

Chapter 1 **General problem factors affecting global mental health and wellbeing**

While our individual mental health and wellbeing are influenced by many factors, so too is that of the overall state of mental health across the globe. The following overview provides a lens through which we can reflect on key aspects.

Problem factor: Global mental health burden

The global burden of mental health conditions is greater than both cancer and cardiovascular disease.¹ Approximately a third of adult health problems and disability across the globe is due to mental illness challenges.² Such an enormous global burden has meant that finding solutions to the problem has become a key priority in many countries. The emphasis is now increasingly on potential preventative measures and early, lighter touch interventions, more than ever before.

The average time to treatment after mental health symptoms first appear has been estimated as 10 years, and that two out of every three people who are depressed will not receive care that is adequate.³ This global crisis has prompted many conversations, as well action plans from institutions such as the World Health Organisation (WHO).

Conversations on mental health issues concerning the general population, a useful starting point for addressing the mental health burden, are increasing in the community. However, these conversations are lagging when it comes to clinicians reflecting on mental health issues in themselves. It is ironic that we instigate and support such conversations, yet – for various reasons as we will discuss – are left with either little insight, or little capacity, for action in regard to *ourselves*.

With these conversations about both the general population and clinicians alike, it is key to remember that mental health conditions are not the fault of the person who is affected by them. Much as we do not blame someone with asthma for having it, we need to ensure that conversations on mental health

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issues – be they involving clinicians or not – do not implicitly blame the person who is affected.

Being affected by stress, burnout, or any other mental health condition is not the fault of the person who is affected.

Burnout, or suffering under the effects of stress, or any other mental health condition, are not due to personal shortcomings and are not due to a failure of some sort in the individual who is affected – whether they are a clinician or not. While this may seem common sense to some of us, on reflection, it may give pause for thought for others.

Burnout can be regarded as a ‘fracture’ or a reaching of ‘breaking point’, and it is important to remember that stress can leave ‘injury’ as it nudges us closer to this point. Just because we have not yet reached breaking point, doesn’t mean that we aren’t being ‘injured’ by the stress. And just because we haven’t been diagnosed with a mental health condition, doesn’t mean that, at times, our mental health is suffering.

Or that our mental health couldn’t be improved.

We spend a significant proportion of our lives working. ‘Workplace stress’ is a common concept in many workplaces, with significant cost associated with many large corporations’ efforts to provide wellbeing tools and support for their staff. Acknowledging the impact of stress from work is thus not dissimilar to that which most of our fellow humans are feeling. Recognised sources of stress in a general workplace include:

- A lack of support
- Unrealistic demands
- A lack of appreciation
- An imbalance between effort and reward.⁴

Working as clinicians, we find that these sources of stress are all too common in our areas of work, too. Yet while it is generally acknowledged that working as a clinician is stressful, the support tools that other occupations are provided with are often lacking for us. Particularly within the existing hospital system of many countries, the stresses of work are also related to the infrastructure that we are working within. They may be due to a range of factors, including excessive workloads, a workplace culture that is unsupportive of lowering stress at work, and other aspects of the overall work environment.

In times of crisis, efforts to expand the healthcare system lead to increases in these stresses. Doctors being moved to areas of practice where they have lesser familiarity working in – some even returning from retirement – leads to increases in stress. Inadequate personal protective equipment (PPE) and

staffing rotas lead to clinicians being put in positions that can harm not only their own health but that of their patients, too. There is often an ‘all systems go’ approach to handling crises, while the ‘recovery’ or ‘debrief’ phases of such times are often viewed as being less important. After periods at war, the returned servicemen and women have current practice guidelines for debriefing techniques.⁵ Given their exposure to death and suffering during their work, it is well recognised that some kind of support will benefit them once they return. We, as clinicians, are also constantly surrounded by death and suffering and may be physically and mentally stretched beyond our coping resources. We are trained to manage both patients and our feelings about their health in times of crisis, but perhaps current practice guidelines should afford us similar support. Reflecting on the support offered in corporate environments may highlight that mental health education and stress management support is offered more extensively there, too, than it is for health-care professionals.

