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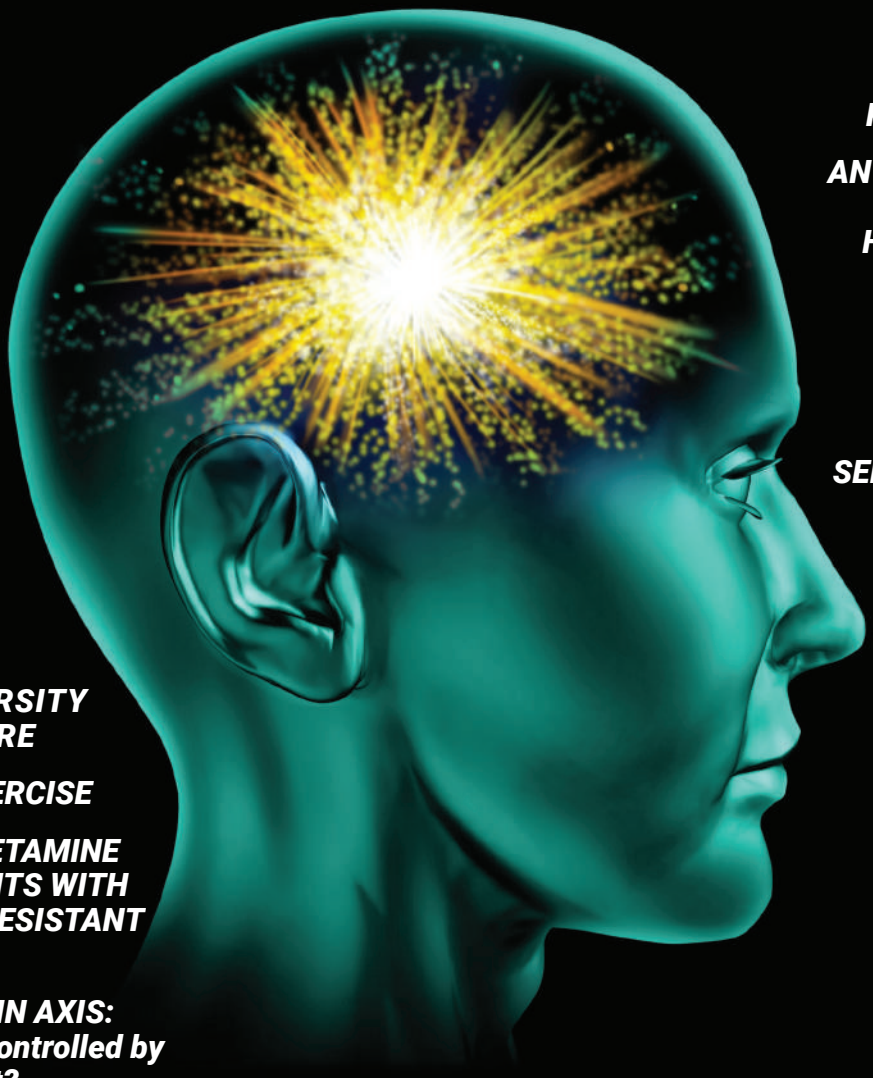
MHM

MENTAL HEALTH MATTERS



WHAT IS OUR RIGHT TO HEALTH?

AN ORGANISATIONAL CULTURE IN HEALTHCARE THAT SUPPORTS THE HEALTHCARE PROFESSIONAL'S WELL-BEING

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CRISIS INTERVENTION SKILLS FOR DOCTORS

THE SOUTH AFRICAN DEPRESSION AND ANXIETY GROUP

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Making Mental Health Matter

Chris McLachlan
Clinical psychologist

NAVIGATING GENDER DIVERSITY IN HEALTHCARE:

A GUIDE FOR DOCTORS, PSYCHOLOGISTS AND SOCIAL WORKERS

Today, we delve into a crucial aspect of healthcare: serving the trans, gender diverse and non-binary (TGDNB) community in South Africa. At least an estimated 3 in every 1000 individuals identify as TGDNB, making it imperative that we ensure they receive the care they deserve. It's noteworthy that South Africa boasts a robust Constitution that upholds the rights of all individuals, including those of the TGDNB community, further emphasising the importance of providing equitable access to healthcare services. However, TGDNB individuals often face significant barriers in accessing Gender Affirming Healthcare (GAHC), particularly those residing in rural areas.

The Participatory Approach: In our practice, we embrace a participatory approach. This means involving not only the TGDNB individual but also their immediate family (when feasible), support system, and community. Collaboration with other gender affirming healthcare providers, such as speech therapists, can also play a vital role in holistic care provision.

Affirmative Stance in Gender Affirming Healthcare (GAHC): Central to our approach in GAHC is affirmation. Recognising

gender as a spectrum of identities is essential. Moreover, understanding that diverse gender identities are natural and not pathological is fundamental to providing compassionate care.

Guidelines to the Rescue:
In our practice, we're fortunate to have access to valuable guidelines that assist us in providing quality care. The Gender Affirming Guideline, released by the Southern Africa HIV Clinicians Society in 2021, provide invaluable insights tailored to our region. This guideline was inspired by the Practice Guidelines for Psychology Professionals Working with Sexually and Gender-diverse People that was developed by the Psychological Society of South Africa (PsySSA). Additionally, the Standards of Care 8, crafted by the World Professional Association for Transgender Health (WPATH), offers a comprehensive roadmap for best practices in TGDNB healthcare worldwide. It's worth noting that many of us did not receive formal education on sexually and gender diverse topics during our studies, highlighting the importance of ongoing learning and professional development in this area. Here in South Africa, the Professional Association for Transgender Health (PATHSA) plays a vital role in supporting the healthcare community. Through avenues such as webinars, trainings, and networking opportunities, PATHSA facilitates learning and collaboration among healthcare providers.

The Importance of Education:
Continual education is paramount for healthcare providers. Staying informed about the latest research, attending workshops, and, importantly, listening to our TGDNB patients' experiences are crucial components of providing effective care.

Creating Safe Spaces:
Creating welcoming and inclusive environments in our offices is vital. Using correct pronouns, asking respectful questions, and advocating for our patients' rights are integral to fostering trust and respect in the patient-provider relationship.

Challenges and Solutions:
Undoubtedly, challenges may arise in providing care to TGDNB individuals. However, with creativity and compassion, we can overcome these obstacles. Whether it involves connecting patients with support groups or advocating for policy changes, there are myriad ways we can support our TGDNB patients.

Conclusion:
In conclusion, serving the TGDNB community requires a multifaceted approach rooted in affirmation, education, and empathy. By embracing these principles and leveraging available guidelines, we can make a meaningful difference in the lives of our TGDNB patients. Together, let's strive to ensure that healthcare is accessible and inclusive for all individuals, regardless of their gender identity. Social and/or medical transitioning enables a TGDNB person to live freely in this world, and it's our responsibility as healthcare providers, including doctors, psychologists, and social workers, to support them every step of the way.

Chris McLachlan
Clinical psychologist

Chris McLachlan is a board member of the World Professional Association for Transgender Health (WPATH) and co-chair of the World Health Organisation's (WHO) guideline development group. Chris is also Chairperson of Professional Association for Transgender Health South Africa (PATHSA) and chairperson of the Sexuality and Gender division (SGD) and council member of the Psychological Society of South Africa (PsySSA).

References available on request. MHM

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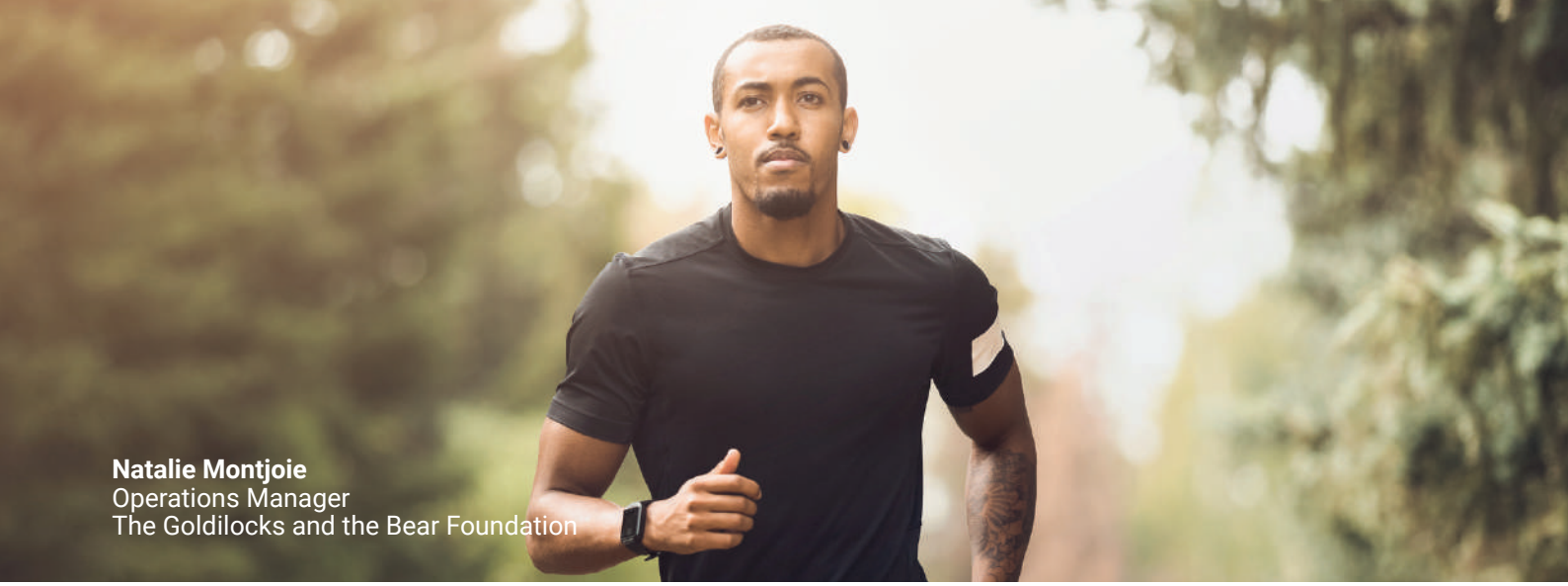

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ADHD AND EXERCISE

There are many benefits of exercise on mental and physical health. Exercise has been shown to assist with cognition, improve motor skills and coordination, as well as assist in improving the side effects of medication, namely of ADHD and in the management of comorbidities associated with ADHD.

