

VOLUME 10 • ISSUE 1 • 2023

MHMM

MENTAL HEALTH MATTERS



SUICIDE PREVENTION FROM A GLOBAL PERSPECTIVE
- Progress and challenges

GOING PSYCHO-SOLAR AND INSULATING OURSELVES AGAINST ANXIETY SHOCKS

ATTENTION DEFICIT/ HYPERACTIVITY DISORDER AND COMORBID LEARNING DISORDERS

A FACE OF ANXIETY
DEPRESSION DURING PREGNANCY

UNDERSTANDING FLOURISHING AND ITS POTENTIAL IMPACT ON PATIENT HEALTH

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Making Mental Health Matter

SUICIDE PREVENTION FROM A GLOBAL PERSPECTIVE

PROGRESS AND CHALLENGES

The 35th European College of Neuropsychopharmacology (ECNP) Congress took place from 15 – 18 October 2022 in Vienna, Austria. A campfire discussion session was held with the topic Media and Suicide: from Werther to Papageno Effects. The discussion was led by Benedikt Till from the

Medical University of Vienna (Centre for Public Health, Department of Social and Preventive Medicine, Unit Suicide Research & Mental Health Promotion). The aim of the session was to explore the influence of the portrayal of suicide in the mass media on suicidal behaviour. The ultimate outcome of the discussion was that media plays and should play an important role in preventing suicide.

This article will give an overview of the discussion held with added South African data to make it more relevant. The discussions centred around worldwide suicide statistics and exploring the Werther and Papageno effects.

During June 2021, the WHO published the most recent available data on worldwide suicide statistics. In this paper they report that more than 700 000 people die due to suicide every year. It's also known that for every suicide there are many more people who attempt suicide. Analysis

has indicated that a prior suicide attempt is the single most important risk factor for suicide in the general population. A major concern is that suicide is the fourth leading cause of death among 15–29-year-olds. Furthermore 77% of global suicides occur in low- and middle-income countries with ingestion of pesticide, hanging and firearms being among the most common methods of suicide globally.

In published data from the USA Centres for Disease Control and Prevention (CDC) they reported that nearly 46,000 people died by suicide in the USA in 2020 equating to 1 death every 11 minutes. Many more adults think about or attempt suicide. It's estimated that in the USA 12.2 million seriously thought about suicide, 3.2 million made a plan for suicide, and 1.2 million attempted suicide. The most concerning statistic was that teen suicide increased by 29% since 2012/2014 to 2018/2020 (deaths per 100,000 adolescents ages 15-19 years).

The WHO ranks South Africa as number 10 on the list of countries with the most suicides in 2019 with 23,5 per 100 000 population (1). Of the 13 774 suicides reported in South Africa, 10 861 were men whilst 2 913 were women, translating to a rate of



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37,6 per 100 000 for men and 9,8 per 100 000 for women. This statistic indicated that men in South Africa are five times more likely to die by suicide than woman. It's interesting to note that the highest suicide rate in the world was Lesotho with 72.4 per 100k people and third on the list was Eswatini (Swaziland) with 29.4 per 100k people. These worldwide statistics unfortunately indicates that three of the top ten countries with the highest suicide rates are in Southern Africa.

SOUTH AFRICA

10TH HIGHEST
SUICIDES WORLDWIDE 2019

13 774
SUICIDES REPORTED

23,5/100 000
SUICIDES/POPULATION

3 of 10 HIGHEST SUICIDE

COUNTRIES WORLDWIDE ARE IN SOUTHERN AFRICA

MEN 10 861



37,6/100 000
SUICIDES/POPULATION



WOMEN 2 913

9,8/100 000
SUICIDES/POPULATION

LESOTHO

1ST HIGHEST SUICIDES
WORLDWIDE
72.4/100 000
SUICIDES/POPULATION



ESWATINI

3RD HIGHEST SUICIDES
WORLDWIDE
29.4/100 000
SUICIDES/POPULATION

SADAG (The South African Depression and Anxiety Group) operated throughout the COVID-19 pandemic. Before COVID-19 the SADAG helpline call-centre received on average 600 calls per day. Within two months after South Africa went into total lock-down on 27 March 2020 the call volumes doubled to 1000 to 1400 calls per day. From January 2022 to September 2022 the SADAG call-centre received 562 176 calls, now averaging over 3000 calls per day. Analysis of the statistics further indicated that 1 in 4 calls were suicide related with the majority of calls coming from youth in line with the USA statistics. This statistic has also increased from 2021 when 1 in 5 calls were suicide related.

The seminal article on the Werther Effect was published by David Phillips in 1974. The name was taken from Goethe's novel *Die Leiden des Jungen Werthers* (The Sorrows of Young Werther), published in 1774. In the novel, Werther shoots himself with a pistol after being rejected by the woman he loves. Shortly after its publication, there were reports of young men using the same method to kill themselves (shooting) in acts of hopelessness. Phillips noted that suicides increase immediately after a suicide story has been published in the newspapers in Britain and the USA, 1947 to 1968. The more publicity devoted to a suicide story, the larger the rise in suicides thereafter. The Werther effect is thus defined as an increase in suicide rates that follow media coverage of

suicides or a suicide is inspired by reading about other's suicide that are linked to a friend or family member who committed suicide. The Werther effect is a synonym for media-induced imitation effects of suicidal behaviour. This effect is also based on social learning theory. This is a theory of learning process and social behaviour which proposes that new behaviours can be acquired by observing and imitating others.

Two case studies were discussed. The first was imitative suicide on the Viennese subway.

It was noted that the number of subway suicides in Vienna increased dramatically between 1984 and mid-1987. A working group of the Austrian Association for Suicide Prevention developed media guidelines and initiated discussions with the media which culminated with an agreement to abstain from reporting on cases of suicide. The study indicated that in the second half of 1987 there was a decrease in suicides of 75% which was sustained for the next 5 years.

The second case study was that of the suicide of Robin Williams, well-known comedian and actor who died by suicide (suffocation through hanging) on 12 August 2014. This study examined the monthly suicide count before and after his suicide and found a 10% increase in suicides in the two months following his death. A significant increase in the number of suicides by hanging/suffocation in men was also observed.

In 2010 the Papageno effect was described in the *British Journal of Psychiatry*. The Papageno effect (protective effect) is in honour of the character in Mozart's opera *The Magic Flute* (1791). In the opera Papageno fears that he has lost his love and prepares to kill himself. Three boys save him at the last minute by reminding him of other alternatives to dying. In their article the authors conclude that the impact of suicide reporting may not be restricted to harmful effects; rather, coverage of positive coping in adverse circumstances, as covered in media items about suicidal ideation, may have protective effects.

Several countries throughout the world have now published media guidelines on suicide reporting. The World Health Organisation on their website published guidelines on 'Preventing suicide: A resource for media professionals'. Their recommendations for proper reporting are :

DO NOT:

1. Give precise details on the suicide method
2. Give personal information on the person who has committed suicide

3. Give some expressions such as "self-inflicted death".
4. Don't place stories about suicide prominently and don't unduly repeat such stories
5. Don't use language which sensationalises or normalises suicide, or presents it as a constructive solution to problems
6. Don't explicitly describe the method used
7. Don't provide details about the site/location
8. Don't use sensational headlines
9. Don't use photographs, video footage or social media links.

DO'S:

1. Provide accurate information about where to seek help
2. Educate the public about the facts of suicide and suicide prevention, without spreading myths
3. Report stories of how to cope with life stressors or suicidal thoughts, and how to get help.
4. Apply particular caution when reporting celebrity suicides
5. Apply caution when interviewing bereaved family or friends
6. Recognise that media professionals themselves may be affected by stories about suicide.

In conclusion more awareness needs to be created about the Werther and Papageno Effects. Numerous studies worldwide have found that the risk of contagion is real, and that responsible reporting can reduce the risk of additional suicides. Media covering of suicide can change perceptions, dispel common myths, and educate the public on the complexities of suicide. Although such media guidelines do not exist in South Africa every effort should be made to educate and continue to inform journalists about the effects of suicide reporting. Finally it's hoped that this paper would continue to stimulate discussion around the topic of suicide. Suicide helplines should continue to be promoted and supported nationally and regionally.

