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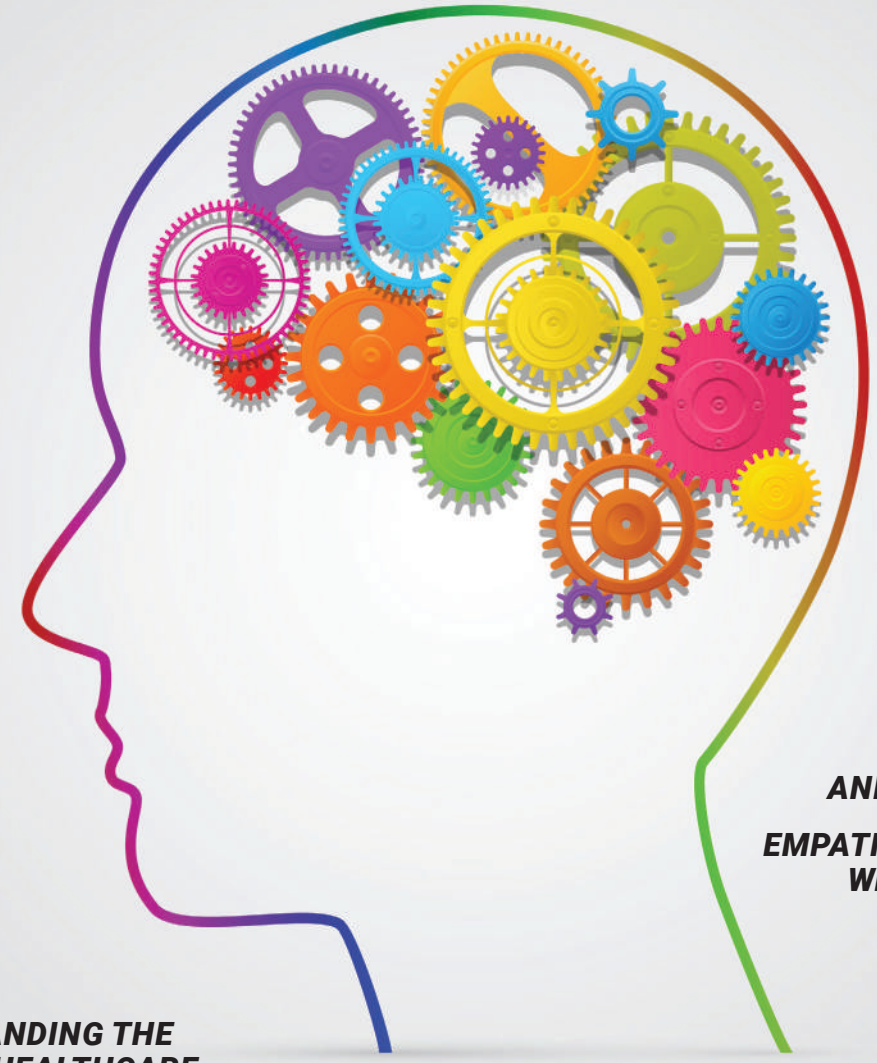
MENTAL HEALTH MATTERS



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THE SOUTH AFRICAN DEPRESSION AND ANXIETY GROUP

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Making Mental Health Matter

UNDERSTANDING THE CURRENT HEALTHCARE WORKERS' MENTAL HEALTH CRISIS AND THE IMPORTANCE OF REDEFINING WORKPLACE CULTURE

Professor Gerhard Grobler
Psychiatrist
Pretoria

Healthcare workers (HCWs), internationally and in South Africa, are facing an increasing burden of mental health care needs. In addition to the usual demands of medical practice the recent worldwide COVID-19 pandemic placed an additional burden on health care workers. Not only burnout, but an array of mental health conditions such as mood disorders, anxiety disorders and substance use disorders are of concern. The workplace culture is of importance in either protecting HCWs from or posing a risk to the development of burnout and other mental health concerns.

The impact of the COVID-19 pandemic

It would be fair to say that healthcare workers have been under severe strain and bore the brunt of the COVID-19 pandemic to a significant extent. Except for the risk factors for poor mental health that the general population were exposed to such as social isolation and loss of community support, risk to the health of family members and loved ones and financial strain, health care workers experienced additional mental strain. This additional strain came from caring for severely unwell and dying patients (who may include even colleagues) during the COVID-19 pandemic, constantly making life-and-death decisions, concerns about infecting family members on returning home, becoming infected themselves and having to work for longer hours, more shifts and under unusually difficult conditions. It also included the lack of PPE, availability of life saving treatments and other budgetary constraints. Even after the worst of the COVID-19 pandemic, healthcare workers remain under strain to the point of a mental health crisis under healthcare workers.

The rates of (emotional) burnout, as well as psychiatric disorders such major depression, anxiety disorders, substance use disorders and posttraumatic stress disorder are rising under HCWs. A study by Farooq and colleagues, for example found an increase in the rates of suicide ideation, compared to the rates prior to the COVID-19 pandemic, in different countries and populations. They further found that low social support, high physical and mental exhaustion, poorer physical care by self-report from frontline healthcare workers, sleep disturbance, quarantine and loneliness were the main risk factors for the development of suicide ideation.

The COVID-19 pandemic exposed the vulnerabilities of the workplace environment. It brought the preparedness or otherwise of the workplace to light. It also uncovered the workplace culture. The moral injury suffered by healthcare workers can often be attributed to the workplace culture.

Workplace preparedness

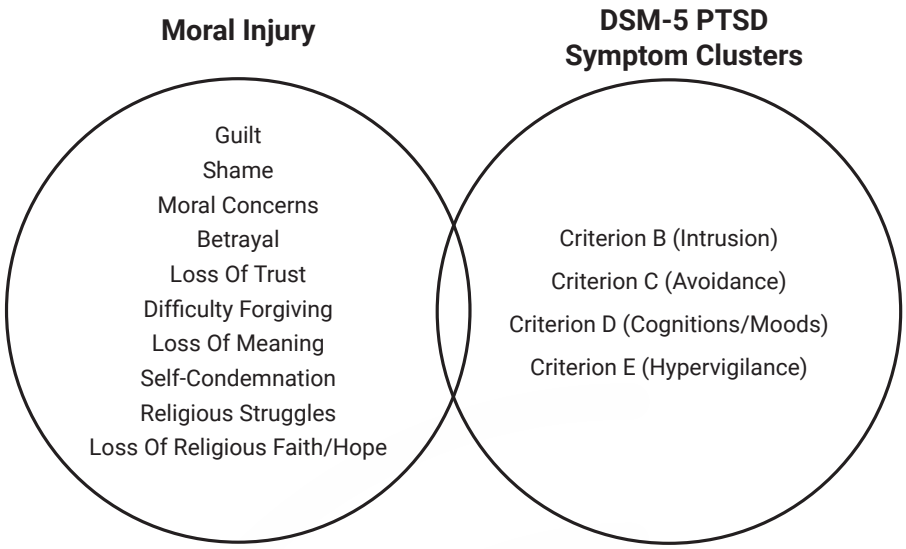
Workplace preparedness refers to the proactive readiness of the workplace environment to deal with both foreseeable and unforeseen demands. Workplace preparedness for foreseeable demands are usually reflected by the workplace standard operating procedures, policies and workflow diagrams. Under standard conditions such measures are suitable to manage the demands of the workplace. During times of unforeseen demands such as disaster events or, in the case of the COVID-19 pandemic, a rapidly evolving and overwhelming threat to the healthcare system, standard operating procedures and policies are no longer sufficient to ensure optimal work functioning. During such demanding times operating procedures and policies should evolve concomitantly. These changes should be evidence based and conscious of resource availability.