While the benefits of regular exercise are numerous, when it comes to ADHD in particular, it has several notable positive effects.

ADHD is a neurodevelopmental condition that impacts attention, impulse control, and executive function. It is characterised by inattention and/or hyperactivity and impulsivity. Symptoms differ from person to person.

The cardinal symptoms of inattentive ADHD encompass distractibility, forgetfulness, poor organisational skills and low perseverance; whereas hyperactivity and impulsivity are associated with impatience for delayed rewards, difficulties in inhibition of untimely and inappropriate motor responses along with an inability to dampen motor activities to appropriate levels for a given situation.

When left untreated, a person with ADHD may find it hard to maintain attention, control their impulses, and manage their energy levels. Various methods can be employed to effectively treat ADHD, including medication, behavioral management techniques and other strategies, that may involve exercise.

Research has shown that exercise and medicine are very similar in nature, given that they must both be explicitly prescribed in an exact dosage specific to the individual. The same research states that to reap the benefits, you need to exercise in the correct manner and engage in the appropriate treatment dose.

The benefits of exercise for ADHD may or may not seem obvious – it tires you out and keeps you active. However, ADHD and exercise link in many ways, with evidence suggesting that physical activity can reduce difficult ADHD symptoms, including aiding in emotional regulation, providing an outlet for pent-up hyperactivity and boosting low dopamine levels. For this reason, it's important to understand the benefits of exercise, particularly when it comes to ADHD.

But what are the benefits of exercise on ADHD? If a patient is uncertain as to whether exercise does help ADHD, ask them to consider implementing an exercise routine to experience the benefits.

Here are some of the main benefits of exercising with ADHD.

Improved executive function

Some research suggests that regular exercise can improve executive function in those with ADHD. Executive dysfunction in ADHD can result in difficulties paying attention, managing time, organising and planning, and working memory. Often impacting work and school performance and causing conflict in relationships.

Physical activity can activate the same brain areas responsible for impulsivity, working memory and cognitive flexibility. Individuals with ADHD can in turn experience increased clarity and focus. Therefore, in kids and adults with ADHD, regular exercise can be a promising adjunct treatment method for improving executive function, which is one of the main skill groups affected by the condition.

Reduced hyperactivity

Hyperactivity can interfere with daily living, with many individuals feeling restless and fidgety. Children may struggle to sit still in class, while adults with ADHD may appear run by a "motor" or talk over others.

Regular exercise can help individuals manage hyperactivity at any age by providing an outlet for excessive/ pent-up energy.

Research suggests that exercise offers several benefits for children with ADHD, including less aggressive behaviors, improvements in anxiety and depression and fewer thought and social problems.

Emotional regulation

Individuals with ADHD may experience emotional dysregulation. In many cases their responses seem disproportionate to the cause. In the long-term these difficulties can exacerbate relationship conflict or lead to impulsive behavior.

Exercise has a positive effect on the limbic system, which regulates emotions. Regular exercise also raises the baseline levels of dopamine, norepinephrine and serotonin, providing a sense of calm and clarity. This in turn, contributes to a general sense of wellbeing by regulating anxiety, mood, aggression, appetite and sleep.

Dopamine release
Dopamine deficiencies are common in individuals with ADHD, often contributing to low task motivation, difficulties focusing and other core symptoms of ADHD.

Instead of seeking impulsive or disruptive dopamine-boosting behavior (i.e. compulsive shopping), exercise can provide a natural and healthy source of dopamine.

Brain-derived neurotrophic factor (BDNF)
BDNF – The "master" molecule in your brain that affects learning and memory.

It has been shown that exercise can enhance the concentration of BDNF in your brain, which correlates with better memory.

Exercise and ADHD: Finding the best activities

The Center for Disease control and Prevention (CDC) recommends that children ages 6 and older get at least 60 minutes of physical activity each day to maintain a healthy weight and promote proper development.

These guidelines apply to children with ADHD as well.

The 60 minutes of physical activity can comprise a combination of various activities throughout the day. Activities could include:

- Going for a bike ride with family
- Playing soccer, tennis, basketball or other sports
- Jumping rope
- Going for a family walk
- Group activities such as karate or dancing

Just as physical activity is beneficial for children with ADHD, the same applies to adults.

For example, The CDC recommends 150 minutes of moderate intensity physical activity each week for adults. One could aim to do 30-40 minutes of moderate intensity exercise 4-5 days of the week.

The most beneficial types of exercise may vary from person to person. Most studies utilise aerobic exercise in research intervention; whereas many experts recommend following a structured programme that incorporates both cardiovascular and strength training exercise.

Adults have a wide variety of exercise options to choose from, all of which can positively affect their ability to manage ADHD symptoms.

Adults typically have a much more regimented schedule than children and should focus on portioning out a part of their day for exercise in order to promote consistency. Consistency is key to reap the benefits of exercise.

There are however barriers to exercise for ADHD. Individuals with ADHD may face challenges when attempting to exercise, as some symptoms can impact their ability to stay motivated. Because executive functions are important for forming habits, they may struggle to adopt long-lasting routines. However, dedication and support can go a long way in sustaining efforts.

The bottom line
Regular exercise may help some people manage their ADHD symptoms and can improve various areas of brain health, such as memory, learning, and mood.

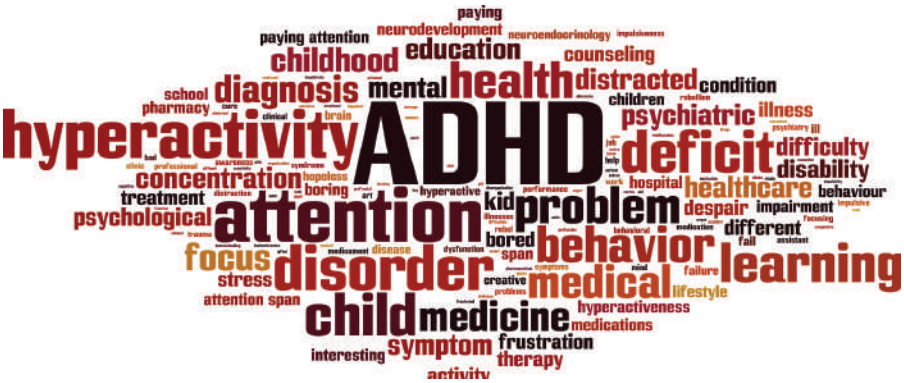
Specifically, in those with ADHD, exercise can promote the release of dopamine and other neurotransmitters, improve executive function, and alter BDNF.

Exercise is not a stand-alone treatment for ADHD, but it may complement other treatments to help manage symptoms in some people. An important view is also that no study has reported negative or adverse effects of exercise.

Regular cardiovascular and strength training exercise may be most suitable for relieving ADHD symptoms, but any form of exercise is better than none at all.

Exercise should be based on the concept of joyful movement and shouldn't feel like another task on your to-do list.

References available on request. MHM



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THE USE OF KETAMINE IN ADOLESCENTS WITH TREATMENT RESISTANT DEPRESSION:

WHERE ARE WE AND WHAT DOES THE CURRENT EVIDENCE SAY?

Introduction
Adolescent depression, a pressing public health issue, affects 3.5% to 8% of young people, with a lifetime prevalence nearing 20% by the end of adolescence. This condition is associated with high rates of relapse and significant developmental disruption.

Adolescent depression is associated with significant morbidity and mortality which includes:

- Poor social and scholastic functioning
- Unplanned pregnancy
- Increased risk of physical illness and substance abuse
- Increased risk of suicide, alarmingly it is the second leading cause of death in the 15-24-year age group

The Current Treatment for Adolescent Depression
The current treatment available for depression include:

SSRI's (Selective Serotonin Reuptake Inhibitors) which are effective for moderate to severe depression and quality evidence based psychotherapy are also reasonable options for adolescents with depression.

A second SSRI is likely a better option than an SNRI (Serotonin and Noradrenalin reuptake inhibitor) if an adolescent does not respond to the initial SSRI treatment, but a sizeable portion of children and adolescents with depression don't respond to first line treatments.

Ketamine, a dissociative anaesthetic has emerged as a promising alternative for treatment resistant depression in adolescents, so it's important to examine the available evidence.