References available on request. MHM

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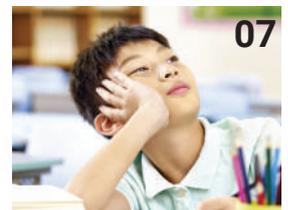
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GOING PSYCHO-SOLAR AND INSULATING OURSELVES AGAINST ANXIETY SHOCKS

INSIGHTS FROM SADAG'S "YOUR LIFE DURING LOAD SHEDDING SURVEY" (2023)

When SADAG launched the "Your Life During Load Shedding Survey" in late January 2023, many South Africans wanted practical, technical solutions to the power supply crisis, assuming that our inner worlds had little to offer by way of help. Load shedding was defined as the province of the engineer, and the ordinary person consequently had zero control over the crisis.

The idea of little control has dangerous consequences, for it can remove more than our response agency, it can entirely eliminate us from the equation. Some of our survey respondents, such as Khelifwe, talked about power cuts as a state of suspended existence, a time of waiting until "life could start again".

As fears mount regarding a powerless future, South Africans may be tired of needing to be resilient in the face of this ongoing power supply deficit. Yet, this is a moment in time, where we can learn what the main triggers are and how to insulate ourselves against the shockwaves reverberating from within the larger social system.

While there is no doubt that general levels of distress increased across the survey sample (n=1836) upon Eskom's announcement of long-term loadshedding, the reality is more complex. Load shedding, as a practice, contains several anxiety-laden shocks that impact our collective psyche and individual nervous systems. There is a load shedding anxiety cycle that started

Anxiety levels remained for some (54%) when the power did not go off as scheduled, and the cycle ended with anxiety levels peaking due to power not being restored on time (92%). The cycle recommenced once new stages of load-shedding were communicated. There are at least two anxiety-inducing shocks at each stage of this cycle, with notifications, and the tardy restoration of power after scheduled outages at the heart of the matter. Long unscheduled power outages produced another anxiety shock, even when not associated with load shedding for 90% of the sample. What are these anxiety shocks doing to our mental health? The 10% of people who were able to attain some independence from the national power grid, through the installation of a solar power system, were clearly the least distressed grouping, with many others struggling with high levels of material, mental and social suffering. With 4 in 10 reporting depression and 6 in 10 owning to diagnostic symptoms of anxiety, the entire sample seemed

"It [load shedding] has made me feel that I cease to exist, basically. My life feels it's at a standstill - what can I do? what must I do? I hate the feeling of pressure it puts on me... It throws [yo]u straight into the unknown when [yo]u already have SO MUCH to deal with" - Mara

For others, like Mara, load shedding had the power to obliterate existence.

for 88% of people surveyed when they were notified of an increase in stages.

psychologically impacted in one form or another.

Some respondents gave accounts of an exacerbation of physical and

"To be honest, just last night I had loadshedding (6pm to 9pm - we have it for 3 hours in eI). And because I'm trying to develop a schedule for when I get home, I came back late from work to the dark and instead of following my proposed schedule, I just sat in the dark and I cried myself to sleep as I am someone who is dealing with depression (diagnosed mdd) and suicidal thoughts. As silly as it sounds, sitting in the "dark" as someone who lives alone, it doesn't help" - Kenni

psychological challenges. Others indicated a new set of psychological challenges, such as emergent anger and a new inability to emotionally regulate. Social relations between households were strained, as many felt unable to effectively entertain outsiders. Within the home, 31% reported problematic family relationships, and feelings of isolation, even amongst introverts, were worrying. A fraying social fabric, coupled with novel and deepening mental health challenges are a recipe for additional anxiety-laden shock waves rippling through society as we grapple with load shedding. How, then, have we been coping? Even in this relatively privileged

"Resurrected Severe Depression that had long been under control. The future holds no promise whatsoever &, though suicide is not an option, I long for death to end it all. I am much more susceptible to colds, flu, stomach upsets & odd infections. I have lost weight & seldom sleep well. Loadshedding is but one symptom of rampant, imminent collapse of society in SA.... There is no cause for optimism in & about SA. The future is bleak & hopeless" - Matt

sample of largely white, urban, female and somewhat affluent sample, respondents were deeply strained by the financial burden of load shedding, and so many could not thus simply reach for the solar power solution. Some people went along with the idea of suspended existence by sleeping

"I am more prone to things that I never was before, such as road rage, losing my temper and even thoughts of committing physical violence" - Vic

(44%) or "numbing out" on their phones (16%) during load shedding slots. Others chose to respond to work pressure, trying to meet professional obligations during outages (32%). Some chose to take a pro-active break and perform wellness activities such

"Family interactions become limited because everyone goes to their respective bedrooms when lights go off. Most of the time is at 6pm in the evening and when it comes back at 8pm, it's difficult to go back and interact. Family dynamics have changed" - Mel

as meditation, yoga or spending time in nature during scheduled power cuts (26%), and still others chose to exercise (20%). Interestingly, there was also a group of respondents (20%) who insisted that they would normalise load shedding, either through the acquisition of alternative sources of power or via planning around the schedule. These South Africans were determined to limit the effects of load shedding on their daily lives, and within their mental realities.

During load shedding I take some "me time after [completing] household chores" - Evelyn
I "carry on as normal" - John

How successful were each of these groups, when it came to reducing their personal experiences of load shedding induced shocks and psychological distress? The more pro-active respondents experienced far lower levels of angst than their sedentary counterparts. Those who planned around the schedule, did not need to buy expensive solar power solutions to cope, though they did expend a great deal of mental and emotional effort. There was clear evidence that pro-active copers, not only normalised their load shedding experiences but that this partially insulated them from the psychologically distressing anxiety associated with this crisis. The key to building self-insulation seems to be channelling our reactions, as opposed to embracing detrimental passivity. We can do this by pro-actively planning and claiming load shedding time slots for productive and wellness activities.

However, we must approach the building of a psychological scaffolding to insulate against anxiety shocks with caution and a healthy dose of realistic flexibility. Unplanned outages and slow restoration still come into play, for solar batteries are not infinite in capacity, and planning requires the solid stability of schedules to ensure we have power outside of load shedding times, in order to succeed. This is not always possible and to we need to encourage the erection of flexible psychological scaffolding.

During load shedding "I Meditate. [Do] breathing exercises. Consider all the things I'm grateful for" - Thandi

Even if most of us cannot afford to go solar in real terms, we can consider what natural resources we possess to help us to go psycho-solar. Just as the sun is available to all, so is the possibility of internal normalisation. This normalisation does not imply mute acceptance of the mistakes that led to load shedding, rather it implies the creation of psychological batteries, or spaces to conserve energy to allow us to better cope with known anxiety shocks.

The findings of this survey matter because they highlight the potential building blocks of our inner shock absorbing infrastructure. Without question, load shedding has led to the disruption of normality, but norms are a human construct, and we are empowered to re-create them. New routines, finding ways to get sufficient sleep, and a refusal to give away our right to exist under adverse conditions are part of the new normal for resilient survey respondents. In the words of survey respondent, Nkosini, "I put my head torch on and do the best I can". We may not know when the power will return, or how to fix damage to the electrical, communications and water infrastructure, but we can (and should) build our own psychological insulation infrastructure and frame the crisis on our own terms.

All respondent names cited in this article are pseudonyms.