Criticism has been leveled at policy and decision makers of decisions made regarding public health policies and operating procedures

which in retrospect was not optimal. Such decision and policy changes defined the workplace culture in which healthcare workers delivered and continue to deliver service.

Workplace culture and moral injury

In a paper by Griffin and colleagues, they recognised that there is not yet a consensus definition and gold-standard measures for moral injury. Despite this limitation, He and colleagues found that moral injury may contribute to the prevalence of suicide ideation and that mental health conditions, especially depressive symptoms, play a significant role as mediators of moral injury. Moral injury, as initially defined by Litz et al in 2009 as "an act of transgression that creates dissonance and conflict because it violates assumptions and beliefs about right and wrong and personal goodness.." is often a result of the workplace environment and prevailing culture. The original definition of moral injury by Shay in 1995 (quoted by Wiinika-Lydon) emphasised three key elements of behavior that constitutes moral injury, 1. a betrayal of what is morally right, 2. by someone who holds the legitimate authority, 3. in a high-stakes situation. Shay further observed that it is the feeling of powerlessness in these situations that leads to helplessness and hopelessness (key elements of depression) as well as feelings of guilt and shame. Shay goes on to link these feelings to erosion of trust, social withdrawal and isolation and emotional numbing. Koening et al link such experiences to the features of DSM-5 defined posttraumatic stress disorder (PTSD) as indicated in the figure below (adapted from source).



A workplace culture where healthcare workers are disempowered to make critical decisions and are unable to care for themselves and their colleagues leads to feelings of helplessness and hopelessness, subsequent moral injury and the resultant mental health concerns. The workplace culture should be one of empowering and enabling healthcare workers.

Looking after our healthcare workers is looking after the nation.

References available on request. MHM

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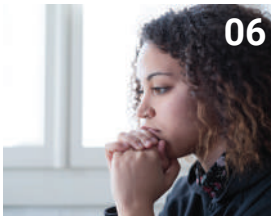

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ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD) AND TEENAGE PREGNANCY IN SOUTH AFRICA

Introduction

Teenage pregnancy and attention deficit hyperactivity disorder (ADHD) are two major challenges afflicting young South Africans, resulting in serious consequences for society and those affected. This article explores the causes and consequences of teenage pregnancy and ADHD in South Africa and the efforts being made to address these challenges.

The World Health Organization's annual figures indicate that 21 million girls, aged 15-19, become pregnant in low and middle-income countries, and 12 million give birth each year. Adolescent girls younger than 15 produce 777,000 births.

Sub-Saharan Africa (the high fertility countries) shows consistently high rates of teenage pregnancy. SA has one of the highest rates globally with 30% of girls falling pregnant before the age of 18, thus posing serious health consequences for both mother and child. One study found increases of 48% in SA teenage pregnancy in younger adolescents (aged 10-14 years) and an increase of 17% for those aged 15–19 years.

ADHD is a global neurodevelopmental disorder where a continuous pattern of inattentiveness and/hyperactivity-impulsiveness occurs, and interferes with the development, or daily functioning of the person. ADHD has three categories or types: mainly hyperactive and impulsive, mainly inattentive, and a combined type. ADHD is also linked to poor social, academic, occupational and health related functioning. The global figure for the prevalence of ADHD in children and adolescents is estimated at 5.3%. In SA the prevalence of ADHD among children across all ethnic groups in the Limpopo province is 5%.

The Adolescent phase and ADHD

Adolescence is a challenging phase. Adolescents with ADHD face extra challenges, as puberty worsens their ADHD symptoms. This combination hinders adolescents' executive functions - therefore, risky impulsivity could be activated. Furthermore, adolescents face: transitional milestones like exploring and engaging in sexual activity, forming peer relations, experimenting with cigarettes, substances, drugs, and learning to drive a car. Therefore, many families, experience the adolescent phase, as a challenging period.

The Centre for Disease Control (CDC) in 2022 found that approximately half of those with ADHD had a behaviour or conduct disorder, predisposing them to risk taking. Approximately 3 in 10 children aged 3-17 with ADHD also suffered with anxiety. Disturbingly, many cases go undiagnosed and untreated. Thus, if ADHD is not properly diagnosed and treated, it can have long-term negative effects on the individual's mental health and well-being.

Consequently, SA teenage pregnancy and ADHD are two major, interlinked, health concerns. As previously mentioned, SA has one of the highest rates of teenage pregnancy globally, i.e., 73 per 1,000 women aged 15–19. The prevalence of pregnancy increased with age, with rates for 19-year-old pregnant women at nearly 7%.

Link between ADHD, risk behaviour and teenage pregnancy

ADHD is associated with sexual risk-taking behaviour. Childhood ADHD is linked to earlier sexual activity, more sexual partners, more sexual encounters outside of a stable, monogamous relationship, higher levels of sexually transmitted diseases, more pregnancies or partner pregnancies, and teenage parenthood.

Globally, adolescents with ADHD have increased risk of early pregnancy compared to non-ADHD adolescents. The long-term use of ADHD medication was linked to a lower risk of early pregnancy.

For individuals with ADHD, both genders engage in risky, sexual behaviours, with substantially more risk for females. ADHD sufferers are more disorganised in daily activities, hence more prone to inconsistent contraception and condom use.

However, the link between ADHD and risk-taking behaviour is not only limited to sexual risk behaviour but, also linked to: higher levels of engagement in other risk-taking behaviours, like, drug and substance use, reckless driving, gambling, tendency for violence.

Adolescent females with ADHD are also more likely to engage in risk factors harmful to their pregnancy like smoking during the third trimester, morbid obesity and alcohol or drug abuse.

Female ADHD sufferers are therefore an important, underreported group, who have various obstetric risks, comorbid mental and health problems, of which substance use disorder, was the most common. Therefore, females presenting with clinical ADHD symptoms require more support.

Contributing factors

Various other factors contributing to the high rates of SA teenage pregnancy include lack of access to contraception and proper sex education, resulting in adolescents lacking knowledge of the risks of teenage pregnancy. Poverty contributes significantly to SA teenage pregnancy with many teens unable to purchase contraception or access the necessary health services to obtain contraception. Poverty also has psychological effects like increased stress and feelings of hopelessness. Furthermore, cultural, and social norms may contribute to early sexual activity and a lack of contraceptive use.

The impact of teenage pregnancy and ADHD on society

The consequences of teenage pregnancy are harsh. Teenage pregnancies are linked to numerous long, as well as short-term, adverse outcomes for young parents and their offspring. Young mothers are more inclined to be school dropouts, resulting in limited job opportunities, perpetuating poverty, causing financial difficulties, and poor socio-economic status. Teen parents risk relying on government social grants and having low levels of education and high unemployment. Risks for children of teen mothers, include perinatal morbidity and mortality, low socioeconomic status, and low quality of life. Children with ADHD often struggle in school and social situations, experiencing relationship problems and low self-esteem. This leads to a higher risk of health and developmental problems, and experiencing poverty and social exclusion.

Moreover, the second leading cause of death for girls aged 15–19 globally is from complications during pregnancy and childbirth. Girls younger than 16 years are at a higher risk for maternal mortality and severe morbidity compared with females older than 20 years. The WHO (2022) estimated the risk of death following pregnancy is twice as high for girls aged 15-19 than for women over 20 years. Girls aged 10-14 have a maternal mortality rate five times higher than women aged 20 years and older. Adolescent mothers are more likely to have poor birth outcomes like increased rates of low birth weight and preterm births. Illegal abortion poses further risks for adolescent girls, particularly in Sub-Saharan Africa. Therefore, teenage pregnancy further contributes to the global cycle of poverty and ill-health.