The challenges with Depression in Adolescents: The Current Landscape

There are multiple challenges with treating adolescent depression and there are challenges with current available antidepressant medication. Current treatment can be effective for many, but a substantial proportion of patient's fail to experience a sustained remission. Approximately 40% remain depressed despite treatment. One in four patients don't achieve remission with available treatment strategies and one in four of those who respond can expect to relapse within a year. The current available treatments for depression take a long time to work and don't work on many patients, and there is a challenge if one of these medications doesn't work as they all work on similar mechanisms. There are few useful antidepressant trials in children and there are no fixed dosed studies, limited head-to-head trials of medications and poor data especially in younger children. This highlights the need for novel treatments to treat adolescent depression that target distinct neurochemical systems that are considered in a developmental context.

One such alternative gaining attention is ketamine, a dissociative anaesthetic. While traditionally used in surgical settings, ketamine has emerged as a promising option for treatment-resistant depression (TRD) in adults. Its potential effectiveness offers hope for those who have not responded to conventional treatments.

Treatment Resistant Depression in Adolescents and what we Know About Ketamine from Adult Studies

Treatment resistant adolescent depression is defined as depression symptoms despite an adequate trial of an evidence-based psychotherapy and an antidepressant with Grade A evidence for treating depression in adolescents (fluoxetine, sertraline, escitalopram).

Ketamine improves a range of depressive symptoms in adults, and it notably reduces anhedonia, a symptom associated with poor therapeutic response in adolescent major depression. Ketamine also appears to have effectiveness in reducing suicidality in adults, a dimension of adolescent major depression that has shown controversial associations with SSRIs. This makes ketamine a potentially valuable new treatment option for the adolescent population. Safety and success in treating adult treatment resistant depression, makes it a potential for consideration for use in severe treatment resistant depression in adolescents. Ketamine treatment is typically administered intravenously or intranasally under medical supervision and requires referral by a psychiatrist for the administration of its use.

Ketamine as an Alternative Treatment

Ketamine entered medical use in 1964 and gained FDA approval as an anaesthetic for adults in 1970 and quickly showed promise for various clinical applications beyond anaesthesia. Despite its versatility, recreational use emerged in the 1970s, escalating in the 1980s. In response, the DEA classified it as a controlled substance in 1999, with its psychotropic effects being formally studied in the same year. In a pivotal moment in 2019, the FDA approved intranasal ketamine for adult treatment-resistant depression (TRD), marking its first psychiatric indication. The eventual off label usage in adolescents is inevitable and anticipated and poses challenges. The relative ease of administration as compared to IV infusion may also make it more popular and accessible adolescent treatment modality.

Mechanism of Action

Ketamine's mechanism of action is intricate, involving interactions with various neural systems. Research has suggested that depressed adolescents exhibit increased intracortical facilitation, indicating excessive glutaminergic activity compared to controls. Considering the unique pharmacological landscape of the adolescent brain, which undergoes active maturation of monoaminergic, glutaminergic, and GABAergic systems, it's essential to contextualise the developmental pharmacology when testing novel therapeutics.

The primary mechanisms by which ketamine exerts its effects are as follows:

1. ***N-Methyl-D-Aspartate (NMDA) Receptor Antagonism:***
   Ketamine is a non-competitive antagonist of NMDA receptors, which are involved in synaptic plasticity, learning, and memory processes. It binds to the phencyclidine (PCP) site within the NMDA receptor complex and blocks the channel and prevents calcium influx.
2. ***Glutamate Modulation:***
   Ketamine's blockade of NMDA receptors leads to a subsequent increase in glutamate release in the prefrontal cortex. This stimulates AMPA receptors, resulting in enhanced synaptic plasticity and the induction of synaptic changes that may underlie the antidepressant effects of ketamine.
3. ***Synaptic Remodelling:***
   Ketamine triggers a cascade of molecular and cellular events, including the activation of neurotrophic factors like brain-derived neurotrophic factor (BDNF) and the mechanistic target of rapamycin pathway. These processes promote synaptic growth, increase the number and function of dendritic spines, and facilitate the formation of new connections in brain circuits associated with mood regulation.
4. ***Modulation of GABAergic Interneurons:***
   Ketamine affects the inhibitory GABAergic neurotransmission by dampening the activity of GABAergic interneurons in the prefrontal cortex. This disinhibition increases excitatory glutamatergic output, thereby enhancing synaptic

plasticity and promoting rapid antidepressant effects.

5. ***Effects on Brain Connectivity:*** Ketamine's actions on the glutamate system and synaptic remodelling have been linked to changes in brain connectivity. Resting-state fMRI studies have shown that ketamine can restore the connectivity between brain regions involved in mood regulation. The precise contributions of these mechanisms to the antidepressant effects of ketamine are still under investigation.

Ketamine's unique mechanism of action sets it apart from traditional antidepressant medications. The rapid and robust antidepressant effects associated with ketamine have sparked considerable interest in its potential as a novel treatment for various mood disorders, including TRD.

Efficacy of Ketamine for Adolescent Treatment Resistant Depression

- Several studies have investigated the use of ketamine in the management of treatment-resistant depression (TRD) specifically in adolescents.
- The research in this area is still limited; there are key findings that provide important insights into the efficacy of ketamine in this population.

The key insights are as follows:

1. ***Rapid and Sustained Antidepressant Effects:*** Research has consistently shown that ketamine administration leads to rapid and significant reductions in depressive symptoms in adolescents with TRD. Studies have reported improvements within hours to days after a single ketamine infusion. The antidepressant effects have been observed to be sustained for several days to weeks following treatment.
2. ***Higher Response Rates Compared to Placebo:*** Multiple studies have demonstrated that ketamine has consistently superior antidepressant effects compared to placebo in adolescents with TRD.
3. ***Treatment-Resistant Subgroups:*** Studies have suggested that individuals with a history of more severe and chronic depression, as well as those with a history of suicidal ideation, may have a greater likelihood of responding positively to ketamine therapy.
4. ***Safety and Tolerability:*** Ketamine has been found to be safe and well-tolerated in the adolescent populations when administered under proper medical supervision. Adverse effects are typically mild and transient, including dissociative symptoms, transient changes in perception, dizziness, and increases in blood pressure and heart rate. Serious adverse effects are rare, including respiratory depression or dependence, which appear to be minimal when sub-anaesthetic doses are used.
5. ***Long-Term Efficacy and Maintenance:*** Limited evidence suggests that repeated or maintenance ketamine infusions may be effective in sustaining the antidepressant effects in some adolescents with TRD. More research is needed to determine optimal dosing, frequency, and long-term outcomes of maintenance in this population.
6. ***Integration with Psychotherapy:*** Studies have highlighted the potential benefits of integrating ketamine treatment with psychotherapy, such as CBT or family therapy. Combining ketamine with psychotherapy may enhance treatment response and provide a comprehensive approach to address the underlying psychological factors contributing to depression in adolescents.

The current limitations with the available evidence and future directions

- Research in adolescents is limited and there is a lack of randomised controlled trials, which is the gold standard.
- The route, scheduling, dosing, and administration of ketamine is not consistent between studies.
- Co-morbidity is a rule rather than an exception in child and adolescent psychiatric conditions, and across the various studies, there is a range of co-morbidities and concurrent treatment.
- The current studies that have been conducted have small sample sizes and are of short duration.
- All available studies in adolescents have utilised IVI formulation of ketamine (FDA approved ketamine for adult TRD is intranasal)

Conclusion: Where to from here?

While research is ongoing, and it is still currently limited. Ketamine shows potential to be well tolerated in the adolescent population with minimal side effects and shows potential to be effective in reducing the symptom burden in adolescents with TRD, however further research is needed before its use in clinical practice becomes standard.

- More research is needed to:
  - To establish safety data Determine efficacy.
  - Comparison with placebo and other standard treatments for depression
  - Method of delivery (a study showed parents' strong preference for intranasal/oral or sublingual routes)
  - Explore the role of psychotherapy during ketamine treatment for depression.

References available on request. MHM

By Dr Aneshree Moodley
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THE GUT- BRAIN AXIS:
ARE WE BEING CONTROLLED BY OUR GUT INSTINCT?

Is it possible that the idiom "listen to your gut instinct" carries old wisdom forgotten by modern generations? Did the humans of yesteryear understand the body and how it works better than we do? Is there scientific evidence that the gut can "dictate" to your brain? Let's explore.

The gut-brain axis (GBA) is complex neuro-endocrine system consisting of:

- The gut microbiome
- The hypothalamic pituitary axis (HPA)
- The central nervous system (CNS)
- The peripheral nervous system (PNS) consisting of the autonomic and somatic nervous system (ANS, SNS)
- The enteric nervous system

The gut microbiome

It's estimated that more than 50% of your cells don't contain your DNA but are in fact protozoa, fungi and bacteria which are collectively called "MICROBIOTA". The majority of the microbiota are found in the gut and hence termed gut microbiota or gut microbiome.

New research reveals that the gut microbiome talks to your brain and influences mood, energy levels, cognition, memory and sleep.

Such research includes mice studies using a cohort of germ free (non-colonized gut) mice vs cohort of normal (colonized gut) mice. Each cohort was placed in the same maze; colonised mice showed natural curiosity, were quick, eager learners, and remembered where in the maze they'd been, compared to non-colonised mice who lacked curiosity and eagerness to learn and were quick to forget where in the maze they'd been. In addition, a further study between the two cohorts showed that the non-colonised mice lacked the normal distress/anxious behavior compared to the colonised mice when separated from their mother.

