VOLUME 11 • ISSUE 1 • 2024

MHM

MENTAL HEALTH MATTERS

THE IMPACT OF SOCIAL MEDIA AND TECHNOLOGY ON MENTAL HEALTH

TRANSFORMING MENTAL HEALTH CARE

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THE SOUTH AFRICAN DEPRESSION AND ANXIETY GROUP

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Making Mental Health Matter

MALE MENTAL HEALTH

OVERCOMING STIGMA

Whilst the media continues to report on the subject of men's mental health, this subject remains one of the most difficult challenges facing society and will most likely continue to face for some time. For this reason male mental health should continue to receive the necessary attention and decisive ongoing action.

The latest Annual Mental State of the World Report 2022 from Sapien Labs was published in March 2023. This report is part of the Global Mind Project and included 407,959 responses from 64 countries in 9 languages. The survey measured mental well-being using a scale on a spectrum from "distressed" to "thriving". In between these two poles were struggling, enduring, managing, and succeeding. The study questionnaire considered five functional dimensions: drive and motivation, mood and outlook, cognition and social self, and the mind-body connection. The researchers also recorded information on demographics, lifestyle factors, traumas and adversities to evaluate the key drivers of risks.

According to this report South Africa ranks and remains one of the worst countries regarding mental health together with the United Kingdom and Brazil. South Africa shows the greatest proportion of respondents who are distressed or struggling. The purpose of this report is to provide policymakers a basis for the more effective management of population mental well-being through evidence-based social policy and interventions. Against this background one should understand the current state of male mental health/wellness in South Africa.

The most recent suicide worldwide report with 2019 data was published by the World Health Organization in 2021. In this report, South Africa ranked 10th worst worldwide with the highest rate of suicides, i.e. 23.5 per 100 000 people. Of the 13 774 suicides reported in South Africa, 10 861 were men whilst 2 913 were women, translating to a rate of 37,6 per 100 000 for men and 9,8 per 100 000 for women. These statistics highlight the fact that South African men are five times more likely to die by suicide than woman calling us to urgent action. As is well known, suicide rates in South Africa are poorly reported and the figures might even be higher.

Already in 2011, Bilsker and White published an article with the appropriate title of 'The Silent Epidemic of Male Suicide' in the British Columbia Medical Journal. They blame the cause on the lack of public awareness, a paucity of explanatory research, and the reluctance of men to seek help for suicide-related concerns. Finally, they write that only by breaking the silence, building public awareness, refining explanatory frameworks, implementing preventive

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strategies, and undertaking research will this epidemic be overcome. Paying attention to all these aspects will require a concerted and comprehensive effort from all stakeholders. One of the causes of the reluctance of men to seek help has been linked to stigma.

The stigma surrounding men's mental illness has been described as having wide-reaching and profound consequences. Stigma negatively impacts men's mental health help-seeking and the use of appropriate services. Although much has been written about

stigma, Corrigan & Watson identify the impact of stigma as twofold, i.e. public stigma as the reaction that the general population has to people with mental illness, and self-stigma as the prejudice which people with mental illness turn against themselves. Both public and self-stigma may be understood in terms of three components: stereotypes, prejudice, and discrimination explained in **Table 1** .

McKenzie and Oliffe et al. published a review of men's experiences of mental illness stigma across the lifespan. Synthesizing the literature, they identified common threads of stigma experienced by men going through diverse mental illness challenges. Aspects of public (social) stigma were highlighted which in turn drove their experiences of self-stigma. Men who anticipated, perceived, and internalised mental illness-related stigma faced a range of consequences. Those consequences included a reluctance to access and engage with mental health services, poor treatment adherence, employment issues, social disconnection, intensifying suicidal behaviour, and heightened risk for severe mental illness. Furthermore, their review findings confirm the links between gender, masculinity, and mental illness stigma.

Strategies for changing public stigma are complex and need a long-term societal strategy and approach. Corrigan & Watson propose three approaches: protest, education, and contact. Through protest the media should stop reporting inaccurate representations of mental illness and the public should stop believing negative views about mental illness. Protest is unfortunately a reactive strategy because it attempts to diminish negative attitudes about mental illness but mostly fails to promote more positive attitudes that are supported by facts.

Table 1:
Comparing and Contrasting the Definitions of Public Stigma and Self-stigma

Public stigma	
Stereotype	Negative belief about a group (e.g., dangerousness, incompetence, character weakness)
Prejudice	Agreement with belief and/or negative emotional reaction (e.g., anger, fear)
Discrimination	Behaviour response to prejudice (e.g., avoidance, withhold employment and housing opportunities, withhold help)
Self-stigma	
Stereotype	Negative belief about the self (e.g., character weakness, incompetence)
Prejudice	Agreement with belief, negative emotional reaction (e.g., low self-esteem, low self-efficacy)
Discrimination	Behaviour response to prejudice (e.g., fails to pursue work and housing opportunities)

The second approach is through education. By providing accurate mental health information the public can make more informed decisions about mental illness. Research has shown that persons with a better understanding of mental illness are less likely to endorse stigma and discrimination.

Lastly, stigma can be further diminished when members of the general public meet and interact with persons with mental illness, who are for instance able to hold down jobs or live as good neighbours in the community. Research has clearly shown an inverse relationship between having contact with a person with mental illness and endorsing psychiatric stigma.

Self-stigma clearly affects a person's self-esteem, self-confidence, and self-efficacy. The reaction of people with self-stigma may be either with indifference or anger. Anger as a reaction to social stigma may energise individuals and they will forcefully react to the injustice. This kind of anger often empowers people to change their roles in the mental health care system. They become more active participants in their management and treatment plans and get involved in improving the quality of healthcare services. In summary, ways in which people with mental illness cope with self-stigma needs to be addressed.

Men's mental health is a significant, complex yet often overlooked issue where stigma plays a pivotal role. Improving men's mental health should include reducing stigma together with addressing all mental health issues in men. Above all men should be encouraged to seek help when needed. Ultimately, men's mental health is a pressing issue that requires an integrated societal, governmental, and healthcare response.

References available on request. MHM

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By Professor Renata Schoeman
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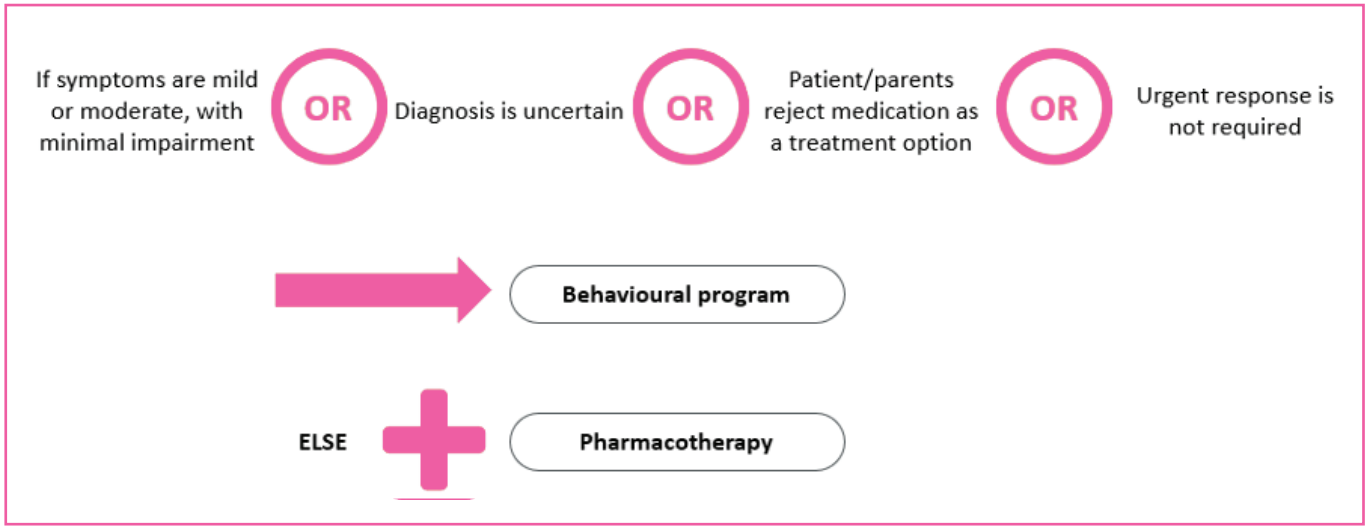
MEDICAL MANAGEMENT OF ADHD: THE LATEST TREATMENT AND MEDICATION OPTIONS FOR PATIENTS

ADHD is the most common psychiatric disorder in children, affecting approximately 1 in 20, and follows about 65% of them into adulthood, affecting about 1 million adults in South Africa. If left untreated, the condition can hamper sufferers' educational performance, self-esteem, relationships, and work productivity, and lead to an increased risk of other psychiatric disorders, reduced social functioning, delinquency, and substance abuse.

