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VOLUME 7 • ISSUE 3 • 2020

MHM

MENTAL HEALTH MATTERS

IS IT TIME TO RETHINK HOW WE DELIVER MENTAL HEALTHCARE SERVICES?

DEALING WITH ANXIETY IS ABOUT MORE THAN JUST TAKING MEDICATION

COVID-19: DEALING WITH A LACK OF CONTROL

COVID-19 AND MENTAL HEALTH IN THE SOUTH AFRICAN WORKPLACE

IMPACT OF TRAUMA ON CHILDREN AND BEST PRACTICES FOR INTERVENTION

THE SOUTH AFRICAN DEPRESSION AND ANXIETY GROUP

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* as defined by DSM IV Criteria

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REFERENCES: 1. IMS TPM Data, January 2020. **2.** Hewett K, Chrzanowski W, Jokinen R, *et al.* Double-blind, placebo-controlled evaluation of extended-release bupropion in elderly patients with major depressive disorder. *J Psychopharmacol* 2009; OnlineFirst, published on January 22, 2009 as doi:10.1177/0269881108100254. **3.** Clayton AH, Croft HA, Horrigan JP, *et al.* Bupropion Extended Release Compared With Escitalopram: Effects on Sexual Functioning and Antidepressant Efficacy in 2 Randomized, Double-Blind, Placebo-Controlled Studies. *J Clin Psych* 2006; 67(5):736-746. **4.** Cooper JA, Tucker VL, Papakostas GI. Resolution of sleepiness and fatigue: A comparison of bupropion and selective serotonin reuptake inhibitors in subjects with major depressive disorder achieving remission at doses approved in the European Union. *J Psychopharmacol* 2014; 28(2) 118–124. **5.** Fava M, Rush AJ, Thase ME, *et al.* 15 Years of Clinical Experience With Bupropion HCl: From Bupropion to Bupropion SR to Bupropion XL. *Prim Care Companion* J Clin Psych 2005; 7(3):106-113. **6.** Stahl SM, Pradko JF, Haight BR, *et al.* A Review of the Neuropharmacology of Bupropion, a Dual Norepinephrine and Dopamine Reuptake Inhibitor. *Prim Care Companion J Clin Psych* 2004; 6(4):159-166.

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A reduced frequency of dosing should be considered in patients with mild hepatic impairment. ***Children and Adolescents:*** Contraindicated in children or adolescents aged less than 18 years. ***Elderly:*** A reduced frequency and/or dose may be required. ***Renal Impairment:*** Treatment should be initiated at a reduced frequency and/or dose. ***Liver Impairment:*** Use with caution in patients with mild liver impairment - a reduced frequency of dosing should be considered. Contra-indicated in patients with moderate to severe hepatic cirrhosis. **SIDE EFFECTS:** ***Very common:*** weight loss, insomnia, headache. ***Common:*** hypersensitivity reactions such as urticaria, anorexia, agitation, anxiety, tremor, dizziness, taste disorders, visual disturbance, tinnitus, increased blood pressure (sometimes severe), flushing, dry mouth, gastrointestinal disturbance including nausea and vomiting, abdominal pain, constipation, rash, pruritus, sweating, fever, asthenia, chest pain. ***Uncommon:*** confusion, depression, concentration disturbance, tachycardia. ***Other:*** more severe hypersensitivity reactions including angioedema, dyspnoea/bronchospasm and anaphylactic shock. Arthralgia, myalgia and fever have also been reported in association with rash and other symptoms suggestive of delayed hypersensitivity; blood glucose disturbances; aggression, hostility, irritability, restlessness, hallucinations, abnormal dreams, depersonalisation, delusions, paranoid ideation; seizures, dystonia, ataxia, parkinsonism, incoordination, memory impairment, paraesthesia, syncope; palpitations; vasodilation, postural hypotension; elevated liver enzymes, jaundice, hepatitis; errythema multiforme and Stevens Johnson syndrome; twitching; urinary frequency and/or retention. **MANAGEMENT OF OVERDOSAGE:** Hospitalisation is advised. ECG and vital signs should be monitored. Ensure an adequate airway, oxygenation & ventilation. Gastric lavage may be indicated if performed soon after ingestion. The use of activated charcoal is also recommended. No specific antidote is known.

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BACK TO THE FUTURE OF COVID-19 AND MENTAL HEALTH CRISIS: START WITH THE PAST

Dr Kagisho Maaroganye
Specialist Psychiatrist
SASOP National Public Sector Convener
Centurion, Gauteng
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South Africa's already strained mental healthcare services now face increased numbers of patients relapsing on treatment along with rising new cases due to the stresses of the COVID-19 pandemic, while many psychiatric patients are at higher risk for COVID-19 due to co-morbid diseases and difficulties in following preventative measures such as mask wearing and physical distancing.

There need for resource parity with other medical disciplines has been soundly argued based on the high prevalence rate of psychiatric illnesses in South Africa and their cost to the country's GDP. Further justifying the need to pay greater attention to the mental health of the nation is the higher mortality rate seen in psychiatric patients. Researchers have produced several studies to establish mental health care system's norms and standards for the country to aim for. Norms and standards that are acknowledged within the country's endorsed mental health policy - National Mental Health Policy Framework and Strategic Plan(NMHPF) 2013-2020. It is the contention of most psychiatrists that these barometers have not been reached, not least in the areas of the fair distribution of mental health resources and bed capacity. Indeed, one of the key findings in the South African Human Rights Commission (SAHRC) 2017's Report of the National Investigative Hearing into the Status of Mental Health Care was that "comprehensive implementation of the NMHPF has not yet occurred". There could be several reasons why this is the case, but perhaps a combination of omitted language and significant governance change introduced in the NMHPF could have been some of the contributory factors.

The aforementioned policy points out that by 2020, the district mental health system will have been strengthened by existence of inpatient units in district and regional hospitals. But unlike "community mental health services (which) will be scaled up, to match recommended national norms", there appears to be no such requirement from those responsible for the establishment of these inpatient units. Indeed, the policy asks for the "establishment of a Mental Health Directorate in each province, with responsibility for both community and hospital based mental health services". Does this mean that these hitherto unknown entities based at provincial health departments will have the responsibility of creating hospital based inpatient (psychiatric) units? A laudable demand as it acknowledges the enormity and complexity of developing a comprehensive mental health care system, but one which blurs the lines of responsibilities between the District/Regional Hospitals CEOs and the said Directorate. Whose responsibility will it ultimately be to get this psychiatric bed-creating policy implemented? This singular question is significant enough to warrant a health summit on its own as it needs to be answered sooner rather than later. The lack of establishment of mental health directorates in some provinces in the year 2020, makes the achievement of this

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1. IQVIA, TPM data, Nov Mat 2019; Impact RX, Mat. November 2019.

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important task, or any task of the Directorate, simply unachievable.

Therefore, at the beginning of the National Framework's last year for significantly increasing the number of psychiatric beds in the country, the on-the-ground situation is still behind the curve. Then in March 2020, our consistent cry for beds was suddenly superseded by the medical bed-hungry COVID-19. This time, it was clear who should act and decisively so! All of the country's hospital managers went into action to find, create or plan for COVID-19 beds. Some succeeded, others struggled but a few started considering psychiatric beds as possible outposts for non-COVID-19 patients or Persons under Investigation. A form of hospital bed re-engineering as opposed to hospital bed creation. Psychiatrists start feeling the pressure, which they rightly felt was unwarranted because psychiatric patients are sick patients too and needs beds as well. SASOP then applied its mind on this issue which appeared to be root of an impending psychiatric bed crisis. SASOP reflected on 5 reasons why psychiatric beds needed to be preserved and in fact increased for the foreseeable future. Firstly, despite SASOP releasing a statement on the 6th April 2020 encouraging mental health care users to keep to their clinic appointments and remain compliant with medication, colleagues have reported reduced clinic attendance or postponed appointments. Secondly, the mental health care system continues to be compromised by chronic medication shortages and now more recently, intermittent closure of clinics for deep cleaning. Thirdly, telemedicine continues to be a pipe dream especially in the public sector and some therapists may not find much comfort in it. Fourthly, it is anticipated that the general public will experience prolonged psychological distress from the socio-economic effects of the pandemic and thus need psychological support and treatment in the near future. Finally, psychiatric patients themselves are regarded as being more vulnerable to contracting COVID-19 and a severe form of it, if they have co-morbidities. The conclusion became obvious, there is going to be a dramatic rise in persons and/or their families seeking help for themselves and their affected relatives during and after this pandemic. The general population and existing psychiatric patients will not be able to cope with the "new normal" from the comfort of their homes, if they still have one. So our mental health care system is going to need all the beds it has and more.

Thus SASOP pitched a stepwise strategic plan to address this bed crisis. It comprised of the following components: a) fast-track current licensing applications of NGO Residential Homes that can accommodate users with profound and severe intellectual disability in order to free up acute or specialist psychiatric beds b) re-procure contracted beds at larger long-term facilities that can house users with complex mental illnesses with risk factors that cannot be contained in the community c) immediately inspect all hospital facilities to search for underutilised wards d) pre-emptively hire more mental health providers to cope with the expected influx of new patients and to contain patients in the community so that they do not end up requiring hospitalization e) re-organize local hospital systems so that not all hospitals end up being designated COVID-19 hospitals that will not be able to admit psychiatric patients and f) proactively engage the private sector to assist in addressing any shortfalls in hospital bed capacity.

To answer a question that I was asked by one well known news anchor recently: "is government listening?", the answer is: it appears so! Through the national health department, attempts are afoot to conduct rapid situational analysis of the current shortfalls of psychiatric beds and seek ways to address these. Some regions have committed to build new psychiatric units and it is hoped that the bureaucratic system will not put paid to such plans. Other regions have created more posts for mental health providers not in response to this crisis but as a result of years of advocacy by their mental health technical advisory teams. Will these actions be enough to cope with the expected mental health crisis? How much worse will the economy get and how many citizens will be able to have the resilience to cope with that reality? Will a system that is still geared towards severe mental illnesses be able to adequately deal with the more prevalent common mental illnesses like depression and anxiety or will we see an increase in suicide attempts? Will the unbanning of alcohol and tobacco relieve the economy on one hand but lead to self-medication for psychological distress on the other hand? Will this self-medication result in overdoses or severe withdrawals and will casualty department be able to cope? Will families fear accepting psychiatric patients who became COVID-19 positive even after they have been stabilized both physically and psychiatrically? Will we ever have enough psychotropic medication in the community to help contain relapsing or new patients in the community and prevent admissions? Is this the future we are facing? Have we fixed enough of our past in order to cope with this future? A future whose "new normal" is unsettling and needy of even more psychiatric beds. It appears that the barometer for mental health care system's norms and standards may have silently gone up as SARS-CoV-2 decimated the social, physical and economic fabric of the country's citizenry. Only time will tell if we fixed enough of the past to cope with the future that is "new". MHM

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UNBUNDLING THE MENTAL HEALTH ACT

To begin with what is the Mental Health Care Act 17 of 2002? It's a 10 chaptered Act that provides guidance for the care, treatment and rehabilitation of persons who are mentally ill. It sets out different procedures to be followed in the admission of such persons. It ensures establishment of Review Boards in respect of every health establishment to determine their powers and functions. It provides for the care and administration of the property of mentally ill persons. It also repeals certain laws; and to provide for matters connected therewith.

PSYCHIATRIC HOSPITALS MAY ADMIT, CARE FOR, TREAT AND REHABILITATE

1. Voluntary mental health care users in special programmes
2. Assisted mental health care users
3. Involuntary mental health care users
4. State patients
5. Mentally ill prisoners
6. Persons referred by court for psychiatric observation in terms of the Criminal Procedure Act
7. Persons admitted for a long period as part of their care, treatment and rehabilitation

CARE AND REHABILITATION CENTERS MAY

1. Conduct assessments of intellectual abilities
2. Provide care, treatment and rehabilitation services to persons with severe or profound intellectual disabilities, including assisted and involuntary mental health care users.

Persons providing care, treatment and rehabilitation services must provide such services in a manner that facilitates community care of mental health care users.

Mental Health Care Act 17 of 2002 has been around since 2002 replacing what used to be called Mental Health Act. 18 years later the act is not fully understood nor implemented in RSA as there is insufficient training to relevant stakeholders on this act.

The common problem issues identified: -

- Insufficient resources to fully cater for care, treatment and rehabilitation on Mental Health Care Users
- Insufficient knowledge of the act by the public at large
- Insufficient knowledge of the act, stigma, discrimination, reluctance to help and lack of resources of the South African Police service members;
- Insufficient knowledge of the act, timeous and correct filling out and processing of relevant forms under this act by health care professionals
- Inconsistencies in the appointment of review boards

As much as the act is promoting de-institutionalisation of Mental Health Care Users there are social issues impacting it. The same Mental Health Care Users that are supposed to be re-integrated back into society are sometimes rejected by the families and the communities.

HOW TO IMPROVE THE ACT?

The improvement of the act also relies on involving all stakeholders at all levels, even at grass root level. There are issues on involuntary admissions currently looked into by activists thus when such amendments or improvements are made they are to be well informed.

The down referral of Mental Health Care Users from all levels of care needs to be clearly stated and implemented. The resources for such referrals also need to be strengthened or re-established.