References available on request. MHM

SADAG'S "YOUR LIFE DURING LOAD SHEDDING" SURVEY (2023)

Participants
1836

Fear surrounding perceived socio-economic consequences of load shedding



Survey Sample

Employment status:

- 74% are currently employed
- 26% are currently unemployed

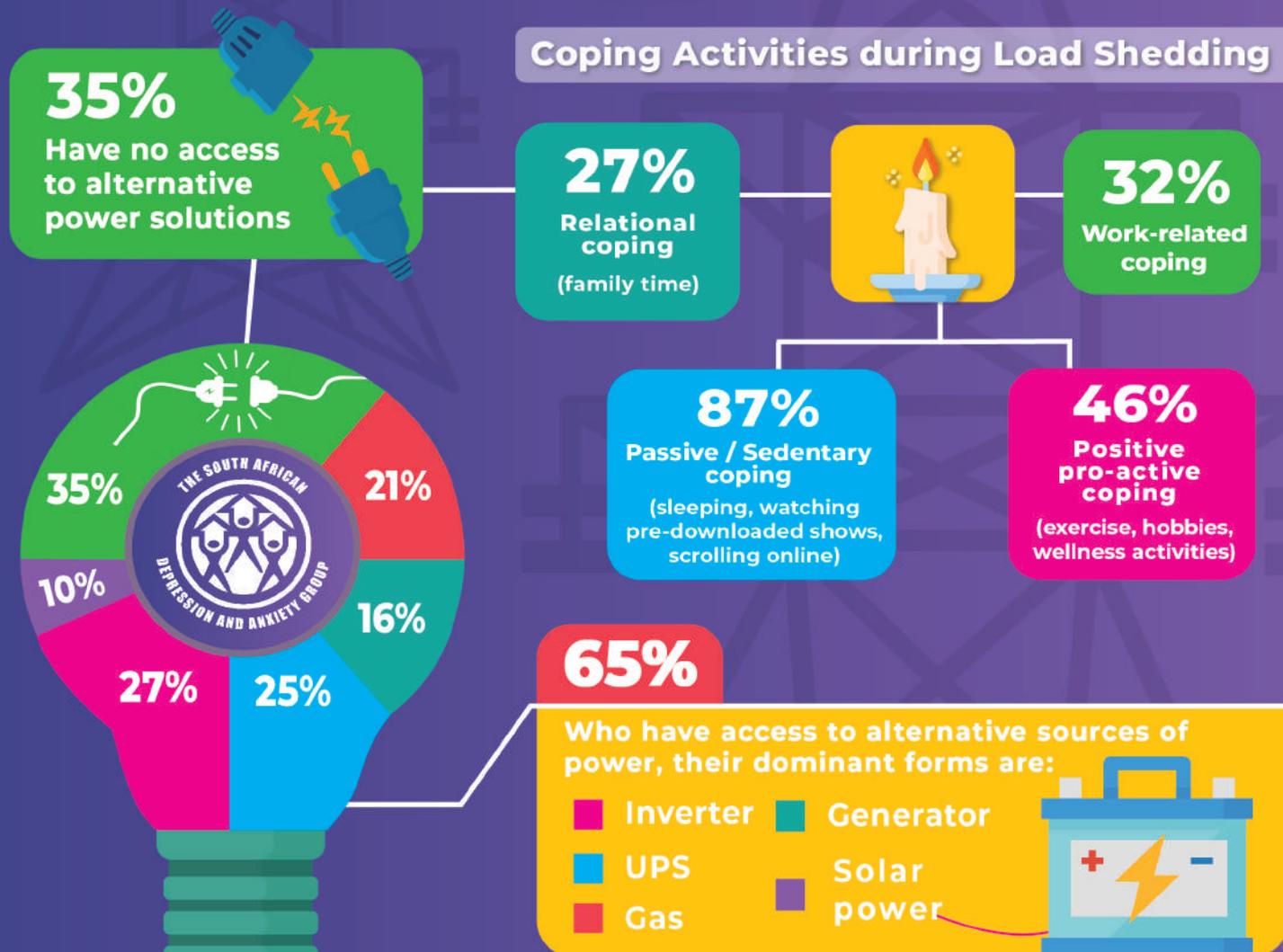
Age of participants:

- 25% (18-35 years) young adults
- 49% (36-55 years) adults
- 26% (56+ years) mature adults

Main Challenges Faced by Individuals



Coping Activities during Load Shedding





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ATTENTION DEFICIT/ HYPERACTIVITY DISORDER AND COMORBID LEARNING DISORDERS

Introduction

Although Attention Deficit/Hyperactivity Disorder (ADHD) is more prominent in children, it can be diagnosed across the human lifespan. ADHD often persists into adulthood and can lead to many challenges on an individual level such as underachievement, employability, and interpersonal difficulties. Genetics is the major contributing factor to the aetiology of ADHD, and it accounts for 80% variability of the disorder. Nonetheless, as with any other disorder, there are other contributing social factors such as low socioeconomic status, illiteracy, and parental smoking (during pregnancy) that leads to higher incidences of ADHD. This article takes a closer look at ADHD and comorbid Learning Disorders (LDs).

ADHD

ADHD can be defined as a neurodevelopmental condition characterised by developmentally inappropriate and impairing patterns of inattention, hyperactivity, and impulsivity. In the majority of cases, the onset of ADHD is evident in

children of a very young age and often persists into adulthood. Because of the characteristics of ADHD, children can present with impaired functioning academically, socially, and behaviourally in both school and home environments. Academically, children with ADHD are often associated with grade retention, expulsion, suspension, and difficulties building and maintaining relationships with their peers. Because of the extent of impairment, ADHD is considered a public health problem due to the increased resources needed at school to help enhance the learning experiences for the children (resulting in extra costs). ADHD is still under-recognised, especially in South Africa due to the limited resources available in most impoverished communities.

ADHD and Comorbid Learning Disorders (LDS) among Children

Because of the developmental period of the onset of ADHD, it's frequently found that individuals with ADHD also present with comorbid LDs. Research suggests that approximately 30% of

children diagnosed with ADHD also suffer from LDs. The impairments of children with ADHD and comorbid LDs are more severe than those with ADHD alone. LDs affect approximately 5–10% of school-aged children and involve various classified disorders. These include reading, mathematics, written expression, expressive language, and mixed receptive–expressive language disorders. It's very common for ADHD to present with comorbid LDs. It's estimated that 15–20% of children with LDs present criteria for the diagnosis of ADHD and that 25–40% of children with ADHD present comorbid reading disorders, while 11–26% have mathematics disorder.

Children with ADHD and comorbid LDs experience higher levels of stress as each disorder individually brings about stress, not only for the child but also for the family and community. This type of comorbidity also leads to lifelong difficulties impacting the social and economic areas of the individual. Regardless of the high prevalence, little effort has gone into strategies to promote or better the livelihood of

these individuals.

Furthermore, children with ADHD show substantial impairment in inhibition and working memory. Those with LDs presented with significant difficulties in central executive functions, specifically working memory. Findings from studies show that children with ADHD were specifically impaired in the control and inhibition of impulses, while the children with LDs were impaired in phonological awareness, verbal memory span, storytelling, and in verbal IQ.

When diagnosing ADHD, the practitioner needs to be aware that, along with ADHD, a person may experience symptoms of other disorders such as autism, Asperger's, Tourette's syndrome, dyslexia, and dyspraxia. Studies show that approximately one in two people with ADHD have dyslexia, approximately one in two people with ADHD have dyspraxia, nine in ten people with Tourette's have ADHD, two in three people with ADHD have autistic spectrum traits, and people with ADHD are eight-fold more likely to meet the full criteria for an autistic spectrum diagnosis. So it's beneficial for the practitioner to know that individuals with neuro-diverse disorders might present difficulties with organisation, memory, concentrating, time, direction, perception, sequencing, and poor listening skills.

In addition, those with Dyscalculia have difficulties with number concepts and calculations. Whereas persons with Dyslexia have trouble with words including reading, writing, spelling, speaking, and listening. These individuals prefer non-linear thought. They also seem to have a lack of concentration and struggle with increased distractibility. Tourette's Syndrome involves verbal and physical tics.

Furthermore, autism spectrum disorder (ASD) involves:

- social and communication problems
- obsessive interests
- differences in imagination
- over and under-sensitivity to light, noise, touch, and temperature
- and speech and language difficulties.

Developmental co-ordination disorder (DCD), also known as dyspraxia, is a condition that affects physical coordination. This disorder is marked by clumsiness. Dyspraxia/DCD involves difficulties with:

- planning, movement
- coordination, and practical tasks, balance, poor spatial awareness, and poor muscle tone.

