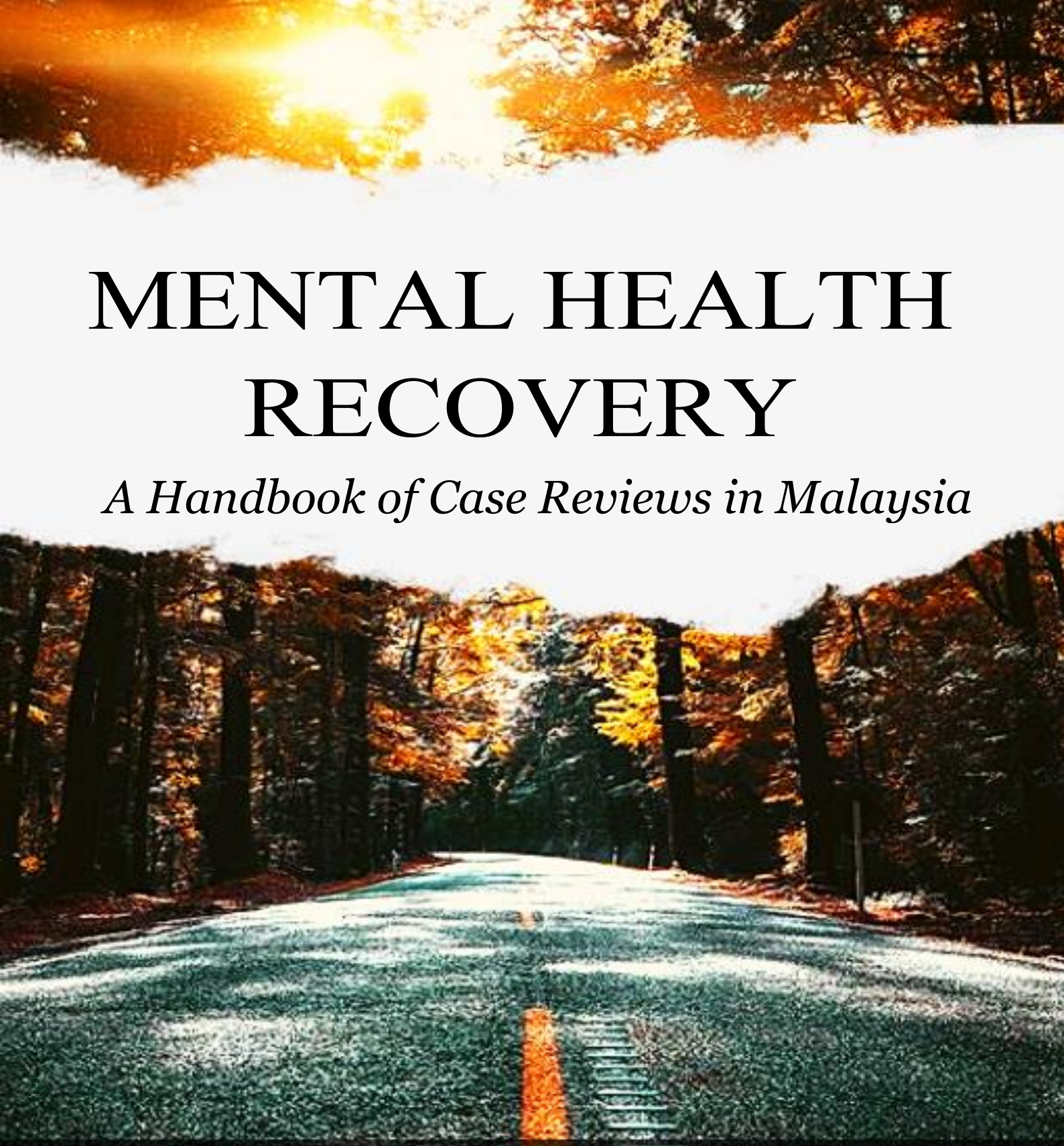

MENTAL HEALTH RECOVERY

A Handbook of Case Reviews in Malaysia

BY
PROF. DR. PHILIP GEORGE
DR. PETER NORRIE
DR. SINTHIA RAMANI
GIRISH NAMBIAR

Supported by MMHA MALAYSIAN MENTAL HEALTH ASSOCIATION

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This book is supported by the Malaysian Mental Health Association (MMHA).
Malaysian Mental Health Association is a non-government organization established to promote mental health awareness and public mental wellbeing.