The Mental Health Care Act has good intentions to deal with stigma and discrimination and integrate our Mental Health Care users, however it's not always practical as realistically our Mental Health Care users are sometimes a danger to self and others. There needs to be serious engagements of all relevant stakeholders.

There should be clear guidance on handling inpatient issues of various sexual orientations, especially as the judgement is usually impaired.

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SSRI = selective serotonin-reuptake inhibitor

References: 1. Cipriani A, Furukawa TA, Salanti G, *et al.* Comparative efficacy and acceptability of 12 new-generation antidepressants: a multiple-treatments analysis. *Lancet* 2009;373(9665): 746-758. **2**. Cipriani A, La Ferla T, Furukawa TA, *et al.* Sertraline versus other antidepressants for depression. *Cochrane Database Syst Rev* 2014;(4):CD006117. Doi:10.1002/14651858.CD006117.pub4. **3.** Parissis J, Fountoulaki K, Paraskevaidis I, *et al.* Sertraline for the treatment of depression in coronary artery disease and heart failure. *Expert Opin Pharmacother* 2007;8(10):1529-1537. **4**. Muijsers RB, Plosker GL, Noble S. Sertraline: a review of its use in the management of major depressive disorder in elderly patients. *Drugs Aging* 2002;19(5):377-392. **5.** Data on file. Bioequivalence study of sertraline.

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TRAINING ON HOW TO IMPLEMENT IT?

It's unfortunately evident that currently there is insufficient training on the implementation as there are still gaps.

It's evident on observation on the entire process there are gaps of insufficient training on the Mental Health Care Act and Mental Health Care Act Forms at various levels.

In our institution we conduct in-service training for staff and have been doing community talks, i.e., local radio stations. We have an up and coming outreach programme to the surrounding district hospitals, as specialised services level have identified gaps on transfer of the Mental Health Care users for further management and treatment at our level. Such initiatives should also be done for all institutions and continuously.

HOW AND WHY DOCTORS SHOULD TAKE/CONSIDER THE ACT?

Doctors are usually the first health professionals to assess and enter the Mental Health Care users under the act. Such health professionals should also bear in mind the highlights of the Mental Health Care Act i.e:

- De-institutionalisation,
- Establish the Review Board,
- Promotion of patients' rights
- Intervention by members of SAPS. It's imperative doctors understand how the act works and the required forms i.e. if the Mental Health Care user has been brought by the South African Police Service to ensure that the relevant form is submitted.
- Admit under correct status & process forms accordingly - i.e. voluntary, assisted or involuntary admission
- 72-Hour assessment and subsequent provision of further involuntary care, treatment and rehabilitation. The observation of timeframes, filling, processing and submission of relevant forms is also critical as admission of such patients without necessary forms is deemed illegal.
- Submit periodic review and annual reports on health care users
- Leave of absence and conditional/un-conditional discharge
- Appointment of administrator for care and administration of property of mentally ill person or person with severe or profound intellectual disability

THERE ARE ALSO RIGHTS & DUTIES RELATING TO MHCU TO BE TAKEN INTO CONSIDERATION SUCH AS:

- ✓ Respect, human dignity and privacy
- ✓ Consent to care, treatment and rehabilitation services and admission to health establishments
- ✓ Unfair discrimination
- ✓ To be protected from exploitation & abuse
- ✓ Privacy to their information
- ✓ Limitation on intimate adult relationships
- ✓ Right to representation
- ✓ Discharge reports
- ✓ Knowledge of rights

It's important doctors and other health practitioners teach people that health isn't like an on/off switch as there are different degrees of health. For example, some people have good health and have no problems going about their lives. Some people experience serious health problems, and their poor health has a very negative impact on their life. Some people have serious health problems that last for a long time, and others have serious health problems that resolve very quickly. Many people fall somewhere in the middle—they're generally in good health, though the occasional problem may come up. Mental health is the same way. Just as someone who feels unwell may not have a serious illness, people may have poor mental health without a mental illness. We all have days where we feel a bit down, stressed out or overwhelmed by something that's happening in our lives. An important part of good mental health is the ability to look at problems or concerns realistically. Good mental health isn't about feeling happy and confident 100% of time and ignoring any problems. It's about living and coping well despite problems.

Just as it's possible to have poor mental health but no mental illness, it's entirely possible to have good mental health even with a diagnosis of a mental illness because mental illnesses (like other health problems) are often episodic, meaning there are times (episodes) of ill health and times of better or good health. With the right support and tools, anyone can live well—however they define well—and find meaning, contribute to their communities, and work towards their goals.

As the World Health Organisation says "There's No Health without Mental Health", the mental health issues are paramount and must be handled as such. MHM

References available upon request

SADAG Office	011 234 4837
Suicide Crisis Helpline	0800 567 567
Dr Reddy's Mental Health Helpline	0800 21 22 23
24 Hour Cipla Mental Health Helpline	0800 456 789
Pharmadynamics Trauma Helpline	0800 20 50 26
Adcock Depression & Anxiety Helpline	0800 70 80 90
ADHD Helpline	0800 55 44 33
24 Hour Substance Abuse Helpline	0800 12 13 14

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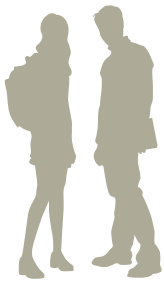
The South African Depression and Anxiety Group | TheSADAG

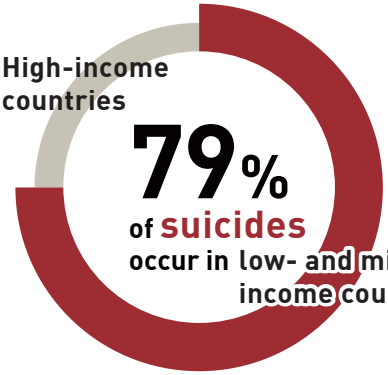
Suicide: facts and figures

Suicide is the **second** leading cause of death among **15-29** year-olds



Close to **800 000** people die by **suicide** every year

1 death every **40** seconds



There are more deaths from **suicide** than from war and homicide together

Pesticides, hanging and firearms are the most common methods used globally

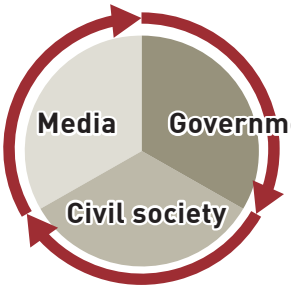
Suicides are preventable

- Restricting access to means
- Responsible media reporting
- Introducing alcohol policies

Effective preventive measures

- School-based interventions
- Training of health workers in early identification and treatment
- Follow-up care and community support

Key is a comprehensive multisectoral approach



Most countries currently do not have a **national suicide prevention strategy**

Reduction of suicide rates:
by 10% in the WHO Mental Health Action Plan 2013-2020
by 1/3 in the UN Sustainable Development Goals 2030

World Health Organization

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- **In Non psychotic disorders to depress excitation and also psycho-reactive or neurotic symptoms**[1]
- **Etomine sedates and exerts good antipsychotic effects and helps the patient re-establish contact with their environment**[1]

Refrences: 1. Etomine South African Approved Package Insert. Approved 19th September 1995. 2. González CA. Expert Report ons Clotiapine (Etumina®). Department of Pharmacology, Universidad de Alcalá. 3. Katerine A. Lyseng-Williamson. Clothiapine in Schizophrenia. Guide to use. Adis. 16th September 2015.

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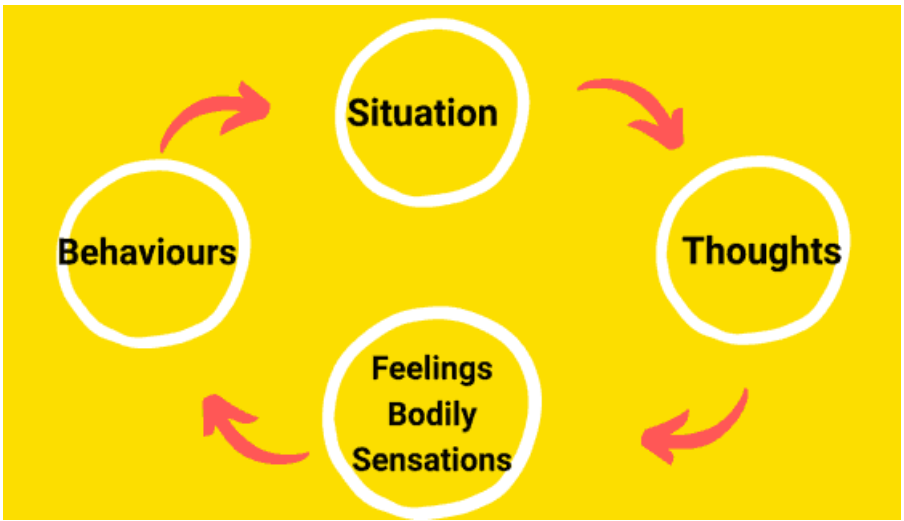
DEALING WITH ANXIETY IS ABOUT MORE THAN JUST TAKING MEDICATION

I probably don't need to be the one to tell *you* anxiety is at an all-time high right now. Many people are experiencing heightened levels of anxiety, as they're faced with great uncertainty, instability, loss of control, connection with loved ones and normal coping mechanisms. So it's to be expected that many will be seeking ways to treat such anxiety, as it can be debilitating to manage it otherwise.

Which is where you come in. As GPs, people turn to you with expectations that you will cure their ailments, which in many instances you can do. When it comes to anxiety however, it's not as straightforward and I can imagine it causes a great deal of anxiety in itself to be held to such unrealistic expectations by patients. Whilst of course medication does make a difference in treating anxiety it doesn't take it away – especially in a pandemic setting, where being anxious makes a lot of sense. So in order for you to be effective in helping them it's vital you manage their expectations.

This article will help equip you with additional tips around the management of anxiety, to help you help your patients within the bounds of realistic expectations. Expectations play an extremely important role in managing anxiety, because they're often the most common triggers of anxiety. Why? Well let's look at this from a cognitive behavioural perspective (CBT):



The Coronavirus has technically placed us all in a situation that by definition is traumatic. The reason being that our lives or the lives of our loved ones are under threat. This, coupled with the uncertainty of how long we'll be faced by this threat, inevitably leads to a storm of thoughts about the future, assuming all the worst case scenarios and fearing the unknown.

Such thoughts understandably trigger anxiety. Usually people would manage by making plans or getting support from loved ones, however these strategies aren't feasible at the moment which is what makes this situation particularly anxiety provoking. Many don't know what to do and are left needing to develop new coping strategies in the midst of intense anxiety which is very challenging.

Whilst medication is highly effective in managing the experience of anxiety, it doesn't magically change the way we think, which is why it takes more than medication to manage the anxiety people are currently experiencing.

Just to clarify, I'm certainly *not* telling people to stop thinking what they're thinking, or to just think more positively – as that's probably the worst thing to tell an anxious person. What I *am* suggesting is that people learn to react to their thoughts in ways that are more helpful, which you can assist them with.

How? Well, for one people need to start actually noticing what they're thinking. The reason being we're often not aware of all the thoughts flying around our heads, we're just used to reacting to how we feel. This isn't helpful because our thoughts are often not true or fair but are merely subjective perspectives that shouldn't be accepted by default.

Once people notice what they're thinking it's then helpful to consider whether or not these thoughts are truthful, fair and/or helpful to hold on to and focus a lot of attention on. It's common for people in uncertain situations to focus on what may happen in the future. However, focussing a lot of attention on future orientated predictions isn't helpful and tends to just increase anxiety and distress. As humans, we don't do well when we're not in control – it's a survivalist thing – so when we focus on the future, the past, or situations out of our control, we tend to become distressed.

People tend to judge themselves when distressed – wishing they felt or could think in a different way, which ends up increasing their difficult feelings and gets them even more tangled up in these unhelpful patterns of thinking. What's most effective is to remind people that it's not helpful to judge themselves for something out of their control. What people CAN control is how they react to these thoughts and feelings. One of the most effective techniques to assist people to shift their way of reacting to their own thoughts and feelings is pointing out that if they were reacting to a loved one's distress and anxiety, they would most likely respond with compassion and patience, as this is far more helpful than berating someone in this state (which is often what we do to ourselves in these moments).

What I'm suggesting is popularly known as mindfulness. It takes practice, but people can learn to notice when they're focussing on unhelpful thoughts, NOT judge themselves for it, but rather accept their present experience and bring their attention to the present moment, where they can be more in control. This doesn't necessarily mean their anxiety goes away, but it certainly does decrease distress and can provide them with the opportunity to respond to themselves with compassion and patience. Whilst this may seem counterintuitive to many, it's more helpful to accept their present experience and rather focus on what they *can* do to cope.