Fascinatingly, when the non-colonised mice were colonised (with gut microbiomes appropriate for their species), their behaviour changed to that of the "normal" mice.

Some research has been able to transfer information from mice studies to humans. Gut microbiome from human twins were transferred to mice with the following results: Gut microbiome from the obese twin transferred to mice caused obesity in the mice, whilst gut microbiome transferred from the thin twin to mice caused mice to remain thin/ lose weight. The mice diet was kept the same across chohorts.

Another fascinating study involving all non-colonised mice, showed that when gut microbiome from a depressed human was transferred to mice, the mice displayed depressive behaviour e.g., losing hope when trapped in a water tank and quick to stop swimming, whilst gut microbiome from non-depressed person transferred to mice showed the mice persevered to swim longer and fought to stay alive.

How can GUT BACTERIA be so powerful?

Let's refresh on the anatomy of the small intestine. The small intestine lumen is lined by a velvety layer of villi. Each villi is covered by a single layer of epithelium consisting of different cell types. One significant cell type is the *enteroendocrine* cell which can communicate through *synapses* with the vagus nerve. *Enteroendocrine cells* with synapses are called **neuropod cells** *which can sense mechanical, thermal and chemical stimuli such as nutrients in the gut lumen.*

Inside the **neuropod cell**, signals from the stimuli are converted to electrical impulses which propagate onto nerve connections directly with the vagus nerve, thereby directly linking the gut to the CNS. That chemical stimulus (nutrient) can travel from the gut lumen to the CNS within a few seconds.

More about the gut microbiome

The gut microbiome develops intrauterine. A healthy gut microbiome consists of a large variety of different bacteria. For optimal health we need a balance between healthy and unhealthy bacteria which means a small amount of unhealthy bacteria IS needed for good health.

Food supplies nutrients which are metabolised by various enzyme reactions in the gut. The microbiome plays an important role in breaking down and absorbing important proteins from food. Some of these important proteins absorbed will serve as building blocks for essential neurotransmitters such as SEROTONIN, DOPAMINE, GABA etc.

Research has shown that the following bacteria are involved in the synthesis of respective neurotransmitters:

- Lactobacillus and bifidobacterium-the synthesis of GABA from monosodium glutamate
- E. Coli, Bacillus and Saccharomyces - norephedrine synthesis.
- Candida, streptococcus, Escherichia and enterococcus - serotonin synthesis.
- Bacillus and Serratia-involved in dopamine synthesis.

What causes gut dysbiosis/ disruption of the gut microbiome?

- Physical stress -inflammation, pain
- Mental stress - BOTH real and perceived trigger same response
- Environmental stress-extreme temperatures
- Nutrient deficiency or excess esp. excess of sugar
- Alcohol use disorders
- Excessive sedentary lifestyle
- Lack of good quality sleep
- Aging

Any form of stress triggers overgrowth of some species and undergrowth of other species of bacteria in the gut, e.g. decrease in bacteroides and increase in clostridium species in the caecum, thereby triggering an immune response which results in inflammation at the gut. The inflammatory markers travel to the CNS via both:

- The blood stream and
- Change in protein/ neurotransmitters produced by the microbiome via the neuropod cells to the vagus nerve

Is there hope?

We CAN improve gut microbiome by several simple but consistently applied strategies:

<u>Stress management</u>

- Meditation
- Mindfulness
- Regular exercise: consistency is more important than intensity
- Maintain a consistent diurnal eating pattern because the gut microbiome also follows some form of circadian pattern. Gut microbiomes differ from day to night.
- Good quality and adequate sleep
- Healthy and varied diet with fresh fruits and vegetables and healthy meats OR where this is not possible supplement the patients diet appropriately e.g. omega supplements or IMI vitamin B supplements.
- Encourage prebiotic foods which are high in fibre
- Encourage probiotic foods - such as plain natural or Greek yogurt. Where necessary- probiotic supplements may be used.
- Small amounts of fermented foods are evidenced to help maintain a healthy microbiome.

Vagal Nerve stimulation (VNS):

There is novel treatment for treatment resistant depression which has recent FDA approval. A new hypothesis is the current from the chest electrode may trigger changes to the gut microbiome and thereby trigger important neurotransmitter proteins such as serotonin, dopamine, GABA to be produced relieving depressive symptoms.

Early clinical trials show positive evidence for the use of VNS in treating:

- ADHD
- OCD
- PTSD

Autism spectrum disorders (ASD):

Some evidence suggests that patients with ASD have high amounts of a certain bacterial molecule/by-product in the blood. Rodents with the same molecule displayed irritability, anxiety and brain activity similar to that seen in ASD patients.

Parkinson's disease (PD):

PD is characterised by tremors, muscle stiffness and unsteady gait believed to be caused by the mis-folding of a protein in the motor part of the brain. A new hypothesis that a particular strain of

E. Coli in the microbiome is responsible for producing a mis-folded protein similar to that seen in PD. In a study, when the same strain of E. Coli was transferred into mice, the same misfolded protein was detected. After 2 months, the same mice displayed the neurological changes and symptoms common to PD.

Overall there seems to be an increasing understanding of what the gut microbiome is and its function in the body. It's likely that ongoing scientific research in this field will reveal stronger evidence for the role that the gut microbiome plays in important human behaviour such as mood, memory, cognitive function, and perhaps even motor function. New scientific wisdom in this field will enable better and holistic management of mental well-being. In the meantime, there can only be benefits to obtaining a thorough dietary and lifestyle history for all patients including those presenting with mental illness.

References available on request. MHM

By Alexa Scher
Alexa Scher
Clinical Psychologist

EXISTENTIAL DREAD IN TEENS

Try looking at the world through the eyes of a South African teenager today… you'd be looking at escalating crime statistics, child trafficking and social media's distorted reality of what life should look like. This leads to immense pressure to meet unrealistic expectations, whilst confronting the realities of having the highest unemployment rate in the world, inconsistent water supply, loadshedding, war, genocide, and the impending doom of climate change, which is already impacting people globally.

Now, try to imagine what it's like to be expected to care about things such as school grades.

In relation to all these issues, why would you care? You don't have to have depression or anxiety, for these issues to keep you up at night, disrupting your sleep, impacting your mood, energy, and motivation levels, leaving you with a general sense of meaninglessness and hopelessness regarding the future.

Of course, if these issues are impacting you in these ways, the likelihood of you meeting the criteria for depression and/or anxiety are very high. Which is where we, as healthcare professionals, need to be very careful not to pathologise an individual for what's essentially a very understandable human reaction to very depressing and scary experiences.

Just like with the note of caution to differentiate between grief and depression in the DSM, we need to be careful of not diagnosing a normal part of the human experience.

A label used for this common human experience is existential dread, or an existential crisis, which has been explored for centuries and is by no means a new phenomenon. What's of particular concern, is how it's presenting in younger

age groups and the impact this is having on their lives.

Research has shown that whether a direct experience with, or just the unknown future effects of climate change, is exacerbating fears of losing control over an unknown future, developing into a variety of mental health issues, such as depression, anxiety, phobic behaviours and symptoms of PTSD.

We're seeing rates of depression and anxiety in teenagers increasing globally, and within the South African context, around 9% of all teenage deaths are due to suicide, which is continuing to rise.

This should come as no surprise, however, as in their short life spans, they've already endured the trauma and disruption of COVID-19, and are more in-tune with and exposed to what's happening to others around the world. They're far more informed about environmental disasters and the risks of climate change on the world and their future than any previous generation ever has been.

For many teenagers, this has left them with apocalyptic fears feeling powerless, hopeless and in a state of despair impacting their parents, who are experiencing a lot of helplessness, spilling over onto us, the healthcare professionals they're turning to for help.

For many adults, the initial reaction is to downplay these experiences as 'normal teenage angst', due to hormones, being too dramatic and emotionally immature. In all fairness, it's very difficult to distinguish between the expected ups and downs of adolescence and something more serious. However, if a teenager who is experiencing an existential dread receives such a response, this will likely exacerbate the crisis.

To differentiate between the two, it helps to understand what exactly an existential crisis is and what some of the signs are. Wikipedia's definition describes an existential crisis as "a moment at which an individual questions the very foundations of their life: whether this life has any meaning, purpose, or value." An existential crisis occurs when an individual's previously held beliefs in values, faith and purpose seemed to have become pointless, leaving the person feeling ungrounded and adrift in the world.

While beginning to individuate from your family in the process of figuring out who you are and who you want to be is a very normal developmental process to undergo in adolescence, it generally doesn't devolve into such an intense level of despair to the point of contemplating suicide, which you see in existential crises.

Here are some other signs that could indicate an existential crisis:

- A fixation on life's deeper meaning, yet the inability to find answers to these existential questions, results in a sense of hopelessness or meaninglessness.
- Realising the world isn't fair or just.
- Attempting to discover your sense of purpose, yet because of the hopeless outlook on the fate of society and the world in general, you're left with a sense of futility or helplessness at trying to create meaning or change in your life.
- A sense of guilt at confronting your inability to make a difference in the lives of others.
- Desiring more from life's everyday routine, which is perceived as unimportant and mundane, with perspectives that nothing you do will make any difference, so why bother?
- Losing interest and motivation to do things you previously enjoyed because they now seem pointless.
- Difficulties relating to people who don't share similar concerns about these existential concerns, increasing isolation and resulting in a sense of disconnection from your personal relationships. All of which exacerbates the general sense of emptiness.
- Fearing death, yet frequently thinking about death, dying and/or suicide.

