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# MHM

# MENTAL HEALTH MATTERS

BEING MINDFUL OF MENTAL HEALTH ISSUES WITHIN THE AFRICAN CONTEXT

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THE SOUTH AFRICAN DEPRESSION AND ANXIETY GROUP

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*Making Mental Health Matter*

# BEING MINDFUL OF MENTAL HEALTH ISSUES WITHIN THE AFRICAN CONTEXT

The mental health field seems to be gaining global attention within health and wellness topics, especially following the COVID-19 mayhem. Similarly, Africa and South Africa have seen an increase in mental health conditions. In the same breath, the number of charismatic churches, traditional healers and "*sangomas*" are increasing alongside unemployment, poverty, substance use, and crime. Subsequently, conversations and discussions on mental health topics are increasing with relevant questions being asked and reflections made such as:

- *Is current research, teaching and practice of mental health care relevant to the South African mental health care users?*
- *Are mental health care practitioners competent and adept in assessing, diagnosing and treating mental health problems within the contemporary and modernised South Africa?*
- *Are mental health care practitioners providing 'culturally-appropriate' health care services?*

Owing to the mixed and diverse culture of Africa, mental health and illness in Africa and South Africa needs to be re-conceptualised. Practitioners need to be mindful of the various, unique qualities presented by individuals in assessing, diagnosing and treating mental health problems. The *Biopsychosocial* medical and psychiatric model adopted, for decades now, has been established on western interpretations of healing and health. This model seems to limit the holistic attempt to understand and classify experiences considered to be outside the boundaries of what is regarded as 'normalcy'. In essence, the *bio-psycho-sociocultural* system seems integrative of the dynamic factors that make an individual. Dubbed '*the rainbow nation*' by the late Archbishop Desmond Tutu, the colours of the rainbow seem to capture the diverse cultural representation of the South Africans according to:

- Ethnicity
- Gender
- Language
- Religion
- Social and economic class
- Spirituality, and so on…

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It's within this context of diversity that mental health care practitioners need to be mindful of cultural factors impacting on mental health. The following scenario illustrates how religion and culture may have an impact in the assessment, diagnosis and treatment of mental health issues.

*'A 24-year-old *Lerato (pseudonym) was brought to the hospital casualty unit, accompanied by the Emergency Medical Services (EMS) practitioner and her university room-mate. She appeared agitated, aggressive, and uncooperative. She was preaching loudly and praying, holding a Bible and a glass of water. The doctor on-call sedated and admitted her for psychiatric management including diagnosis and prescription of medication for Brief Psychotic Disorder (BPD). Upon investigation, the room-mate reported that Lerato told her that she saw a black cat sitting by the window of her room the previous week. Lerato seemed preoccupied, disturbed and worried about the said cat. She called her mother and they prayed together on the phone. The morning of the incident under investigation, on her way to class, Lerato saw another black cat crossing in front of her and she started praying, pacing around, and talking so fast her room-mate couldn't understand what Lerato was saying. Lerato ran back to her room and started sprinkling water in the room and under her bed, praying loudly whilst holding a Bible in her hand.*

*The following morning in the ward, Lerato appeared calm with a cooperative attitude showing no symptoms of psychosis as previously 'assessed and diagnosed'. She gave the background that when she visited her church during the previous university recess, she was told that something bad was about to happen to her due to jealousy from her community about her studies. The pastor told her that she needed to pray, a lot. She had been praying so much that she wasn't sleeping adequately. She was also instructed to mix salt with water and sprinkle in her room. Lerato explained that seeing the black cat twice, caused fear and panic on her part. She believed that a black cat was a symbol of bad luck and suspected witchcraft. She remembered what her church pastor said and engaged in intense prayer to get rid of the bad luck.*

*The routine blood tests were normal. Lerato reported no history of mental illness before this incident. She was discharged home to her residence after a week.'*

There are so many people experiencing and identifying with Lerato's psychosocial and cultural woes. Some have been found 'paralysed' and others 'blind' without biomedical reasons. These stories seem to have psychiatric similarities of 'madness' according to the medical diagnostic model and cultural and belief systems. In practice, similar cases are being referred for mental health attention with possible diagnostic challenges. Contextually, Lerato belongs and subscribes to certain cultural and religious views which can be misdiagnosed as core psychiatric conditions. In her culture, witchcraft is common and specific rituals are practiced to heal and get rid of the evil spirits. If not mindful and understanding of influencing factors such as culture, practitioners can easily misdiagnosed Lerato with delusions and psychotic presentation. Consequently resulting in treatment being inappropriate and ineffective.

The continuous revision of the *Diagnostic and Statistical Manual of Mental Disorders*, now on fifth edition (DSM-5) is an effort to bring up-to-date and advance the assessment and diagnosis of mental health issues. For comprehensive and all-inclusive assessment and diagnosis, it's often helpful for practitioners to assess the *V and/or Z codes* of the DSM-5 to integrate psychosocial and cultural problems into psychiatric diagnosis. Seemingly, both V and Z codes are not used appropriately and effectively by practitioners with the reported lack of mindfulness about these codes. These codes aid in the formulation of mental health problems and their treatment. Mental health care practitioners are reminded to assess, diagnose and treat mental health issues in the context of what is considered 'normal' behaviour within a particular culture and setting.

Equally, teaching and learning programmes on mental health and illness have to be aligned to the current context. Updated and revised teaching material will also assist to locate training to be relevant and suitable to the communities and individuals receiving mental health care services. In the context of training, mental health care practitioners and trainers need to be mindful of cultural dynamics of healing and mental health, to integrate to the curriculum. Well trained practitioners will then be competent to address mental health issues.

Further to teaching and practice, more research and studies are needed to update knowledge on the current trends related to mental health and illness. This will add value to diagnostic processes and treatment procedures to be used to manage mental health.

So, mental health care practitioners' inclusion and mindfulness of bio-psycho-sociocultural factors in assessing and diagnosing mental health issues in Africa may result in best treatment outcomes. Therefore, improving mental health and wellness of the African people. Let's be mindful - mindful of our context.

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# SECTION 27 ON THE LIFE ESIDIMENI INQUEST INQUIRY


**Sasha Stevenson**
Section 27

The Life Esidimeni Inquest hearing has now sat for 110 days of evidence, 76 days of which were this year. We've had another 21 days of case management meetings, postponement applications or similar. We have heard from 36 witnesses, all of whom SECTION27 has cross-examined. The record is sitting at 50485 pages.

This has been the year that we have heard from high level government officials including former Gauteng Health HoD Dr Selebano; former Director for Mental Health, Dr Manamela; and former Deputy Director in charge of NGOs, Hanna Jacobus. We have also heard from NGO owners including the owner of Precious Angels where 20 people died, many of whom were drastically underweight at the time of their death and succumbed to pneumonia.

Expert witness called by SECTION27, Dr Mvuyiso Talatala, gave evidence highlighting the care needs of the mental health care users in question and the foreseeability of adverse health outcomes, including death, when they were not given the required care and medication. Importantly, Dr Talatala's evidence tied the decision to cancel the contract and to move people without an adequate plan for their care, to their deaths, sometimes only days, sometimes months later.

The court term ended with SECTION27's cross examination of Dr Makgabo Manamela who led the Mental Health Directorate and was the key designer and implementer of the project to move mental health care users from Life Esidimeni to NGOs. Dr Manamela's testimony under cross examination showed up the inadequacy of the plan and its implementation. We were not able to finish our cross examination of Dr Manamela and will continue with the cross examination on 30 January 2023 when the hearing starts again.

The last witness scheduled to give evidence before the Life Esidimeni Inquest is former MEC for Health, Qedani Mahlangu. She will start giving evidence on 10 April 2023.

We are proud of the work that SECTION27, acting as attorneys on behalf of its bereaved family clients and SADAG, has done this year to shine a light on those responsible for the Life Esidimeni disaster, that cost at least 144 lives. Our legal team of Mbali Baduza, Sasha Stevenson, Adv Adila Hassim SC, Adv Thabang Pooe and Adv Nasreen Rajab-Budlender SC has worked tirelessly to ensure that Judge Mmonoa Teffo has everything she needs to make a decision on whether, on the face of it, the action or omission of any person caused or contributed to the death of any of the 141 deceased whose deaths are being investigated by the inquest court. We have consistently forefronted the experience of the mental health care users whose lives, health and dignity were treated with such lack of care by those responsible for keeping them safe.

We look forward to the finalisation of the inquest in 2023 and trust that the bereaved families, and all those who value accountability and the fulfilment of constitutional obligations, will see justice for the deaths of the 141 mental health care users.

**Thanks**
**Sasha**

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# COMPLICATIONS OF RECOGNISING BIPOLAR DISORDER IN CHILDREN

Bipolar mood disorder in children has been controversial for a long time, but the controversy has now shifted from whether it can be diagnosed in children and adolescents to how it's diagnosed and how it can be differentiated from other more common childhood psychiatric disorders.

There are many diagnostic challenges in children and adolescents with bipolar, and on average it takes 10 years before bipolar patients are properly diagnosed and treated. For each year of untreated illness, bipolar youth have a 10% lower likelihood of recovery.

This is important as bipolar disorder affects the normal development and psychosocial functioning of a child and is associated with:

- Increased risk for suicide
- Psychosis
- Substance abuse
- Behavioural, academic, social and legal problems

## DIAGNOSTIC CHALLENGES

1. Children are not 'little adults' but unfortunately, in the Diagnostic and Statistical Manual of Mental Disorders (DSM), adult criteria are used to diagnose bipolar disorder in children. It's universally accepted that the clinical presentation of bipolar in children is significantly different than adults. (See Table below)
2. There is a high rate of co-morbid psychiatric disorders (especially Attention Deficit Hyperactivity Disorder (ADHD), and there is significant symptom overlap, which makes the task of reaching a diagnosis even more difficult
3. Children and adolescents find it difficult to verbalise their emotions, and symptoms can have different meanings based on the developmental level of the child.
4. We always need to consider the developmental stage of the child when making a diagnosis as bipolar mood disorder as for e.g., mania during adolescents, usually presents as psychosis, also labile, unstable and changeable mood is a prominent feature of stages of development, and having to recognise when it's developmentally appropriate vs when it's developmentally inappropriate is often very difficult.
5. The assessment process is equally challenging as multiple informants are required, with a minimum being the child and one parent. There are usually discrepancies between informants. Parents are better at reporting behavioural disturbances and the time course of symptoms and children are better at reporting mood, anxiety and sleep/ neurovegetative symptoms. In the case of bipolar mood disorder, children are better able to report on symptoms like elevated mood, grandiosity, flight of ideas, racing thoughts,

decreased need for sleep.

6. Depression may be the presenting episode, and there is a challenge in identifying unipolar vs bipolar depression. The following are factors that may predict onset of mania in children who are depressed:
   - Rapid onset of depressive symptoms
   - Psychomotor retardation
   - Depression with psychotic features
   - Family history of affective disorders especially bipolar mood disorder
   - Switching to mania / hypomania after treatment with an antidepressant

Bipolar in children is distinctly different from bipolar in adults and the table below illustrates the differences

| | Bipolar in Children | Bipolar in Adults |
|---|---|---|
| **Onset** | Pre-pubertal, early adolescence | Late adolescence or early twenties |
| **Nature of Symptoms** | Longer symptomatic stage. Chronic difficulties regulating mood, emotions and behaviour | Episodic in nature. Clearly demarcated phases of mania/hypomania/depression |
| **Mixed Episodes (concurrent depressive/manic symptoms)** | Very common | Relatively less common |
| **Psychotic Symptoms** | Less common | More common |
| **Family history of bipolar mood disorder** | Common | Common- less common than in children with bipolar |
| **ADHD comorbidity** | 60-90% | Relatively less common |

## CLINICAL PRESENTATION OF BIPOLAR MOOD DISORDER IN CHILDREN

### Mania

Symptoms of mania can include the following:

- Elevated, expansive or irritable mood
- Easy distractibility
- Decreased need for sleep
- Racing thoughts
- Pressure to keep talking
- Grandiose delusions
- Excessive involvement in pleasurable but risky activities, poor judgement and in some cases hallucinations

### Depression

Symptoms of depression can include:

- Pervasive sadness and crying spells
- Sleeping too much or inability to sleep
- Agitation
- Irritability
- Withdrawal from activities previously enjoyed
- Drop in academic performance
- Inability to concentrate
- Thoughts of death and suicide
- Low energy and significant changes in appetite

In children with elevated mood, they may laugh hysterically and act infectiously happy without any reason at home or school.

*Grandiose behaviours* in children include acting as though rules don't pertain to them, for example they believe they're so smart they can tell teachers what to teach and other students what to learn.

*Flight of ideas* is when children jump from topic to topic in rapid succession when they talk, and it happens even in the absence of a special event. For flight of ideas ask whether topics of discussion change rapidly, in a manner confusing to anyone listening.

*Racing thoughts* are expressed in a more concrete way in children. They may say 'It's hard to do anything because my thoughts keep distracting me'.

A *decreased need for sleep* is manifested in children who sleep only three to five hours a night and don't feel tired the next day. Whereas children with other forms of insomnia (due to inadequate sleep hygiene, excessive environmental stimuli, anxiety, depression, or ADHD) may lie in bed trying to sleep, children in a manic state may be on the computer, talking on the phone, rearranging furniture in their rooms, or watching television.

*Hypersexuality* can occur in children with mania without any history of physical or sexual abuse. Hypersexual behaviour in mania has a more pleasure seeking quality to it, whereas the hypersexual behaviour of children who have been abused is often anxious and compulsive in nature

Manic children show an *increase in goal directed behaviour*, such as increased drawing, building elaborate Lego, writing poems or books in a short period of time.