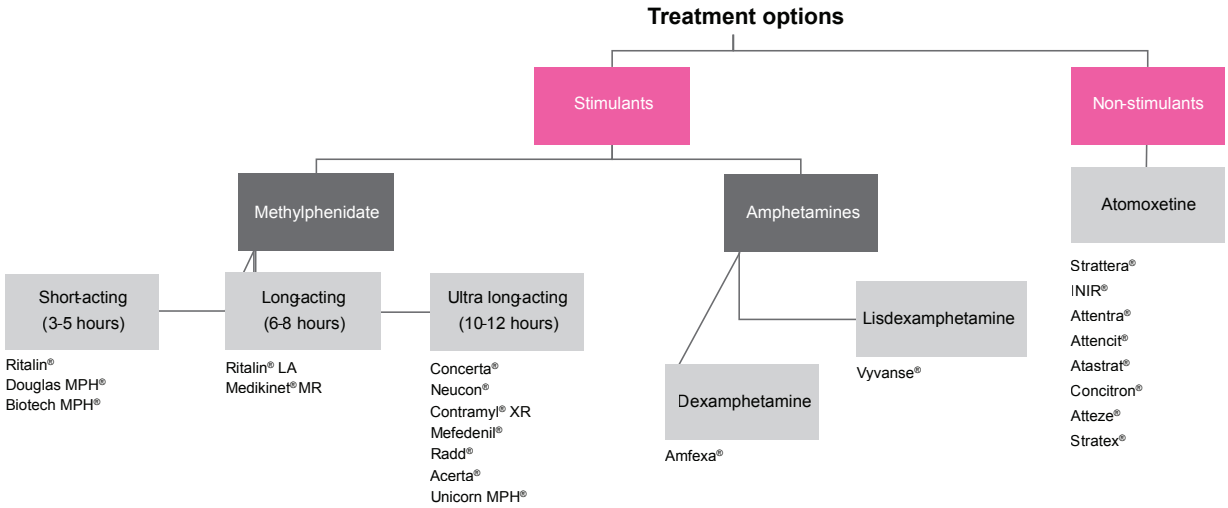
By not using the correct medication, children can fall behind in school, struggle to manage their emotions and relationships, see a rise in depression, anxiety and an increase in impulsive behaviour that could cause harm to themselves or others. Adults, if untreated, are also at risk as their interpersonal and work functioning may be affected, and the risk for developing comorbid mental health disorders, increases.

Since the publication of the South African management guidelines for adult ADHD (Schoeman & Liebenberg, 2016), many generics and new formulations of available substances, as well as new molecules have entered the South African market. Please consult the guidelines which emphasise the importance of a comprehensive diagnostic assessment, holistic treatment approach, and individualised care.

GENERAL APPROACH



Current treatment options (registered for the treatment of ADHD) available in South Africa



Medication schedule (registered, as well as off-label products available)

Substance	Trade name	Formulation	Doses	Dosing strategy
Methylphenidate	Ritalin® Douglas MPH® Biotech MPH®		Available in 10mg tablets	Approximately 1mg/kg/dose. Initiate at 5mg bd or tds with daily or weekly increments according to efficacy and tolerability (max 100mg/day po).
Methylphenidate Extended release	Ritalin LA®	Spheroidal oral drug absorption system (SODAS)	Available in 10mg, 20mg, 30mg, and 40mg capsules	Once or twice daily dose at equivalent of total daily dose of IR.
	Medikinet MR®	Modified release pellets	Available in 5mg, 10mg, 20mg, 30mg and 40mg capsules	Once or twice daily dose at equivalent of total daily dose of IR.
	Concerta® Neucon® Mefedenil® Unicorn MPH®	Osmotic controlled release oral delivery system (OROS)	Available in 18mg, 36mg and 54mg capsules/tablets	Once or twice daily dose at equivalent of total daily dose of IR.
	Contramyl XR®	Multi-unit pellet system (MUPS)		
	Radd®	Hydrophilic matrix release system		
	Acerta®	Extended release film coated tablets		
Dexamphetamine sulphate	Amfexa® *registered for children and adolescents aged 6-17 years		Available in 5mg and 10mg snap tablets	Initiate at 5-10mg/day po, with 5mg increase per week, to a max of 20mg/d (40mg for older children in exceptional cases).
Lizdexamphetamine dimesylate	Vyvanse® *registered for adolescents and adults from age 13 years	Amfetamine based pro-drug	Available in 30mg, 50mg and 70mg tablets	Initiate at 30mg per day, with 20mg increase after 2 weeks, to a max of 70mg/d. In patients with severe renal impairment, the maximum dose should not exceed 50mg/kg.
Atomoxetine	Strattera® NIR® Attencit® Attentra® Atteze® Atastrat® Concitron® Strattex®		Available in 10mg, 18mg, 25mg, 40mg, 60mg and 80mg capsules	Initiate at approximately 0.5mg/kg/day in patients <70kg with recommended daily dose 1.2mg/kg/day. In patients >70kg initiate at 40mg/day with monthly increments of 20mg/day to a maximum of 100mg/day (*maintain at least 12 weeks before judging clinical response).
Bupropion	Wellbutrin XL® Budep® Weldep XR®	XR (extended release)	150mg and 300mg tabs	Initiate at 75mg – 150mg/day po. Dosage may be adjusted in increments of 150mg at approximately monthly intervals to a maximum dose of 450mg/day.
	Voxra XL®	SR (slow release)		
	Bupropion XR Adco®	XR	150mg capsules	
Venlafaxine HCl	Efexor XR® Venlor XR® Efegen XR® Sandoz Venlafaxine® Venlafaxine Unicorn XR® Venlafaxine XR Adco®	XR	37.5mg, 75mg and 150mg capsules	Initiate at 75mg/day po. Dosage may be adjusted in increments of 75mg at approximately monthly intervals up to a maximum dose of 300/day.
	Illovex XR®	XR	37.5mg, 75mg, 150mg, 225mg and 300mg tabs	
	Odiven®		75mg and 150mg tabs	
Imipramine HCl	Ethipramine® Tofranil®		10mg and 25mg tabs	Initiate at 20mg to 70mg/day (10mg in elderly patients) and increase gradually to a maintenance dose of 100mg to 150mg/day (50mg in elderly patients).

Substance	Trade name	Formulation	Doses	Dosing strategy
Clonidine HCl	Equi Menoglo Drops®		0.025mg/5ml sol	Initiate at 0.025mg bd po and increase gradually to a maximum dose of 0.075mg bd po.
	Menograine®		0.025mg tabs	
Modafinil	Provigil® Modafinil 100 iPharma®		100mg tabs	Initiate at 100mg/day po. Can be increased to 200mg/day po.
Armodafinil	Nuvigil®		150mg and 250mg tabs	Initiate at 150mg per day po. Can be increased to 250mg/day po.

With the worldwide shortage of attention-deficit/hyperactivity disorder (ADHD) medicines due to increased global demand and manufacturing problems, many patients and parents are feeling despondent in their unfruitful search for medication.

