VOLUME 10 • ISSUE 6 • 2023

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Making Mental Health Matter

THE ROLE OF TRADITIONAL HEALERS IN THE TREATMENT OF MENTAL HEALTH

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Perceptions and impressions of what is mental illness, its causes and preferred treatment differ significantly from one cultural context to another. Consequently, a holistic conceptualisation and ways to care for mental illness are typically dependent on sociocultural, spiritual, and economic factors. Within the African and particularly the South African context, people are considerably influenced and guided by religion and traditional beliefs, which generally have an impact on how they perceive mental illness. Several studies on mental health in Africa state that mental illness tends to be linked to witchcraft, punishment for sins, and supernatural causes. So, people seek out mental health care from providers such as priests, spiritualists, and/or traditional healers. The use of water, biblical verses, fasting, prayer, and counselling is common.

Relative to other African countries, South Africa, as a young democracy, is still divided between the Western and African philosophies. Despite this, traditional African healing has been in existence for many centuries and the use of traditional and indigenous medicine is not a new practice. Traditional healing used to be dominant in the rural areas because of the tendency towards the cultural way of living in those areas. The situation has changed in the 21st century with the influx of people from the rural to semi-urban and urban areas in pursuit of better economic conditions.

Traditional healers are recognised, in South African communities, as a significant source of care including mental health care. They provide a belief system that compliments individual's cultural belief in terms of the causes of mental health problems and, as a result, the treatment for them. These healers are available and easily accessible to the society. Relatively, the traditional healers are affordable when compared

to the formal professional mental health care services. Given the scarcity of mental health services, especially in the rural and underserved parts of South Africa with fewer psychiatrists and psychologists, traditional healers are used even more so. Furthermore, consultation with formal mental health care practitioners seems uncomfortable due to fear of a formal psychiatric / psychological diagnosis. Particularly in the African communities, people suffering from mental health conditions are stigmatised.

The aetiology and treatment of mental illness is understood in a variety of ways including possession by spirits in some conditions. Witchcraft and ancestor spirits are common cultural beliefs thought to have caused mental health illness and this guides the African's health seeking behaviours. According to several studies, there seems to be increasing evidence that supports the contention that traditional healers can deliver effective psycho-sociocultural solutions, facilitating social engagement and improving coping mechanisms. The following case scenario demonstrates how traditional healing can be integrated holistically in treatment.

"Mabel (pseudonym) is a 54-year-old African lady who was brought by her husband to an academic hospital a month back following multiple complaints including back pains, walking difficulties, worry, exhaustion, and insomnia. After medical examinations and tests, she had been admitted in the spinal unit with a diagnosis of TB of the spine and was due for a corrective surgical procedure. Two weeks into admission, a referral to the psychologist and psychiatrist were made for multidisciplinary management following Mabel's depressive and anxiety symptoms and subsequent deterioration. The treating orthopaedic surgeon mentioned that Mabel had not been herself and was unresponsive to treatment. Specifically, she stopped attending physiotherapy, slept a lot and has had difficulty eating. She lost weight, inquired a lot about the anticipated surgery, was uncooperative in the ward, and her mood was relatively sad and irritable. When questioned by the psychologist Mabel acknowledged that she was exhausted and in pain. She further explained that she feared for her life and lost hope when her doctor refused her 'a discharge' to go home and consult the family's traditional healer. She believed that she needed her traditional healer's opinion concerning the diagnosis but most importantly whether to go ahead with the planned surgical treatment. She suspected witchcraft because, according to her she started experiencing problems after her son bought a new car. She also questioned how come the hospital allowed a priest to pray and counsel patients (without her consent) but refused her a visit to her 'ngaka' (traditional healer)*

Through the psychologist's intervention, a weekend leave of absence pass was arranged for Mabel to benefit from some time outside of the hospital while still an inpatient. Being with family and having consulted the traditional healer seemed to have reassured and informed her healing process. She mentioned that the traditional healer ruled out witchcraft and acknowledged that spinal tuberculosis was a family disease. As stated by Mabel, she understood that she inherited the medical condition from her ancestors. She was encouraged to undergo the surgical procedure as proposed by the medical team. She came back optimistic and uplifted to continue with the hospital treatment."

Insight into the relationship between cultural beliefs, perceptions, and mental health may inform interventions that could enhance the understanding of the causes of mental illness, fast track commencement of treatment and reduce the duration and the severity of the condition. As seen in the case study above, Mabel* was slowly drowning into depression due to her own perception of her condition. She felt misunderstood and needed her traditional healer's intervention. Denying her a consultation with her trusted source of care would have possibly delayed and complicated her healing process in more ways including physically (TB spine) and mentally (depression).

Concerns about harmful practices associated with traditional healing and the absence of scientific evidence on safety and effectiveness of traditional mental health care have been raised. On the other hand, traditional healers continue to play a significant role in mental health care. What is more concerning is the increase of mental health conditions taking a huge toll and causing suffering especially in the poorer communities. Given the scarcity of (western) trained mental health care practitioners in state facilities and the large quantity of traditional healers in both urban and rural areas, there seems to be a demand for integration of traditional healing into mainstream health care system in South Africa.

The previous Minister of Health, Dr Manto Tshabalala-Msimang supported and advocated for the need to have such a collaboration to alleviate pressure carried by the health care system. This will also help regulate the traditional healing system. Traditional healers should not be overlooked when it comes to holistic mental health. As an alternative, they should be engaged gainfully to promote better understanding of mental illnesses, diagnosis, and possible referral, while at the same time discouraging harmful practices. This can be done through efforts to formalise and standardise traditional healing, integratively, into mainstream health care system through development and implementation of policies, training programmes, research, and regulatory methods.

References available on request. MHM

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MENTAL HEALTH MATTERS
is published by In House Publications,
P.O. Box 412748, Craighall, 2024.
Johannesburg, South Africa

Cell: 082 604 5038
Email: inhouse@iafrica.com
Website: ihpublishing.com
ISSN: 2313-8009

PUBLISHER
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Interview with Dr Mvuyiso Talatala
Psychiatrist (SASOP)

SCHIZOPHRENIA PATIENTS NOT RECEIVING ESSENTIAL CARE

Schizophrenia, although affecting only about 1% of the population, is a profound mental illness for which over 80% of individuals do not receive the essential mental health care needed.

The South African Society of Psychiatrists (SASOP) called on this year's Mental Health Day for the government and medical schemes to enhance mental health care for individuals with schizophrenia, aligning with the United Nations Sustainable Development Goals, the World Health Organization's Comprehensive Mental Health Action Plan 2013–2030, and South Africa's National Mental Health Policy Framework and Strategic Plan (2023-2030).

Dr Mvuyiso Talatala, Past-President of SASOP says schizophrenia patients face a significantly higher risk of premature mortality, with their life expectancy reduced by 10 to 20 years, and the lack of access to mental health care is weakening their quality of life as well as their families.

"Schizophrenia is a debilitating mental illness characterised by episodes of psychosis, which encompass symptoms like hallucinations, delusions, disorganised behaviour, and incoherent communication. Without timely intervention and proper management, schizophrenia can have severe consequences on social, occupational, and interpersonal functioning."