MENTAL HEALTH RECOVERY – A Handbook of Case Reviews in Malaysia

e-ISBN:978-967-18129-2-1

Perpustakaan Negara Malaysia

Cover image by Sivakumar Ganesan
Cover page and book designed using Canva © by Dr. Sinthia Ramani

Published by:

Malaysian Mental Health Association (MMHA)

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Date of publication: July 2020

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All information provided in this book is strictly for general information only. It is not intended to and does not amount to advice which you should rely on. It is not in any way a substitute to specific medical advice. You must therefore obtain the relevant professional or specialist advice before taking or refraining from any action based on the information given in this book. If you have questions about any medical matter, you should consult your doctor or other professional healthcare provider without delay. Please seek immediate medical attention from a doctor or other professional healthcare provider if you think you are experiencing any medical condition.

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PREFACE

Preface

Mental disorders are among the most common and disabling health conditions worldwide and should therefore, be considered as a top global health priority. The recent National Health and Morbidity Survey, Malaysia reports the prevalence of mental health problems among adults aged 16 years and above in Malaysia as 29.2%. By gender, the prevalence was higher among females as compared to males and more among younger adults (NHMS, 2015).

Mental Illness is wrought with stigma and prejudice that affects the people who suffer from it and the healthcare professionals involved in helping these people. It prevents many from seeking effective treatment early and thus making recovery a challenge. A lot of this stigma and taboo is based on misinformation that is rife in the community especially in a developing country like ours. Some of this includes that mental illness is not treatable and that people with a mental illness will always be disabled and a menace or unpredictable. This can sometimes be the narrative that healthcare professionals believe leading to a decreased interest in a career in mental health. For a country of 32 million, Malaysia has only 400 plus Psychiatrists making the ratio of about 1 Psychiatrist per 100,000 populations. The recommended WHO ratio is 1 psychiatrist to a population of 10,000.

This handbook is a compilation of stories of real patients in Malaysia and their journey with mental illness. It highlights their recovery and return to society and community. There is an overview by a Psychiatrist on the illness that the patients described which helps to get a better understanding of some of the more common mental health disorders in Malaysia. This book is hoped to help medical students, doctors, other healthcare professionals and the population at large to better understand mental disorders as a health condition that can be treated and where recovery is a reality. Recovery may be modified but the eventuality is the person with a mental illness can return to being part of a community and society and have a quality of life that is same as everyone else.

Care is taken to ensure that identities of patients are not revealed in this book. All patients contributed their stories willingly and with consent. The authors thank all patients who have decided to share their journey for the benefit of others. We also thank the Malaysian Mental Health Association (MMHA) for supporting this handbook and for helping to make it available for free to as many people as possible. Special thanks to Dato Dr Andrew Mohanraj, the President of Malaysian Mental Health Association for his kind foreword. Finally, remember, **"*Recovery in Mental Health is Real*"**

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FOREWORD

Foreword

I am delighted to write this foreword because I too deeply believe that recovery from mental illness is possible. There is no universally accepted definition of recovery and it carries different meanings to different people. Not all can return to full function but meaningful outcome is possible. That is the clear message that this book sends.

This is a timely publication led by two prominent names in Psychiatry. Prof Dr Philip George, eminent teacher and psychiatrist in Malaysia needs no introduction. Dr Peter Norrie is the former Chief Psychiatrist of Canberra, Australia, whom I had the privilege of meeting several years ago, is also a man of deep wisdom. They are joined by Dr. Sinthia Ramani and Girish Nambiar, two young individuals with a passionate interest in the subject of recovery, who have also contributed to this excellent publication. Unlike other books of this nature, this is written in a crisp and easy to read manner without overwhelming the reader with tenuous concepts on the subject.

Eleven inspiring stories succinctly written with each followed by an overview by the Psychiatrist. These are the finest examples of stories of recovery I have come across - poignant yet laced with unmistakable hope.

Mental Health Recovery is not only about stories meant to inspire and inform those who are fraught with doubts and challenges in the quest to regain and retain their individuality. This book is also about motivating potential mental health workers and others who might continue to entertain the outdated concept that there is no real hope for those with psychosocial challenges.

Glossary of mental health services in Malaysia included in this book will prove to be particularly useful for those seeking credible support in their quest for self-improvement. In this era of increased digitalization, the information included on useful online sites for mental health improvement will also be much appreciated.

This book gives a meaning and purpose in life and above all a positive sense of self for those who are embarking on their personal journey towards recovery.