Measures to reduce Teenage Pregnancy in ADHD adolescents in South Africa

Numerous policies and programs exist aimed at reducing teenage pregnancy and ADHD globally and in SA. The WHO (2017) has realised that investment in adolescent girls results in triple rewards. These are: the immediate outcomes gained during the adolescent phase, during the adult phase and, through their future children's, wellbeing.

Preventing maternal deaths is a target of the sustainable development goals (SDGs 3.1) - to reduce maternal death rates to under 70 deaths for every 100,000 live births by the year 2030. Furthermore, preventing teenage pregnancy can assist in achieving this goal, as it is interlinked to maternal and child health outcomes, and an increased risk of death during teenage pregnancy and childbirth.

The SA Department of Basic Education (DBE) developed a policy on the prevention and management of learner pregnancy in schools. Central to the policy's goal is the protection and promotion of the various rights applied to minors, concerning the Constitution and other legislations.

Recommendations

Implementing policy, evaluation, and intensive engagement with stakeholders in the sphere of adolescents' sexual and reproductive health are key to ensure the realisation of the Sustainable Development Goal 3 (SDG 3) by 2030.

Regarding, ADHD, Schoeman and Liebenberg (2017) found that many SA patients are not provided with access to healthcare and treatment regardless of the known efficacy of treatment, as well as the significant costs of untreated ADHD. Furthermore, at the primary health care level, common mental disorders are inadequately identified and treated, and patients have limited access to specialist resources.

The implementation of harm-reduction models, early assessment, and intervention of ADHD, to reduce the risks linked to impulse control and psychosexuality, is advised.

Furthermore, sexual education programmes, which are specifically focused on contraceptive use, should be customised to suit teens with ADHD, as these teens may not relate to traditional educational programmes.

Conclusion

Adolescents with ADHD encounter various challenges, including the increased risk of engaging in risky behaviours which may lead to teenage pregnancy. The effects of teenage pregnancy can be severe and long-lasting, affecting both the child as well as the young mother. It is, therefore, vital that healthcare professionals and policymakers in South Africa prioritise the development of effective interventions to prevent teenage pregnancy in adolescents with ADHD. By providing comprehensive and targeted support to young people with ADHD, we can empower them to make informed decisions about their sexual and reproductive health and ultimately reduce the incidence of teenage pregnancy in South Africa.

References available on request. MHM

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MYTHS AND MISCONCEPTIONS ABOUT BIPOLAR DISORDER

Introduction
As the world transforms itself into a more technological era, mental health evolves, and myths around bipolar disorder are maintained. Compared with other mental health disorders, posts about bipolar disorder were found to be more stigmatising in social media spaces where people can express themselves. People living with bipolar can find this complex online narrative difficult to navigate. It may trigger feelings of shame, disgust, denial, and difficulty processing their diagnoses, impacting not only their compliance with treatment, but also their ability to accept themselves. We hope to debunk some of the most common myths and misconceptions about bipolar disorder in this article.

Myth #1: Bipolar disorder is just mood swings, nothing more.
The mood fluctuations experienced by people living with bipolar disorder are much more severe and prolonged than those experienced by people with typical mood swings. Those suffering from bipolar disorder experience episodes of manic mood, energy, and activity, followed by periods of depression. When these episodes last for weeks or months, a person's daily functioning may be severely impacted.

Bipolar disorder causes extreme mood swings, but most people present as depressed rather than manic. It's normal to have good and bad days. With bipolar disorder, mood swings are often more intense and continue for a longer period of time than with regular mood swings. Those living with bipolar disorder may feel high for days, weeks or months, racing around, talking a lot, fasting and not sleeping much, leading to destructive behaviours such as running through money. In some cases, psychotic features may also occur during manic or hypomanic episodes.

People living with bipolar disorder may stay in bed for prolonged periods of time, days or weeks, which may negatively impact their job security. They might feel unmotivated, sad or even suicidal. This usually occurs during the depressive cycle.

Myth #2: It's rare to have bipolar disorder.
Worldwide millions of people suffer from bipolar disorder, which can develop at any age. affecting both men and women, with no single cause.

The diagnosis of bipolar disorder in children can be quite tricky because of their temperament. It's common to see mood fluctuations during adolescence misinterpreted as pathological. Over time, many people have learned to manage it. Understanding how it presents in each individual enables one to track when periods of mania and hypomania, as well as depression, begin to oscillate. While using alcohol or illicit drugs can trigger bipolar disorder, the exact cause of bipolar disorder is unknown.

Myth #3: There's a lack of willpower or personal weakness behind bipolar disorder.
Genetics, environment and biology all contribute to bipolar disorder. Family history, trauma, and brain chemistry changes can all cause or contribute to bipolar disorder.

The ability to "always" control your mood states can be a source of judgement and ridicule for those living with bipolar disorder. Having to control mood states and move out of mood states often places a lot of pressure on someone in this position. An underlying sense of helplessness can create a sense of failure. As a result of these experiences, the risk of depression and suicidality increases significantly. It's important to manage bipolar disorder on both a biological and therapeutic level.

Myth #4: It's just a phase, it'll go away.
The symptoms of bipolar disorder can worsen if left untreated. Bipolar disorder patients may "be okay" after a few months of treatment. If someone is asymptomatic, they often default on their medication because others tell them they're okay and they shouldn't keep taking it. As a result, they often relapse into depression, mania, hypomania and even psychosis in their presentation. A psychiatrist and psychologist are always needed to manage bipolar disorder closely. The treatment for bipolar disorder must be ongoing, unlike colds or flu, which pass after treatment.

Myth #5: It's hard to lead a normal life when you are living with bipolar disorder.
People living with bipolar disorder are often successful, such as professors and doctors. Living with bipolar disorder may require consistent monitoring of thoughts and moods. People living with bipolar disorder often benefit from work because it gives them a sense of structure and reduces their depressive symptoms. Careers and relationships can be fulfilling for people living with bipolar disorder.

Myth #6: There's always a manic or depressive episode when you have bipolar disorder.
Bipolar disorder includes milder mood changes like hypomania and dysthymia; it may also be accompanied by periods of stability between episodes. Bipolar disorder sufferers often have periods of clarity when they really think about the impact their behaviour may have had on those they care about. Mania, hypomania and depression are not the only symptoms of bipolar disorder that oscillate, but there are also long periods without symptoms. The rapid cycling of mood states is experienced by a small percentage of individuals living with bipolar disorder. It occurs when there are several mood episodes per year. Usually, this fluctuation occurs over a longer period of time.

Bipolar disorder sufferers can now make themselves comfortable in their own homes with technology. The use of pornography or sexting could increase during manic episodes. Through cellphones people have instant access to some of these behavioural addictions.

Myth #7: There's only one treatment for bipolar disorder: medication.
Psychotherapy can provide coping skills and strategies to manage symptoms for patients living with bipolar disorder. Stress management and exercise can also help manage bipolar disorder symptoms.

When someone suffers from bipolar disorder, treatment goals include creating a balance in their life and continuing treatment despite their good moods. Cognitive behavioural therapy can help people living with bipolar disorder overcome unhelpful thinking patterns and learn how to avoid and navigate their way through triggers. Sharing experiences and coping skills is also a powerful tool for those living with bipolar disorder. It's helpful to break down the stigmas and myths they may carry about their diagnosis, as well as their judgments about themselves.

Myth #8: There's always violence or danger associated with bipolar disorder.
During manic episodes, some people living with bipolar disorder may be irritable or impulsive, but the majority aren't violent or dangerous. Bipolar disorder sufferers are more likely to be victims than perpetrators of violence. It's harder for individuals living with bipolar disorder to get treatment if they are stigmatised as violent or dangerous.

