guidance counseling program of OSA, assessed the emotional state and resiliency of our students. Also, an algorithm was developed to improve and streamline the process of referring students in distress. Mentoring programs and academic support were provided by all colleges. Webinars promoting mental health activities, self-care practices and work life balance were provided. Wellness checks of students were done regularly. Despite these initiatives, mental health concerns were still increasing. Cognizant of the increasing mental health problems of the students, the University of the Philippines System required all of its constituents to create their respective Subcommittees on Students in Distress. By intervening early with evidence-based universal or targeted programs and fit-for-purpose youth mental health services, we have the potential to strengthen the mental health of our children and young people (Dodge, 2020; Malla et al., 2016) and reduce the number of young people who go on to having mental health problems in adulthood.

Strengths and Opportunies

Let us take advantage of the strengths and opportunities that we have today.

Strong families make healthy minds. According to the Filipino family core values, “When you are a parent you will only have once chance – and only one chance – to raise your children right,” and “your children will learn these things through word, example, and practice.” These core family values include:

- Family orientation. The basic and most important unit of a Filipino’s life is the family.
- Joy and humor.
- Flexibility, adaptability, and creativity.
- Religious adherence.
- Ability to survive.
- Hard work and industriousness.
- Hospitality

Another strength and opportunity that we have is the new Mental Health Act. With the new Mental Health Act and other initiatives, public and private, ongoing to address the mental health crisis particularly among Filipino youths, there are various ways individuals, and their support groups can work to deal with anxiety and stress even before they seek psychiatric help.

The Universal Health Care Law of 2019 is another strength and opportunity. This landmark piece of legislation seeks to revitalize health care through a whole-of-system, whole-of-government, whole-of-society, people-centered approach that puts primary health care center stage through reforms aimed to improve health system performance.

Mental health and Wellness for every Filipino everywhere is another one of our strengths. With the advent of technology, help has become more accessible than before. One effective alternative to conventional mental care is called TeleMental Health, also referred to as E-health or Telemedicine which is online therapy: the usage of technology and the internet as a means to provide psychological counseling and support, usually via e-mails, video conferences, online chat, or phone calls. The Telemental Health service uses online videoconferencing technology for delivering treatment and therapy to our patients and members over distances – conveniently and securely.

There is a myriad of free mental health apps easily available to smartphone users that can be downloaded in a matter of minutes. These apps could address certain mental health issues or even help manage stress levels in our daily lives:

Talkspace: Counseling Therapy - Among the leading online therapy apps, Talkspace connects you with a licensed mental health professional so you can receive therapy from your digital devices.

Happify - A fun self-guided app that uses science-based games and activities to help reduce stress, build resilience, and overcome negative thoughts.

Depression CBT Self-Help Guide - An app made to counter depression aimed at educating users on depression and strategies for managing symptoms.

Headspace – an app to counter depression aimed at educating users on depression and strategies for managing symptoms. If anxiety, stress, or depression you are expecting begins to take over and affect your personal or professional life, or your sleep or appetite, one may need to seek professional help.

Sanvello - The app, formerly called Pacifica, offers clinically validated techniques and support to help you relieve symptoms. It is believed to be the best for relieving stress. Sanvello teaches mindfulness skills and provides mood and health tracking tools that can be used to improve mental and physical health.

Mood Mission - As its name suggests, it is a 'mission' based app that improves mood and coping skills.

Established by Buddhist monk Andy Puddicombe, this app particularly specializes in meditation and mindfulness. Some of the things that can be learned through Headspace are mindfulness and cognitive diffusion, breathing exercises, meditation practice, tips for increased relaxation, and concentration.

Moodfit - A tools and insights app designed to "help you feel better." It supplies daily goals to improve your mood fitness, and has actionable data for you to determine what brings you up or down.

Prevalence and causes: the what, why and how?

"We need to understand the causes to inform prevention" (Gunnell et al, 2018)

The nature vs nurture debate on the determinants of mental illness continues. While nature or genetics, has been proven to be an important contributing factor in the development of some mental health conditions, such as schizophrenia and bipolar disorder and major depression, the development of mental illness is not purely genetic. Nurture is most commonly defined as environment, culture and experience.

For young people, there are clear risk factors, but also protective strategies that can prevent the youth from developing mental health problems. Predictors of mental distress include:

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- Cyber-aggression
- Loneliness and assessment stress
- Alcohol and drug misuse
- Financial distress
- Lack of enjoyment with the academic course
- Conflict with friends
- Other individual factors influenced by childhood and the surrounding environment: poverty and socio-economic in equalities, physical abuse and emotional neglect are predictive of mental disorders.

The content of a student's worries and anxieties may vary depending on their year of study (Macaskill, 2018) and it can be challenging to uncover whether academic dissatisfaction is the cause of their mental health problems, or whether it is an effect (Lipson & Eisenberg, 2018).

On the other hand, there are protective factors. University education can play a positive role, and students' educational engagement was found to be associated with a shorter duration of untreated psychosis, better adherence to medications for early treatment, immediate recovery, and with maintenance treatment there are fewer injuries to the brain. A common theme throughout all these studies was the importance of social connectedness and its protective mechanism against loneliness and mental distress. However, social support should not replace other therapeutic interventions but opportunities to establish strong social bonds may particularly benefit first year students adjusting to university life .

Overall, maximizing the potential for positive familial relationships and supporting vulnerable youth requires a multi-agency approach, whole society approach, with research collaborations across sectors.

Intervention options

Many interventions have been utilized to promote student mental health. Creative and innovative interventions are welcome. It would also be good to incorporate the voice of the service user, involving young people, and qualitative studies across different cultural settings are an essential part of the research process.

Below are some of the interventions that we have observed:

- Physical activities: sports, an exercise program, dance or any team sport; canine therapy
- Promotion of cultural activities: reading club, visits to historical sites, promoting local tourism
- Structured peer support
- Service accessibility (e.g. appointment schedules, feeling listened too, structured sessions are useful)
- Teacher training skills to provide emotional support as many do not feel equipped to deal with youth mental health problems.
- At an institutional level, the university may wish to consider introducing services and courses that increase self-efficacy and motivation in students with mental health problems, encouraging faculty members to display a more regular, active interest in their student's progress.
- Most cost-effective treatments, funding can support the fair financing of services and how best to measure clinical outcomes for monitoring treatment response.

Looking ahead: Future directions for youth mental health research.

There is no one-size-fits all solution to tackling the mental health crisis, fatigue and trauma. But, something can always be done.

Prevention and early intervention may be popular buzz-words in mental health but the potential benefits are emerging, as we can see below:

1) By creating youth-focused, integrated services and adopting a whole-school, whole-community, approach to mental health that equips young people with the tools and resources to manage their mental health, the mental health of populations worldwide can only improve

2) An evidence base of universal interventions in the classroom is developing as is our understanding of which skills may enhance psychological well-being. For example, positive mental health is predicted to increase if young people can develop positive psychological strengths, such as hope, efficacy and optimism, and the capacity for self-compassion has positive implications for help-seeking behaviors, as well as mental health and connectedness to others.

3) Mental health literacy is also important for reducing stigmatizing and misinformed views among the public and professionals alike, and integrating lessons about mental health as part of the school set has showed great promise.

4) Finally, teaching practical life skills in adolescence (e.g., managing independence, building new social networks, protecting oneself against crime) are low-cost strategies that may help adjust to adult life post-secondary education, enabling them to flourish.

What needs to be done?

Whatever the intervention, researchers can gain a lot from:

1) Actively seeking out the youth voice and understanding their lived experience from qualitative interviews that explore topics such as the clinical or educational experience in greater depth to novels and books narrating the realities of mental distress.

2) Young people should be supported in moving from “characters” in research to “authors” who are actively involved in shaping research questions, study design, its delivery and impact. Notably, when drawing conclusions from the data, it remains important to keep in mind individual variation in treatment preference, and the vast heterogeneity which may exist within populations of similar age groups.

3) Any such research collaborations, and youth mental health services or programs more generally, should be actively promoted in local communities to increase awareness, as a step towards normalizing mental health in the community, reducing stigma, and reducing barriers to help-seeking behaviors.

4) At the National Institute for Health Research (NIHR) Maudsley Biomedical Research Centre (BRC) in London, our strategy for service user and carer involvement is anything but tokenistic (NIHR Maudsley BRC, 2020). We have several advisory groups, including one for 16 – 25-year-olds, and each member is encouraged to participate across the research cycle: from shaping research design, to overseeing projects and dissemination of findings. By drawing on insight from lived experience, and commenting on the lay friendliness of documents, researchers can truly benefit from research co-production.

Moving Forward: NSMHW Prevalence Study

Mental illness is the second largest contributor to years lost due to disability in the Asia-Pacific Region. Nowhere do more than half of those affected receive any medical treatment.

This is the first ever national survey on mental health. The survey provides information on the prevalence of the MNS Disorders (e.g. Schizophrenia; Anxiety Disorders; Affective Disorders, both Depression and Bipolar Disorders; and Alcohol and Substance Use Disorders) and for children and adolescents population (e.g. which will also include Conduct Disorder).

The main objective of the study is to establish the lifetime and 12-month prevalence of select mental disorders and neurological disorders in the Filipino adult, child and adolescent resident population at both the national and regional levels.

The framework that we use is a public mental health one, and public mental health is all about promoting and protecting the mental health and well-being of the population.

A Public Mental Health framework is definitely population-based, because it:

- Emphasizes COLLECTIVE RESPONSIBILITY
- Recognizes KEY ROLE OF THE GOVERNMENT

- Necessitates PARTNERSHIPS among the different stakeholders – public and private; institutions and organizations; communities, families and individuals

The WHO established the World Mental Health (WMH) Survey Initiative to help governments throughout the world and to provide the necessary information on prevalence, treatment, and correlates to help government policy planners address the disparity between need for and use of mental health services. This was recently concluded, and we were able to cover all the regions in the Philippines.

For children, we used the Strengths and Difficulties Questionnaire (SDQ) in order to identify common behavioral problems in children. This survey can be used by the teacher, by parents, or by the child, and has been translated into the Filipino language.

The Mini-International Neuropsychiatric Interview for Children and Adolescents (MINI Kid) developed by Dr. Sheehan helps us to screen out and differentiate the common mental health issues in children. This survey helps us answer the following questions:

- How many children and adolescents have mental problems and neurological disorders?
- What is the nature and impact of these mental health problems and neurological disorders among children and adolescents?
- How many children and adolescents have used services for mental health problems and neurological disorders?
- What is the role of the education sector in providing services for children and adolescents with mental health problems and neurological disorders?

We would like to implement the WHO World Mental Health International College Student (WMH-ICS) Initiative, which is an international collaboration in the area of student mental health in higher education. The initiative conducts

needs assessment surveys, designed to generate accurate data on mental, substance, and behavioral disorders among students, to be used by colleges and universities in optimizing their mental health services. Some colleges in the initiative are doing experiments with interventions but these are currently conducted separately by members and are not centrally coordinated. On joining the consortium, members have access to the WMH-ICS survey instrument, which is a standardized instrument used across international sites, with minor cultural adaptations allowed. The surveys use validated screening measures to generate estimates of the presence of a wide range of mental disorders thought to be common among college students e.g. Major Depressive Episode, Generalized Anxiety Disorder, Panic Disorder, Bipolar Disorder, adult ADHD, substance abuse and dependence, and suicidal thoughts and behaviors. Members will have access to the scoring algorithms and will receive a dataset with frequency distribution for diagnoses for their own national reporting. The use of a standardized survey allows pooling of data to create a cross-national dataset and publication of papers based on this. This requires that the facilitator of each country (see below) signs a data-use agreement with Harvard Medical School, which is the data coordinating center. There is a cost to the use of this instrument.