"While precise data on the prevalence of schizophrenia in South Africa is lacking, the challenges faced by patients are evident in our healthcare facilities. These challenges include limited knowledge about the illness, difficulties accessing care at the primary level, insufficient access to appropriate medications, inadequate support for both patients and their families, resource limitations within the healthcare system, and the persistent stigma surrounding mental health issues."

Dr Talatala emphasise that stigma remains a significant obstacle to the proper treatment of individuals with schizophrenia.

"The stigma is glaringly evident in the insufficient funding allocated to mental health care, despite the devastating consequences of untreated mental illnesses like schizophrenia. Shockingly, less than 5% of South Africa's healthcare budget is directed towards mental health care, encompassing contributions from the private sector."

"A considerable portion of this budget likely caters to individuals with severe mental illnesses like schizophrenia, but it predominantly focuses on hospitalisation rather than community-based mental health care services and district hospitals. Existing plans and policies designed to ensure equitable resource distribution to the community have yet to be fully implemented. In addition, injectable antipsychotics, recommended for ensuring treatment adherence, are still not widely prescribed for individuals with schizophrenia."

He says in the private sector, the regulations of the Medical Schemes Act stipulate 21 days of hospitalisation per year for individuals with schizophrenia, with limited guidance on outpatient care, despite the existence of treatment algorithms for schizophrenia that advocate for comprehensive outpatient care.

"Medical schemes are often hesitant to fund outpatient care for people with schizophrenia. In the public healthcare system, the predominant approach revolves around providing care for individuals with schizophrenia only when they are severely ill and in need of hospitalisation. Despite the current reliance on hospitalisation as a cornerstone of schizophrenia treatment in South Africa, there is still a shortage of psychiatry beds, falling short of the recommended target of 28 mental health care beds per 100,000 population."

SASOP urges both the government and medical schemes to bolster community-based mental health care services for individuals with schizophrenia, requiring increased funding and improved care models.

Dr Talatala says, "This includes providing sufficient space for therapists in community-based clinics, implementing relapse prevention strategies for schizophrenia in both the public and private sectors, early diagnosis and treatment, preferably with injectable antipsychotics, adequate treatment of schizophrenia and the management of substance use from the first episode, and better funding for community-based care to ensure treatment adherence and adequate psychosocial support."

"Overcoming the stigma associated with schizophrenia demands that it be recognised as a priority by both the government and medical schemes. Overall, South Africa must strengthen its community mental healthcare services to reduce barriers to access for individuals in need."

References available on request. MHM

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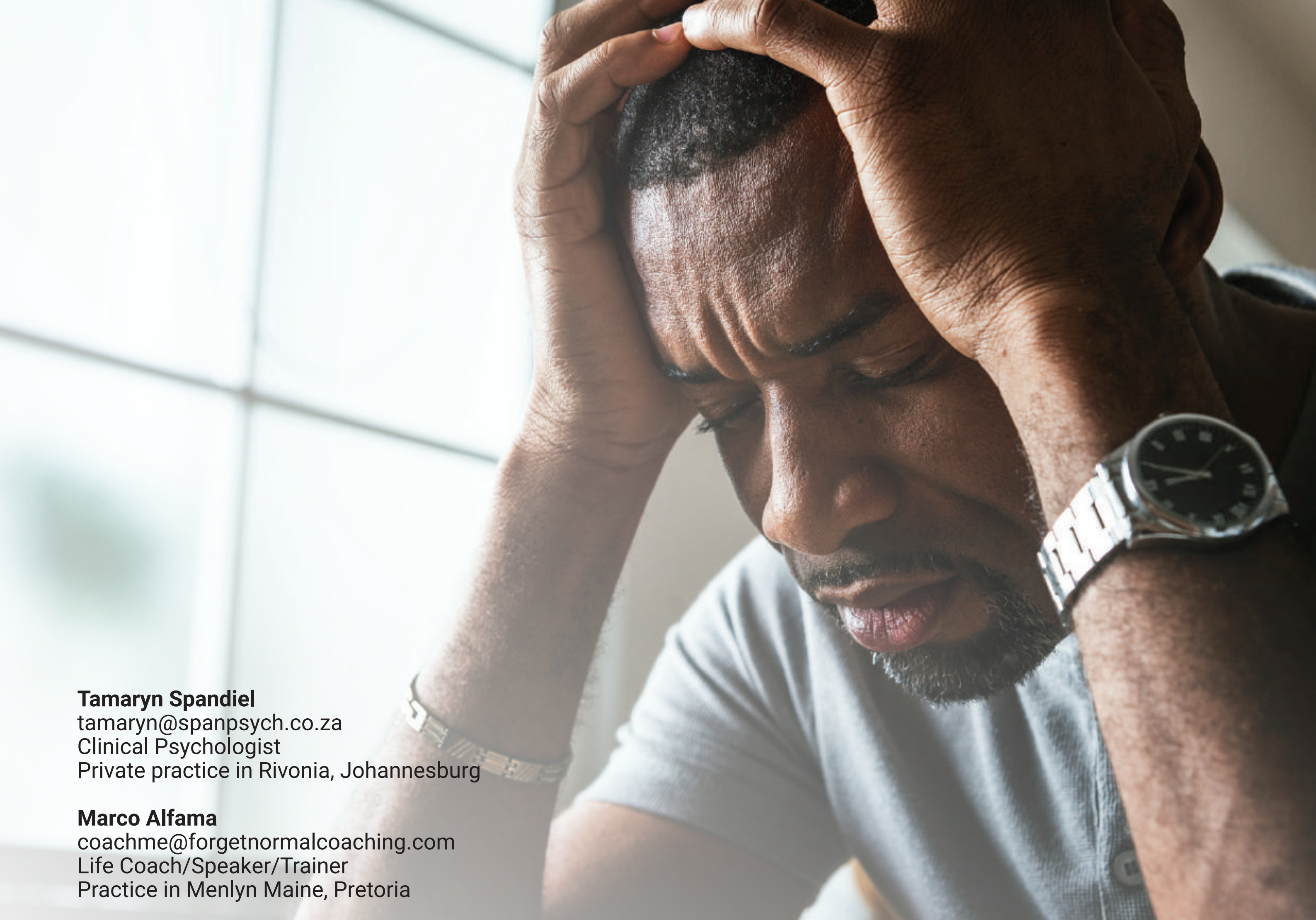

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LET'S START TALKING ABOUT MALE SUICIDE

International Men's Day is observed November 19 each year and the aim of this day is to address the unique challenges faced by men. These include but are not limited to, promoting healthy masculinity, raising awareness around men's health, as well as celebrating their lives, achievements and contributions in different areas.

The theme for 2023 was "Zero Male Suicide". Suicide is a profound societal issue and the mental health issues around men are often overlooked. It's time for us to break the silence and work together to create a world where no man feels he has no way out. Suicide is the 10th highest cause of death globally and men die by suicide four times more often than women. We need to start talking about male suicide more seriously.

By talking about the real problems that men face, it doesn't devalue or detract from the struggles women go through. We need each other. In Portuguese there is a word "conviver" which means to live and get along with each other as a community. This concept is paramount to our wellbeing. We can only address male suicide if we work together.

To achieve "Zero Male Suicide" we must start by dismantling the stigma surrounding men's mental health. Men, often conditioned by societal expectations to be stoic and resilient, may find it challenging to express vulnerability. Being stoic and resilient can be amazing traits and goals in our lives but that should not get in the way of asking for help when it is needed. As practitioners, we need to foster an environment where seeking help is seen as a sign of strength and not weakness. We need to work towards helping men feel comfortable about opening up conversations about mental health where no one feels judged for sharing their struggles.