Psychosis, irritability and aggression are some of the mood states associated with bipolar disorder. People living with bipolar disorder are often misunderstood as violent. It's quite possible for someone living with bipolar disorder to appear quite confident during periods of hypomania or early mania; this causes moods to become erratic during this time. The feeling may initially be pleasant, but without treatment it escalates into loss of control of our thoughts, diminishing insight, and in severe cases, psychosis. These states are characterised by increased anger and irritability, as well as less sleep.

Myth #9: Bipolar disorder is like two different people.
The idea of having a split personality is often used to describe people who shift between mood states in society. While bipolar disorder causes a shift in energy and motivation, the personality remains intact. A person suffering from hypomania or mania may become more impulsive in making decisions, which can have an impact on their relationships, or their financial health. As a result of their inability to discern risk, their behaviour may come across as irrational or inconsiderate to others.

Conclusion
Technology and mental health are growing together, and clinicians need to be aware of this. Social media is a double-edged sword that provides support and opens new behavioural avenues for presentations. Health professionals and patients must be educated about bipolar disorder in order to lead healthy, fulfilling lives. When supported and treated properly, bipolar disorder is treatable like any other mental illness.

References available on request. MHM

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THE IMPORTANCE OF BREAKING THE STIGMA AROUND SEXUAL DISORDERS, AND HOW TO RECOGNISE AND TREAT THEM

Sex is the most basic of acts for human beings. It's an instinct we all are born with. Yet this is often the one topic that people don't feel comfortable talking about, don't honestly discuss with their partners, family, friends and unfortunately not with professionals. Talking about sex is a taboo in so many cultures and people are often left to learn about sex through trial and error, internet platforms or from peers. Searching internet platforms, misguided peer-group conversations and often over the counter remedies should not be the go to place, but unfortunately this is the reality.

Unaddressed wants, needs, desires and challenges (discomfort, concerns) can lead to various psychological distresses in people such as anxiety, depression, various sexual disorders as well as other underlying physical problems.

Too many people are left feeling "broken" when they experience challenges regarding their sexual performance and discomfort. They are left feeling not good enough and alone. There is a stigma around sexual disorders. In the mind of society if you're experiencing any form of sexual dysfunction or disorder you are less of a man or woman, and that's far from the truth.

It's time to break the stigma around talking about sex and expressing sexual desires / and disorders. Too many individuals are not getting correct and healthy information and are left with relationships falling apart and living in unnecessary physical and mental discomfort and pain.

This needs to stop - we have a responsibility to break the stigma

Stigma hinders access to appropriate and professional medical and psychological treatment, and can result in a person's condition (mental and physical) worsening.

It's time for us as professionals to take action to break the stigma around sex and sexual disorders.

We have the knowledge, skills, treatments and platform to "heal" so many individuals and relationships.

How do we break down the stigma?

- Become a sex friendly practice.
- Ask about sex and sexual concerns – a questionnaire that gets completed beforehand can open the conversation and save time.
- Talk in a non-judgemental way about sex.
- Normalise sex and sexual experiences – especially if you know that some other medical conditions or treatments could negatively impact a person's sexual expression.

Recognising Sexual Disorders

The four major categories of sexual dysfunctions include disorders such as:

- Desire disorders: lack of sexual desire or interest in sex.
- Arousal disorders: inability to become physically aroused or

excited during sexual activity.
- Orgasm disorders: delay or absence of orgasm (climax).
- Pain disorders: pain during intercourse.

Treating Sexual Disorders and or concerns

Sexual problems may be classified as physiological, psychological, and social in origin. Any given problem may involve all three categories. A physiological problem, for example, will produce psychological effects, and these may result in some social maladjustment.

A multi-dimensional and professional approach is the most effective - Bio-Psycho-Social approach.

- BIO = Biology
- Psycho = Psychology
- Social = Sociology

A Case Study following the Bio-Psycho-Social approach

(Fictional names have been used in the case study)

Frank and Mary had been married for six years, have two children (Mary had one child from a previous marriage and together they have one child). Frank was also married before and his ex-wife died by suicide. Mary made an appointment with me (psycho-sexologist) for them as a couple, as she needs help to address her low sexual desire. Their sexual relationship was satisfactory until a year ago when Frank developed erectile dysfunction. He had a fall-out with his father and most of his childhood he felt he was never good enough. Before that, he'd never had a problem. Frank is able to get an erection most of the time with an injection, but even with this he sometimes struggles. Irrespective of his own performance challenges he is obsessed with sex and most of the times feels satisfied when Mary reaches an orgasm – with his help, either orally or manually. His erectile dysfunction is leaving him frustrated and feeling that he is less of a man. By his own admittance the more he struggles with getting an erection, the more obsessed he is with sex. Mary feels frustrated by his obsession and feels that sex once a day is enough for her, but he wants it more. Frank also started taking anti-depressants after the breakdown in relationship with his father.

Treatment plan and approach

- Bio = Biology:
  - Frank' erectile dysfunction: The fact that Frank was able to have spontaneous erections before and that it only started after the trauma with his father and since taking anti-depressants, indicates that we're dealing with secondary erectile dysfunction. The most likely cause being not a physiological problem although it presents as one. The impact of the anti-depressants also needs to be explored. An appointment with a medical practitioner, medical examination and medication adjustment allowed Frank and Mary to have a better understanding and contributed to a supportive and empowered approach.
- Psycho = Psychology
  - Mary's Desire Disorder: It was established that Mary in fact does not have a sexual desire disorder, but rather the presence of a sexual desire disparity along with a strong need for an approach where her needs are being taken into account as well (more a "team" approach than the feeling of an "object" approach).
  - Frank's Erectile Dysfunction: Time was spent on addressing the underlying psychological frustrations around the erectile dysfunction as well as the pain (father emasculated him during the fallout incident and it turned out that Frank had been emasculated from childhood).
- Social = Sociology:
  - Couple counselling / marriage counselling was a helpful process to assist the couple to develop better understanding for one another and were equipped with practical tools on how to support one another.
- Outcome: Frank and Mary's relationship is "healthier" on all levels (physical and psychological). Frank's depression has improved and he is starting to regain his erection without assistance. Mary is more open to sexual advances without resentment.

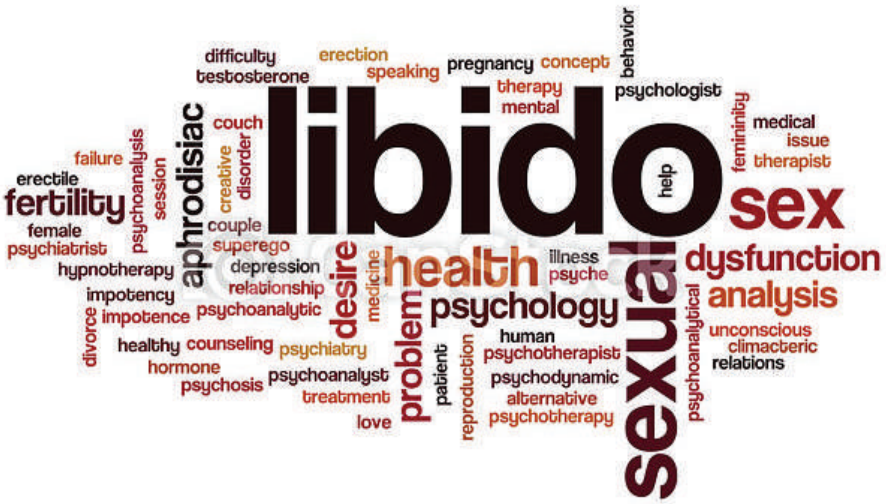
Conclusion:

There are so many Franks and Marys out there that need us as professionals to break the stigma around sexual disorders and dysfunctions.

