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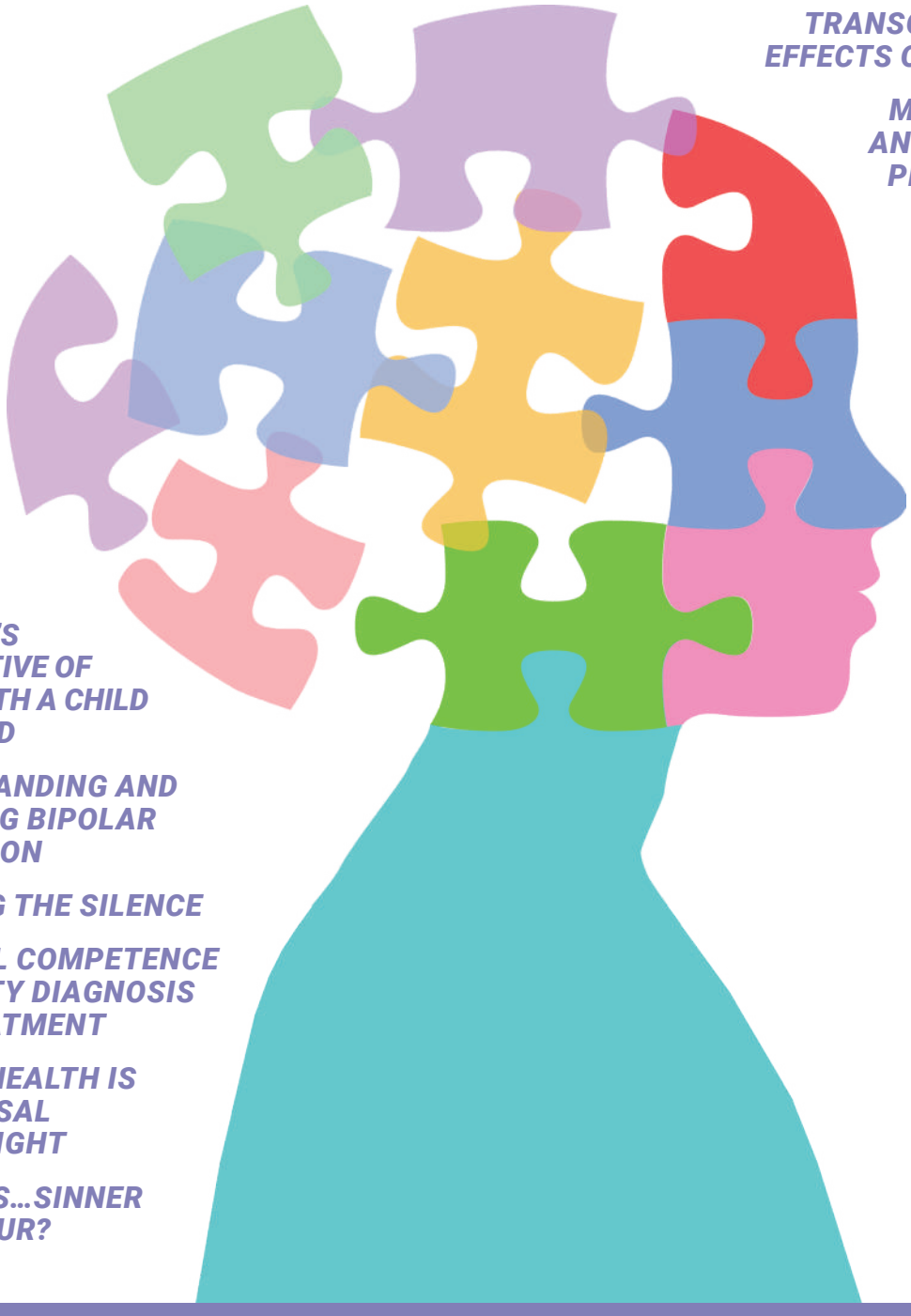
MHM

MENTAL HEALTH MATTERS



TRANSGENERATIONAL EFFECTS OF DEPRESSION

MENTAL HEALTH AND HEALTHCARE PROFESSIONALS

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An epidemic of unkindness

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Borderline as a superpower

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CANNABIS...SINNER OR SAVIOUR?

THE SOUTH AFRICAN DEPRESSION AND ANXIETY GROUP

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Making Mental Health Matter

MENTAL HEALTH IS A UNIVERSAL HUMAN RIGHT

The global theme for World Mental Health Day in 2023 was "Mental Health is a Universal Human Right". This is an important topic in the context of South Africa where health care including mental health care, is a right according to the Constitution but is not always accessible to all its citizens. Public health facilities are under resourced and there are severe constraints to providing quality of care. In addition, mental health care users are vulnerable to neglect and abuse in mental health institutions.

The Life Esidimeni disaster was a clear illustration of the inadequacies of the mental healthcare system and the failure by key role players who are responsible for ensuring access to mental health care services to do the right thing. It was arguably one of the most significant human rights violations of our democratic era.

There is a lot to be learned from this disaster, however. While it highlighted the vulnerability of mental health care users, it also demonstrated the importance of collaboration between organisations and individuals who are working on similar issues. The Life Esidimeni case saw the families of the users coming together with organisations working on mental health to try and prevent the disaster, and then to seek justice once it unfolded. This is a model for stronger advocacy.

Mental Health Care users are unfortunately not always familiar with the provisions in the Mental Health Care Act that empower users to exercise their rights e.g., consent to admission, types of treatment and how to escalate complaints to the Mental Health Review Boards. More needs to be done by providers of mental health care services to educate mental health care users.

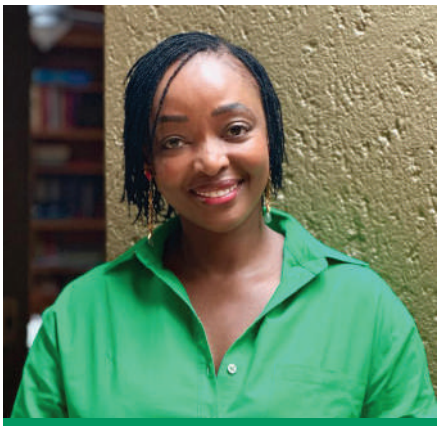
Breaking the Stigma

Stigma and discrimination remain significant barriers to treatment in seeking help by mental health care users. Mental health care users are fearful of being labelled as mentally ill within their families and communities and in particular in the workplace. They are fearful they will be subjected to unfair and discriminatory labour practices. Mental health care users are often unaware of the protections afforded by the Bill of Rights, labour law, and the Employment Equity Act. The employer is obliged to provide reasonable accommodations in the workplace for employees with a disability.

There has been increased awareness around the importance of mental wellbeing in the workplace which was brought into sharp focus during the COVID-19 pandemic. Since then organisations have been recognising the need to improve support for staff and have happier, healthier, and productive work environments.

Stigma results in mental health care users presenting late in the progression of the mental health condition when they display disruptive behaviour, violent or suicidal behaviour. The opportunity for early interventions is missed. Misconceptions about mental health are often culturally and contextually bound. It's incumbent upon health care service providers, mental health care advocates and users of mental health care services to be get involved in demystifying mental health, raising awareness, and improving mental health literacy.

Research has shown that exposure to individuals with mental illness decreases discriminatory behaviour and that celebrities sharing their mental health challenges has a positive impact in shaping people's views on mental health. There has been a discernible shift in South Africa in the past 20 years in terms of the engagement on mental health care issues in the public domain and this is largely attributed to the work of SADAG, an organisation that occupies a pre-eminent position in terms of advocacy work for mental health care users.



Dr Mashadi Motlana
Psychiatrist & SADAG Board Member

Centering mental health

The global theme for World Mental Health Day is significant in South Africa as it is a call to action, to centre mental health as a human right which means that mental health is understood in its socio-economic and political context. The rise of mental health problems in communities is related to issues of poverty, violence, food insecurity, and unemployment and tends to be a gendered as women more likely than men to experience adversity.

Centering mental health also means that it's seen as an intrinsic part of good health and recognising that there is no "health without mental health". The disparities in funding for mental health care compared to physical health services in both the public and private sector may be attributed to stigma and lack of recognition of the significance of impairment, disability and loss of life associated with mental health conditions.

Bringing mental health care to the community is an important extension of mental health as a human right and moving away from the institutionalisation of mental health care users. It's for society to ensure that users are integrated into their communities and have the right to employment with their dignity preserved.

References available on request. MHM

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A PARENT'S PERSPECTIVE OF LIVING WITH A CHILD WITH ADHD

Attention deficit hyperactivity disorder (ADHD) brings challenges for the whole family, not just the child or children diagnosed with the disorder. The core symptoms of ADHD are inattention, hyperactivity, and impulsivity, characterised by fidgeting; difficulty paying attention, being easily distracted; always in motion, as if being driven by a motor; and difficulty controlling impulses which can lead to interrupting conversations and excessive talking.