These experiences compound the standard overwhelm that comes with being a teenager, converging into a painful state of being. While the obvious solution may be to diagnose depression and/or anxiety and initiate the appropriate treatment, we must ask ourselves if just treating the symptoms is comprehensive enough in dealing with an existential crisis?

The irony is that what's often very helpful, is to create space for these struggles to be acknowledged, heard, felt, and validated. Trying to get teens to just think positively and not take life too seriously, telling them to just enjoy their childhood and leave the worrying to the adults, is in fact the last thing they're needing to hear and will likely come across as condescending and invalidating.

For us as healthcare professionals, it's in our very nature to strive to cure or treat our patients' ailments, so it can feel very counterintuitive and difficult to try not to solve these issues. It's important to not underestimate just how helpful it is however, to accept their existential crisis, encouraging them and their parents to engage with the questions and uncertainties they're faced with. Openly engaging with this existential dread can help teens learn to tolerate a lack of resolution and live with uncertainties.

I'm in no way suggesting that medication wouldn't be necessary, as it could, of course be essential in stabilising the patient enough so they have the capacity to engage in the process of coming to terms with their existential crisis. The recommendation is to consider the role that therapy can play when it comes to addressing these experiences comprehensively.

Having a space to communicate difficult thoughts and feelings without judgment, can be vital in grappling with existential dread – for both the teenager and their parents. It's often easier for a therapist, than it is for parents, to tolerate the helplessness, whilst listening empathetically to the teenager as they process these complex experiences. Instead of trying to control for what they're thinking and feeling, it's helpful to facilitate a process for them to create their own meaning and establish for themselves how to access a sense of purpose and fulfilment in life.

This can take a huge toll on parents however, so parents having their own mental health support can also make a significant difference in their ability to then tolerate what their child is going through.

References available on request. MHM

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CRISIS INTERVENTION SKILLS FOR DOCTORS

In the realm of psychiatric emergencies, the ability of medical practitioners to respond swiftly and effectively can be lifesaving. Crisis intervention on the other hand is not just about managing the immediate danger but also about providing a bridge to long-term care and recovery. Let's explore the essential skills and techniques medical practitioners should have in their toolkit for these critical moments.

Understanding Crisis:
At its core, crisis intervention aims to provide immediate, short-term assistance to individuals experiencing an emotional upheaval that renders them unable to cope using their usual problem-solving mechanisms. While the terms crisis and emergency are used interchangeably it does have subtle differences. A crisis usually occurs after an intense psychological or social stressor and the person experiences a profound disruption to their life routine, which may overwhelm their ability to cope. It is time limited and does carries a potential for growth as new coping stages can be learnt and implemented, whereas an emergency is a serious, unexpected, and often dangerous situation requiring immediate medical action.

There are different types of crises one can experience, the most common are:

1. Developmental Crisis: Occurs during normal life transitions when individuals struggle to adapt to new roles or life stages, often related to specific life events such as adolescence transitioning into adulthood or new social roles and identity issues.
2. Situational Crisis: Arises from unexpected, traumatic events that disrupt an individual's daily life, such as sudden loss or a major accident.
3. Existential Crisis: Involves deep questioning of one's purpose, values, or existence, leading to feelings of despair or disconnection.
4. Environmental Crisis: Caused by external factors such natural disasters, often requiring collective coping strategies.

A suggested approach to crisis management as follows:

1. Prepare and Prevent:
   - Develop protocols and guidelines for crisis situations in your practice.
   - Train staff in recognising early signs of crisis and intervention techniques.
2. Identify the Crisis:
   - Recognise and respond promptly when a patient is experiencing a crisis, marked by acute changes in behaviour/ shift from their baseline, emotional distress, or risk of harm to self or others.
   - Assess the severity and immediate risks associated.
3. Ensure Safety:
   - Be calm and prioritise the safety of the patient, the treating practitioner, staff, and others involved.
   - Implement immediate measures to reduce the risk of harm, such as securing a safe environment and removing potential dangers.
4. De-escalate:
   - Use de-escalation techniques to calm the situation, such as speaking in a calm and reassuring

manner, maintaining a non-threatening posture, and offering support.
    - Engage the patient in a way that respects their autonomy while ensuring safety.
5. Assess and Evaluate:
    - Conduct a thorough assessment of the patient's mental, emotional, physical and social state to understand the underlying contributing factors.
    - Evaluate the need for further medical evaluation or psychiatric assessment.
6. Plan and Implement Interventions:
    - Develop a short-term action plan to address the immediate crisis, such as crisis counseling, medication, hospitalisation, or other interventions.
    - Utilise the patient's existing social support and collaborate with the patient, family, and other multidisciplinary team members.
7. Follow-up and Review:
    - Ensure throughout the initial intervention and recovery process, ongoing treatment and support services are provided
    - Address any residual effects of the crisis and work on strengthening coping mechanisms to prevent future crises.
    - Review the effectiveness of the crisis intervention with the patient and make adjustments to the care plan as needed collaboratively.

Psychiatric emergencies:
In our daily practice we may experience emergencies and when we do it is impervious to have a rapid response. The following psychiatric emergencies are covered briefly:

1. The Suicidal Patient:
    - Assess Risk: Determine the severity of suicide risk through direct questioning about thoughts, plans and means.
    - Ensure Safety: Remove any means of self-harm and provide constant supervision if necessary.
    - Engage and Support: Build rapport, listen empathetically and validate their feelings.
    - Plan and Act: Develop a safety plan involving family members, caretakers or associates and ensure follow up with a mental health practitioner.
    - Provide contacts to SADAG or other hotlines, involve multidisciplinary team members such as social workers and psychologists, and consider hospitalisation if risk is high.
    - Treatment: gastric lavage with activated charcoal. Remember to refer to internal medicine / ICU in cases of organophosphate or antifreeze/coolant ingestions.

Common Antidotes:	
Medication	**"Antidote"**
Paracetamol	Acetylcysteine
Iron	Deferoxamine
Opioids	Naloxone
Benzodiazepine	Flumazenil

2. The Aggressive Patient
    - De-escalate: Use calm, non-threatening communication to reduce tension.
    - Maintain a safe distance and ensure an escape route.
    - Ensure there are security guards in the facility and if necessary to involve SAPS.
    - Assess: Evaluate the cause of aggression, considering causes using DIMPTOP.
    - Physical Safety: Use the least restrictive means and only resort to five point physical restraints or sedation only if absolutely necessary.
    - Follow-Up: Once the situation is controlled, assess and treat the underlying cause.

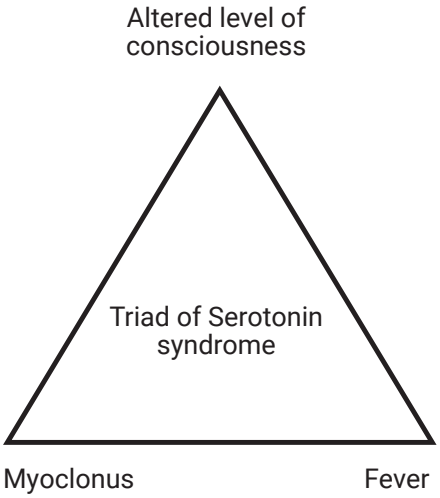
1. D: drugs / delirium
2. I: infections
3. M: Metabolic
4. T: Trauma/ Toxins
5. O: Oxygen deprived
6. P: Psychiatric and perceptual

3. Drug-Related Side Effects:
    a. Neuroleptic Malignant Syndrome (NMS) Recognise symptoms: use pneumonic:

F: Fever,
E: Elevated CK and other enzymes such as LFTs, U&E, leucocytosis and myoglobinuria
V: Vitals unable - autonomic dysfunction
E: Encehalopathy: altered mental status
R: Rigidity of muscle

- Discontinue the offending agent immediately (remember not only antipsychotics can cause NMS - any medication with dopamine receptor blockade such as maxalone can cause it too).
- Initiate supportive care, including hydration and cooling and short course of benzodiazepine.
- Administer specific treatments like dantrolene or bromocriptine as indicated with consultation of specialist psychiatrist.

b. Serotonin Syndrome:



- Identify symptoms: Other signs include: agitation, rapid heart rate, dilated pupils, sweating, diarrhoea, seizures and hyper-reflexia.
- Stop serotonergic medications such as antidepressants.
- Provide supportive care including rehydration and

correcting electrolyte imbalances.
- Exclude other medical causes such as UTI / delirium.
- Consider serotonin antagonists like cyproheptadine for severe cases.

c. Lithium Toxicity:
Narrow therapeutic index: 0.6 - 1.2 meq/l.
Steps: Recognise stages and discontinue lithium immediately. Remember to complete examination: Lithium level, U&E, FBC, Thyroid function, Pregnancy test (if indicated) and ECG.

e. A cute Alcohol or Drug Withdrawal:
- Assess severity: Determine the level of withdrawal symptoms and potential complications.
- Supportive care: Provide a safe environment, hydration, and nutritional support.
- Medication: Use benzodiazepines for alcohol withdrawal; consider appropriate medications for other substance withdrawals based on the substance type.
- Monitor: Regularly assess withdrawal symptoms and potential complications.