In addition to taking medication, people should seek out therapy if they're not coping – but this isn't always a viable option as it's not easily accessible, so here are some other tips. Learning and practicing mindfulness can make a huge difference – there's a lot of information online, as well as many apps that are particularly helpful (especially for those battling with sleep):

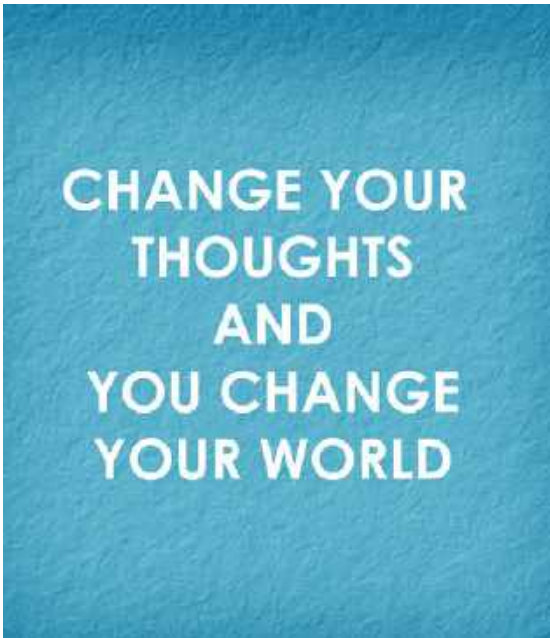
- Headspace
- Smiling mind
- Calm
- Insight timer

Acceptance plays a big role right now, however people tend to get a bit confused when it comes to this. Often, when people accept the situation they're in isn't within their control, they expect to not have feelings about it - "it is what it is". This isn't realistic or helpful – if they accept the situation for what it is, then of course they'll have difficult feelings about it. The process of acceptance includes accepting the subsequent feelings and finding helpful ways to let them out because bottling those feelings up makes it almost impossible not to focus a lot of attention on them.

The sooner people learn to accept their experience; the sooner they can respond to themselves more effectively. During these uncertain times people who're expecting themselves to be fine and keep functioning as 'normal' aren't being realistic or fair to themselves, which can exacerbate their anxiety. They need to find ways to be more realistic in their expectations, whilst being patient and compassionate with themselves.

They need to understand that taking a pill isn't necessarily going to be enough to allow them to continue functioning normally, as medication can't take away the stress that comes with Covid. It may help physically, but unless people are willing to accept that 'it's okay to not be okay' right now, and in turn place more compassionate and realistic expectations on themselves, they will continue to battle. Whilst it's not your job to help them change their expectations, it's important to clarify that they need to do more than just hope the pill takes it all away, as this can make a massive difference to the management of their anxiety. MHM

References available upon request



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* Depression, as defined by DSM-IV Criteria; DPNP = Diabetic peripheral neuropathic pain

Reference: 1. Yelate 30/60 package insert. Dr. Reddy's Laboratories (Pty) Ltd. December 2012

S5 Yelate 30/60. Each capsule contains duloxetine hydrochloride equivalent to duloxetine 30/60 mg. Reg No's 44/1.2/0114;0115. Dr. Reddy's Laboratories (Pty) Ltd. Reg no. 2002/014163/07. 204 Rivonia Road, Block B, Morningside, Sandton. 2057. www.drreddys.co.za. ZA/01/2020-22/Yel/001

For full prescribing information refer to the package insert approved by the medicines regulatory authority.

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COVID-19 AND MENTAL HEALTH IN THE SOUTH AFRICAN WORKPLACE

Life during the COVID-19 pandemic and subsequent lockdown measures has changed everything familiar about 21st century living. As social distancing measures were introduced to contain the spread of the virus, many people's usual routines and livelihoods were significantly impacted which lead to a rise in levels of loneliness, depression, harmful substance use, and suicidal behaviour.

The South African Depression and Anxiety Group (SADAG) reported that calls to their helpline have doubled since the start of lockdown, receiving 1200 – 1400 calls per day. In an online survey conducted in April 2020, they found that 59% of respondents felt "stressed/very stressed" before lockdown. This figure rose to 65% during the lockdown. The survey found that the main challenges during lockdown were Anxiety, stress, financial stress and Depression.

Health experts are comparing the COVID-19 pandemic to an ongoing 'cardiac stress test'. The pandemic is testing the world's infrastructures and systems, and magnifying their functional and structural vulnerabilities.

New South African research by Afriforte (WorkWell Research Unit, Faculty of Economic and Management Sciences, NWU Potchefstroom) conducted an online assessment tool looking at the COVID-19 experiences of 1656 South African employees between 15 May – 15 June 2020. The *MyCovid19Experiences* found that everyone is experiencing crisis at some level.

Most people are familiar with the term Post-Traumatic Stress Disorder. PTSD is a long-term mental health disorder that people experience following a traumatic event. Pre-TSD, on the other hand, involves experiencing stress and anxiety because of an anticipated trauma or a traumatic event.

Pre-Traumatic Stress Syndrome is an anxiety condition which differs from the day-to-day stress that people experience. Pre-TSD is a syndrome involving involuntary, intrusive images, and flash-forwards of haunting events that could be experienced. Pre-TSD results in fear of the future and loss of control which explains the dynamics of irrational panic buying.

Symptoms of Pre-TSD:

- Racing thoughts and constant worrying
- Constant feelings of uncertainty and insecurity
- Loss of objectivity and fearful anticipation,

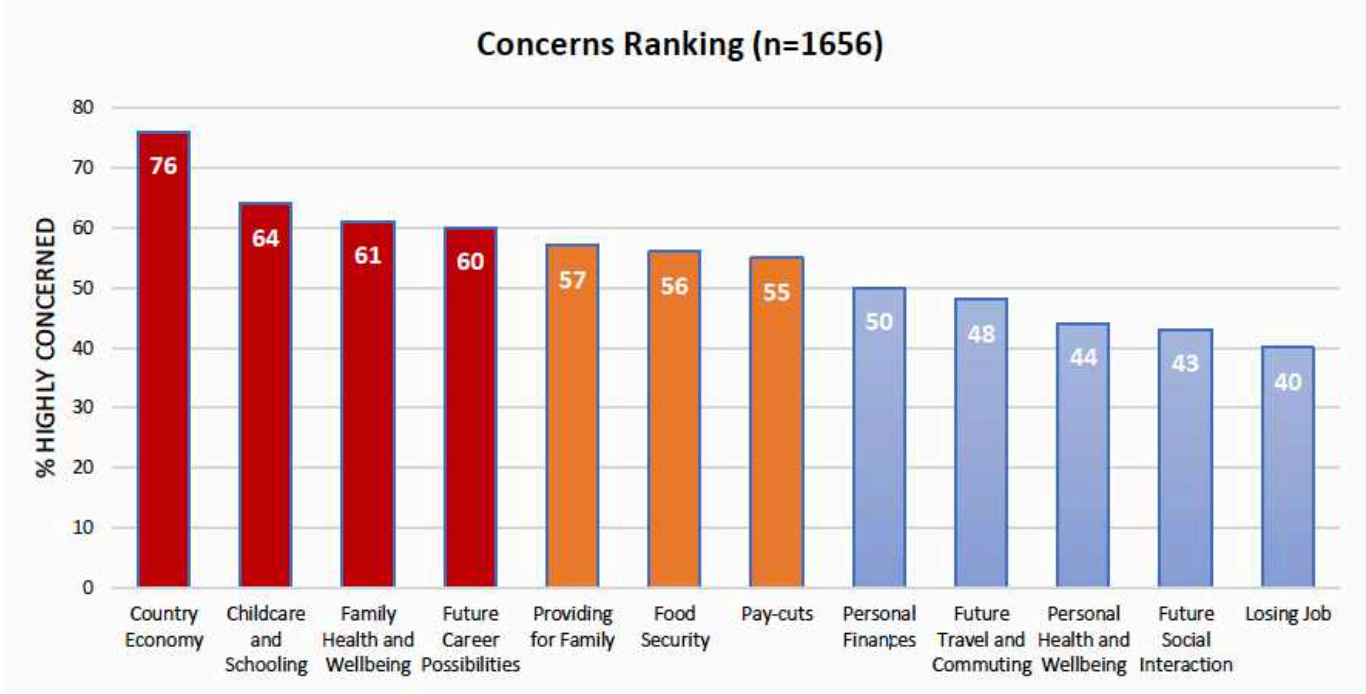

FIGURE 1: CONCERNS RANKING FOR A SAMPLE OF SOUTH AFRICAN EMPLOYEES

- Mood swings,
- Concentration issues,
- Poor judgment and
- Risky decision-making/ Risk behaviour: e.g. suicide ideation, social risk behaviour e.g. domestic violence.

If the psychological symptoms of Pre-TSD are not addressed, it progresses to physical symptoms such as headaches, gastrointestinal issues, problems with eating and sleeping, heart palpitations, and muscle pains. These symptoms often cause individuals to feel chronically stressed and generally unwell on a psychological and physical level.

"The most concerning research findings are that 49%, of employees have high levels of concern. A further 46% of employees are at high-risk of developing Pre-TSD and associated symptoms. Over a third (35%) of employees are experiencing high incidences of stress-related physical symptoms" says Professor and Managing Director of Afriforte, Prof Ina Rothmann.

The main COVID-19 stressors for South African employees include the country's economy and ability to recover (76%), childcare and schooling (64%), family health and wellbeing (61%), and future career possibilities (60%). This shows that South Africans are not only concerned about the economy but are also extremely concerned about the well-being of their families – a concern that was more prevalent for female respondents.

Prof Ina Rothmann continues, "High levels of psychological distress can result in risky behaviour, and the development of anxiety syndromes and depressive disorders. Pre-TSD explains how the COVID-19 pandemic has psychologically impacted South Africans. If these factors are not addressed proactively, the mental wellbeing of people is impacted more negatively, possibly predisposing the individual to the development of anxiety, depression or PTSD".

The authors postulate that the concept of Pre-Traumatic Stress Disorder (Pre-TSD) may contribute to the discourse around the psychological impact of the COVID-19 pandemic as it could be a predictor for the development of post-traumatic symptoms (Berntsen & Rubin, 2015; Bomyea, Risbrough, & Lang, 2012). It should be made clear however, that pre-TSD is not a recognized psychiatric diagnosis and hence should not be used on medical certificates.

Prof Christoffel Grobler, Associate Professor WSU, psychiatrist and medical advisor to Mindful Revolution, says that mental health service providers, the medical insurance industry and employers need to take note of this research. "These results indicate the negative impact that COVID-19 has had on the functioning of employees at work, which include lower productivity, increase in mistakes and errors, poorer customer service, and higher risks for accidents and injuries at work".

"Furthermore, mental health services providers can expect an increase in patient volumes and the medical insurance industry should prepare for an increase in mental health expenses for the next two years. Employers need to include mental health promotion programmes as part of their COVID-19 business recovery strategy," says Prof Grobler.

The research does however show that feelings of HOPE counteract

the experiences of Pre-TSD. Hope, which is the presence of the positive, is a mitigating factor of stress. A combination of support (vocationally and socially), a sense of 'taking action' and some level of control decreases the experience of stress and trauma.

"From years of study, we know that as hope levels increase, trauma and stress symptoms decrease. From our sample, an important finding is that although employees are concerned about the future, 77% of them experience decent hope levels, where only 4% are in despair with no presence of hope," explain Prof Rothmann

Prof Grobler further states that "what we need now is inspiring leadership, politically and in the workplace. While it is good to remain realistic about the pandemic, leaders also need to inspire and create hope for the future." Sharing positive recovery efforts and highlighting the important part that each employee plays in achieving recovery will instil hope in South African employees. Prof Grobler recommends that employers need to show that being at work, working safely and staying healthy, contributes to business and economic recovery. Unclear direction and focus, impede hope and contribute to pre-TSD experiences.

Employers are best positioned for recovery when they proactively mitigate the mental health impact of the COVID-19 pandemic and this is why mental health protection and promotion should be part of the COVID-19 business recovery strategy. Mental health protection and promotion can be achieved through the facilitation of *COVID-19 touch base sessions* with teams in the workplace. Prof Rothmann states that as a result of the research, a real-time COVID-19 touch base platform has been developed for employers to assist them to do this effectively.

It's so important that employers create a safe space for employees to have conversations about the mental health impact of COVID-19. This can serve as mental health first aid and reduce the load on mental health service providers such as SADAG and others. MHM

References available upon request

Key Findings from *MyCovid19experiences* Mental Health in the SA Workplace Research:

- 1656 South African employees completed the *MyCOVID19experiences* assessment (15 May – 15 June 2020)
- 50.4% males versus 49.6% female
- Age Group:
  - 33.1% are 30 – 39 years old (career builders)
  - 28.5% are 40 – 49 years old (mid-career)
  - 18.5% are 50 – 59 years old (mature career)
- 49% of employees indicated high concern levels following the COVID-19 outbreak
- While only 2% reported not to have concerned about the future following COVID-19
- Concern levels appear to be higher for young age groups (20 – 39 years) and employees with children
- 77% of the sample experience decent levels of hope about the future, whereas slightly less overall hope for older age groups (50 and older)
- The country's economy is the top concern for all biographical groups
- 40% of the sample ranked losing their jobs as a huge concern
- 46% of the SA employees are at high risk Pre-TSD and associated symptoms, only 26% are at low risk
- Females (52), remote workers (53%) and pre-retirement groups (49%) are at higher risk
- 35% are experiencing a high incidence of stress-related physical ill health symptoms
- Females, Remote workers, and mid- and mature-career employees show higher risks for experiencing stress-related physical symptoms.
- The overall physical health impact of the Covid-19 disruption on this older group of employees is a concern – might contribute to metabolic syndrome risks in future.
- The results for the sample of South African employees support the mitigating effect of Hope on the development of Pre-TSD. As Hope levels increase, the experience of Pre-TSD symptoms decrease. Promoting Hope could have a positive impact on employee functioning

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References:
1. Taipale H, Mittendorfer–Rutz E, Alexanderson K, et al. Antipsychotics and mortality in nationwide cohort of 29 823 patiens with schizophrenia. *Schizophrenia Research* 2017. Available from: http://doi.org/10.1016/jschres.2017.12.010. 2. Decuypere F, Serman J, Geerts P, et al. Treatment continuation of four long-acting antipsychotics medications in the Netherlands and Belgium: A retrospective database study. *PLoS ONE* 2017;12(6):e0179049. https://doi.org/10.1371/journal.pone.0179049.