Our conversations on wellbeing and mental health need to start focussing more on organisational change. However, since organisational change tends to evolve slowly, it may be useful for us to ‘put on our own oxygen mask first’, as the airline safety videos so aptly phrase it, and learn a few techniques that may help ourselves to relieve the situation on a personal level, until the required systemic changes are eventually implemented. Part of this ‘top down’ change can begin with a ‘bottom up’ approach: learning and implementing techniques on a personal level will contribute to the required attitude and institutional changes further up in the system.

It may well be that, given the significant burden of mental health across the globe, our global approach to how it is managed needs to be reviewed. Whether it is increased education in school systems or increased access to telehealth resources – there are multiple avenues for improvement. Maybe the most effective remedies will prove to be institutional as well as personal; only time will tell. In the meantime, however, we clinicians tend to, by necessity, be practical and solution focused. We also tend to appreciate an approach with different and complementary prongs – a multi-disciplinary team approach. While reflecting on greater policy change, it makes sense to reflect not only on some of the wide issues relating to our wellbeing, but also on some of the solutions.

Problem factor: Accessing resources

The issue of the lack of adequate resources for mental health and wellbeing is universal. Across the globe 70% of the general population with a mental illness do not receive any treatment from trained healthcare staff (Figure 1.1).⁶ The reasons for this are multiple and complex; however, they include:

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Figure 1.1 Around 7 in 10 of the general population across the globe with a mental illness do not receive any treatment from trained healthcare staff.⁶

- Ignorance of presenting signs and symptoms
- Ignorance of treatment access pathways
- Perception around mental health
- Concerns about being discriminated against.²

Approximately one-third of global adult disability is due to issues surrounding mental health.² So sobering are these statistics that bodies such as the WHO have responded with ‘Mental Health Action Plan’ directives.² These include:

- More effective leadership and governance for mental health
- The provision of comprehensive, integrated mental health and social care services in community-based settings
- Implementation of strategies for promotion and prevention
- Strengthened information systems, evidence, and research.⁷

As mentioned, evidence suggests that it may take almost a decade for treatment to begin for depression after depressed symptoms have first appeared.² There is also evidence that delays in health professionals seeking treatment are greater than those of the general population. Hence the statistics for us and our colleagues could clearly be improved.

There are a range of different care options for mental health. While traditional face-to-face consultations with a trained clinician are key in some cases, there are a range of other, potentially more accessible treatment options that may be suitable in some cases. Some may include telemedicine, or complementary and alternative treatments. While some of these are in relative infancy, their potential is promising. Internet-based cognitive behavioural

therapy programmes aim to teach both cognitive skills – such as identifying depressogenic biases in how information is being processed – and behavioural skills, such as strategies to solve problems.

A range of factors may delay clinicians accessing mental health and wellbeing resources.

Clinicians also may delay access to care due to concerns around confidentiality.⁸ There are other factors affecting how and why we access support in the way we do, as we will cover in the coming chapters.

Problem factor: Multiple potential impacts on individual mental health

The biopsychosocial (BPS) model framework is used to explore how a mental health condition has arisen.⁹ The BPS model outlines the broad scope of areas that impact on our mental health, and systematically shows their inter-connections. According to this framework, there are various interconnected components that contribute to mental health conditions. These include the biological, the psychological, and the social. It shows that social parameters, the surrounding personality, and our emotional tone, as well as many other aspects all influence our mental health.¹⁰

Some factors include (Figure 1.2):

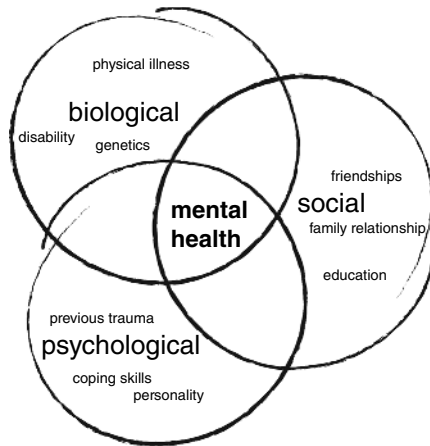


Figure 1.2 The biopsychosocial model indicates the interconnectedness between biological, psychological, and social factors that influence mental health.