The problem that arises is that men often express their feelings differently and in different environments when compared to women. The system as it exists right now may not feel ideal for opening up for men, as it may mean going against what they feel is their nature in some or other way. If we pay attention, we may

notice that men require an action, project or space to organically open difficult conversations versus actively starting a conversation and speaking openly about their feelings. Men may worry that by using the latter approach, that they may be shut down, dismissed or emasculated. The reality is that we all need to use sensitivity and stoicism at different times in our lives. Knowing when to use each of these is what can make the difference.

The Operations Director, Cassey Chambers, at the South African Depression and Anxiety Group (SADAG) stated "the interesting thing is that more women are diagnosed with depression than men and not necessarily that women have more depression than men. Men just don't talk about it and don't seek help". This is a huge societal concern. The statistics surrounding male suicide are alarming, and each number represents a life lost, a family shattered, and a community affected. Behind every statistic there is a unique story of a person who suffered in silence.

When we take a closer look at suicide, we find that men use more "aggressive" methods of suicide and have more access or means to complete suicide. Women may overdose on medication rather than hanging themselves or using a weapon which is often found in the case of a male suicide. There is never one reason or contributing factor that results in suicide. It's a combination of difficulties; each case is unique and different. It could be a relationship with family, partners, colleagues, wives and friends. Trauma is also a unique contributing factor. We should not forget that financial status may add to challenges such as losing a job, difficulty finding work, increased stress at work and all other financial aspects, which may contribute to men taking their own lives.

Spring is also a useful time to be aware of potential suicides. Difficulties manifest differently for different people and that is why it is important to get to know your patient as there are often patterns to pick up difficulties. Seasonal depression is an example of this. In winter the patient may be very depressed and will not have the physical and mental capacity to act on their suicidal ideation. However, as the weather changes, energy levels lift and whilst still in a depressive state the patient may have just enough capacity to plan and act on their suicidal ideation. Sometimes, we as practitioners may miss this very crucial period which may just save a life.

Now that we have somewhat fleshed out what suicide may entail, let's look at what suicide prevention looks like. It doesn't only include providing support when men are in crisis but also checking in with them when things seem off or their behaviour is unusual. Practical tips that may just save a man's life include but are not limited to:

- noticing changes in behaviour,
- noticing when men become unusually quiet, and check in on them,
- noticing when men are not acting their normal selves,
- checking in when men have disengaged or lost interest in activities they usually enjoy, and
- noticing increased feelings of guilt, shame or that they are a burden to others.

As practitioners we need to be sensitised to the patient's unique difficulties and not just listen to what they are telling us but what they, perhaps, not saying or what is behind what they are communicating.

Men just like women, are yearning for connection. It's a fundamental human need. Men have emotions and need a functionally specific manner to understand and work through them. Men want to grow, support, and love the significant others in their lives. Let's celebrate men and their significant achievements to society. Let's notice differences in personality or character that do not divide us unless we chose to discriminate. Let us rather work together in humble and complimentary ways to be bigger than the sum of our parts. The first step towards all of this is getting unstuck from unhealthy patterns and becoming open to facing the messiness in each of us.

Achieving "Zero Male Suicide" is not just a goal; it's a call to action. It requires a commitment from each of us to create a society where mental health is prioritised, and every man feels valued and supported. Together let us strive for a future where no man walks alone in his struggles, and where the darkness of despair is replaced by the light of hope. Why do we acknowledge International Men's Day? To promote basic awareness of men's unique difficulties. Also, to celebrate their lives, achievements, and contributions in their various communities. It is of utmost importance to acknowledge the different roles men play in our community and how these are often extremely challenging.

"Soak up the views. Take in the bad weather and the good weather. You are not the storm."
- Matt Haig

References available on request. MHM

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BURNOUT IN SOUTH AFRICA: IS THERE ENOUGH LEAVE?

The average working adult human brain can concentrate (to focus on a particular topic, task, or stimulus) for up to two hours before needing a 20-to-30-minute break. The average working adult human brain can pay attention (to remain interested for the benefit of understanding) between 20 and 50-plus minutes before needing a break. The human brain has biological limitations and the importance of taking a break before returning to a task or stimuli increases the ability to function at optimum.

How long then does it take before someone needs to go on leave for them to function optimally? Not only just the break at the end of a workday or the break during the weekend but a complete switching off, before returning to work or even their daily home life.

According to the South African Labour Relations Act full time employees are entitled to 21 days annual leave (consecutive or in segments) and 30 days sick leave per 3-year cycle. There are also some other leave provisions such as family responsibility leave, maternity or paternity leave, study leave, unpaid leave, and sabbatical that vary per company or institution. Despite the aforementioned leave that South Africans are entitled to, I have seen a strong pattern of severe burn-out in the adult working population in psychotherapy. For those who have not chosen to work longer hours or for longer periods of time, or for those who don't fit the picture of being a workaholic, burn-out can be clearly linked to not taking enough breaks from work.

In South Africa, school or tertiary teachers (despite common debates about their low salary and needing to mark papers during their break) have been the envy of most when is comes to the amount of breaks they are afforded due to their work hours or responsibilities coinciding with the school or tertiary

holidays. In one year, both primary and tertiary school attendees (including teachers, lecturers, and associated staff) have a break of between (more or less) 100 to 203 days depending on the tertiary (study leave, course etc.), school institution (private or public), and depending on the exclusion or inclusion of public holidays. That is between 4 to 10 times more rest than the general adult working population is afforded. However, the South African adult working population are diagnosed with the most chronic diseases of lifestyle (diabetes mellitus, high cholesterol, stroke, heart attack/myocardial infarction, hypertension); these are immensely intertwined with work-life balance or lack thereof and ultimately burn-out. The working adult population are also the main labour force of the economy of South Africa, yet the least allowed to recuperate to continue to contribute to this work force.

There also seems to be an unwritten rule that the working adult population need to hold on until retirement to switch off and enjoy the fruits of their labour. However, the way the work and leave system are structured, by the time people reach this age (60 to 65 years) they are likely to have burnt out their bodies and mental states, with many having accumulated severe chronic lifestyle diseases and developed poor coping habits such as smoking, drinking, and excessive indulgence in unhealthy food. Some of these adults may also adopt psychological mechanisms such as quiet quitting (doing the minimum at work), cutting corners, or complete absence from work, just so they can feel a sense of relief from not having enough rest.

Recent studies have shown that individuals are able to work past the previously set retirement age due to advances in medicine and the need for vocation in the geriatric population. Furthermore, when people retire too soon (may be person dependent) they are likely to struggle with boredom, lack of purpose which brings about depression or unhealthy coping mechanisms such as drinking, and over depend on their loved ones (emotional and financially). In addition, statistics show that 90% of South African's can't afford to retire.

Why then has there been an emphasis on the adult working population to overwork rather than thoughtfully pace themselves throughout their adult and initial geriatric lifespan?