We have an ethical and social responsibility to:

- stop the silent suffering and
- prevent mental, sexual and physical disorders as far as possible
- People need to know that
- they are not broken,
- they are not the only ones (alone) and
- that there is help!

References available on request. MHM



Interview with Dr Terri Henderson
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SELF-HARM

TEENAGERS HURTING THEMSELVES TO REGULATE EMOTIONS

Self-harm, the act of deliberately inflicting pain and damage to one's body by means of cutting, burning, scratching, and self-poisoning through medication or substances in order to relieve emotional distress, is a growing concern amongst teenagers.

A 2021 UNICEF report found that more than 65% of South African young people have had some form of mental health issue but didn't seek help. More than a quarter of respondents didn't think their mental health problem was serious enough to seek support, while 20 percent didn't know where to access help and 18 percent were afraid of what people would think.

Dr Terri Henderson, child psychiatrist and member of the South African Society of Psychiatrists (SASOP) says self-harm is a cry for help and should never be ignored, downplayed as attention-seeking behaviour or a means of 'acting out'.

"Contributory and co-occurring challenges for a teen such as depression, anxiety, post-traumatic stress disorder, ADHD and substance misuse often lead to self-harm as one of the methods teenagers engage in to cope with their undiagnosed and untreated mental health conditions.

"The age of onset is approximately 12 years although there is a stronger association to puberty rather than chronological age. The number of teens presenting with self-harm infliction is increasing significantly due to heightened levels of anxiety, depression and stress experienced amongst teenagers, availability to medication, alcohol and drugs, and the social transmission

of the behaviour via social media channels."

Dr Henderson says research shows that fifty percent of teens who self-harm will use self-harm repeatedly. She attributes the high rate to depression, ongoing physical, verbal and sexual abuse, continuing interpersonal negative experiences and dysfunctional support systems.

"Most young people who self-harm don't seek help for the behaviour, fearing the associated stigma, the reaction of parents, peers and other adults. They fear others will judge them, or they may be viewed as a burden to caregivers and are often ashamed of their self-harming activities. When self-harm is used regularly as a coping mechanism, symptoms are often hidden to avoid the recognition of numerous and especially new scars. Eventually, self-harm is a behavioural pattern or coping mechanism that is difficult to break."

What triggers self-harm?

Dr Henderson says there are numerous and variable predisposing factors that contribute to self-harm such as:

- Puberty - a neurodevelopmentally vulnerable time for teenagers, especially females, when there is an increase in emotional disorders and risk-taking behaviours
- Child and family adversity
- Emotional neglect
- Maladaptive parenting (little time or attention is given to children/ teens and families in which negative emotional displays by children are punished)
- Disruptive, unsupportive home environments
- Exposure to negative life events such as parental separation or divorce, loss of a parent, the experience of any form of abuse, past or current bullying and peer interpersonal challenges
- Sexual abuse
- Individual biological vulnerability in the form of emotional reactivity (high sensitivity to emotional stimuli) and emotional intensity (the tendency to have extreme reactions)

"Self-harm is often associated with perfectionism and self-criticism, creating a scenario where hurting yourself is used as a form of self-punishment, providing a behavioural model for vulnerable teens," says Dr Henderson.

"The combined set of invalidating home environments (where very few positive affirmations are given) and emotional vulnerability interact to contribute towards self-harm by creating emotional dysregulation - the inability to calm yourself emotionally," she said.

"The home environment is fundamental in teaching children how to regulate emotions, manage emotional arousal and tolerate emotional distress. If role models at home are not functional, children are ill-equipped to manage their emotions. This coupled with childhood traumas of abuse and neglect contribute to chronic hyperarousal, increasing the risk for emotion dysregulation."

The rate of self-harm is six times greater amongst the LBTQ+ teenage community due to an increased prevalence of mood disorders, substance misuse, victimisation, bullying and social stress.

"Low self-esteem, peer interaction difficulties or exposure to psychological bullying (social exclusion, cyberbullying, repeated rejection from peers and social isolation) are significant triggers. There is an association with smoking and alcohol use where both are used as maladaptive coping mechanisms."

Why teens use self-harm to cope

Adolescents who self-harm externalise their pain in a physical and real form that makes it less abstract and easier to understand in order to:

- Relieve anxiety
- Release anger
- Relieve unpleasant thoughts or feelings
- Release tension
- Relieve feelings of guilt, loneliness, alienation, self-hatred and depression
- Externalise emotional pain
- Provide an escape from emotional pain
- Provide a sense of security or control
- Self-punish
- Stop racing thoughts
- Stop flashbacks
- Facilitate relaxation

Signs to look out for

Dr Henderson says parents who discover their teen is self-harming are inevitably going to be frightened, and filled with questions as to the underlying reasons for the behaviour.

"Parents may feel confused, angry and helpless when they see signs that their child or teen is engaging in self-harm. Clues that may lead you to detect that a teen is self-harming include behaviour that is trying to hide scars such as wearing long sleeves no matter the weather or flinching in pain if their arm is touched. Other signs of mental distress are often present such as depression, increasing isolation, and withdrawal from activities, friendships, schooling and sports, decreased focus on self-care behaviours such as bathing, changes in sleeping and eating patterns, irritability or markedly erratic moods."

Dr Henderson says once self-harm has been identified and it appears to be minimal and limited to one or two incidents, a short-term invention with a family doctor or psychologists will be adequate.

"More specialist support and intervention is required for severe or recurring cases especially if there is concomitant suicidality. Group or individual dialectical behaviour therapy is an effective therapeutic intervention. Medication is not used to treat self-harm but may be necessary to treat psychiatric disorders such as depression and anxiety co-occurring with the self-harm. "

"As a parent, your role is to provide support and make changes that allow your teen to know that you support them one hundred per cent. You are not able to fix them but walking with them through support and treatment is going to get you and your teen into a much better and healthier mental health space."

References available on request. MHM

Kim Kidson
Clinical Psychologist
EAPISA Chairlady
Gauteng

EQUINE ASSISTED PSYCHOTHERAPY

People can be more loving, trustworthy, communicative, strong, compassionate, honest, patient, and resilient with each other, work more effectively in a team and be creative… all with the help of horses.

Research has shown time and time again that Equine Assisted Psychotherapy (EAP) can help people develop and improve these traits and more…

What if a horse could motivate & empower a person to be their best and happiest?

They can!! And with EAP they do!!

"There is something about the outside of a horse that is good for the inside of the man" - Sir Winston Churchill

It doesn't matter if you have horse experience or not. The focus of EAP is not on riding or horsemanship. In fact, EAP takes place 100% on the ground. It is an interactive, experiential, hands-on-approach and involves partaking in activities involving horses which require the client to apply certain skills and decision making about how they approach the horses and the activities, as they navigate their way through trying to accomplish the task at hand. How these activities and horses are approached and managed, are representative of the direct impact the persons' behaviour has on others, within their daily lives and working contexts. The client's behavioural patterns as well as the impact of these patterns, become clearly visible to them, which is more often than not, easily and effectively translated back to their current life situations.

Regardless of these activities, horses each have their own distinct personality, and just like humans experience certain emotions or moods on certain days and during exposure to certain people or situations. This in turn impacts the manner in which they should be handled. Herein lies the power of the process…

The client needs to accurately observe the non-verbal body language of the horse whilst at the same time being acutely aware of their own body language and the impact they're having on the horse. The client then needs to decide what is the most appropriate and effective action and communication in that moment and what will yield the best possible results for both horse and human. The objective of EAP is not about completing these tasks or activities, but rather allowing the client to reach their own solutions to the "problems" they're faced with, whilst being acutely aware of their behaviour and the impact of their behaviour on others.