Prof. Dato' Dr Andrew Mohanraj
President, Malaysian Mental Health Association (MMHA)
Board Member, World Federation for Mental Health

INTRODUCTION TO MENTAL HEALTH RECOVERY

Introduction to Mental Health Recovery

By Dr. Peter Norrie

Mental health is now increasingly recognized in our society. Depression is the second commonest illness worldwide, only behind heart disease. Half of us will experience psychosocial difficulties and one in five of us will experience low to severe mental illness at some point in our lives. Suicidality is often misunderstood, unrecognized and undetected and for some is a great risk without appropriate acceptance and intervention.

Recovery is possible and can be a reality for people with mental illness and also for those with less severe psychological problems. We increasingly see this now with the effective and assertive use of modern medications as well as appropriate and holistic approaches to care involving psychosocial rehabilitation and psychotherapies. This is supported by the active involvement of patients, care givers and advocates at every stage of treatment, support and care. However, before exploring the concept and role of recovery in current mental health settings, let's go on a historical journey that will put this in context.

Older practitioners and colleagues in many countries will have had experience early in their careers of working in large institutions where patients stayed for long periods, if not most or all of their lives! There was a paternalistic approach to treatment and care which assumed chronic and long-lasting illnesses would change little. Therefore, there were few who improved or got better. To a large extent, the advent of the first generation antipsychotics and antidepressants (despite their often disabling side effects) gave the first signs of possible cure, particularly for depression and schizophrenia.

Some patients were able to leave institutional care and manage with support in the community. Family and other care givers began to play meaningful parts in ongoing support and care but the opinions of professional staffs dominated treatment planning. There was also widespread stigma surrounding mental illness with fear and prejudice dominating community attitudes.

Even though community transition and care became more frequent, the problems of chronicity and ongoing illness were the prevalent norm. Poor supports and non-adherence resulted in frequent re-admissions to hospital. The concept of "revolving door" patients became accepted, albeit with frustration of patient, care givers and professional alike. Recovery seemed unlikely in this environment, more an acceptance that the cycle of illness was inevitable. We now know from more recent research that each relapse can be toxic to the brain, so that maintaining optimum wellness rather than accepting illness is the key to minimizing continuing pathology.

In schizophrenia, there was and is no doubt that non-adherence is more prevalent in those on oral medication. So in these patients, a depot (long acting injectable) medication was used,

which assured stable delivery of the first generation medication dose over 2-4 weeks. Side effects, however, remained a problem. The search continued through the 1970s/80s for safer and more effective medication options.

A strange twist occurred through the 1980s with the care givers movement advocating for the return of Clozapine. Introduced in the 1960s with good success, the dangers of its use soon became apparent with agranulocytosis, a major side effect causing a significant risk of death. Myocarditis was also a serious side effect. Most countries subsequently withdrew Clozapine, but its use continued in some parts of the world, including Scandinavia.

Two things happened a few decades later. Firstly, a strong campaign motivated by carers and supported by clinicians led to Clozapine becoming available, with close monitoring for side effects. Secondly, because of the effectiveness of Clozapine, researchers were prompted to find drugs with similar efficacy but without the risky side effects.

In the early 1990s, these new medications became available. The first were Fluoxetine for depression and Risperidone for schizophrenia. Many others have followed in the last two decades and indeed they have revolutionized treatment for mental illness. Many younger colleagues have not practised in a clinical setting without these drugs (sadly they remain too costly and therefore inaccessible in many developing countries). New side effects replaced older ones and this has challenged psychiatrists to continue to use their general medical knowledge to manage obesity, metabolic syndrome and hyperprolactinaemia alongside the improving mental health conditions.

Many more patients started to re-claim their lives and patient driven consumer movements encouraged holistic care, supported too by carers. Accordingly clinicians widened their focus to include “quality of life” as well as symptom attenuation. Treating teams and mental health administrators took into account consumer and carer challenges. Policies and procedures began to reflect partnerships aimed at improved outcomes in mental health care.

Recovery frameworks were developed and Recovery plans with goals were regularly reviewed. They are now a standard part of care in many mental health services. Some partnerships have also included non-government and community organisations which have been well placed to educate in important areas such as prevention, early detection and reducing stigma.

There are many definitions for Recovery, some of which now follow. It is “***a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his/her choice while striving to achieve his/her potential***”. Recovery means gaining and retaining hope, understanding one’s abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life and a positive sense of self.

The principles of a recovery approach to treatment and care includes understanding that each person is different and should be supported to make their own choices, listened to and treated with dignity and respect, seeing each person as an individual and not just focusing on their mental health condition.