The health system is often burdened by additional responsibility that can be mitigated by putting in place better preventative systems on a level of policy setting in the field of labour relations. South Africans could benefit from having more days of leave from work (both structured an unstructured) in tandem with being educated on living healthy mental and physical lifestyles. This is despite the fact that at 21 days annual leave South Africa is fairly in line with the top 10 countries of the best leave allocated to employees: France being the highest at 30 days annual leave. Currently, the leave allocation per the Labour Relations Act does not appear to be determined by the physical and psychological needs of employees. Thus, the allocation of leave days as it is in South Africa (and in fact globally) is quite a poorly researched topic, appearing to be focused on cost to company and the economic life force and less so on health-based research.

In conclusion, if it takes 21 to 28 days (may be person dependent) to break a habit, or mentally rewire the mind as various research supports, then perhaps for every four months of the year employees should be allocated 21 days of leave. This would mean 63 days of annual leave excluding the approximate 12 to 14 days of public holidays in South Africa. In total this would potentially tally up to 77 days of leave per year (over two months of rest) for a 10-month working period. With the addition of sick leave (that would be dependent on each individual), this may contribute positively to South Africans experiencing less burn out, which also cost company's an immense amount of money per year.

References available on request. MHM

Dr Alicia Porter
Psychiatrist

CONFRONTING WORKPLACE BULLYING AMONG DOCTORS

THE SILENT PANDEMIC

Workplace bullying among healthcare workers has been termed "the silent pandemic", although there has been a lot said in the past few years on the topic in the media. Workplace bullying is a global phenomenon that has been described by the World Health Organisation (WHO) as "a major public health problem". There is reported prevalence, which varies from 0,3% to as high as 86,5%, depending on the investigator's methods and definitions of bullying. Even at the low estimates, it is suggestive of a problem of great magnitude. Studies have suggested that bullying occurs more frequently in the healthcare sector than in other workplace settings. This has been theorised to be due to: the interpersonal and emotional nature of healthcare work, the hierarchical structure of healthcare institutions, and the conflicting priorities of multidisciplinary teams.

There are varying reports of this, with young doctors feeling victimised by senior doctors questioning their work ethic and efficacy. This has been somewhat normalised within our healthcare sector, with many doctors having examples of this during their training years.

Workplace bullying is represented by a persistent pattern of unwelcome conduct that a reasonable person in the same circumstances would consider unreasonable, and it is often enforced by those who are not of "equal strength". The bullying includes behaviour that is belittling, intimidating, offending, humiliating, or disempowering, and has the cumulative purpose of effect of harming an employee's health, reputation, career success, or ability to perform. While workplace bullying has been normalised to some degree, these definitions assist us to recognise that what is happening within the healthcare sector may not be as acceptable as it is set forth to be.

Within a study in South Africa where experiences of workplace bullying among academics in health sciences were investigated, it was found that 58% of respondents experienced workplace bullying, with 44% having experienced it more than once, and 2/3 of respondents reporting that they had witnessed bullying. Workplace bullying within

the healthcare sector was reported to be more prevalent amongst junior staff and registrars, and in females more than males. A higher percentage of bullying was present in those who identified as Black, Asian, or Coloured.

MENTAL HEALTH CONSEQUENCES

The mental health of medical students is under threat, with 1 in 4 experiencing a Major Depressive Disorder, 1 in 5 experiencing an anxiety disorder, 1/3 at risk for MDD and ½ at risk for anxiety. What is concerning about this is that it means that junior doctors entering the workforce may be entering the space already struggling with their mental health, magnifying the consequences of workplace bullying.

Bullying itself has been associated with altered hypothalamic-pituitary-adrenocortical (HPA) axis, a complex set of endocrine interactions eliciting cortisol responses. HPA-axis dysregulation has been associated with adverse health consequences such as depression, anxiety, sleep disorders, burnout, obesity, diabetes, and hypertension.

A large meta-analysis found that of all psychological stressors the largest cortisol changes were associated with tasks containing uncontrollable or social-evaluative elements, which is particularly relevant within the medical workforce. Healthcare work is inherently socio-evaluative, with interpersonal interactions involving judgement from patients, family, and colleagues. Bullied healthcare workers may therefore be at particular risk of cortisol dysregulation and the associated health consequences.

A review of the evidence found that workplace bullying was significantly associated with poor mental health, including conditions such as depression, burnout, anxiety, suicidal ideation and attempted suicide, and intense psychological distress. Physical health consequences of workplace bullying include insomnia, sleep changes, and sleep deficiencies, headaches, gastrointestinal problems, and nausea. These are independent or not necessarily as a result of the aforementioned mental health challenges that were reported.

With regards to sick leave, there was reportedly a much higher rate of absenteeism and sick leave from both physical and mental health consequences, and lends itself to decreased productivity and decreased motivation. These consequences impact not only the individual, but the team and the system as a whole, creating adverse impacts on an already-strained healthcare system within our context.

HELP AND HOPE

Fortunately, there is help available. On an individual level, the Healthcare Workers Care Network (HWCN) is available to support all healthcare workers, with both a prevention and treatment option available. HWCN is available to reach 24/7 at 0800 21 21 21.

Group support is also available through the HWCN, with a monthly group meeting available on the last Thursday of every month via Zoom. Details are available at healthcareworkerscarenetwork.org.za.

Although there is a high prevalence of workplace bullying in South Africa, both experienced and witnessed, it shouldn't fall on the individual to deal with these. There is a call for systemic changes in organisational culture, including policies legislated for management of negative workplace behaviours. There is hope on the horizon – there is a new code of Good Practice on the Prevention and Elimination of Harassment in the Workplace, which was effective as of 18 March 2022, and has placed a duty of care on employers to play their part in preventing and managing workplace bullying at a more organisational level.

References available on request. MHM

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GENDER IDENTITY DIVERSITY IN INDIVIDUALS WITH ATTENTION DEFICIT/HYPERACTIVITY DISORDER (ADHD)

Today's generation of children and teenagers are increasingly questioning their sex assigned at birth and the use of alternative pronouns is becoming more the norm. The use of "they/them/their" is becoming gradually more common and gender is slowly evolving to be viewed as a "gender spectrum" rather than a binary one. For those living with ADHD, impulsivity, emotional dysregulation, and planning may further complicate this picture. More research and information are becoming available on how the notion of gender intersects with neurodiversity.

Both ADHD and gender identity or gender diversity are related to one's self-expression and their experience of the world around them. But before these topics are explored further, it's important to define a few terms:

- **ADHD:** is a neurodevelopmental condition that affects a person's ability to focus, regulate their emotions and control their behaviour. Additionally, ADHD can cause significant challenges in various aspects of life, such as at work, home, school or with relationships. Often, people with ADHD also struggle to navigate social settings and tend to have low self-esteem.
- **Gender identity:** The American Psychological Association defines gender identity as: "A person's deeply felt, inherent sense of being a boy, a man, or male; a girl, a woman, or female; or an alternative gender (e.g., genderqueer, gender

non-conforming, gender neutral) that may or may not correspond to a person's sex assigned at birth or to a person's primary or secondary sex characteristics."

- **Sexual orientation:** this defines who a person is physically and emotionally attracted to, based on their sex/gender.
- **Gender diversity:** This concept encompasses the many ways that people express their gender identity (not just the binary male/female concept). This is expressed through their appearance, behaviour, and use of pronouns or names (gender expression). Gender diversity also includes a person's sexual orientation and people who identify as transgender, nonconforming, non-binary, genderfluid, genderqueer, etc.
- **Gender dysphoria:** This is a negative reaction to a person's gender identity which creates discomfort and distress due to the incongruence between a person's sex assigned at birth and their gender identity.