Although frustrating at times for the client, it brings about awareness of current patterns of behaviour which motivates change. Simply put, the client learns that as they change their attitude, behaviour and actions, so too does the horse's reaction change.

The beauty of this approach is not only that it takes place outdoors ut also it's often less intimidating than the traditional office setting. Clients

can immediately see the effects of their actions and explore what needs to change to become more effective. They also learn that interaction with others takes time, effort, respect, honesty and consistency.

While EAP is a practical means of assisting the client to learn how to function more effectively within their immediate environment and daily living, it should be remembered that it's an advanced form of psychotherapy. This means that EAP should only be facilitated by a two-man team, consisting of one of the following mental health professionals from the list below as well as a certified equine behavioural specialist:

- Clinical, Counselling or Educational Psychologist
- Registered Counsellor with a registered practice number
- Social worker or Clinical Social worker

It's essential to have a qualified team of professionals ensuring both the physical and emotional safety of the client and horses alike. EAPISA works on a strictly do no harm policy and therefore certification is of the utmost importance.

EAP is a powerful and effective therapeutic approach that has an incredible impact on individuals, youth, families and groups. It's all inclusive approach has been successfully used across all ages, genders, ethnic groups, abled and disabled people, small groups such as families as well as large corporate groups.

People often ask why horses?

Horses are both intuitive and strong, they pick up on the emotional state of the client and respond immediately, where humans may hold back. This immediate response helps the client understand themselves better with greater clarity as they can't hide their feelings from the horses. **Unlike humans horses don't respond to negative reinforcement but challenge us to always seek a positive and empowered way of dealing with situations.**

The benefits of a good work ethic, responsibility, assertiveness, communication, and healthy relationships have long been recognised. Horses naturally provide these benefits. The size and power of the horse are naturally intimidating to many people. Accomplishing a task involving a horse, in spite of those fears, creates confidence and provides for wonderful metaphors when dealing with other intimidating and challenging situations in life. There are infinite possibilities of including horses for emotional growth. The greatest benefit is that through learning with the horses, positive behaviours are not only taught, but experienced.

EAP addresses a wide variety of mental health and human development needs such as:

- Anxiety
- Depression
- Bipolar
- Post Traumatic Stress Disorder (PTSD)
- Eating disorders
- Adjustment due to divorce, death, medical conditions
- Relationship difficulties
- Communication needs

Please note that this is not an all-inclusive list, there is so much more that is covered.

It's an encounter of change and new growth. The immense value of EAP is that it promotes change through action - it's not just talk. Another great benefit of using horses is that it can be a lot of fun also!

Case study

Many years ago a 35 year old male approached us for assistance. A brief condensed history and sequence of events follows below:

- Still living at home with his parents
- No promotion at work for many years
- Chronic pain due to a car accident
- No siblings
- No friends
- Poor and extremely ineffective communication skills
- Lonely and isolated
- Struggled to identify and express emotions
- Suicidal thoughts as a result

This client attended up to eight traditional therapy sessions with very little success due to his presenting style.

A decision was made to try EAP. Initially the client was very hesitant, but due to his desperation he agreed. Only 15 minutes into his very first session, he experienced a major breakthrough. He became aware that the horse was responding to his thoughts, behaviour and actions. Initially the horse completely ignored him, even facing in the opposite direction to the client and not acknowledging him at all. It's important to note that his was the complete opposite behaviour to this horse's personality and general daily observed behaviour.

Once the client understood the process and became aware of the impact he was having on the horse, even although he was extremely sceptical, he attempted to change his thoughts, behaviour and actions. The horse immediately responded, turned and walked across to the client and put his head on the clients shoulder and remained there for an extended period of time. Needless to say the impact on the client was immediately visible. He was shocked and overwhelmed by emotion. He cried and spoke about how he experienced the process for the rest of the session. This was a life changing moment for this client.

The client was able to identify how this related to his daily life. He booked a follow-up session and requested that all future sessions be EAP. The progress this client made over the next few sessions was absolutely amazing! Over a relatively short period of time, he started making friends, entered into a relationship with a significant other for the first time in his life, managed to work towards a promotion at work and moved out of his parental home and into his own apartment. All of this due to the realisation and mobilisation which the EAP process and experience offered this man. It's a therapy like no other.

The best therapists have four hooves...

For more information on please email k.kidson@eapisa.co.za or send a Whatsapp to 083 222 9376

References available on request. MHM

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MENTAL HEALTH IN RELATIONSHIPS AND SUICIDE ATTEMPTS

Charcoal-stained lips, petechial haemorrhages, and pumped stomachs are a common occurrence in the acute wards of public and private hospitals. These markers and treatments are common for individuals who have ingested toxic chemicals, an overdose of medication, and/or have unsuccessfully tried to hang themselves. These, all in attempts to end their lives and frequently due to conflict or a dissolution of a romantic relationship. In the same breath, we often see individuals present to casualty with stab wounds, abrasions, bruises, blisters, contusions, and periorbital haematomas (popularly known as a black eye) amongst others. All markers of physical abuse falling under frequently discussed topics of Gender Based Violence and Battered Woman Syndrome in South Africa as well as globally. At the core of these medical occurrences and socio issues lies mental health in relationships.

Relationships immensely impact daily life and can contribute to well-being; they can also, however, be the reason for poor mental health. This is because individuals commonly enter relationships without having done enough mental work on themselves, resulting in verbal and physical conflict in relationships. In addition, individuals may enter relationships with maladaptive attachment styles formed from childhood or previously abusive relationships perpetuating a cycle of mental instability and abuse.

This article endeavours to explicate the inner workings of the self in relationships and how the self, intertwining with another individual may lead to mental breakdown in a relationship and or after a breakup (divorce, termination of a romantic/ committed relationship).

The Self and Relationships
The self houses core features that allow one to control and regulate impulses, desires, emotions, and other behaviours. Individuals who have a positive intrapersonal relationship with themselves have likely developed healthy: self-esteem, self-acceptance, self-compassion, and a secure attachment style. Alternatively, individuals who have a negative relationship with themselves are likely to experience emotional distress and have an underdeveloped or poor self-reassurance pattern and have a maladaptive attachment style.

Attachment Styles
How an individual attaches to their partner in their adult life is largely informed by their attachment style from their childhood. According to Bowlby's Theory of attachment, infants form attachments to significant primal figures early in life. These attachment styles are largely informed by the caregiver's responsiveness to infant needs.

Three Styles of Attachment

Secure Attachment:
- Confident in themselves and the ability of their relationships to satisfy their needs.
- Characterised by greater trust and closeness, more positive emotions, less jealousy, more marital satisfaction, sensitive and supportive responses to the needs of their partners.

Anxious/Preoccupied Attachment:
- Need approval and affection to enhance low self-esteem.
- Characterised as needy, clingy and greedy in their need for intimacy/acceptance.

Avoidant Attachment:

Dismissive Avoidant Attachment:
- Confident, self-reliant and proud of independence
- View others as irrelevant – think that intimate involvements with others are full of problems and not worth the trouble relationships have less commitment, enjoyment and intimacy compared to other styles.

Fearful avoidant attachment:
- Afraid of being rejected because they have a low opinion of themselves.
- View others as untrustworthy and likely to let them down.
- Others perceive them as emotionally distant & even hostile.

How Attachment Styles Lead to Mental Breakdown In Relationships
For the individual with a secure attachment style, they are likely to have a positive view of relationships, finding it easy to get close to others, and are not overly concerned or stressed out about their romantic relationships. This may result in the individual being blind sighted when entering a relationship with another individual who has a maladaptive attachment style, or they may stay is a poor relationship in attempts to fix their emotionally broken partner.