ADHD and autism share mutual symptoms, including:

- Inattention
- atypical movement (such as fidgeting or stimming behaviour) social difficulties
- and differences in learning style.

Both autistic people and those with ADHD can experience sensory sensitivities as well.

Educational assessments and ADHD and LDs

Most educational assessments rely on processing speed and working memory which may be affected by the impulsivity and attention deficit characteristics of ADHD. There is also an increased variability in reaction time among children with ADHD which may impact the results of their assessments. Children with ADHD have a poor academic prognosis compared to their counterparts (children without ADHD). This is due to ADHD affecting working memory, concentration, ability to focus, pay attention, listen, or complete their schoolwork. Additionally, ADHD can also make a student fidgety, restless, talkative, or disruptive in class, thereby negatively affecting their learning process.

Why is the prevalence of ADHD and comorbid LDs so high?

There is a strong neurodevelopmental overlap between ADHD and LDs. These disorders seem to be alike in terms of being able to focus on one task at a time, working memory, processing speed, planning, organisational difficulties, and executive functioning difficulties. In addition, overlapping signs or symptoms include distraction, fluency, and writing. Children with ADHD and Dyslexia for instance will

both appear distracted even though the nature of their distraction is different. With ADHD they may appear distracted due to a lack of attention and a lack of decoding ability, hence with comorbid dyslexia it requires increased effort and attentional input. Fluency appears to be an obstacle in both ADHD and Dyslexia. The fluency of readers is determined by reading accuracy, reading speed, and oral reading expression. For proper comprehension, fluent reading is a necessity. Both ADHD and Dyslexia affect the ability of the reader to comprehend what they have read. Furthermore, both ADHD and Dyslexia seem to cause difficulties with executive function, memory, and processing symbols rapidly and efficiently. The differentiation between these two disorders is evident in the reading, spelling, and writing problems of the person with dyslexia and the behavioural symptoms of the person with ADHD. Furthermore, ADHD and LDs are classified as neurodevelopmental disorders. However, they strongly impact each other thus leading to even greater academic challenges.

Conclusion

This article has highlighted the comorbidity relationship between ADHD and LDs. With genetics playing a significant role in the development of ADHD, socioeconomic factors are equally important. The core presenting symptom of ADHD is a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with overall functioning. These symptoms tend to be accompanied by associated behavioural, cognitive, emotional, and social problems which can lead to work-related and interpersonal difficulties.

Thus, it is important that the necessary assessments should be conducted to determine the various areas that are affected by ADHD due to the high comorbidity rates of LDs in individuals with ADHD. This is particularly important to take into consideration when interventions are found to not be effective, and further assessments need to be considered.

References available on request. 



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A FACE OF ANXIETY

She is a dainty, petite woman. You notice her silver hair held tightly in a bun and her thin, soft fingers curled around the pen as she signs her details on the form. This is your first encounter with the 75-year-old lady, who appears apprehensive at the sight of a clinical office set within a psychiatric hospital.

She wears a floral blouse and blue long skirt, cloaked by a white knitted jersey with simple, black, flat shoes.

She appears young for her age. Her face creased with many years of living, shows a gentle demeanour, with carefully placed makeup and a smile that urges you to step forward, touch her shoulder and welcome her into your consulting room.

You were expecting her. Two weeks back you received an email from one of the psychologists with whom you have an excellent clinical relationship. You highlight the important text. The email reads as follows:

“Dear doctor

*Thank you for seeing my 75-year-old patient, Ms du Toit, who lives alone in a retirement village. She has been consulting with me for the past 6 months and seeing her GP regularly for **general body aches, difficulty sleeping, poor appetite, and mild***

***irritability** (although you would not say this by looking at her). She has **stopped** visiting her friends, going to the shops, and partaking in any social engagements.*

*She has told me that, for the last **8 months**, she feels **nervous** spending time outside her home. She has a **fear** of falling, getting lost, and other drivers on the road, and making a fool of herself with friends. These symptoms appeared to have begun just after the **loss of her husband of 42 years**.*

*She initially consulted with her **GP** as she was finding it difficult to fall asleep saying that as she climbs into bed her **mind is racing** with thoughts of the following day, and that she cannot stop thinking of her late husband, even **wanting to ‘join him’**. Eventually she falls asleep, but the night is **restless, with frequent awakenings**. She has begun to get **into bed an hour earlier** than her usual time and wakes up well before her alarm clock. But she feels exhausted in the mornings and for most of the day, taking a **2-hour nap in the afternoon** - unusual for her. The GP decided to trial **Benzodiazepines** (Urbanol 10mg three times per day or as needed), with minimal response and, unfortunately sedation.*

*Her body has begun to **ache** and*

*she is **battling to walk** the distance of her home needing to sit and rest. Too often she has **almost fallen**, resulting in her clutching onto railings whenever she feels unsteady. She has begun to sit more frequently, watching anything on TV, to ‘take her mind off the day and what has to be done’. She finds she struggles to hold her teacup as her **shaking has been getting worse**’.*

*Importantly she has been experiencing **episodic** moments of being **overwhelmed, short of breath, with a racing heart, and ‘stars’ in her vision**. This passes after about 15 minutes but leaves her crying and lying on her bed. These ‘episodes’ have contributed to her **avoiding** social engagements and leaving her house altogether.*

*She also finds she is **short-tempered**, and often gives up trying to make meals, both due to her loss of appetite and that she is **battling to read the numbers** on her oven and recipes she’s always used.*

Our journey together has been productive. She works hard and engages well in therapy.

The GP has diagnosed generalised anxiety and depression, with panic attacks and agoraphobia.

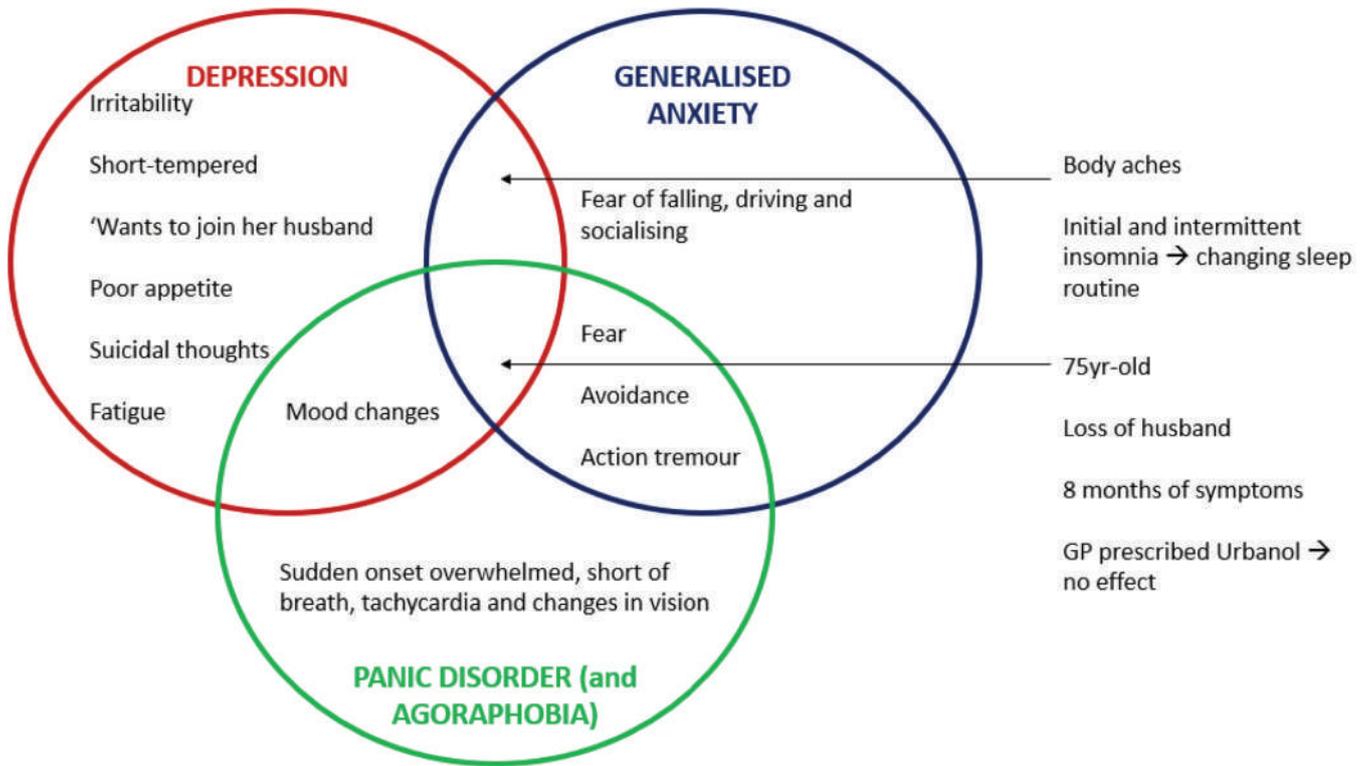
Kindly manage the patient further and provide me with feedback.