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- Biological: age, genetics, gender, disability, co-morbid disease
- Psychological: beliefs, attitudes, self-perception, self-esteem, coping skills
- Social: friendships, occupation, employment, family relationships, social support systems, socioeconomics.

Some of these aspects are modifiable; for example coping skills are highly modifiable.

Neurobiology and genomics research provide strong evidence on the complexity of the expression of mental health conditions. A simple, linear cause and effect model rarely, if ever, can explain a mental health condition. Instead, it is more like a looping and complex chain of multiple causes and effects.¹⁰

In recognising areas that impact on our mental health, we can identify those that we can improve in order to help protect and promote our mental health. Therefore, this framework presents a way to not only look at factors that negatively affect our mental health, but to also highlight areas that contribute positively to our mental health.

Problem factor: The acute and chronic stress responses

As many of us are aware, our stress responses can be acute (quicker and shorter) or chronic (over a longer timeframe). Research supports that the implications of stress can extend beyond our physical health to our mental health, too.

An acute stress response follows the perception of a stressful event, and leads to changes in the

- Endocrine
- Cardiovascular
- Nervous
- Immune

systems.¹¹ These changes, known as the ‘acute stress response’, or the ‘fight or flight’ response, are, when short in duration, important adaptations for our survival.

Chemical cascades are generally activated (Figure 1.3) to:

- Release energy stores for immediately available use
- Distribute energy to tissues – such as the brain and skeletal muscles – which perform more actively during periods of acute stress
- Redirect energy away from body activities such as growth, sex hormones, and digestion which are less critical for immediate survival.¹¹

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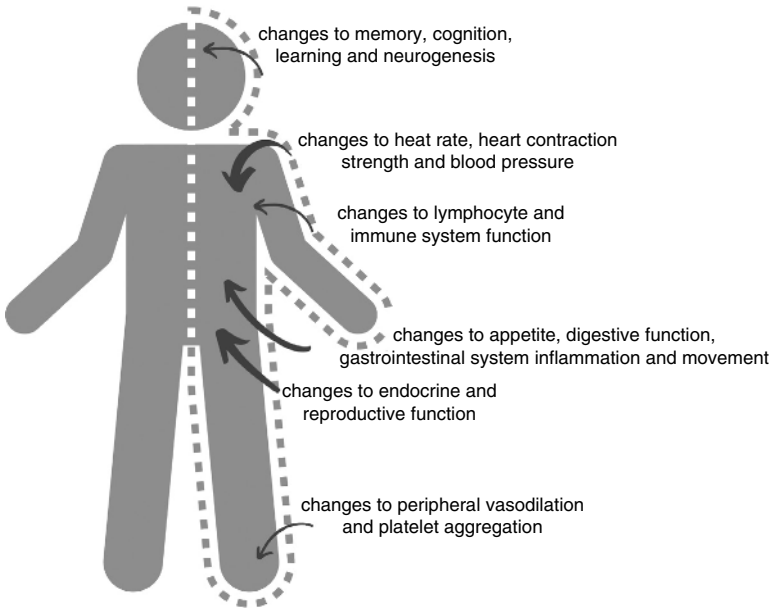


Figure 1.4 The stress response can impact on many different body systems.¹⁴

The sympathetic nervous system stimulates the adrenal medulla to produce catecholamine such as epinephrine. The hypothalamic-pituitary adrenocortical axis is also activated. Corticotropin releasing factor from the hypothalamus stimulates adrenocorticotropin from the pituitary gland. This stimulates cortisol secretion from the adrenal cortex.