Before our son was diagnosed with ADHD, we spent years at breaking point, emotionally and physically, tired from the constant demands and physicality of living with a child who ignored our requests, was always in motion, and impulsively reacting to internal desires and his external environment. We experienced feelings of insecurity as parents, questioning our parenting techniques. Were we being too hard in giving out consequences, or were we giving in to demands being made because of the screaming and shouting from our son when he didn't get his own way or pay attention to the instructions given. Both our sons experienced negative parenting more than positive and supportive parenting from us because of the intense and disruptive emotions swirling around.

Our eldest son experienced bullying when playing with his younger brother; simple games could lead to him being hit repeatedly because of a perceived offence, an apology not timeously given, or pain caused through an accident. He also received numerous consequences from us for irritating or distracting his younger brother when we needed focus and attention, especially in moments of pressure to get to school, appointments, or even to sit down at the dinner table just so that dinner could finish within an hour.

As parents our ability to communicate with each other regressed as we became accusatory and judgemental towards one another. We saw in each other the parent we didn't want to be. We found ourselves arguing over our parenting more than partnering together to get the best results for the family, especially in the stressful moments of trying to communicate with our son when he wasn't listening to instructions or was behaving in an inappropriate manner.

As a family we found ourselves isolated, not wanting to attend events or meet up with friends just in case there was an incident, and our son threw a 'tantrum', which was how we viewed his behaviour at the time. We noticed that there were issues within his class at school where he was being isolated, and negative and disruptive behaviour was being highlighted by his classmates. We were called into meetings with the principal and teacher to discuss his oppositional behaviour, inability to sit still, and walking out of the classroom when he desired.

In April 2022 we were given a pamphlet on the indicators of ADHD and our son ticked almost all the boxes. We felt the enormity of the potential diagnosis and yet have never experienced such relief. Finally, we understood what our son was experiencing and had something we could work with, in managing his behaviour; and towards, in getting him the help he needed. The process took some time and due to his age, the doctors were not comfortable to initiate medication until he was six years old. Diagnosing a child younger than six years old is more complicated due to the developmental changes that are happening as well as limited attention span.

We decided to approach the diagnosis through more comprehensive

evaluations by experienced professionals in the field. We had him assessed by an educational psychologist and had psychometric testing done to determine whether he presented with any other cognitive difficulties. He attended occupational therapy sessions weekly, which helped him with emotional regulation and sensory integration.

Throughout this process we researched various medical treatment options for ADHD. We worked with the school on how to manage his behaviour there, with the help of his occupational therapist. With all the research and with the input from various medical practitioners and parents who are living with a child with ADHD our parenting techniques changed, and our understanding of ADHD grew. Initially, the stigma attached to children with ADHD concerned us, until we realised how prevalent ADHD is in South Africa. Throughout this process we experienced some strong opinions from various people related to the pros and cons of medication, diet, and parenting techniques.

While waiting and researching ADHD, and the effects of Ritalin, we had numerous and strong discussions between ourselves on whether we should give our son ADHD medication or not when he turned 6 years old. We had different opinions on the way forward, which was indicative of public sentiment.

Our general practitioner was extremely helpful in the information and support he gave us throughout this process. After all the results from the psychometric testing reflected combined type for ADHD, he assisted with prescribing ADHD medication for our son when he turned six years old. Initially he prescribed a month's trial of medication, which gave us the opportunity to continue discussing and exploring our options. However, once we saw the improvement in our son's behaviour, we decided to continue with the medication, and at each stage that a higher dosage was required, there was a ten-day trial period at the increased dosage before continuing for a month. When it became clear that our son required a higher dosage than he was willing to prescribe, he suggested it would be best to see a psychiatrist who would then be able to assist with the correct dosage for ADHD and who could prescribe medication for the anxiety our son had been experiencing as well. This highlights the importance of a general practitioner's role in the process of managing our child's condition.

The improvement in our son and family since the beginning of this journey has been significant. He has gained the ability to better interact with other children socially and within the classroom, he pays closer attention in class to instructions given, his academics and art has improved quite noticeably as he is able to focus for a longer period, and he is able to follow requests more effectively. Our family life has improved, the emotional turmoil has gone, and we have all learnt to work together to help him through the difficulties he still experiences due to ADHD and anxiety to bring about the best outcome in any given situation. He still struggles when the medication wears off and the anxiety is high, but with the help of continued occupational therapy and his weekly psychotherapy sessions he is learning how to manage his emotions and own expectations as well as learn self-awareness in the process. We have learnt ways to support him and have all learnt a better way of interacting during moments of disruptive behaviour.

ADHD is a disorder and can be treated. We acknowledge that this is how our son is wired and processes the information that he sees, hears, and feels, and recognise that the medication he receives helps him to focus and learn at school, interact with his peers, and regulate his emotions and thoughts. It is also important that, any parent who is living with a child with ADHD be equipped with the knowledge and understanding of their role in managing their child's difficulties.

References available on request. MHM

Dr Antoinette Miric
Psychiatrist
Johannesburg

UNDERSTANDING AND MANAGING BIPOLAR DEPRESSION

Why is recognition of Bipolar Depression important?

Recognising bipolar depression in patients is crucial as untreated episodes increase the risk of attempted and completed suicide in patients. An accurate diagnosis also guides medication choices for optimal outcomes. Primary care providers, as first responders, play a critical role in the detection and management of bipolar disorder for effective outcomes to be possible. Accurate diagnosis can also be vital in identifying co-occurring conditions and assisting patients in understanding their treatment options.

Bipolar disorder is relatively common, affecting 2.8% of the adult population. While Bipolar I Disorder is equally prevalent in males and females, Bipolar II Disorder is more commonly diagnosed in females. The age of onset of Bipolar disorder is late adolescence into early adulthood. The average time it takes for a patient to reach a correct diagnosis is ten years, indicating the complexity of the diagnosis. Bipolar Disorder is a chronic illness with remissions and exacerbations arising even when patients are on medication, with 50% of their time being unwell.

How Bipolar I and II present in patients also differ. In patients with Bipolar II, more time is spent unwell, with the predominant mood state being depression. In Bipolar I Disorder in comparison to Bipolar II the mood state is more frequently elevated.

Patients living with Bipolar Disorder have significant and chronic interpersonal and occupational difficulties. The completed suicide rate in these patients is approximately 10%, with attempts of suicide falling in the 30% - 50% region. Suicide attempts are increased in patients presenting with mixed depressive states. Significant functional and cognitive impairments are associated with untreated lengthy episodes of Bipolar Disorder.

Misdiagnosis

60% of patients who go on to be diagnosed with Bipolar Disorder initially are misdiagnosed with Unipolar Depression, specifically those presenting with Bipolar Depression. The reasons for misdiagnosis vary. Firstly, there seems to be an incomplete understanding of Bipolar Disorder by healthcare professionals. Bipolar disorder that presents first with a depressive state is often overlooked, especially in patients with no history of mania. There is also, at times, a failure to differentiate symptoms that can help differentiate Unipolar and Bipolar depression.

Misdiagnosis has many consequences and direct implications for adequate and relevant treatment. Consequences include the inappropriate use of antidepressant agents, lending itself to an increased acute risk of switching from depression to mania or hypomania, and a delay of proper treatment. Often if an antidepressant is prescribed for these patients, they may initially get well, and after that, it may 'stop working'.

Diagnosis

Making an accurate diagnosis of bipolar depression entails knowing the DSM 5 criteria of a major depressive episode, which includes five symptoms for at least two weeks (one needs to be a depressed mood or anhedonia). Exploring a patient's history of a past manic or hypomanic episode or atypical responses to antidepressants plays a crucial role in diagnosis.

A helpful mnemonic screening tool for bipolar depression or the presence of Bipolarity is WHIPLASHED. This tool can be used in all patients presenting atypical signs or poor treatment response to typical antidepressant pathways. The more WHIPLASHED features the patient has, the higher the

likelihood that you are dealing with a bipolar disorder rather than a unipolar depression.

Worse or "wired" when taking antidepressants, which includes failed trials and switching antidepressants
Hypomania or hyperthymic temperament
Irritability and mixed features during the presenting episode of Depression
Psychomotor retardation
Loaded family history of **B**ipolar Disorder
Abrupt onset and/or termination of depressive bouts
Seasonal or postpartum pattern of depression
Hyperphagia and hypersomnia
Early age at the onset of depression (younger than 25 years)
Delusions, hallucinations, or other psychotic features, which are more present in Bipolar Disorder

Management

The management of bipolar depression ascribes to general principles and assessment of medication status:

- A risk assessment determines if the patient needs in or out-patient care.
- Laboratory investigations are often needed, if not recently done to exclude any medical causes of depression and substance use.
- Recent discontinuation of psychotropics medication and response to previous medications
- Consideration of Electroconvulsive Therapy (ECT) – specifically in those who are a high suicide risk, present with psychotic depression, or are catatonic

Treatment options for bipolar depression are various. Pharmacological treatments include mood stabilisers, antipsychotics, and antidepressants, while non-pharmacological treatments include lifestyle changes, sleep hygiene, light therapy, and psychotherapy.