In addition to the core symptoms, *hallucinations and delusions* can be present in children.

A distinct feature of irritability in children with bipolar is extremely aggressive and/or self-injurious behaviour. Children with bipolar have frequent extreme rages or meltdowns over trivial matters ( e.g. a 1-2hour tantrum after being asked to tidy up their rooms).

## CO-MORBIDITY

Co-morbidity is the rule rather than the exception in children and adolescent psychiatric disorders which complicates the diagnosis as there are many overlapping symptoms. The two commonest co-morbid conditions are ADHD and conduct disorder

## BIPOLAR MOOD DISORDER AND ADHD

ADHD is a common comorbid disorder with ADHD and some studies report rates of up to 90% comorbidity in children and up to 23% in adolescents. It's important to recognise the comorbid disorders as this has

significant implications for treatment and recovery.

The *overlapping symptoms* of bipolar mood disorder and ADHD are:

- Distractibility
- Increased motor activity
- Impaired attention
- Poor impulse control
- Rapid or pressure of speech
- Irritability

It's however difficult to differentiate 'pressure to keep talking' (mania/hypomania) and 'often talks excessively (ADHD) and psychomotor agitation (mania/hypomania) and 'often runs about or climbs excessively (ADHD), and distractibility which occurs in both.

In order to make a diagnosis, clinicians should be able to rely on the periodic nature of the disorder as a way to distinguish the disorders, as ADHD is not an episodic illness. However, a review of relevant studies, show that bipolar mood disorder in children presents with a chronicity of symptoms as illustrated in the table above.

Symptoms like grandiosity, elevated mood, flight of ideas, decreased need for sleep, hypersexuality, and increased goal directed activity occur exclusively in mania/hypomania and are important features in distinguishing between the two disorders. Family history of bipolar mood disorder is also very important.

| SYMPTOM | BIPOLAR MOOD DISORDER | ADHD |
|---|---|---|
| **Elevated Mood** | Common with grandiosity | Late adolescence or early twenties |
| **Irritable mood** | Very prominent | Episodic in nature. Clearly demarcated phases of mania/hypomania/depression |
| **Flight of ideas/Racing Thoughts** | Could be present | Relatively less common |
| **Psychotic symptoms** | Common | More common |
| **Hypersexuality** | Common | Common- less common than in children with bipolar |
| **Self-injurious/suicidal behaviour** | Common | Relatively less common |
| **Family History** | Bipolar mood disorder and depression common | ADHD |

## BIPOLAR MOOD DISORDER AND CONDUCT DISORDER

Conduct disorder is a common and often ignored comorbid diagnosis in bipolar disorder children. Studies report up to 74% of children with bipolar disorder have comorbid conduct disorder.

The overlapping symptoms are;

- Irritability
- Hostility
- Impulsivity

Interestingly in adolescents with overlapping symptoms of hypersexuality and impulsivity, these symptoms are more often interpreted as inappropriate sexual behaviour or disinhibited social interaction and are more likely considered as part of a conduct disorder rather than a bipolar disorder.

The main difference between conduct disorder and bipolar disorder is the long prodrome period in conduct disorder with progression from less to more severe rule-breaking, whereas mania presents as an abrupt onset of impulsive behaviour.

## CONCLUSION

Bipolar mood disorder is a challenging diagnosis in children and adolescents, but despite the challenges and controversies, it's possible to diagnose bipolar mood disorder in children and adolescents. Developmental stage and co-morbidity need to be taken into account when making a diagnosis. The presentation is mostly atypical in children compared with the classic adult disorder and it's important to consider these differences in a clinical setting. Children and adolescents with bipolar mood disorder typically present with rapid fluctuations in mood and behaviour and are often associated with co-morbid ADHD and disruptive behaviour disorders. This atypical but common presentation seems to be related to developmental differences in manic symptom expression and the evolving picture of the disorder in children.

The following steps are useful in the evaluation of bipolar mood disorder in children:

1. Ask families to keep daily logs for at least 2 weeks and track:
   - mood,
   - activity level,
   - energy,
   - sleep
   - Frequency, Intensity, Duration, Triggers of tantrums
   - Check functioning at home, school and with peers
2. Review past medical records, take a good history and order appropriate investigations(as needed), which can include EEG, brain scan, toxin screen, and basic blood work
3. Important to gather information from multiple informants. Pay special attention to a family history of mental illness. During evaluation pay special attention to the cardinal symptoms like elevated mood, grandiosity, racing thoughts, decreased need for sleep, psychosis, and hypersexuality, also note the intensity of irritable mood and level of aggression. Assess safety issues.

***References available on request.*** MHM

**When do sleep difficulties become a problem?**

Sleep difficulties might become a problem if a child continues to struggle to

1. fall asleep,
2. stay asleep,
3. sleep enough hours, or
4. have good quality sleep,

even though there is enough opportunity and circumstances for sleep, leading to the child not being able to do important day-time tasks (such us concentrating in class – to learn new things -, and playing and interacting with friends).

**What are some sleep problems encountered in children?**

- *Bedtime resistance*
  When a child refuses to get ready for bed, refuses to remain in bed or requires a parent to be present at bedtime. These are often called limit setting sleep disorders, which are often the result of parental difficulties in setting limits and managing the child's behaviour. **In such cases receiving parental guidance from a professional might be helpful.**
- *Sleep onset difficulties*
  When a child has difficulty with falling asleep (within 20 minutes after going to bed). Reasons that may contribute to sleep onset difficulties include psychiatric conditions (e.g., mood disorders), poor sleep hygiene, or objective sleep disorders (e.g., restless legs syndrome – when a child has an uncomfortable feeling within their legs and needs to move them to make this feeling go away*). **Consulting a professional (psychologist or psychiatrist) might be needed when a child suffers from a mood disorder or restless legs syndrome.**
- *Night awakenings*
  This is when a child wakes up at night and requires parental help to return to sleep: e.g., prolonged night awakenings may occur when a child gets used to falling sleep in circumstances that are not readily available during the night, such as having a parent present.
- *Difficulties with morning awakenings*
  Behaviours such as a child refusing to wake up by himself or difficulties getting out of bed in the morning. They may be the consequence of inadequate sleep or the result of parental difficulties in setting limits and managing behaviour. **Parental guidance might be needed.**
- *Daytime sleepiness*
  It's reflected in persistent tiredness and lack of energy, with a tendency to fall asleep during the day. Causes of daytime sleepiness include:
  - Not enough sleep at night.
  - Underlying conditions that disrupt sleep (e.g., sleep apnoea*, and restless legs syndrome*).
  - Psychiatric disorders (e.g., mood disorders).
  - Post-traumatic excessive sleeping.
  - Excessive daytime sleepiness with an irresistible urge to fall asleep is the hallmark of narcolepsy – it often includes the muscles of the body relaxing without being able to control it.

**A professional might need to be contacted for these occurrences, especially if excessive sleeping after a traumatic event continues for longer than one month.**

- *Sleep disordered breathing*
  Most commonly known as snoring and sleep apnoea – breathing that stops and starts while a child is sleeping*. **Removal of adenoids and/or tonsils might be needed.**
- *Restless sleep*
  Sleep characterised by excessive movements of some parts or the whole body.
- *Parasomnias*
  Parasomnias are unwanted physical events or experiences that happen while falling asleep, while sleeping, or during awakening from sleep. They include:
  1. Sleepwalking: Intense need to walk while asleep with no memory of this when child has woken.
  2. Sleep terrors: When a child experiences intense fear while sleeping and struggles to wake up – they are different from nightmares. **Don't awaken a child during a night terror — this just prolongs the episode.**
  3. Nightmares or bad dreams. **Reassuring a child that these types of dreams are normal**.
  4. Nocturnal enuresis: Bed wetting after a child has been successfully potty trained.

**Most children tend to grow out of these experiences as they become older and don't require treatment. If necessary, safety measures need to be considered as the first line approach (especially when it comes to sleepwalking) as well as scheduled awakenings (waking your child half an hour before the time they usually have an episode) and naps (sleep terrors, for example, are often associated with children not getting enough sleep).**

**Psychology and sleeping – lifting the veil**

In the end it's important to remember that parents' lives, family histories and relationships are the framework within which they bring up families. Sleep problems may punctuate uncertainties between parents and children and bring out doubts in parents about their parenting abilities. These are some of the prevalent underlying troubles a parents face. When, for example, a parent has experienced separation in their own lives as unbearable, it may make the small separation of a child going to bed unbearable as well. Sometimes, it's also important to look at how parents experienced their own upbringing, and how bedtime and sleep were managed when they were children. Sometimes parents rigidly cling to practices of how they were brought up or become determined to act differently from their own parents. When linked with bedtime, parents may re-enact traumas in their past, coming in the way of being able to notice and respond to their child in a manner that the child need most. MHM

significant implications for treatment and recovery.

The *overlapping symptoms* of bipolar mood disorder and ADHD are:

- Distractibility
- Increased motor activity
- Impaired attention
- Poor impulse control
- Rapid or pressure of speech
- Irritability

It's however difficult to differentiate 'pressure to keep talking' (mania/hypomania) and 'often talks excessively (ADHD) and psychomotor agitation (mania/hypomania) and 'often runs about or climbs excessively (ADHD), and distractibility which occurs in both.

In order to make a diagnosis, clinicians should be able to rely on the periodic nature of the disorder as a way to distinguish the disorders, as ADHD is not an episodic illness. However, a review of relevant studies, show that bipolar mood disorder in children presents with a chronicity of symptoms as illustrated in the table above.

Symptoms like grandiosity, elevated mood, flight of ideas, decreased need for sleep, hypersexuality, and increased goal directed activity occur exclusively in mania/hypomania and are important features in distinguishing between the two disorders. Family history of bipolar mood disorder is also very important.

| SYMPTOM | BIPOLAR MOOD DISORDER | ADHD |
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| **Irritable mood** | Very prominent | Episodic in nature. Clearly demarcated phases of mania/hypomania/depression |
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| **Psychotic symptoms** | Common | More common |
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| **Family History** | Bipolar mood disorder and depression common | ADHD |

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Conduct disorder is a common and often ignored comorbid diagnosis in bipolar disorder children. Studies report up to 74% of children with bipolar disorder have comorbid conduct disorder.

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- Hostility
- Impulsivity

Interestingly in adolescents with overlapping symptoms of hypersexuality and impulsivity, these symptoms are more often interpreted as inappropriate sexual behaviour or disinhibited social interaction and are more likely considered as part of a conduct disorder rather than a bipolar disorder.

The main difference between conduct disorder and bipolar disorder is the long prodrome period in conduct disorder with progression from less to more severe rule-breaking, whereas mania presents as an abrupt onset of impulsive behaviour.

## CONCLUSION

Bipolar mood disorder is a challenging diagnosis in children and adolescents, but despite the challenges and controversies, it's possible to diagnose bipolar mood disorder in children and adolescents. Developmental stage and co-morbidity need to be taken into account when making a diagnosis. The presentation is mostly atypical in children compared with the classic adult disorder and it's important to consider these differences in a clinical setting. Children and adolescents with bipolar mood disorder typically present with rapid fluctuations in mood and behaviour and are often associated with co-morbid ADHD and disruptive behaviour disorders. This atypical but common presentation seems to be related to developmental differences in manic symptom expression and the evolving picture of the disorder in children.

The following steps are useful in the evaluation of bipolar mood disorder in children:

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3. Important to gather information from multiple informants. Pay special attention to a family history of mental illness. During evaluation pay special attention to the cardinal symptoms like elevated mood, grandiosity, racing thoughts, decreased need for sleep, psychosis, and hypersexuality, also note the intensity of irritable mood and level of aggression. Assess safety issues.

***References available on request.*** MHM

**Contribution by Dr Frans A Korb**
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# UNDERSTANDING MALE MENTAL HEALTH

Societal stereotypes related to mental health are still preventing many men from accessing critical healthcare. This is having a catastrophic effect, with depression and suicide among the leading causes of death among men globally. In South Africa alone, men are five times more likely to lose their lives to suicide than women. Some are afraid of being ridiculed by their family and peers, while others are simply too embarrassed to seek help.

Their depression or anxiety can sometimes be masked by other illnesses. It's therefore paramount for healthcare professionals to provide a safe space for men in particular to accept treatment, while slowly letting go of the associated fears. Attitudes and perceptions around support for mental health patients' needs to evolve and healthcare professionals can play a critical role in this regard.

## SIGNS OF MENTAL HEALTH DEFICIENCIES:

- Sleep disturbance
- Fatigue
- Weight fluctuations
- Poor appetite
- Feelings of depression, sadness or irritability
- Low motivation and reduced productivity
- Feelings of guilt, failure and worthlessness
- Social withdrawal

- Experiencing suicidal thoughts
- Absenteeism or poor performance at work
- Alcohol or drug abuse

While mental health has been placed higher on the agenda in South Africa in recent years, it still pales in comparison to the attention given to other illnesses. This despite global predictions by the World Health Organisation, that by 2030 the leading cause of debilitating illness will be AIDS, depression and heart attack. South Africa is ranked number 10 on the list of countries with the most suicides, with almost 24 per 100 000 people. Almost 75-percent of those who commit suicide in South Africa are men, highlighting the extent of mental health issues facing our society, and males in particular.

According to the Male Mental Health survey 2015, by the Eaton Foundation, the most commonly reported life difficulties by respondents were depression (79%), debt worries (71%), anxiety (68%), unemployment (55%) and suicidal thoughts (47%).