Cortisol and catecholamines act to liberate energy sources by:

- Increasing glycogen conversion into glucose
- Increasing fat break down into energy sources such as glycerol and fatty acids.¹¹

In young, healthy people, an acute stress response will more likely lead to a level of adaptation, rather than creating an actual health burden.^{11,13} However, in less healthy or older people, it is more likely that repeated stress responses may be damaging to their health.¹¹

Under chronic stress, this acute response may be repeatedly activated without resolving. Given the actions listed above of the acute stress response, continuous activation may lead to physical problems such as:

- Increased blood pressure
- Vascular hypertrophy
- Immune suppression

amongst other issues.

We know that prolonged exposure to stress is a risk factor for mental health conditions such as depression.¹⁴ Prolonged stress can also exacerbate the symptoms of conditions such as bipolar and schizophrenia.¹⁴

Exposure to stress over long periods of time is likely to affect our efficiency at work. Evidence confirms that two out of three healthcare workers report significantly high levels of work stress, according to a UK workplace stress report.¹⁵ It is clearly time to start doing something differently. Almost all of the healthcare workers – 95% – reported that the stress impacted tangibly on their lives, and almost half (47%) felt that their work-related stresses led them to suffer anxiety.

One in two health care workers in the UK reported that work-related stress has led to them suffering anxiety.

We use the pre-frontal cortex (PFC) region of our brain for many tasks that our daily jobs require us to successfully perform. The so-called ‘higher executive functions’ include planning, decision-making, and problem-solving. The PFC area is one of the most sensitive to stress.¹⁴ We have good research evidence that our PFC is impaired under stress, leading to decreases in functions such as working memory.¹⁶ Many of our required tasks as clinicians require the optimal functioning of our PFC, so it stands to reason that learning to manage our stress will help us be more effective in our work in various ways. When being stressed impairs our decision-making ability, this has the potential to impact negatively on patient outcomes – thus our work stress may lead to further work stress in a negative cycle.

Reduced functioning may also be linked to behaviours we fall back on during periods of stress, such as losing self-control, overeating, smoking, or excessive drinking.¹⁴

Problem factor: The diathesis-stress model

Numerous health conditions are categorised according to genes and their environmental interactions.¹⁷ The diathesis-stress theory is the increased risk of a condition, such as depression, calculated by multiplying the impact of the genes by the environmental impact.¹⁷

‘Diathesis’ is a person’s predisposition towards an illness, based on their specific set of biological factors.¹⁷

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Much research supports an association that is significant between stressful life events and major depressive disorder.¹⁷ Some of this even suggests that in more than half of the cases of depression, there is an instance of severe adversity.¹⁸ The converse is also supported as true – that some of us will not present with cases of depression after severe life events. This evidence supports the idea that the symptom development is related to the complex interaction between how vulnerable and individual is – diathesis – and the stress that they are subject to.¹⁷

This model, which has been applied to many different psychopathologies, highlights that any periods of increased demand may be considered as stress. However, this may be a relevant way of viewing the impacts of crises and pandemics in the healthcare system, as these may be considered as serious life events for many clinicians. This reinforces the fact that during and after such events, additional support may be required, as we cover below.

We can do little about our genes, except perhaps to attempt to promote positive epigenetic changes in order to possibly affect their expression. We can, however, influence our environments – if not at the time of crisis or significant life event, then hopefully immediately after. Where we are unable to alter our external environment, we may potentially be able to at least change our internal – psychological – environment.