Pharmacotherapeutic agents in monotherapy include Quetiapine at 300 – 600mg (although evidence exists for efficacy at 150mg and above), Lithium at a target of 0.8 – 1.2meq/l, and Lamotrigine at a target of over 200mg (with a need to titrate slowly 25mg every two weeks), Carbamazepine, Olanzapine and Fluoxetine, and Valproate. Please see the South African Psychiatry Guidelines or EMGuidance for more information – link to bipolar guidelines. https://sajp.org.za/index.php/sajp/article/view/942 .The consensus is that if a patient is depressed on an antidepressant, switch or stop the antidepressant by tapering or cross-titrating.

Quetiapine is generally well-tolerated and is effective in preventing depression during maintenance treatment. It has a rapid onset of action and is also suitable for treatment for mixed Episodes. Like all atypical antipsychotics, side effects, specifically metabolic ones, must be closely monitored (specifically weight gain). Lithium is effective in its treatment of acute bipolar depression and prevention of mood episodes, not to mention its efficacy in treating mania. It is considered a first-line agent for treating bipolar depression and is ranked at Level 2 for efficacy. Lamotrigine is also rated at Level 2 for efficacy in treating acute bipolar depression. It is a first-line treatment option due to its demonstrated efficacy in maintenance treatment and tolerability profile. It is effective in combination with Lithium and Quetiapine for treating bipolar depression. The concern with using Lamotrigine is the need for a slow taper upwards, making it unsuitable as a monotherapy in severely depressed individuals.

Agents not recommended for treating bipolar depression are antidepressant monotherapy, Aripiprazole monotherapy, Ziprasidone monotherapy, Gabapentin, and Risperidone.

The International Society for Bipolar Disorders (ISBD) Antidepressant Task Force has guidelines for prescribing antidepressants for bipolar depression. Experts agree that practitioners should use antidepressants in bipolar depression with caution. This is especially true for patients who switched to mania or hypomania when previously treated with antidepressants. Considering a low dose of an antidepressant alongside an adequate dose of a mood stabiliser or atypical antipsychotic is an option. It's crucial to weigh each patient's potential risks and benefits when prescribing antidepressants. Moreover, monitoring patients for signs of mania or hypomania is essential, especially in the initial weeks or after adjusting the dosage. If a patient doesn't show improvement after 4-6 weeks, experiences severe side effects, or transitions into mania or hypomania, the antidepressant treatment should be halted.

For Bipolar depression, recommended therapeutic approaches include Cognitive Behavioural Therapy (CBT), Family Therapy, and Interpersonal Rhythm Therapy.

Patients must receive education about medication adherence, recognising signs of relapse, maintaining sleep hygiene, understanding side effects, identifying stressors and triggers, exercising, joining support groups, maintaining a balanced diet, and seeking family support. Engaging in a collaborative discussion about adherence is crucial, given the approximately 50% non-adherence rate in bipolar disorder. It's essential to understand the reasons for non-adherence, as the repercussions of non-compliance and symptom relapse can be profound. Such setbacks might lead to job losses, academic struggles, substance abuse, family conflicts, debt accumulation, legal issues, risky behaviours, and a deterioration of the disorder itself.

Bipolar depression is a complex disorder often misdiagnosed as unipolar depression, leading to delayed and inappropriate treatment. Early recognition and accurate diagnosis are vital to mitigate severe consequences such as suicide attempts. Treatment comprises a blend of pharmacological and non-pharmacological methods, with some agents, like Quetipaine, Lithium and Lamotrigine, emerging as primary options. Patient education and adherence is essential, given the profound repercussions of non-compliance and symptom relapse.

References available on request. MHM

Interview with Dr Ian Westmore
Psychiatrist (SASOP)

BREAKING THE SILENCE

MENTAL HEALTH NOT RECOGNISED ENOUGH AMONGST THE DEAF COMMUNITY OF SOUTH AFRICA

In South Africa, the deaf community faces unique challenges including neglected mental health and access to care. Often overlooked and marginalised, this community grapples with a host of emotional, psychological, and societal issues that can significantly impact their well-being.

According to the World Health Organization over 1.5 billion people, nearly 20% of the global population, live with hearing loss whilst 430 million of them experience disabling hearing loss. Researchers project that by 2050, the number of individuals with disabling hearing loss could surge to over 700 million.

Within South Africa, a staggering 12 million peoplee contend with some form of hearing loss which has a devastating impact on the individual, manifesting in academic difficulties, heightened unemployment rates, poorer general health and social isolation. The Deaf community like any other is not immune to mental health challenges, with depression, anxiety, and substance abuse being common adversaries.

Dr Ian Westmore, a board member of the South African Society of Psychiatrists, underscores that one of the most prominent obstacles facing the deaf community is communication.

“Despite sign language being one of the nation's 12 official languages, it remains largely unrecognised and unspoken by most hearing individuals. This lack of proficiency extends to medical professionals, creating a significant hurdle for deaf people in expressing their emotions, thoughts, and feelings. This lack of communication can breed isolation, frustration, and exacerbate pre-existing mental health conditions.”

He says there is a glaring lack of awareness among healthcare providers and policymakers regarding the unique mental health needs of the deaf community. This oversight has resulted in the underdevelopment and inadequacy of services tailored to their specific requirements.

Dr Westmore emphasises, "The mental health challenges faced by the deaf community are fundamentally distinct from those of the general population. Healthcare professionals must account for gaps in knowledge and emotional vocabulary, cultural backgrounds, and the inability to communicate mental health symptoms.”

“Communication within the deaf community presents its own set of challenges. In many cases, certain mental health concepts

cannot be adequately conveyed through sign language alone. Lip-reading often falls short, and written communication cannot fully substitute for spoken language. Additionally, the availability of interpreters proficient in sign language is limited, further complicating matters. Interpreters can, in addition, inadvertently introduce barriers that hinder the expression of emotions, ultimately leaving individuals feeling uncomfortable or misunderstood."

"Without proper methods for assessing mental health conditions, there is a risk of incorrect diagnosis and treatment or even undiagnosed conditions."

In addition to the communication barrier, stigma remains a harsh reality for many deaf individuals. Social stigmatisation and discrimination frequently plague the deaf community, leading to issues such as low self-esteem, anxiety, and depression. Access to crucial information and resources is also severely limited, impeding early intervention and support.

For those born deaf, Dr Westmore says early life stressors associated with the disability can exasperate mental health conditions later in life.

"The inability to communicate and participate in conversations, linguistic neglect, poverty, trauma and abuse can influence a child born deaf's functioning and stress response which, in turn, impacts how they cope with stressors in adulthood."

"Access to quality education is another challenge, particularly for deaf children in South Africa. This educational disadvantage can lead to lower socioeconomic status and heightened stress, contributing further to mental health issues."

Additionally, there are varying degrees of deafness, including those born with the disability and individuals with sensorineural hearing loss due to inner ear damage or age-related factors.

"Sensorineural hearing loss, one of the most common types of age-related hearing loss, is often overlooked but significantly diminishes the quality of life. It leads to feelings of isolation, reduced social activity, and a sense of exclusion, culminating in a higher prevalence of depressive symptoms."

Dr Westmore underscores that addressing mental health within South Africa's deaf community is an urgent matter requiring both acknowledgment and action.

"It is vital that society recognises the unique challenges faced by deaf individuals and takes proactive steps to address them. By breaking down communication barriers, improving access to mental health services, and raising awareness, we can ensure that the deaf community in South Africa receives the support and care they deserve, ultimately improving their overall mental well-being."