Both ADHD and gender diversity affect how people understand themselves and interact with others. There have only been a few studies conducted on the correlation between ADHD and gender variance. A study from 2014 found that people with ADHD were more likely to experience gender diversity (gender variance). Another study from 2017 found that ADHD was a leading comorbidity (75%) in people who are struggling with gender dysphoria. It's important to note that there is still a lot of research that needs to be done in this field. Although the research is limited, it does appear that people with ADHD may be more likely to question their gender identity than people without ADHD. There are several reasons that researchers have theorised for this including:

- People with ADHD frequently face social exclusion, harassment, and disapproval from both their peers and the figures of authority in their lives. Consequently, many individuals with ADHD start to view the world from a different perspective and recognise that many of the demands imposed on them lack a clear rationale. As a result, they may choose to disregard these conventions in favour of developing their own systems and behaviours that more effectively accommodate their requirements and preferences.
- People with ADHD seem to have challenges with social interaction and self-regulation which may affect the way a person explores and express themselves.
- Gender identity development is a complicated process and symptoms of ADHD may impact this. People with ADHD often have challenges with their executive functioning, fitting into social norms, self-regulation, and self-concept and this could potentially lead to more exploration of their gender identity.

Many people with ADHD and gender identity diversity face a lot of stigma, discrimination and misunderstanding from others who do not experience or share their experiences or perspectives. This can affect a person's mental health and overall well-being. This may be further compounded by environmental and cultural factors.

Gender differences in ADHD prevalence

It's also important to be aware that throughout history, boys are more likely to be diagnosed and treated for ADHD-related symptoms than girls. It's thought that girls may be consistently underdiagnosed or misdiagnosed because of how the symptoms manifest in girls. Girls tend to internalise more of their symptoms, are less impulsive and have better coping skills than boys, so it may not appear as if they're struggling. Because they are less likely to seek help or be aware of their difficulties, it can result in the development of secondary psychological distress or co-morbid anxiety and depression. Some of the gender differences are highlighted in the table below:

GIRLS

- Less obvious and "internal" symptoms
- Tend to withdraw more than boys
- More likely to develop comorbid depression and anxiety
- More inattentive symptoms
- More likely to be more verbally aggressive rather than physically aggressive (teasing and namecalling)
- Hormonal fluctuations can influence ADHD symptoms

BOYS

- Obvious and "external" symptoms
- More impulsive than girls
- Seem to display more outward symptoms of hyperactivity
- More physically busy (running around)
- May be more physically aggressive

It's important to also consider these differences when thinking about ADHD, gender, and gender diversity. Healthcare professionals should be aware of the potential intersection of ADHD and gender diversity when a diagnosis and supporting their patients. Unfortunately, people who are gender diverse or transgender tend to experience more difficulties with their mental health and are more prone to self-harm and suicide. Providing a safe, supportive, and understanding environment for those who have ADHD and/or diverse gender identities, can help them significantly to improve their well-being.

While there is no significant evidence to support the intersection of gender diversity and ADHD, it's important to be mindful of this topic and understand the unique experiences that individuals may have, especially with the gender perspectives of the new generation of youth. It's also important to highlight that ADHD doesn't "cause" a person to question their gender identity or experience gender dysphoria. However, it has been suggested that ADHD may increase the likelihood of someone's exploration of gender. Although it can be a complex and sensitive subject for some, the more people are aware of these unique differences and challenges, the likelihood of people reaching out for support increases.

References available on request. MHM

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IT'S NOT ONLY THE ENVIRONMENT WE NEED TO PROTECT – IT'S OUR MENTAL HEALTH TOO

INTRODUCTION

Climate change has long surpassed being a threat and we are amid a climate emergency. It can feel overwhelming with local and global messages and campaigns about going green, recycling, reducing carbon emissions, and saving the planet. What is often missed is how we care for ourselves while living in a state of global warming and its far-reaching consequences. The increasing awareness and concern about the environmental crisis, coupled with the visible effects of climate change such as extreme weather events, rising sea levels, and ecosystem disruptions, contribute to feelings of distress, helplessness, and fear about the future. Climate change can directly and indirectly cause disruptive human pathologies that are physical and mental.

Although the climate crisis is a global one, it has incontestably more destructive and noticeable effects on communities living in the Global South, which have been marginalised and have fewer resources to adapt or respond to natural catastrophes. The global call to reduce carbon emissions puts limits on countries in the Global South to grow economies to equitable and comparable levels, with people already experiencing inequitable access to healthcare and whose livelihoods are affected by climate change events

ECO-ANXIETY AND ECO-DISTRESS

Climate change can have profound psychological impacts on individuals and communities, giving rise to a phenomenon known as eco-anxiety. Sometimes referred to as eco-distress or climate anxiety, eco-anxiety refers to a chronic fear of environmental doom and a sense of loss or impending catastrophe due to the worsening state of the planet. It can manifest in various ways, including anxiety, depression, feelings of grief, anger, or guilt related to personal carbon footprints, or the perceived lack of action taken to address climate change. In countries such as South Africa, we are also susceptible to feeling powerless in the fight against climate change due to other immediate pressing challenges such as lack of resources, unaffordable living costs, and not having the means to contribute to climate action.

There are many examples of climate-induced events in the South African context. Since 1980, there have been 86 weather-related disasters, which have affected more than 22 million people and have cost more than R113 billion in losses. In 2018, Cape Town weathered the "Day Zero" water crisis, nearly becoming the world's first major metro to run out of water. Record-breaking water scarcity like that experienced during the water crisis exacerbates urban fires. Fires are further exacerbated by densely populated low-income housing and reliance on fire and gas

for cooking. In April 2022, a year's worth of rain fell in two days across the provinces of KwaZulu-Natal and the Eastern Cape causing floods and landslides. More than 400 people died because of the floods, which also destroyed more than 12,000 houses and forced an estimated 40,000 people from their homes.

The psychological impact of climate change can extend beyond eco-anxiety. Natural disasters and environmental disruptions can lead to trauma, post-traumatic stress disorder (PTSD), and other mental health issues among those directly affected. Displacement due to climate-induced events like hurricanes, floods, or wildfires can cause long-term psychological distress, especially in vulnerable populations.

MULTIFACETED CLIMATE-INFORMED MENTAL HEALTH CARE

As much as there is a need for urgent climate action, there is also an urgent need to address mental health and care associated with eco-anxiety. To address the climate change – mental health crisis, care should entail the provision of eco-informed policies, engaging communities in eco-activism, integrating eco-awareness into research praxis and knowledge building, and eco-therapeutic counselling services and interventions.

Eco-informed policies form the foundation of climate action, and these refer to institutional, governmental, educational, and health policies. Engaging communities in eco-activism can foster a sense of agency and empowerment through activism, community engagement, and sustainable practices that can mitigate eco-anxiety. Young people, who are reported to be most affected by climate change events, have been at the forefront of climate action and visible in awareness raising. Encouraging climate action and promoting environmental stewardship not only benefits the planet but also provides individuals with a sense of purpose and hope, potentially alleviating some of the psychological impacts associated with climate change. Eco-awareness in research and knowledge building is to acknowledge the agency of the environment in research praxis. Theories have long acknowledged the role of the environment and it has taken on many forms from being defined as a space occupied by persons (such as the home environment or work environment) to a habitat where people find themselves in nature. However, acknowledging the environment does not often go as far as thinking through the agency of the environment or naming the environment as an active role player in research praxis. In my recent work informed by the theory of new materialism, we modelled the intra-related dimensions that affect one another and converge to produce behaviours in response.