We would also like to propose the implementation of Wellness and Resilience for College and Beyond. “Wellness and Resilience for College and Beyond” is a 3-credit undergraduate course originally developed at the University of Washington (UW) by Dr. James Mazza as well as by Dr. Carla Chugani. The course will help them to cope with the normal stress of college life as well as provide interventions for those developing mental health problems. The Wellness course teaches students evidence-based skills derived from psychotherapeutic practices including Dialectical Behavior Therapy, Cognitive Therapy, Acceptance and Commitment Therapy, and the field of Positive Psychology. It is a universally delivered psychoeducation designed to address the most pressing mental health problems facing college students today.

Summary

“The youth are the most vulnerable to mental illness because of the pressure and the changing times.”

In summary, I have discussed the strengths and opportunities in our country, we’ve identified the risk factors and protective factors which are important for us, as well as looked at the intervention options – structured peer support, teacher training skills, courses and services on wellness and resiliency, and fair-financing services. Right now the government is offering financial aids for students. The future directions that we want to look at are creation of youth-focused integrated services; evidence-based universal interventions, mental health literacy, and teaching practical life skills. Moving forward, other than presenting the NSMHW Prevalence Study, we want to embark on the WHO World Mental Health International College Student (WMH-ICS) Initiative and maybe introduce the Wellness and Resiliency for College and Beyond.

Presentation 2: Indonesia

Learning from Adversity: A Story from Indonesia

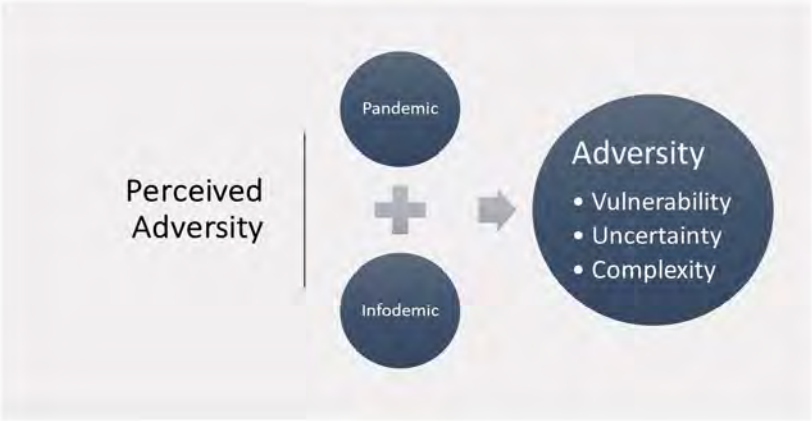
Dr. Hari Setyowibowo

Abstract

The COVID-19 pandemic has created concerns about the mental health of Indonesian people. Some mental health problems are reported in Indonesia, ranging from anxiety to suicide intention. This presentation will reveal the adversity we have been facing, such as economic hardship due to the pandemic, health problems, and disruption in our daily life. Despite struggling with this situation, Indonesian people also have meaningful learning experiences. Several reports from our research network found that the pandemic accelerated the capacity and willingness to learn at every level in Indonesian populations: intrapersonal, interpersonal, organization, community, and policy.

This morning I would like to share some experiences from Indonesia. As you know, Indonesia is a land of beautiful islands, with over two hundred and seventy million people, a thousand tribes, and unique languages.

My presentation consists of three parts. The first is the adversity during the COVID-19 pandemic in Indonesia and the mental health concerns due to the COVID-19 crisis. I will share some stories based on our working group discussions, summarising some of our findings. I will also recommend a framework to be discussed and explored in this presentation.



The first topic concerns perceived adversity. COVID-19 has impacted countries worldwide and affected many changes in our lives. The focus group discussion in our working group classified three hardships often found in most Indonesians due to COVID-19: vulnerability, uncertainty, and complexity.

First vulnerability. As you know, COVID-19 cases rapidly escalated and resulted in many deaths. This condition worsened because of limited access to healthcare facilities, especially in the first year or month of COVID-19. The vulnerability during COVID-19 also extends to socioeconomic impact, so it regards health and the economy. To mitigate the spread of the virus, the Indonesian government has taken many measures to prevent and control the pandemic. These policies restrict the activities of citizens in specified areas with suspected infection or contamination to avoid spreading. The consequences of this policy have led many Indonesian people to experience vulnerability due to financial insecurities. In particular, people who have an unstable job situation or do not receive a regular income, such as those working in the informal sector, experienced this. Vulnerability is not only about how you feel but also about financial difficulty.

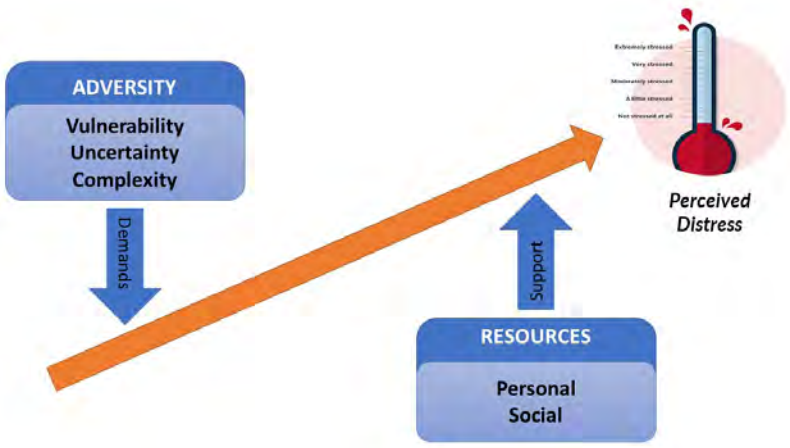
The second adversity is uncertainty. People have started asking many questions during the pandemic, such as “Should I return to work at the office?”, “Should I visit relatives?”, “Which businesses should open?”, “When can I go to school again?”, “what if the situation worsens?” “what’s going on with my career?” and so on. The primary question is, “When is this over?.” Those questions are like a sum equation that leads to uncertainty, and this question increases anxiety and confusion. Many Indonesian people try to find more information to cope with this uncertainty, primarily via social media. Finally, they find the news, but lacking digital literacy, they have difficulty filtering it. Soon some people need help filtering what a hoax is and what is factual information. And accurate information can also be confusing and overwhelming. People who seek information to cope with uncertainty also encounter another problem. They are overwhelmed by the news. People who have inadequate financial resources will perceive a higher level of stress. For example, Indonesian people who have unstable job positions, receive unpredictable income, or experience a loss of household income are vulnerable to feeling more anxious due to the uncertainty of the pandemic.

The third issue is complexity. The policies restrict activities, and based on this policy, people must work and learn from home. For most Indonesians, the situation leads to complexity due to increased role demands. For example, Indonesian women have more burdens. Mothers in Indonesia must take on the responsibilities of child-rearing and children’s school activities, handling home learning, and caring for the family. During the pandemic, some people feel their lives are more complex due to increased role demands.

Our discussion in the research working group recommends this simple framework to recognize perceived adversity and psychological distress. As we know, demand and support influence psychological distress. The pain level will increase if you face many demands with little help. On the other hand, the more support you have will decrease the level of distress. In this framework, adversity consists of vulnerability, uncertainty, and complexity experienced by an individual as a

demand. Personal resources and social resources serve as a form of support. Individual resources include, for example, positive coping behavior and skills to solve the problem, such as a woman trying to learn cooking or other practical skills for cooking and parenting. Social resources could be close-knit family, friends, and communities.

Regarding the mental health issue during the pandemic, our colleagues at the Faculty of Psychology Universitas Padjadjaran conducted an online survey involving 3686 participants from 34 provinces in Indonesia. This survey revealed that most participants perceived COVID-19 as dangerous and felt anxious about the spread of COVID-19 in Indonesia. As many as 23% of participants felt the psychological stress condition in this pandemic. The increase in mental health concerns has been worsened by the lengthy waits for professional mental health care access due to the limited spread of mental health practitioners in Indonesia, especially in areas outside Java island.



Despite struggling with the situation, many in Indonesia have also managed to have meaningful learning experiences. A report from our research network found that the pandemic accelerated the capacity and willingness to learn.

Firstly, the hybrid learning model in the education field. For example, in our university, we employ the hybrid learning model, with students who attend class in person and those who join virtually from home. COVID-19 not only gave us adversities but also opportunities, especially to learn. The pandemic helped us with this new learning model and accelerated its development. These changes happened not only in education but also in business. Companies are developing a digital business model to keep their business afloat. Given the difficulty of conducting sales in person, this model has become increasingly popular. Last but not least, online psychological services have also been expanding. Psychologists have offered online services to individuals experiencing psychological problems during the pandemic.

Like the Philippines, the Indonesian government launched an online counseling service during the pandemic to maintain psychological well-being. This

program involves 522 psychologists in 34 provinces throughout Indonesia to provide a free online counseling service. Given the difficulties in accessing mental health professionals, this service has proved very helpful. In addition to this online service, HIMPSI, the Indonesian psychological association, also provides a free hotline service in every province for anyone who wants to consult by phone with a psychologist in the area they live. The development of these services has accelerated and grown during the pandemic.

I will close my presentation with a story from my client. He is a CEO and co-founder of a small business enterprise. His business focuses on providing travel essentials and has many offline stores. During COVID-19, he has experienced difficulties such as financial vulnerability, especially in the first three months of the pandemic. He needs to keep his business growing despite low demand in the market, as well as thinking about his employees.

At the beginning of the pandemic, he kept on thinking about when it would end while having to provide for his family as a father. He strengthened his coping behavior by practicing self-help through his religious beliefs and personal affirmations geared towards transformation. This self-help practice aligns with the previous presentation, which stated that self-help intervention is helpful. He also tried to develop his social support through his family and actively got his team at work to cooperate and work together. He realized that social support is beneficial in coping with adversity, mainly through developing support networks with significant others. My client ensured he maintained a good relationship with his family and colleagues. He also decided to seek professional help to help develop his company. His expertise in making waterproof items grew into a new business plan for producing personal protective equipment that became high in demand. He received help from team development, and they worked together to create a product that would fit the current market. COVID-19 led to revenue profits – his business multiplied and had the highest revenue compared to previous years.

In the first three months of the pandemic, he experienced financial problems, but his business grew in the end. Working on himself and his team has allowed him to achieve economic growth and personal transformation.

Based on this story, mental health is essential. Dealing with personal problems and social support are crucial in dealing with difficulties. Based on the story above, we can see that COVID-19 creates both adversities and opportunities. It can also lead to growth and new learning experiences.