Mental health related illness can affect anyone. While support is available, men need to have the courage to reach out for help. Doctor-patient confidentiality often provides a safe environment for men to begin the conversation. It's important for healthcare professionals to steer this engagement in the right direction, highlighting their support and unconditional acceptance. Doctors are well placed to offer advice and encourage patients to open up about their mental health, before referring them to a relevant professional.

## COMMON CONDITIONS

**1.Anxiety Disorders**

Men are often undiagnosed because symptoms are overlooked.
Instead of worry and nervousness, they may display anger and irritability.
Men seek help for physical symptoms rather than mental illness.

**2.Substance Abuse**

Men use drugs and alcohol to cope with feelings they can't express. Men are almost twice as likely as women to binge drink and are more likely than women to use illicit drugs.

**3.ADHD**

Common symptoms include impulsivity, hyperactivity, and a low attention span. Undiagnosed adult men may have trouble identifying the root of their problems as ADHD is usually diagnosed in childhood.

**4.Schizophrenia**

Men are more likely to develop this condition. They are also likely to experience an earlier onset of the condition with lower social functioning compared to women.

## "I WILL BE RIDICULED IF PEOPLE KNEW I WAS DEPRESSED"

We know the gender stereotypes that define a healthy woman and the psychological consequences that these have had over decades. For instance, society has created a perception that a woman is beautiful if she fits into a size six dress, possesses flawless skin and has perfectly long legs. It's important to understand that societal stereotypes and expectations can also be damaging to men. Imagine sitting at a bar during a guy's night out and sharing feelings of anxiety or depression. As a man, you would probably leave feeling worse than when you arrived, as many social circles frown upon what is considered an "emotional man". This is despite expressing your emotions being identified as a form of therapy.

If a man struggles with mental health, he is considered weak and lacking fortitude.

These outdated gender norms are tying men to social taboos and masculine behaviour, preventing them from seeking help for their mental health, out of fear of being ridiculed.

For example, the average male patient is more likely to conform to the social norms of masculinity than open up about their feelings. A patient who fits this profile stands a higher chance of suffering from heighted stress and depression. Their symptoms are also likely to last for prolonged periods.

## DIFFERENCES BETWEEN MALE AND FEMALE DEPRESSION

| Woman tend to: | Men tend to: |
|---|---|
| **Blame themselves** | Blame others |
| **Feel sad, apathetic, and worthless** | Feel angry, irritable, and ego inflated |
| **Feel anxious and scared** | Feel suspicious and guarded |
| **Avoid conflicts at all costs** | Create conflicts |
| **Feel slowed down and nervous** | Feel restless and agitated |
| **Have trouble setting boundaries** | Need to feel in control at all costs |
| **Find it easy to talk about self-doubt and despair** | Find it "weak" to admit self-doubt or despair |
| **Use food, friends, and "love" to self-medicate** | Use alcohol, TV, sports, and sex to selfmedicate |

Thirty-two-year-old Nkanyiso Dube (not his real name) identified with many symptoms relating to depression after being retrenched from his job as a restaurant manager in Johannesburg in 2020. "Initially I didn't know it was depression until I started reading about my symptoms. I used to sit around the house while my wife went to work which made me feel useless. When she got home, I would take out my frustrations on her and scream at my son. In my culture, any issue around mental health is linked to being possessed by the devil. I knew that if I spoke about it, I would have been labelled crazy," explained Dube.

Dube represents a typical example of how undiagnosed and untreated mental health eroded different aspects of his life, destroying key relationships. The reality is men may not even recognise symptoms of mental health disorders, especially if their symptoms are less severe.

## COVID-19 AND MENTAL HEALTH

In 2020, President Cyril Ramaphosa declared the scourge of domestic violence in the country as a second pandemic, after COVID-19 swept through the nation. Men and women lost their jobs, people were confined to their homes as a result of the global lockdown and depression set in for many. Prevalent cultural norms and stigmas prevented many men from recognising that the abuse and anger meted out to their partners', may have been related to their own state of mental health. Therefore, they went undiagnosed and untreated, wreaking havoc on women and families across the country.

## MANAGING MEN'S MENTAL HEALTH

Many men disguise their depression, unwaveringly continuing their daily tasks. They often paste on a smile while in the public eye. However, inside they may feel like they are trapped in deep dark hole that is impossible to escape.

Fortunately, there are many forms of treatments as well as behavioural changes thatcan be implemented to overcome depression. First and foremost is to identify the issue with the patient, to evaluate their dominant feelings and to look at how the mental illness has altered their life negatively. They must be encouraged to go back to activities that used to offer them fulfilment. Depression management tools may include :

- Physical wellness
- Relaxation
- Healthy eating
- Medication
- Therapy
- Holidays
- Life coaching
- Brain stimulation

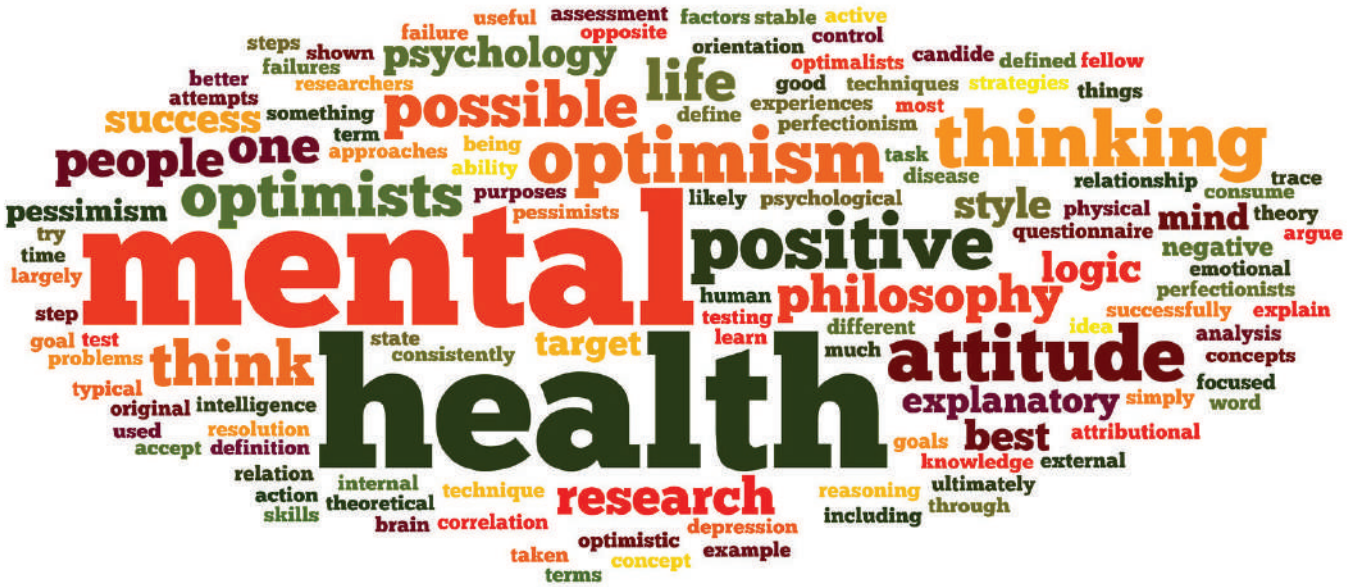
## SUPPORTING MEN'S HEALTH

- Men who are encouraged to express emotion rather than suppressing them are more likely to admit to suffering from mental health issues, and find it easier to seek help.
- Use gender-responsive language like 'coaching' and 'skill building' rather than 'therapy'.
- Build a culture of mental health awareness in corporate environments. This promotes discussion and encourages de-stigmatisation.
- Understand the challenges facing men in different communities, e.g. race or cultural related stressors, LGBTQIA etc.
- Education about mental health and seeking support from family and friends is essential.
- If a loved one is battling with symptoms of severe anxiety or depression, schedule an appointment for them to see a professional.

Health professionals pay much attention to treating serious illnesses like cardiovascular and pulmonary disease in men. While these are critical conditions to manage, male mental health deserves similar priority status, as it affects every dynamic of our lives. The rate of suicide and depression in men is likely to drop if we are to prioritise issues around mental health. Productivity and well-being, in turn, is likely to improve. Proper mental health treatment can guarantee men a better quality of life – a life of meaning and purpose. Key to this, however, is tackling the stigmas associated with mental health, and in particular, allowing patients to express their thoughts and feelings, without fear of being judged.

*This article was based on a webinar presented by Dr Korb at a SADAG counsellors meeting.*

***References available on request.*** MHM



**Linda Christensen**
South African Society of Psychiatrists (SASOP)
Press officer

# CHILDHOOD EMOTIONAL ABUSE

## A LIFETIME OF INVISIBLE SCARS

More than a third of South African children under the age of 17 suffer emotional abuse and neglect, resulting in invisible scars that put them at greater risk of mental illness and limit their chances of a fulfilling a functional adult life.

Psychological abuse and neglect of children's emotional needs for affection and support is committed most often by those closest to them and responsible for their nurturing and development – parents, caregivers and relatives, and it cuts across all levels of society and income.

Although physical abuse in childhood is the most prevalent, affecting 56.3% of children, the risk of developing serious mental health problems is four times greater for the 35.5% who suffer emotional and psychological abuse, says Dr Eugene Allers, spokesperson for the South African Society of Psychiatrists (SASOP).

While physical and sexual abuse are regularly seen in the courts and the headlines, psychological abuse, including emotional neglect, receives much less attention and awareness but is one of the most traumatic forms of abuse that a child can experience, he said.

"Children should be given the best opportunities in life; living in loving homes, free from all forms of abuse. This will ensure their optimal development, with less chance of psychological or psychiatric problems later in life. Children that are abused, sometimes become abusers, continuing the vicious cycle.

"The childhood trauma of emotional abuse and neglect affects the child's sense of self and their capacity to trust and build healthy relationships. It can also affect a child's physical health and educational outcomes,

all with great impact on their future prospects," Dr Allers said.

The types of abuse overlap, in that children who suffer physical and sexual abuse are likely also to experience emotional abuse and neglect. Almost 70% of South African children will experience any type of abuse before the age of 17 and 27% will be victim to multiple types of abuse.

Exposure to family conflict and domestic violence also constitutes emotional abuse and leaves lifelong scars, Dr Allers pointed out. This was particularly concerning for South African children, with domestic violence at "epidemic proportions" and intimate partner violence affecting between a third and a half of households.

"All abuse leaves emotional or psychological scars. While physical injuries can heal, emotional scars are disabling and crippling to most individuals, and psychological abuse and neglect are much more prominently associated with mental illness in later life than physical or sexual abuse," Dr Allers added.

The impact on children's future mental health is substantial, he said, with a third of all psychiatric disorders originating before the age of 14 and half before 18 years of age.

The Children's Act of 2005 defines abuse as any form of harm or ill-treatment deliberately inflicted on a child, including assault, deliberate injury, sexual abuse, bullying, exploitation or exposing or subjecting a child to behaviour that may harm the child (such as exposure to domestic violence).

Dr Allers said there was a lack of knowledge of what emotional abuse entails and the signs and symptoms, and it was often not addressed as it is more difficult to define and recognise than physical abuse.

Emotional abuse is more subtle, ongoing, and generally not connected to a single incident such as a beating or sexual assault.

Forms of emotional or psychological abuse include withholding love and support, rejection, berating and threatening the child, insults and name-calling, belittling or humiliation, cold-shouldering, guilt-tripping, and emotional blackmail.

Acts of emotional neglect include spending little time interacting or talking with the child, being unresponsive to or dismissing their feelings, giving little positive feedback or praise, persistently finding fault, and offering little help or encouragement when they are struggling with schoolwork or other tasks.

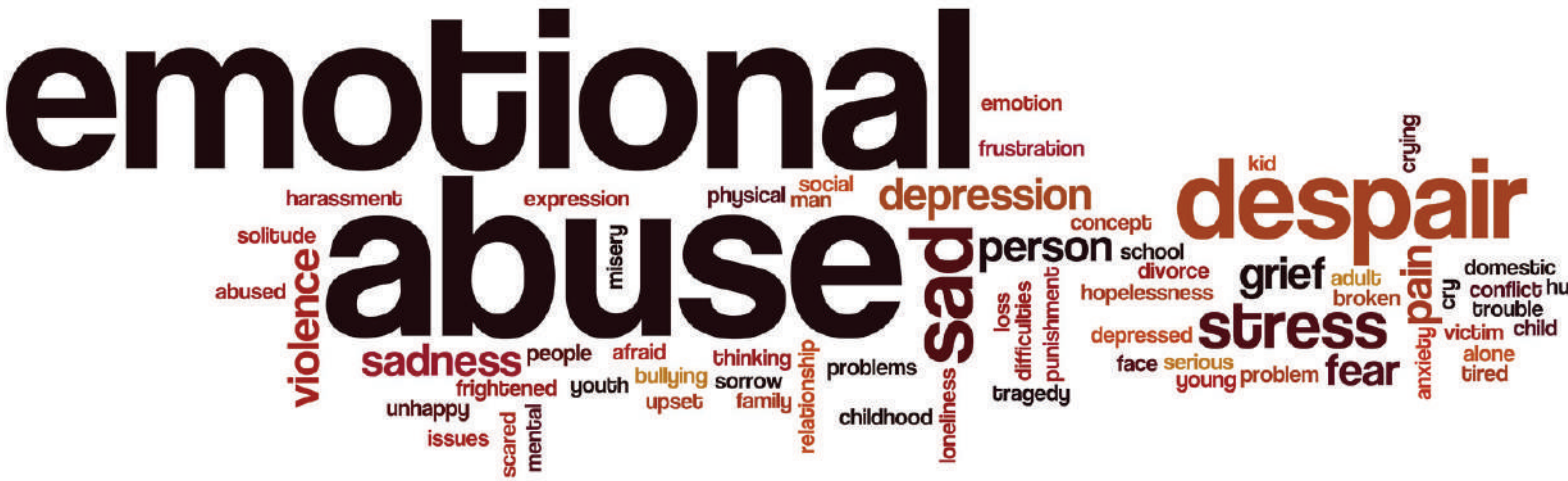
"At the other end of the scale, overprotection is just as detrimental to children as neglect. A child cannot live a normal life and develop positive life skills if they are overprotected. There needs to be a balance in protecting children, as both ends of the spectrum amount to child abuse," Dr Allers said.