Mental health professionals are increasingly acknowledging the significance of addressing eco-anxiety and related climate-induced distress. Therapeutic practices that integrate eco-therapy, mindfulness practices, and resilience-building techniques can help individuals cope with their eco-distress. It is a difficult area to work in for two reasons. First, while in other trauma work, clients may be able to change environments, move to safer spaces or deal with the consequences of past traumas. When working with eco-anxiety, there is no place for safety from climate change and its catastrophic consequences. Second, if a counsellor is not attuned to the context-specific consequences of climate change or dismissive of anxiety linked to climate change it can compromise the treatment of clients.

Although not formally recognized as a disorder in the DSM-5 the symptoms are those commonly associated with anxiety, depression, and grief. While climate anxiety is largely considered an adaptive response, it is also acknowledged that maladaptive climate anxiety can occur when symptoms cause severe distress and greatly interfere with an individual's occupational and social roles. Current guidance prompts counsellors to rely on their expertise in treating anxiety, depression, and grief as they would when associated with other traumas and phenomena. There is a need for further capacity development in the mental health fraternity to address eco-anxiety and the mental health consequences of climate change. While organisations such as the APA have some guidelines available, there is a need for local contextually relevant guidelines. The Climate, Environment, and Psychology Division of the Psychological Association of South Africa (CESD, PsySSA) have taken on this task, and we welcome any input from others on this project.

CONCLUSION

The pressing issues posed by the intersection of climate change and mental health demand immediate, diverse strategies. The intensifying climate emergency has triggered a rise in eco-anxiety—a persistent dread of environmental calamities—and deep emotional strain due to the deteriorating state of our world. This anxiety isn't just an individual burden but also a shared challenge, with communities in less affluent regions disproportionately affected by their limited resources and heightened vulnerability to climate-related incidents. The psychological repercussions, such as trauma, post-traumatic stress disorder (PTSD), and enduring distress from natural disasters, underscore the urgent need for comprehensive mental health support. Addressing eco-anxiety necessitates a holistic approach that integrates eco-informed policies, community engagement in eco-activism, eco-awareness in research practices, and tailored eco-therapeutic interventions. Collaboration among policymakers, communities, researchers, and mental health experts is crucial in confronting the entangled issues of climate change and mental well-being. Collectively, with sustained efforts and collaboration, we can strive towards a more resilient and mentally healthier future in the face of the climate crisis.

References available on request. MHM

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MORE THAN JUST MEDICINE

Several weeks ago, I was asked to write an article for Mental Health Matters and was told that the publication is aimed at doctors, not at clients / patients. I was also given considerable latitude with regard to choosing a topic. This was at once daunting and exciting… which topic to pick? Then it occurred to me to ask myself, "What would my clients want to say to their medical practitioners?" If given a voice, what would they wish their doctors to hear?

There were several themes that emerged from my clients' stories about interacting with their doctors, and I have selected three of these to discuss here. In each case, there is plenty of research to corroborate patients' anecdotal experiences.

1. Clients want their medical practitioners to talk more to them about mental illness and mental health.

As we know, good physical health is closely linked to both mental and emotional health. When someone is struggling with one of these aspects, it almost always affects the others. This is why doctors – general practitioners and specialists - should be concerned with their patients' mental health and emotional wellness in addition to treating their physical ailments.

Ideally, the topic of mental health issues should come up early in the doctor-patient relationship, if possible, on the patient's first consultation, even if the person is seeing the doctor for a reason other than mental health. One way in which doctors can communicate the importance of mental wellness is to screen for it in the same manner that they would screen for physical disorders. Questions about mental and emotional health should be asked during the initial evaluation, along with other questions about a patient's personal and medical history.

Here are a few examples of

questions that can be used to elicit information about mental wellness:

- Has a patient felt depressed, sad, or hopeless recently, and if so, how often?
- Has the person had thoughts of suicide or self-harm?
- Are there any significant stressors in their lives?
- Has the person lost interest in activities they once enjoyed?
- Is the person having sleep disturbances such as bad dreams, insomnia, or problems with early waking?
- Has the patient noticed an unexplained change in appetite recently?
- Does the patient find it difficult to focus on tasks, or are they having difficulty making decisions?

There are also some "red flags" that doctors can look out for, which could signal the presence of underlying mental health problems. These include:

- Signs of impairment in work, home or school life
- Frequent infections
- Unexplained chronic fatigue, or persistent aches and pains
- Changes in appetite and / or sleeping patterns
- Alcohol or substance use
- Deterioration in personal hygiene or self-care.

2. A second topic that frequently features in my clients' conversations about their medical practitioners, is that they want doctors to have a more wholistic approach to patient treatment.

Individuals today, are increasingly aware of the influences of behaviour and lifestyle choices on their health. This is due in part to the abundance of information available on social media and the internet. Patients want their doctors to discuss ways to optimise their health through exercise, diet and good sleep hygiene. Linked to this, people are also wanting to have more conversations with their medical practitioners about non-drug treatments. One of the ways in which doctors can ensure that they advocate for whole-body health, is by communicating and collaborating across disciplines and specialisations. In so doing, healthcare practitioners can learn more about each other's roles and find ways to best address their patients' physical, mental and emotional concerns.

3. The third theme that I've chosen to discuss is something that causes patients much distress. It relates to the prejudice and stigma faced by individuals who have been diagnosed with mental illness.

Alarmingly, it has emerged that people with psychiatric diagnoses encounter discrimination and face false preconceptions when seeking help from the medical profession. This is especially true for female patients, but it applies to men with mental health challenges as well.

Unfortunately, the general public feeds into inaccurate, harmful stereotypes about people living with mental illness, but medical professionals can also display bias in their attitude towards and treatment of these patients. Despite their education and expertise, doctors aren't immune to implicit prejudice and they sometimes perpetuate stigma against mental health. Several clients report feeling judged and dismissed and they sometimes spend much time during medical appointments trying to convince doctors to take them seriously.

"Diagnostic overshadowing" - the process by which healthcare professionals wrongly attribute a person's physical symptoms to their mental illness - is pervasive in medicine. People living with mental illnesses feel that doctors disrespect them, judge their credibility as they describe their physical symptoms, and even ignore or dismiss their concerns. Clients find that, for instance, their doctors are less likely to believe that their severe headaches or stomach pain are symptoms of a serious illness and order further diagnostic evaluations, if the person has a history of depression.

In summary, my clients are asking their healthcare practitioners to pay more attention to mental health; to adopt a more wholistic and integrative approach to treatment; and to consciously and actively avoid adopting preconceived notions regarding patients with psychiatric diagnoses. The recent research indicates that my clients' requests are echoed by the voices of patients across the globe.

References available on request. MHM

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USE OF SCELETIUM TORTUOSUM FOR MENTAL HEALTH PURPOSES

INTRODUCTION

In a world where we often seek comfort in nature, herbal remedies are becoming increasingly attractive. This trend likely reflects a broader interest in alternative and complementary medicine, with attempts to find a balance between traditional and modern approaches to healthcare. In recent years, there has been growing interest in the potential of *Sceletium tortuosum* as a remedy for mental health issues.