Presentation 3: Japan

COVID 19 Mental Health Disparities: Pursuing Equality in Japan

Vickie Skorji

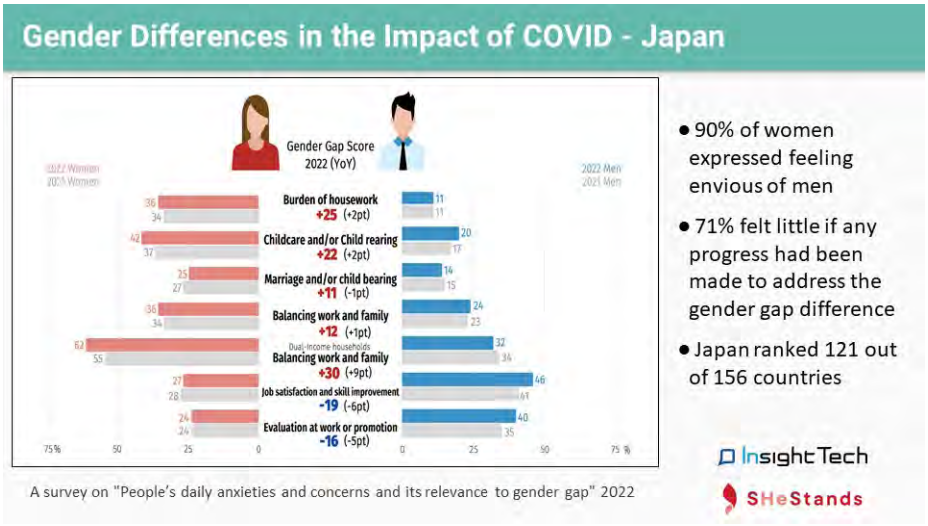
Abstract

Regardless of our country or region, issues related to mental health have been significantly impacted by the events of the past few years. Earlier this year, the World Health Organisation reported a 25% increase in the incidence of anxiety and depression globally as a result of the pandemic and went on to state this was the tip of the iceberg and a wake-up call for all countries to better pay attention to mental health. Here in Japan, we have seen an in crease in suicide rates for the first time in ten years, with over 40,000 lives lost to suicide in 2020 and 2021, far exceeding the lives lost to COVID. In particularly amongst youths and women. The pandemic has highlighted gaps in care and supports for people's needs, specific challenges youths and women face, and the ongoing stigma surrounding mental health here in Japan. As we look forward, investing in mental health and building resilience for all members of our society will be key to Japan's future success.

Thank you for inviting me to talk at this conference today. I'll start off by telling you about TELL. TELL is a mental health organization that will have been around for 50 years as of 2023. We provide a crisis lifeline and we're a member of the Japanese lifeline here in Japan. We also provide professional face-to-face counselling and we do a lot of outreach programs. In this presentation, I will tell you about what has been going on in Japan, as well as touch on some of the points that some of the other presenters have talked about, as well as discuss it in relation to some of the work that we have been doing for quite some time regarding trauma-informed care and psychological first-aid.

As everyone has been saying, the impact of COVID-19 is something we have all experienced. The World Health Organization has said that in the first year of the pandemic, there was a 25% an increase in mental health conditions, particularly depression and anxiety. We know that that is a similar figure to what happens in disasters, so looking at what happens in disasters and knowing what populations are going to be at risk and providing them with support is going to be really critical. The other thing that we do know is that when we have a disaster, the longer that we are in a disaster the likelihood of more mental health conditions. And that is something we have been seeing throughout this pandem-

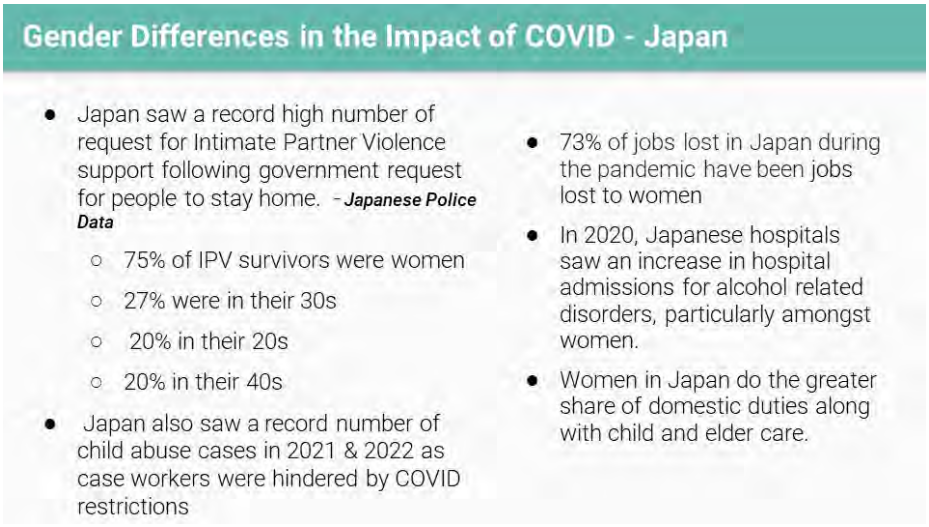
ic. The other thing that happens in any disaster is that we have to make changes. The way that we used to do things stops instantly and we don't really have any control over it. That adjustment period that some of the presenters have been talking about is those initial stressors that we are all experiencing. Here in Japan, like some of the other countries in Asia, the populations really experiencing that distress were youth, women, those with part-time or low income and unstable work, those who work in the health industry, and as we learn more about it, those who have long-term COVID. I will talk about this in more detail.



The above references a survey done by a group here in Japan, SheStands and Insight Tech. They surveyed around 4000 Japanese women and men in 2022 and 2021. You can see the differences across genders in how they were experiencing some of the stressors during the pandemic. What I think is interesting here is that 90% of the women in Japan were saying that they are envious of men, and the reason that they felt envious was because men had more choices and options for how they could approach things in Japan than what the women had. 71% of women felt that very little progress had been made to address that gender gap. It should be noted that Japan ranked 121 out of a 156 countries in the Global Gender Gap. When you look at this survey you can see that women are experiencing the greater burden of looking after their children and household responsibilities and balancing work and family. This is despite many people working from home. Even in 2022, a couple of years after the pandemic started, the women are still feeling significantly more burden than what the men are, and that has been causing them a lot of stress and anxiety.

Looking at this in more detail, we know that during this period we had huge numbers of domestic violence, or intimate partner violence, that was going on. While this may have been across both genders, we know that primarily this is going to affect more women. The research that we have so far shows that 75% of survivors were women, and the largest majority were in their 30s, with 20% in their 20s and 40s. During this time we have also had record numbers of child abuse cases, we don't even know what some of them were because our ability to go in and assess families that were struggling was hindered by some of the restrictions that were in place during the COVID pandemic. We also know that

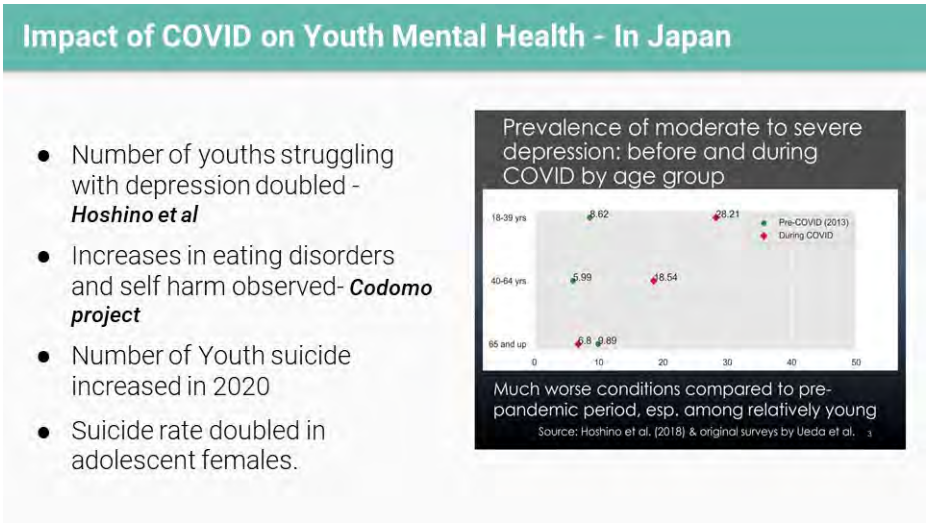
when it comes to part-time workers or those working in the hospitality and tourism sectors, most of the people are women or younger workers, such as those studying at a university level. The people who lost their jobs in Japan initially were women in those industries. They were feeling that impact, in particular single families where the mother was looking after the children. They were really feeling that impact. We also know that many of the people working in the hospital industry and teaching industry are women, so many of the nurses in the healthcare industry were really feeling that burden. Despite all this, the women were doing the lion's share of looking after the children and elder care.



When we look at youth, I'm looking here first at the global impact. The UNICEF study looked at huge numbers of young people and found that a lot of them were feeling really anxious and depressed. This was in 2021. And that they were finding similarly that the women were feeling greater pessimism, or less optimism for the future, compared to men. So even though Japan was feeling this huge weight within the women it's happening globally as well. What was more interesting was that even if people did have a mental health condition, and this was the case in the SheStands survey as well as the UNICEF survey, people weren't really willing to go out and ask for support. That's concerning.

Next I will discuss some research and surveys conducted in Japan. The number of youths struggling with depression doubled. It was 6.8% pre-COVID, and during COVID it has gone up to around 30%. While it did increase in other age populations, it was significantly greater within the younger population. We also saw that there was an increase in eating disorders and self-harm, and we've also had a huge increase in youth suicide. I'm going to talk about the suicide rates in a little bit more detail in a minute. In particular, we saw the rate of young females who took their lives double. Clearly both globally and here in Japan, young people were feeling the strain of the pandemic. Many of them were feeling that they had lost those opportunities of having the experience of going to university. Many of the international students that we spoke to felt that they were struggling with going home and not having support, not understanding what was going in the country, and feeling a huge stress and pressure about what was going on. This was happening across all young people, not just university students,

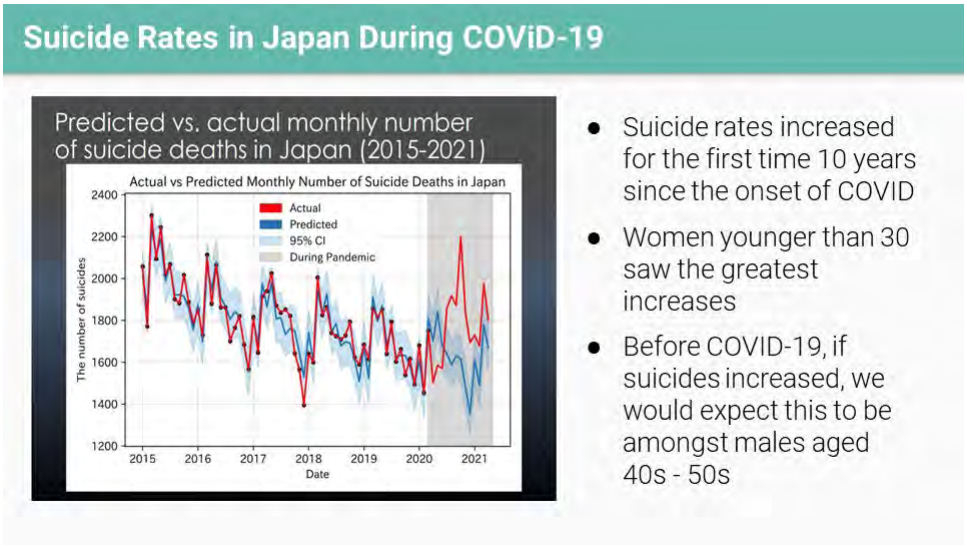
although they were experiencing it significantly.



The other thing going on in Japan was that the health workers were really experiencing a lot of distress and pressure. Many of them were being ostracized and harassed because people were worried that they might have gotten COVID-19 and would pass it on to them. So here you have these nurses and care workers, often on the frontline, and their children weren't being allowed to go into daycare centers or schools. They were not getting the support they needed. They were on the frontline, yet receiving this pressure from the community, instead of getting the support that maybe they did in other countries. They were also feeling a huge demand on their work, while feeling scared that they were going to get COVID as well. They worried about what would that do to their children and the people they were caring for. As I mentioned in the beginning, when we think about the research that comes from psychological first aid, we know that in the initial stage we may come together and try to look for solutions, and then you will see the stress and the pressure and the ongoing impact from the disaster, not just from the mental health aspect. Many of us are going to get burnt out, and that's what we are seeing. When we look at those in the healthcare industry, many of them are saying, "I don't want to be in this anymore." We're seeing that in workplaces and in many industries, people are saying, "No I don't want to go back into the office. I don't want to work this way. I feel I've had enough. I can't take this anymore." That burnout, that ongoing pressure from the last few years, is also something that, from a mental health perspective, we need to look at further.