At present, some methylphenidate and atomoxetine medications are affected, as well as all lisdexamphetamine and guanfacine. A study found that roughly 38% of all patients have had trouble finding and filling their prescription medication over the past year and 21% continue to experience treatment disruptions today.

Although medical staff are trying their best, this global shortage is out of their control.

This leaves parents and patients spending hours monthly in search of their medication from alternative pharmacies, an increase in doctor visits to transfer or rewrite prescriptions. In some instances, children and adults are now using less effective medication or go for weeks or even months without medication due to the lack of resources to find alternatives or have the monetary means for the additional expense.

The heightened awareness of ADHD the past couple of years has had a positive impact on early diagnosis and intervention and increased the number of users worldwide. Unfortunately, there are also some individuals being misdiagnosed, medication is being sometimes oversubscribed and even misused for perceived better performance. This increased demand for medication, as well as strict regulations in terms of production, are leading to the shortage in active ingredients for the medication.

The relaxed prescribing regulations brought on during the COVID-19 pandemic when fewer people were visiting their doctors but still needed their medication has certainly contributed. With the rules loosened, prescriptions were done via telehealth making it much easier for people to receive access to medication and for inadequate evaluations and the inappropriate prescribing.

HOW TO BEST MANAGE THE SITUATION

1. Always adhere to the established guidelines in managing ADHD. Do a comprehensive clinical assessment to establish the diagnosis BEFORE initiating treatment.
2. In the case of mild and moderate symptoms, consider complementary and alternative strategies, lifestyle interventions, and therapy prior to initiating controlled medications.
3. Emphasise the importance of nondrug treatments and lifestyle management strategies. Up exercise, decrease screentime, take omega 3/6 supplements, consider therapy to learn healthy coping mechanisms for time management and social skills.
4. Establish a relationship with your local pharmacies and medical representatives which you can use as resource to assist in sourcing medication for your patient.
5. Some of the available products/ tablets/capsules can be split into smaller doses and in some instances one can lower the dosage over weekends and holidays to keep a steady supply. During less active times ration the medication such as days where there is no homework and rather replace the medication with an active afternoon of sport or play.
6. Consider a temporary switch to alternative medications.
7. Be vigilant for the development of additional problems such as anxiety and poor self-esteem and monitor symptoms.
8. Consider the ethical implications of off-label/ non-ADHD use of medication. The consequences can be severe for those patients who desperately need the medication but cannot find a steady supply.
9. Healthcare providers must also adhere to guidelines and be thorough in their assessments before prescribing ADHD medication.

References available on request. MHM

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NARCISSISTIC PERSONALITY DISORDER

Narcissism is a term that has become both over-used and abused in popular culture. A common accusation levelled towards ex-partners and an umbrella term for abusive behaviour, narcissism, can be more accurately viewed as a trait that runs the gamut of normal human behaviour. Like all personality traits, it becomes problematic when used rigidly and indiscriminately, while thinking about oneself and relating to other people.

Narcissism is a term that was first used by Freud in relation to his theory of psycho-sexual development. He borrowed the term from the Greek myth of Narcissus, a beautiful young man who fell in love with his reflection in a pool, and eventually died there because he couldn't look away. It's a romantic image, but it only tells half the story. There is a lot more to narcissism than excessive self-love. In fact, it is better understood as the opposite. People with narcissistic traits are extremely self-absorbed, but this is a defence against an inner emptiness and feelings of unworthiness. Their personalities are organised around maintaining their fragile self-esteem by seeking attention and affirmation from outside themselves as compensation.

It's important to distinguish between narcissistic traits and Narcissistic Personality Disorder (NPD). A healthy personality uses a range of responses depending on the situation, whereas personality disorders, by definition, habitually utilise a very restricted range of defences. People who meet these diagnostic criteria are very rigid and unable to act or think outside their particular zone of experience. This is quite different to those who act in certain ways when under extreme psychological stress or circumstances such as substance abuse.

NPD is a psychiatric condition. It's one of the four cluster B personality disorders, the others being Anti-Social Personality Disorder, Borderline Personality Disorder and Histrionic Personality Disorder. All of these are marked by inappropriate and volatile emotions and unpredictable behaviour although internal motivations for these behaviours differ. It's important to note that there is a great deal of overlap amongst the cluster B disorders, and a person may show traits of more than one. The Diagnostic and Statistical Manual 5 (DSM5) conceptualises personality disorders as occurring on a spectrum, so NPD can be viewed as mild, moderate or severe.

Narcissists are greedy for what is termed 'supply'; attention, compliments, whatever nourishes and inflates their inner sense of unworthiness. To access this, those with a narcissistic personality organisation typically rely on the defences of idealisation and devaluation. They have a need to view another (child, partner, friend) as all good, so that they can become good by association. In relationships, narcissistic people battle to see others as separate entities, and this is where so much of the relational damage is done. They respond very badly to any criticism, and depending on the extent of their psychopathology, even normal feedback. The previously idealised other is then sharply knocked off their pedestal and devalued, becoming an object to be reviled. This is to defend at all costs against an inner sense of badness which cannot be contained.

Different theorists have suggested various pathways for the development of narcissism, but it seems to have, at least partly, a developmental etiology, meaning parenting practices and certain life experiences have created a particular template of self and others. The template produces diverse and subtle external manifestations. So, personalities exhibiting a variety of different behaviours may all have a fragile, narcissistic core that is sometimes difficult to see.

Consider, Donald Trump. The former US president is infamous for running his own narratives, despite all evidence to the contrary. His behaviour suggests he appears to be devoid of any capacity for self-reflection, is unable to take responsibility for his actions or accept criticism. It's dangerous to indulge in armchair diagnoses but Trump's behaviour does epitomise some narcissistic traits taken to extreme. His overtly grandiose behaviour is what is most people associate with the term "narcissist'. However, a core difficulty with identity and self-esteem can manifest in many guises. See below.

Case Study

Carol is a married woman in her thirties. Her husband is an academic who is emotionally remote, usually preoccupied with his latest research. Carol worked a few jobs before she got married but never really found her 'thing.' She is a small, mousy-looking woman, quietly spoken and passive. She has an adored only child, Theo, who she believes to be exceptional in every way. A primary school teacher who once suggested Theo might benefit from a different environment was harshly condemned. Carol proclaimed to her husband that: "No child of mine will go to a remedial school," and Theo was immediately moved to a different school. Carol insists that any difficulties Theo experiences are because he is special and gifted. She believes he will attend an Ivy League University one day and go on to "change the world."

Carol is using Theo as a narcissistic extension, attempting to live vicariously through him and co-opt his achievements as her own. Theo is likely going to grow up with the message that he is critically important to his mother, not because of who he really is but because of the function he fulfils for her. The development of a realistic self-esteem will be inhibited. If their relationship follows its current trajectory, one can speculate that his mother might be jealous of his friendships and future relationships. Separation and individuation, a normal and necessary developmental phase for young adults, is fiercely resisted and punished by parents with narcissistic tendencies.

Mental health practitioners have long recognised that narcissistic traits predict complicated and dysfunctional family dynamics, and very probably, more psychopathology within the family. It is a dynamic that is inter-generational. Children of narcissistic personalities tend to either partner with other difficult personalities to satisfy the people pleasing template they have developed growing up or exhibit narcissistic traits themselves. People with narcissistic tendencies do not typically seek out treatment or have good outcomes in therapy. This is because they battle to accept the "badness" that comes with taking responsibility; any problems they may encounter in their personal and professional lives are usually blamed on other people. In addition, narcissistic people do not age well. Youth brings opportunities for attention, relevance and affirmation and they battle to adapt to the changing circumstances and indignancies of old age, plus the lack of supply available to shore up their fragile egos. Many will resort to manipulations to hold onto power, indulging in attention seeking and guilt inducing behaviour.