Dr Westmore offers several potential solutions:

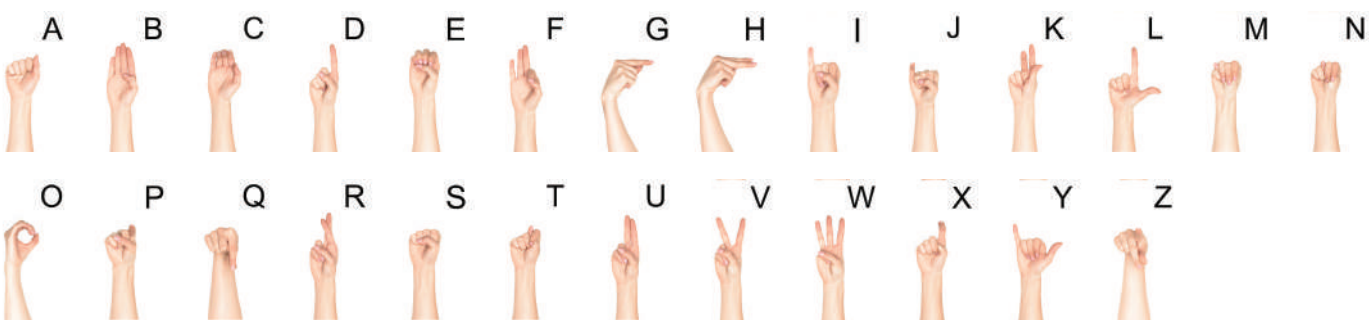
- Training of medical professionals: GPs and clinics are in many instances the first point of call for patients. Healthcare providers need to be trained in basic sign language to help bridge the communication divide and improve the quality of care for Deaf individuals.
- Deaf-friendly mental health services: Specialised mental health services designed to cater to the deaf community should be established, providing a safe and welcoming environment where individuals can seek help without fear of miscommunication or discrimination.
- Awareness campaigns: Initiatives to raise awareness about the mental health challenges faced by the deaf community are essential. These campaigns can help reduce stigma and foster greater understanding among the general population.
- Community support: Peer support groups and community organisations can play a crucial role in providing emotional support and resources for deaf individuals struggling with mental health issues.
- Education: Mental health providers need a deeper understanding of hearing loss, its association with psychiatric disorders, and the treatment of these disorders. Accurate diagnoses hinge on healthcare professionals' familiarity with the unique challenges faced by the deaf community and the profound impact of hearing loss on their lives.
- Checklists: All healthcare professionals should be equipped with symptom-based checklists that the deaf person or their family member can complete, keeping in mind poor literacy and educational attainment.
- Careers in mental health: Encouraging members of the deaf community to consider careers in mental health can help bridge the gap in accurately diagnosing conditions and providing culturally sensitive care.

For additional resources and to seek support the deaf community and their family members can reach out to:

South African National Deaf Association

National Institute for the Deaf

References available on request. MHM



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CULTURAL COMPETENCE IN ANXIETY DIAGNOSIS AND TREATMENT

A GUIDE FOR MEDICAL PRACTITIONERS

Introduction

In our increasingly globalised world, healthcare professionals encounter patients from diverse cultural backgrounds. When diagnosing and treating anxiety disorders, cultural competence isn't just a professional courtesy; it's a clinical necessity. This article aims to guide medical professionals in honing their skills for culturally competent care in the realm of anxiety diagnosis and treatment.

Understanding the Cultural Context

Cultural variability in expression of anxiety:

Symptoms of anxiety may manifest differently across cultures. For instance, some cultures may emphasise somatic complaints over emotional or cognitive symptoms. In South Africa, a country with diverse cultural backgrounds, the expression of anxiety can vary significantly. Within the country, you'll find people from various ethnic groups, including Zulu, Xhosa, Afrikaans, and more. These groups have distinct cultural norms and ways of expressing anxiety. For instance, in some communities, there may be an emphasis on communal support, and individuals might be hesitant to express personal distress openly.

The Zulu culture, known for its strong sense of community, may lead individuals to rely on family or traditional healers for emotional support. In Ndebele culture, a person experiencing anxiety could be guided by their elders to participate in traditional ceremonies to address the issue, as these ceremonies are seen as important for maintaining balance and well-being. Similarly, a Swati individual may rely on the close-knit community to provide emotional support for anxiety related to family or personal matters. Sharing their concerns within the community may be more common.

Conversely, some South Africans from urban and westernised backgrounds may express anxiety more similarly to Western and Eurocentric cultures, with open discussions and seeking professional help. However, even in urban areas, the stigma around mental health can persist, particularly among older generations.

Cultural stigma:

Stigma surrounding mental health can significantly impact how and when individuals from certain cultures seek treatment for anxiety disorders. Mental health stigma is a significant concern in South Africa. Many South Africans, influenced by cultural and historical factors, may view mental health issues as a sign of weakness or associate them with evil or demonic spirits. This can lead to individuals suffering in silence, fearing the stigma associated with seeking help. In some communities, like the Zulu culture, there's a belief in ancestral spirits and traditional healers. People may attribute their anxiety to spiritual causes, which could deter them from consulting western or biomedically trained medical practitioners.

Cultural beliefs around healthcare:

Differing attitudes towards medical intervention can impact patient compliance and treatment outcomes. Understanding these beliefs is crucial for effective patient care. South Africa's cultural diversity extends to healthcare beliefs as well. Traditional medicine and healing practices are often deeply ingrained in various communities. Indigenous knowledge systems, such as traditional African healing, play a fundamental role in managing health issues, including anxiety. Moreover, the influence of family and community is strong. Families are considered the cornerstone of support and decision-making in healthcare within African communities. Therefore, understanding the family's role is crucial when diagnosing and treating anxiety in the South African context.

Diagnostic Challenges

Language barriers:

Linguistic limitations can create significant obstacles in diagnosing anxiety disorders, as nuanced clinical

conversations may be difficult to translate. In South Africa, a nation characterised by its linguistic diversity, language barriers can pose significant challenges in diagnosing anxiety disorders. With 11 official languages and numerous dialects spoken across the country, mental health professionals may encounter difficulties in conducting nuanced clinical conversations. For example, a clinical interview conducted in English may not effectively capture the nuances of anxiety expressions in a patient whose primary language is Setswana or IsiXhosa. Misinterpretations or omissions of critical information can occur when anxiety symptoms are described in a non-native language, potentially leading to misdiagnosis or insufficient treatment. To address this, mental health practitioners must seek to understand their patients' linguistic preferences and, when necessary, employ trained interpreters to facilitate more accurate and culturally sensitive assessments.

Cultural nuances in standardised testing:
Psychometric instruments for diagnosing anxiety are often developed within specific cultural settings and may not be universally applicable. Standardised psychometric instruments designed for diagnosing anxiety are often developed in specific cultural settings and may not be universally applicable. This challenge is particularly relevant in South Africa, given its diverse cultural landscape. For example, an anxiety assessment tool created based on Western and Eurocentric cultural norms may not effectively capture the anxiety experiences of individuals from indigenous South African cultures, such as the San people. These tools might fail to account for culturally specific expressions of anxiety, leading to misdiagnosis or an incomplete understanding of the patient's condition. Mental health professionals must recognise these limitations and supplement standardised assessments with culturally relevant questions or qualitative interviews to gather a more comprehensive understanding of anxiety within the unique cultural contexts of their patients.

Acculturation stress:
Especially relevant in immigrant populations, the stress of adapting to a new culture can compound anxiety symptoms and should be considered in diagnosis and treatment. South Africa is home to a significant immigrant population, and acculturation stress is a relevant diagnostic challenge. Immigrants often face the dual stressors of adapting to a new culture while dealing with pre-existing anxiety issues. For example, a Zimbabwean immigrant might experience heightened anxiety due to the challenges of adapting to South African society, which can include language barriers, legal issues, and cultural differences. Mental health professionals need to be mindful of these factors when diagnosing and treating anxiety in immigrant populations. A comprehensive assessment should consider both the anxiety symptoms and the specific stressors associated with acculturation, with interventions designed to address the unique needs of these individuals. In the South African context, these diagnostic challenges underscore the importance of cultural competence, sensitivity, and flexibility in mental health practice. Practitioners must be attuned to the linguistic and cultural diversity within the country, adapting their diagnostic approaches to ensure that individuals from various backgrounds receive accurate and effective diagnosis and treatment for anxiety disorders.

Integrated Strategies for Culturally Informed Treatment in South Africa

Cognitive-Behavioural Therapy (CBT) and traditional healing:
Adapting CBT to South Africa's cultural diversity is essential. For instance, tailoring CBT for a Zulu patient with social anxiety might involve techniques that address communal interactions within their cultural norms. Similarly, acknowledging traditional healing, such as collaborating with a sangoma when treating a Venda patient, can complement evidence-based methods, enhancing trust and personalising the treatment plan.

Pharmacotherapy, psychoeducation, and family involvement:
The success of pharmacological treatments often hinges on culturally sensitive patient psychoeducation, particularly in communities sceptical about medication. Explaining the rationale, benefits and potential side effects in a culturally congruent manner promotes compliance. Moreover, involving family—a cornerstone of healthcare within many South African cultures—strengthens support networks and aligns treatment with cultural values, which is crucial for communities like the Ndebele, where family involvement is paramount.

Continuous cultural education:
Healthcare providers must pursue ongoing education to remain culturally competent. This includes learning about specific cultural practices, such as the San people's storytelling, and integrating this understanding into therapeutic strategies to enhance engagement and effectiveness.

Cultural assessment and collaborative care:
Performing comprehensive cultural assessments provides insights into the patient's worldview and informs culturally responsive care. Collaborative approaches, such as including cultural liaisons or co-therapists, especially with linguistic and cultural expertise like in the Tswana community, bridge gaps and ensure culturally coherent treatment.

Ethical considerations:
Respecting cultural differences is a fundamental ethical obligation. Practitioners should balance cultural respect with professional standards to deliver ethical and culturally competent care.