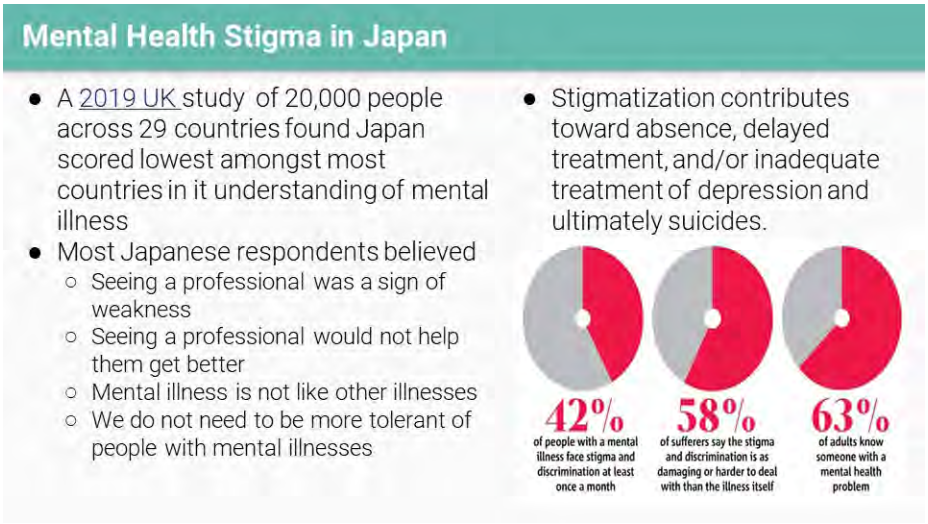
Let's have a look in a little more detail about the suicide rates in Japan. There's a lot of attention about the suicide rates in Japan – it gets a lot of media attention. As I was saying earlier, in a disaster, we know that people often get together in the early months, in the early period. In Japan the suicide rate typically goes up around March or April. This is the end of the financial year, the start of the academic year, or your first step into the workplace, and that can be a really stressful period. You've also got your tax returns due. That period in Japan often has the highest suicide rates, but in 2020 that actually went down, following the research that comes from disaster work. But later in the year the

suicide rate spiked significantly, and it is still running higher than it was before the pandemic. But in particular it was women that were taking their lives at greater rates than men during this period. Part of that was because of those pressures and stressors. We also saw from the workload that they were doing, from the lack of support they had, the job losses, the types of work that they were doing. Perhaps they were in those care industries. We also saw huge numbers of divorces happening during that time because of the pressure on relationships. Also during that time there was a suicide of a famous actress and the way that the media was reported that created what's called the Werther effect, a contagion effect. For a few months following this we saw a number of other high-profile women taking their lives, and within that a cluster of women within those age groups taking their lives also. There's a lot of pressure on the media to start talking about and reporting suicide responsibly. There has been a shift in the way that we talk about reporting suicides in Japan which the WHO has clear guidelines on how to follow. We have seen those changes. We would have been expecting, if there had been an increase in suicide rates, that it would have been those men particularly between their 40s and 50s that are feeling the impact of their businesses, etc., as we've seen in previous years. But the research clearly reflected that those populations that were experiencing greater distress because of the pandemic were the ones that were at risk. This is following on from the research on psychological disasters and disaster and trauma research.



We know that mental health is a growing concern globally. We know that it is a leading factor when we have a disaster. We knew all of these things before the pandemic. We had also not addressed some of that stigma that goes around these mental health conditions. Perhaps if there's anything I am thinking is a positive thing to come out of this pandemic, is that all of us have felt that the last few years have not only impacted us in the way that we do our work, in the way that we have been able to communicate and connect with each other, but we have all felt that impact psychologically. And perhaps that will give us a greater respect and understanding for some of those who have been and will struggle with more serious mental health conditions. We know that in Asia in particular and in Japan, stigma is a huge barrier in helping people get the support that they need. Even in the way that we talk about these conditions. Even in the way that

companies and schools and families support or talk about these conditions. So much research over the last decade have shown that here in Japan we still see it as a sign of weakness, and that we should be able to get better by ourselves, and if we can't, that is some sign of failure on our behalf. Which is a really unusual conundrum, because we would expect the person with a mental health condition to maybe have these thoughts, because they have a thinking distortion. But we are supposedly the well, and it always astounds me as someone working in the mental health industry, why are we the well not helping those with mental health conditions? Why are we putting up so many barriers, or allowing them to still exist? Why are we not listening to those with lived experiences, and trying to support them, like we would with any other health condition? Even here in Japan, when we think about maybe getting medication, we have such a stigma against it, saying things such as, "do you really need that?," and taking it as a sign of weakness. But we wouldn't say this to people with other conditions. We wouldn't say that to someone who had diabetes, we certainly wouldn't say that to somebody who had cancer. Although the medication that somebody would take with cancer has such significant impact and side effects, we would never say that to them. But we say it to people with mental health conditions all the time. And we lose lives at a greater rate than we've been losing them to COVID-19. So those barriers, those stigmas, are also a huge component of the struggle that people are facing at the moment.



When we think about all of these things that are happening because of COVID, one of the things that we need to address is that stigma surrounding mental health conditions, because we know that the impact of the last few years is going to exist going forward for at least 3 to 5 years from our research on trauma and disaster from other previous studies. Here in Japan and around the world we have also seen more women impacted by this particular disaster. Addressing those gender gaps and inequalities in those impacted groups is really important if we are serious about saving lives and reducing mental health conditions. We have poor reporting and standards of suicides in many countries and in the media. If we are going to talk about these topics we need to do so responsibly, so that we create awareness and support, and not buy into stigmas that are already there and put vulnerable people at further risk. We also need to increase the

supports and services to those that are vulnerable, and those with mental health conditions. Many of the people who have mental health conditions could not get access to those services during the pandemic and that added to that already vulnerable population. The same is happening to those with existing mental health condition. While you may hear about that in the media, you very rarely hear about those with the mental health conditions. Workplaces, parents, educators, need greater understanding and training in how to recognize and support mental health conditions. It was already a growing concern amongst young people. We know, and we have known for some time, that 50% of all mental health conditions happen before we're 14, and that 75% happen before we're 25. Yet the education for parents and educators on recognizing those mental health conditions and getting support quickly is way behind our knowledge here. So how do we bring these two things together? When we think about the impact of the last few years, educating parents so that they can support their young children to not be feeling those pressures of the pandemic would be critical. That period is already gone, so what can we do to support them going forward? We need to really increase our research, understanding and education of trauma informed care. How do we foster resilience – we've heard some great discussions on that – and our training of psychological first aid. Our media throughout the last few years has pumped into us and is still pumping into us about the dangers out there. About the dangers of COVID, the dangers of wars, the dangers of upcoming recessions. This is not helping any of us to feel positive about the future, and it's not helping any of us who are already feeling burnt out to develop resilience. If we are serious about the future of our young people and the future of all of us and our mental health addressing all of these things is going to be really important. And I look forward to hearing some of the discussions that we are going to be having on addressing some of these issues.

I'll finish my presentation here. Thank you everyone.

Question and Answer Session

Moderator: Sonja Dale

Sonja: Thank you for the wonderful presentations. We will now open up the floor for questions pertaining directly to the content of the presentations. We will have a discussion about larger themes following the break. Any questions?

Participant: I'm from Indonesia. Thank you for your interesting research. My question is for Vickie. I was interested in the dual income households. Were women able to better balance work and family compared to men? If you don't mind, could you explain why? The second question is from the same slide about job satisfaction and skill improvement. The men are more likely to have satisfaction and skill improvement after 2022. Why is this the case?

Vickie: The women were feeling more anxious. The men, even though they were working from home, if they were in a dual income household the wife was taking the responsibility for figuring out the schooling and childcare at home. The women were taking on all of these issues and burdens even if they had a higher level job. The men were not feeling that impact, but the women were. So that was why you had a lot of divorces happening. There was a lot of tension within relationships, and couples weren't having discussions about this. The men were just riding along saying, okay, my job is more important than yours, you're going to do this work. So that balance wasn't happening nor discussions within their relationships about that. One of the things I'll just throw in there, if you were talking about couples counselling, in Asia that's really something that doesn't happen a lot. In other countries, that would be something that you might address or use as a tool to address some of these conflicts. It's more likely to end up in divorce in many Asian countries, and that's going to place in particular single female mothers at greater stress, pressure and risk. Even having that discussion is missing from the dialogue here.

Sonja: Marissa and Hari, would you like to tell us more about the situation in the Philippines and Indonesia for dual income households? Is it a similar situation over there?

Marissa: There's a lot of work for women here. With two years of online schooling on top of the work that they have to do, whether it's taking care of the home or outside work, which they also do online, they still have to continue teaching their kids. And many of them resort to asking older students to tutor their kids because that's a big problem now. The average household here in the Philippines is about 4 to 5, so that means two to three children. So just imagine teaching 3 children at home, doing online schooling. That's a lot of work, and that's on top of the household chores that they have to do, and maybe on top of the other work that they do outside but they're doing at home.

Sonja: So women don't just have to work, they have to become teachers. They have full-time work, housework, they become teachers…

Marissa: That's right.

Sonja: Hari, would you like to share the situation in Indonesia?

Hari: I think it's the same situation in Indonesia. But especially when the children are in preschool. An example is my wife. We have three children. She is also a psychologist. She works at the hospital. But she has to try to teach our children. So we have to share our responsibilities. But the challenge is, one of my children is in preschool. So imagine, we have the school where they give instruction. My son in elementary school we just monitor him, we just ask him questions sometimes. But my son in preschool, we have to really assist him. So we have to collaborate and work together. But even though we can share our responsibilities when it comes to teaching, I still feel my wife has more burdens compared to me because she has to also prepare meals and things like that. We have to do better when it comes to sharing our responsibilities. But concerning the issue in Indonesia, I think it's different between people of middle or high economic status, especially areas in urban areas compared to rural areas, especially between middle and lower economic status. I think for women in rural areas with middle and low education the process of sharing responsibilities between husband and wife is more challenging.

Sonja: Thank you for sharing that. I think it ties into the issue of education that Marissa brought up as well. If you are higher educated it's easy to access certain resources. And I guess being aware of how to negotiate these issues in a relationship is more acceptable in different education groups. So thank you for bringing that up – the importance of negotiation in a relationship. This is something I'd like to bring up in the discussion later, but I thought it was interesting that Vickiee mentioned that a lot of relationships end in divorce rather than negotiation. Because divorce is something that is stigmatized in a lot of Asian societies, and something that's not even allowed in some. I think that's something we can talk about later, and what happens in those situations. When you can't divorce a partner or remove yourself from that situation.

I have a quick question for Vickie. Marissa and Hari, you both mentioned how the government in the Philippines and Indonesia had launched an app for people to access mental health services. I was quite impressed by that. Is there something similar in Japan, Vickie? Did the government have any kind of mental health initiative related to COVID?

Vickie: It does have mental health initiatives it's trying to work through, and it's trying to look at various groups that are looking at how we address mental health issues in the workplace and access to mental health support. This is a bit of a struggle at the moment because counselling is not included in the national health insurance scheme, only going to the psychiatrist. I know that they're working on those things and I know that they're looking at helping workplaces to be more supportive in helping those with mental health conditions. But I haven't seen any apps or anything as great as what they were doing in the Philippines.

Sonja: That's quite interesting. Thank you. Presenters, if you have any questions for each other, please go ahead. Vickie?