Stages of Lithium toxicity

Stage	Toxic level	Symptoms	Treatment
Mild	1.5 - 2.0 meq/l	GIT symptoms: nausea, anorexia, abdominal pain, vomiting and diarrhoea	Prevent further absorption by gastric lavage and induce emesis with activated charcoal. Supportive management: Rehydrate orally
Moderate	2.0 - 2.5 meq/l	The above + CNS symptoms: blurred vision, marked tremor, confusion, increased deep tendon reflexes.	Manage in medical ward and IVI fluids.
Severe	>2.5 meq/l	GIT + CNS signs and progression to cardiac arrhythmia, oliguria, seizures, altered LOC, coma and death	Initiate hemodialysis and intensive supportive care with specialist referral and guidance.

d. Catatonia:
- Identify Symptoms: Look for signs like mutism, immobility, negativism, posturing, or rigidity use the Bush Francis Scale to determine severity and response to treatment.
- Emergency Care: Ensure patient safety, hydration, and nutrition.
- Medication: Administer benzodiazepines (e.g. lorazepam) for immediate relief.
- Further Assessment: Evaluate for underlying psychiatric or medical conditions.
- Treatment Plan: Consider electroconvulsive therapy (ECT) if unresponsive to medication.
- Long-term plan: Initiate addiction treatment services including counselling and rehabilitation.

f. Acute Dystonia:
- Immediate recognition: sudden muscle spasms, abnormal postures, or oculogyric crisis.
- Treatment: Administer anticholinergics (Biperiden) intravenously or intramuscularly.
- Monitor and adjust: Observe the patient closely and consider adjusting the causative medication.

4. Seizures:
- Initial response: Place the patient in lateral (recovery) position, and secure airway while monitoring breathing.
- Abort the seizure with medication as soon as possible: emergency trolley and establish IVI line if possible.

Commonly used to abort seizures:
7. 4mg lorazepam IVI
8. 10mg Midazolam IVI/IMI (both can be repeated 5-10mins if seizures continue)
9. Unsuccessful IVI line: 10mg Diazepam per recty or if available, 10mg buccal Midazolam

- After the Seizure: Check for injuries, measure blood glucose and treat hypoglycaemia if present.
- Medical Evaluation: Assess for new-onset seizures, electrolyte abnormalities and post seizure psychosis. Refer if necessary, identify potential triggers, and underlying conditions.
- Treatment and Monitoring: Administer anti-epileptic drugs as per guidelines depending on the patient and monitor for recurrence or complications.

In conclusion, the purpose of this article is to provide an overview and emphasise the importance of swift, empathetic and strategic responses in psychiatric emergencies while highlighting essential skills. By integrating these techniques into practice, doctors can effectively navigate psychiatric emergencies and provide crucial support to patients in distress.

References available on request. MHM

Interview with Professor Renata Schoeman
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WHAT IS OUR RIGHT TO HEALTH?

WORLD HEALTH DAY

Access to healthcare is a basic human right, but achieving the healthy nation that South Africa needs for productivity and economic growth will take more than universal free healthcare.

Social determinants of health such as lifestyle choices - diet, exercise, and substance use – play a crucial role in ensuring a healthy South Africa.

Although the death rate in South Africa has slightly decreased, the number of deaths due to non-communicable diseases such as diabetes, cardiovascular diseases and cancer is on the rise.

Diabetes has rapidly increased in South Africa – from 4.5% in 2010 to 12.7% in 2019 according to the latest statistics and is one of the highest contributing underlying causes to death. Of the 4.58 million South Africans aged 20-79 years who are estimated to have diabetes, more than 52% were underdiagnosed.

Prof Renata Schoeman, Head of the MBA in Healthcare Leadership programme at Stellenbosch Business School says on World Health Day (7 April) the continued focus on health as a human right, and on the accessibility of care through universal health insurance, disempowers people from taking responsibility for their own health.

"We confuse health care with health – having access to care is not a promise of health. Everyone has the responsibility for their health and cannot view a health care system as the answer to a healthier society."

Prof Schoeman says that viewing health as a personal and social value, rather than exclusively as a right, would increase personal responsibility and "investment" by people in their health.

"When people are allowed to be active participants in their own care, instead of passive recipients, and their human rights respected, the outcomes are better and health systems become more efficient.

"It doesn't help to have free healthcare, such as the proposed NHI, but people make poor lifestyle choices – in terms of healthy eating, exercise and substance abuse, for example – and don't take responsibility for their own health," she argues.

Prof Schoeman points out that health goes beyond the absence of disease and is influenced by genetics along with social and economic factors such as poverty, unemployment, housing, education, nutrition, and the surrounding environment, as well as the choices made by individuals."

She says that the NHI alone, as a strategy to fund healthcare, is only part of the solution and that focusing on the three interventions that aim to reduce the health risk, is crucial for a healthy society:

- **Primary prevention:** to prevent disease or injury before it occurs
- **Secondary prevention:** to reduce the impact of disease that has already occurred

- **Tertiary prevention:** to limit the impact of ongoing, chronic illness, or impairment

Pointing to the success of disincentives to unhealthy lifestyles, such as "sin taxes", and incentives such as discounts and loyalty rewards for exercise and healthy food purchases, she says "such measures for promoting health and preventing disease should be extended to the public sector, and would be 'significantly more affordable' than the NHI."

"Ensuring access to healthcare is a social and government responsibility, but this needs to go along with the promotion of health, which goes beyond the health system to entrenching health as a shared social value, and this is the task of all those involved in shaping and influencing values – families, schools, the media and the legal system."

She emphasises that governments need to think beyond simply the accessibility and funding of healthcare, to the quality of the health care as well as "getting the basics right" in terms of addressing poverty and unemployment, health promotion and prevention strategies, and safe and healthy living environments.

"Citizens on the other hand need to take care of themselves, not only physically but mentally too. Undiagnosed mental health can negatively affect your physical health leading to substance abuse, obesity and eating disorders."

Prof Schoeman suggests that everyone takes responsibility for their own health through:

- Regular exercise (at least 30 minutes a day)
- Following a healthy diet high in fruits and vegetables and low in processed sugars and fats
- Stop smoking and avoid the use of drugs
- Limit alcohol
- Prioritise sleep (at least 7 hours a night)
- Limit screentime
- Seek help for physical and mental health issues as soon as they arise.

References available on request. MHM

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AN ORGANISATIONAL CULTURE IN HEALTHCARE THAT SUPPORTS THE HEALTHCARE PROFESSIONAL'S WELL-BEING

Our patients' health depends on the well-being of our healthcare professionals, and the current realities faced in private and government institutions are causing burnout rates to soar. The distressing environments experienced on a daily basis mean physical, mental and emotional well-being are rapidly declining, and these concerns are echoed across demographics and specialisations. Many healthcare workers are choosing to leave the profession in search of other jobs offering greater work-life balance, even if that means leaving healthcare entirely.

The pandemic may have highlighted the prevalence of declining mental health and soaring burnout rates among healthcare professionals, but these issues have been simmering for years. The consequences of not addressing declining well-being at work are two-pronged. For the individual, issues may arise such as:

- Substance abuse
- Reduced engagement and satisfaction
- Chronic stress and related illnesses
- Deteriorating relationships

For the organisation, concerns include:

- Increased medical errors
- Reduced productivity
- Lower patient satisfaction
- Higher absenteeism and turnover; and ultimately
- Reduced profit.

So, what can be done to reduce and resolve, if not prevent these issues from occurring in the first place? The solution generally starts from the top in the form of a supportive organisational culture aimed at creating healthy work environments, which has been planned for and integrated as a key strategic objective by leadership. That this should be initiated by executive leadership, it may not always be possible. Each department, team, and individual can take the initiative to start creating small steps toward positive change. This change could result in more supportive and conducive working environments that encourage work-life balance, the pursuit of professional development, enhanced communication, and most importantly - happier and healthier staff.

An organisational culture which fosters the health and well-being of its staff must take into account the potentially deep-seated psychosocial hazards in the workplace that lead to reduced well-being in the first place, such as:

- Excessive workloads and shifts
- Staff shortages
- Unnecessary administrative burdens
- A lack of organisational support
- Well-being not addressed as a strategic objective.

It's suggested that an organisational culture conducive to well-being implement interventions at a primary, secondary and tertiary level. At the primary level, work-related mental and physical illnesses are prevented. This is done through eliminating exposure

and certain behaviours, for example, legislation, education, and preventative check-ins. At the secondary level, the aim is to reduce burnout and other related issues from progressing and the prevention of long-term problems from developing. For example, modifying the work environment or improving current initiatives. At the tertiary level interventions are introduced to manage existing problems in the organisation. For example, support programmes or sick-leave. Consider the third level a type of triage system to be put in place once issues have become highly problematic.

At each level, the individual healthcare professional and organisation as a whole should participate in these interventions. As the individual, the healthcare professional has a role to play in preventing and managing their own risks related to well-being. However, for interventions to be successfully sustainable, organisational leadership will also need to play their own role. Studies show interventions which are introduced by the organisation in the management of well-being are far more likely to be successful than individual interventions alone.