So what does all this mean in reality? Recovery may be a full cure/remission for some, or small to medium gains that allow ongoing ability to live with a problem or illness to the best extent possible. Examples could be…

- someone with psychosocial problems has successful short or long term psychotherapy that allows full return of function.
- someone with borderline personality traits has supports in place so that chaotic lifestyle and self-harm/parasuicide attempts are minimized.
- someone with moderate depression has appropriate medication and probably also psychotherapy that enables return to work and improved quality of life with minimal risk of relapse.
- someone with anxiety learns more about the triggers to symptoms and in managing these, lessens episodes and the impact of their condition. In some, anxiety may disappear almost completely.
- someone with mild psychosis has short term medication, education and support (possibly also about risks/harms of illicit drugs) and is able to make a full recovery. A mentor or peer may assist with wellbeing and healthy lifestyle choices.
- someone with bipolar understands more about the cycles of illness and the need for maintenance medication to reduce relapse and benefits of early detection of mania and more active treatment at that stage. Friends and advocates may assist in spotting early warning signs.
- someone with chronic schizophrenia may be stabilized enough on medication (most likely a long acting injectable) such that with ongoing psychosocial supports in place, living independently in the community or in assisted accommodation is possible.

Some of these possibilities for consumers were initially a challenge for mental health professionals, who either focused solely on a near or complete cure, or paradoxically were too quick to accept ongoing morbidity. Training in Recovery principles has assisted, starting with university education for emerging workers, but also ongoing training and experience for those already in the workforce. Consumer and carer inputs are also vital, having the “lived experience” of illness to share.

This “lived experience” input also then grew to an acceptance of a peer workforce. Those who have their own journey of Recovery are now formally employed as team members to assist/mentor those currently in need of treatment, care and support. Mental Health legislation has also been revised in many countries to enshrine rights of consumers and carers, including the

capacity to make decisions. Also, concepts such as “advanced care directives” have been agreed as a way in which a consumer can make decisions when well about future treatment options in the future if any relapse were to occur.

As a clinical and administrative leader and teacher through the last 20 years of my psychiatry career, I have been privileged to spearhead the journey to Recovery practice in the services in which I have worked. I quickly learned both in clinical and administrative work that explaining and indeed “marketing” the trajectory of the problem or illness as well as the benefits and risks of any plan or treatment, allowed people to make informed decisions.

I emphasise that this applied in both patient care and for service development! So for the end of this chapter, I want to share a few clinical insights which I hope will be further examples that underpin the value of a Recovery framework for mental health care.

The issue of adherence needs to be raised if a patient needs medication. It is important to understand non-adherence from a patient’s viewpoint. Few of us are perfect at taking medication, with good evidence that even doctors fail to complete a course of antibiotics when they have had a bacterial respiratory illness. Why? Maybe because often when we get well, we no longer feel the need for treatment. In contrast to a relatively straightforward respiratory illness, many mental health conditions are complex and need longer term treatment.

Maintaining treatment when well greatly reduces the risk of relapse. A corresponding medical example would be the use of long term treatment for rheumatoid arthritis, where judicious and continuing use of medication even when free of joint pain helps minimize future joint flare-ups. Good psychiatric care needs to introduce these issues at the start of treatment so that an open and honest discussion on adherence can occur at any stage of care.

Psychiatric medications often take a long time to be fully effective. In an ideal world, medication treatment would occur without side effects. Often this is not possible and, despite best efforts, side effects can be a nuisance or at times interfere with wellbeing. Once all options to ameliorate side effects have been made, sometimes I have used the illustration that feeling 80% well with a 20% side effect liability is better, long term, than achieving remission, stopping medication, and then relapsing and feeling 40% again whilst medication is re-started, titrated and takes time to be effective again. Many patients have, I believe, maintained adherence once they understand the rationale.

In clinical practice when a patient needed antidepressants, prior to commencement I would raise the need for treatment for a year or longer, along with an open discussion on side effects and what to expect. Wherever possible the carer also attended the consultation. Very often I would remind the patient of this discussion when, at a later stage of wellness (often at about six months), the patient asked about stopping medication. This usually ensured ongoing adherence and better long term prognosis. Vitally, once severe depressive symptoms dissipated, an integral

part of ongoing treatment was psychotherapy as well as ongoing medication. This doctor-patient partnership was a good example of recovery principles.

Ongoing care under a psychiatrist is not always necessary but often the patient becomes dependent on regular consultations and support. This is not always healthy and can negate recovery. I carefully considered in some patients a flippant comment early in treatment that my job was to get them to independence so at some point they could "sack me". You could only imagine my surprise, joy and apprehension when the first patient 'DID' sack me! We made sure supports were in place and he let me know sometime later that he was doing ok. I have only used this example in educating about reclaiming autonomy after a period of illness.