He said signs of emotional abuse and neglect in children included anxiety and depression symptoms, isolating themselves, disruptive behaviour, mood changes including aggression and agitation, depression, sleep problems, school refusal or lower school performance, and developmental and language delays.

There is also a heightened risk of self-harm and suicidal behaviour, he said.

He emphasised that medical professionals and social workers are bound by law to report any form of child abuse, including emotional abuse.

"Where emotional abuse or neglect is suspected, children should be referred for psychological interventions that can help them to cope and rebuild their self-esteem, and abusers must be dealt with by the legal system", he said. MHM



**Professor Christine Lochner & Gizela van den Berg,**
SA MRC Unit on Risk and Resilience in Mental Disorders, Department of Psychiatry,
Stellenbosch University

# PROBLEMATIC USAGE OF THE INTERNET, YOUTH AND FAMILY DYNAMICS

**Introduction**

Life without the internet is unimaginable. People use the internet for various activities, including social networking (e.g., Facebook, Instagram), streaming movie/television content (Netflix, Showmax), watching pornography, playing games, shopping, and gambling. There are numerous advantages associated with its use, such as enhanced interconnectedness, communication, and improved learning. In this way, the internet has the potential to improve life satisfaction and productivity. Especially during the COVID-19 pandemic, internet use has become essential for many people - for work purposes but also to stay connected with friends and family.

It was recently estimated that there are currently more than five billion internet users worldwide, i.e., 63 percent of the global population. The situation in South Africa is similar, with two thirds of the population (approximately 41 million people) using the internet. Considering the unprecedented circumstances caused by COVID-19 / lockdown, the percentage of internet users has rapidly increased in the last couple of years.

While many individuals use

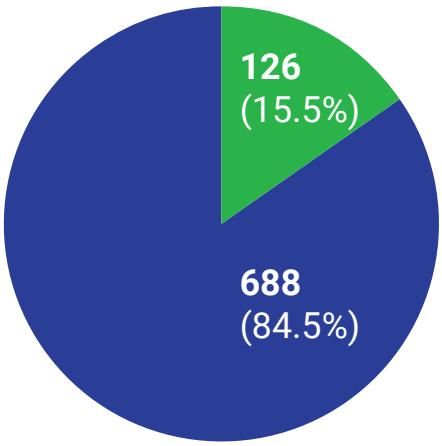
the internet without untoward consequences, it's increasingly recognised that a vulnerable subset of people may develop problematic online behaviours. When these behaviours develop into habits that are difficult to break, they are referred to as problematic usage of the internet (PUI) or generalised internet addiction. PUI is widely considered a behavioural addiction and is an umbrella term referring to excessive and/or maladaptive internet use associated with various psychological, social, academic, health, and/or professional problems. All of the diverse online activities listed above may become problematic. Moreover, internet use does not only become problematic when it's time-consuming or interferes with work/task-completion, but can also become problematic when the nature of the activity causes distress or impairment, e.g., financial / relationship difficulties associated with uncontrollable gaming, gambling, buying/shopping, or cybersex/ pornography watching.

**PUI and youth**

People of all ages use the internet. One age group that possibly access the internet more regularly than any other are adolescents and young adults, and they're often called "digital natives". Individuals aged 18–24 years account for 18% and those aged from 25 to 34 for a third (32%) of global internet users. Online activities preferred by young people include social networking, entertainment, academic work, and online gaming. Various problems, such as physical ailments, sleep disorders, social withdrawal, and poor interpersonal relationships are associated with excessive engagement in such online activities. There is evidence to suggest that unhealthy family functioning (characterised by conflict, poor parent-child relationships, insecure attachment, childhood abuse, divorce, and parental substance abuse) may lead to PUI, or reinforce the behaviour when members excessively engage with the internet as a mechanism to cope with such adversity within the home. In turn, PUI may also result in unhealthy family functioning, marked by conflict, low levels of cohesion, and poor communication. Indeed, one of the most widely considered issues pertaining to internet use is its ability to rob families of their shared time. This is problematic in the sense that quantity of time spent together strengthens relationships, increases cohesion, and functions as a barrier against unhealthy family functioning.

**Internet use, PUI and South African youth**

To our knowledge, there has been relatively little research on PUI and family dynamics, and no publication on such data from South African youth. Our research group (the SAMRC Unit on Risk and Resilience in Mental Disorders) recently conducted an investigation, supported by the National Research Foundation, on the relationship between PUI and family functioning in local youth between the ages of 18 and 30 cross-sectional survey data was collected from 814 individuals during 2020. Among the respondents, the prevalence rate of PUI was 15.5%, indicating that PUI may be a significant mental health issue locally.




**Non-PUI** **688** (84.5%)

**PUI** **126** (15.5%)

**126= 75** (59.5%) F | **51** (40.5%) M

As scores on the IAT-10 (assessing severity of internet use) increased, scores on the general functioning scale of the family assessment device (GF-FAD) increased linearly, indicating that increased internet use was associated with increased severity of unhealthy family functioning. Moreover, a significant difference in the GF-FAD scores of individuals with PUI and those without PUI, suggested that individuals with PUI experienced unhealthier family functioning than individuals without PUI Increased severity of social networking, online pornography, streaming media, and cyberbullying were also positively correlated with "increases in family dysfunction. Our findings suggest that PUI is common in South African youth, and shed light on the nature of the strong relationship between PUI and unhealthy family functioning among young South Africans.

**Assessment of online activity**

It's important to objectively assess whether someone's internet use is excessive or problematic. There are numerous unvalidated scales to assess the extent and the nature of individuals' problematic online behaviours. Reliable and validated tools would allow better identification of the problematic behaviour however. One example of such a tool is the Compulsive Internet Use Scale (CIUS), (3-5 minutes to complete) which has good psychometric properties, including items typical of compulsive internet use: i.e., the inability to control internet use, mental and behavioural preoccupation with online activities, agitation associated with the inability to go online, mood change, and conflicts with significant others about internet use. Recently, another scale, namely the Internet Severity and Activities Questionnaire (ISAAQ), was developed, providing a useful, psychometrically robust

measure of PUI severity (Part A), and capturing the extent of engagement in a wide gamut of online specific internet activities (Part B). A publication on validation of data generated by a South African and UK sample is now being prepared.

**Treatment interventions for PUI in youth**

Family-based interventions seem to be more fruitful in reducing signs and symptoms of PUI compared to any other treatment. It has been argued that it's especially important to intervene at the level of the family since behavioural addictions such as PUI often prevail in families. Family-centred prevention and intervention strategies would involve both parents/caregivers and children, and emphasise a collaborative approach to conflict resolution among family members. During PUI-focused therapeutic sessions, parents are taught practical strategies to prevent the maintenance or increase of PUI. During these sessions, parents are encouraged and trained to exhibit desired internet-related behaviour (such as moderate internet use), to implement rules that limit screen-time, and to monitor their children's online activities actively and effectively. Children, in turn, are taught how their internet use impacts on the family environment and how they can adjust their internet use to contribute to healthy family functioning. One of the recent studies on problematic online gaming (also known as gaming disorder) in youth suggested that greater affection and understanding among family members correlated with a gradual decline in the behaviour. Since young adults frequently model the internet-related behaviours of parents or other family members, family-based interventions that effectively intervene at the level of the people who exhibit maladaptive internet use, may decrease the chances of children replicating problematic internet related behaviours.

**Conclusions / key points:**

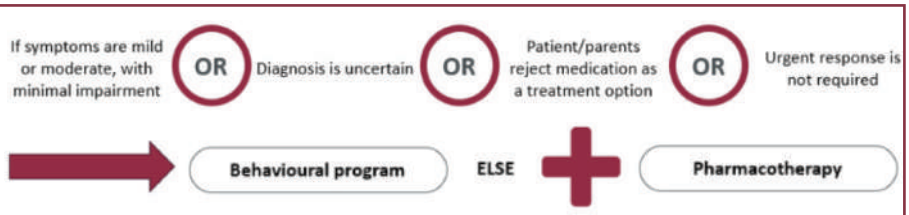
- While many individuals use the internet without untoward consequences, it's increasingly recognised that a vulnerable subset may develop problematic online behaviours.
- When these behaviours develop into habits that are difficult to break, they are referred to as PUI or generalised internet addiction.
- Increased awareness of PUI and risks or dangers of excessive or inappropriate internet use are crucial.
- Adolescents and young adults use the internet more than any other age group and are therefore at increased risk of PUI.
- Patterns of problematic family functioning are strongly associated with PUI.
- Positive family relationships and constructive interaction may play an important role in managing internet use in the home and protecting individuals against PUI.
- Family-based interventions are fruitful in reducing PUI.

***References available on request.*** MHM

**Professor Renata Schoeman**
Psychiatrist

# ALTERNATIVE STRATEGIES TO MANAGE ADHD

Not everyone with ADHD needs medication. Not everyone with ADHD wants to use medication. According to the South African guidelines, we as psychiatrists ascribe to the following approach:




Treatment should always be holistic, and therefore the value of alternative strategies should not be underestimated. Complementary and alternative medicine has never been more popular. Nearly 40 percent of adults report using complementary and alternative medicine (CAM) – those products and techniques not presently considered to be part of conventional medicine. This hodgepodge of practices and products can leave healthcare professionals, and patients, bewildered. However, many products marketed for the management of ADHD, have not been thoroughly tested in terms of efficacy, or safety. So what evidence do we have?

## BACKGROUND

In 2013, Sonuga-Barke et al. conducted a systematic review and meta-analyses of randomised controlled trials of dietary and psychological interventions 2904 published randomised controlled trials of dietary (restricted elimination diets (RED), artificial food colouring exclusion (AFCE), and free fatty acid supplementation) and psychological interventions (attention and working memory training, cognitive training, neurofeedback (NF), and behavioural interventions (BI)) for ADHD were screened. Of these, 54 trials met inclusion criteria for the analysis.

Two different analyses were performed: one where the outcome measure was based on ADHD assessments was completed by

parents or teachers, and the other where the best possible blinded assessments (i.e. placebo- and non-placebo controlled trials where the assessments made were by an individual blinded to treatment) of improvement on ADHD measures were included.

Although all dietary and psychological interventions produced statistically significant effects, in the latter group only free fatty acid supplementation and artificial food colouring exclusion remained significant. It therefore seems that free fatty acid supplementation produced small but significant reductions in ADHD symptoms even with probably blinded assessments, although the clinical effects of these effects remain to be determined. Artificial food colouring exclusion produced larger effects but often in individuals selected for food sensitivities. But what is the current evidence?

## COGNITIVE TRAINING AND NEUROFEEDBACK

There has been an increasing interest in and the use of computer-based cognitive training (CBCT) as a treatment of ADHD, with some empirical support in recent years from controlled studies. However, a review of the current evidence found that the effects were stronger for unblinded measures, while controlled trails with blinded measures could not support any significant effect.

## DIET

Throughout the years, many dietary fads and beliefs have made their appearance: from the exclusion of food colourants, sugar, and other restriction elimination diets, to supplementation with fish oils, mega-dose vitamins, amino acids, magnesium, iron and zinc. However, a systematic review of the literature found that only elimination diets and fish oil supplementation seem to be able to reduce ADHD symptoms – although both interventions need more thorough investigations prior to recommending them as part of ADHD treatment.

N-3 omega-3 polyunsaturated fatty acids (n-3 PUFAs) are promoted as cognitive enhancers in the general population, as well as for patients ADHD. Not only is there evidence that mild symptoms of ADHD respond well to omega supplementation, but omega also enhance the effectiveness of the prescription ADHD treatment, which means lower doses can be used, which then lessen the potential of side-effects.

Recent studies highlighted the role of micronutrients and vitamins, although the findings remain controversial. Vit D supplementation (if deficient) has some benefit, but no evidence was found for supplementation with nutrients such as zinc, vitB12, iron and folate.

Other dietary supplements available on the market (but which we can't recommend as evidence-based treatment for ADHD) include citociline (which increases phosphatidylcholine, acetylcholine and dopamine (DA)), acety L-carnitine (an amino acid), dimethylethanolamine (an acetylcholine esterase inhibitor), and L-theanine (which increases GABA and DA).

## COMPLEMENTARY AND ALTERNATIVE MEDICINE (CAM)

CAMs include health and wellness products and techniques not presently considered to be part of conventional Western medicine. CAM includes mind-body medicine (such as meditation, acupuncture, and yoga), manipulative and body-based practices (such as massage therapy and spinal manipulation),

and natural products (such as herbs and dietary supplements).