WHAT IS *SCELETIUM TORTUOSUM*?

Sceletium tortuosum, better known as “kanna”, “channa” or “kougoed” (roughly translated as “things to chew on”) is a succulent plant native to South Africa. Traditionally, *Sceletium tortuosum* has been chewed, snuffed, and smoked, but it can also be ingested in the form of tea. The indigenous Khoikhoi and San communities have used this plant for its mood-enhancing and stress-relieving properties. More recently, these properties have drawn attention in psychiatric research as studies demonstrated *Sceletium tortuosum*’s potential effectiveness in treating mental health issues such as anxiety, depression, substance use disorder, and bulimia nervosa. It has previously also been noted that *Sceletium tortuosum* may be of benefit in the treatment of obsessive-compulsive disorder (OCD) given its apparent ability to inhibit serotonin reuptake. Not much attention has been given to the use of *Sceletium tortuosum* in common OCD-related disorders (OCRDs) such as trichotillomania (TTM, or hair-pulling disorder) and skin-picking disorder (SPD, or excoriation disorder), which also fall under the umbrella of body-focused repetitive behaviour disorders (BFRBDs). The understanding of BFRBDs is still evolving, and there is a lack of well-established, evidence-based treatments for many of these conditions, warranting further research.

WHAT ARE BODY-FOCUSED REPETITIVE BEHAVIOUR DISORDERS?

As the name suggests, BFRBDs involve self-directed body-focused behaviours such as compulsive nail-biting, cheek-biting, or nose-picking, and repeated unsuccessful attempts to decrease or stop the behaviour. TTM is another BFRBD, characterised by repeated hair-pulling despite efforts to stop, often resulting in significant hair loss or bald patches. SPD is also a BFRBD in which individuals excessively pick at their skin, despite attempts to stop, often leaving scarring and causing infections. Besides medical complications, these conditions have many psychosocial consequences such as feelings of embarrassment and shame after a hair-pulling or skin-picking episode and diminished self-esteem and self-confidence. Both TTM and SPD are associated with avoidance of social situations and difficulties in interpersonal relationships, which can further exacerbate the psychosocial consequences of these disorders. The aetiology is multifactorial, involving genetic factors as well as psychological and emotional components. Anxiety, stress and depression are often comorbid in these conditions and can trigger or exacerbate pulling or picking. The most effective treatment for TTM and SPD appears to be behavioural therapy, i.e., more specifically habit reversal therapy (HRT). N-acetylcysteine (NAC), olanzapine

or naltrexone may potentially reduce the problematic pulling and picking behaviours when used in combination with HRT. Treatment outcomes are disappointing and inconsistent, with only partial responses. Therefore, alternative, and more effective treatments are being explored, especially for areas where HRT or NAC is not available or affordable. Local researchers have become particularly interested in the therapeutic potential of *Sceletium tortuosum* (see, for example, Manganyi et al., 2021).

WAYS IN WHICH *SCELETIUM TORTUOSUM* MAY BE OF USE IN BFRBDS

As evident from *Sceletium tortuosum*'s nickname – "kougoed/ things to chew on", this plant is typically consumed orally. When ingested, the isolated key compound present in *Sceletium tortuosum* – an alkaloid known as mesembrine – interacts with the serotonin neurotransmitter which works similarly to the mechanism of action of SSRIs by inhibiting the reuptake of serotonin, allowing more serotonin availability in the brain, and thus enhancing mood, and lowering anxiety. As mentioned, people with BFRBDs often struggle with high levels of anxiety, which can trigger hair-pulling or skin-picking episodes. The anti-anxiety and mood-enhancing effects of *Sceletium tortuosum* could potentially help with emotional regulation in breaking the repetitive and compulsive nature of BFRBDs by decreasing urges to engage in hair-pulling or skin-picking. Due to these benefits and their herbal nature, many individuals may consider this natural agent an attractive alternative as fewer adverse effects are expected in comparison to synthetic pharmaceuticals.

Sceletium tortuosum use in BFRBDs in humans has not yet been studied. However, an animal study found that a low dose of *Sceletium tortuosum* reduced psychological stress in rats, which resulted in a 30% decrease in the time spent on self-soothing behaviour such as grooming. Further research on its potential to decrease self-soothing behaviours (arguably a component of body-focused repetitive behaviours) in humans was recommended and could provide insight into these behaviours in TTM and SPD. Another animal study done on rats found that *Sceletium tortuosum* had therapeutic potential in treating depression, a condition often comorbid in BFRBDs. Even though it has antidepressant properties, studies suggest low response rates to *Sceletium tortuosum* monotherapy, with recommendations for use in conjunction with evidence-based pharmaceutical treatment. Furthermore, *Sceletium tortuosum* decreases amygdala activity and increases serotonin availability and may thus reduce anxiety. Moreover, cognitive enhancement effects and positive impacts on emotional processing have also been associated with *Sceletium tortuosum* usage. Researching these properties in TTM and SPD would therefore add value.

CONCLUSION

Some research evidence and historical use support the potential psychiatric benefits of *Sceletium tortuosum*. However, research on the use of this plant in psychiatry is in its infancy and is non-existent in specific disorders such as these BFRBDs. Further research on the safety, feasibility, acceptability, tolerability, and efficacy of *Sceletium tortuosum* in adults with TTM and SPD is warranted.

References available on request. MHM

Disclaimer: It is essential to acknowledge that research pertaining to the utilisation and safety of Sceletium Tortuosum in human subjects is currently at an early stage of development. Consequently, this article does not advocate for its current use.

Interview with Dr Anusha Lachman
Psychiatrist
President of the South African Society of Psychiatrists (SASOP)

SHIFTING FROM A DOCTOR-PATIENT TO A DOCTOR-COMMUNITY FOCUS IN MENTAL HEALTH

With less than 5% of South Africa's healthcare budget directed towards mental health care, encompassing contributions from the private sector, the South African Society of Psychiatrists (SASOP) aimed to discuss interventions that delegate healthcare services to less specialised health workers at the community level, at their congress held from 19-23 November in Cape Town.

With the theme "Shifting the Paradigm towards Community Health and the Unheard Voices in Mental Health," the congress spoke to the urgent need to expand perspectives and inclusively integrate diverse voices in enhancing mental health care in South Africa and addressing the resource shortage.

SASOP's incoming president, Dr Anusha Lachman, says mental healthcare continues to be underfunded while mental health conditions such as anxiety and depression are on the rise.

"One in three South Africans suffer from mental illness, with 75% unable to access treatment. This is largely due to medical facilities being under-resourced, but also to the stigma, which is a persistent deterrent to seeking help," she said.

"The focus of the mental healthcare system is skewed towards more severe mental health conditions that affect less than 1% of the population. The underfunding of mental healthcare hampers prevention and diagnosis of mental illness, and limits access to treatment. We need to incorporate more lived experiences, patient perspectives and evidence-based options for mental health interventions at the community level as a way for us to deal with the huge mental health burden of disease. Part of this approach in Southern Africa is task shifting - the upskilling and shifting to lay people and communities to help co-manage mental health and also decrease stigma."

Dr Lachman says it's vital to address the persistent stigma surrounding mental health and to support family members for whom caring for loved-ones with mental health disorders is an immense challenge.