It is often not possible for patients with schizophrenia to disengage with treatment because most commonly this is a life-long illness. Due to lack of insight, this illness can also make adherence a challenge. I have seen many well-meaning colleagues persuaded to reduce and stop medication and/or move from depot to oral formulations to support patients, only for this to result in significant relapses.

In my opinion, this is probably one of only a few examples where the safety and wellbeing of the patient and the community must be balanced against full autonomy. Again, an open and honest discussion with the patient about ongoing need for treatment and preferably assisting adherence by using a modern long acting injectable is best. Wherever possible get the agreement of the patient (sometimes reluctantly).

Involuntary treatment should be used if needed, but with regular reviews, and only as a last resort. It is interesting that some patients have later appreciated someone taking control when severe illness inhibited their ability to do so! And indeed, in feeling respected, some of these go on to stability and successful management of their illness.

Recovery has allowed consumers, carers, advocates and professionals to speak much more about mental health, as opposed to mental illness. Even though stigma remains an issue, and in some cultures being mentally ill is misunderstood and seen as shameful, there is a growing understanding, knowledge and acceptance. This can only lead to better care. I am sure the case examples in this book will highlight the success of the recovery journey.

PATIENTS' STORIES ON RECOVERY JOURNEY

Story 1: Bipolar Disorder and Drug Dependence

1.1: *My Journey*

I am 32 years of age and I have studied to the level of senior high school. I have been grappling with substance addiction for several years after having first been exposed to drug use at the age of 15. My drugs of choice which I had most trouble with were Cocaine and Heroin. At the age of 15, however, I started with using only Cannabis. At that time, I felt rejected by my family and ended up living a life off the streets. There were periods of recovery and in fact in one of those periods I was engaged to be married. Nevertheless, it did not come to be and instead I continued with my drug use. I often experienced dire living conditions, having had to sleep in train stations from time to time as a result of losing work and a place to stay. I also spent time in prison after briefly being involved with members of the criminal underworld dealing with drugs. When I did decide to seek help with mental health professionals, I was still using drugs on and off and so most of the therapies were fruitless. I was diagnosed with Bipolar Disorder and drug dependence and understand that this combination is common.

1.2: *My Recovery*

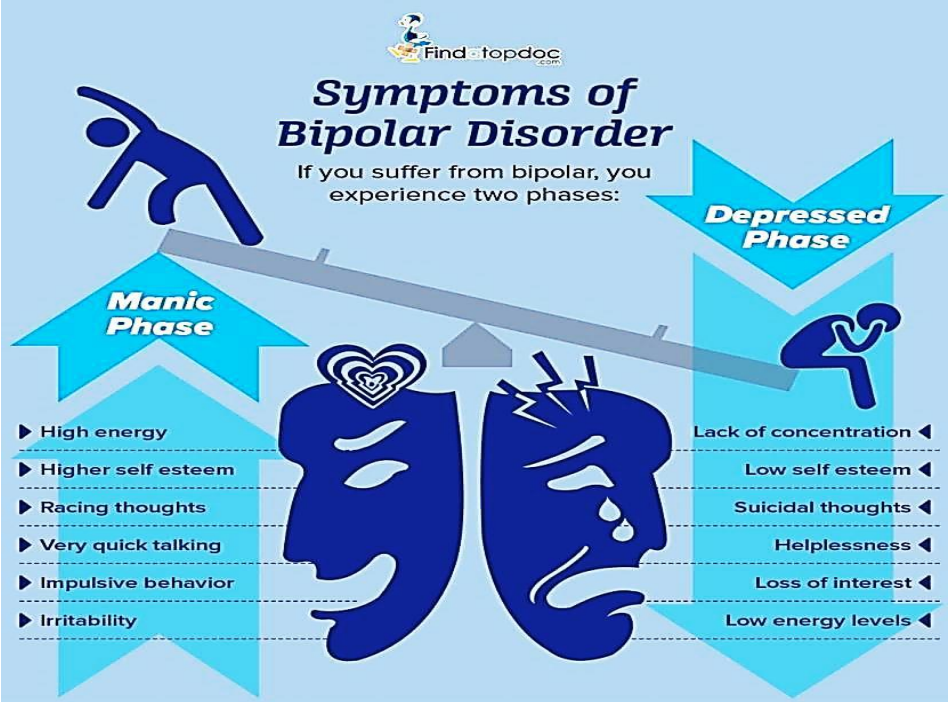
I have been recovering under the guidance of counsellors, mental health nurses and Psychiatrists for approximately nine months. Apart from medication and therapy, the other things that contribute to my recovery are regular routines and exercise. I now have found a new passion in reading. I feel that medication helps to calm me down but I still experiences stress on and off and I am learning to better control that. My parents are presently separated but I am close to my brother and sister who provide me a lot of support. I want to be drug and addiction free, moving ahead my goal of being a professional trainer. I believe my experience has taught me to always consider choices in life and follow the right path.