There is a vast array of products available on the shelves. Some of the most common of these products contain:

- Bacopa monnieri (water hyssop), which has some evidence for improving cognition through reducing anxiety – presumably through effects on dopamine, serotonin and GABA. Side-effects include decreased motivation and spermatogenesis, gastrointestinal side-effects, and more serious problems such as asthma, bradycardia and hyperthyroidism.
- Withania somnifera (Indian ginseng), with an anti-anxiety effect which aids in learning and memory. It can cause drowsiness, auto-immune aggravation, hyperthyroidism, ulcers and hypotension
- Celastrus paniculatus ("the intellect tree"), which delays the reuptake of DA, 5HT and NA. Side effects include vivid and lucid dream states.
- Ginkgo biloba, which claim to sharpen mental focus through improving brain glucose metabolism, increasing brain blood flow, vasodilatation, anti-oxidant effect, and blocking 5HT3 receptors. Side-effects include bleeding tendencies, serotonin syndrome, convulsions, and even cases of inducing coma (in combination with trazodone).
- American and Asian ginseng (Panax ginseng), which claims benefits such as increased energy, lowered blood sugar and cholesterol levels, reduced stress, and the treatment of sexual dysfunction in men. However, the side-effect profile is disconcerting: Steven-Johnsons syndrome, mastalgia, vaginal bleeding, mania, diarrhoea, insomnia, headaches, tagicardia, blood pressure fluctuations, and vaginal bleeding. "Ginseng abuse syndrome" is also described and marked by hypertension, nervousness, insomnia, skin eruptions, morning diarrhoea, depersonalisation, confusion and depression
- Siberian ginseng (Eleutherococcus senticosis) seems more promising. Benefits include improved working memory and concentration, processing speed, and reduced hyperactivity and impulsiveness – without the dangers associated with Panax ginseng.
- Cordyceps sinensis (Caterpillar fungus) may have some value. It improves memory and mood through increasing 5HTP, BDNF and anti-oxidants. However, it can aggravate autoimmune disorders and cause bleeding tendencies.
- Curcumin and Rhodiola rosea both are MOA-A inhibitors
- Guarana, a stimulant, is used for weight loss, to enhance athletic performance, to reduce mental and physical fatigue, and to enhance libido. However, it can cause anxiety, bleeding disorders, irritable bowel syndrome, dysrhythmias, hypertension, glaucoma, and osteoporosis. It should not be used in combination with antidepressants and lithium.
- Huperzine A may improve concentration, learning and memory, but may also worsen asthma, epilepsy, bradycardia and ulcers.
- Other products with anxiolytic and/or antioxidant effects, and potential indirect benefits on cognition, includes lemon balm, valeriana, kava kava, passion flower, ginger and cinnamon.

## CONCLUSION

Although many individuals, with and without ADHD, report benefits from 'brainsmart food', formal studies of the effectiveness of these agents are lacking and there is no consistent evidence from randomised control trials for the use of any food supplements. When deciding to use CAMs, you need to be cautious - even more so when giving it to children. Not everything is safe. More research is needed before doctors can confidently recommend the use of CAMs instead of the ADHD treatment registered in South Africa.

***References available on request.*** MHM

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Lehlogonolo HR Consulting, Gauteng

# ANXIETY IN THE WORKPLACE

## INTRODUCTION

Life, as we know it is changing daily and requires individuals to adapt accordingly. These changes affect people differently. Some people can adjust with ease to the changes, while others struggle. The unexpected changes tend to take a toll on most people. The challenges people experience in and outside the workplace tend to increase the likelihood of the individual suffering from anxiety. For example a young man, Stanley, joined an organisation and was excited and looking forward to taking on the world. He was keen to work with his team, engage with other team leaders and contribute to the success of his unit. He was disappointed and frustrated by the reaction of his team members; he felt that some of the team members were not pulling their weight, and he ended up working after hours to catch up with the work.

He later resigned and joined another organisation, where he was deemed a highflyer. He was doing well and received accolades over the years. He went through significant challenges in his personal life, which changed his outlook on life. He was no longer that energetic, go-getter, go-to person. Instead, he showed frustration, irritability, withdrawal, and doubt in his capability and struggled to deliver on his job. His manager was very observant and introduced some interventions to assist him. He later learned that what he went through was complicated and that he needed support to help him manage the condition. The information below would have given him more insights had he known before.

## ANXIETY IS DESCRIBED AS

excessive worry and apprehensive expectations, occurring more days than not for at least six months, about several events or activities such as work or school performance.

It's characterised by fear, dread, uneasiness, restlessness, tension, increased heartbeat, and shortness of breath. For example, Stanley may have felt anxious before a major presentation, starting a new job or driving to work. Most people may experience anxiety, which helps them excel and become the best in what they do. The challenge occurs when the anxiety persists, making it difficult for people to cope with daily activities and work. Stanley learned the importance of mental health issues in the workplace. He got the help he needed and was equipped to deal with it. Given the information overload most people are faced with, there is a danger of people self-diagnosing. Self-diagnosis can become a self-fulfilling prophecy; you start noticing some of those symptoms, even if they are not pronounced. The best thing to do if people feel concerned or in doubt is to talk to a relevant practitioner who can assist them appropriately.

## SOURCES AND CONTRIBUTING FACTORS OF WORKPLACE ANXIETY

There are different sources and contributing factors of anxiety - the most common are the nature vs nurture debate, development, trauma and environment.

- Nature: Some people are more prone to anxiety due to their genes. We hear people saying anxiety runs in the family although there may be other members of the family who don't suffer from it. These people may be more vulnerable to workplace stress and require coping mechanisms that others may not.
- Nurture and how people are brought up affects how they perceive things. Some people are brought up in a pressurised environment that results in increased anxiety. The workplace can be a major contributor to anxiety if the environment is conducive to stress.
- Development: Individuals experience anxiety at different stages of their lives. The source of anxiety may differ at different stages. Some people may suffer from anxiety at a younger age but learn to cope with it as adults. Young adults taking on a job for the first time, or those changing roles or companies, may be at a higher risk of experiencing anxiety.
- Trauma: People who experience trauma without EAP interventions are likely to develop anxiety. It could stem from the actual event and the concern that it might happen in future. Trauma can make individuals more susceptible to stress, which can be exacerbated in stressful work environments.
- The environment: Internal factors in the organisation also affects employees. The key areas are the organisation, the job, and the people.

External factors such as economic, social, political and technological changes affect employees.

- Economy: The cost of living is too high, and people struggle to make a living. There is a loss of jobs stemming from the COVID-19 pandemic
- Social: Problems such as poverty, crime and violence are increasing, causing significant amounts of stress to ordinary South Africans
- Political: Instability and corruption are a major cause of stress for most working people
- Technology: Increased use of technology brings about challenges such as access to data and exposure to criminal elements; blurred boundaries where employees are expected to work longer hours; exhaustion and lack of sleep may result in anxiety
- The organisation - A conducive environment is required for individuals to flourish at work. This environment is where individuals have clear roles and responsibilities, are given the autonomy to make decisions and growth opportunities and are supported by their managers.
- The job – individuals need to be provided with resources and support to feel capable of doing the job and at times, stretched to do more. Performance anxiety results when individuals are not coping with the demands of the role and feel they are not supported.

They must be guided and given training opportunities to learn more about their jobs. When employees leave, some organisations usually don't appoint new people. As a result, the people left behind are supposed to take on more responsibilities without change in their income, leading to work overload and anxiety. The people: creating a good working relationship with people in the workplace is essential. In most cases, team work is required to achieve certain goals.

## WHAT CAN THE ORGANISATION DO TO HELP INDIVIDUALS TO DEAL WITH ANXIETY?

There are different interventions that individuals, teams and organisations can use to deal with stress.

- Wellness programmes
- Training of managers and staff to understand how anxiety and mental illness can manifest and be dealt with in the workplace
- Create a conducive environment where there is empathy and empowerment for people to flourish
- Treat people as human beings and provide work-life balance

## HOW YOUR PATIENTS CAN COPE WITH WORKPLACE ANXIETY

It may take time to determine how personal and work challenges are affecting your patients. Each person experiences surface issues, but sometimes deep-seated problems are not easily accessible to most people. Relevant healthcare professionals can provide clarity.

- Advise them to talk to a trusted person and only share what they're comfortable sharing with others, such as a family member, friend or pastor. They can express their feelings and get different perspectives when they talk to someone.
- Seeking help: It's a sign of strength to seek help. Some may need to see a therapist or a psychiatrist depending on the case.
- Encourage them to acknowledge their strengths and weaknesses.
- Self-care. When people take care of themselves, they fill up their cup so it overflows and allows them to pour into other people's lives.
- Enlist Support. Look for support at work and be supportive of others. Let them know that they don't have to be strong all the time.
- Forgive self and others. This will help them to let go of the past

## CONCLUSION

Stanley, like most people, had to learn the hard way about his condition. He started noticing specific changes in himself, such as dreading going to work, his performance dropping, fear of failure, isolating himself, having difficulty concentrating, struggling to complete tasks and neglecting himself and his family. He was fortunate to have a caring manager trained to notice the patterns and refer him for counselling. It's common for people to struggle with the daily challenges of an increasingly demanding and stressful society, but being able to recognise when anxiety is manifesting empowers people to seek help and find ways of managing their stress more effectively.

***References available on request.*** MHM

**Alexa Scher**
Clinical Psychologist
Johannesburg

# ASSISTING PARENTS OF TRANSGENDER TEENS THROUGH THEIR CHILD'S TRANSITIONING JOURNEY

By the time you're seeing your teen patient and their parents to discuss gender affirming healthcare, it's evident the transitioning journey has begun.

Most parents will arrive feeling very apprehensive, if not downright unwilling, to explore what gender affirming treatment

options are. They have likely already embarked on their own research which tends to lead them down a rabbit hole of fear inducing information on risks and stories of those who regret their transitions later in life, often exposing parents' prejudices. Not to mention their internal battle coming to terms with such immense changes in their child's life, which can be experienced as a process of grieving.

This can result in parents being very defensive, which places doctors in the difficult position of trying to get parents to engage with an open mind, whilst explaining the risks involved with the various options for medical transition.

This article aims to provide doctors with some tips around approaching these interactions effectively.

Firstly, try to ascertain what their perspectives and feelings are around their child's transitioning journey. Should they express concerns, it helps to normalise their experience showing understanding and empathy. It's likely a lot of their fears are due to uncertainty or misunderstanding, giving you an opportunity to clarify and educate them, which could diminish their resistance somewhat.

Essentially, it's not about telling parents not to be afraid or resistant, as it's an inherent part of the informed consent process to be open and honest about the real risks involved. It's more about balancing their concerns out with the benefits of supporting their child through their transitioning journey. It often helps for the teenager to participate in this conversation, so they can share the impact transitioning will have on their lives holistically.

Most parents prioritise the health of their children and so are naturally resistant to consenting to their child undergoing any form of treatment that could have an adverse effect. However, it's important to highlight the fact that health is not solely about physical wellbeing, but mental and emotional wellbeing too. While parents may only be concerned with the research regarding health risks, it's important they're made aware of the research regarding mental health risks for transgender teens who are not able to begin the transitioning journey.

Transgender youth are at a particularly high risk for mental illnesses (e.g. depression and anxiety) and life-threatening behaviours, with more than a third having a history of self-injuring behaviours and a third reporting at least one suicide attempt Suicide amongst teenagers is already a major concern, with the risk of suicide amongst transgender youth who don't receive the support they need being even greater.

According to Prof Gerhard Grobler, psychiatrist and past president of the South African Society of Psychiatrists (SASOP, one of the reasons for such mental health risks is due to gender dysphoria - the experience of intense distress as a result of the sex assigned at birth not aligning with their gender identity – and not because identifying as transgender is a disorder in itself. Other factors that increase risk of mental health issues in transgender youth are stigma, discrimination, having to hide who they truly are, low self-esteem, bullying, social rejection, harassment and abuse.

It's for these reasons that receiving gender-affirming healthcare is so necessary and beneficial. Research has widely shown mental health risks are significantly reduced in those who receive medical, social and psychological support in transitioning to the gender identity they feel aligns with their authentic selves.

Of course some parents' resistance will persist, especially regarding medical interventions which have certain non-reversible effects. Many will attribute their child's request to transition as a 'phase' and refuse any medical interventions due to predicting their child will regret the decision later and won't be able to undo the changes.

Should you find yourself faced with such resistance, it's helpful to highlight that:

- Navigating and establishing their identity isn't something that happens overnight; they generally would have spent a significant amount of time considering this within themselves, which the parents may not have been aware of.
- It's important for parents to recognise their child's expressed identity and show acceptance of who they are now.
- All humans change throughout their lives – especially from adolescence into adulthood – yet this doesn't mean that just because they don't continue acting/dressing in the same way or having the same likes/dislikes, their current way of being is any less valid.
- Just because some transgender individuals may not be 100% sure about their gender identity or shift their gender identity at later stages in their lives, this shouldn't take away from the value of respecting and appreciating who they are at this time!

Understandably, some parents will take issue with their child initiating certain medical gender affirming treatments that may be non-reversible in light of the lack of certainty, believing their child should wait until they're sure about who they are. It's at this point it's essential

to highlight as being equally significant, a number of other aspects to the transitioning journey that don't involve medical intervention, in their child's journey to becoming their authentic selves.

Different aspects to the transitioning journey parents should consider include:

- Internal transition – a process of self-exploration, where the individual processes what triggers their gender dysphoria and considers how they'd like to look, what clothes they feel comfortable in, hairstyles, how they want their voice to sound and perhaps what name and pronouns they feel comfortable using.
- Social transition – coming out, asking to go by a different name and/or pronouns, dressing, grooming and speaking in a way that feels more congruent to their identity.
- School transition - speaking to the principal and teachers about their gender identity and their particular needs, with the child's consent. Requesting the child be referred to by their chosen name and/or pronouns and not previous name, (dead-named) especially in front of classmates and requesting they have access to appropriate bathroom facilities.