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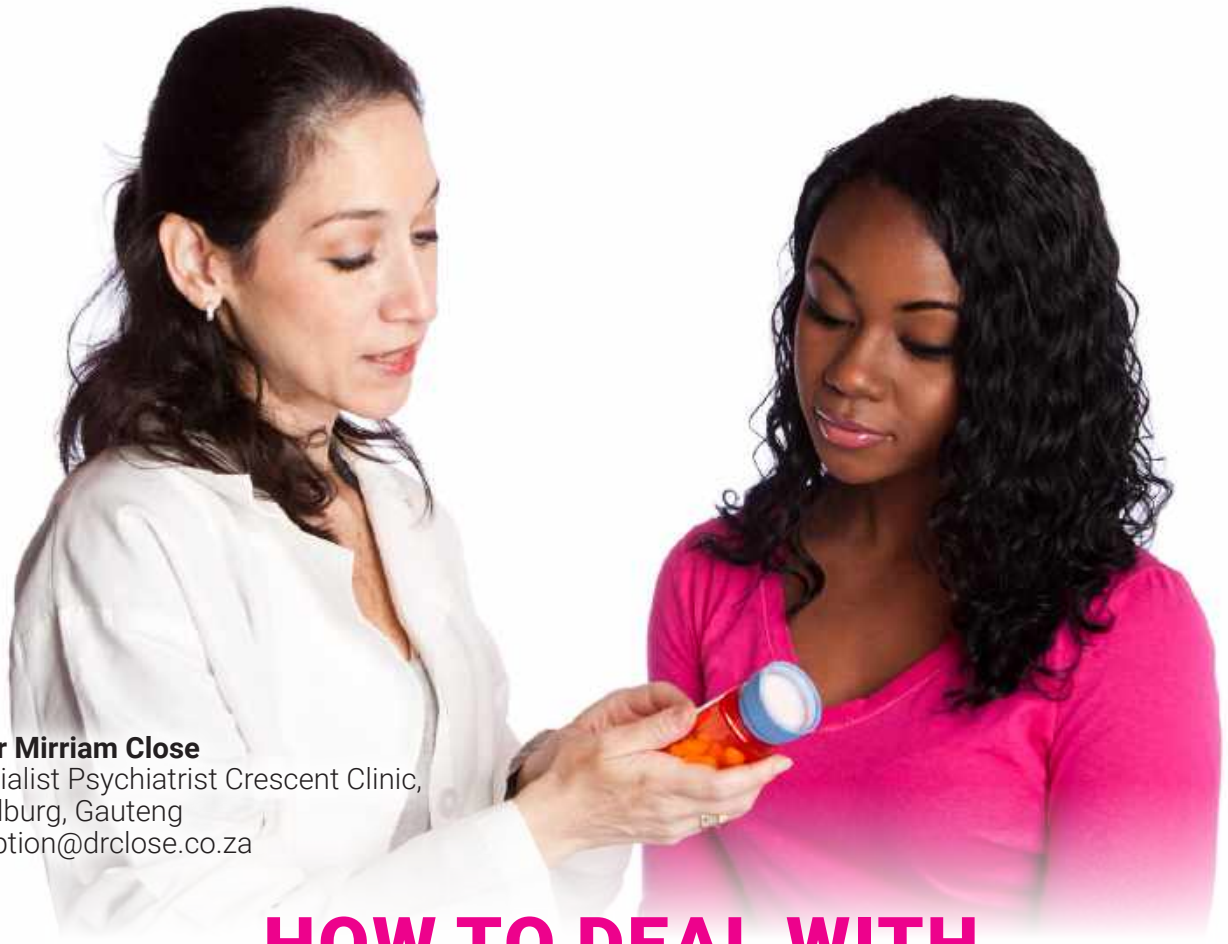

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HOW TO DEAL WITH ANTIDEPRESSANT SIDE EFFECTS

Available antidepressants have provided safe and effective management of mood and anxiety disorders. However, side effects may remain as a limiting component to symptom resolution. The presence of side effects could contribute to treatment discontinuation in up to 23% of patients, suboptimal response by limiting dose escalation and negative impact on quality of life.

The management of adverse effects would therefore contribute to improved patient adherence, comfort and symptoms remission. Common side effects include sexual dysfunction, gastrointestinal difficulties, weight gain, apathy, somnolence and fatigue and sleep disturbances. Psychiatric complications with central nervous system changes may occur. Peripheral side effects and other serious side effects are important considerations with regards to the utilisation of antidepressants.

SEXUAL DYSFUNCTION

Upon direct enquiry of sexual disorder symptoms, the prevalence occurs in 58% of patients. Certain antidepressants, such as the selective serotonin re-uptake inhibitors (SSRI) medications are deemed problematic, with paroxetine presenting with the higher side effects profile.

The approach to the management of the side effects includes:

- Obtaining a comprehensive history, including the baseline sexual functioning and noting concerns relating to the choice of antidepressant treatment.
- Dose reduction of the antidepressant medication, with consideration of the impact on the mood or anxiety.
- Timing of sexual activity prior to the next dose minimises sexual side effects.
- The alternative antidepressants, with noted efficacy on depressive symptoms and fewer sexual side effects include: bupropion, agomelatine, desvenlafaxine, moclobemide, trazodone and vortioxetine.
- Erectile dysfunction treatment includes the phosphodiesterase type 5 inhibitors such as sildenafil.
- Steroid therapies including oestrogen and testosterone may be utilised as augmentation strategies to counter antidepressant side effects.

GASTRO-INTESTINAL DIFFICULTIES

In 17% to 26% of patients utilising antidepressant medications, nausea and stomach complaints with SSRI medications, are prevalent. Venlafaxine and vortioxetine are associated with increased nausea. The management includes:

- Slow-release formulations, if available.
- Dose administration at night may ameliorate symptoms.
- Divided dosing regimens, to be taken with small amount of food may assist with symptoms.
- Ginger-containing foods and beverages or sugar-free candy may be utilised.
- Anti-emetic medications and proton pump inhibitors may be used to treat side effects.
- Diarrhoea is documented to occur in 16% of patients on SSRI medication. Although usually transient, it may persist. The management includes anti-diarrhoeal agents, lactobacillus acidophilus culture or psyllium which might be beneficial.
- Constipation occurs in 11% to 12.5% of individuals. Paroxetine

is the SSRI most associated with this side effect. Management includes optimised water and fibre intake together with appropriate constipation medication regimens including stool softeners.

WEIGHT GAIN

Weight gain presents as a complex factor with regards to antidepressant management. The increased weight may represent improvement of depressive symptoms and resolution of a loss of appetite, residual symptoms of unresolved depressive disorder, medication related symptoms or another, independent factor.

- Paroxetine is associated with weight increase in contrast to placebo.
- Mirtazapine and venlafaxine demonstrated weight gain side effect profile.
- Fluoxetine and citalopram do not demonstrate significant weight changes.
- Less weight gain is noted with bupropion. Newer antidepressant agents including agomelatine and vortioxetine are associated with less weight gain effects.
- Topiramate, an anticonvulsant, has weight decreasing effects.
- Effective lifestyle modifications would be an important component of weight management.

FATIGUE AND SOMNOLENCE

Drowsiness is a common side effect occurring in 10% to 38% of depressed outpatients. In descending frequency of occurrence of symptoms, mirtazapine, trazodone and SSRI presented with fatigue and somnolence.

Management of drowsiness includes:

- Assessment of sleep patterns and counseling on sleep hygiene measures.
- A shift in antidepressant dosing schedule from morning to nighttime administration.
- Divided dosing or use of a slower release preparations are effective strategies.
- Psycho-stimulant augmentation may be considered.
- Graduated increase in exercise would also help reduce fatigue.

INSOMNIA

Due to the stimulating effect of certain medications of the serotonin noradrenaline re-uptake inhibitor (SNRI) class and bupropion, insomnia may be a side effect. Sedating antidepressant medication may therefore be utilised to counter this side effect. Insomnia is reported in 12% to 22% of depressed outpatients.

Management of antidepressant-induced insomnia includes:

- Educating patients on sleep hygiene.
- Modification of use of caffeine and stimulants.
- Changing the timing of doses to the morning.
- Adding adjunctive medications including melatonin, trazodone, mirtazapine, and/or low doses of anticonvulsants and atypical antipsychotics.

APATHY

A complaint of dullness, lack of motivation or feeling numb may be a side effect of long-term antidepressant usage. Although an elusive symptom, it may herald relapse or represent residual depressive symptoms.

The management of apathy includes:

- Usage of stimulating medications.
- A dose reduction of the causative antidepressant or switching may be considered.

DISCONTINUATION SYNDROME

An abrupt dose reduction of antidepressant medication may present with a discontinuation syndrome, simulating antidepressant side effects.

To minimise this occurrence:

- A cross-titration down of one antidepressant and optimisation of the replacement medication.
- The utilisation of fluoxetine, as a longer acting antidepressant to cover a shorter-acting antidepressant, may minimize withdrawal side effects.

CENTRAL NERVOUS SYSTEM

- Epileptogenic potential may considered higher for tricyclic antidepressants and bupropion. Therefore, in a patient with a predisposition or concern with regards to epilepsy, these medications are to be used with caution.
- The SSRI medication have been shown to be associated with increased risk of extrapyramidal symptoms. The management would include adjusting the dose, switching the medication or utilisation of other effective treatments.
- Neuroleptic malignant syndrome has been attributed to the usage of antidepressant medication, or the withdrawal of the medication. As an urgent condition, hospitalisation and specific management would be required.
- Although antidepressants may be beneficial with regards to cognitive optimisation, there is limited evidence to suggest impairments in certain cognitive parameters. Neurocognitive assessments would be beneficial to clarify these aspects.
- Headaches are common initiation symptom of SSRI antidepressants which is usually transient. Conservative management would be recommended.

SERIOUS SIDE EFFECTS

- Serotonin syndrome, as a potentially life-threatening condition, requires urgent management. Serotonin syndrome manifests with myoclonus, hyperreflexia, sweating, shivering, incoordination, and mental status changes. To minimise the risk of a serotonin syndrome, with the usage of two or more serotonergic agents, a discontinuation of the replaced medication and a wash-out period should occur.
- Bleeding may occur with SSRI medications.
- Cardiac complications, seizures or agranulocytosis may occur with tricyclic antidepressants.

PSYCHIATRIC COMPLICATIONS

With regards to antidepressants, the initiation, usage or discontinuation may mimic or potentiate various other psychiatric manifestations.

- Monitoring for suicidality and clinical worsening is required. Should these effects occur, stopping or switching the medication may be necessary. Referral for urgent psychiatric care would be warranted.
- Tricyclic antidepressants, bupropion and venlafaxine are associated with highest mortality rates in overdose. Of the SSRI medications, fluoxetine and sertraline are the safer options when considering safety in overdose profile.
- Anxiety symptoms may present on initiation. Slow and low dosage optimisation may assist with this side effect.
- A presentation may occur whereby patients experience feeling numb or blunted. Dosage of the antidepressant is to be reviewed and adjusted, if possible.
- Antidepressants may potentiate mixed or manic symptoms in the presence of Bipolar Disorder. Various management options exist including: stopping the antidepressant, switching to another antidepressant with less potential to cause phase changes such as bupropion and optimising the mood stabilising medication.
- Paradoxical effects have been noted to occur with fluoxetine and sertraline. This entails the resumption of depressive symptoms during the maintenance phase of antidepressant treatment or the emergence of new symptoms and exacerbation of the initial clinical presentation. The management includes a discontinuation of the antidepressant.

PERIPHERAL EFFECTS

PERIPHERAL EFFECTS	CAUSATIVE ANTIDEPRESSANT	MANAGEMENT
Tremor	SSRI Venlafaxine	• Moderate caffeine intake. • Consider antipsychotic or other medication side effect. • Utilisation of ß-blockers.
Orthostatic hypotension	Trazodone	• Reduce or discontinue medication. • Rise slowly from seated position. • Use medication at night.
Hyponatraemia	SSRI- fluoxetine, citalopram and escitalopram Venlafaxine	• Monitor at risk population such as elderly patients. • Fluid restriction. • Diuresis to be considered.
Adverse cutaneous drug reactions	Tricyclic Antidepressants SSRI	• Reduce or discontinue medication. • Antipruritic and/or topical or oral steroids. • Hospitalization if severe.
Ophthalmic Concerns	SSRI	• Eye drops usage for dry eyes. • Monitor and complete a • risk assessment for previous history and age with regards to glaucoma. • Monitor visual concerns for development of cataracts.
Dry Mouth	Tricyclic Antidepressants	• Regular sips of water. • Chewing sugar-free gum. • Avoiding acidic beverages. • Usage of a suitable mouthwash.
Sweating	Bupropion SNRI	• Reduce or switch medication. • Usage of anti- andrenergic or anti- cholinergic treatments.
Hepatotoxicity	Agomelatine Duloxetine Venlafaxine	• Citalopram and escitalopram are safer alternatives. • Monitor liver function tests prior to dose initiation, as per guidelines or after dose increments.
Genito-urinary	SSRI Duloxetine	• Adjust or discontinue medication. • Mirtazapine may be considered for management of SSRI- associated urinary retention.