Overview by Psychiatrist

Dual Diagnosis is the terminology used to describe people who may have both a substance use disorder and a mental disorder. It complicates outcomes and the treatment has to focus on both conditions. Typically substance use can be a form of self-medication in those who may have a mental illness and do not seek professional help for their illness. Once they move from recreational use to daily heavy use, the drug use becomes an illness just like their mental illness. Alternatively, some drugs can cause symptoms that resemble a mental illness. The usual way to differentiate the two is to first treat the substance use disorder and then after a period of abstinence for at least 1 month, reassess the mental illness symptoms.

Bipolar Disorder is a mood disorder where there are mood swings that include highs and lows. People with bipolar disorder experience intense emotional states that occur in distinct

periods called mood episodes. Each mood episode represents a drastic change from a person's normal mood and behaviour. An overly joyful or overexcited state is called a *manic episode* and an extremely sad or hopeless state is called a *depressive episode*. Sometimes, a mood episode includes symptoms of both mania and depression. This is called a mixed state. People with bipolar disorder may also be explosive and irritable during a mood episode. Extreme changes in energy, activity, sleep and behaviour go along with these changes in mood.



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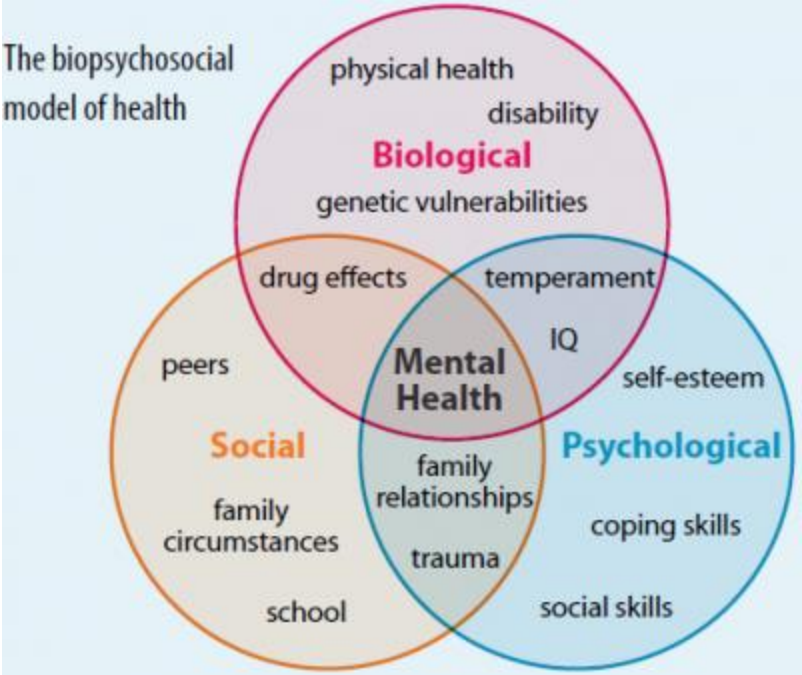
In Bipolar Type II, people may experience hypomania which is a less severe form of mania. During a hypomanic episode, you may feel very good, be highly productive and function well. You may not feel that anything is wrong but family and friends may recognize the mood swings as possible bipolar disorder. Without proper treatment, people with hypomania may develop severe mania or depression.

Like all mental disorders, Bipolar Disorder is due to a combination of **biological, psychological** and **social factors**. Biological include genetic risks or neurochemical changes in the brain and psychosocial includes major life changes, substance abuse and severe stress. Bipolar Type I occurs in about 1% of the population but Bipolar Type II is more common. Suicide is a risk factor for patients with Bipolar Disorder especially in the depressive mood episode.



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Treatments for Bipolar include medications such as mood stabilisers and atypical antipsychotics. This in combination with psychological treatments such as cognitive therapy, interpersonal therapy, social rhythm therapy and psychoeducation are effective in managing the condition.