You look gently at Ms du Toit. Despite her smile and softly spoken words, there is evidence of deep

pain, grief and profound worry. You explain you will help her, easing her distress, comforting her with

professional reassurance.

For you the best way to summarise this clinical picture is to draw a diagram:



After taking a thorough history from Ms Du Toit, you perform a physical examination which renders no abnormal findings.

You decide on a multidisciplinary management plan as an outpatient (as Ms du Toit can consent, is not actively suicidal, requests to be

at home, with a support structure from her son and daughter who visit her every day). Consideration is given to each step.

Stop the Benzodiazepine	There has been no improvement and increases Ms du Toit's risk of sedation with a potential fall.
Continue clinical psychotherapy	This can be used instead of medication. But in the case of Ms du Toit, her symptoms appear moderate-severe, and medication is indicated.
Discuss with Ms du Toit all the benefits and risk factors for starting a first-line SSRI medication	Evidence-based medicine describes the use of Sertraline/Citalopram (20-60mg/day) for the treatment of anxiety and depression in the older age. One could also consider an SNRI such as Venlafaxine (150-300mg/day).
What if Ms du Toit does not respond?	Psychotherapy + Bupropion (150-300mg/day)/Vortioxetine (10-20mg/day).

What if Ms du Toit's mood progresses to severe depression (for example, she has worsening suicidality)?	Electroconvulsive Therapy (ECT) in the case of severe depression could be considered with a combination of psychotherapy and medication.
Should Ms du Toit be prescribed a sleeping medication? And what can be done about her Tremor and panic attacks?	You decide to initiate Circadin 2-4mg. This is evidence-based for insomnia for the older patient. You want to avoid Benzodiazepines. Instead, you prescribe a β-blocker (Propranolol at 10-20mg/day up to three times per day, depending on her response).
You do blood investigations and consider radiological studies	This is to rule out an organic cause for her mood pathology.

You form a wonderful rapport with Ms du Toit, and she agrees to follow your management plan. You also psycho-educate her on a healthy diet, a structured and hygienic sleep routine, and perhaps consider attending physiotherapy for core body strength and regular exercise. You also encourage her to have her vision checked.

You return the email to the psychologist, informing her of your management plan and the promise to continue your contact with her so as best to assist the patient.

Ms du Toit is grateful for all you have done to help her along this journey. She says goodbye with a far greater smile than what she walked in with. Claspng her handbag, she gets up from her chair slowly and

carefully. You wish her well and plan to consult with her in a month, the time taken for the medication to have its therapeutic effect.

As you drive home from your rooms you smile to yourself as you know you have made a significant difference to somebody's quality of life.

References available on request. MHM

RECRUITMENT OF PATIENTS AND THEIR SIBLINGS FOR A STUDY ON OCD AND THE BRAIN, TITLED:

Identifying Reproducible Brain Signatures of Obsessive-Compulsive Profiles

Professor Christine Lochner

SAMRC Unit on Risk and Resilience in Mental Disorders,
Department of Psychiatry,
Stellenbosch University

This international study on obsessive-compulsive disorder (OCD) is funded by the National Institutes of Mental Health (NIMH) and is a collaboration between five sites in different countries (U.S.A., Brazil, India, Netherlands and South Africa). In South Africa, this study is conducted at the universities of Cape Town and Stellenbosch respectively, and it has been approved by the respective research ethics committees.

The goal of this global study is to identify reproducible brain signatures of adults with OCD. Once identified, we will examine how these brain signatures are linked to behavioural performance on neurocognitive tasks and to a range of clinical profiles that are common to OCD. We also aim to explore how specific environmental features (e.g., childhood trauma, socioeconomic status, and religiosity) may moderate this brain-behaviour relationship. We have now reached our target of 250 participants with OCD and 250 age and sex-matched healthy volunteers.

CURRENT RECRUITMENT EFFORTS ARE FOCUSED ON 1) SIBLINGS OF PATIENTS WITH OCD, AND 2) PARTICIPANTS IN THE OPTIONAL TREATMENT COMPONENT:

1. We are now recruiting siblings (brothers and sisters) of individuals with OCD. Several studies have examined the familiarity of OCD, and twin and family studies indicate that OCD aggregates in families, and both genetic and environmental factors are relevant to the etiology of the disorder. It has been suggested that obsessive-compulsive symptoms are common in first-degree relatives of individuals with OCD. The rationale for the addition is that unaffected siblings can be seen as an intermediate group

between patients with OCD and HCs, and addition of data from this additional cohort to analysis will likely assist in identifying brain signatures of OCD.

Recent MRI work in adult and adolescent patients with OCD and their unaffected siblings have for example, shown that there are similar morphological abnormalities in cortical and subcortical regions of the caudate nucleus, thalamus and the right orbitofrontal cortex in these groups. In addition, both patients with OCD and unaffected siblings, as compared with healthy controls, have shown increased thickness of the right precuneus.

The current urgency is to recruit an additional 5 siblings of people that have been diagnosed with OCD before end of April 2023.

2. There also is an optional treatment component to this project; we hope to identify those variables that are associated with response to sertraline in adults with OCD. Treatment entails taking flexible-dose sertraline, a selective serotonin reuptake inhibitor, for 12 weeks. This is not an experimental medicine: it is FDA approved for use in OCD. Sertraline is taken to the maximum recommended or tolerated dose (e.g., increasing the dose gradually, and under supervision of a psychiatrist and psychologist for 12 weeks.) MRIs are done at baseline and at week 12. After that treatment proceeds under naturalistic conditions, i.e., as the patients would ordinarily receive from a typical mental health clinician for weeks 12-52. There are assessments at weeks 2, 4, 8 and 12, as well as 3-monthly follow-ups after these, until month 12.

3. There is scope for the addition of 13 additional patients from Cape Town over the next year. All study procedures including MRI and medication (up to 12 weeks) are cost-free to participants.

For more information or to make a referral to this project, please contact

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Research Assistants:
OCDRSA@sun.ac.za

Landline: 021 938 9654

WhatsApp: 076 233 6270

Website: global-ocd.org

Facebook: @OCDRSA 

OCD?

We are recruiting participants for a study on Obsessive-Compulsive Disorder (OCD) & the brain

Researchers from Stellenbosch University are inviting:

1. People with OCD
2. Brothers & sisters of people with OCD

Contact:

WhatsApp: 076 233 6270

Landline: 021 938 9179

Email: CL2@sun.ac.za or OCDRSA@sun.ac.za

 @OCDRSA

global-ocd.org

2023



By Linda Christensen
Press Office
South African Society of Psychiatrists (SASOP)

DEPRESSION DURING PREGNANCY HARMFUL TO MOTHER AND CHILD, BUT TREATABLE

Between 21% and 47% of South African women experience depression during pregnancy, and 31% to 50% suffer postnatal depression, compared to the global rate of approximately 12% of women experiencing depression during or after pregnancy.

Up to half of expectant mothers in South Africa experience depression during pregnancy and following childbirth that goes undiagnosed and untreated – with risks to their own and their babies' health and future development.