Although antidepressant side effects may occur, effective management approaches are available to reduce the impact. Various strategies can be utilised including monitoring symptoms, using alternative options and conservative treatments that are symptom targeted.Education and advice for patients with regards to side effects has shown to be valuable. This would serve to minimise the risk of discontinuation and optimise the potential of beneficial antidepressant usage. The information would serve to reassure patients and provide knowledge to optimally manage their conditions and medications. MHM

References available upon request

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IMPACT OF TRAUMA ON CHILDREN AND BEST PRACTICES FOR INTERVENTION

Exposure to violence and other life-threatening events is unfortunately a part of daily life for many children in South Africa. For example, in a national prevalence study of South African adolescents aged 15-17 years, 20% reported being sexually abused and 30% reported being beaten by a caregiver during their lifetime. Outside the home, many South African children regularly witness or directly experience community violence. Accidental traumas within the home (for example, burn injuries) and in the community (road accidents) also affect many South African children. However, just because such events are commonplace doesn't necessarily mean children are desensitised to them, or that their impact is benign. Trauma can affect children psychologically in different ways.

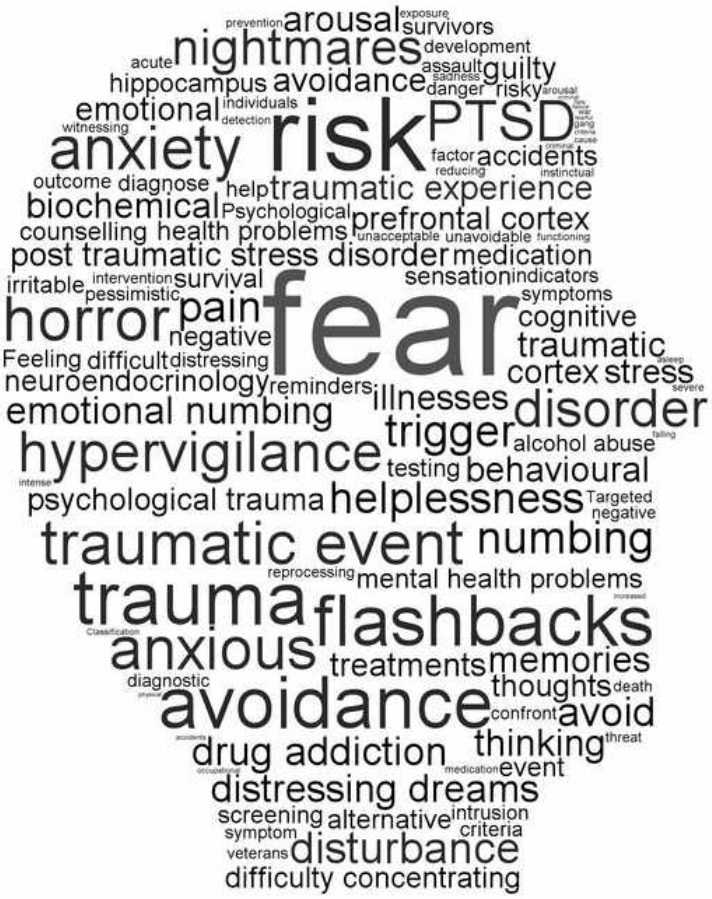
POSTTRAUMATIC STRESS

When children experience or witness an event that involves a threat to their own, or another person's, physical safety it can result in temporary symptoms of posttraumatic stress (PTS) that alleviate within a few days or weeks or, in some cases, a more protracted, full-blown posttraumatic stress disorder (PTSD) that requires formal intervention.

PTS can be expressed in four symptom clusters. First, the child may re-experience a past traumatic event in unwanted, intrusive ways. This includes memories, images or flashbacks. Flashbacks are a kind of sensory re-living of the event, where the child hears the same sounds as they heard during the traumatic event, smells the same odours etc. Second, the child may start to avoid reminders of the trauma, such as places or people that were part of the traumatic event or that the child associates with the traumatic event. For example, children who have been bullied at school may refuse to go back to school, even if those who bullied them are no longer there, because they associate school with threat. Third, the child may be in a constant state of vigilance and preparedness for danger, even if the actual threat has been removed. For example, they may always be scanning the environment for

possible threats, may struggle to fall asleep or concentrate on daily tasks due to feeling constantly unsafe, or may react with aggression to interactions that are not actually threatening. Finally, PTS can also include feelings of fear, guilt or shame, and negative beliefs about oneself, others and the world, resulting from the traumatic experience. For example, feelings of shame and self-blaming beliefs are common amongst children who have experienced sexual abuse.

When a child who has experienced a traumatic event continues to experience *all* the above symptom clusters for longer than four weeks, resulting in difficulties with school and social functioning or significant distress, a diagnosis of PTSD can be made. While PTS is a typical human response to trauma and often resolves spontaneously, a diagnosis of PTSD indicates that the natural processes of recovery from trauma have become impeded. After isolated traumatic events, only a minority of children will develop PTSD: international epidemiological studies indicate that about 5% of adolescents have met criteria for PTSD in their lifetime (there are no comparable studies in South Africa as yet). However, children who experience repeated trauma (such as prolonged abuse), continuous trauma exposure (such as daily gang violence in their neighbourhood) or a combination of several different forms of trauma are at higher risk of developing PTSD. PTSD in children is often accompanied by symptoms of depression (including low mood, low self-esteem, loss of interest in usual activities, feelings of hopelessness and sometimes suicidal feelings) and at times depression may develop in the absence of PTSD after a traumatic experience.



DEVELOPMENTAL IMPACTS

While many children who experience traumatic events will not develop full-blown PTSD, trauma can impact on children's development in other ways that are important to recognise. Even babies can be impacted by a traumatic experience (such as abuse or a burn injury), despite not being able to fully cognitively comprehend what has happened. Children younger than two years tend to express their distress primarily through physical symptoms such as sleeping or eating difficulties, crying or unusually clingy behaviour. Children between the ages of three and six years may display regressive behaviours, such as losing skills they have recently acquired (like the ability to feed or dress themselves). They may also have a re-activation of old fears (for example, of strangers or of animals) and a resurgence of separation anxiety that can manifest as psychosomatic complaints (like headaches or stomach aches). In children of primary school age, the effects of a traumatic event may be evident in marked changes in classroom and playground behaviour, ranging from social withdrawal to signs of hyperactivity, impulsivity and distractibility. Children may also start to act out traumatic themes in their play.

Flashbacks are a kind of sensory re-living of the event, where the child hears the same sounds as they heard during the traumatic event, smells the same odours etc.

Children with PTS are constantly attuned to signs of possible threat and danger, and focused on how to keep themselves safe, even if there are no objective threats in the classroom or school environment. As a result, their brain is not able to concentrate on learning, remembering and thinking about school tasks. Marked changes in a child's school performance in the aftermath of a traumatic event can therefore be a signal of distress, of a brain that has shifted into survival mode rather than learning mode. Amongst adolescents who have experienced trauma, defiant, aggressive and reckless behaviours can sometimes develop as a defensive response

to feeling scared and vulnerable. This can be mistakenly attributed to 'typical' teenage acting-out behaviour, rather than being recognised as a sign of trauma-related distress.

Whenever children or adolescents present with sudden, marked changes in behaviour or regressions in their development, such as those described above, it's important to explore whether the child or a close caregiver has experienced any recent traumatic experiences.

HOW TO HELP TRAUMATISED CHILDREN

While many parents may be extremely concerned if their child develops signs of PTS immediately after a traumatic event, a wait-and-see approach is generally recommended. As noted above, after an isolated traumatic event most children will experience only temporary PTS and naturally return to their usual functioning over a few days or even several weeks. In such cases no formal intervention is required. However, the family and school systems may benefit from having PTS symptoms explained and normalised, and from guidance on how to support the child's recovery by:

1. Providing emotional support and comfort as needed to make the child feel safe and secure.
2. Not punishing the child for difficult or disruptive 'acting out' behaviours after a trauma (rather, clear communication, setting of boundaries, and use of non-physical consequences will provide a sense of structure and security).
3. Returning as soon as possible to normal routines which provide containment and security.
4. Ensuring the source of threat or danger is removed or, if this isn't possible (for example, in a context of ongoing gang violence in the neighbourhood), that clear safety plans are set up within the family.

The risk of a child with PTS going on to develop full-blown PTSD is heightened when a parent or caregiver is extremely distressed or fearful for a prolonged period following a traumatic event. It may therefore assist the child's recovery if the parent or caregiver is able to receive support or treatment.

If, despite the above strategies, a child's PTS symptoms don't remit after four weeks and continue to impair their functioning or cause the child significant distress, a diagnosis of PTSD may be appropriate. A psychotherapeutic intervention is then indicated. The first-line treatment for PTSD in children is trauma-focused cognitive behaviour therapy (TF-CBT). A therapist, trained in TF-CBT will help the child to explore and re-process their traumatic memories within the safety of a supportive therapeutic relationship. Trauma re-processing enables the child to safely express, and then gradually master, their fear and anxiety about the trauma. At the same time, the therapist will help the child to develop emotional and cognitive coping strategies to deal with both the traumatic memories and other stressors they may be experiencing. The therapist may also work with the parents or caregivers to enable them to support the child's recovery. In numerous international studies, and in recent South African research, TF-CBT has been shown to be effective in addressing the symptoms of PTSD for many children. The evidence to support use of medication for paediatric PTSD is still limited and medication isn't recommended as a stand-alone treatment. Where the child's PTSD symptoms are severe enough to prevent them from engaging with psychotherapy, medication may be considered as an adjunctive treatment to enable the child to benefit more from psychotherapy.

CONCLUSION

Although exposure to trauma is common amongst South African children, in many cases the psychological impact of the trauma will resolve itself so long as adequate natural support systems and a safe recovery environment are in place. However, some children will go on to develop PTSD and/or disruptions to different aspects of their development. Fortunately, PTSD in children appears to be amenable to intervention. Referral to a mental health professional with training and experience in trauma-focused therapy can resolve the PTSD and place the child back on a healthy developmental path. MHM

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References: 1. Matsumoto AK, Cavanaugh PF (Jr). Etoricoxib. *Drugs of Today (Barc)* 2004;40(5):395-414. **2.** Coricib® 30 mg, 60 mg, 90 mg and 120 mg tablets package insert, February 2020. **3.** Escudero-Contreras A, Vazquez-Mellado J, Collantes-Estevez C, *et al.* Update on the clinical pharmacology of etoricoxib, a potent cyclooxygenase-2 inhibitor. *Future Rheumatol* 2007;2(6):545-565. **4.** Brooks P, Kubler P. Etoricoxib for arthritis and pain management. *Ther & Clin Risk Man* 2006;2(1):45-57. **5.** Data on file. Bioequivalence study of etoricoxib.

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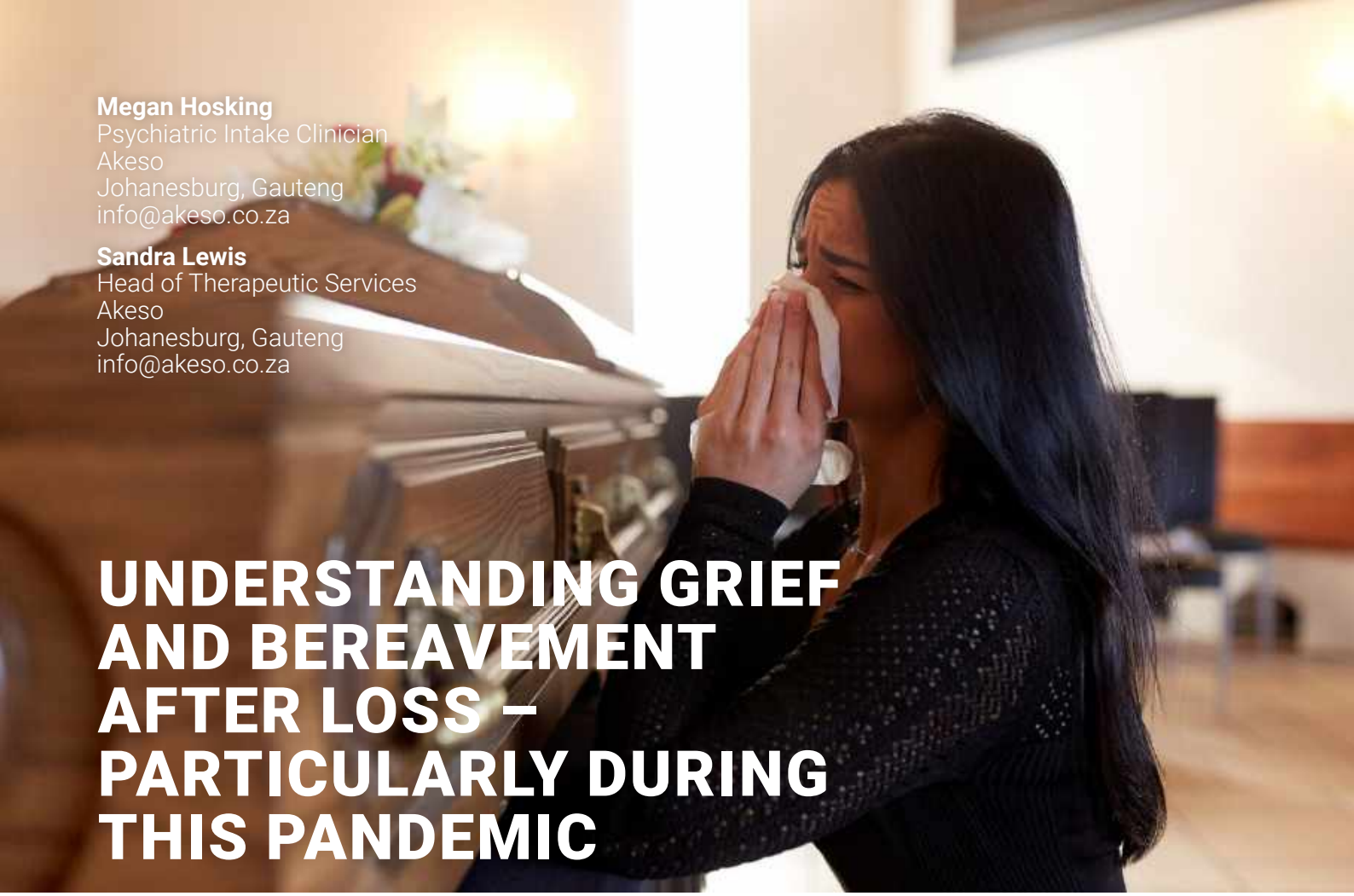

UNDERSTANDING GRIEF AND BEREAVEMENT AFTER LOSS – PARTICULARLY DURING THIS PANDEMIC

The loss of a loved one is an intensely painful and devastating experience, and may often feel unreal. While grief and bereavement are experienced differently by everyone, there are some common aspects that may be helpful to understand, and to help one to eventually cope better with loss.