Conclusion

Recognising the role of culture in anxiety disorders is key to effective diagnosis and treatment. Cultural competence and sensitivity not only enhances patient outcomes but also fosters a stronger bond between healthcare providers and patients, leading to better mental health care across diverse communities.

References available on request. MHM

Dr Hemant Nowbath
Psychiatrist
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CANNABIS...SINNER OR SAVIOUR?

The storm around COVID-19 settles gently and matters more mundane rear their not so ugly heads again. And so, to revisit the clouds and confusion around cannabis.

Google, AI and social media has created a host of experts and along the way fact and fiction have become blurred. The entry of those with vested commercial interests into the debate has further muddied the waters. The confusion relating to the legalisation of recreational cannabis use and decriminalisation persists. The cognitively challenged presume that decriminalisation means safe. And CBD shops have mushroomed everywhere...

History

The tale is not new. Cannabis has been used in its different forms by various groups of people from antiquity. The ancient Egyptians used 'oil from hempseed' to treat vaginal inflammation, the Hindu god Shiva is said to have been given cannabis as an antidote after he was poisoned. Hindu scriptures refer to cannabis as a 'source of happiness'. Followers of the Sufi sect in Islam felt that cannabis helped them gain spiritual insight by the arousal of ecstatic states. The Rastafarians believe that cannabis helps penetrate the truth and brings them closer to God.

THC vs CBD

The cannabis plant (leaves, stems, flowers and buds) contains over 120 active ingredients, cannabinoids. The 2 most abundant are delta-9-tetrahydrocannabinol (THC) and cannabidiol (CBD). THC binds to CB-1 receptors (found in the central nervous system, heart, testes, and immune system) and modulates the release of the neurotransmitters serotonin, noradrenaline, acetylcholine, glutamate, GABA, dopamine, and the opioid systems. All these transmitters are relevant to psychiatry. Receptor stimulation modulates mood, cognition and appetite and brings a sense of well-being and relaxation. Impaired motor coordination, delayed reaction times and cognitive deficits may also ensue. THC is psychoactive and genetic modification, and the development of hybrid strains has seen the concentration of THC increase from 1 to 5% in the 1980's to 27 to 29% in some strains currently.

The effect of THC on the individual depends on a variety of factors – the manner of ingestion (whether it is smoked, vaped or consumed as edible gummies and brownies), the amount used, the environment in which it is used and its use in combination with other drugs. Individual patient factors (weight, metabolism) also play a role.

CBD should have no more than 0.3 % THC. It does not cause euphoria and is not psychoactive. It may help relieve pain and inflammation but can also cause diarrhoea, fatigue, and weight loss. The peripheral effects of CBD – bronchodilation and decreased intraocular pressure suggest its use in the treatment of asthma and glaucoma.

Addiction

Cannabis is the most used illicit drug in the United States – in 2021 35.4% of young adults (aged 18 to 25) reported its use in the last year. 9% of those who experiment and 25% to 50% of those who use it daily will become addicted.

Short term effects on health include:

- Intoxication - disturbances in level of consciousness, cognition, and behaviour
- Problems with motor coordination leading to increased risk of injury
- Anxiety, panic attacks, hallucinations
- Acute cardiovascular effects – increased heart rate and blood pressure, myocardial infarction and strokes

Long term use causes dependence which increases health risks. Magnetic resonance imaging (MRI) studies report structural changes in

the hippocampus, prefrontal cortex and the hippocampus. Hence the problems with memory, decision making and movement. The risk of developing chronic bronchitis and cancer is also increased.

It's unfortunate that the uninformed believe that cannabis is safe to use. There is no documented evidence for the safety / benefit of recreational cannabis. All evidence indicates the contrary. The use of cannabis for medicinal purposes is a different debate. Many people have confused the issues.

Addiction is a complex medical condition and people should be offered treatment rather than punished for using substances. However, to merely decriminalise recreational cannabis use without having appropriate structures in place to educate and to treat is short-sighted and spells disaster.

The risks of the unfettered use of cannabis are many. Cannabis is addictive and its use may lead to dependence and withdrawal. People who use cannabis are at higher risk for developing depression and anxiety. Cannabis may also cause psychosis and lower the age of onset for Schizophrenia. Impaired cognitive function as a result of the use of cannabis leads to poor school performance and diminished achievement.

Adolescents are particularly at risk if exposed to cannabis. During this period of rapid neuro-development cannabis use may impair neural connectivity in specific brain regions concerned with learning and memory.

Limited resources

The decriminalisation of the use of recreational cannabis in private spaces may well lead to the greater abuse of cannabis, increase rates of addiction, and aggravate the myriad of medical, psychosocial and psychiatric problems caused by cannabis.

South African society is marked by inequality and economic disparity. The vulnerable will be more affected by these problems. The poor don't have ready access to resources, medical aids and rehabilitation facilities. In a country with limited resources the provision of an adequate health service is a constant struggle. Mental health services and treatment for addiction has never been a priority.

Medicinal benefits

There is a growing body of evidence for the medicinal use of cannabis. Evidence has emerged for the use of cannabis in:

- Appetite stimulation in patients with cancer and HIV
- Control of nausea and vomiting in patients undergoing chemotherapy
- Muscle spasm in multiple sclerosis
- Involuntary movements in Parkinsons Disease
- Neuropathic pain in diabetes and fibromyalgia
- Glaucoma

Epidiolex is a CBD product which was approved by the FDA in June 2018 in the USA for the treatment of rare forms of severe childhood seizures – Lennox-Gastaut Syndrome and Dravet Syndrome. The FDA has also approved synthetic THC agents Dronabinol and Nabilone to decrease nausea post chemotherapy and stimulate appetite in HIV patients. In the UK and Canada Sativex spray is available on prescription only for the treatment of pain and spasm in patients with multiple sclerosis.

Politics and the law

Doctors have an ethical duty to get involved in drafting policies in relation to drugs. Often this is left in the hands of politicians, lawyers, and social workers. The criminalisation of the use of drugs is irrational and causes harm. It encourages a black market and criminal behaviour.

In March 2017 the Western Cape High Court ruled that laws that prohibit the production and use of cannabis at home for private use violated the South African constitution. This decision was ratified by the Constitutional Court in September 2018 and Parliament was given 2 years to implement the decision.

In May 2019 then Minister of Health, Dr Aaron Motsoaledi, gazetted an exemption for CBD preparations excluding them from the scheduling system that controls drugs for a period of 12 months. Two conditions applied – the maximum daily use could not exceed 20mg and the products could not claim to treat or cure any condition. CBD products flooded the market. There are no evidence-based quality controls or safety data for these products. Hence the South African Medical Association advises doctors against their prescription.

The Cannabis for Private Purposes Bill was ratified earlier this year but both pro and anti-cannabis lobbies have objected to the provisions in their present form. Further legal challenges loom and the road ahead is uncertain. And again the poor and the marginalised are victims of those who seek to enrich themselves in a commercial cannabis market...

References available on request. MHM

Based on the webinar *Healer, Heal Thyself*
Neil Amoore
Clinical Psychologist

MENTAL HEALTH AND HEALTHCARE PROFESSIONALS

Introduction

Doctors are often referred to as healers of society and shoulder the responsibility of caring for the health of others. However, the demanding nature of their work can take a toll on their mental wellbeing. They tend to have an understanding of patients but overlook their own mental healthcare challenges as healthcare professionals and how they cope with that. The Covid-19 pandemic highlighted the challenges of coping and working in different settings whilst experiencing their own difficulties. Although the pandemic is not as urgent as it once was, there is somewhat of a hangover in significantly adjusting to mental health.

Healer, Heal Thyself

Healing ourselves does not mean treating ourselves but opening up and obtaining the necessary care and concern from others in the healthcare network. It is well known that healthcare workers tend to not seek assistance and healthcare services when they could and should, specifically within the mental healthcare context. Mental health, however, does not care about our profession or status, affecting everybody alike.

Stigma

Healthcare providers suffer the same stigma as those in communities but are said to suffer a second layer of stigma, especially as they are seen as superheroes. This was especially prevalent during Covid-19, with many media images circulating with healthcare professionals wearing superhero capes. Although healthcare professionals don't wear capes, many wear a mask to make themselves seem intact enough to continue with the demands of the job. The faces of medics in warzones echo this, with the desperate need and demand to carry on working in the face of exhaustion and trauma.

Dealing with stigma involves understanding it. Stigma is a negative perception of someone with a mental illness, defining the individual by the illness rather than by their personhood. It is socially constructed and reinforced through media, social media, and organisational structures. Sympathy for healthcare providers who struggle with their mental health is not easily found within these spaces. There are many misconceptions of healthcare workers and mental healthcare professionals as wearing a hero's cape, someone who could not possibly "succumb" to these stressors or illnesses. When acted upon, stigma leads to discrimination against others, or in self-destructive behaviours within the individual.