While postnatal depression is well known, depression during pregnancy is almost as common and carries

risks of increased complications during pregnancy and childbirth, explained Dr Bavi Vythilingum

member of the South African Society of Psychiatrists (SASOP). However, she said that treatment

is available and effectively reduces the risks. "Psychotherapy, group therapy and even antenatal support groups are all very helpful. Antidepressants are effective and, used in consultation with the mother's healthcare provider, most are safe in pregnancy," she said.

In National Pregnancy Awareness Week from 6 to 9 February, aimed at promoting health during pregnancy and early motherhood, Dr Vythilingum said South Africa's high rates of poverty and intimate partner violence, together with lack of awareness of mental health, the related stigma and under-resourced mental health services, contributed to the country's high rates of maternal depression.

Between 21% and 47% of South African women experience depression during pregnancy, and 31% to 50% suffer postnatal depression, compared to the global rate of approximately 12% of women experiencing depression during or after pregnancy.

"Pregnancy-related depression is often dismissed as 'just the baby blues' and women are told to 'just pull yourself together', but it's a serious mental health condition which not only negatively affects women's quality of life and experience of motherhood, but the prospects of the next generation too," Dr Vythilingum said.

Women who experience stressful life events, and especially intimate partner violence, during pregnancy are more likely to experience long-lasting severe depression that extends from pregnancy through to a year or more after giving birth.

"Antenatal depression increases the risks of hypertension (high blood pressure), which puts both mother and baby at risk of complications during the pregnancy and in childbirth, and of low birthweight and premature births", Dr Vythilingum added.

Untreated depression during pregnancy leads to the mother being more likely to experience postnatal depression and difficulties in bonding with her baby, which affects the vital mother-child attachment relationship, and can

affect the child's social, emotional and cognitive development and lead to mental health problems later in life.

"Depression is one of the greatest risk factors for alcohol and substance abuse during pregnancy, not only worsening the depression but putting the unborn child at risk of developmental delays, congenital abnormalities and intellectual disabilities," Dr Vythilingum said.

"The lack of awareness and stigma around mental health conditions, along with the tendency to focus more on a woman's physical health than her mental health during pregnancy, means that depressive symptoms are often not picked up. In addition, some of the symptoms of depression, such as changes in sleep patterns, appetite and energy levels, are sometimes simply attributed to the physical changes of pregnancy.

"Because many women in lower income groups, using under-resourced public health services, only access those services during pregnancy, this is often the first time that depressive symptoms are picked up. Antenatal care should go beyond the mother's physical health to mental health and social needs too, in a holistic, integrated way. This would go a long way to addressing generally high levels of depression, anxiety and other mental health conditions that go undiagnosed and untreated in South Africa," she added.

Dr Vythilingum said women experiencing moderate to severe depression should ideally be treated with both psychotherapy and medication.

"Ideally, when women have persistently high levels of depression symptoms, an integrated approach should be followed, to deal with pregnancy-related depression, domestic violence if present, and other stressful life events and substance use.

"Group therapy is very helpful, as is the support and interaction, a sense of community and of not being alone, in support groups with other expectant mothers and

mothers of newborns."

"Many clinics, both public and private, have antenatal support groups and there are moms' support groups active on social media that also meet in person in various centres."

On antidepressant medication in pregnancy, Dr Vythilingum advised women who are on antidepressants when they fall pregnant to consult their healthcare provider before stopping the medication. If necessary, an alternative can be prescribed or the dosage altered.

"Antidepressants are very effective for moderate to severe depression, or where a patient has not responded to psychotherapy. In cases where the woman doesn't have access to psychotherapy, antidepressants are a recommended and effective solution.

"Most antidepressants are very safe to use during pregnancy; they don't cause congenital abnormalities or neurodevelopmental problems. For pregnant women presenting with depression for the first time, antidepressants are the first line and we see a significant difference to their quality of life and positive outcomes for both mother and baby."

As with all medications during pregnancy, she said it was vital for the mother to consult with her healthcare provider before stopping existing medication or starting any new medication.

The South African Depression and Anxiety Group (SADAG) lists toll-free helplines for general depression and anxiety, and has free support groups around the country for various issues, including support for expectant and new mothers. Call **0800 21 22 23** for help and information.

In addition, mothers and mothers-to-be can join the network **mumsupport.co.za** for a caring community of women supporting women.

References available on request. MHM

SADAG SUPPORT GROUPS

Borderline Personality Disorder Support Group for Young Adults Aged 18-35

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.

Living with Borderline Personality Disorder (BPD) can sometimes feel like a very isolating and lonely journey without the right network of support. Often people with BPD may be perceived as “difficult to treat and handle”, but it’s vital to provide spaces where they can be heard, feel seen and experience support.

This month’s featured Group is the **Borderline Personality Support Group for Young Adults Aged 18 - 35** hosted by Kia Cordeiro.

Kia’s Support Group is a safe space where people living with BPD can share their challenges and be supported by like-minded individuals who have had similar experiences. By providing coping mechanisms and activities aimed at channelling energy in healthy ways, the Group creates a space for members to not only walk their journeys together, but to do so more sustainably. The Group aims to empower each member to build self-efficacy and resilience through the experience of a non-judgemental and supportive space that embraces people living with BPD from all walks of life.

Some words from Kia:

Why did you start this particular Support Group?

On a personal level I started this Group because my sister was diagnosed with Borderline in 2021 and I witnessed how difficult her mental health journey became with very little support and lack of understanding from loved ones. As a social worker, I have also seen how certain people, even some

health care professionals, view BPD as something that makes people “difficult to help” or “difficult to treat”. This makes it so much harder for people living with BPD to tell others about their diagnosis and often prevents them from reaching out to seek help or receive treatment. I started this Group to break the stigma around BPD. Starting this Group from a place of deep empathy towards people with BPD has equipped me to facilitate and support this unique group of individuals.

What are the benefits of joining this Support Group?

By joining this Group, members enter a space where we adopt the mentality “come as you are” without judgement. Meaning whether Members are having a good day or bad day, the Group is there in its capacity to support, encourage and uplift each other. The benefits of joining this Group are that people living with BPD meet others walking a similar path to them on their Mental Health journey which fosters unity and inclusion and can help one feel heard, understood and motivated to comply with their treatment plans. It’s a place of encouragement, which affords members the opportunity to practice better behaviours, develop communication techniques and the problem-solving skills required for a healthier future.

Who can join this Group?

Anyone between the ages of 18-35 who has been diagnosed with Borderline Personality Disorder by a Mental Health professional such as a psychiatrist, who is on medication, and has their own individual therapist outside of the group.

What do you hope to achieve with this Group?

I hope to help my Group members and others living with BPD understand that a space does exist where they will not be judged and be accepted for who they are. I wish

everyone could understand that being diagnosed with BPD doesn’t mean your world now crumbles, and doesn’t define you; having a diagnosis means you can walk the path that was set for you, and that with the right support, healing is possible. I hope by giving members a platform to share their stories, it helps to end the stigma around Borderline, and that more people seek to understand the disorder. I also hope to equip everyone who joins my group with the skills and knowledge to develop resilience. My hope is to also bring education and awareness to those with loved ones who have been diagnosed with BPD.

MHM

Join us at a FREE Online
Borderline Personality Disorder Support Group
For young adults 18 - 35
Where: Online using Zoom
When: First and Third Tuesday of the month
Time: 6pm - 7pm
For more information contact Kia on 082 319 9924

Evolution
"We cannot shame ourselves into change - we can only love ourselves into evolution."
- Roger Wolsey
SADAG SUPPORT GROUPS
KIA CORDEIRO
SADAG SUPPORT GROUP LEADER
ONLINE, NATIONWIDE

2023

MENTAL HEALTH CALENDAR



23rd-29th January

Support Group Awareness Week

12th-19th February

Teen Suicide Prevention Week

30th March

World Bipolar Day

26th May

Bipolar Awareness Day

26th June

Substance Abuse Awareness Day

1st-31st July

Mental Health Awareness Month

10th July

Panic Awareness Day

10th September

World Suicide Prevention Day

10th October

World Mental Health Day

1st-31st October

World Mental Health Awareness Month



www.sadag.org



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UNDERSTANDING FLOURISHING AND ITS POTENTIAL IMPACT ON PATIENT HEALTH

The concept of eudaimonia can be traced back to the writings of the Greek philosopher Aristotle (384-322 BCE). For Aristotle, the broad concept of eudaimonia speaks to the highest of all human goods, a virtue indicated by a life of flourishing, in which an individual is able to fully develop their skills, capacities and virtues. Contemporary research has further built on this concept toward the notion of eudaimonic well-being, which integrates contemporary theories of positive psychological functioning and is accepted as being an evolving, multidimensional concept.