"It`s not only the passing of a loved one that leads to feelings of loss. People also experience grief in other events, for example when a relationship ends, or one loses a job or possessions such as one's house as a result of financial difficulties. These instances have become increasingly common during the current COVID-19 pandemic," says Megan Hosking, psychiatric intake clinician at Akeso mental health facilities.

STAGES OF GRIEF AND BEREAVEMENT

The most widely recognised stages of grief were first described by Dr Elizabeth Kübler-Ross, who was a Swiss-American psychiatrist. While these stages are often presented as a linear process, it's most important to realise they are not meant to create neat and tidy packages for emotions, and don't necessarily follow in this order for everyone.

According to Kübler-Ross, individuals experience each stage of grief and bereavement differently, and the length of time each stage lasts also varies from one individual to the next. A person who grieves may also move backwards and forwards between the stages of the grieving process.

1. **Denial**
   The first emotion many people experience following a loss is a state of shock and denial. Things may not feel real, make any sense, and the reality of the loss will not yet have set in. Denial may result in a person carrying on with life as though the loss hasn't happened and not feel the emotions associated with the loss.
2. **Anger**
   Anger can often feel endless; one may feel angry at others – the deceased person, one's family, the circumstances, the health system, doctors, their employer, other people, and even a higher power. Feelings of regret and guilt (whether perceived or real) often manifest as anger against others who one thinks may have contributed to, or caused, their loss.
3. **Bargaining**
   One may try to make arrangements, promises or bargain with others or a higher power to try and 'reverse' the loss, minimise one's own sense of being harmed. This often happens when relationships end and one tries to get their partner 'back'.
4. **Depression**
   This stage is often where reality starts to set in and a person moves their attention to the present situation. One may feel intense sadness, want to withdraw from others, or feel like doing nothing. Depression as a stage of grief is not the same as depression as a diagnosable mental health illness. A state of depression following the loss of a loved

one or other significant loss is a normal and appropriate response, and often with time, will transition into a space of acceptance.

5. **Acceptance**
Acceptance does not mean that everything suddenly feels right again, or that you are completely healed or 'okay' with the loss you have suffered. This stage is more about realising that life without your loved one or in your changed situation is the way things are going to be, and learning to live with that – even though it will still hurt, and you may still feel intense sadness or feel the loss daily.

SUDDEN LOSS

Losing a loved one suddenly, as may be the case with the current COVID-19 pandemic, can be very traumatic and is also often experienced differently to a loss following a long-term illness or an expected loss.

There is no time to prepare for the loss, and often one may not have their full support system around. There may be lots of questions about the loss, the circumstances leading up to it, and what happened, and feelings of shock may last longer.

It's not uncommon following a sudden loss to experience strong emotional and physical responses, which can include:

- Shock symptoms such as shaking, inability to move, stomach aches and headaches, exhaustion, and feeling on edge. These will usually pass after a few days; if they don't, one should seek professional assistance.
- Insomnia and nightmares.
- Feeling alone and that no one understands you and what you are going through.
- Anger and regret.

Following a loss, feelings of sadness, desperation, guilt, anger, loneliness, difficulty sleeping, mood changes, appetite and energy changes are normal. However, if any of these emotions feel overwhelming or persist for a long time, then seeking professional help is a wise option.

People also experience grief in other events, for example when a relationship ends, or one loses a job or possessions such as one's house as a result of financial difficulties

SUPPORTING A LOVED ONE

If someone close to you has lost a loved one – partner, parent, child or friend – it can be challenging to know how to support them and care for them," adds Sandy Lewis, head of therapeutic services at Akeso.

"When talking about loss, you need to be very mindful of your words, as it's a sensitive situation for all involved, and emotions are heightened. The conversation and support largely depend on the person experiencing the loss, your relationship with them, and their current circumstances," she notes.

When talking to someone who has experienced a loss, saying the following may be helpful to express support:

- "I am so sorry for your loss"
- "I don't know how you feel, but I am here to help in any way I can"
- "You and your loved one are in my thoughts and prayers"
- "I am just a phone call away" or "I am up early or late if you need anything"
- "My favourite memory of your loved one is..."

It's important to avoid saying things like:

- "At least they lived a long life, many people die young" (if an elderly person has passed)
- "Only the good die young" (for a young person)
- "They're in a better place"
- "There is a reason for everything"
- "I know how you feel"
- "Just be strong"
- "It's for the best" (if the person who has passed had suffered seriously)

Other ways of showing support include making sure the person is safe, that their basic needs such as food are met, family support - helping with their other responsibilities. However, they should be involved in decision-making where possible.

Be supportive but don't try to fix the loss or the situation. Don't tell people what to do or feel – even if you have experienced loss, remember that everyone's experience is not the same. Recognise the loss and what it means to the person, and don't put a time-frame on how long they can grieve. MHM

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IS IT TIME TO RETHINK HOW WE DELIVER MENTAL HEALTHCARE SERVICES?

Meet Sthandiwe*, a mother of four living with her elderly mother in Soweto. Like many in the dense urban township, she's worried about contracting COVID-19 for many reasons: she lives next door to a popular tavern, the sole breadwinner in her family saw a huge salary cut during the pandemic, and she's on treatment for her chronic condition.

"People are afraid… they tell you that this thing they use to test for Corona harms the brain, do you understand? We just live in confusion. So, it's better we don't know. Others are weak. If they hear they have it, they become scared – 'oh, I might die.' So, it's just that, whatever will be will be," she explains over the phone.

The crippling realities of the pandemic have led Sthandiwe to believe she developed a mental illness since her problems are "overwhelming" her. And if she needed to seek treatment for her psychological problems, Sthandiwe explained, she didn't know where to go.

MENTAL HEALTH IMPACTS OF COVID-19

The monumental and ongoing shifts brought by the COVID-19 pandemic have raised widespread concerns for the mental well-being for many in our country. For some, the crippling conditions of the lockdown have provoked acute mental distress among those without any past history of psychiatric morbidity. And for others, previously contained illnesses may now have worsened.

In our recent research, we found those who perceived their risk of contracting COVID-19 had exhibited worse symptoms of major depressive disorder early in the pandemic (Figure 1), particularly those who reported greater histories of childhood trauma (Figure 2). And while a majority of respondents (74%) believed their experiences under the COVID-19 pandemic didn't affect their mental health, about a quarter still reported major concerns around anxiety, fear of infection, and excessive rumination on top of already facing difficult socioeconomic situations.

The growing mental health burdens of the COVID-19 pandemic exist against a stark backdrop of an overburdened and under-resourced national healthcare system. National epidemiological data shows over a quarter of all current psychiatric cases are classified as severe DSM-IV disorders. Yet only a quarter of all severe cases actually received treatment.

Sthandiwe's experiences give life to these statistics, highlighting the numerous barriers that those in need of mental healthcare have faced for too long, both before and during the pandemic. And while numerous commitments and legislations have been set forth to alleviate our nation's state of mental suffering, many are skeptical about the ability of the public healthcare system to right its wrongs.

Given the building pressure on our already strained public mental healthcare system and the consequences of the lockdown, is it time to rethink how we deliver mental healthcare services?

OLD PROBLEMS CREATE NEW BARRIERS AND MORE PROBLEMS FOR PSYCHIATRIC PATIENTS

The growing pressure of the pandemic on the public mental healthcare system has exacerbated existing problems and erected new barriers for those seeking care.

Consider the following scenario: You are a psychiatric patient diagnosed with an anxiety disorder triggered by the fear of infection. Residing in North West province, you're unable to attend your routine follow-up appointment scheduled at Helen Joseph Hospital in Johannesburg because of the ban on interprovincial travel during Level 5 lockdown.

"[The lockdown] impacted people's ability to travel and get from home to clinics, so there were a significant number of patients unable to attend clinics, collect their medications and see their psychiatrists for their follow-ups," shared Dr. Yusuf Moosa, Clinical Head of the Psychiatry Unit at the Johannesburg Health District.

The mere lack of working telephones at government hospitals has also posed major barriers to scheduling and patient communication, especially when smaller clinics were scheduled to close due to staff shortages.

As the pandemic snowballed, healthcare staff sometimes worked through high patient volumes with limited PPE, placing both themselves and patients at risk. This meant fewer staff and psychiatric beds available leaving the small handful of uninfected staff to care for acute psychiatric and COVID-19 affected patients.

"One of our biggest challenges is the issue of managing really unwell patients as outpatients since the hospitals are full, and most wards have been turned into COVID wards," explained Nokuthula Mdaka, the lead psychiatrist for the Gauteng Department of Health overseeing the district mental health clinics in the West Rand.

Drug shortages and stockouts also continue to limit access to key psychotropic medications, such as lithium, an important drug for treating depression and bipolar disorder. The lockdown and its widespread societal impacts, however, further restricts access to medications due to greater financial strain and limited mobility.

Furthermore, the global impact of the pandemic in regions where these pharmaceuticals are manufactured have also left South African hospitals with limited supply. Consequently, patients may face major risks of relapse. No medication and not coping? You turn to drugs - recreational ones.

"Some patients have been using more substances, so someone with schizophrenia is now just at home where there's no alcohol. And although tobacco wasn't accessible, cannabis was readily available," adds Mdaka.

These risks aside, direct infection from SARS-CoV-2 may have its own psychiatric sequelae. A recent review shows that those affected with COVID-19 may present with a wide variety of psychiatric presentations, including delirium and psychosis. The acute spike in the body's immune system activity is believed to cause toxic neuroinflammatory conditions, which may trigger a range of psychiatric outcomes.

FUTURE OPPORTUNITIES FOR PANDEMIC INNOVATIONS

Amidst these difficult times, social service organisations and healthcare systems have worked beyond their capacity to innovate novel solutions to combat the pandemic. Below I highlight two ways to potentially improve the provisioning of mental healthcare services during and after COVID-19.

1) **Telepsychiatry**

Widespread evidence highlights the therapeutic effectiveness and accessibility of phone-based counselling, particularly during public health crises and healthcare restricted settings.

Telepsychiatry, or the use of telecommunications to deliver psychiatric care outside of healthcare facilities, are critical resources for high-risk and hard-to-access communities during public health emergencies.

Telehealth interventions worldwide have shown to be cost-efficient, lead to sustained, decreased mental illness risk, and improve mental well-being, particularly during public health emergencies.

In addition to South Africa having the highest rate of cellphone usage in the continent, low costs, convenience, and privacy have made telemedicine a prioritised mode of healthcare delivery in

South Africa. South Africa already has a strong platform in place that is ripe for integrating mental healthcare services - a recent priority of the National Department of Health.

SADAG provided numerous virtual counselling and referral services through telephonic and WhatsApp counselling. SADAG's call volumes have doubled since the start of the lockdown, though rural communities or individuals who lack access to the proper equipment are unable to benefit from such services.

2) **Stronger infrastructure for community psychology and psychiatry**

The mental health impacts of the pandemic may also see a spillover into tertiary care centres, thus adding further pressure to the system.

Diverting major portions of the case load onto well-equipped and well-staffed community outpatient clinics can mitigate the overflow of future patients and also build an infrastructure to screen, treat, and prevent future mental illnesses.

Building a stronger infrastructure for community psychology and psychiatry is multifold. This includes the development of greater home-based and non-specialty care centers for psychiatric patients situated in patients' communities, rather than 60 km away.

Finally, greater funding for community psychology infrastructure can lay the groundwork for sustainable changes in the mental healthcare system. Mdaka describes the revolving door that acute psychiatric patients enter and leave throughout tertiary care settings: "...until [acute psychiatric patients] are readmitted again, they are managed by us. So I feel that the pyramid needs to shift a little bit. We almost need to put community psychiatry on top in terms of the budget," concludes Mdaka.