Consistent with their reputation, narcissistic people can behave in ways that are bewildering and hurtful to others. But they are not deliberately and wilfully 'toxic' or 'predators.' Their behaviour is better understood as unconsciously motivated, stemming from a certain understanding of themselves and their place in the world. Friends and family members of narcissistic individuals would do well to remember that such people have a mental health condition, and to modify their behaviour, emotional responses and expectations accordingly.

References available on request. MHM

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PSYCOSOCIAL STRESS AND RELAPSE IN BIPOLAR DISORDER

Introduction
Bipolar disorder is a prevalent psychiatric disorder and presents with high rates of recurrences, relapses, comorbidities, co-occurring pathology and functional impairments. Genetic and environmental factors are assumed to be present in the onset and course of bipolar disorder. In this regard bipolar disorder is considered one of the most genetically mediated disorders. Although there are high concordance rates of bipolar disorder in identical twins, the concordance rates are 50-60%, leaving room for other influences such as psychosocial stress. Bipolar disorder tends to run in families, but approximately 50% of patients with bipolar disorder don't have a family history of bipolar disorder. It appears that the role of the environment and psychosocial stress are markedly underestimated. It's therefore important to explore the role of psychosocial stressors in the onset, development, and course of bipolar disorder.

Psychosocial Stress
Psychosocial stress plays an important role at various junctures in the onset and course of bipolar disorder. Furthermore, an array of psychosocial stressors may be relevant not only to the onset, recurrence, and progression of mood episodes, but the high prevalence of substance use disorder in bipolar disorder as well.

Various studies have indicated that patients with bipolar disorder reports the presence of stressful life events prior to episodes of depressed and manic mood dysregulation compared to euthymic mood in patients and control groups. Psychosocial stress related to achieving goals, the disruption of social rhythms, high expressed emotions and seasonal factors impact on bipolar disorder negatively.

Psychosocial Stress and Relapse
Psychosocial stress independent of bipolar psychopathology occurring within one year prior to bipolar mood dysregulation resulted in faster relapses and slower recovery. In this regard there is a bidirectional influence, namely that psychosocial stress impacts on the course of bipolar disorder and that mood dysregulation generally leads to psychosocial stress especially within relationships with significant others and work colleagues.

It is interesting to note that patients with bipolar disorder are exposed to significantly more stressful psychosocial life events than the physically ill. Data shows that patients with bipolar disorder experience an increased number as well as higher intensity of psychosocial stress events prior to an acute mood episode.

Childhood and Trauma
Traumatic life events in childhood causes a dysregulation of the inflammatory immune system and may be a risk factor for vulnerability to psychiatric and physical illnesses.

Studies have shown that patients with bipolar disorder who had experienced early severe environmental adversity, such as physical or sexual abuse as children, had an earlier age of onset of bipolar disorder compared with non-abused patients, and presented with an overall more serious, complicated, and treatment-resistant course once bipolar disorder manifested. These patients also present with faster cycling frequencies (four

or more mood episodes per year), an increased incidence of suicide attempts and higher level of more severe manic symptoms.

Tasks at the neural-developmental level, including emotional regulation and modulation and the ability to exert higher levels of cortical and cognitive control over activity in lower centres may be seriously impaired due to childhood adversity.

Comorbidities
Patients with bipolar disorder that experienced childhood adversity developed more axis (DSM) 1, 2 and 3 disorders compared to patients that did not experience such childhood adversity. There is a higher risk for the co-occurrence of substance use disorder and substance abuse mediate higher risk for poor outcomes and higher degrees of non-compliance to treatment leading to an increased risk of relapse.

Childbirth
When patients diagnosed with bipolar disorder experience childbirth as a stressful life event a significant number of these patients will present with mood dysregulation. It's also important to note that hormonal changes that occur during childbirth may impact negatively on mood regulation. Therefore, patients diagnosed with bipolar disorder may present with a depressed or manic mood episode. When compared to patients diagnosed with major depression fewer of them will experience an episode of depressed mood after childbirth. It's important to note that childbirth can be a positive or negative experience. For example, worrying about one's ability to look after the newborn or feeling confident to do so, the quality of social support, the type of family environment, the temperament of the baby can all mediate as either a positive or negative experiences. The disruption of sleep is of concern after childbirth in patients with bipolar disorder.

Stress Sensitisation
Psychosocial stress sensitisation may also occur, meaning that when psychosocial stress acts as a trigger for a mood episode in bipolar disorder, the patient may become more sensitive to relapse into a dysregulated mood with a similar stressor and leading to increased reactivity to stressors later in life. Thus, the occurrence of a sufficient number of "triggered" mood episodes result in lesser degree of stress and the anticipation of stress, to be associated with mood dysregulation.

Suicide Behaviour
Suicide attempts are a serious risk factor and predictor for suicide attempts in the future. Suicide attempts are usually preceded by a psychosocial stressor. Patients with bipolar disorder presenting with suicide attempts show a worse course of their mood disorder especially severe episodes of depression. Psychosocial stressors that are linked to suicide attempts are loss of social support, abandonment, financial difficulties, and lack of a good family structure. Furthermore, the loss of a family member by suicide is a stressor significantly associated with the onset of a manic episode. Also, the death by suicide of a mother or sibling is a greater risk factor for subsequent hospitalisation for a manic episode compared to death by suicide of other relatives. Attending a funeral has been shown to increase the risk of a manic episode. It appears that in men psychosocial stressors involving employment, legal matters and medical adversities are higher rated risk factors leading to suicide attempts. In women early childhood abuse and adult physical abuse as well as the pressure of multiple social role demands are risk factors for suicide attempts. Being hospitalised for more than four depressive episodes increase the risk for suicide in both men and women, although the odds ratio is much higher for women.

Gender Differences
In women the loss of their social network and support system are pertinent to triggering episodes of depression. In contrast, work related problems, divorce or separation tend to trigger depressive episodes in men.

Time Towards Mood Dysregulation
Research indicates that there is a substantial difference in time lapse from when psychosocial stressors occur until the presentation of mood dysregulation, in this regard it is approximately four weeks for manic episodes and up to six months for depressive episodes.

Mediating Factors
Of interest is that the following factors have been shown to be mediators of negative psychosocial stressors leading to relapse namely: interpersonal dependency, obsessionality and introversion.

It appears that family conflicts and financial problems are present in a significant proportion of relapses in bipolar disorder. Furthermore approximately 71% of patients with bipolar disorder experience a psychosocial stressor prior to mood dysregulation. Patients that experienced a psychosocial stressor and then relapse into a depressive or manic episode, perceive the stressor(s) as more severe than patients that remained euthymic after the occurrence and experience of a similar stressor. It therefore appears that there are certain factors that may positively contain mood destabilisation. It seems that the severity of depressive episodes correlates with the level of severity of the psychosocial stressor. This does not seem to be the case with manic episodes.

Conclusion
Bipolar disorder is a severe and disabling mood disorder, with an unpredictable course that varies strongly among patients. It's important that both positive and negative life events and their respective stressors be evaluated clinically because psychosocial stressors are associated with the occurrence of manic and depressive symptoms as well as functional impairment. Mental health practitioners should also be aware that psychosocial stressors tend to have a bidirectional relationship with bipolar disorder namely to precede mood dysregulation and to occur because of mood dysregulation. Furthermore, practitioners should be mindful to include treatment modalities that would improve resilience towards psychosocial stressors as this will help patients to acquire the necessary skills to improve mood regulation and stabilisation.

References available on request. MHM

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HOW CBT CAN CONTRIBUTE TO PREVENTING AND MANAGING BURNOUT IN HEALTHCARE PROVIDERS

"The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet."
- Rachel Remen

Hospitals, medical and psychology practises are the place where patients seek help when in distress, physically and/or emotionally. Nobody consults a medical or mental health professional when all is going well - or they're in glowing health!

Following the pandemic there has been a "second pandemic" of sorts, referring to the surge of those struggling with mental health. Global numbers estimate that one in three are currently

experiencing impaired mental health, which is far exceeding available resources among already stretched healthcare services. The broader context of a vastly different world than it was in 2019, socio-economically, politically and with many more experiencing losses on multiple levels, also affects everyone equally –patients and healthcare professionals who are trying their best to provide care.