At its core, flourishing, as a component of eudaimonic well-being, speaks to the realisation of human potential, and achieving the best within us. One of the most prolific eudaimonic approaches to flourishing is that of Carol Ryff (1989), which offers six psychological aspects for

eudaimonic well-being, namely:

- **Autonomy:** the capacity to be self-determining and independent, to regulate behaviour intrinsically.
- **Environmental Mastery:** Sense of competence in managing the environment, effective use of resources, capacity to create contexts which match personal values and needs.
- **Personal Growth:** A feeling of sustained development in which the self is perceived as growing and expanding, an openness to new experiences, and a perception of the self as growing over time.
- **Positive Relations with Others:** Experience of warm, satisfying relationships with others, concern for the welfare of others, capacity for empathy and understanding the give and take of human relationships.
- **Purpose in Life:** Having goals in life,

a sense of directedness, sense of purpose in past and present life, holding objectives and aims for living.

- **Self-Acceptance:** Holding a positive attitude and evaluation of the self, acceptance of various aspects of the self, both good and bad.

Satisfaction of the criteria contained in the aspects above is salient in the experience of flourishing in life. When these aspects are further considered in terms of overall well-being and health, the notion of purpose in life is highlighted in multiple studies as being linked to reduced mortality rates, and where in some cases, purpose in life can be linked to a reduced risk of all-cause mortality, with further specific reduced risk of mortality from heart, blood and circulatory conditions. Those who have higher eudaimonic well-being show a greater prevalence

for engaging in preventative healthcare services, and engage with better health behaviours, such as diet and exercise. Indicators of poor health and disease have conversely been found to be associated with poor eudaimonic well-being.

From a biological perspective, eudaimonic well-being has been linked with:

- better regulation of the endocrine system;
- lower prevalence of cardiovascular risk factors;
- lower allostatic load;
- better sleep and;
- better inflammatory profiles.

Neurologically, eudaimonic well-being is linked to:

- lower amygdalic response to negative stimuli;
- greater activation of the ventral anterior cingulate cortex;
- lower cortisol output and;
- greater insular cortex volume.

The potential valence of eudaimonic life purpose for patient health and health promoting behaviours is further noted against recent empirical findings from Oxford University which demonstrate that much of the guidance offered by physicians to obese patients does not result in effective behaviour change and consequent weight-loss. The study promotes that physicians speak opportunistically with patients living with obesity, and where such discussion should support patients in making beneficial, meaningful lifestyle changes by way of evidence-based practice, tailored to the individual patient. The study further finds that a structured, deliberate approach to such dialogue is critical.

Consequentially, by employing Socratic patient dialogue with key application of Ryff's six key aspects of eudaimonic well-being, healthcare practitioners have the opportunity to meaningfully probe into both the 'why' and the 'how' of patient health and in so doing create the foundations of sustainable behaviour change. It's noteworthy that the affective neuroscience perspective (ANP) considers flourishing an outcome of various interrelated motivations,

interpretations and behaviours in the brain, and where probing into both the why and how of the various flourishing aspects holds promise in satisfying the multiple-cause nature of flourishing. Specifically, such Socratic dialogue would perhaps provide an intervention platform from which patient positive evaluations of flourishing domains through ventromedial prefrontal cortex activity is promoted.

From a practical perspective, application of Socratic dialogue to Ryff's key aspects of eudaimonic wellbeing holds promise toward the creation of a deliberate, structured approach in promoting patient health through eudaimonic well-being. For instance, discussion with a patient regarding the need for behavioural change for health reasons could be extrapolated as follows:

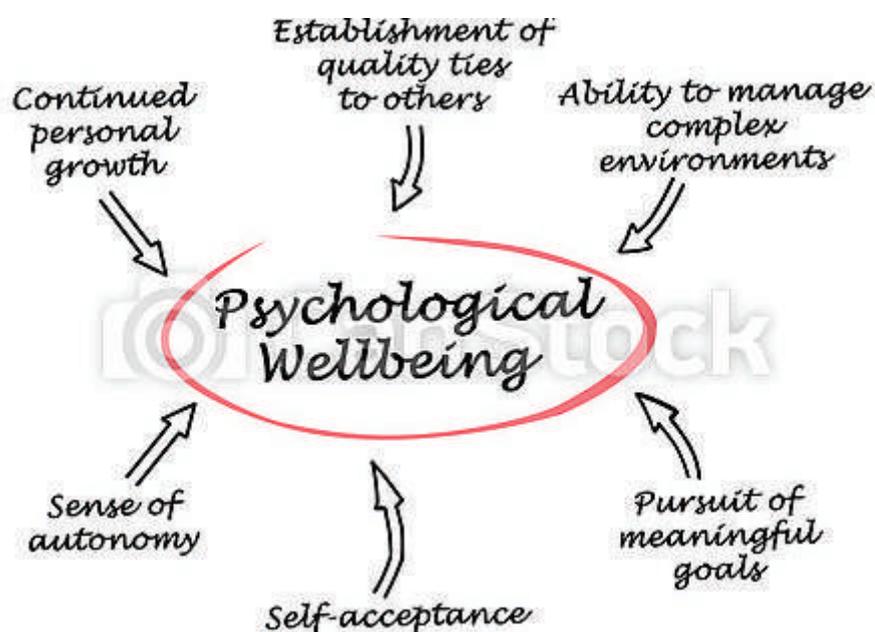
- **Autonomy:** To what degree is the patient able to take ownership of the behavioural change, and to what degree are they in fact aware of their agency in this regard.
- **Environmental Mastery:** To what degree is the patient cognisant of supportive resources in their environment, to what degree are such resources in fact capable of enabling required health behaviours?
- **Personal Growth:** What is the patient's perception of themselves in this process, do they view the process as one of growth, or one of punishment. If punishment, why, and how can the process be better

incorporated into a perspective of growth.

- **Positive Relations with Others:** To what degree does the patient present with relationships in their lives that will enable and support their proposed change in behaviours, to what degree do these relationships enable negative, or positive behaviours.
- **Purpose in Life:** What objective, purpose or rationale exists for the behavioural change in the patient's life? Does this in fact relate to a deeper reason (family, achieving a personal goal as examples) or is the behavioural change construed as one that must be done (extrinsically motivated)?
- **Self-Acceptance:** To what degree does the patient present with acceptance of the self, the reality of behaviour change, and to what degree will the behavioural change satisfy a process of greater self-acceptance and growth.

The notion of eudaimonic well-being and applying Socratic dialogue to Ryff's key aspects of eudaimonic well-being provides a means of creating both depth and individualisation of key health related conversations with patients, and where the small investment in consultation time herein holds further promise for meaningful and sustained health related behaviour change in patients.

References available on request. MHM





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GENDER BASED VIOLENCE (GBV) EPIDEMIC IN SOUTH AFRICA AND ITS EFFECTS ON THE MENTAL HEALTH OF WOMEN

After the coronavirus pandemic, our President characterised gender-based violence (GBV) in our country as a “second pandemic”. Statistics and police reports are worrying and incomplete as many victims don’t report their abuse. Despite the lack of accurate statistics, it’s evident that the rates are high, both for women and for THE LGBTIQIA+ community.

The campaigns to bring GBV to an end in South Africa have been relentless. However, despite countless attempts, there has been little to no change thus far with SA having been framed as ‘the destination of femicide’, where more than 2,700 women were murdered between 2000 and 2021, a number that has surely increased all as a result of GBV. That’s one woman every three hours. Femicide is defined as sex-based hate crime by the World Health Organisation as “the intentional murder of women because they are women”. It’s the most extreme manifestation of GBV, and is widely prevalent in South Africa, not only with

regards to women, but children and the gendered community.