COVID-19 presents an overdue opportunity for South Africa to learn from its past and build a better future towards positive mental health.

**Pseudonyms were used to protect the identity of these individuals.*

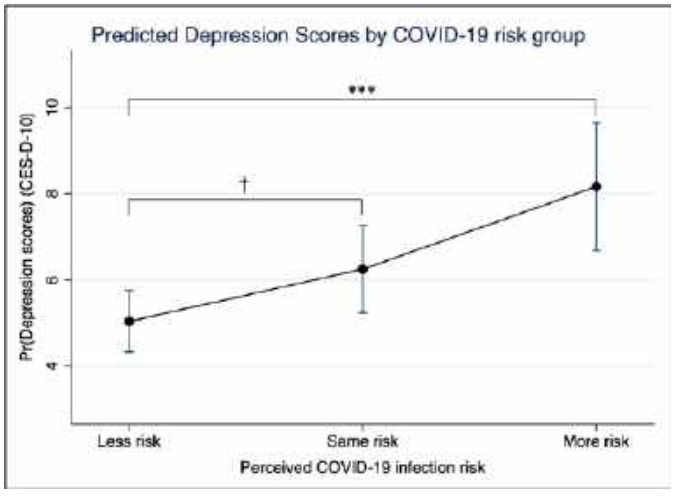

FIGURE 1. PREDICTED DEPRESSION SCORES BY PERCEIVED COVID-19 RISK GROUP

Note: Greater perceived risk of COVID-19 infection corresponds with greater depression symptomatology in adults living in Soweto. The effect of being in the "More risk" group is highly significant (p = <0.001) relative to being at "Less risk", while the effect of perceiving that one is at the "Same risk" of COVID-19 infection relative to other individuals living in Soweto on depression symptoms is marginally significant (p = 0.095). The respective predicted CES-D-10 scores for each group are as provided: Less risk = 5.04, Same risk = 6.25, More risk = 8.17.

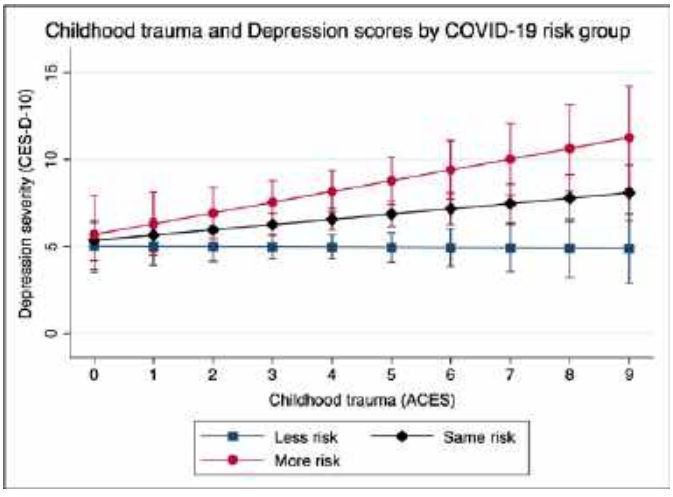

FIGURE 2. CHILDHOOD TRAUMA (ACES) AND DEPRESSION SCORES (CESD) BY COVID-19 RISK GROUP

Note: Greater childhood trauma (ACES) potentiates the positive relationship between greater perceived COVID-19 risk and the severity of depressive symptomatology. The effect of the interaction between childhood trauma and perceived COVID-19 risk on depression is marginally significant (F[1, 206] = 3.53, p = 0.0617). MHM

References available upon request

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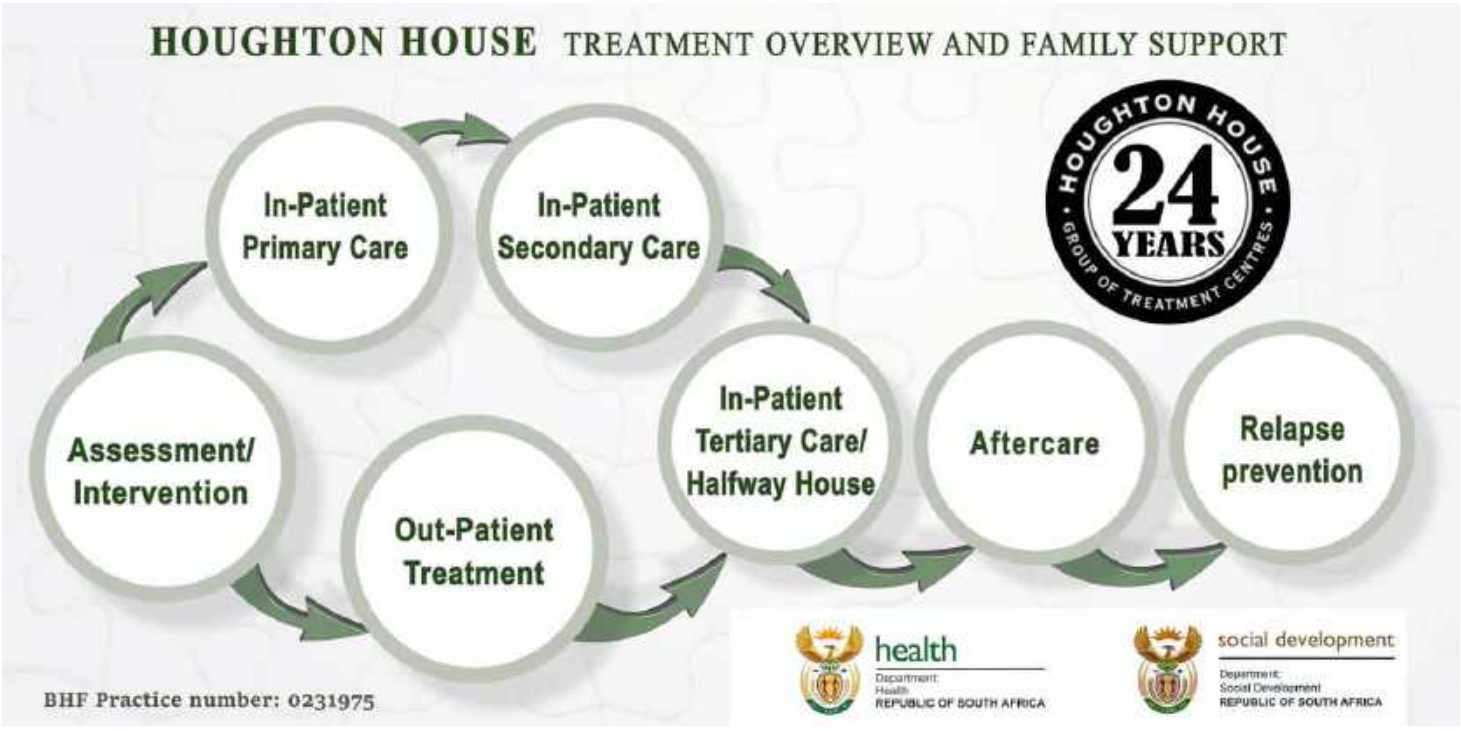

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Houghton House
ADDICTION RECOVERY CENTRES

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MORAL INJURY

A discussion by Dr Joanna Taylor (Psychiatrist) on behalf of the Healthcare Workers Care Network

South African health care workers (HCWs) are no strangers to tight rationing of resources, nor to encountering brutal trauma in the course of their daily work. In considering whether these cumulative experiences might make our HCWs more or less vulnerable to the unique stresses of the COVID-19 pandemic, the idea of moral injury has proved useful. Moral injury and related concepts can enrich our thinking about the psychological effects of extreme working conditions, and what the most helpful types of support are for this particular population and situation.

The language of moral distress and moral injury have gained ground in the healthcare context to articulate something more specific than the idea of burnout. Terminology emerging from nursing literature and adapted from military trauma research includes the useful concepts of moral dilemmas, moral distress, and moral injury.

Moral dilemmas are expected, difficult parts of clinical practice. There is often no comfortable answer to the problem posed, and training must offer best-practice approaches that include ethics consultations, team discussions, and supervision. Opportunities to grapple with such dilemmas with appropriate support and guidance make for clinicians capable of crafting sophisticated and compassionate solutions to complex problems.

Moral distress occurs when an individual knows the right thing to do, but institutional or other constraints make it difficult to do what is right[1]. Each episode of moral distress is either resolved with sufficient processing or leaves moral residue. Moral residue is constituted by the unresolved emotional and psychological conflicts that make subsequent incidents less tolerable.

Moral injury a term coined by psychiatrist Jonathan Shay, is defined by Litz et al as resulting from "perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs and expectations"[1]. In health care, these beliefs and expectations include the oaths individual HCWs took to provide the best care possible for patients and to make a patient's needs the first priority.

While stretched and increasingly 'managed' health care systems globally are a breeding ground for moral distress and injury, the COVID 19 pandemic magnifies the pressures in a number of ways. There are the painful and complex end of life decisions and care made so much harder by the absence of family members, and there are myriad day to day dilemmas with layers of complexity. Oncologists can't provide services and know that their patients are suffering and acquiring worse prognoses without their usual investigations and treatments. Underutilisation of TB and HIV screening and treatment continues to be of concern to all HCWs. Where there are PPE shortages, HCWs are having to choose between serving their patients and protecting themselves and their families.

Rationing of health care resources is something that we could place in the category of a moral dilemma, and if well-managed doesn't have to result in undue residue and injury, although there may well be some distress. South African HCWs are very familiar with rationing, and know that it can contribute to sound clinical decision-making. But if protocols are unclear, out of date, or non-existent, support is not in place, and systems

are overwhelmed, the pressures on individuals to make and convey rationing decisions will lead to moral injury.

In March 2020 professional societies and ethicists were swift in providing guidance on such matters as the rationing of ventilators and ICU care, and many SA hospitals quickly endorsed the Critical Care Society of SA guidelines of 2019. What emerged over the ensuing months was that some of the daily vexing ethical dilemmas for HCWs presented themselves far lower down the decision-making tree.

Who to admit to hospital and when, how to explain to families how you're allocating an oxygen outlet, whether to continue certain essential but not-quite-urgent services, whether to go to work with mild symptoms and risk infecting others or stay at home and know your team was taking strain… the list is long. Many health care workers have also struggled with distress and ambivalence about current allocation of resources after years of witnessing a health care system stripped bare, with the resultant thousands and thousands of deaths and reduced quality of life each year from preventable causes.

Frontline clinicians need real-time support with the decisions in front of them. Some ethics committees have become more agile and responsive during this time and their availability has considerably lessened the mental burden on clinicians. It's advisable to have this kind of assistance separately available to each unit in larger hospitals, and creatively devised to assist outpatient services too. Existing ethics committees may not have the flexibility for the functions currently required. This is an area in which retired experienced clinicians or clinicians in temporary isolation could be called upon to deliberate remotely to advise active clinicians.

Moral injury is not a mental illness, but experiences of potentially morally injurious events (PMIEs) can lead to negative thoughts about oneself or others and deep feelings of shame, guilt, or disgust, which in turn can contribute to the development of mental health problems including depression, post-traumatic stress disorder (PTSD), and anxiety. Not everyone exposed to potentially injurious events will develop moral injury or complications thereof.

MHM

Some may even experience post-traumatic growth. On reflection of what went right and how many lives were saved in adverse conditions, there can be a resumption of normality with a sense of strength and accomplishment. This has been seen after medical responses to other disasters. However, it has been noted that this pandemic, with its reach and protracted timeframes, isn't comparable to other disasters for which we have data.

Factors that increase the risk of moral injury include the loss of life of a person considered particularly vulnerable (eg a child), if leaders are perceived not to take responsibility for the event/s and are unsupportive of staff, if staff feel unaware or unprepared for emotional/psychological consequences of decisions, if a PMIE occurs concurrently with other traumatic events, eg death of a loved one, and if there is a lack of social support following the PMIE.

Relevant supportive and preventative measures include:

- Preparation: preparing psychologically for the impact of PMIEs is helpful.
- Seeking informal/peer support early on is protective. In every aspect of managing workplace stress in extreme conditions, evidence tells us that people prefer to talk to their peers, and particularly to those with the experiences closest to their own.
- Confidential professional support must be available, and help-seeking encouraged.
- Clinicians should be made aware that individuals who develop moral injury-related mental health disorders are often reticent to speak about guilt or shame and may instead choose to focus on more classically traumatic elements of their presentation. Therefore, sensitive enquiries about PMIEs are advisable.
- If the shame or guilt is missed, Greenberg says, and the thought gets planted that "if people knew what I was really like, I'm a monster", and is not addressed, it dooms future treatment. We have also found it important to bear in mind the prevailing hero discourse, which makes it even more difficult for HCWs to admit to any ambivalence about their own performance and deepens any shame they might feel about the perceived gap between how a hero might behave and how they feel they might have broken their own moral code.