There are three basic forms of stigma:

1. Public stigma, which is negative or discriminatory attitudes that others have about mental illness and is often reflected in the language used by healthcare professionals, with 44% of patients being stigmatised by their treating doctors.
2. Self-stigma is the negative attitudes, including internalised shame that people with mental illnesses have about their own condition, including negative self-talk about being weak or incapable of performing their duties.
3. Institutional stigma involves the

policies of government and private organisations that intentionally, or unintentionally, limit opportunities for people with mental illness. These manifest in decisions of resource allocation, funding, and a prescient focus on "presenteeism" and the guilt that accompanies diminished performance or not showing up for patient care.

Barriers to treatment

One of the biggest concerns that inhibit treatment is vulnerability or exposure to peer criticism and mistrust of colleagues. This is reflected in healthcare professionals choosing to open up to strangers rather than their own colleagues. Another big barrier to treatment is the fear of professional censure, with up to 80% of healthcare professionals being afraid to report not coping. This lends itself to a pressure to cope and appear competent. Healthcare workers also find that their training "immunises" them, desensitising them to their own concerns after being exposed to a multitude of illnesses. Confidentiality, too, is a risk and barrier, as healthcare workers are worried about reputational damage and isolation. This isolation occurs more commonly within a private practice context, inducing a greater pressure. Personality factors such as inhibitions, introversion, and longstanding traumas also present a barrier to treatment, as do relationship factors such as strained relationships and a lack of the protective mechanism of supportive relationship structures.

Burnout

The invariable response to this barrier to treatment is burnout, which is defined by the ICD-11 as the result of chronic workplace stress that has not been successfully managed. Burnout is characterised by three dimensions:

1. Feelings of energy depletion or exhaustion.
2. Increased mental distance from one's job, negativity, or cynicism towards the job.
3. Reduced professional efficacy.

Meaning and fulfilment are lost in burnout, only to be replaced by a sense of futility and resentment. Energy that was there before turns into exhaustion, engagement becomes cynicism, and efficacy replaced by ineffectiveness.

Burnout rates are significantly increased across all medical specialities internationally, with South Africa not faring much better. In the USA, psychiatrists were third on the list of most burnt-out medical professionals, behind Emergency Medicine practitioners and Internal Medicine practitioners. Rates of burnout in South Africa are aligned with those internationally. In the South African context, 50% of nurses reported burnout soon after the start of the Covid-19 pandemic. 67% of doctors in both rural and suburban areas were also burnt out at this time. The dramatic increase in demand for services since 2020 has stretched all mental healthcare professionals. Psychologists, Social Workers, other Allied Healthcare Professionals and Nurses are at particular risk for burnout due to the length of therapy provided, the detailed nature of interventions required, exposure to the trauma of patients being treated, and the daily management of very ill patients. Caseloads, arduous work involving difficult conditions, and financial demands to keep working, coupled with poor peer-support and unhealthy coping mechanisms are all contributing factors in the continued growth of rates of burnout.

Depression and Suicide

South African psychiatrists are 2.5 times more likely to die by suicide than the regular population. Psychologists comprised 4,9% of all healthcare worker suicides in the USA up to 2019. 25% of South African healthcare and mental healthcare workers suffer from depression and anxiety. Mental healthcare practitioners suffer from depression, anxiety, and PTSD at rates higher than the general population. It was reported that 11% of American psychiatrist contemplated suicide in 2022.

Substance Abuse

Due to increased access and the increased vulnerability to the mental health issues described above, healthcare workers are particularly vulnerable to substance abuse. Chemical dependency has a lifetime prevalence approaching 10-15% within healthcare workers. Alcohol dependence alone varies from 8% to 15%. Abuse of opiates and benzodiazepines, on the other hand, are enabled by self-prescribing. These are often hidden due to a fear of being reported as impaired to governing bodies such as the HPCSA.

Improving Mental Health among Healthcare Workers

As stated before, healer heal thyself does not mean treating oneself. There are many other options available to improve mental health among healthcare professionals.

Protective factors include adequate access and use of professional counselling or therapeutic services, developing and utilising professional or collegial relationships, speaking to friends and family, diversity in life activities with spaces for decompression, exercise, hobbies and activities, and employer support and effective leadership to protect healthcare workers. Understanding the difference between self-care and self-soothing is important. Self-soothing provides immediate gratification with short-lasting effects, while self-care concerns changing structures longitudinally to provide long-term effects.

Coping with these challenges involves upping the standard to what healthcare professionals feel they need to give to each other, taking it out of the informal discussion and starting to put it in good quality care pathways acknowledging this mental health crisis in a way that is non-judgemental and not seen as being immediately leading to censure. Provoking a discussion as far as possible can challenge us to utilise resources available effectively.

One such resource is the Health Care Workers Care Network (HWCN) which provides a confidential safe space for healthcare workers to receive mental health assistance by counsellors and other mental healthcare professionals. The line is toll-free and available 24/7 at 0800 21 21 21.

Link to webinar: *https://www.healthcareworkerscarenetwork.org.za/support-tools-resources/webinars/159-webinar-mental-health-and-healthcare-professionals*

References available on request. MHM

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TRANSGENERATIONAL EFFECTS OF DEPRESSION

Depression is the most common mental illness in the world. It is an insidious and silent disease that affects families and communities, as well as individuals. Like other diseases, depression often has its roots in the young person, even if it only manifests later. Child and adolescent depression can affect education and hence employability, negatively impacting on economic activity and quality of life. It's a disorder that exacts a real cost in terms of human suffering.

Depression often runs in families, but the aetiology is varied, complex and multi-faceted. Mood disorders have a clear genetic component, particularly bi-polar disorders. This has been supported by twin and adoption studies but what is being inherited may not be as simple as a certain type of brain functioning or biochemistry. For instance, it may be a type of personality and temperament that is negatively impacted by environmental factors such as stressful life experiences. Epigenetic changes suggest that traumatic life experiences may 'turn on' the expression of certain genes.

Different psychological theories propose various explanations for the development of depression, including that of a depressive personality. These theories are mostly developmental in nature, meaning a child will grow and adapt to various influences across his lifespan. An early loss, anger-turned inwards, learned helplessness, guilt inducing parental behaviour, abandonment and parental criticism all have been suggested as possible pathways towards developing depression.

Sophie

12-year-old Sophie is the eldest of 3 children. Since she was a baby, her mother has suffered periodic bouts of MDD. On such occasions, she spends most of her time in bed, with her curtains closed. It then falls on Sophie to care for and look after her mother and younger siblings. When her mother is relatively well, Sophie tries to do everything perfectly, in the hope that her mother will stay healthy. She feels guilty making normal demands of her mother as she's come to believe this will drain and exhaust her. Her father is very preoccupied with his high-powered job and appears distant and overburdened. Sophie is popular and a high achiever at school but recently she's found it difficult to concentrate on her work. She feels tired and anxious, and small obstacles in her day overwhelm her. She has started cutting herself, as she's found it helps her feel calmer and more in control. Her class teacher has noticed the marks on her arms and

has made an appointment for her with the school counsellor.

Sophie's case illustrates how a genetic vulnerability and environmental factors may interact to facilitate trans-generational depression. She may have inherited a tendency towards developing depression both from her mother's biology and from the environment created by her mother's illness.

Research into transgenerational depression has examined how children are affected by a depressed parent, particularly a mother with post-partum depression. (The risks associated with parental depression may not be specific, that is, a variety of emotional problems may result, not just depression). A baby's earliest years are critical in establishing their basic attitudes and expectations of others. The earlier their dependence on someone who is deeply depressed, the greater is the emotional damage. Depressed parents are not able to parent effectively; they are usually withdrawn and absorbed in their own difficulties. Their behaviour can also be accompanied by inappropriate anger or hostility, as the cognitive distortions that accompany depression may cause depressed parents to perceive certain behaviours to be problematic that other parents do not.

Another way parental depression can impact on a child is through the social environment. Depressed parents may withdraw socially, restricting their ability to involve their children in activities outside the home, limiting the family's social network, and denying the child other avenues of social support. Maladaptive ways of thinking may also be modelled by the parent, as depressed individuals typically hold inaccurate and negative ideas about themselves, other people, and the world around them.

Emotionally healthy caregivers who respond in sensitive and appropriate ways to a child's distress, allow children to develop internal working models of the parent (and the self) as being available and worthy of love. This becomes the blueprint for their expectations about the world and their place in it. When parents are less available or inconsistently available, children develop insecure attachment styles, which are associated with the development of depression and other psychopathology. Influences between parent and child are bi-directional. So, a difficult or demanding child may generate additional stress for an emotionally fragile parent, further diminishing their ability to parent effectively.

When assessing the risk of transgenerational psychopathology, psychologists tend to think in terms of risk and protective factors. A risk factor is any characteristic (biological, psychological, family, community or cultural) that is associated with a higher likelihood of a negative outcome. A protective factor is a characteristic that may reduce a risk factor's impact. If we look at Sophie, her risk factors include the long history of her mother's illness, her father's emotional absence and the fact that she is a parentified child. However, her family has a high socioeconomic status, meaning she does have access to various resources. Her success in different spheres at school gives her an area where she can achieve, thus buoying her self-esteem. She also has access to therapy, which may mean she is afforded the opportunity to do the necessary work to overcome her difficult childhood and gain the necessary insight to break the inter-generational cycle of depression when she herself becomes a parent.