For the individual with an anxious attachment style, they're likely to demand closeness, be more emotional, jealous, possessive, and be less trusting. These individuals are also likely to leave an abusive relationship and return because they experience doubt regarding their self-worth. They're also intensely passionate which creates a false immunity to their partner's toxic traits.

For the individual with an avoidant fearful/dismissive attachment style, once in a relationship they tend to distance themselves from their partner. They're also likely to experience a lack of worth in relationships, tending to be dismissive, and seldom express warmth rather focusing on being extremely self-reliant.

Dissolution of Relationships
Breakups are entailed with a great deal of emotional pain, conflict, and relative trauma. Individuals who experience romantic dissolutions have elevated scores in anger, vengeance, drugs and alcohol use, intrusive thoughts (and difficulty controlling these) and engage in other extreme attempts to re-establish the relationship or cope with the overwhelming emotions of its termination.

Because of the design of intimacy, individuality is negotiated in an endeavour to integrate identities allowing for a synergetic existence, also known as a relationship. Erik Erikson, known for his theories of development, describes intimacy as finding oneself while losing oneself in another person. If a person fails to develop an intimate relationship in early adulthood, according to Erikson, isolation occurs. Thus, despite relationships having many risks they're important in the human life cycle. It is for this reason it remains vital that when individuals enter relationships, they remain aware of their self (who they are) taking careful note of their own maladaptive coping skills and needs whist engaging in intimacy (emotional, spiritual, and physical) with their partners. It also remains important to shed, discard or rework the perspective of the self that was actualised in a relationship or linked to a previous partner when the relationship has ended.

Tools and Techniques for Patients
Practitioners can encourage their patients to scrutinise their childhoods to better understand their attachment styles, for the purpose of developing adaptive coping skills when navigating a relationship. With this, patients can also be encouraged to view themselves as complex unique individuals that require secure and stable loving relationships, by understanding their own brokenness before committing to another individual. Practitioners can also encourage their patients to attend psychotherapy for the benefit of developing psychologically adaptive methods of coping with the conflict or dissolution of a relationship. This assists in patients developing long term practical solutions to their emotional distress related to a relationship, rather than temporary scare tactics that allow individuals to return to toxic relationships.

References available on request. MHM

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EMPATHY OVER AUTHORITY: WHAT PATIENTS REALLY NEED

In Maya Angelou's wise words 'I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.'

As doctors who are often working against the clock, it can be very tempting to rush through our appointments. Keen to make a swift diagnosis, we can easily overlook the primary need of our patient to be seen and heard as a human being, not just a problem to be solved.

Deep listening is one of the tools at our disposal that can enhance trust and increase empathy. If you were lucky enough to be read to as a child, deep listening will not be an alien concept to you. Perhaps you remember that cosiness, that safety as you settled in for the next fairy tale or instalment of a long-running narrative? The wonder you probably experienced in those moments was not just due to the skill of the storyteller, but because every atom of you was listening without judgment.

Jump forward to medical school, where we were taught to listen very differently. Gone is the sense of wonder and exploration, in its place a radical efficiency. Our training prepares us to ask questions, recognise patterns and solve problems. When we take a patient history, any trace of imagination or subjective emotion is brushed aside in favour of objective evidence. As we hurtle down the route of diagnostic questions our only aim is to eliminate possibilities and come to a feasible conclusion as quickly as possible. This mechanistic approach gives us a valuable skill that can be very effective. It's also a skill that can be carried out by a computer!

The real treasure lies in our ability to connect as people, which is where the art of healing meets the science of medicine. When two human beings meet with the time and presence available to form a bond, the healing potential of that experience is augmented. That's because a resonant field is created between the two people. With the practice of deep listening, both doctor and patient enter a therapeutic alliance, an agreement to be fully seen and heard.

Deep listening vs active listening

Drawing out important information from people doesn't just depend on the questions you ask; it also depends on the attitude you bring to the listening. Whereas active listening is defined as using your language to affirm that you've fully heard what the other person is communicating, deep listening involves paying attention with all of you, not just your mind.

In my book 'Dare to Care' I share the story of Tina, one of my patients who presented with a myriad of symptoms. Her mother was perplexed, and keen to get to the heart of her daughter's various conditions. Tina shuffled into my practice staring at the floor, her body language clearly indicating that she felt uncomfortable being put 'under the microscope'. Over the course of two appointments with her, I took a patient history, performed a full examination and ordered lab tests but nothing was conclusive. I had a distinct gut feeling that we were not asking the right questions.

We scheduled Tina's third appointment for the end of the day when I knew we would have more time together. I decided to take an unconventional approach. 'Tina, we've only known each other for a few hours but I feel there is something you know that I don't which might explain a lot of your suffering. Is that possible?'

With a nod of encouragement from her mother, Tina eventually looked at me with tears in her eyes. Very quietly she said, 'I feel...like a man in a woman's body. I am ashamed and I don't know what to do.'

I took her hand. For five minutes nobody said a word. While she settled, I continued to give her my full attention, 'listening' to the resonant field we'd created between us. 'Congratulations! I'm so proud of you. You just took a tremendous step.' I assured her that we were on this journey together and could assemble a team to find the best route forward.

Her whole posture had changed. The slumped, awkward teenager was now sitting up straight in her chair, her gaze penetrating, her voice deeper. When I asked her how many of her symptoms she attributed to feeling this way, she didn't miss a beat. 'All of them, Dr Bonhoeffer.'

Every cell in my body knew she was right. Yet if I had followed my familiar training and not listened deeply, my initial list of suspected diagnoses would have included chronic gastritis, juvenile arthritis, atopic dermatitis, anorexia and many more, followed up by extensive lab tests, an MRI and gastroscopy. I could also have prescribed antibiotics, antacids and anti-inflammatories to treat her symptoms. Instead, I suggested she listen intently to her body and her feelings, inviting her body to realign with this new perspective.

Rather than making suggestions for her treatment, I decided to ask her what the best next step might be for her. She responded immediately, advocating rest, eating lightly and taking walks in nature. I encouraged her to sketch her thoughts and feelings as they arose and recommended a series of soothing massages and Feldenkrais movement exercises to help her inhabit her body with more confidence. By now my teenaged patient was smiling broadly.

As I reflected later, Tina had taught me a valuable lesson. Exploring traditional diagnostic pathways and employing active listening techniques would have only given us a partial picture of what was really going on. Only by taking the time to build a more heart-centered relationship, engaging her trust by listening deeply without judgment and inviting her to co-create her own treatment plan was I able to support her with my knowledge and experience.

Deep listening is a skill that can be learned, but only with the sincere intention of practicing it from the heart. It cannot be faked. When you have a profound desire to fully understand the other person, deep listening becomes second nature.

How can you practice deep listening?
When you're with a patient, colleague or loved one, first practice noticing every single detail around them and paying undivided attention, not only to the words they are speaking, but also their expressed and implied emotions and their body language. Notice how this contributes to your understanding of your patient and their current condition.

Second, allow yourself to become deeply absorbed in the person in front of you and adopt an attitude of genuine curiosity. This is a precious opportunity to shift into seeing the world through your patient's eyes. Which means taking the risk of relinquishing your medical interpretation and daring to let the insight change you and how you relate to the patient.

Third, if emotions surface in you, check in with yourself to see if they belong to you or your patient. If you suspect you might be mirroring emotions, you can gently verify how it feels for them. If you become aware that your feelings are personal and reactive, you were just gifted a tremendous opportunity for growth! Make a note and embrace it in your reflective practice.

Fourth, when judgments or divisive emotions threaten to separate you, you can step forward with compassion without letting go of your centre. Here, compassion is the key to moving from judgment to understanding. You can become aware of both your own and your patient's over-identification and dissolve the illusion of separation. In practice, this may feel like seeing the situation from above with loving kindness for both.