This has resulted in prolonged and severe stress levels in healthcare workers. And it's no wonder then, that levels of burnout and impaired mental health among healthcare providers has surged as well.

"Healer, heal thyself"

Self-care and work-life balance are two of the most frequently discussed topics, in the direction of provider to patient. However, healthcare providers are notorious for neglecting to take their own advice. The issue is often not in the principle of stopping to take a break through a day of helping and healing. Rather, there tends to be a conflicting narrative, which sabotages this.

The cognitive component of cognitive behaviour therapy (CBT) focuses on exactly this narrative, which is often more important than the behavioural (habit) side of the patterns that lead to burnout. Taking breaks, regular exercise, drinking enough water, and good sleep hygiene, are all behaviours that can buffer chronic high stress levels. This advice is often dispensed to patients, as we know it works. Again, I point out that while this is agreed upon in principle, why is it that medical and psychological professionals fail to take their own (good) advice?

I invite the reader to consider which of the following are thoughts and beliefs they have had.

"If not me, then who (will help, fix, heal)?"

"While I'm taking a break, people are dying" (this more so in hospitals)

"I have to fit this extra person in; they need the help urgently" (psychologists are the main offenders here)

"If I don't fit them in, they won't make it"

"They can't wait"

"I'm tough, I can take it"

"There's no time (to stop/take a break)"

"I'll rest on the week-end/when I take leave"

And of course, after years of study, directed by a desire to make a difference, it's natural that 'service' overrides 'selfish.' If you identify the need and possess the skills that can make a difference to someone in distress, do you not then have a duty to act?

One way of modifying these unhelpful narratives, is to take a both-and approach. Consider the difference between "I don't care, I'm tired and I'm taking a break" (common when compassion fatigue sets in) and "of course I will help, others need me; don't be selfish." Then consider a both-and which would look something like "I need to schedule micro breaks and micro recovery moments, so that I can sustain my focus and energy over days and years." Add to this, "I can do more harm than help when I'm physically and mentally exhausted" (this is when you miss critical information due to fatigue or scattered thinking from too much mental juggling and volume or make a poor call due to impaired judgement). Studies abound showing how fatigue impairs cognitive functioning. And yet…

A second key insight to take on, and not just intellectually but at a visceral level, is that of *over-responsibility* versus *own responsibility*. While you may possess specialised education, specific skills, and the ability to alleviate suffering, you are only one in a collective of people. There is the patient, their family, their genetic predispositions, their own behaviours and habits, and their own narratives. (In a hospital setting, there are many additional factors). And each person or factor plays a part, with your part being one among many. There's the well-known proverb around it 'taking a village to raise a child' and this holds true here as well.

A third method of modifying unhelpful thoughts, is to practise *mindfulness*. I am referring specifically to methods which enhance being present in the current moment, which is a useful counterbalance to the internal pressure and scatteredness from trying to assist everyone, and the guilt arising from saying no. There are also mindfulness practises which focus on stepping out of the thought stream and watching mental activity instead of becoming absorbed in it - observing without judgement. This allows for a space to regroup and recover, also allowing for choice in how to respond wisely rather than to follow patterns of automatic reactivity.

Finally, there is the concept of *self-compassion*. When attention is largely focused outward (toward patients), there is at best a neglect and at worst a tendency to treat one's own needs with criticism and judgement, while comforting and soothing others. Self-compassion is defined as treating ourselves in the same way as we would treat a close friend, partner or child.

The aim of this article is to remind healthcare professionals of why they chose this profession, and that it is possible to develop a sustained ability to really help, instead of overworking, burning out, and then being impaired or unable. Fortunately, anything that is learned (thought patterns and beliefs) can be unlearned and relearned.

"As you grow older, you will discover that you have two hands - one for helping yourself, the other for helping others"
– Maya Angelou

References available on request. MHM

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THE IMPACT OF SOCIAL MEDIA AND TECHNOLOGY ON MENTAL HEALTH

In the dynamic landscape of modern medicine, the influence of technology and social media on mental health is undeniable. As physicians, it's crucial to understand the complex interplay between these digital platforms and the human mind. This article delves into the multifaceted dimensions of this relationship, examining its evolution, effects, and potential strategies for mitigating adverse outcomes.

THE TECHNOLOGICAL ERA AND THE HUMAN MIND

In the era of rapid technological advancement, our minds are continually exposed to an influx of information and stimuli. This digital revolution has reshaped how we communicate, consume information, and perceive the world around us. As our reliance on technology deepens, it becomes imperative to scrutinise its impact on mental well-being.

Social media platforms have transformed the way we connect and interact with others, fostering virtual communities and amplifying social dynamics. From Facebook to Instagram, Twitter to TikTok, these platforms offer unprecedented opportunities for self-expression, collaboration, and networking. However, they also present challenges in managing privacy, comparison, and digital overload.

MENTAL HEALTH & INCREASED USE OF SOCIAL MEDIA AND TECHNOLOGY

The psychiatric risks associated with prolonged exposure to social media and technology are diverse and far-reaching. One notable concern is the exacerbation of preexisting mood disorders such as depression and bipolar disorder. Studies have shown a correlation between excessive screen time and depressive symptoms, attributed to factors such as social comparison, cyberbullying, and decreased face-to-face interaction. For individuals with bipolar disorder, disruptions in sleep patterns caused by late-night screen use can trigger manic episodes or destabilise mood regulation. Furthermore, anxiety disorders, including generalised anxiety disorder (GAD) and social anxiety disorder (SAD), are significantly impacted by the pervasive nature of social media. The constant stream of notifications, likes, and comments can perpetuate feelings of hypervigilance and social scrutiny, amplifying anxiety symptoms.

Moreover, the phenomenon of "doomscrolling," wherein individuals compulsively consume negative news and distressing content online, can exacerbate symptoms of anxiety and exacerbate catastrophic thinking patterns.

Another concerning implication is the potential for technology addiction, particularly among adolescents and young adults. Internet Gaming Disorder (IGD) and Smartphone Addiction Disorder (SAD) are recognised as behavioural addictions characterised by excessive gaming or smartphone use, respectively. These addictive behaviours can lead to functional impairment, social withdrawal, and neglect of real-life responsibilities.

Additionally, emerging research suggests a link between excessive social media use and disordered eating behaviours, particularly among adolescents and young adults. The pervasive nature of body image ideals portrayed on social media platforms can contribute to distorted self-perception and unhealthy weight control practices. Moreover, exposure to content promoting extreme dieting, detox teas, and cosmetic procedures can fuel body dissatisfaction and perpetuate harmful behaviours associated with eating disorders such as anorexia nervosa and bulimia nervosa. The implications of these psychiatric risks extend beyond individual well-being to encompass broader societal concerns, including healthcare utilisation, academic performance, and social cohesion.

TEENAGERS, SELF-ESTEEM, AND SOCIAL MEDIA: A RECIPE FOR DISASTER

Adolescence is a developmental stage characterised by heightened self-awareness and a quest for identity, making teenagers particularly susceptible to the influences of social media on self-esteem. The curated nature of social media profiles often fosters unrealistic standards of beauty, success, and popularity, leading adolescents to engage in social comparison and experience feelings of inadequacy.

The prevalence of image-centric

platforms such as Instagram and Snapchat emphasises physical appearance and external validation, further exacerbating self-esteem issues among teenagers. Research has shown a correlation between excessive social media use and negative self-perception, body dissatisfaction, and disordered eating behaviours, particularly among adolescent girls. Additionally, the pursuit of online validation through likes, comments, and followers can create a perpetual cycle of seeking external affirmation, undermining authentic self-esteem and fostering dependency on digital feedback. The pressure to maintain a carefully curated online persona can also contribute to feelings of inauthenticity and disconnection from one's true self.