The idea of moral injury adds depth to conversations about health worker distress that have recently become mired in debates about depression vs burnout and resilience. These conversations can move beyond the characteristics of individual practitioners toward examinations of how patients and health care providers interact with health care systems, and the role that values play in these dynamics. MHM

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References: 1. De Bruyckere K, Bushe C, Bartel C, Berggren L, Kan C, Dittmann R. Relationships Between Functional Outcomes and Symptomatic Improvement in Atomoxetine-Treated Adult Patients with Attention-Deficit/Hyperactivity Disorder: Post Hoc Analysis of an Integrated Database. *CNS Drugs* 2016; **30**:541–558. **2.** Young JL, Sarkis E, Qiao M, Wietecha L. Once-Daily Treatment With Atomoxetine in Adults With Attention-Deficit/Hyperactivity Disorder: A 24-Week, Randomized, Double-Blind, Placebo-Controlled Trial. *Clin Neuropharm* 2011; **34**:51–60. **3.** Lenzi F, Cortese S, Harris J, Masi G. Pharmacotherapy of emotional dysregulation in adults with ADHD: A systematic review and meta-analysis. *Neurosci Biobehav Rev* 2018; **84**:359–367.

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COVID-19: DEALING WITH A LACK OF CONTROL

As mentioned in my previous article, "Covid-19: the ABC's of surviving Psychologically", one of the primary negative consequences of the Covid-19 pandemic sweeping through the globe has been a loss and disruption of our sense of 'normality' in the form of our pre-pandemic mode of existence. For most of us, our social lives in various forms has been radically curtailed and reduced via personal distancing, a lack of socialising, bans on tobacco and alcohol, cancellation of sporting and religious events etc. This is essentially interfering with what we call our locus of control in our lives.

I was once asked by a reader about what you can do when your sense of control at a particular stage of/situation in one's life is lost or disappears completely, a phenomenon that seems to be the norm for many people in this Covid era. What she was essentially asking is how do you deal with what you can change and what you can't change in a given situation. The term for this is plasticity.

In order to deal with and understand plasticity, the issue of control is key. It's usually referred to as locus (place) of control or perception of control when bad (or good) things happen in our lives. This is usually perceived in two forms- internal or external. When you have an internal locus of control, then you believe the event/situation/outcome is largely influenced by yourself and your behaviour/actions –i.e., you can be proactive.

An external locus of control on the other hand refers to believing/perceiving that any control in the particular situation is out of your hands and that your fate is in the hands of other person(s), external circumstances, the environment etc., so you're reactive. The evaluation or perception of your locus of control will often vary, depending on the situation. Sometimes it will be more internal and amenable to personal intervention while in other situations, the locus of control is external and there is seemingly nothing you can do to influence the outcome (i.e. weather,

environmental factors etc.).

It's clearly to the latter situation (where there's seemingly nothing you can do to influence the outcome) that my reader was referring to; in other words where the level of plasticity is zero or very close to it. This is where our ability to cope/our response/ our adaptability to this seeming "powerlessness" comes in. The famous psychiatrist Viktor Frankl stated that in the space between a stimulus and response, man has the freedom to choose. This space allows for 'response-ability' – the ability to choose your response. So even in a situation of limited responses, we can still choose, we still have options. Thus we can still be proactive - we can choose how we're going to respond, even if/when the options open to us are severely reduced.

An example of the above often cite is the extreme example of the person about to appear before a firing squad or face a life sentence; they can choose to sing, pray, curse the firing squad or their enemies and accusers etc - there are always options even in the direst of situations and still remain intentional.

Martin Seligman the father of Positive Psychology stated that, "Much of successful living consists of learning to make the best of a bad situation." So how do we go with the flow and remain resilient at the same time? One way to do so, referred to by Steven Covey (The seven Habits of Highly Successful People), is to have a clear view and understanding of what he refers to as one's 'circle of concern and 'circle of influence'. The circle of concern refers to those things which we have a particular mental or emotional involvement in, like our health, our children, work problems, politics, the economy etc. However within this circle it becomes apparent there are some things over which we have no control and others that we do have some control over (circle of influence). Proactive people, according to Covey, focus their time, energy and efforts working on those things they can do something about, thus strengthening their circle of influence. Conversely they avoid, ignore and intentionally let go of those events, issues, relationships that fall outside their circle of influence. The extent to which they can successfully do this influences their level of Resilience.

Resilience is the ability to bounce back from adversity, thrive on challenges, reach our full potential and have a positive impact on others. It suggests emerging from the adversity stronger and more resourceful. Resilience is linked to the ability to learn to live with ongoing fear and uncertainty, namely, the ability to show positive adaptation in spite of significant life adversities and the ability to adapt to difficult and challenging life experiences. In the current Covid-19 South Africa and the world in which we live in, resilience has become the name of the game if one wants to survive in our present business and social environment.

In order to deal with and understand plasticity, the issue of control is key. It's usually referred to as locus (place) of control or perception of control when bad (or good) things happen in our lives.

Interestingly, research conducted by the American Psychological Association(APA) into gender differences in men and women in the US armed forces have found that men and women don't differ when it comes to resilience. Also, the good news is that our level of resilience is not static and can be enhanced through self-learning and development as well as psychotherapy, counseling and coaching with a trained mental health professional or professionally facilitated support group. These forms of support will become critical in the days ahead, particularly should the control of the virus by the authorities not go according to plan, as well as in dealing with the psycho-social aftermath of the Covid-19 virus induced economic downturn. MHM

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Having any kind of disability does not necessarily mean that the person cannot be educated or gainfully employed. What prevents them from accessing education or employment are the physical and social barriers which place them at a disadvantage when performing the required tasks. Reasonable accommodation allows a person with a disability to make certain reasonable requests for specific structures to be put into place, which will enable them to perform and function at the same level as non-disabled students or employees.

For persons with psychosocial or intellectual disabilities, the following list of reasonable accommodations may be applicable:

- Quiet workspace – limiting distractions due to sound sensitivity
- Flexi-time due to medication side-effects resulting in difficulty in getting up in the mornings
- Tasks conveyed via email or in writing - to refer back to where memory is affected
- One task at a time - due to difficulty to prioritise
- Assistance with prioritising - where too many instructions will cause confusion
- Avoid long sentences when giving instructions - to ensure that information is not lost due to concentration and interpretation of content
- Providing the person with the opportunity to work from home when required, especially when certain tasks require focus and intense concentration
- Provide frequent breaks - due to concentration difficulties
- Allow for absence from work for monthly and / or weekly follow-up visits to the clinic or treating practitioner and / or the collection of medication
- Extended sick leave when relapses occur - recovery

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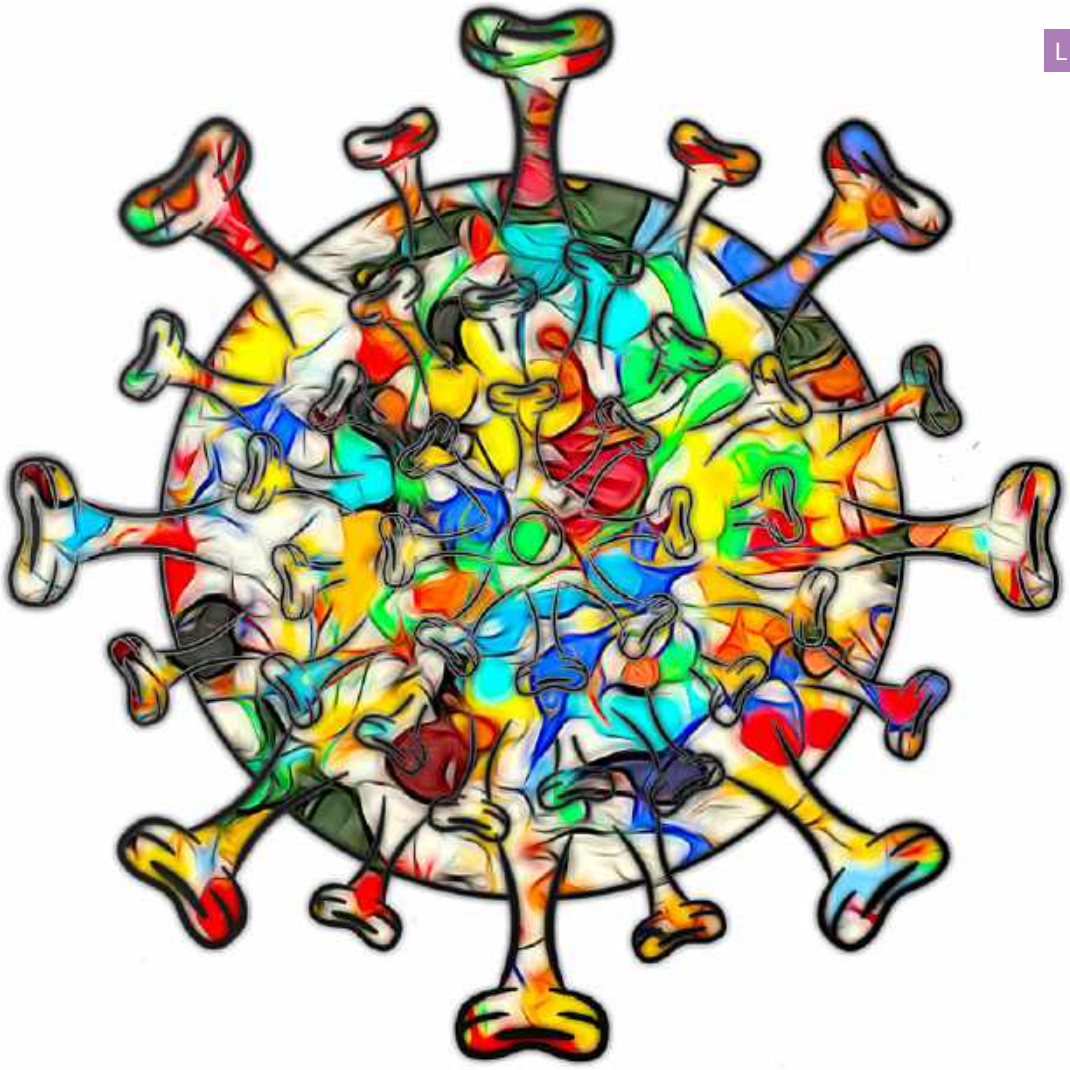

COVID-19 - THE AFTERTHOUGHT...

For Dr Lisa Jose COVID-19 became more than cases she was dealing with at her job at Chris Hani Baragwanath. Testing positive she found herself in isolation – a journey that was both highly distressing and introspective.

By the time I reached day 14 of my incredible isolation journey with my dear friend, COVID-19, I could truly appreciate how daunting it must seem to anyone at the beginning of such a journey.

Being a doctor with all the scientific and clinical background at my fingertips you'd imagine it would be an easy ride. Strangely when we fall ill all our superhero masks disappear and we become as vulnerable as anyone else. Doctors aren't invincible disease fighters. We feel pain and fear like every mortal.

The current frenzy around COVID-19 the 'ultimate villain' conquering our planet doesn't reduce the anxiety accompanied with this journey.

TIME FOR REFLECTION

Having had so much time to reflect and pray on my own in a room for 14 days I can appreciate how a captive feels when they have the luxury of seeing everything within their grasp and yet it's all an illusion. You're isolated, fighting to survive the demons within you as much as the monsters around you.

My life has been a rat race so far, with many of my actions driven by the pressures around me to keep going even when I knew I was burnt out.

CONFRONTING REALITY

The concept of burn-out like depression is so easy to sweep under the carpet. In a world where success is determined by achievement the 'real raw story' doesn't matter - it's the end we all focus on.

The diagnosis of COVID-19 for me was a blessing in disguise, as it gave me space to just breathe and appreciate the moment.

I had to learn to love and prioritise myself. It's not a crime to care for yourself. Without loving

oneself we can never truly love another human being or even truly appreciate them as they are. Love comes in so many beautiful ways - the most important being the human connection of holding another person's hand when they feel defeated by life's demons.

SUCCESS FROM FAILURE

Failure isn't the end of the world - it's a chance for an even more exciting, new beginning. Without failure we never appreciate the journey and the value of the lesson - to keep growing, keep pushing our comfort zones and never give up. Just when the mountain seems impossible, push a little harder, the view from the top is spectacular and worth it.

In the journey of life the real rollercoaster moments are in the 'now moments'.

We meditate on a past that crushes our soul and keep preparing for a future that's unknown - only to lose the precious moment in front of us.Be kind and compassionate to others. Enjoy the abundant beauty around you as these are completely free, given to us by mother earth.

During isolation just watching from my window I was fascinated at the beautiful animals and plants right at my doorstep. My own miniature paradise. We search for paradise only to realise that it's within us and around us. Our perceptions of life determine the picture we see. Life is as colourful as we make it, despite the challenges.

Failure isn't the end of the world - it's a chance for an even more exciting, new beginning.

COVID-19 BRINGS LONG LASTING CHANGES

This is an opportunity to recreate your present. Many people are fighting just to stay alive so perhaps this is the moment to have a truly inspirational reawakening. COVID has given us the opportunity to make positive changes in the way we live and the way we think.

This time can either be wasted or can be a reawakening of our true being.

As I step out of my 'sanctuary' into the real world tomorrow I'm scared and excited for what lies in front of me. After 14 days of not being able to hold and cuddle my kids I feel excited by the prospect of being able to see them and share this new found love. And to keep serving others in my own special way.

I bid farewell to my dear friend COVID-19 till we meet again in the battleground of my hospital wards. I'm grateful for the lessons and the experience of a lifetime. I now value my every breath and my goal going forward will be to fill every moment with meaningful purpose and positive energy. I hope as communities, we remain united and humane in our response to this crisis. Let's create a breath of fresh new beginnings

God bless MHM

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