Despite the advances made in mental health awareness in recent years, there is still much social and cultural resistance to admitting to a problem that might make you appear weak or feeble minded. However, there have been huge advances in anti-depressant drugs in recent years, exciting research into brain functioning and new therapeutic methods developed. Perhaps more than ever before we have the tools to manage chronic mental health conditions and prevent their transmission to future generations. Depression doesn't have to be a life sentence of misery. Intervention, the earlier the better, is key.

References available on request. MHM

Jean Augustyn
Former professional emergency nurse and educator

HEALTHCARE PROVIDERS' PSYCHOSOCIAL ROLE IN RECEIVING AND MANAGING SUICIDAL PATIENTS

Patients who have tried to take their lives through, for example overdose, or who are struggling with suicidal thoughts are most-often not always priority in a trauma-filled (or medical emergencies) Emergency Centre (EC) or ambulance. This comes from personal nursing experience as well as being such a patient myself. First line healthcare providers (HCPs) (referring to emergency care providers, nurses, and doctors) are extremely important in dealing with such patients as secondary trauma is uncalled for (and further suicide must be prevented).

The most important goal in medically managing patients who have attempted to take their life or are who seeking assistance due to suicidal ideation/threat/attempt is to provide a physical and psychological safe space, treat self-inflicted medical problem and further prevent any more complications (such as further self-hurt).

Nurses are often first in contact with patients arriving in ECs, especially where an effective triage system is place. The South African Triage Scale (2017) states clearly that patients who have taken an overdose or have been poisoned are triaged orange/very urgent (unless any of the 'red' criteria apply) and must be treated within 10 minutes.

Emergency medical care providers and emergency care doctors are also first line responders and so this article is applicable to them as well. Other systems though, allow receptionists to be on the receiving end of new patients and although not ideal, receptionists should also be given some guidelines on identifying and dealing with patients who are in psychiatric distress.

This guideline however will focus on the behavioural or psychosocial management of such patients (these may be patients who have already self-inflicted harm or those who seek assistance due to suicidal ideation/threat/attempt). Such patients may be suffering from a range of psychiatric disorders such as major depression or depression due to bipolar disorder or post-natal depression, anxiety disorders, PTSD (post-traumatic stress disorder), schizophrenia, substance abuse and/or personality disorders.

My own experience (and I am also guilty) and experience of some South African emergency nurses and other healthcare providers shows that they sometimes struggle to show the necessary empathy in managing suicidal patients. There may be several reasons for this, such as:

- Little or no training in psychiatric emergencies
- Copying colleagues' poor management of such emergencies
- No general psychiatry training
- Necessary prioritisation of patients with physical problems (e.g., 'red' patients) and general busyness of the EC
- General blunting to such 'difficult' or 'non-emergency' patients (especially non-overdose patients) may unfortunately be another reason for a lack of empathy

Unfortunately there is also the

stigma around depression and mental health emergencies which fortunately is slowly decreasing with several NGOs' help

Dealing with such patients can be emotionally and professionally draining. Values and beliefs around suicidality should also be considered as healthcare providers must take note of their own verbal and non-verbal behaviour and reactions towards the patient.

SUICIDE LANGUAGE GUIDE

(This is taken directly from SADAG - South African Depression and Anxiety Group - all acknowledgements to them)

DO SAY	DON'T SAY	WHY
'died by suicide' 'took their own life'	'successful suicide' 'un 'successful suicide'	Because it suggests suicide is a desired outcome. No one wins if someone dies by suicide dies.
'took their own life' 'died by suicide'	'committed suicide' 'commit suicide'	Because it associates suicide with crime
'increasing rates' 'higher rates'	'suicide epidemic' 'failed suicide'	Because it sensationalises suicide
'suicide attempt' 'non-fatal attempt'	'failed suicide' 'suicide bid'	It means that someone hasn't died, they are still alive and there is an opportunity to get them help. So not dying by suicide is not a fail
Refrain from using the term suicide out of context	'political suicide' 'suicide mission'	Because it is an inaccurate use of the term 'suicide'

SADAG Project Manager, Krystle Kemp, reminds us that someone who has a mental illness is not defined by their mental illness. The person 'struggles with depression', rather than he/she is depressed. As SADAG describes, "We don't say that someone who has cancer "is cancer", rather they have been diagnosed with cancer.

Major depression and bipolar disorder (or any of the above stated problems) are illnesses, just as is hypertension and diabetes. Suicidal ideation and an attempt to take his/her life is a desperate attempt to end the pain or situation that the person is in. Medical treatment may not have worked anymore, and such patients are often in total despair.

HOW TO MANAGE PATIENTS WHO FEEL SUICIDAL OR HAVE ATTEMPTED TO TAKE THEIR LIVES THROUGH SUICIDE

Health Care Providers who are inclined towards psychiatry may be tempted to counsel the patient in the emergency centre/ambulance; however this is neither the time nor space to do so. Emergencies' unpredictability as well as the healthcare provider's short encounter with the patient (normally) is unfortunately unsuitable to 'counselling'.

However, the following principles apply to any healthcare provider dealing with a patient who has attempted to take their life or patient who is experiencing suicidal ideation/threat/attempt.

1. Where at all possible, attempt to keep such patients away from the mix of physical trauma, medical emergencies, and even death.
2. Show empathy. Convey sincere concern. Really listen, try to understand things from their perspective.
3. Make regular eye contact and refer to the person by name.
4. Be patient. Allow the patient time to digest what is happening around them.
5. Take on a non-judgmental attitude and avoid criticism. Avoid telling the patient what he/she should do or should have done as this can be seen as criticising.
6. Attend to these patients frequently, even if it's just to check they are okay or need a cup of tea/water (where not contra-indicated) and tissues etc. It's extremely important to know where your patient is at all times.
7. When able, sit quietly with the patient, especially if they are extremely emotional (crying) – silent moments are okay. The patient may feel more comfortable or be trying to deal with their feelings at that time.
8. Validate emotions: reinforce that crying/distress is 'normal' to experience in such a situation.
9. Ensure the area is safe. ECs are areas with equipment that could be lethal (such as defibrillators) as well as drugs and equipment that could inflict great harm/death.
10. Avoid giving (uncalled-for) advice.
11. Keep the family up to date with developments and reassure them as much as possible.

A FAMILY'S REAL EXPERIENCE …

Having myself been a patient who has attempted to take my life, my family has experienced the difficulty to get the necessary medical care for me. This was an extremely traumatic experience for them. As they recall the situation my family took me to a local government-based EC. Once at the EC, triage was never applied (I had overdosed) and eventually my family took me home after hours of waiting in the EC's waiting room. I could have died (although that is what I wanted at the time). In retrospect this should NEVER have happened. Private hospitals can also assist patients in these situations and should be used where at all necessary and affordable (through medical aid or other means).

IN CONCLUSION

Healthcare providers are in the privileged position to assist those in crisis, whether it is physical or psychiatric. It's important to acknowledge that many South African healthcare facilities, Emergency Centres, and hospitals' pressure experienced by healthcare providers are not always conducive to dealing with psychiatric emergencies. However, may this guideline be a reminder to deal with suicidal patients with utter respect and non-judgmental. They require empathy during their medical crisis as does any other person with any medical/traumatic emergency.

References available on request. MHM

By Marion Scher
Author of Big Bully: An Epidemic of Unkindness

BIG BULLY

AN EPIDEMIC OF UNKINDNESS

The first question I get asked as the author of this book is why bullying? Quite simply, after writing my previous book which highlighted 11 people's lived experiences with various mental health issues, the one topic which reoccurred during interviews was bullying. Whether at school, home, the workplace and of course online, I realised this needed more research and exposure.

With Lundbeck's encouragement and backing I was able to spend valuable time researching this topic which we decided to break into four categories: teen/school bullying; relationship bullying; workplace bullying and social media bullying. This latter category, given how it's insidiously woven into the very fabric of our society, runs through every chapter of the book.

Perhaps the hardest part of writing this book was actually getting people to open up to me on their bullying experiences, insisting on anonymity to protect themselves – against further bullying! When I did interview people I could sense just how tough it was for them to relate their experiences to me. They felt ashamed that they'd allowed themselves to be bullied.

Another question I'm asked is what do I think is the worst area of bullying? There is no one area, but social media definitely has seen this scourge increase with a powerful, subsequent impact. In my previous book 'Surfacing' a number of the interviewees related how when they were bullied at school at least when they went home and closed the door on the outside world they felt 'safe'. These days that doesn't exist, as social media follows you wherever you are. It also makes bullying easier because the bully is able to hide behind a screen.