Story 2: Drug induced psychosis

2.1: *My Journey*

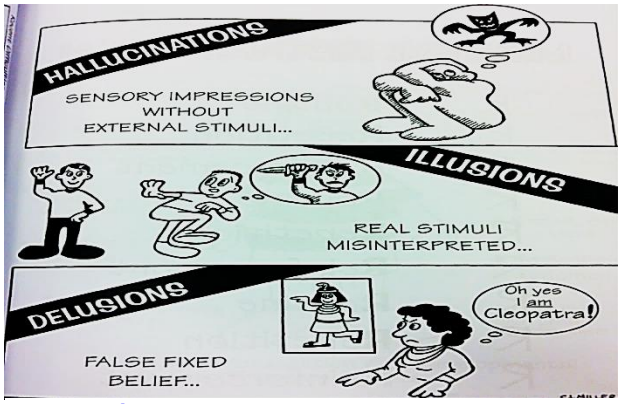
I have always lived at home with my parents and siblings. I have a postgraduate degree in commerce and law. I was originally diagnosed with Bipolar Disorder in 2013 and had admissions to the Psychiatric Unit. I was prescribed medication but was often not taking them regularly as they gave me side effects. Looking back, the illness was really related to my drug use. In 2017, after a long binge of amphetamines, MDMA, Cocaine and Erimin-5, I was readmitted with the diagnosis of drug induced psychosis. The police had to come to take me to the hospital as I was violent towards my family.

2.2: *My Recovery*

I remained drug free after discharge for 7 months but some friends made me drink some alcohol and later use some drugs. Hence, I went back to using drugs heavily and daily again. I find it a challenge to gain the trust of my family and this sometimes leads to arguments and miscommunication. This can be frustrating and so sometimes, I look for friends to ease my stress. I now have learned that I have to avoid people who are still using drugs and find friends who will be of better influence. Peer support in the form of Narcotics Anonymous is helpful. I follow the advice of my therapist and am truly hoping this time, I can stay drug free and not experience psychoses again.

Overview by Psychiatrist

Drug induced psychosis is psychosis that is triggered by drug use. Psychosis is often characterized by delusions or hallucinations, which are experiences that are not in touch with reality. ***Delusions*** are fixed false, irrational beliefs that a person holds, even when they are presented with evidence that contradicts these beliefs. Delusions may include believing that people are after you or that you have a serious or life-threatening physical illness or that you are responsible for terrible things happening to other people when you are not. ***Hallucinations*** refer to intense sensory perceptions of phenomena that are not real and are characterized by individuals feeling, seeing or hearing things that does not truly exist.



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Drugs such as amphetamine, cocaine, cannabis and hallucinogens can cause drug induced psychosis. Drug-induced psychosis can happen when you take too much of a certain drug so that its level of toxicity provokes paranoia and a psychotic episode. Drug-induced psychosis is more apparent when your symptoms wear off after you have stopped using the drug or only occur when you are heavy into its use. Drug-induced psychosis has been associated with suicidal thoughts, dangerous and violent behaviour. Most patients with this condition are best treated as inpatient to help manage both the withdrawals and the psychoses and to keep them safe. Short course of antipyschotics may be required. After symptoms have settled, it is important to focus on drug relapse prevention.

Story 3: Drug Dependence

3.1: *My Journey*

I have an undergraduate level of education in accounting and finance. At the age of 18, I left home to live with my aunt. After a period of time, I moved out into my own apartment to live with my ex-colleague who happened to be using drugs. This was when my involvement with substances began to increase dramatically. My drug of choice was methamphetamine or "Crystal Meth" (known as Syabu). I found myself taking drugs more frequently even after my housemate had moved out. I started to feel extremely low especially after prolonged use of drugs. This made me to attempt suicide. After my parents found out about my suicidal attempt, they sent me to stay with my aunt again but this did not stop me from making a second attempt at suicide as I was still feeling extremely low. It was then my parents took me to a rehabilitation centre. I was diagnosed with Depression and Addiction.

3.2: *My Recovery*

After undergoing several therapies and taking medication at the rehabilitation centre, I felt that I am gaining back my self-confidence and felt much of my original-self prior to involvement with drugs. My family has been very supportive in my recovery journey even though they would be disappointed at times when I fail during the recovery process. I just hope that they would be more aware of my struggles and be more patient. I am planning to look for a proper job to help sustain my life and also wish to have my own family in future. I hope that substance addiction would be de-stigmatized in the future so that it would allow people like me to receive help and support in order to return to society with little hindrance as possible. I would also like to remind those people out there who are struggling with drug addiction that they are not alone and they should be brave and seek help as soon as possible for their own good.