Encouraging teenagers to cultivate offline relationships, pursue meaningful activities, and engage in self-reflection can help counteract the negative effects of social media on self-esteem. Moreover, fostering resilience, self-compassion, and a strong sense of identity can empower teenagers to navigate the digital landscape.

TECH AND TEENAGE SUICIDE

The rise of technology and social media has coincided with concerning trends in teenage suicide rates. Researchers have observed a troubling association between increased screen time and suicide risk among adolescents. The constant connectivity afforded by smartphones and social media platforms has blurred the boundaries between online and offline interactions, creating new challenges for mental health professionals.

Cyberbullying, defined as the use of digital communication to harass, intimidate, or humiliate others, has emerged as a significant risk factor for suicidal ideation and behaviour among youth. Victims of cyberbullying may experience feelings of isolation, hopelessness, and worthlessness, leading to an increased risk of depression and suicidal thoughts. The anonymity afforded by online platforms can embolden perpetrators to engage in more aggressive and harmful behaviour, exacerbating the psychological distress experienced by victims.

The phenomenon of "suicide contagion" on social media platforms has garnered increasing attention in recent years. Exposure to posts or content depicting suicidal behaviour or self-harm may inadvertently normalise or glamorise these actions, particularly among impressionable individuals. This contagion effect can contribute to a clustering of suicide attempts within social networks and communities, amplifying the risk of copycat behaviour and escalating the public health impact of suicide. Added to this the proliferation of online communities and forums dedicated to discussing suicide and self-harm poses unique challenges for suicide prevention efforts.

SOCIAL MEDIA AND SELF-IMAGE

The prevalence of filtered photos, edited images, and curated lifestyles on platforms like Instagram and Snapchat can create unrealistic beauty standards and foster feelings of inadequacy among users. Research has shown a correlation between excessive social media use and negative self-image, body dissatisfaction, and disordered eating behaviours, particularly among young adults and adolescents. The culture of comparison inherent in social media can exacerbate insecurities and fuel a cycle of self-criticism and validation-seeking behaviour.

The pressure to conform to beauty ideals perpetuated by influencers and celebrities can erode self-confidence and perpetuate harmful beauty standards. Recognising the impact of social media on self-image is essential for promoting body positivity and self-acceptance in the digital age. Encouraging users to curate their online feeds mindfully, follow body-positive accounts, and engage in activities that foster self-esteem and self-care can help mitigate the negative effects.

MANAGEMENT STRATEGIES TO IMPROVE OUTCOMES

As healthcare providers, we play a crucial role in addressing the mental health challenges posed by technology and social media. By incorporating proactive strategies into our clinical practice, we can empower patients to navigate the digital landscape safely.

Firstly, it's essential to prioritise education and awareness among patients, parents, and caregivers about the potential risks and benefits of technology use. By fostering digital literacy and critical thinking skills, individuals can make informed decisions about their online behaviours and consumption. Additionally, clinicians can integrate screening protocols for technology and social media use into routine assessments, enabling early detection of problematic patterns and behaviours. The Haddon et al study reveals that children don't simply view the online world through a lens of caution; rather, they actively weigh potential risks against perceived benefits, demonstrating agency and adaptability in their digital experiences. By understanding children as active agents in their digital lives, healthcare professionals can tailor interventions to promote digital literacy and safety effectively. The study also emphasises the pivotal role of parental guidance and education in fostering responsible online behaviour.

Multidisciplinary teams e.g. OT's, school teachers, and technology experts, can facilitate comprehensive care and tailored interventions.

In the South African context, recognising the impact of socioeconomic factors and parental mediation on digital maturity underscores the need for targeted initiatives aimed at bridging the digital divide among youth from disadvantaged backgrounds. Healthcare providers can play a pivotal role in advocating for equitable access to digital resources and education, particularly for underserved communities. By addressing these factors comprehensively, healthcare professionals can contribute to fostering digital inclusivity and ensuring that all young individuals have the opportunity to thrive in an increasingly digitalised world.

By leveraging evidence-based interventions such as cognitive-behavioural therapy (CBT), mindfulness-based practices, and digital detox strategies, clinicians can empower patients to develop healthier relationships with technology. Moreover, advocating for policy changes and industry regulations aimed at promoting digital well-being and safeguarding user privacy is essential for creating a supportive environment conducive to mental health.

References available on request. MHM

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TRANSFORMING MENTAL HEALTH CARE: FROM COERCION TO SUPPORT

As members of the community and healthcare providers, many of us grapple with the complex issue of ensuring the rights of individuals with severe mental conditions. Often, including in South Africa, legislation states that when a person is a risk to themselves or others, and has

lost their mental capacity, they can be involuntary detained. This means a person is treated against their will in an attempt to help restore their ability to make decisions in their and other's best interests.

However, the presupposition that a person with a mental condition can lose their mental capacity and act in dangerous ways is being challenged by the United Nations Convention on Persons with Disabilities General Comment 1 (UNCRPD GC1), a pivotal global guideline for supporting individuals with disabilities. The UNCRPD GC1 argues that accurately measuring a person's mental capacity is inherently flawed and that depriving individuals of their legal autonomy is discriminatory. The GC asserts that assuming individuals with mental health conditions can't make decisions serves interests of social control and the maintenance of the status quo, essentially erasing differences and leading to what some have called the "hygienising" of society. GC1 also argues that the idea that people with mental conditions can become dangerous is unproven, and when such people do apparently become violent, it's probably in reaction to stigma and mistreatment, rather than a result of a mental illness.

Aside from the UNCRPD's global influence, these arguments carry weight in the context of historical injustices where certain social groups have had their autonomy unjustly denied in the past. For example, women being denied the vote, and racial justifications for slavery. Furthermore, the traumatic impact of involuntary care on individuals with mental health conditions cannot be overstated. One participant in our research conducted at Stellenbosch University vividly described the experience as feeling like "the property of the state, feeling "so lost" and experiencing involuntary care as "a nightmare".

In place of involuntary care, the UNCRPD advocates for "supported care". This approach involves providing individuals with the necessary environmental and interpersonal support to make autonomous decisions. It encompasses the importance of destigmatising mental health conditions within communities, fostering an environment where individuals feel understood, and offering empathetic listening without preconceived notions about the decision-making capabilities of a person with a mental condition. According to GC1, with these supports involuntary care will never be necessary, and people with mental conditions will always be able to make their own decisions, and therefore, have their autonomy protected. There is already some evidence that with the proper care, rates of involuntary care can be drastically reduced. Trieste psychiatric hospital in Italy has much lower levels of involuntary care than in most other countries and has become a hallmark of mental health services that are holistic and respect the autonomy rights of people with mental conditions.

In our own research, we found many instances where fear, shame, and panic could often make decision-making harder for people with mental conditions. These experiences could arise due to a person being faced with social stigma, feeling criminalised, losing control or in interaction with the general poor state of care in hospitals. There is often nothing to do in hospitals, and mental health workers are regularly overworked. This can make consenting to treatment an unviable choice for many people with mental conditions, and increase the likelihood that such people will be prevented from expressing themselves or exercising their rights to legal decision-making.

Nevertheless, implementing supported care proves challenging, particularly in a South African context. Limited professional support and heightened risks faced by individuals with mental health conditions in their communities complicate the availability of support. Further, the majority of people with mental conditions interviewed by us and the South African Federation for Mental Health report found that most people with mental conditions in South Africa value involuntary care and still see its use in the country.

While many of us may want to re-evaluate our knee jerk assumption that people with mental conditions are susceptible to being a danger to others, or can lose mental capacity, providing adequate supported care to people with mental conditions in South Africa is a challenge compared to in many more resourced countries. It seems critical to strive towards circumstances where coercion is no longer necessary, and this requires sensitive, holistic engagement with people with mental conditions in order to avoid the denial of their autonomy, however, in the interim careful and considerate involuntary care may have its place; the question is an open and debatable one that doctors, psychiatrists, and the general community must face.