Vickie: I mentioned in the presentation about the healthcare workers. And as we're all looking to moving forward and trying to leave COVID behind us, they're still having to deal with it. It hasn't gone. And we might be psychologically saying

hey, we're going this way, but we're still putting them at the frontline, and I don't think that there is enough work and research on them in all the countries where the burden is still being placed on them, to have to deal with the fact that we're all going to go out and move about. So I think it's important to look at this population as well.

Sonja: Thank you so much for bringing that up. Marissa and Hari, do you have anything to say about mental health workers in your respective countries? Is there research being done about them? Are they discussed in the media still?

Marissa: I work at the National University Hospital, so definitely the first year, or rather the first six months of the COVID 19 pandemic, definitely has put a strain on our health system. For this, we immediately set up a psychosocial wellness program. Not only for students, but also for health workers. And we engaged the administration to come up with policies to provide rest every two weeks, I think for every week of duty they have two weeks of rest. Second, we increased the salaries of the healthcare workers, considering the amount of time they had put in. And we hired more healthcare workers because the turnover of health workers was very high. The hiring of more healthcare workers to get into the COVID wards was something that the administration was able to address. And this was something that was piloted not only by our hospital initially, but eventually went into the other government hospitals. I don't know about the private hospitals, but that was the effort on the side of the government to address the burden of care on healthcare workers.

Sonja: Thank you so much for sharing that. You're working on the frontlines as well, working at the hospital. I'm just so impressed with how it seems the government is cooperating with and listening to what health workers are saying. It's really impressive.

Marissa: You know what we did. We got endorsement, with the help of UNICEF, we were able to come up with TikTok and trained all our bloggers, the young youth bloggers, on mental health. That was part of the training that they had. To come up with TikTok videos because we're a smartphone country. Philippines is a text messaging country. So with the TikTok app and with the help of UNICEF and the Department of Health they were able to penetrate the young adult population and come up with blogs and TikTok presentations about mental health, and that eventually raised the sensitivity for addressing mental health problems early on.

Sonja: That's so impressive, just utilizing social media very smartly as well. That's great. The time is up for this first session. We've already had some really great discussions and I'm looking forward to many more in the next session.

Discussion and Comments

Moderator: Sonja Dale

Commentators:
Carine Jaquet (Associate Researcher, Research Institute on Contemporary Southeast Asia (IRASEC))
Dr. Ranjana Mukhopadhyaya (Professor, University of Delhi)
Kritaya Sreesunpagit (Facilitator & trainer in personal transformation)

Sonja: Before we start the discussion and get the comments from the commentators, we've got some questions in the comments. Thank you to those of you asked questions. I'd just like take a question first that should be kind of straightforward to answer. This is a question for Hari. The question asks if there is a national study on the impact of COVID-19 on children, and if there are any gender-based statistics on the impact of COVID-19 in Indonesia?

Hari: Thanks for the question. I will try to look for a national study. But as far as I know there aren't any studies concerning this issue conducted by any center, so I will look into this issue and pass on what I find. But as of right now, national research concerning this issue is still rare, and usually the research is conducted by a research center or collaborating research center.

Sonja: Thank you. We actually have another question, but this is a bigger question that I'd like to take up in the discussion. So, next let's have the comments first. I'd like to introduce the commentators. Our commentators today have participated in our previous dialogues or have connections to participants in our previous sessions. We are very happy to have been able to continue the Asian Cultural Dialogues network in this way. As I mentioned in the introduction to this session the Asian Cultural Dialogues is an event that happens every year along with the Asia Future Conference, and we're trying to foster a network of not just researchers but also activists, social workers, and people who work in various fields. Our commentators today are Carine Jacquet, who's an associate researcher at the Research Institute on Contemporary Southeast Asia, Dr. Ranjana Mukhopadhyaya, professor at the University of Delhi, and Kritaya Sreesunpagit, facilitator and trainer in personal transformation. I'd like to start with Carine, if you'd like to share your comments on the presentations, as well as the situation in Myanmar, since you're quite familiar with that region.

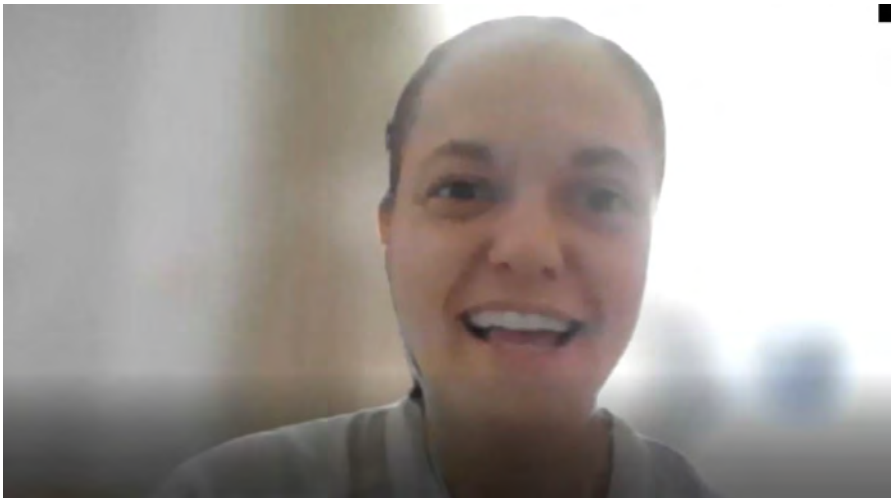
Carine: Thanks Sonja. Thanks to all the presenters. It was very interesting to hear you and to a certain extent there are certain aspects that we all share around the world in this crisis. On the other hand I think it highlighted some of the structural issues in Myanmar, not that I'm a specialist in mental health or health in general, but I have done some research out of interest and for this panel over

the last few months. What came to mind first, is that it would be very difficult to draw a comparison because in Myanmar, accessing data is the primary challenge. We don't even know the infection rates in Myanmar, or the number of deaths, which has been a big controversy. There are estimates from the government, the official government being the military, that are fairly unreliable. It's considered that there may have been 14,000 deaths, but just to give you an idea, the former government, or the political opposition, actually put it at 3 or 4 times this number. In every country there have been controversies over the figures but I think in Asia, in Myanmar it became extremely political and difficult to take a factual approach to the lessons learned from the COVID-19 crisis. The lack of collected data is unfortunately a legacy of the policies of the country, and says something about the health system which is very weak in many areas of the country. This is not just because of the recent Myanmar uprising, but an inherent lack of interest and investments, unfortunately, in the health sector in Myanmar.

Some aspects resonated, like the stress and anxiety generated within the families at the individual level. It's had a similar impact on the people in Myanmar. We also don't have figures on the suicide rate or on divorce. However, it is quite certain that the people are quite distressed and suffer anxiety, and that this crisis has and will continue to have some long-term consequences in the country's economy and social systems. Some of the challenges and some of the anxieties were created by the fact that because of the unpredictability of the situation as highlighted by Hari, the people don't know what to do. It was a very new situation. There are epidemics in Myanmar very often, unfortunately. Every rainy season there's something called elephant fever, and a few other crises, but of course nothing of this scale. So it's not really the act of getting sick that made the people worried, but rather the new rules put in place by the government and local authorities and it was also about not understanding what the disease was about. I think that was very stressful for a number of people. The Ministry of Health has been trying to communicate to protect the people. But there are a number of challenges because electricity coverage of the country is very low compared to other countries. In terms of linguistic diversity, the people who live where the health coverage is poorest tend to speak languages that are never translated. The Ministry of Health has communicated in the main language which is Burmese, but hasn't reached out to less educated and the most isolated communities geographically and ethnically. A number of surveys have shown, as in other countries, that communities that tended to be discriminated against before the COVID crisis had less access to prevention information. That could cover quite a huge portion of the population because in Myanmar that could include ethnic minorities, of which there are up to 200, and although this number may be debatable there are more than 135 groups listed in Myanmar meaning there are probably more than this. These groups have their own languages and do not necessarily read the official language, nor are they necessarily interested in messages from the government. But you also have a lot of migrants, and the communication doesn't necessarily reach them. The IDPs (internally displaced persons) or refugees – there are massive numbers in Myanmar, unfortunately. The LGBT community was also isolated and we heard a lot of testimonies afterwards about how nobody spoke to them. It's interesting because this provides

insight into who is pushed out of these government messages in Myanmar over a non-political issue. This time there was a strong sense of keenness by the government to reach out to as many people as they could. And we can see that lots of people do not recognize the state, and as such, even if they understand the Burmese language, they don't really pay attention to public messages. It was interesting from a theoretical perspective but a sad situation for the nation.

On the other hand, we can say that, like in many other countries, there has been a lot of confusion regarding the messaging. Especially at the beginning of the crisis, of course. Not knowing about how the virus spread and all that, the first information out wasn't really reliable, or changed quickly. This created a sense of distress amongst the public. An example of this was when a spokesperson said other countries are getting this sickness, but the Burmese lifestyle is healthier, and because of the quality of oil and rice that they were eating this sickness should not reach Myanmar. That didn't help – to have that as an endorsed public message at the start of the crisis. It just reinforced misconceptions and stereotypes.



One positive aspect is that it highlighted the role of women in medical care. Unfortunately there were no measures to help those health workers. They were really stigmatized against as well. It was really strange because people really recognized their role, and that women are part of the health workforce, and consist of up to 75% of the health workforce in Myanmar. In Myanmar healthcare is very much a woman's field. They were recognized for their work and praised in the media and social media as well. However, there is a lot of discrimination against them and their families. There was no way anyone would take care of their kids because people were afraid to get the disease. So there was a bit of an imbalance in recognition. Still it's maybe the first time that women were recognized for their leading role in healthcare. That was probably one of the positive aspects, and I'm trying to find some because I think for Myanmar there aren't many from this crisis. Another aspect is that the country has been involved in conflicts in various locations with various armed groups for many years. The armed group of ethnic minorities requested a national ceasefire to deal with the pandemic, and they had to provide healthcare themselves, because in many

of those places there's no healthcare system for them. So it was up to the local groups to create quarantine centers, try to find medicine, oxygen and what not. There was a hope that this could lead to a longer-term ceasefire or negotiation around the health system, or a dialogue based on facts about the access to healthcare for minorities, but it didn't really work out and the mistrust was even deepened with some of those minority groups.

I think that's important, because the stigma of these ethnic groups and minorities that have less access to those messages has become part of the public discourse. We could see the distinction between "us" and "others," who is an "other" became anyone else but me, which tended to be read into the official national identity in Myanmar for many decades. But it became really common to hear even the Ministry of Health, on TV, speaking about the migrant virus, the Chinese virus. It was really criminalizing and sensationalizing the risk which became counteractive when you wanted to get people to isolate and have a proactive attitude if they felt sick to prevent contamination. But because of the negative stigma associated with the disease and the fact that you became connected to the otherness, it created more secrecy and deepened the atmosphere of mistrust, if you will. That was part of generating anxiety and part of a vicious cycle in how you define the disease and how you connect the discourse to longer term identity-related conflicts in Myanmar.

In many cases you could see the grassroots mobilization online. It was impressive to see the resilience of some of the medias, society, youth groups, students…. Who moved into the online sphere to continue their activities including COVID prevention. The universities were of course closed, but a lot of students came together to try to share online classes and do things without the support of the state because there was very little of this in education. However, it had to be limited in the context of very low literacy, low access to internet, to electricity, etc. So of course that had to be mitigated. You had of course the gap between the elites and those people who had access and tried to do something about it, and those with less access to information and were confused about the information they had, less critical sense, and more distress with the system and the rest of the country, basically.