By practicing deep listening in this way we can be fully present, returning to our sense of wonder and exploration and learning to trust in the innate wisdom of our patients and their own journey towards greater health. It's my sincere desire that the field of medicine embraces this heart-based approach as we move forward into a co-creative future.

About the Author: Dr. Jan Bonhoeffer is founder of Heart Based Medicine, a non-profit foundation that promotes and supports the wellbeing of health professionals with heart-centered training, tools and resources. He cares for patients and teaches pediatrics at the University Children's Hospital in Basel, Switzerland. He has built and led large global research networks to improve child health, has published over 100 scientific papers and book chapters on infectious diseases and vaccines, and worked with the World Health Organization to shape global health programs. He is the author of the new book "Dare to Care — How to Survive and Thrive in Today's Medical World. Learn more at heartbasedmedicine.org. Email: contact@heartbasedmedicine.org.

References available on request. MHM

PATIENT-CENTRED CARE

Onnie: The therapy dog, working with Doctors Without Borders

Meet four-year-old Onnie, a Labrador Retriever, who is a therapy dog for victims of torture and extreme violence at the Comprehensive Care Centre in Mexico City.

Onnie works alongside Alicia de la Rosa, a psychologist specialising in animal-assisted psychotherapy, and for two years they have been part of a Doctors Without Borders (MSF) comprehensive care team. MSF has been providing mental health support to migrants and Mexicans who have experienced horrific journeys along the migration route to North America or extreme violence in their origin countries. The centre has been managed by MSF since 2017.

Onnie began his training as a puppy, when he was exposed to different sound stimuli, textures, environments, people, and objects. When he was a year old, he began his training to become a therapy dog. The training was accompanied by basic obedience classes to learn, for example, to sit, lie down, turn, give his paw, jump, and move so that patients with motor difficulties can brush or pet him.

He is trained to provide therapeutic support to children, adolescents, the elderly, and people living with disabilities. The support that Onnie and Alicia provide is one component of the psychosocial care that some patients receive.

"Some of the people who have experienced traumatic situations of extreme violence or torture find it difficult to express their emotions and find trust again in other people and in their environment. Working with Onnie gives them a chance to break down barriers so that they can eventually open up to therapists and feel confident to talk about the difficult situations they have experienced."

- **Alicia de la Rosa**

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VISIT: MSF.ORG.ZA/WORK-WITH-US

MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

TREATMENT RESISTANT DEPRESSION

By Jean Augustyn

Being diagnosed with major depression as a student in 1996 was a relief after many years of struggle and not having a name for the 'black dog' I lived with. On top of the depression, I also had trichotillomania (compulsively pulling my hair out). Being a nursing student with depression was tough, but my university was supportive by providing psychiatric help.

On qualifying as a registered nurse I thrived in working in emergency medical situations. I was extremely active in the specialty and studied further to develop my skills. I volunteered in the emergency medical services and enjoyed the adrenaline-rush at the time. In the years that followed however, the depressive episodes persisted (and the volunteering reduced). I was prescribed various antidepressants – which I took with limited success.

2012 saw the first of many admissions to a psychiatric clinic as well as multiple suicide attempts through overdoses. After the first admission in 2012 and exhaustion of my Prescribed Minimum Benefits in that year, I was transferred to a government psychiatric facility for the first time. Again, because of lack of funds (exhaustion of benefits), I was admitted to the same government facility in subsequent years.

Several depressive episodes later, I'd been prescribed various antidepressants, antiepileptics, mood stabilisers and antipsychotics (augmentations). Unfortunately, my treating psychiatrists had to change for various reasons which didn't help the situation. I was fortunate though to be able to see a psychologist, (and pastoral counsellor in later years) who supported me through the difficult times.

2015 was an extremely difficult year. At that stage I was a nurse educator and had been placed on extended sick leave after being referred to yet another psychiatrist and clinic for Electroconvulsive Therapy (ECT). Managing this difficult depression has been challenging over the years. Electroconvulsive therapy has helped me many times, but it has had some negative effects with resultant memory loss.

Eventually my treating psychiatrist identified the problem as "treatment resistant depression (TRD)". One definition of treatment resistant depression reads that it "typically refers to inadequate response to at least one antidepressant trial of adequate doses and duration." By the time this diagnosis was made, I had, in a period of 19 years been on so many medications, I'd lost count.

It's tough living with TRD – or, as some refer to it - "difficult to treat depression". The depression has caused me to isolate myself, feel anxious, extremely inadequate and made me want to die on multiple occasions. My family have suffered through multiple absences while I was hospitalised, as well as through several overdose attempts. Also living with a depressed mother, wife and daughter has not been easy on my family. The financial burden this has placed on our family is often something I feel very guilty about.

One extremely difficult aspect of living with TRD is that of funding treatment. Medical aid PMBs (Prescribed Minimum Benefits) are so limited that funding treatment is an extremely costly affair. The past few years have seen at least one (and two per year more recently) admissions to a psychiatric facility that depletes my psychiatric benefits for the year and so further admissions, ECTs, ketamine treatments, psychiatrists' and psychologists' visits are all paid for by myself. I am fortunate that most medications are funded, though.

Unfortunately, the major depression that I was living with during my professional years took its toll and eventually I was too ill to carry on working. It was then that I was declared unfit to work and I entered the world of workplace disability after a lengthy six months of assessment and processing. It was a major disappointment for myself – I was a professional woman, loved my work and specialised in an area where there was a dire shortage of nurses. I often still regret this course of events.

My depression has probably worsened since the termination of my working career. I have been hospitalised at least annually in the past few years (some years, twice) with episodes of TRD. I am blessed with both a caring psychiatrist and psychologist who have stood alongside me during very difficult times. My family have also

been extremely supportive during my illness. There have however, been many frustrating times and I sometimes feel as if I've used almost every psychiatric drug known for treating depression. I have also had a course of minimally successful TMS (Transcranial Magnetic Stimulation) and occasionally still need courses of ECT.

According to research, "Work can have a therapeutic effect without actually being therapy". As the authors describe in this article, at work I achieved a sense of "accomplishment and effectiveness" (which helps during feelings of "exhaustion and cynicism" experienced in depression). I still struggle with the question as to what the effect of staying at work (or moving to another, less stressful, position) would have done to my course of depression.

Being at home, although a privilege (especially regarding my family life), has been frustrating at times. Work gave me a "daily routine" and had a "stabilizing effect". It's also recognised that work that is stressful, demanding and uncontrollable or lacks social support, can add to the development of depression. On the one hand work gave me a sense of purpose, although on the other hand it probably had added to my depression (through its demanding nature).

Professor Schoeman's recent article on 'Stigma & the Impaired Practitioner' so resonated with me. Being a nurse and being mentally ill, has not been easy. I've also experienced stigma, public stigma, self-stigma and institutional-stigma.

See Professor Schoeman's recent article on 'Stigma & the Impaired Practitioner

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I am still wary about who I inform regarding my illness because of discrimination around mental illness. Institutional stigma I experience through my perception of poor medical aid benefits for mental illness. Physical illness' hospitalisation seems so much more available compared to the limited 21 days (per year) that one is allowed for in-patient psychiatric healthcare.

Where do I find myself today?

I still struggle with the depression and trichotillomania. I struggle to socialise and get out and about on my own. At the moment I feel as if I'm still "existing" but not "living". My treatment for the TRD is ongoing – but at great cost.

Currently I am having occasional ECTs, receive psychotherapy and use medication to try and control the major depression. I also attend a SADAG depression and anxiety support group which really provides meaningful support. Thank you to them, my family and treatment team for their continuous patience and support.

References available on request. MHM