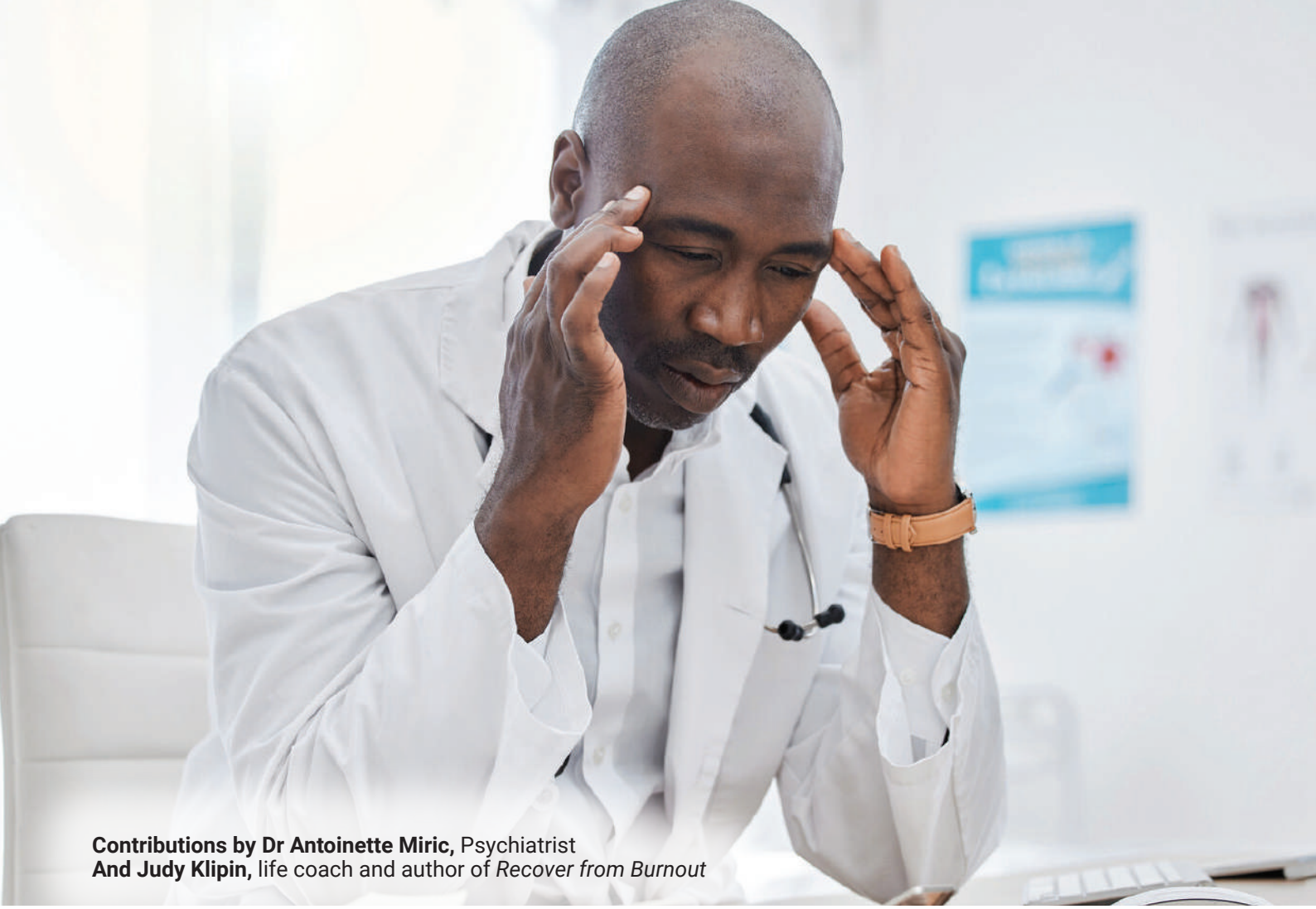
- Legal transition – changing the child's information regarding their gender and/or name on official documents and records, such as ID, passport and medical aid, which can assist in school transition too, as their academic record will then reflect their accurate name and ID number.
- Physical transition – process of changing their body either temporarily or permanently, to align with their gender identity.
    - Medical – what's often most relevant in teens are puberty blockers or gender-affirming hormone therapy, which doctors would be able to explain extensively, including various other procedures people can undergo.
    - Non-medical – temporary strategies to lessen dysphoria, which are especially helpful for adolescents whose bodies are starting to develop in ways incongruent to their gender identities.
        - Voice training – assistance from a professional to use their voice differently.
        - Hair removal – shaving, waxing and/or laser hair removal.
        - Chest binding – binders and sports bras help flatten the chest.
        - Packing – packers, cups or balled-up socks to create a bulge in the groin.
        - Stuffing – padded bras/underwear or tissue to make the chest, hips or bottom look fuller.
        - Tucking – tucking the penis and/or scrotum to make the groin flatter.

Engaging with all this information is a lot for parents to take in, which is why it's helpful to empathise with how overwhelmed they may be feeling. Acknowledge just how much patience and understanding they're having to draw on and validate what a significant difference it will make in the well-being of their child and their ongoing relationship, if they can:

- Respect their child's chosen name and pronouns otherwise they may feel as though their existence is being denied.
- Educate themselves on transgender terms, issues and rights, so their child doesn't have to constantly explain their existence to them.
- Receive consent from their child when discussing their gender identity with others, in order to respect their privacy.
- Advocate on behalf of their child and their needs (especially in school settings).
- Not make assumptions about their child's sexual orientation or how they should be acting/dressing and to not stereotype them or expect them to conform to certain gender norms.

Assuming the child is the only one who needs therapy to process everything is a mistake. Parents who are struggling to navigate this should seek their own support from mental health professionals and to speak to other parents' of transgender teens. Parents need their own therapeutic space to come to terms with these changes which can often involve a process of grieving, needing specialised support, making theirs and their child's journey easier.

***References available on request.*** MHM



**Contributions by Dr Antoinette Miric,** Psychiatrist
**And Judy Klipin,** life coach and author of *Recover from Burnout*

# BURNOUT AMONG HEALTHCARE WORKERS:

## PREVALENCE, IMPACT AND SOLUTIONS

As an ICU nurse working in Johannesburg, thirty-seven-year-old Priya Naidoo leads a busy life that leaves no time for self-care. This wife and mother of two children is always between a flurry of activities - from taking care of critically ill patients and attending meetings to running a household, doing school runs and preparing meals at home. This leaves no time for adequate rest or relaxation. As a healthcare worker, her life is focused on putting others first, often neglecting herself. As a result, she has suffered from burnout consistently over the years.

As a healthcare worker people are reliant on you for their physical and mental well-being which often leaves little time for yourself. More and more healthcare workers are finding themselves suffering from burnout, which is a systemic condition that affects every element of life - body, mind, spirit, emotions, and relationships.

During the COVID-19 pandemic, from April 2022 to August 2022, the Healthcare Workers Care Network in South Africa, conducted a total of 775 individual therapy sessions for healthcare workers who reached out for help after suffering burnout. The care network recorded that 447 healthcare workers requested help online, of which 60-percent were in Gauteng. 279 of them have started sessions. During this time, the telephonic helpline received more than 4000 calls, indicating the extent of strain placed on South Africans working in this sector.

**Healthcare workers who made contact online:**

| | |
|---|---|
| Allied Health (physiotherapists, dieticians) | 117 |
| Doctors | 137 |
| Nurses | 148 |
| Support Staff | 89 |
| **TOTAL** | **491** |

**Of the 491 healthcare workers who reached out for help, 279 began therapy.**

| | Average number of sessions per profession |
|---|---|
| Allied Health | 3.2 |
| Doctors | 2.9 |
| Nurses | 2.5 |
| Support staff, admin, cleaning | 2.1 |

Psychologists who saw patients during this time reported the following as being some of the most common themes:

- COVID-19 infection contributing to emotional discomfort.
- COVID-19 infection contributing to emotional discomfort due to occupational stress.
- COVID-19 pandemic contributing to emotional discomfort due to relationship stress.
- COVID-19 pandemic contributing to psychological problems.
- COVID-19 pandemic exacerbating prior psychological problems.
- Emotional discomfort related to effects of COVID-19 on family.
- Emotional discomfort related to contracting COVID-19.

Healthcare workers, above all, battled with stress related to Covid-19, family, and relationships. They were at the coalface of fighting the pandemic, often contracting the virus themselves and passing it on to their families. Thousands lost colleagues to the deadly pandemic and had to persevere through it all.

## A QUICK FIX

Judy Klipin, author of the book Recover from Burnout, says many healthcare workers believe going on holiday will help them relax and recover from burnout. However, she says, living through burnout and then using an annual holiday as a quick fix will only put you at risk of being a repeat sufferer. Klipin says you should be able to manage and deal with burnout throughout the year.

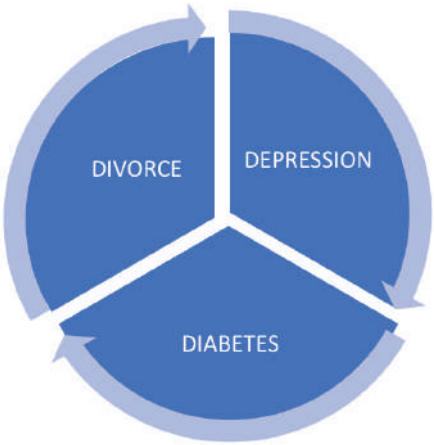
The more other-centered you are, the less attention you pay to yourself. Naidoo suffered from burnout because, like many other healthcare workers, her scale tipped strongly towards doing things that benefitted others, rather than herself. These are not purely confined to work related tasks, but include social events and family gatherings that are time consuming and prevent you from connecting with yourself. It's crucial to remember that your body is the best source of information about how you feel and what you need. It's essential to listen to our bodies and give them what they need in order to be in good mental and physical health.

Naidoo has suffered from burnout for years. These were some of her symptoms:

- Physical: Headaches, fatigue, difficulty sleeping, digestive ailments, craving sugar, carbohydrates, caffeine
- Emotional: Irritable, sadness, worry
- Mental/Intellectual: Impaired concentration, fog brain, memory loss
- Social: Reduced motivation, social isolation and withdrawal from relationships
- Spiritual: Things that used to make one feel meaningful and important are no longer rewarding

Often people that suffer from burnout question why they are in the profession that they are in. They lose interest in community work and erode the pleasure in their lives. As the burnout progresses, so do the symptoms. They find themselves feeling tired, angry and depressed. Some people experience insomnia, anxiety, physical exhaustion, and sometimes begin substance abuse. There is often a breakdown in relationships, inability to function normally, and acute chronic illness. All the above are quite serious on their own, but when strung together, could have disastrous consequences.

If not treated, burnout can result in the dreaded 3 D'S




## TYPES OF BURNOUT

Compassion fatigue

- The cost of caring
- The response to the ongoing stress of caring for others
- Emotional and physical exhaustion of caring for people, particularly those in significant emotional pain and physical distress
- We become exhausted of being exposed to emotionally drained clients that look to us for help

Anyone who cares for others is in danger of getting compassion fatigue. It's often because healthcare workers care too much and are exposed to people who are experiencing varying degrees of pain and suffering. It's important to remember that it's your empathy that makes you both good at what you do and at the same time vulnerable to emotional overload.

COVID-19 fatigue

- A response to the anxiety and stress associated with the COVID-19 pandemic
- The pandemic has taken its toll on everyone, and many people are experiencing

symptoms of burnout because of the emotional exhaustion that has come with the living through this challenging period
- This is true for healthcare workers that have borne the brunt of covid stress and anxiety

## THE SYMPTOMS

- Emotions are amplified and erratic
- Concentration impacted
- Cravings for sugar, carbs, caffeine and coffee
- Questioning of life choices
- Exhaustion

## YOUR ENERGY IS A CURRENCY

Your physical energy is a finite resource, and you should be spending it wisely. To lead a happy and healthy life, you should make sure you bring in as much energy as you spend. You can garner energy by doing the things that make you feel good. Cut back on activities that drain your energy. We must begin to treat our energy as a precious commodity.