According to this model, there are certain points in life which act as serious life events. These may then, in turn, trigger mental health conditions in those of us who may, for many different reasons, have a genetic or biological vulnerability. We have little insight into predicting who has these vulnerabilities; however, with this information, we can aim to offer improved support to everyone in the wake of such events. This, in a healthcare context, may relate particularly to crises and pandemics which may act as such a trigger, as may other complex clinical cases.

Studies looking at the impact of COVID-19 on healthcare practitioners are also revealing the impact this crisis has had on us. One multi-centre study with 1,257 front-line staff in Wuhan, China found that healthcare staff who were involved in the care of patients with COVID-19 were associated with a greater risk of depression, insomnia, and anxiety symptoms.¹⁹ Their levels of these symptoms were significantly higher than those of their colleagues in secondary roles, with men less likely than their female colleagues to report such symptoms.

Problem factor: Stigma

Mental health issues are subject to greater stigma than many other health conditions.²⁰ While there are an increasing number of conversations on mental health in the wider community, it is still a highly stigmatised area

with regard to its impact on clinicians and other health professionals. There are a range of different resources for support with aspects of mental health for the general public, but there are significantly fewer specifically for clinicians. While these resources are relevant and supportive of anyone and everyone, the specific concerns of healthcare practitioners may at times need more specific support.

This stigma can create barriers to being able to seek access to care.²¹ It can have different components– the emotional, the behavioural, the cognitive – as well as activities on different levels – the structural, the interpersonal, and the intrapersonal – that can be active all at once.²¹

Stigma may still act as a significant barrier to accessing mental health resources for clinicians.

There is an extensive amount of research, some of which will be discussed in the coming pages, supporting the facts that clinicians are generally late to seek help for mental health conditions or to disclose their own mental health conditions. Despite treating patients with similar conditions, we are generally reluctant to seek help for ourselves.

By aiming to improve our own conversations that we have around our own mental health and wellbeing, we can also aim to improve the care that we can ultimately deliver to our patients.

Mental health conditions are also often subject to stereotypes. Stereotypes are useful in some areas of life, enabling us to make decisions based on patterns that we may have seen before – and so while these may not necessarily always be right, they may not necessarily always be harmful, either. However, with regards to mental health, stereotyping may lead to a generalised response pattern, rather than a customised one.²⁰ And given the obviously personal and widely differing natures of our mental health, it is clear that a generalised response based on a stereotype may not be the most helpful one. Stereotypes can also lead to characterisations of those affected as being completely defined by their condition, rather than recognising the ebbing and flowing nature of aspects of our mental – as with our physical – health.

Many factors may contribute to these feelings.²² These factors, according to the Director of the Institute of Healthcare Policy and Innovation in the University of Michigan, USA, have the ability to ‘lead to psychological symptoms.’³ These include the stress of caring for colleagues who one moment have worked alongside of us, and the next moment are critically ill from COVID-19. Inevitably, some of these colleagues may pass away. The burden of caring for any patient who is acutely unwell is stressful – with this multiplied when there are multiple cases in rapid succession, with the potential to rapidly deteriorate. There is stress around the ability to provide adequate care, particularly when

there are shortages in treatment devices such as ventilators, as well as concern about healthcare systems being inundated and pushed to breaking point. Given the changes in roles, stress can come from being allocated a different role in an area of clinical practice that we are less familiar with, as discussed. And finally, crucially, the lack of access to support services for managing these psychological symptoms is also a contributing factor.

The lack of suitable PPE can also cause significant stress. This stress may include a fear of contracting the virus through workplace, and a fear of transmitting it to family household members. These stresses led some clinicians to feeling that they needed to live away from their family during the pandemic, in turn bringing them additional stress through further straining their support network.

Moral injury, a term based initially on work within the military, may also occur when we have insufficient resources with which to care for critically unwell patients.²³ The term describes our feelings of psychological distress when our actions, or lack of actions, lead to us violating our ethical or moral code.²³ This can cause us to have negative thoughts about ourselves, and while it is not strictly a mental health condition, it may well affect our mental health.