Below are some interventions that could take place at an organisational level to promote a well-being centric culture:

- Analysis and assessment through established measures of well-being can help inform the core issues at play when it comes to ailing mental and physical health of staff. Not only would this allow for greater insight into the symptoms being experienced, but provide more information on the job conditions, demands, and resources.
- Psycho-social educational programmes offered by the organisation provide a platform and expertise through which staff can access the information and assistance they may need. These programmes could range from better sleep hygiene to asking for more help at home.
- Changes to the physical workplace design can have a huge impact on the organisational factors contributing to poor health, such as light exposure, temperature, noise, (a lack of) clean private break rooms or availability of healthy meals, and the use of colours and plant life. Staff who need to engage in work requiring focus and attention should be provided with quiet spaces to do so. Healthcare workers who work shifts may not be exposed to enough natural light during the day, which compromises circadian rhythms and overall health. Also note that some staff may feel unsafe travelling late at night and then again in the early morning; larger healthcare organisations could provide staff with sleep pods in such cases.
- Lastly, an organisational culture that cultivates employee well-being may need to see substantive changes to organisational structures, leadership capabilities, and working conditions. Certain structural and leadership factors drastically reduce the risk of burnout, such as advocating for a human-centred leadership style; streamlining and enhancing internal communication systems; redressing problematic and outdated institutional rules, structures and equipment; introducing robust human resource management practices; conducting updated job analyses; implementing strong mentorship programmes with a focus on capitalising institutional knowledge and fostering development; and suitable benchmarking against international best practices.

What individual interventions can healthcare workers implement to improve their own well-being, which will hopefully have a ripple effect on co-workers and team culture? Let's take a look:

- At the heart of wellness lies better sleep management, and often, we are our own worst enemies. Avoiding the use of technology before bed; aiming for at least eight hours of sleep; keeping the bedroom clean, dark and clear of clutter are just some little ways recommended to get a better night's rest. As a manager, consider instructing employees not to respond to messages after hours.
- The development and sustainability of healthy habits such as nourishing one's body and exercising can assist at all three levels of wellness interventions. Not only do healthy habits prevent the onset of certain illnesses, but improve one's ability to recover from such.
- Social support is critical in not only preventing anxiety, depression and burnout, but in recovery as well. Healthy social support may mean prioritising time for friends and family; engaging in hobbies; talking to someone when struggling; establishing supportive co-worker relationships; and engaging in community or spiritual practices, such as attending church or volunteering.
- Therapeutic interventions such as counselling may assist individuals who are more prone to developing depression, anxiety, and burnout. Working in the healthcare sector often means seeing more trauma than the average person, and seeking help builds resilience and encourages the use of healthier coping mechanisms.
- Despite working a full-time job, unfortunately many women still shoulder the burden of social labour in the home (cleaning, cooking, and childcare). Asking for help from family or one's partner or seeking ways of easing chores (such as pre-cooking meals, outsourcing cleaning duties, or even requesting more uniforms for the week) may allow the healthcare professional to return to work feeling rested and revitalised.

With the positive impact of wellness interventions having been researched over an extended period of time, poor work-related mental and physical well-being should and can be successfully managed and hopefully prevented. In the end, the goal is not only to improve the wellbeing of healthcare professionals, but ensure better care for patients, and a thriving organisation.

On a last note, don't think that culture changes aimed at employee well-being can only happen at an executive level, or that well-being is only aimed at formal skilled labour. Do remember that if you're a manager or head of department, set an example for your team and lead the way in work-life balance and small steps to greater well-being.

References available on request. MHM

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BOUNDARIES AND SELF-PRESERVATION FOR HEALTHCARE PROFESSIONALS

Within the health professions, professional boundaries speak to the 'edge' of what is deemed acceptable professional behaviour. Such boundaries are typically associated with the psychological and social distance required between the healthcare professional and their patient. The enablement of such boundaries provides the patient with protection from the power differential whilst assisting the professional in making objective decisions for their patient. Indeed, given the power-differential, and fiduciary nature of relations between healthcare professional and patient, it's the legal and ethical responsibility of the healthcare professional to enable and maintain appropriate boundaries.

Internationally, many health care professionals are subject to ambiguous and sometimes non-existent standards to inform professional boundaries in practice, with some territories having frameworks and legislative mandates that are relatively scant when it comes to non-sexual professional boundaries. South African health care professionals are fortunate to have a robust system of ethical rules of conduct as per the HPCSA's ethical rules of conduct and guidelines for good practice in the health care professions, amongst others.

Yet, whilst the notion of professional boundaries is beneficent in definition, the meaningful application of the principle may be frustrated by the specific practice context of the healthcare professional. Some healthcare professionals face the challenge of unavoidable social relationships outside the professional context, consequent to their rural or remote practice, whilst others might have specialisations with relatively low numbers of practitioners, which would increase the likelihood of friends, family or even colleagues seeking out consultation.

However, by trying to keep the peace by not setting boundaries or allowing patients and colleagues to cross professional boundaries is a known trigger for psychological burnout.

Research indicates a connection between frequent experience of challenges related to professional boundaries and burnout. Pioneering researchers in the field of burnout describe the psychological syndrome as a product of prolonged exposure to chronic interpersonal stressors at work, and where boundary challenges are a known stressor for healthcare professionals. For the healthcare professional, burnout may lead to:

- Cognitive outcomes: Which can include cognitive impairment such as a compromised capacity to concentrate, increased risk of errors, reduced quality of care, low work engagement and intention to retire early.
- Emotional outcomes: Such as the development of mood disturbance, depressive and anxiety symptoms, decreased life satisfaction and an eroded sense of compassion.
- Health-related outcomes: Transient health problems such as recurrent infection or chronic health problems including cardiovascular disease, musculoskeletal pain, sleep difficulties, increased biological aging and possible early mortality.

The healthcare professional therefore faces a catch-22 type situation, i.e.: maintaining appropriate boundaries with patients can be a taxing process, which contributes to the need to replenish physical, emotional, or cognitive energy resources, and if these resources are not meaningfully replenished, the healthcare

professional is exposed to an increased risk for burnout. However, by not establishing and enforcing appropriate professional boundaries, the healthcare professional fails to meet the legal and ethical mandate to do so, whilst also exposing themselves to an increased risk of burnout.

The answer to this dilemma is perhaps found in meta-analytic studies of burnout, which indicate a moderate correlation between chronic exposure to stressors and burnout. Such moderate correlations indicate that moderators are likely present in the relationship between chronic stress and burnout. Research identifies several moderators in the stressor-burnout relationship, which include meaningful coping strategies, job resources, personal resources, and post-work recovery from stress. Whilst it might be difficult to entirely avoid the aspects which can result in frustration of enabling and enforcing professional boundaries, the healthcare professional can aid their well-being through the meaningful application of personal boundaries in promotion of recovery and self-preservation.

However, to establish meaningful and impactful personal boundaries which support the ability to sustain professional boundaries, delineation of the factors that promote personal recovery from burnout and its antecedents is warranted. Research indicates the following aspects are key in recovering from, or warding off the onset of psychological burnout:

- Psychological detachment from work
  This means refraining from work-related activities after work hours, whilst also actively relinquishing work-related thoughts, that is to say; to 'switch off'. Psychological detachment from work further speaks to being mentally involved in other areas, such as sports, hobbies and activities with other people. A key aspect in creating psychological detachment from work is by setting non-negotiable personal boundaries between work and non-work time. Individuals who can psychologically detach from work hold more positive associations with work, enjoy increased life satisfaction, positive affect, work engagement and increased professional efficacy.
- Opportunities for recovery:
  Taking shorter planned and more frequent periods of respite from work is more effective than taking longer, yet more infrequent periods of respite. Secondly, the period of respite should be bolstered by planned experiences for relaxation, and active detachment from work (such as switching off one's work phone, and not having access to work related emails). Thirdly, periods of respite which occur over weekends are associated with lower burnout, and higher workplace vigour levels than compared to taking off two days in the work week. Furthermore, having clearly defined start and end times for the workday, opportunities to take regular breaks and capacity to adjust workload in accordance with one's need for recovery are important in warding off sleep disturbances and health complaints commonly associated with burnout.
- Physical activity and related leisure time activities
  Physical activity enables biological changes which reduce the physiological sensitivity to stress, whilst also acting as a behavioural distraction which alleviates the psychological impact of experienced stressors. Higher engagement with active leisure activities, hobbies, and exercise – are linked to better sleep, improved recovery, and lower incidence of maladaptive fatigue related symptomology. Furthermore, research indicates that when time is spent on physical activity, a positive effect occurs for burnt-out employees, irrespective of the initial level of burnout.