References available on request. MHM

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HOW MINDFULNESS IS TEACHING ME TO BE A DOCTOR

"Sometimes to cure, often to relieve, always to comfort."

When I first saw these words, I was in my early twenties, a medical student at the University of Cape Town. They are inscribed on a plaque at Valkenberg Hospital.

I chose medicine, like many of us, with the idea of 'helping' and the more heroic the help, (i.e. the more it was removed from what the lay person could do) the more excited I was to learn it. The first time I took blood, the first baby delivered, the first caesarean section performed, all steps on a ladder where I could do what ordinary people couldn't. Where I could alter a patient's course away from its natural path using expert skill and knowledge.

If placing medical professions along a theoretical spectrum from comfort to relief to cure, the closer they appear to be to "cure" (such as surgery) the more status they have; the closer to comfort (such as nursing and psychotherapy) the lower the status. In spite of this I still pursued psychiatry, figuring that this frontier dealt with the source of suffering. That no matter what the body was doing, the mind was really the source of our quality of life, our meaning and learning to cure ailments of the mind would be the ultimate way to relieve suffering.

However, as I had found with the rest of medicine, I was confronted with many opportunities to face suffering where I didn't have the skills or resources to take it away. And I faced the cost to myself of the anger and frustration I felt when I couldn't 'fix it' - whether because of the

patient not complying with treatment, systemic flaws or incurable illness. And I met with all the ways health professionals deal with this, both wisely and unwisely.

In her poem, The Invitation, Oriah Mountain Dreamer challenges us; *"I want to know if you can sit with pain, mine or your own, without moving to hide it, or fade it, or fix it"*. The clinical expertise we hold as doctors is necessary. But my training did not offer sufficient mentorship in the trickier problem of how to face pain and suffering for a living.

My own personal psychotherapy was helpful to a point in seeing where this came from and learning more about my limits and healthy boundaries. However, it was when I was introduced to mindfulness that I first received instruction on how to do this incredibly challenging thing of being with things just as they are, including another person and their story.

When I was a registrar in child psychiatry, a visiting mindfulness teacher Sue Cooper (find her at https://stillmindretreats.com) led our academic programme with a short meditation. In the midst of the busy outpatient unit, hearing the children causing chaos in the waiting room, I was introduced to a skill I could use right then to be with the reality of my day in a different way. The unpleasant did not disappear. I was not denying it. I was shifting my relationship to it and altering how I allowed experience to land. Jon Kabat-Zinn, widely viewed as the father of mindfulness in the west, describes this as *'an orthogonal rotation in consciousness'*. And it changes everything.

This introduction prompted years of exploring mindfulness. Training as a mindfulness teacher, I realised how difficult, perhaps even heroic it is to comfort another soul in pain without rushing to first take that pain away. How to comfort is the first skill we should be taught as medical students but is the last one I'm still learning.

There are different techniques, teachers and paths to practice mindfulness but essentially it's about learning to meet life with open arms. Not because you like it or welcome it, but because this is the way things are. And if you can't be with things as they are, how can you hope to know and see what is really happening? How can you hope to live fully and to take wise action where needed.

The root of being with a patient in this way, is being with ourselves with an attitude of kindly acceptance. I teach a mindfulness course to fourth year medical students at UCT. Over ten hours of in person teaching time, the lesson we come back to again and again is how self-critical we are in the medical profession and how difficult it is to be kind to ourselves. The incredible work of Kristin Neff on Self Compassion (see https://self-compassion.org/) shows the evidence for this and how it can be developed. In the eight-week MBSR course (Mindfulness Based Stress Reduction) we teach the Attitudes of mindfulness as described by Jon Kabat-Zinn in his book Full Catastrophe Living

- non-judging
- patience
- beginner's mind
- trust
- non-striving
- acceptance
- letting go

The growth and support for mindfulness has been phenomenal and we are all being told to do it by someone. We are bombarded by reminders that mindfulness will transform our lives. But medicine and mindfulness should never pretend to be a "cure" for everything. There are situations in which mindfulness can fix a problem. During my specialist examinations, I did a walking meditation in the passages while waiting for my oral examination which settled my anxiety. But if you are coming to mindfulness to take away life's challenges, you will likely be disappointed.

When people approach us to register for one of our Mindfulness Based Stress Reduction (MBSR) courses, we insist on a screening interview where we discuss the programme in more detail. Many come with professional objectives of wanting to share this with patients or wanting to address stress and anxiety in their own lives. Often the stressors they describe are overwhelming and at some point, I need to give them a tough reality check. Mindfulness will not offer a quick fix relief from your suffering. It's not a way to manage an overwhelming schedule or an unreasonable boss who overworks you. It will provide skills in order to be with things more lightly, but it's not an escape.

Mindfulness taught me humility. The humility to allow patients to be their own guides, knowing that I have some medical expertise, but I'm not the expert on their life. It teaches us how to sit with a story full of anguish, and to bravely tolerate the silence and the torment without pushing it away or drowning in it. It taught me a way to practice and improve my ability to accept, be kind, be patient, and be still. The work of a lifetime.

For those who would like to explore mindfulness for themselves I have these pointers:

- You need a teacher and a community, this is really hard to do on your own using an App, no matter how enticing their free trial is.
- Regular practice is more important than occasional long periods of practice. Perhaps you could start with three minutes with your feet on the floor before standing up when getting out of bed each morning. This is to notice the sensations in your body and your breath.
- Beware of getting caught up in books, podcasts and articles about mindfulness at the expense of practice. The only way to learn or understand mindfulness is to practice it.

Specific places to practice:

- IMISA (Mindfulness Institute of South Africa) website which includes live weekly Monday morning meditations 8h00-8h30. Simply register: https://mindfulness.org.za/explore-mindfulness/online-guided-meditation-south-africa/
- The author's CPD accredited programs and free guided meditations www.capemindfulness.com

References available on request. MHM

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PSYCHOLOGICAL FIRST AID FOR PATIENTS IN CRISIS

Why Psychological First Aid?
Previously, when faced with a person who had just experienced a trauma, healthcare workers were encouraged to engage in debriefing with the person. Evidence now suggests that this approach could be more harmful than helpful, as it over-consolidates the painful and new memory in the person's mind and can even lead to increased rates of PTSD in the aftermath of a trauma. This phenomenon is due to stress hormones remaining too active during the direct aftermath, and debriefing efforts becoming toxic in effect and leading to poorer outcomes. Instead, it is recommended that Psychological First Aid be the first port of call following traumatic situations.

Psychological First Aid is a baseline, evidence-informed support for patients who present in a crisis. It provides coping skills and fundamental support during times of extreme stress. Within our context, we come across many such individuals, who may have just experienced a traumatic situation. This isn't the time to provide deeper therapeutic theory and practices, as the person is likely still in fight-or-flight mode and requires more of a brief intervention.

Psychological First Aid can be done by anyone and is not only for professionals or mental healthcare professionals. It's not the same as professional psychotherapy or counselling, and doesn't rely on psychotherapeutic skills. Psychiatric or psychological training is not needed, although it does form the first step in a person's journey with these resources.

Patients can often feel better over the long term if they feel safe and connected to others following a trauma, with access to different types of support, including physical and emotional support. This type

of intervention enables individuals to regain a sense of control over time by being able to help themselves.

When to provide Psychological First Aid

Psychological First Aid entails the most basic, non-intrusive and pragmatic care, with an intense focus on listening only. It's important, during this First Aid, to assess what the patient requires on not only a psychological, but also a physical level, ensuring that their basic needs are met. It's defined as humane, offering practical assistance and care. These are practices that are not readily taught but are valuable when encountering clients of any nature who are in acute distress following exposure to traumatic stressors.

Both adults and children can benefit from Psychological First Aid, and not everyone who experiences a crisis event will want or need it. It is important not to force this care onto anyone who doesn't want it, but to make yourself available and accessible should they require it. Psychological First Aid would normally need to be done immediately following a traumatic event but can sometimes only take place a few days or weeks after, depending on the patient's access to treatment and care.