## STEPS TO REGAIN AND MAINTAIN YOUR ENERGY AND ENTHUSIASM

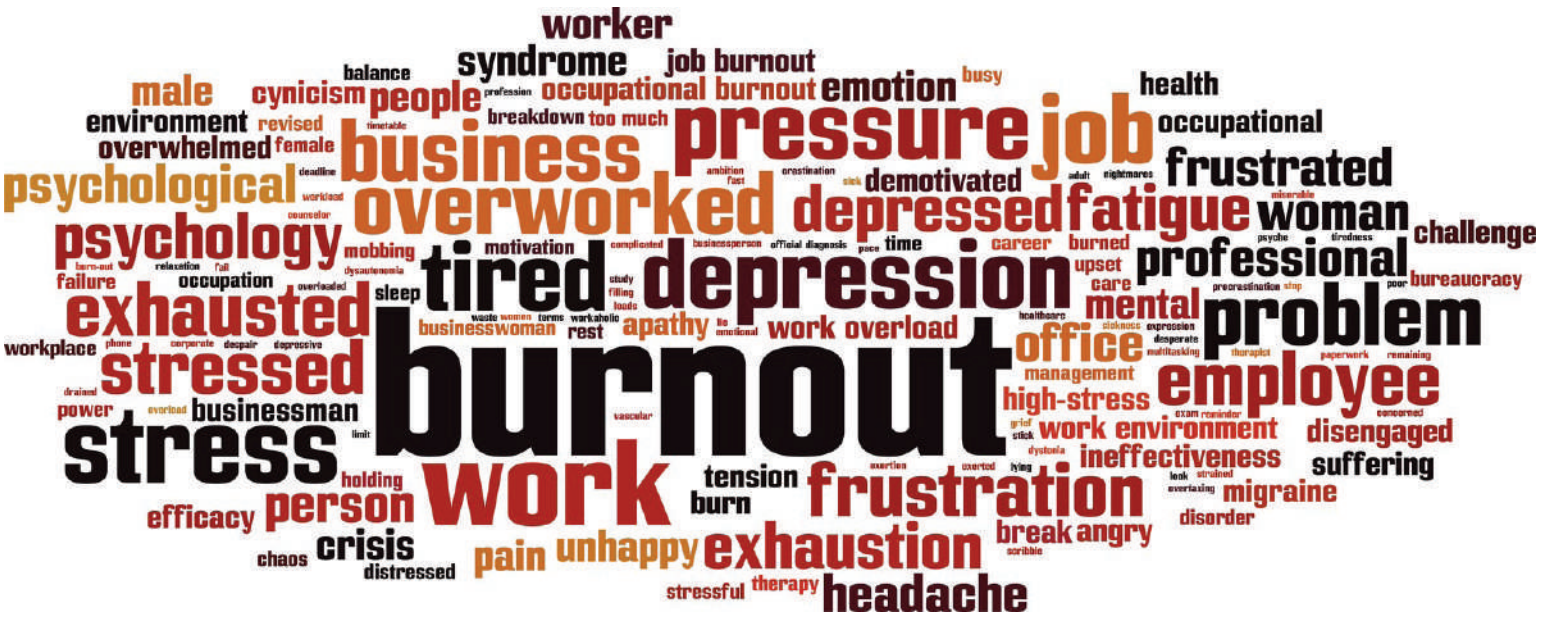
- Ask for help: This is not a sign of weakness, but a sign of maturity. Be honest about what you can and can't manage.
- Set and maintain boundaries: Train yourself to leave work behind at the end of your working day. Quiet quitting is a way of setting boundaries.
- Having a healthy ecosystem: Maintain healthy relationships with partners and family. Get adequate sleep, exercise, and recreation. Financial stability, nutritious food, creative pursuits, prayer, and introspection, learning and growing are all part of a healthy lifestyle.
- Practice Self-care: People that are others-centered are prone to burnout because they neglect themselves. We must take care of ourselves, to be able to take care of others.
- Give yourself a break: It's important to take regular breaks and not work for extended periods.
- Plan: To conserve your energy, be organized. Do not over commit yourself. Allocate time for different tasks.
- Be you: Remember to feed your soul by engaging in activities that make you happy. To keep learning and growing, be honest about your strengths and challenges.

If you've experienced burnout once, the chances are high that you'll be prone to it again. Identify your warning signals and when the alarm bells ring, take action immediately. In order to prevent burnout it's critical for us to be aware of our bodies and to strive to reach a place of healthy balance.

## HOW CAN WE TACKLE BURNOUT IN THE MEDICAL PROFESSION TOGETHER?

- Continue to raise awareness about burnout
- Promote wellbeing and awareness amongst healthcare workers
- Offer stress management and resilience training
- Advocate for better resource provision and support for healthcare workers
- Ensure access to mental health support
- Collaborate with the Department of Health and Occupational Health teams

***References available on request.*** MHM



# SA Mental Health Conference 2023

## Join the movement

24 – 25 April 2023 • Gauteng, Emperors Palace

**This Conference will feature topics, identified by the Programme Committee, that cuts across all tracks.**

## Examples Could Include:

- Human rights
- Inclusion of people with lived experience
- Ethics

## Conference Tracks:

**Track 1:** Clinical, psychology & behavioural sciences
**Track 2:** Technology and innovation
**Track 3:** Policy and Public Health
**Track 4:** Best practices & Programmes
**Track 5:** Communications and Community Engagement

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# THE PERVASIVE STIGMA SURROUNDING MENTAL HEALTH

April 2021 - South Africa woke up to shocking and inhumane Facebook, Twitter and YouTube videos of a women who was being brutally beaten by a group of men, and it was reported that she was later burned due to 'mob justice'. She was 59-year-old Jostina Sangweni, and it was later discovered through the family that she had been diagnosed with schizophrenia and then taken to a nearby religious healer where the incident took place. Because of her condition, she found a way to escape from the religious healer's house. She then went to hide in a nearby house where a man saw her and assumed she was sent to bewitch him, judging by her attire, dreadlocks, and elusive answers. This man and his friend acted violently towards her and eventually dragged her outside their yard, opposite the man's home and this was when some of the community members joined to watch.

The man was said to have asked two younger adult males to go and buy petrol in a nearby petrol station, which they then poured over Ms Sangweni, who at this time seemed to not understand what was happening to her. She was then set on fire. Ms Sangweni was later taken to hospital where she passed away. This case showed the limited mental health education, particularly in rural communities, with its stigmas being perpetuated by socio-cultural norms.

**MENTAL ILLNESS & THE COMMUNITY**

What is often considered to be a person with mental illness by community members is a person who is dirty, maybe showing violent behaviour, talking to themselves, walking and picking up trash, etc. This is the picture that community members have of an individual who may have psychiatric disorders and not of a person who may be clean, calm, capable of conversing, with some level of understanding and daily functioning. Due to the nature of the individual's behaviour, the stigma of mental illnesses increases and sows confusion, resulting in those individuals being thought of as lazy, rude, irresponsible, misbehaving, or difficult to get along with. Such labels

come from the limited education, awareness, and understanding of psychiatric disorders. For this reason, individuals with severe mental illnesses are often challenged doubly: on the one hand, they struggle with the symptoms and disabilities that results from the disease and, on the other, they are challenged by the stereotypes and prejudice that results from misconception about their illness.

Studies have reported that mental health is increasingly recognised as an important public health and development issue in South Africa, with mental health stigmas playing a major role in persistent suffering, disability, and economic loss associated with mental illnesses. Hence, it is crucial to work toward breaking the stigma around mental illness within our communities.

**MENTAL HEALTH STIGMA**

The modern definition of the term stigma was first described by Ervin Goffman in 1963 as the character or attribute by which a person was devalued, tainted, or considered shameful, or discredited. Seeing as mental health stigma was later defined as the disgrace, social disapproval, or social discrediting of an individual with a mental health problem, this definition could be broadened to also include the community. Such an inclusion may be important in breaking stigma, especially in South Africa or Africa, where community values and identity originate from Ubuntu. Being able to understand mental health stigma from the perspective of Ubuntu may be the start for addressing these in a more socio-culturally appropriate manner. Umuntu ngumuntu ngabanye abantu (I am because we are) speaks of how we see and relate with each other within a community.

To have a broader understanding of Ubuntu within the definition of mental health stigma may be one other way that Africans may be able to understand the seriousness of mental illnesses, particularly how these stigmas violate human dignity, discriminate, marginalise, isolate, and reject individuals with mental illness. Based on Ubuntu, both the family and the community may have been impacted in similar ways by psychiatric disorders of an individual within that community. The impact and misunderstanding of mental health stigma are a problem when analysing Ubuntu and its relation to these stigmas. Ubuntu could be used as a theoretical system to addressing the four types of mental health stigma holistically.

MENTAL HEALTH STIGMAS

Mental health stigmas may include:

1. Self-stigma: This type of stigma refers to an individual with a mental illness who has a negative attitude towards their own mental illness, and is sometimes called internalised stigma. This negative attitude is often because of the prejudice and discrimination that these individuals may experience due to their illness, and/or may have a diminished self-esteem and efficacy due to living in a society that widely endorses stigmatising ideas.
2. Public-stigma: Refers to the negative attitude towards those with mental illness held by the public, often based on misconception, prejudice, fears and exclusion. For example, research has indicated that certain mental health discriminations can appear in the public about how to treat individuals with mental illness, with misconceptions such as the belief that people with severe mental illness are irresponsible and display childlike behaviour.
3. Professional stigma: This happens when healthcare professionals hold stigmatised attitudes towards their patients, which is often based on fear, misunderstanding of the causes and symptoms of the mental illness, or when the professionals themselves have experienced stigmatisation from the public or other healthcare professionals because of their work. These healthcare workers may be diagnosed with a mental illness themselves and stigmatise others as a result.
4. Institutional stigma: This refers to national and/or organisational policies, legal frameworks, and cultures of negative attitudes and beliefs toward stigmatised individuals. This type of stigma may also be understood to be systemic.

**WHAT CAN WE DO?**

Based on research, the burden of mental health is increasing in Africa and is estimated to be responsible for 9% of non-communicable diseases. Common mental illnesses such as depression and anxiety disorders contribute about 8% and 3%, respectively, to the years lost to disability in Africa. Currently, mental illnesses are responsible for 13.6 million disability-adjusted life years (DALYs) in the region. These statistics are truly alarming and only indicate that mental health awareness campaigns at a community level need to increase.

However, stigma is strongly influenced by cultural and contextual value systems that differ over time and across contexts. Therefore, starting early, for instance by adding mental health education as a part of the curriculum and incorporating Ubuntu in the fight to break the stigmas, may assist with changing the perspective on mental illness in Africa. Since mental health stigma consists of three related issues: Ignorance – which is a problem of knowledge, Prejudice – which is a problem of attitude, and Discrimination – which is a problem of behaviour, education, awareness, and moral development may help to break the pervasiveness of mental health stigma.

***References available on request.*** MHM

# SADAG SUPPORT GROUPS

## Depression and Anxiety Support Group for Moms

SADAG has over 160 Support Groups around the country dealing with a variety of mental health related issues, as well as Support Groups specifically for family members and loved ones.

SADAG guides and trains new Support Group Leaders on running a group step-by-step. We help with training webinars, materials, handouts, information and more.

Being a mother is an overlooked and underappreciated job, but any mom knows just how taxing and demanding this role can be. When depression and anxiety are added to the mix, being a mother can become overwhelming. Mothers are the pillars of society and it's vital to acknowledge their challenges and provide them with support when they need it.

This month's featured Group is the Depression and Anxiety Support Group for Moms Support Group hosted by Lisa Drummond.

Lisa's Support Group offers a safe space for mothers with depression and anxiety. Mothers in this predicament are often faced with the idea that they need to be perfect and should not be struggling. In the safety of the Group, mothers can be vulnerable and discuss their problems and difficulties in a non-judgemental space where they will find support from others who understand exactly what they may be going through.

**Some words from Lisa:**

**Why did you start this particular support Group?**
As a mom living with both depression and anxiety, I realised that moms in this situation have a unique set of circumstances that make it difficult for others to understand. We often have this expectation of ourselves to be the perfect moms, the supportive partners, the strong one that keeps the family going, and so it's very difficult to admit when we're struggling, when we're feeling down, or when we're no longer coping. Often we feel like a failure and that we're alone in this failure. Meeting up with other moms who have similar experiences and problems is hugely beneficial in dispelling this myth.

**What are the benefits of joining this Support Group?**
Knowing that you're not alone, that there are people out there, moms out there, that understand and share some of your experiences and struggles, immediately makes you feel better, gives you hope and allows a safe space to express yourself and find support

**Who can join this Group?**
Any moms over 18 who are living with depression or anxiety.

**What do you hope to achieve with this Group?**
I hope to create a safe, supportive, non-judgemental space for moms to come together and be heard, understood and uplifted. MHM


# TAFTA LAUNCHES NATIONAL TOLL-FREE ELDER ABUSE HELPLINE

Ahead of the United Nations' Global Campaign for 16 Days of Activism for No Violence against Women and Children, The Association for the Aged (Tafta) launched a National toll-free Elder Abuse Helpline on the 23 November 2022. The active Helpline now enables older persons, family members and members of the community to access information to report abuse and to receive crisis counselling.

## THE STATISTICS

According to the World Health Organisation, one in six persons that are 60 years and older have experienced some form of elder abuse. In a study by the University of Cape Town on Covid 19 and elder abuse in 2020, it was found that only 4% of elder abuse cases were reported to the authorities. The data collected suggests that elder abuse is prevalent and can be fatal.

Femada Shamam, CEO of Tafta said, "The world's population is ageing, with older persons making up an increasing share of the population in most African countries." South African statistics on the subject places South Africa's total population at 60.14 million people, of whom 5.51 million or 9.2% are over 60 years of age. "These statistics highlight the concern that the number of elder abuse cases will continue to grow in the future. There is a gap in this type of support to elders, and based on the statistics we felt compelled to reinstate a toll-free helpline for older persons that would be accessible nation-wide," explained Shamam.

## WHAT IS ELDER ABUSE

The South African Older Persons Act 13 of 2006 refers to elder abuse as 'a single or repeated act or lack of appropriate action, in a relationship with an expectation of trust, which causes harm or distress to an older person'. Abusers are usually the caregivers or trusted individuals such as a family member, friend or acquaintance. High unemployment rates, poverty, alcohol and drug abuse, breakdown in family structure and the high crime rate in South Africa are all contributing factors to elder abuse.