I have to conclude on the role of the doctors in the crisis. As you all know there was a military coup on the 1st of February 2021. So unfortunately the big crisis in Myanmar is no longer COVID, although I wish it was still COVID. Although the third wave was terrible in Myanmar and there were people queueing for oxygen in Yangon and other centers, you can imagine that it was a total disaster in the rural areas. However since the military coup there are many other sources of anxiety for the people. It became a non-issue since 2021 in the media and elsewhere. Of course the official figures are still mentioned in the state's newspaper, but people have totally stopped caring about it. The vaccines have also arrived, so the spread of the disease has slowed down, but of course the main issue is that the coup has created at least 7000 IDPs, and many refugees. There has been a reemergence of conflict all over the country but what's important as well is that in spite of COVID 19 a lot of doctors have quit their jobs. They had joined a national strike following the coup because people were asking the army to let the people's will to be respected after the election, asking the army

to hand back power to parliament and the country to the civil government. The civilians have conducted a huge strike for over a year, and the doctors were among the most active members, and the most targeted by the government, who want them to go back to work because the hospitals are full. And this shows the personal dilemma of the doctors – they know how terrible the crisis is, probably they want to help their peers, but they have decided to quit because of longer term political views and their personal judgement is that their job is more to oppose the coup than helping a system that is flawed in so many ways to provide very limited health care. I think the fact that they had so little means to deal with the crisis is probably part of the disheartening fact that it makes no difference to go back to work and they'd rather stand up for democracy. Usually it's not the doctors striking in Myanmar, this is quite new. It's the imperative of working for the government. People also support this fact. They don't want to go to the hospital, they don't want to have anything to do with this military junta, so people boycott public services a lot. It's kind of unheard of, in such a crisis, to have doctors walking out and people supporting them. We suffer but it's better than supporting what the army is trying to do to us. They've been striking for a year and a half. There has been previous turmoil in Myanmar, but to see the country siding against the army, the whole civilian population is against the army, is very unusual.

Sonja: When we talk about Asia we have to remember, it's not just COVID. In many cases there are also a lot of political issues and conflicts happening at the same time and overlapping with COVID which makes the situation so much worse and complicated as well. It's not just an issue of mental health but also survival in a way. Thank you for bringing that up. So much more to add to discussion later on and thinking about this other aspect of the issue. Thank you Carine.

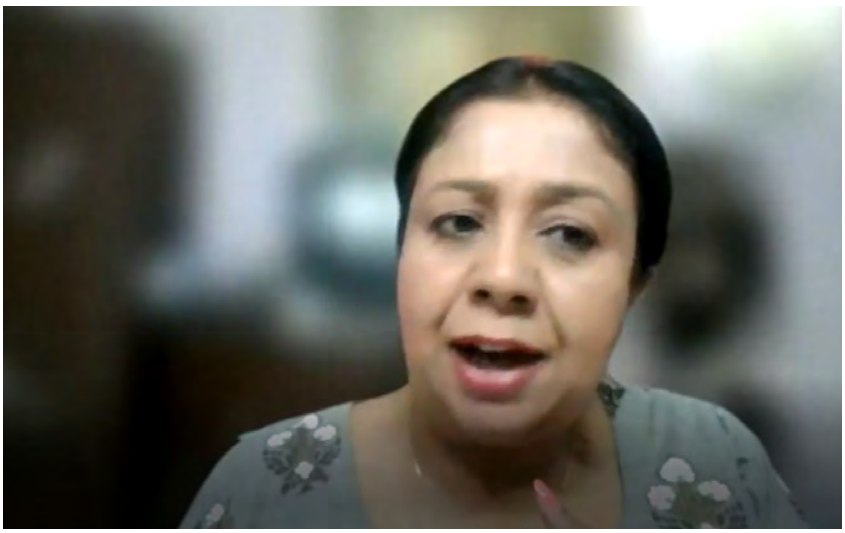
Next, Ranjana, would you like to share your comments?

Ranjana: Good morning everybody. I'd like to thank Sonja, Tsunoda-san, and the secretariat and staff and members of the AFC for conducting this first ever hybrid conference. This is one of the outcomes of COVID, that we are meeting all virtually. The presentations were wonderful and the best part was that we were hearing the voices from the field. All three presenters were presenting on their research, which is really wonderful. I congratulate Sonja and everyone else for bringing this panel together. It is my privilege to be a commentator in this session. I think I'm one of the people who has been here since the first roundtable that we had and it's a great thing to be here, but unfortunately we are not meeting in person.

I'll just tell you about the situation in India. As you all know I come from India. When COVID started in 2020, the real concern of the government was to contain the spread of the virus. So the first thing that happened was we went into lockdown. I think it was one of the most severe lockdowns in the world. We were given less than 12 hours notice that the lockdown was going to start. No more travel, no more going out and everything. What came along with lockdown was the word "social distancing." India is a very social country. We are very community based. In all of the religions, we have a series of festivals throughout the year and a lot of community participation in these events. I think what was damaging

was that the lockdown and COVID brought out a lot of the fault lines that existed within our own communities and societies.

We have all been speaking about the status of women, and how women have been negatively impacted. Women are all family based in Asia, mostly. Even if women go out to work, family is the center of their major activities. I would not say that is a very negative thing, because in all social and community life, women play a very important role. They may not hold that importance in economic life, but in social and community life women are very important and most of our religious festivals are very women driven. A lot of this participation from cooking meals to making offerings to the deities, women play a very central role in all of this. I think in a very major these roles are very important. They may not have as much of an economic significance, but they have a social significance, and they add a lot to the social stature that a woman carries. What happened was that the lockdown disrupted these community and social gatherings, so a lot of these places where women would go out and express themselves and bond with their communities got disrupted. That is where women in Asia get most of their social and psychological support. It is not just from her husband, it is from her mothers, from her sisters, from her relatives, and other female friends that she has. That is the largest social and psychological support that a woman has. I would say, in many ways that her world shrank to her own house, and the wider traditional, religious, social roles which a woman usually plays in a community were really shrunk to just her taking care of her children, and making sure that her children sit in front of their laptops to attend their online classes, or making sure her husband's online work from home is not disturbed, whereas her larger life was highly compromised.



I think that in most research, this part really gets ignored. How a woman's larger social involvement, which is not necessarily economic, is also the center of the psychological support she gets. Marriages are also an important aspect of this social life. In the last two years I have not attended any marriages, because there was a restriction in India that not more than 50 could attend. In India usually more than 500 people attend a marriage, or there is a huge gathering. All reli-

gious gatherings were stopped. That is one aspect that I felt had a large impact on women's psychological wellbeing, because there was a loss of social life for most women. Most women have felt very restricted, and they are not able to mix around and have a normal outside life. For women, economic work is not as much a part of social status, as they are mostly doing low paid jobs. Women's social status comes from their social activities. A lot of data doesn't actually acknowledge this, but it comes up in our own experiences and interactions with friends. From my interactions with my friends who aren't working, they really felt like they had just become reduced to being a housewife in that time. Taking care of four meals in a day, the husband is always there. I think the presenter from Japan mentioned how the husband wasn't really present in childrearing, which I think is the same across all societies. But what COVID actually did was that it exposed these aspects to the husband as well. Although the husband might want to have avoided taking an active role in the child's life before, being at home when the child is not studying, it also became a father's responsibility. Although he might not have liked it or done it, he was in some way getting involved in household activities. And that became a major source of tension in most couples because they have very different attitudes towards parenting. Previously it might have been the mother who was single-handedly parenting, but to have the husband coming in and trying to tell her what to do, that became a source of tension.

Another issue I have with data collection and surveys is the sample size. For example, regarding what we heard about the Philippines, it's wonderful that there are college initiatives. But in the last few years we have seen that a lot of people have not gone to colleges, a lot of education has gone online. There is a huge chunk of youth who are not in university, who are not going to college, or who start working right after school. So for this data, we have to take into consideration the youth who don't go to college, or who started working early on because of family or economic pressures. So that is a data group in the youth that I think we are ignoring.

In India, when the lockdown happened, what came up was the issue of the daily wage workers and migrant workers. They literally earn from day to day. If the economy is not running and is in lockdown, if there is no transportation and the shops aren't opening and no luggage to be carried, what do you do? There is a huge chunk of people who have become jobless. I'm not sure what data has looked at the psychological impact on migrants, or on migrant women, because a lot of these migrant laborers are women who have come from the villages to work in the cities, and suddenly they are out of work. Often they don't want to go back to their villages or hometowns, because they have settled into life here or they are the source of income for their families and don't want to go back and become a burden on their families, or in some cases even their families don't want them to come back. That's another important group to look at. These lower-class women, who are left out on their own.

When we look at the sociological impact of COVID, I think there is an aspect of social class to it as well. Every social class responded in their own way. Class difference, caste difference. Everything became very apparent during this crisis. It actually brought out the different kinds of people living in a society – different

social statuses, people who had never had much access to education and healthcare. And for the people who were used to getting healthcare and education, there was the problem of not getting what they needed. Even now there is the issue of getting access to vaccines. The government is under pressure to ensure that everyone gets vaccinated, but still there is a lack of information. Accessibility issues have become very critical. When the resources are limited, the spaces available in hospitals are limited, the oxygen cylinders are limited, who gets access are the people who previously had access to them. I'm not an expert on this, but this is what I've felt over the last two years.

As an educator, since I myself am a university professor, I don't think we are often considered as frontline workers. However, in a major way, I do think of us as frontline workers, because in particular during the second or third wave, which was really severe in India, and the death rate was really high, during classes there would be children crying in the class. It feels like the younger generations are able to express themselves more openly virtually than when they are in the classroom. Probably they feel more intimate through the virtual medium. And sometimes they would just burst out in tears because they'd gotten a call informing them that someone in the family had passed away. It was very challenging for us teachers to deal with the situation. What do we tell them in that situation? Should we just tell them to leave the class and go? During the second wave it became obvious to many of us, working at home and online, that we are actually intruding into each other's privacy and private personal space. One of my students told me that he came from a very large family, living in a very small house. And the first time in his life, when he had a room for himself, was when he came to university and lived in a hostel. Up until then he had shared his room with his siblings. When he started staying in the hostel he started saying to himself, I have a room to myself, I have a space for myself. And when COVID happened, the students were told to leave the hostel and go back home, as the university did not want to take the risk of the pandemic spreading in the hostel, and the issue of responsibility that would result from that. So students had to return to crammed spaces where they weren't able to work and weren't able to do anything. When I was teaching I could see that there were many things going on around my students at home. You never think about what a privilege it is to have a room of your own and maintaining complete silence. Most people in India don't actually have that privilege, because they live in a small house with a big family, or joint families, father, mother, everyone at home and jumping on one another. So it was an intrusion into their private spaces, which was also psychologically disturbing for many people. There was a time when some students said that they didn't want to turn on the camera, because they didn't want others to see their home. When you are outside, you give a different image of yourself, but once you have seen a person's home you see something else. Not everyone has a study room, not everyone has a dedicated study space. There were these different levels of psychological impact on people. Some of my female students wear "western clothes" outside their homes, but at home they are not allowed to dress like this. Some female students said that they didn't want to be seen dressing like this, as it would give the impression that they are conservative, and they didn't want to show that side of themselves. They wanted to project themselves as being modern women. These are the various things that actually

brought out the fault lines in society. I'm glad that many of the presentations touched on some of these cracks that exist, but I think many of the presentations need to be more wide based, and we need to see how we are more inclusive in our data collections. I think that is where a lot of government surveys go wrong, because they are not going to the people who they should study.

They were all wonderful presentations. I'm sorry I went a bit off-track. It was really nice and great listening to all of you. Thank you so much.

Sonja: Thank you so much Ranjana. These issues impact all of us. It's something we experience in our everyday life and something we can relate to too – it's personal. It's easy to talk about because we all have experience with it. Thank you for bringing up the issue about how our lives are really multi-faceted, and how COVID has cut off a lot of people's lives and made our worlds smaller, and I think that's something we can think about and talk more about as well. I also like how you brought up how that distinction between public and private is becoming so blurred, and uncomfortable for people as well. They can't keep things that they wanted to keep private private anymore, because of the intrusion of webcams into our own personal spaces, much like we are doing now. I guess blurred backgrounds are a way to try to avoid that! We try to avoid giving too much of ourselves away. It's interesting to think about.