Teen bullying

This is where social media plays a massive role and where bullying rather than being an 'in your face' experience takes on a whole new look. For instance a teen goes online over a weekend and immediately sees a group of their school mates having fun at a party. A party they weren't invited to! This type of exclusion is just as bad as a slap in the face as that child has to go back to school the next day aware of being left out...

One of the most horrific, but I discovered not uncommon features of teen bullying, is when sexting goes horribly wrong. Imagine discovering your 11 year old daughter has texted nude photos of herself to her 'boyfriend', who when they break up then proceeds to send these out to his social media group, which could be vast. This girl, at 11 years old may well feel her life is over – and as we're seeing more and more, decides life is no longer worth living. A growing factor in the rise of teen suicide.

The role of schools

The first thing I did when I began my research was to email various well-known high schools to ask permission to speak to teachers and pupils. I received one reply only – from the wonderful Westerford High School in Cape Town, who were enormously helpful in this regard. The rest – as far as they were concerned didn't have a problem. What I came to realise was that it was all about their protecting their brand. They felt if they participated in this project it would look as though they had a problem with bullying, which of course all schools have.

After speaking to schools, parents and teachers the main issues are: lack of willingness to take real responsibility for bullying; communication between all parties; understanding just where teens are with social media.

Relationship bullying

This has been going on since the first caveman grabbed his spouse by her

hair and dragged her out of the cave. The difference again is the subtlety of the bullying. Whether it's financial, emotional, physical or all of these factors, I discovered a common thread was the difficulty in walking away. It's almost easier to stay and battle on, particularly where there were children involved. Again there was almost a shame in admitting abuse had taken place. What surprised me here were colleagues who I'd known for many years and thought were in good relationships, who told me their gruelling stories. The bottom line is that very few people have someone they feel they can trust to open up to and feel supported by. Going to therapy in this country still carries a stigma, which hopefully this book may help disappear.

Workplace bullying

Several key issues came out of my research here. The main one being that human resources is there for the employer not the employee, who generally felt pretty hopeless when it came to reporting any bullying incidents. The other factor being simple economics - if you're lucky enough to have a job, you must shut up and carry on rather than make any waves.

Social media bullying

As social media and AI grow each day, so their effect on people's lives, especially teens becomes part of this phenomenon. So many young people in particular told me that even though they were aware of the damage social media can inflict, they couldn't stop themselves going online – sometimes up to seven hours a day. This impacts their lives not just when it comes to interacting with those they know, but being exposed to what is seen as the perfect life, with the perfect people, which they simply can't aspire to. They then see themselves as less and this is often a fast track to depression, but that as they say is another whole story – perhaps my next book...

Be kind

And what about the bully? Where and when does bullying begin? For me, this can be any time between birth and death, caused by imitation or circumstance. In the case of a child are they just replicating what they see at home? In the workplace will they seem weak if they don't take a firm stance, particular for women bosses? There are many scenarios and very few answers here. Perhaps what we need now more than ever is simply a reminder to be kind. Setting a good example with a simple 'please and thank you' to supermarket staff, waiting staff at restaurants, the cleaner at the office. Anyone and everyone we meet on a daily basis. Showing empathy and understanding goes a long way towards a better, happier society.

BIG BULLY – An epidemic of unkindness (Bookstorm) is available at all good book stores.

References available on request. MHM

Marion Scher
Author of Big Bully:
An Epidemic of Unkindness

Due to a printing error in Volume 10 Issue 4, this article has been reprinted.

BORDERLINE AS A SUPERPOWER

Sasha Schafli

I was diagnosed with BPD when I was 23, whilst studying for my honours degree, but the reality is I'd lived with my disorder for a long time, not truly understanding what it was.

As a child, I'd have intense emotional reactions that no one really understood. Crying fits that wouldn't end. Pain that would last well after arguments and desires to end the pain from the age of 17 years old.

Aside from BPD not being well-understood for many years, the information available online makes it sound like a death sentence. The diagnosis has always been viewed as an "Other" label for personality disorders, for people that don't quite fit the bipolar box. These extra fears of abandonment and rejection combined with lack of boundaries in relationships tend to form struggles with independence or having a "favourite person", who is where one's emotions are stored. These are typical traits for BPD. I had my first favourite person at 13 years old and my last relationship with one ended a year ago. These traits are also what cause it to be the most negatively viewed online, with words like "manipulative" and "toxic" labels. The label and categorisation has led this disorder to be the diagnosis for "people that don't get better" and it has become shameful for people to be associated with it.

I have been told by most of my medical professionals - if you're admitted for a suicidal attempt, whatever you do, don't tell them you're borderline. This, and the horrible misinformation out there on Google, reminds me of silent protests we'd do at university where you're unable to say anything

Throughout my years of struggle behind closed doors of seeming success to the outside world, I felt I had no voice and no one truly understood the pain I was experiencing, that often appeared out of the blue. The worst was both the misunderstanding, as well as the invalidation of the feelings and reactions, which left me feeling like an alien. Even when seeking help I often fear telling people about my borderline, including the professionals that seek to help me, for fear they will treat me differently, even losing empathy for me completely.

Borderline has been spoken of as the most emotionally painful disorder. My own episodes feel like I'm being held with a vicelike grip underwater, completely unable to breathe, whilst simultaneously being stabbed with multiple sharp objects. I've often described it as a deep hole where no one can reach me. There's a reason it had been termed as on the borderline of psychosis. Without a support group it's also one of the loneliest disorders. The lack of knowledge and understanding from non-borderlines just feeds into fears for borderlines of rejection and black and white thinking patterns.

However, the majority of borderlines I know are some of the strongest and most resilient people on the planet. Since the entire disorder is triggered from trauma, they are both trauma and often suicide survivors. We are also the most empathetic and caring of people, and are excellent in professions with those emotions, such as teachers and health care workers. They are often also the most intelligent and creative people on the planet. Due to the emotional intensity, artistic expression is often natural to the borderline. Some of my many hobbies include drawing, playing guitar and bagpipes, calligraphy, writing poems and slam poems, French knitting, decoupage, scrapbooking, dancing and creative writing. I currently write campaigns for DnD games and act as Dungeon Master for the game.

In describing my experience of BPD, I wish to highlight the superpowers of this mental health condition, and not just focus on the negative qualities and stigmatisations of these personality traits that the media constantly highlights. Even though the name itself BPD, like most mental health conditions, is labelled "a disorder," the word becomes a self-fulfilling prophecy for borderlines with low self-esteem that already feel like they do not fit into society and that there is something wrong with them.

Despite a divorce in 2022 and overall abuse in workplaces, I have studied full-time while working 5-8 jobs from the year 2017. As I finish my final year of PhD in Linguistics in 2023, I still work two jobs and have moved cities, living alone. My full-time job and after-hours teaching on the side I do to ensure my bills are paid. I've been called a machine by people, showing admiration for how I cope. The truth is, when my borderline shouted at its loudest I wasn't respecting myself and my boundaries, taking on more work to try and enter the academic world of permanent employment. The crash came after my experiments I'd self-funded for the thesis didn't do what I'd hoped they would. A few months later, I worked a job I should have been remunerated for, yet was not, and missed my own graduation.

After a massive dispute in divorce proceedings I wound up in a government emergency ward for a suicide attempt in a town without water. Not only was there no psychiatric help provided to me, but all patients were forced to wear diapers, due to the toilets being unable to operate in the conditions of the town itself. Yet, it is at rock-bottom that diamonds form. I was admitted on a Friday but by the following Monday I was not only back at work, with barely anyone aware of what took place, but also presenting to a group of over 200 people, as if nothing happened.

This year, I've had to work through that trauma, and it's a long process. I realised that the academic space was causing my mental health to decline, as I fought in a system to be seen as valuable, and knew I had to leave and find a workspace that would value me.

It has taken me five years to learn the skills and practical side of therapeutic information to treat my borderline, and even so, I still get episodes. But they have lessened and are easier to deal with and now Borderline is no longer the scariest thing in my life. My borderline co-occurs with PTSD, ARFID (avoidant restrictive food intake disorder) and ADD. Treating these is really important, as food intake and the executive functioning issues that come with ADD increase the instability of moods and emotional dysregulation.

The biggest lesson I've learned through the past year in particular was to respect myself more, that I deserved more and nurturing my self-esteem. My intense emotions now, even though they hurt me sometimes, are often a miracle balm that can soothe friends and colleagues that are going through terrible times. They help me put myself in other people's situations and understand others better. My emotions often have the power to change a room's dynamic, without me even trying to change the environment. I love how my emotions act like watercolours on a blank canvas, and how it leads me to be able to be artistic and creative in my hobbies. For so long, people like me have put ourselves down and felt we are not normal because of our intense emotions. But why blend in when you were born to stand out? Why be human when you could be superhuman? And by finishing my PhD soon, and finding a lack of success reports from borderlines, I hope to cross that stage and show borderlines exactly how powerful they are.

References available on request. MHM