"We need to shift the focus to the unseen supporters and voices of advocacy. Families and community members often bear the burden of mental illness on behalf of the person diagnosed. This conference aimed to voice their struggles but also offer messages of hope, encouragement and advocacy."

The congress which took place at the Century City Conference Centre, Cape Town
saw psychiatrists, mental health activists, and community members, both locally and internationally, in attendance. More than 15 keynote addresses, 6 workshops, and more than 25 panel sessions were presented showcasing the unique and diverse strengths of Sub-Saharan Africa, unified in improving treatment, early diagnosis and intervention, and access to care.

One of the keynote speakers, Charlene Sunkel, who lives with schizophrenia, discussed her extensive work on the principles that can be applied to transforming current mental health practices, empowering front-line medical personal and how our entire society can work together in preventing mental illness and providing care.

The range of international speakers focused on the paradigm shift – moving away from a doctor-patient focus to a doctor-community focus, bringing lessons from other settings to collaborate on how better to support communities in the challenge of early recognition support and treatment of mental illness. level.

References available on request. MHM

SEEN AT SASOP 2023

VIATRIS
LYRICA
CELEBREX
Xanor SR
CONTRAMYL XR

adcock ingram
prescription
REAGILA
CARIPRAZINE
Cipralex
STRESAM

NETCARE
akeso

Exsira
desvenlafaxine
Pfizer

CNS
ARIZOFY

PRAMISUL
Amisulpride
PRAMISUL
AUROGEN
Dedicated to Patients,
Committed to Excellence:
Our Patients Health, Our Priority.
Depreta

SUBSTANCE USE DISORDER

"You cannot conquer that which you do not confront!" ***– Paula White***

Substance use disorder or addiction does not just happen overnight; it's a complicated process that gradually unfolds over time. The process of substance use disorder has various phases.

Firstly, you enter into the initial or experimental phase. This is where it starts, with just experimenting and trying it for the first time. Then you find yourself using regularly and more frequently without really noticing.

Then your body builds up a tolerance level to the substance. This means that you don't get the same "high" as before, which results in needing more and more to obtain the much needed high.

Next, you become dependent on the substance and experience withdrawal symptoms, so you have to use to be able to function. As a result, you lose control and start doing things that have significant negative consequences in all aspects of life, including relationships, work and your physical and mental well-being.

This is when the final stage kicks in – full-blown addiction or substance use disorder. At this point, your life is significantly impacted by the compulsive need to use the substance.

The reason why I started off with this explanation is to give context to what I am about to share with you, that being my personal journey being diagnosed with substance use disorder.

IN THE BEGINNING

I had it all – I was living the dream. I was employed in the banking industry, specialising in home loans. I got my learner's and license the first time round and was the youngest in my department, excelling in my career. My parents and family were very proud of me, and I was a role model to some in the community.

On the other hand, I was partying every weekend, whether it was

Byron Veldman

going to a club or a sports bar to shoot pool or just chilling at someone's house and drinking. I didn't know this was a steady build-up to a major change in my life and that of my family.

I felt good about myself, not knowing this was all a build-up to a part of my life that was not good. I always went out with friends every weekend, thinking I was drinking socially. Not knowing that I was headed for destruction.

I had many friends who always told me what I wanted to hear. Reflecting back on my life, I see now they were all there just for the fun times and the money I used to spend on them.

LIFE-CHANGING MOMENT

We were at a sports bar, shooting pool and drinking, when two friends of mine borrowed my car to pick up someone. They were gone a long time, and I went outside to see if they were back. I noticed my car standing far in the parking lot in a corner. As I approached the car, I saw the two of them sitting in front and smoking something. I got in the car and asked them what they were doing, and I also wanted to try it. I was drunk at that moment, and immediately after I had a "hit," I was sober again, and I couldn't understand it. That was the beginning of the end of the "good life."

After that first "hit," I couldn't get enough of the drug. I quickly spiralled out of control, and soon I was using every day. I had hit the regular use phase. With continued use, my tolerance levels went up, and I had to increase my usage every day, being dependent on the substance. I couldn't wait to finish work so that I could use. My work standard declined, and I wouldn't report for work on time regularly. I was dependent on crack cocaine now, and with this dependence came withdrawal symptoms, coupled with a range of emotional states like depression, isolation, anxiety, rage, anger, self-pity, regret. The list of negative feelings and emotions goes on and on.

Realising I'd lost control of my life and the use of the drug, things started to get real for me. I lost my job, my car, my friends and my family, and most importantly, I had lost myself. I didn't recognise the person staring back at me from the mirror anymore. I was officially a drug addict.

This went on for many years until I got "sick and tired of being sick and tired," and I had to reach out for help. My family has always been there for me, always wanting to help and at the same time being very cautious of my manipulation. I even believed my own lies and couldn't even remember the lies I told people to get money, but my family was always there for me.

I went through a total of four rehabilitation centres: one private rehab, one government and twice in a Christian recovery home, namely Victory Outreach Cape Town, then years later, Victory Outreach Johannesburg. I got saved by the grace of God in Victory Outreach, and I was very well-equipped with leadership skills, life skills, not forgetting my spirituality. To this day, I am truly grateful for what was ingrained in me by Victory Outreach because it's what is helping me stay clean.

Coupled with this, the process of going through a secular treatment centre was unmatched. I got equipped with tools so I could look after my overall well-being as a person. Here I'm referring to skills like conflict management, how to manage stress, drug prevention plans, active listening, assertiveness, conflict resolution, and rebuilding trust amongst other things.

The rocky road of addiction is not an easy one to embark on, and I'd like to encourage anyone who is reading this article, who might be struggling with addiction or knows someone who is battling with addiction, that recovery is possible. Why I say that is because I am here as a living testimony. There are FREE resources available for assistance, especially through SADAG; their support is immeasurable, and the level of professionalism is unprecedented.

LIFE AFTER ADDICTION

I have started a SADAG Support Group for families and friends of people who use substances, after having completed the free training and the support groups in Eersterust, Pretoria, at St. Joseph's Catholic hurch. We've had two sessions and are already averaging 12 attendees per session.

I can also very proudly say that it is by God's grace I'm now able to help others struggling with substance abuse by way of the organisation I started called Byron Veldman Addiction Support Services. Our services are Family Support, Referrals for Counselling/Treatment, and Educational Seminars on Substance abuse.

Why I use my name is a question I get asked a lot, and my answer is always the same – it's encouragement for others who are struggling with addiction, to say that once my name was synonymous with drug abuse and now it's known for the opposite - recovery. So, that eliminates the stigma attached to addiction and the so-called saying, once an addict, always an addict.

This past November, we had our first three-phase educational seminar on substance abuse on the first three Saturdays of November, with more than 150 people passing through the seminar across the three sessions. Focusing on the family and friends of the substance user is often overlooked, and this is where our focus is also.

In my experience, it has been helpful to believe in a higher power. This has provided me with the ability to let go of control and surrender to the process. Having a drug prevention plan in place and having an accountability partner are some of the strategies I have in place to support me on my journey of sobriety. Programs like NA, CA, and AA are also available as support on your journey of recovery.

Please don't give up on your loved one because there is always hope, and if you're battling with substance abuse, I implore you to "Make the choice to make the change" - Robin Sharma.

References available on request. MHM