How to help

Psychological First Aid relies on a few core principles that are done sequentially. It's important, while adhering to these principles, to respect the patient's safety, dignity, and rights, and not to force them to analyse or detail the trauma that happened to them – this is what comes afterwards, through more intensive psychotherapy. Psychological First Aid also requires us to be aware of other emergency response measures that are needed, and to take them into account.

The principles of Psychological First Aid are as follows:

- **Prepare:** before engaging with the patient, learn about the event, available resources and supports, and any ongoing safety or security concerns. Ask the patient about these in a non-obtrusive manner. If there are topics the patient is not ready to disclose around, be mindful of this and allow them the space to not feel pressured into telling their story with details, or even how they feel about what happened.
- **Look:** while assisting someone in psychological distress, observe where it is safe, and be on the lookout for individuals with obvious basic urgent needs, or serious distress reactions. Ensure the patient has a sense of safety by reducing any chaos and removing them from any potential threats to sit alone with you while you can listen to them actively. Reflect this evidence of safety to them.
- **Listen:** make yourself available to those who are needing support by making gentle contact with them and enquiring about their immediate needs and concerns in the moment. These may be as simple as a glass of water or to call a loved one for them. Listen to patients while they detail these needs and help them to establish calm through your own tone and manner. Encourage this sense of calm by being calm yourself, and by emphasising the present, what is practical, and what is impossible.

  Create a firm connection by building on the relationship and providing simple things such as eye contact and undivided attention. Helping someone in crisis to feel calm may also entail assisting them if they are having a dissociative reaction, or describe that they feel "unreal", by asking them to make contact with - themselves (such as feeling their feet on the floor, or their fingers on the chair), their surroundings (by noticing sounds, smells, or sights around them), and their breath.
- **Link:** assist patients to address their basic needs and access the services that they require. This may involve referrals to Crisis Centres or police services, for example. Help patients in intense psychological distress to cope with their immediate problems and don't worry about dwelling on any emotional content unless it comes up organically by the patient. Offer the patient basic information about what is to be expected in the immediate future, without becoming overly emotional or technical.

  Assist these patients in connecting with their loved ones and being afforded social support. It's beneficial to involve the patient in the problem-solving and self-care process by recognising and reminding them of their existing strengths. Hope may be created by reflecting specific, accurate, and positive facts, as well as presenting the patient with information regarding predictable and realistic next steps. This may involve detailing what is likely to occur with the referral you have given and encouraging them to engage in social support on their journey.

In a nutshell, the process of Psychological First Aid is not dissimilar to medical first aid, where safety needs and basic needs are met first. Following this, active listening takes place with encouragement and validation of normative reactions and feelings, and assisting those in need with future steps and, if necessary, referrals to follow and what these may entail. After the dust of the trauma has settled – sometimes weeks or even months later, vulnerable people should be re-assessed and provided with appropriate referrals to mental health professionals if needed to further their trauma treatment. Until then, Psychological First Aid remains the gold standard of care following a crisis.

References available on request. MHM

Based on the webinar with:
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DEALING WITH DEATH AS HEALTHCARE WORKERS

Introduction
A crucial and often overlooked issue in the medical field is grief and the loss of patients, and the profound impact that this can have on healthcare professionals and the quality of patient care. Healthcare workers are trained to save lives, but it is a harsh reality that despite the best efforts, there is profound sorrow to be found in the loss of a patient, and this sorrow needs to be confronted and addressed. Grief is a testament to the compassion and connection formed with patients

and their families. This is a complex aspect in the healthcare profession, as grief is multi-faceted and it may be difficult to cope with feelings of loss as healthcare workers.

What is a normal response when a patient dies?

There is no one normal reaction or response when a patient dies, and a whole range of different thoughts and feelings are quite expected, depending upon the circumstances of the death and a range of personal experiences. Some may feel apprehension about what end of life care will entail. Some healthcare workers may notice themselves thinking about past bereavements or personal experiences witnessed prior to the death, evoking difficult emotions that may have been felt before. Fears about one's own mortality are also common, as are anxieties regarding how long the end-of-life experience may go on for and how one may cope.

The death of a patient is likely to leave a healthcare worker with different feelings, from numbness and disconnection, through to sadness, worry and anxiety. Healthcare workers may also find it difficult to continually feel compassion when faced with death, and this does not mean they don't care. Numbness or lack of emotion is often due to exhaustion and is the mind's way of protecting individuals emotionally. It's important to be gentle with oneself, as there is no one set way to feel or not feel. Sometimes, the death may stay with a healthcare worker for a long while. All these reactions are normal, and often even common.

When a patient dies

It's important to create a small amount of space within the busy working day to allow oneself to acknowledge the death, but there is no right or wrong way to acknowledge a death. It may be helpful to do something to mark any deaths within healthcare teams, such as a moment's silence together or some other ritual. It may also help to acknowledge aspects of that person's end of life care that went well.

Talking to others is also helpful. Reaching out for support from managers or immediate colleagues can be immensely helpful, to assist in sharing experiences and the meaning-making behind it. Acknowledging any struggles is also a helpful engagement with others through social support, and even talking to friends and family and allowing opportunities to debrief.

Self-care in end-of-life care

It's important for healthcare professionals to think about the topic of death and dying so that they don't feel underprepared or taken aback when this comes up. Considering one's own triggers or indicators that stress, or burnout is cropping up, is something to always keep in the back of one's mind to manage that appropriately and timeously. Sometimes, post-traumatic stress can even occur with healthcare professionals, and this is something to consider when normative stress reactions don't resolve for over a month and begin to impact daily functioning.

Some things one can do to self-care in end-of-life care is taking small breaks, maintaining routine to feel more in control, looking after basic needs, creating peer support networks for emotional concerns, using end of day team huddles to talk about the loss of patients, staying connected to loved ones outside of work, and trying to move one's body, even with short walks at the start or the end of the day. Of course, this list isn't exhaustive, and it is helpful for healthcare workers to work on their own care routine with time.

Managing trauma

Sharing stories and experiences is crucial to enable one to start the natural process of assimilating the experience. Grounding or physical activity and breathing exercises and somatic experiencing can also assist in this. Facilitated debriefs are also useful within the healthcare environment, especially when experiencing complex or difficult deaths.

Self-compassion is a key tool in managing death in the healthcare environment. It's important to be thoughtful with oneself, engaging in positive self-talk and avoiding the critical voice by dealing with repetitive thoughts or using evidence-based techniques such as noticing feelings or looking for evidence of distorted thoughts to combat self-blame or shame.

It's important to stay attuned to oneself and create spaces and rituals for self-care when noticing persistent negative feelings or changes within functioning that are, in any way, impacting any day-to-day capabilities.

What can we do differently?

Dealing with patients' deaths can obviously have a massive mental health impact on healthcare workers. These experiences can run the full gamut of mental health difficulties. There are, however, opportunities to do things differently to circumvent this. This would require systems change with a range of interventions such as working on team cultures, debriefings offered by institutions, and education for healthcare professionals to be more informed with regards to their own mental health experiences or what to expect and competencies relating to death of patients.

Integration between disciplines is also hugely important when thinking about attitudes towards mental health and death and dying as well. This may include addressing mental health needs in cancer care, for example, or multidisciplinary teams working together to address the needs of healthcare workers, too.

In addition to debriefing, pre-briefing is also a useful tool for coping with the loss of patients. This involves anticipatory thinking, placing more of an emphasis on support before the event occurs. Preparation and priming are arguably just as important if not more important to overall learning. The more confident healthcare workers feel beforehand, the less adverse effects may follow. Pre-briefing involves considering different scenarios and goals, and then integrating these into the event thereafter.

Systems change involves exploring problems, such as difficulties in healthcare workers regarding death of patients, identifying problems, understanding them, and then creating systems that will lead to improved outcomes.

References available on request. MHM

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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LONDOCOR Event Management