So let's move onto our final presenter. Kritaya, if you'd like to go ahead please.

Kritaya: Hi, thank you. First, I really appreciate all of the presenters, as well as the previous two commentators. I think this is a very insightful presentation of the common issues that we see across countries, but which are also country specific and we see how important issues impacted different countries, for example the unique government regime in Myanmar. Thailand also has some similar problems, but that's a longer discussion. The high impact of the social and community factors that was just mentioned in India. I really appreciate getting a picture of the differences and similarities that we have across cultures and countries.

In the case of Thailand I think there are many similarities in the challenges that we faced. At the beginning of COVID there was chaos, none of us had been through this before, we didn't know how long it was going to last. All the chaos, the uncertainty, the anxiety that everyone experienced similarities and differences. And also the challenges that came in this long pandemic that we have never experienced before. Even now, when it feels like we are at the end tail of the pandemic – people are going back to work, travelling again, life is getting back to "normal," whatever that means. We also know that COVID is still here, it's not going anywhere. Even though we have vaccines people are travelling, taking off their masks. Who knows what the next wave might bring. I think that sense of anxiety it still there, I think this is the next wave. So what happens next when we go back to life, when we go back to work, when our children go to school? What will happen? This is another wave of adjustment, and it's also unseen. The world has never seen this kind of global pandemic for this long. I think we are all learning about this together, and I really appreciate what Vickie said, about global empathy, that everyone is in the same situation. We get to understand the challenges we face together as a part of humanity. But there are also very different challenges that we are facing based on income and societal background.

Specifically in Thailand, I think this is similar culturally to other Asian countries as well. We place a lot of value on compassion and generosity. Putting others first, and putting ourselves last. Those are great values, but in the perspective of mental health and wellbeing, that is a key challenge, because it never occurs to us that we can ask for help, that we can put ourselves first, especially for women. It's also difficult for men, but I assume that it's more difficult women worldwide, and especially for Asian women to say that "I can't take this anymore." Sometimes it doesn't even occur to us to say that to ourselves – I can't take this anymore, this is too much. I need help. I need help with the dishes today, because I have a meeting. It's so ingrained in us and in our culture and structure that this is the role of the woman – to do it all, to handle it all, and to smile while doing it. I think that's really put a huge pressure on us in general, and even more so during COVID times. In Thailand there is still a huge stigma in asking for help, especially for mental health. That's much stronger in the lower income communities where mental illness is still equated with being crazy. If you go to a mental health hospital or clinic, or even if you call the hotline, it'll be like, are you going crazy? That kind of stigma is really deeply ingrained in people. It really prevents them from even considering the possibility of getting help. Previously most of the mental support has been handled by communities. We talk when we go to lunch, we talk when we go to the market, we talk when we do gardening. That sense of societal community support has really been absent in the lockdown, especially during the strict lockdown in the first year. Each country has different levels of strictness during the lockdown. In Thailand the lockdown wasn't that strict and wasn't that long compared to other countries, but we still saw more people having problems. I think that the statistics don't really show the extent of it, because there are only limited people that formal surveys can reach. I can see from working with people, talking with people, and also working in collaboration with the Mental Health Department in Thailand that they are having problems reaching out and getting data as well as offering help that had

previously been offered by communities. During lockdown you are alone in your household and cut off from your usual support networks.

We have several online platforms providing support, but not a national platform or app, and I'm not sure about the development of that. But there are many informal social sectors offering these services. We've found that it's only been possible to reach the middle and high income communities, but not the low income, because even though they have phones they are not used to long chats or online conference calls like Zoom. These new opportunities still can't reach the people who really need it. It's also still challenging for people from older generations, who are forty plus, to get used to talking about emotions and life online. Some people are getting used to using Zoom for work and formal meetings, but usually the things that are important for your wellbeing is the time that comes before or after that. During coffee breaks or lunch time, which we don't have in our online interactions. That is a really big gap in general mental health support that we have as human beings in Asia. Working online and social distancing has really brought each of us into our own shell, and I think we really need to learn how to get back to receiving support and getting support, and how to learn to recognize if people around us need help. Before we could see it in their faces if we walk by our friends by the elevator or when going to lunch or at the carpark, or at the market. But even now, as the pandemic is easing up, most of our interaction is online. How do we bring back the relational support that we had previously? I think that's a big issue.

Another thing that was prevalent in Thailand and still is is the grieving process. During the pandemic, especially during the strict lockdown, you were not allowed to visit family or friends in the hospital, COVID or not. Many people lost their loved ones without being able to say goodbye or look after them in their last days of life, and I think that's really traumatizing and can be scarring. Usually the end period is a time for the family to gather and talk about unresolved issues with the family and the person passing away. It is a time for family and friends to gather. You talk about the important things, and you come to understand that life is fragile, death happens every day, and how important it is that we connect with each other. I think all that has been missing. It's such a lonely place to be when your loved one passes away and you're stuck at home, and you can't even have a full funeral most of the time. In Thailand, our Buddhist tradition is to have a funeral for at least seven days. And that's when family and friends come together to show your condolences, your support. We're not very good at talking about our emotions or saying our condolences, but we come and we offer flowers, we offer food, we show up. That's the way we show support, and that has been missing a lot during COVID. I think that's put people in a lonely corner that, I'm here by myself, dealing with this by myself. And they don't know to reach out for help and ask for help, and say hey, I don't want to deal with this on my own. I need support. I need my friends. That's something that we don't really know how to do yet, and that is still going on and has left some trauma and darkness in lots of people's hearts.

The last thing I want to mention is that, as I mentioned in the beginning, we are

now going into the next wave of uncertainty, about what life is like after the pandemic. About what's going on, what's happening after people can travel. I see that many people are really feeling like they really need to accelerate themselves in terms of their career or their businesses, in terms of "getting back to normal." And that also creates a lot of stress, especially in this time of uncertainty where we are not sure about where the country or world is going with this pandemic. And then the next wave, on top of all the political conflicts and economic downturn and many other challenges that we are facing. So, no wonder we are all feeling a bit burnt out. I really like that this roundtable included the word "fatigue" in the title, because usually we see "mental health" and "wellbeing," but "fatigue" is something that we usually don't really pay attention to it until we are too burnt out or depressed. But I think we really need to pay attention to it, and how we recognize it in ourselves, in our friends, in our families, in our communities. And how do we redesign our support system, maybe even bringing back what we had before, now that it's possible. But then, how do we really pay attention to all those support systems that would support our mental wellbeing? Thank you.

Sonja: Thank you so much Kritaya for bringing out those great points. Interaction happens so much in everyday life, and we've lost that aspect of it. Just now during the coffee break I was also thinking about how this would be the time when we're chit chatting and talking together, but instead I was on my own, just pacing around. So it's definitely a different experience. Even at conferences, the most important part of the conference is not just the presentations, which are of course also important, but also the conversations that happen afterwards when you continue thinking about these issues as well. So I think a challenge for us is to think about how we can foster those relationships, and the ways we can have those relationships in our present situation. I also liked how you talk about the grieving process, and how often communication is not just about what we say in words, but just being there physically, the actions that communicate. And that's something that COVID has really affected, because it's placed this huge emphasis on speaking or writing, on articulating what you want and what you need. And not all of us know how to say that, how to say our thoughts and needs. It's interesting, now that you've said that, I hadn't thought about that, about how much of our communication actually rests upon communicating without words. That was a great point, thank you.

Next I'd like all of our presenters as well to turn on their cameras. I'd like us to have more of a free-flowing discussion. Please feel free to turn on your microphones and ask each other questions or raise any points that you'd like to. To start off, as this was mentioned by Kritaya and in Vickie's presentation as well, but just that stigma of talking about mental health that is present in Asia. Just to kick off this discussion I'd like to call on Marissa, because you presented the situation in the Philippines and I was just so impressed by all of the work that you have been doing, and all of the programs that you have available. Is there a stigma still in the Philippines, despite all of the efforts that you have in place, or is it easy for people to access these services that are now available to them?

Marissa: There was somebody who mentioned the need for epidemiological data, that's precisely what we're doing now. For the past four decades we didn't

have any data on mental health, and that's why mental health was never considered a priority in the non-communicable diseases. Given that the government had funded an epidemiological survey, now we have data that shows that we have a need to scale down mental health services, not only at the institutional level where you have big government hospitals that just focus on mental health, but mental health services should scale down at the horizontal level, where it has access to schools, to the labour force, to the communities, and even to individuals who suffer from chronic mental illness. The stigma was so strong that when we went to the communities, I'm sure you've seen this in other Asian countries, we saw people locked up in their homes. That was the sad state of the lack of mental health services. Right now the government is more aggressive, more active, because they have data to work on. We have medication access programs, where we make mental health medication accessible to the lower income groups at the primary care level. We've trained doctors on the mental health gap. This is the Mental Health Action Program that was initiated by the World Health Organization to train doctors and other health workers to address the problem of mental health. Now we want to protect the future of our country, which is the young people, and this is the reason why, hopefully, we can set up a program for mental health at the university level, and hopefully down to the secondary and primary levels so that we can try to fight the stigma and discrimination, make mental health services accessible for everybody, for every Filipino. That's where we're coming from. We need data, that's right. So the person who commented, the need for epidemiological data is necessary if we want to reach the OFWs (Overseas Filipino Workers), the migrant workers, if we want to reach the IPs or the indigenous people, if we want to reach all sectors of society.

Sonja: Thank you. So actually data has been helpful in making it less of a stigma. Would anyone like to share their opinion? Go ahead, Vickie.

Vickie: I'd like to jump in there. I don't think we just need just data. I know that data is really powerful, but one of the things I was talking about, this common theme that I'm hearing from everybody, is that in a disaster, and let's face it, the pandemic is a disaster, there are literature and programs and steps available for anybody to do. I might be a clinician, but you don't need to be a clinician to know some steps, or to do things that are going to support your mental health, to manage stress. So in a disaster psychological first aid says these things. It says that the majority of us, nearly all of us, are going to be impacted. And there's going to be a lot of stress, associated with those changes because of the disaster. Dealing with those disasters, it may change how we act as a family, how we live, how we go to work. All of those things may be impacted, and they were. Even though our houses didn't crumble down, in reality all of these things were impacted. It says that loss is going to be a huge component of that, and how do we address it. It says how do we reach out and address those that are vulnerable. What do we need to do for them. It says our mental health is going to be impacted, and that the longer the disaster goes on for, the greater the impact there is going to be. It says that carers play a critical role, and that educating family members, or employees or managers, educators, teachers, you play a key role in helping those under you manage that stress, but you also need to manage your own stress. So there's a lot of information we already have, and if this was rolled out and used, because it's been known from disaster to disaster, and we

could be using it in addition to the powerful data and research that comes out. It's frustrating that this information is out there, and we're not using it as well. We do need data, and we do need to be having better discussions about it. But there's stuff out there that we're not rolling out for anyone to use.

Sonja: That's a great point, and it goes back to the point of accessibility that some of the commentators and presenters have also talked about. There is information, there are resources, but who's getting this information is very limited as well. We're all here, working in different roles in society as well, I think we all have our different networks. We, others, have to find ways to pass on what we know and the information that we have. That's a great point, and it also helps us realize the role that we could all play in disseminating information and resources. Does anybody else have anything to say about this? Hari, please go ahead.