Many healthcare professionals often aspire toward increased exercise, leisure, and recovery time; however, the realities of medical practice and life often make this difficult to initiate and sustain. To meaningfully enable and maintain personal boundaries, the following aspects should be considered:

- Personal boundaries are more than a mindset:
  Research indicates that whilst goals can assist in starting with new habit formation, it is the link between the situation and the behaviour which in fact sustains new habit formation. The mindset must shift from the values that prompted the new habit, to the actual mechanics of the new habit, i.e.:
  o Do you have a clear behaviour to mind?
  o What occurs just before initiating this new behaviour?
  o What can enable, or distract from this behaviour?
  o Is this behaviour rewarding?
  o How often should this behaviour occur?
- Keep it simple:
  New habits require simple, easily repeatable behaviours. To create long term, complex habit behaviours, one must 'stack' discrete, simple behaviours together which enable habitual instigation.
- Habit stacking and environmental cues
  Habit 'stacking' is an empirically known means from which new habits are linked into an existing routine. Habit stacking uses the automaticity of the established habit to build a new one. For instance, when putting your keys down upon arriving home, you could also switch your work phone off.
- Keep friction in mind:
  Friction speaks to how fast, convenient, and easy a new habit is. The two keys to building healthy habits and boundaries are by reducing friction in healthy activities and increasing it for the unhealthy ones.
- Build in enjoyment:
  Temptation building, a strategy of pairing a pleasurable experience with a behaviour which provides delayed rewards is an effective means to engage in activities which are less pleasurable yet are needed to build healthy boundaries. For instance, whilst some might not enjoy the treadmill, yet enjoy binge-watching series, a gym with treadmills that have built in televisions might be the solution.

References available on request. MHM

Sowing Seeds of Hope in Refugees' Future

Doctors Without Borders (MSF) teams in Lesbos, Greece, have been providing mental health services and support to refugees, many of whom are children, for years. The MSF team includes psychologists, medical doctors, psychiatrists, nurses, midwives, case workers, health promoters, and cultural mediators.

Refugees often make a dangerous journey to find safety and stability in Greece. Once they arrive, they face uncertainty with no clear way to rebuild their future. Living day to day, their future is entirely unknown. In response to their plight, MSF mental health specialist, Johanna Bogren, provides a space for refugees to process their trauma at the Lesbos Sea House Clinic. Here, she shares her experience:

"I've learned that crossing the Aegean Sea in an unsafe boat creates wounds filled with horror inside the human being. As a psychologist, I can try to work with that experience to make the wound shrink and perhaps heal, even if the scar will remain."

"This crossing comes after horrifying experiences that are often difficult for me to comprehend. And it is followed by this: being stuck in a refugee camp, waiting for the asylum process. I have seen first-hand how this limbo brutally affects people's ability to handle their current lives and the memories of their past experiences."

Johanna's role is to reassure her patients, reminding them that they are safe, cared for and valued.

> **"I listen to their stories. We share feelings, not infrequently, of helplessness, fear, and sadness. I see the person in front of me. I try to sow a seed of hope and highlight their inner strength."**
>
> ***MSF Mental Health Specialist, Johanna Bogren***

PATIENT-CENTRED CARE

MSF continues to offer medical services in Lesbos and other areas within Greece, providing an average of:

19,600 *outpatient consultations*

10,900 *individual mental health consultations*
600 *group mental health sessions every year*

FIND OUT HOW YOU CAN WORK WITH US:
VISIT: MSF.ORG.ZA/WORK-WITH-US

MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

BIOLOGICAL PSYCHIATRY CONGRESS

Thurs 28 Nov - Sun 1 Dec

Century City Conference Centre

Brain & Mind: Broadening Horizons

We are delighted to invite you to join us at the 2024 Biological Psychiatry Congress. This year's theme is 'Brain and Mind: Broadening Horizons'.

Aligned with the congress theme of broadening horizons, we have curated a programme that showcases the interconnectedness of brain and mind, as well as takes a deep dive into advances in the aetiology, prediction, prognostication, and treatment of psychiatric disorders.

We are honoured to provide this platform for the exchange of the very latest in science, innovation, and practice, in an enjoyable setting in which to share ideas, engage in rich discussion, seek out networking opportunities, and forge new friendships.

We look forward to your presence and contribution. Your expertise, experience and insights will be invaluable to making this an intellectually stimulating and professionally rewarding event. The Organizing Committee is especially keen to welcome participation from registrars, early career psychiatrists, laboratory-based and clinical researchers, and students, and is grateful for the participation and support from industry.

In addition to the many beautiful natural and cultural attractions in Cape Town, the Century City precinct offers excellent accommodation, and world-class shopping and dining facilities.

We are committed to making your experience of the scientific and social program memorable, allowing ample time for both scientific discourse and leisurely exploration.

We look forward to seeing you in November!

Soraya Seedat & Leigh van den Heuvel
On behalf of the Biological Psychiatry Organising Committee
Biological Psychiatry 2024

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Event Management

ABORTION GRIEF

By Anonymous

Understanding Abortion Grief
Abortion grief is a profound emotional response that follows the conscious decision to terminate a pregnancy. It is akin to other forms of grief associated with death, with the unique aspect being that it involves grieving for someone we never met, someone who we personally chose to delay their entrance into this world. This grief often manifests as sadness, guilt, anger, loneliness, a loss of identity, and confusion stemming from unresolved emotions about the pregnancy.

According to an article by South Avenue Women's Services, this type of grief is also referred to as disenfranchised grief. This term describes grief that is not openly acknowledged, publicly mourned, or socially sanctioned. In such situations, the loss is often ignored, minimised, or even considered unjustified by others.

The need for open discussions
I believe it's crucial to have more extensive discussions about abortion grief. Its stigmatisation, especially in African communities, requires urgent attention. Those affected often suppress their emotions, bottling up feelings that need to be expressed. This suppression can result in conscious or unconscious self-destructive behaviours or the development of mental illnesses such as depression. However, it's important to note that not every woman experiences this grief in the same way. Emotional and psychological responses can vary based on individual circumstances, pre-existing mental health conditions, family issues, and religious beliefs.

My personal journey
In May 2023, I had an abortion. It was a dark and challenging period in my life. The initial joy I felt upon discovering my pregnancy soon gave way to anxiety as I considered my circumstances, including my relationship with the father, my financial situation, health, and education. After a doctor confirmed my pregnancy and explained the risks and restrictions associated with it, I decided to terminate the pregnancy.

The aftermath of abortion- a personal experience of grief.
The days following the abortion were filled with a sense of loss and suicidal thoughts. In the aftermath of an abortion, one of the most profound effects is the emotional numbness that engulfs you. It's akin to a blanket feeling, a trance-like state where nothing seems to matter anymore. Things that once bothered you cease to have any impact, and even the warmth of love, especially towards young children, seems to fade away. It's not a feeling of hatred or negativity, but rather a numbing sensation that leaves you indifferent.

This numbness extends to the love you have for your inner child. The love and kindness that you once had for her seem undeserved now. The inner child, once vibrant and lively, is now quieter than ever. Nothing triggers this feeling more than the sound of a baby's cry. It's a stark reminder of the life that could have been, the love that could have been shared, and the warmth that could have been felt.

As the weeks pass, the desire to run away from this reality becomes stronger. Small things start to disturb you. The sight of a pregnant woman lovingly rubbing her stomach, the joyous anticipation of a new life brings tears to your eyes. You start to feel like you have missed out on a significant experience, an experience that was meant for you. The conflict within you grows, especially when you're alone.

Seeking help: coping and healing
As time went on, I searched for support groups and counsellors specialising in abortion grief counselling but I couldn't find any in my area. Eventually, I found a counsellor who agreed to online sessions. These sessions, which continue to this day, have brought significant change into my life. The grief and numbness that had once consumed me began to disappear, replaced by a gradual sense of hope and healing.

This transformation was not spontaneous, but the result of countless hours spent in counselling, and on convincing myself that eventually I would see and feel the difference only if I committed for a bit longer. It was in these therapy sessions that I found a safe space to express my deepest fears, regrets, and sorrows.

As time went on, I learnt various ways to cope with my grief. I started journaling, learning new skills, and created a memory box for myself and my unborn child. I also found solace in nature, collecting shells from the beach to store in the memory box.

The healing journey continues

Healing from abortion grief is an ongoing process. Abortion is a deeply personal and traumatic experience. It's a journey filled with highs and lows, a rollercoaster of emotions. It leaves you questioning your decisions, your faith and future. But amidst the grief and pain, there is also a glimmer of hope - the hope for healing, for understanding, and for a future filled with love and kindness.

10 months after my abortion, I approached the South African Depression and Anxiety Group (SADAG) with the intention of starting Whispering Hope, a community for women affected by abortion grief. This group provides a safe space for women to share their feelings, thoughts, and hopes, and to find encouragement and support. This was something I yearned for so much during the early days of my healing process, and now I can see the impact it has had on the women who have found it and committed to their healing too. This, in turn, has been healing for me. We are a group of women healing through the shared experience of abortion.

Lessons learned from abortion - grief healing journey

I've learned that kindness towards oneself is as crucial as the kindness we extend to others. This journey has also taught me to love myself anew, but in a different light. I had to become the person I needed the most - someone to hold my hand, reassure me, and affirm that it's okay to feel the way I do. I've realised that while therapy and support groups play a vital role in our healing process, it also requires personal effort. It's about showing mercy to oneself, accepting that we are deserving of love, gentleness and forgiveness, regardless of our circumstances. I've learned that it's okay to grieve, to feel and express my emotions, no matter how raw or overwhelming they may be. I've understood the importance of self-forgiveness and realised that it's okay to mourn the life that could have been. Healing, I've discovered, is not a linear process. It's okay to have good days and bad days. This process has taught me that self-love and self-forgiveness are key to navigating through life's lows.

If one of your patients could benefit from the Whispering Hope Support Group for abortion grief, please provide them with the following SADAG number where they can receive more information: 0800 21 22 23.

References available on request. MHM