DEFINING GENDER-BASED VIOLENCE

Gender-based violence refers to any act of: physical, psychological, sexual or economic violence directed against a person or group on the basis of their gender, sex or non-conformity to gender norms and stereotypes. It’s an expression of unequal power relations, underpinned by social norms and beliefs linked to dominance, power and abuse of authority, and formalised through the laws, policies and regulations of social institutions.

GBV can take many forms, including physical, psychological and sexual violence, as well as social violence which cuts survivors off from their communities or social groups, and economic violence, which results in economic deprivation. Further examples of GBV against women include domestic violence, sex-based harassment, female genital mutilation, forced marriages or online violence.

Gender Based Violence is regarded as a human rights violation and a major barrier to achieving gender equality as well as an obstacle to a country’s development. GBV does not discriminate nor does it confine itself to specific communities, socio-economic standing or income level. Any person of any race, age, gender, sexual orientation or religion can be a perpetrator, victim or survivor of GBV.

WHAT ARE THE FACTORS EXACERBATING GBV?

These include:

- Lack of education
- History of exposure to GBV - whether personal experience or witnessing GBV
- An ineffective justice system which does not deter perpetrators from re-offending.

GBV AND MENTAL HEALTH

Girls, women, and gender diverse people experience a wide range of explicit and implicit, nuanced, subtle instances of harassing behaviours,

SCHIZOPHRENIA

I am not a psychoanalyst, neither am I a behaviourist. However, I believe that incorporating these particular mindsets will provide a better understanding around what I'm about to share with you.

During my primary education I was a dedicated student with high potential, especially within the scope of subjects related to science.

This changed dramatically during fourth grade. During this period of my life, I started hearing a female voice encouraging me to deliberately engage in activities that would get me into significant trouble. I became anxious and perpetually confused without a safe outlet. I found myself isolated, without anyone to safely share my experiences with.

I convinced myself not to share what I was going through, in fear of possible rejection and being unfairly judged. I was afraid and embarrassed. I truly thought I was the only person in the world who heard such voices.

Ultimately hiding my own personal trauma became my downfall. In my effort to appear unaffected, I ended up displaying unusual behaviour compared to my peers. I remember vividly being caught out by a teacher during an episode that involved me talking to the classroom walls.

This was made substantially worse by the berating and humiliation, intentional or unintentional, I would receive from other students – people I considered my friends.

My academic performance plummeted. I felt alone, without anyone to turn to.

Thankfully, my class teacher who had noticed my irregular behaviour made the decision to meet with my mum. Although I wasn't privy to that conversation, afterwards my mum and I had a one on one talk.

I made the decision to tell the truth, to let go of the

embarrassment and was honest with my mother.

Her reaction to my admission was understandable, but confusing nonetheless. She was shaken, worried and confused. I understood, because I felt the same emotions, but I can't say that the theories of being possessed or bewitched didn't hurt. I already felt isolated, so this didn't help.

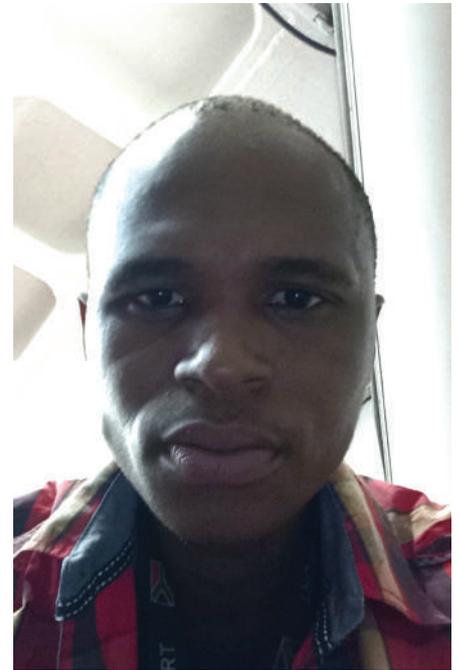
I went along uneasily with the proposed traditional treatment plans of consulting a sangoma, and then a pastor, because at that age with very little access to information, I knew no other alternative but to trust my elders.

Traditional and religious intervention did not prevail. The hallucinations persisted, creating further negative impact for me in class. My teacher became worried and referred the matter to a colleague. More discussions ensued and it was recommended that I attend a special needs school. At that time, it was suspected that I suffered from ADHD, although there was no official diagnosis.

Following their recommendations, I was enrolled into such a school. However, various IQ tests established that indeed, I didn't have a learning disability, and I found myself being transferred back to a normal secular school. Again this didn't quell the hallucinations or improve my behaviour.

The unfortunate tipping point came when I tried to end my life. Suddenly, I was thrust into a psychiatric ward of a hospital for two months. I left, medicated and without knowing my diagnosis – but I left nonetheless, free from hallucinations for the first time in a long time.

I began to excel in my personal and academic life. I became a high achiever at school. But soon followed the downfall. Following my newfound freedom, I began



By Ntetheleo Cebekhulu

indulging in alcohol. I became complacent when it came to taking my medication. I thought I was in control, but that was far from the reality of my diagnosis.

I found myself admitted back into hospital, my freedom gone, and the hallucinations back in full force. After a difficult month of stabilisation in hospital, the diagnosis was shared with me. I was diagnosed with schizophrenia, and entered a lengthy treatment plan. After a while, I began to reap the benefits of such a treatment plan. My mood and concentration levels drastically improved.

I found the diagnosis compelling, even intriguing. Understanding the human mind and its lack of limitations was a wonder to me. I knew this was something I would pursue. I went on to complete my first year at university, majoring in psychology.

My story doesn't end there, it continues to write itself. Complacency reared its ugly head again. The cloud of alcohol hung low over my life. The disease, left unchecked, became debilitating,

leaving me unable to make even the simplest of decisions. Once again, I was admitted, this time as an involuntary patient. This time I refused to comply with the recommendations or the script, to my own downfall. This lasted for a while.

However during my stay in hospital, I was blessed to find a long-lasting friendship with a fellow patient, who was going through a deep depression. We developed a close bond, he became a close confidant, someone who didn't judge me by the stigma of a disease but who saw great value in me, even when I couldn't see it myself. We gave each other support by uplifting each other in dark times. It was a relief to find a friend that understood who I was, and didn't judge me unfairly. We continue to support each other, and even our families share a close bond.

To be clear, I was not failed in any capacity by health officials. They gave me the tools to help myself. However, the experience has highlighted the importance of embracing our mental health, of not being ashamed of it. There

is tremendous value in having an outlet, whether that is via a supportive inner circle, or outside intervention such as being open to various treatments including psychiatric and psychological interventions. Traditional methods didn't work for me, because they didn't treat the root of the problem. Many times, I was made to feel like I was the problem. I was ostracised and felt let down. The path I've chosen has given me the understanding to know that this disease is separate to who I am. It can be controlled, it can be conquered but I have to take charge of my own life and be the maker of my own path.

Much more is needed in terms of educating our communities. Children should never experience what I experienced, and the sad reality is that despite all the advances in technology and social interaction making the world a smaller place, we're still found lacking in making these resources for help available to our younger generation.

When it comes to mental health, making professional avenues of help available to all those in need

within our communities should be prioritised. Traditional remedies will always have a place in our communities, but they should never supersede acquiring professional help. Psychiatric intervention saved my life and gave me my identity back.

Delving into the ideologies of behaviorism, and psychoanalytics, I find myself wavering on the side of psychoanalytics. Indeed I allowed my community to choose my identity, rather than embracing who I was. Ultimately, I had to seek help and find the courage to be who I am, without shame, without doubt and without guilt.

In the end, I am who I am, because I choose to be. In the eternal words of Carl Jung, the first half of life has no meaning, what is important is to be aware of aspects of self that have been neglected. For myself, I see the improvement in my mental health every day.

That is not to say that the hallucinations won't come back but be assured that should they come back, I now have the tools to conquer this fight. **MHM**