## TYPES OF ELDER ABUSE

- Physical abuse - is any act or threat of violence toward an older person that causes physical harm
- Sexual abuse - is any conduct that violates the sexual integrity of an older person
- Psychological abuse - is repeated insults or ridicule, threats to cause emotional pain, and invasion of an elder's privacy, integrity or security
- Financial abuse - is the misuse or theft of an older person's money or assets. This includes intimidating the older person to provide money or assets, depriving them of money for necessities, use of their savings and failure to pay bills on behalf of the older person

## ABOUT TAFTA'S NATIONAL TOLL FREE ELDER ABUSE HELPLINE

Carmel Murugen, the Helpline Project lead said, "People who have experienced abuse are often reluctant to report it, because they're afraid to report a family member they love or depend on; they aren't aware of their rights or they find the reporting process cumbersome and lack the support network to access services. It's important that older persons struggling with abuse understand that they are not alone and that help is just a phone call away."

## HELP IS AVAILABLE

By simply calling the **toll-free number on 0800 10 11 10**, any older person anywhere in the country will be able to receive free, confidential counselling and be referred to the relevant services closest to them. The service is available daily, Monday to Sunday, from 7am to 5pm and will be managed by trained counsellors experienced in cases of abuse. If you are an older person, or know an older person who is experiencing abuse - call the toll-free number and report it. You will help to expose and stop the abuse and exploitation of elders, and protect them from further trauma, injury or financial difficulties.

For more information on the helpline, contact Carmel Murugen on **031 332 3721** or email **carmel@tafta.org.za**. MHM

# MY CHALLENGE TO YOU: LET'S SCALE UP OUR ANNUAL MENTAL HEALTH WALK ACROSS SOUTH AFRICA

**Suntosh R. Pillay**
Clinical Psychologist
Durban

If you're reading this – be warned – there is a challenge for you at the end of this article!

Our seventh annual KwaZulu-Natal Mental Health Advocacy Walk took place in Durban on October 9, a day ahead of World Mental Health Day, to help destigmatise mental illness and create a space for people to talk openly about their mental health.

When we began this initiative in 2016, Professor Suvira Ramlall and I wanted to create a flagship event for mental health in our home province of KZN. The sunny Durban beachfront was the obvious choice of venue, and the amphitheatre off Snell Parade provided a scenic green space for our wellness fair.

The short 5km walk from North beach to South beach, with hundreds of placard-holding activists, has certainly been succeeding in its mission. The number of attendees has grown from a few dozen in 2016, to over 900, despite our online hiatus in 2020 and 2021. I am pretty sure that our walk is now the largest, free, community mental health gathering in South Africa.

This year, some of our wellness exhibitors included Raidah Gangat, a clinical psychologist in private practice; Danielle Reynolds, who started a new psychotherapy app called Upright; Keith Ruthanum from the KZN Provincial Mental Health Directorate; Nerena Ramith from Ekuhlengeni Psychiatric Hospital; and Varsha Pillay from Mondia Health Umhlanga, amongst many others. We also partnered with the Durban Book Fair (reading is, after all, an excellent example of mindfulness, cognitive stimulation, and relaxation – three ingredients for good mental health).

As usual, there was Zumba, dancing, yoga, and music, adding energy and hype to our morning.

My former colleague, Blanche Moila, an 18-time Comrades runner and retired nurse, said that she joined the walk because there's still a stigma against mental illness even though "it can effect anyone, whether you're a professional, a labourer, whether you're rich or you're poor." Blanche has always been our unofficial mascot for the walk – and did us the honour of leading the walk again this year.

Dr Sandile Kubheka, who was once the youngest doctor to qualify from the University of KwaZulu-Natal (UKZN), is now a registrar at Inkosi Albert Luthuli Central Hospital. He said that the walk was a stimulating and exciting morning, reminding him that "taking care of ourselves is crucially important." Indeed, research consistently shows that a 20-minute walk every day can be simple but effective act of self-care, for our mind and body.

According to the World Health Organisation's Global Health Estimates Suicide, published in 2019, South Africa has the third-highest suicide rate of any African country (almost 14 000 suicides were reported in South Africa in 2019 alone, with over 10 000 of those deaths being men). There is, therefore, much work to be done in reducing the burden of mental distress and illness in this country. Together with the pandemic, flooding, looting, and ongoing service delivery failures, people in KZN are trying hard to recover from an especially traumatic period.

How does a walk make a difference in the face of such seemingly insurmountable problems? Ultimately, this more than just a walk. Events like these build social capital in our communities, makes it easier for people to ask for help when they are in distress or suicidal, promotes healthy living, and inspires hope and optimism that the future will indeed be brighter.

The theme for World Mental Day 2022 was "Making mental health and well-being a global priority for all". This is fairly ambitious agenda. How can we action this theme on a larger scale?

I have an idea. Let's create mental health walks across this country.

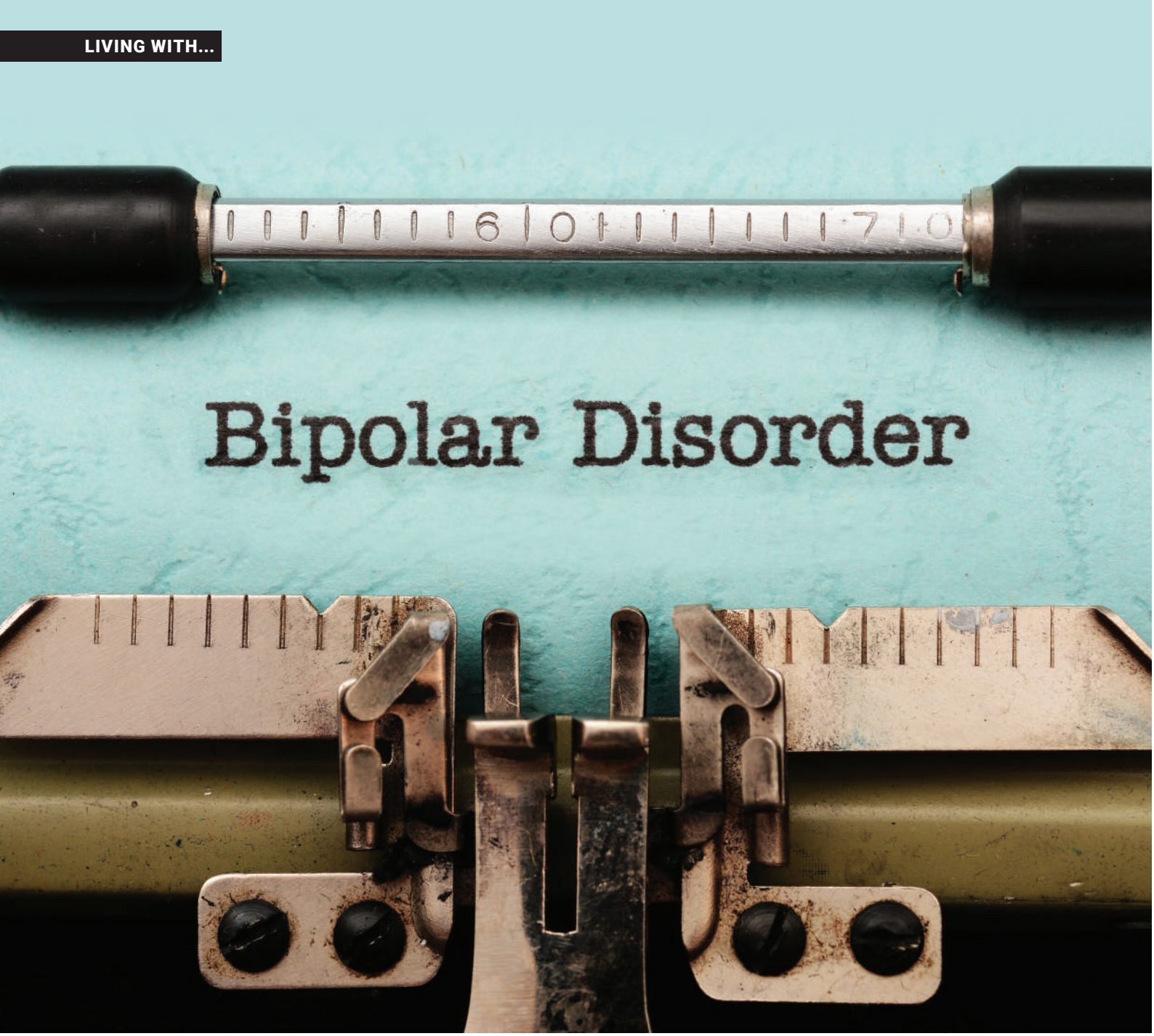
If you're reading this, my challenge to is to help scale up our event and host a walk in your home town. Let's have a mental health walk in all nine provinces for October 2023! It's possible. Let's make it happen. Together we can do more! #StepUpSouthAfricaa

*Suntosh R. Pillay is a clinical psychologist in the public sector in Durban, and co-founder of the KZN Mental Health Advocacy Group that started the annual walk. If you are keen to take up his challenge, email him on* ***suntoshpillay@gmaill.com***

SADAG KZN

# The 7th Annual Mental Health Advocacy Walk






# A STORY SELDOM TOLD

Richard Daye

So, a story seldom told is one I write today, which if you read as fast as I do and get distracted as much as me, might take a few turns.

I was diagnosed with Bipolar (rapid cycle), at 13 years old, although the signs had been there for quite a while before this. Later in my life, I was also diagnosed with ADHD and Asperger's syndrome (a double whammy). If only I'd known this much earlier, it would have explained my brain and behaviours to me. Now I understood that I wasn't crazy and that it wasn't just a case of not fitting in. I had real issues.

## SCHOOL STRUGGLES

During my school years, my violent temper meant I was always in fights and found school really challenging. I could never get things right and was labelled a problem child. However nothing changed when I was diagnosed - the fights continued and my schoolwork went down the tubes. My last fight was the final straw for my school and I was "kindly" asked to leave in grade 10 and the school gates closed behind me, telling me never to return.

This was the first of many failures in my life, and although it was difficult to find other people with similar stories, I eventually realised I wasn't alone in my journey.

## THE NEED FOR UNDERSTANDING

You see, the road to walk with any mental illness is not easy, and judgements comes so quickly from people not knowing the truth, nor what it entails, yet the understanding comes from within. It's all about knowing your own problem and illness and how to better control and deal with it.

As any person with Bipolar knows only too well, going on and off medication your whole life is a cruel cycle. You get some meds from the doctor which make you feel so good that you feel you don't need them anymore (obviously all from the voices in your head), then you hit the low, and you go back on the meds like a merry go round, thinking it will never get better than this.

I can't say I'm normal, I'm not but I can function just as well as the next person. By keeping my disorders a secret I've proved for the most part that I'm able to continue as a "normal" person.

I must tell you writing this is a big deal for me as those of you reading this are the first people outside my family to know my story. For 26 years I have kept my little secret and for good reason. People (friends, the workplace etc) don't want to know about mental illness, nor understand it. Welcome to the mentally "challenged". Tell someone you have bipolar disorder and they think you're about to start a campaign of mass murder, tell them you're on the autism spectrum and they wonder how you can cope and work without having a permanent carer. I just want to say – F*** IT – try understanding me, and help me support others with the same feelings. Although it's taken me 20 odd years to understand and accept my conditions myself, I feel I can make a difference in spending time with those who don't feel as comfortable talking about it as I do now.

So, if I had to describe my life from the start I'd say it's like a wild rollercoaster, no warning of the start where you can see yourself going up slowly until you hit the top - man that feels great up with the birds, and all of a sudden down you drop, how far and how fast, with the measure of a really great rollercoaster being when it hits the end of the track…. and you go backwards.

## THE WORKPLACE

I've had more jobs than I care to remember, some of which I've just walked out of. I've been fired for various reasons, admittedly some were not my fault (again another wonderful thing you keep hearing - nothing is ever my fault) and some well, I guess I just didn't fit in. But if I had to start blaming everything and everyone I would start with – I'm bipolar – it's an unfortunate trait as we just can't keep a job, My Asperger's means I'm not a people person, which is why I've kept it to myself. I don't blame my bipolar disorder and I won't start now.

Over and above all this I have major rage issues. 20+ years ago when I started as a chef that wasn't a problem, chefs were grumpy with foul tempers and worse vocabulary, and didn't have to care about anything but themselves. Unfortunately, that was the only place it was accepted, and luckily I was given the nickname of Ramsey.

Having bipolar disorder it's really difficult managing being depressed or at another level on top of the world, balancing this with a work life, one word that describes this is "masks". You become the great pretender - no-one ever knows what you're really going through. My advice would be to tell everyone you have a disorder but that your disorder does not have you. Tell them you're on 15 tablets a day, and most importantly educate the uneducated. Assure them they have no reason to be scared of you, but when you're sitting at your desk and the tears are pouring, maybe, just maybe a friendly hand on your shoulder would go a long way. Let them really see you, everything will be ok, you don't need to hide anymore and they don't need to be afraid.

I've been on my meds now for almost 10 years and had to come to terms with the fact that I'll be on them for the rest of my life. This was a hard realisation to come to but I guess it had to happen. With my wife I've had to learn that simply relying on my meds doesn't give me a free pass nor are they the answer to everything and a promise of an uneventful life. It's extremely hard work. Sadly, recently I tried to commit suicide and my wife saved my life. I can tell you the only way I got out of that hospital was because of my family, and if that is what I have to hang onto for the rest of my life then I'm richer than most people.

So to sum it all up – life happens. This means knowing who and what you are and actually understanding yourself, and accepting it all. Life gives hard knocks, and so we go up and down to become better people. All I can say, it's HARD, and even HARDER with mental issues. I understand, and I can compare cards and quotes and everything in between. However, living with these masks, makes us stronger, better heroes – but actually living this life can be amazing!