Harissa: Thank you Sonja, I'm inspired by Marissa and Vickie concerning the national data. I think is a challenge in our country and I think this is very important. I'm also inspired by Ranjana, especially on the roles of traditional leaders, informal leaders, and especially religious leaders. For example, concerning the adherence to protocol, sometimes in Indonesia the government is not the only credible institution. Sometimes the rules ordered by the government depends on the religious leaders. But in some cases, in some religions, when there are conflicts between the instruction from the formal leader, say the government, and the religious leader, sometimes the people tend to follow the informal leader. The role of informal leaders, especially religious leaders, is very important. Especially in the case of the virus spreading, religious gatherings are very significant. In Indonesia every year we celebrate Idul Fitri or Idul Adha, this is also a risk factor for the spread of the virus. I'm also inspired by Kritaya, the importance of social support from the communities. In Indonesia, the social support is very important. That's why during the pandemic, we built community participation. For example, we started a yoga club, doing physical exercises, but online together. Some people with the skills to give instruction open the class, and this is all free. This also how to support healthcare professionals, and not only physical support but emotional support. Last but not least I am also inspired by Carine. I remember how challenging it was when we tried to make a program or deal with children's issues when we also had conflicts. I remember when I was working in a conflict area in a previous year in Indonesia, it's really challenging. I can imagine how challenging it must be in Myanmar. Thank you Sonja.

Sonja: Thank you for your comments. I'd also like to ask a question now that Tatsuuma asked in the chat. This is for everyone. It's about the effects of remote work on mental health. What are some of the advantages and disadvantages of this. Tatsuuma mentions that personally she kind of feels that it generates many advantages such as creating networks with the local community and so on. So, what are your thoughts on remote work? Vickie, go ahead.

Vickie: I've given a number of talks on this topic, and there's a lot of good data from around the world where they're looking at employees and looking at the impact of working remotely. Initially, a lot of workers were saying it was very stressful, but now that they're being asked, two and a half years later, to go back to the workplace, you're seeing a lot more of them saying, no, I don't want

that. I want some choices, I want options. One of the things that they're clearly saying is that they miss that interaction, those personal bits, so how can we do that creatively if we are going to be staying in this hybrid state? They say they want meaning in their work. They are clearly saying that their workplaces are not doing enough about their mental health. So I think it was Hari who was saying before, there are a lot of positives that have come out from doing this. For example many people who maybe couldn't afford to go to a conference can attend a conference. Many people who could only hear a presentation in Tokyo, now can join from across the country. There are a lot of barriers that are broken down by this, but also barriers created by this. What we need to do is find better ways of using some of this technology so that we don't just go back to how things were before, and think about some of those stressors that were already going on. If we looked at the workplace before in Japan, there was a huge amount of power harassment and work stress, huge things that the government was doing to address that. So yes, there are stressors because we're not together, but they're different. So going back together isn't necessarily the answer either.

Sonja: Thank you. I think that's something we have to be conscious about. It's not just about returning to how things were but actively thinking about how we can make things better now that we've been given this opportunity to think about things. We just have to make the effort to try to change. Would anyone else like to share their thoughts on remote work and mental health? Ranjana, please go ahead.

Ranjana: I think one of the very interesting things is that when COVID first started, nobody was thinking very much about mental health. Most people were just worried about not getting infected and taking care of their physical health. It's interesting that gradually mental health issues have come to be given as much importance as physical health. I think that has been one of the very important outcomes of the pandemic. I think this is precisely because although we see that online interactions have gone up, I think we have seen that the more clustered you are, the more you need to have a good state of mind. It became very important in this time of crisis. It's not just a physical thing, but also a mental thing, and it's important to maintain a balance for good health. I think someone mentioned yoga. It's interesting because we have all been doing yoga because physical gyms were closed. But what came online was actually yoga. Because you don't need an instrument, because your body is the instrument. And in yoga the mental is also really important, it's not just your physical wellbeing, it's how your mind and body is connected. That's what yoga means – this connection. This is why there was a huge yoga boom across India and the world also. Its doable within the limited space of your house.

When COVID started, before the vaccines were developed, what was focused on was immunity. How well you can fight back is important. So building immunity became a movement. So you find a lot of traditional medicines which came in, like Ayurveda or Chinese medicines were never so mainstream. But now you find there is so much emphasis on health and eating well, being a vegetarian, don't eat a lot of meat. All of these things came up during this time. It's interesting how these new things came up, and we are relooking at older things. Like Zoom and everything was always there, but we never knew it could be used so effec-

tively. And I think this hybrid mode is here to stay, pandemic or no pandemic, it is also becoming very convenient for many of us and has changed the way we work. I think to some extent this has also changed for the better. Vickie mentioned power harassment, and it actually acts as a stopper, as everything is online and documented. Even if it's a private conversation, you can always record it. It has a positive side. There are some good takeaways from this pandemic I would say, like how we look at life as a whole, and how we communicate with people around us. I think that those are important lessons that we have learnt in the last two years from this.

Sonja: Thank you so much. I think we have yet to experience what it will be like when the pandemic is over forever, but it has for sure changed so much. It's made us question things and rediscover things. I like the point that Vickie made about how we have to be intentional about the change we want to bring about. Marissa did you want to say something?

Marissa: There needs to be a gradual incorporation. What we are trying to help with the schools and workplace is a hybrid setup, and that works very well. Two years have changed behavior, have changed attitudes, have changed mindsets. It takes time for change to be implemented once again to go back to the workplace. There has to be constant collaboration and communication with the different agencies about how to go about it. Of course the primary concern of every person is safety. Safety and health protocols are always practiced in the workplace, that's one. Second, how is this hybrid setup going to work, that's also another consideration. Thank you.

Sonja: Thank you. That's the thing – we shouldn't rush it, right? We need time. Vickie, would you like to respond?

Vickie: One more point, I was also mentioning about trauma. At the moment, because the pandemic is still happening, we can think about ourselves as in a traumatic stress response, so we are under heightened stress. It's great that everybody's been talking about resilience, because I like to think about resilience as a petrol tank, if you like. The last couple of years, we are all running in that last quarter. And any other stress that comes to us brings us down to all that we have left. We don't have that reserve to help us bounce back up. But we're also going to have those individuals who are going to go have a post-traumatic stress response, and there is going to be that trauma that we've experienced. How do we look after that? And we want to hope that after that, we have that post-trauma growth, which is what I think we're talking about here. Can we reduce the number of people globally who are going to have that PTSD response? With all our research and all our data, we know there are going to some. How do we reduce that? What are we doing to increase resilience, so that more people are not going to be impacted, so that we can get on with things, and what's that growth going to look like. I think these are important questions going forward.

Sonja: Thank you so much. I think there is so much more that we could discuss, but we are in the final ten minutes. Because we have been talking so much about mental health for this session, I really wanted us to have something that

we could go away with and pass on to others in our everyday lives, if you find it useful. So, I've asked Kritaya to lead us in a meditation practice.

Kritaya: This is another new thing that has come up in the pandemic, similar to yoga being done alone, meditation is also being done online, and many people can get access to it. So, thank you for the opportunity.

(Kritaya led us in a wonderful meditation session, and provided guidance on breathing and taking things one step at a time.)

Sonja: I think that was a great way to end this session, and to end a conference in general. Because after a conference like this, you're just like, what should I do next? It's easy to feel stressed, but this was a nice way to realize, everything's going to be alright. We have all the information we need. We can take our time to take the next action as well.

Profiles of Presenters and Commentators

Ma. Lourdes Rosanna E. de Guzman

Ma. Lourdes Rosanna E. de Guzman is an Associate Professor of the Department of Psychiatry and Behavioral Medicine, University of the Philippines – College of Medicine (UPCM) and the Philippine General Hospital (PGH) – the National University Hospital. She has been into academic teaching, clinical supervision, family therapy, mentoring and research for the past 25 years. She also finished the certificate course of the Harvard Medical School Southeast Asian Leadership (HMS-SEAL) Program for Global Health Care 2018-2019. She is presently the Principal Investigator of the Philippine National Survey for Mental Health and Well-being (2021), the first epidemiological baseline survey since the passing into legislation of the Mental Health Act of 2018, to provide national estimates on the prevalence of physical, behavioral and mental health problems in the Philippines with the hope of improving mental health services and delivery at all levels of care in the community for all Filipinos.

Dr. Hari Setyowibowo

Dr. Hari Setyowibowo has a PhD in psychology from Vrije Universiteit, and is a lecturer at the Faculty of Psychology, Universitas Padjadjaran, Indonesia. Dr. Setyowibowo works in the field of clinical psychology, and has done research on psychoeducation to improve the quality of life among women with breast cancer symptoms in Indonesia. He is also conducting research for SAENA, an interventional study to develop and evaluate an online counseling application, as well as is an Indonesian research collaborator for the COVID Mental Health Survey (COMET), a longitudinal cross-sectional online survey across fourteen countries affected by the COVID-19 outbreak.

Vickie Skorji

Vickie Skorji is the Lifeline Services Director at TELL Japan, and has a Masters in Counseling with Monash University and a Behavioral Sciences degree with honors from La Trobe University Australia, along with specialist training in neuropsychology. Over the last 17 years at TELL, she has developed a wide range of suicide prevention and mental health awareness programs, for schools, the workplace, and the community, along with stress management, resilience building, cultural adjustment, dementia care, and psychological first aid training.

Carine Jaquet

Carine Jaquet is an Associate Researcher at the Research Institute on Contemporary Southeast Asia (IRASEC) in Bangkok. She holds an MA in Political Sciences from La Sorbonne University, Paris 1 and a MA in Intercultural Communication from the National Institute of Oriental Languages and Civilizations (INALCO) in Paris, and studied Myanmar Language and Civilization at the Yangon University of Foreign Languages (YUFL). Jaquet has worked and conducted research in Myanmar for 15 years on a broad year of topics such as peace and conflict, civil society and ethnic identity. As a development specialist, she has worked for the United Nations High Commissioner for Refugees, international NGOs as well as a technical advisor for some Myanmar government institutions under the former NLD government.

Dr. Ranjana Mukhopadhyaya

Dr. Ranjana Mukhopadhyaya is Professor of Japanese Studies in the Department of East Asian Studies, University of Delhi. She received her Doctoral degree in Religious studies from the Faculty of Letters, University of Tokyo, Japan. She is author of a number of books and articles, in English as well as in Japanese, on Japanese Religion, Buddhism and East Asian society and culture. Her doctoral thesis, written in Japanese and published as Nihon no Shakai-sanka Bukkyo (Engaged Buddhism in Japan, Toshindo Publication, Tokyo, 2005.) is recipient of two prestigious academic awards in Japan: Japanese Association for Religious Studies Award and Japanese Association for Buddhist Social Welfare Studies Award.

Kritaya Sreesunpagit

Kritaya started her career as social entrepreneur, founded YIY Foundation working in supporting young people to become social entrepreneursand became Ashoka fellow in 2004. At a peak point in her social change career, she found that her life was extremely off balance and realized that she needed to pay more attention to her wellbeing and in turn found new ways in transforming the world through self-transformation. Now she works as a facilitator, trainer, therapist and healer integrating tools from mindfulness meditation, Satir therapy, Transformation Game, Frameworks Coaching Process, Enneagram, Somato Respiratory Integration, Brainspotting to energy healing. She also works in establishing network of mental health and wellbeing professionals and volunteers to offer variety form of services and support for people in need. Kritaya was selected as Ashoka Fellow, Young Global Leader and Atlantic Fellow for Health Equity.

Dr. Sonja Dale

Sonja Pei-Fen Dale is an independent researcher with a PhD in Global Studies from Sophia University (Japan). Dale's research is multidisciplinary and examines the social structures of inclusion and exclusion as well as identity, with a special focus on LGBTQ issues and non-binary identity in Japan.