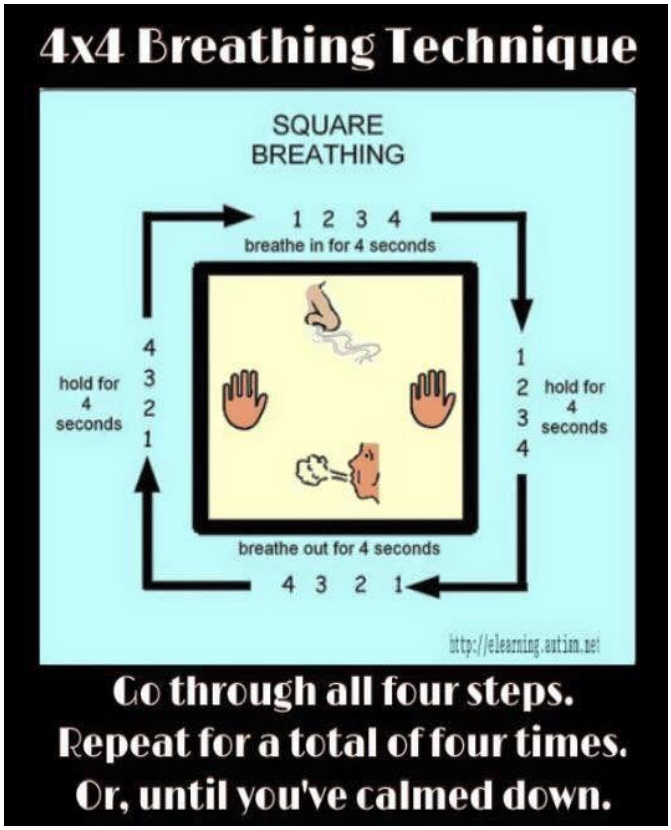
Overview by Psychiatrist

Drug Dependence is a chronic relapsing illness. After using a drug for more than 12 months, there are neurochemical changes in the brain that make it difficult to use ‘will power’ to prevent a relapse. There are warning signs that you may be headed for relapse and being aware of them helps you take steps to prevent it from occurring. Some of the common warning signs are, dreaming or thinking about previous alcohol or drug use, believing one slip will be ok, lying and being dishonest, isolating from others, missing doctors follow-up or support group meetings and interacting with friends or other people who drink or use drugs.

Ways to prevent a relapse includes avoiding triggers or cues that may increase craving and relapse. Cues can be either **people** (those who are using or interactions with people who are critical and hostile), **place** (the places you used to use the substance or buy it) or **time** (the time

of day you usually use it or the end of the week or on your pay day. It may also be periods when you are feeling down, frustrated or even happy). **H.A.L.T.** is an acronym for **H**ungry, **A**ngry, **L**onely and **T**ired. Whenever there is a feeling or craving to use, ask yourself if you are feeling any of these symptoms. The most common triggers for many recovering drug dependents are hunger, anger, loneliness, and feeling tired. By doing a regular inventory of HALT, one can help prevent the risk of relapse. Pre-plan to what your response will be if you have any of the HALT symptoms.

Stress is a common trigger for relapse. Deep breathing is a way to cope with stress. Deep breathing releases neurotransmitters in your brain, many of which trigger feel-good chemicals resulting in relaxation, happiness, and pain reduction. Deep breathing and the resulting increased oxygen flow also encourages your body to exhale toxins. A useful deep breathing technique is the 4 x 4. Take four deep breaths in through your nose and hold, then release for four seconds. You should feel your diaphragm moving in and out while you breathe. Deep breathing is an excellent relapse prevention technique because it can be utilized virtually anywhere without anyone knowing you're doing it.



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Finally it is useful to keep a list of people to contact in crisis. When an urge comes, it can be difficult to manage it, especially in the beginning of recovery. A very helpful relapse prevention skill is making a list of healthy family members or friends who are also in recovery that you can call for support. Having a safe person to talk to can help you get past the craving and remember why you do not want to return to previous behaviours. Keeping that list on you at all times is important because it is a readily available resource you can use by quickly calling someone safe.

Story 4: Alcohol Use Disorder

4.1: *My Journey*

I am a graduate in Bachelor of Science, majoring in Marketing and Management. I am married and have 2 daughters who are all living with my father. My mother passed away due to cancer two years ago. Ever since then, I started drinking heavily and was diagnosed with Alcoholism in 2018. I attempted to abstain from alcohol but it was futile due to strong craving and withdrawal effect like tremors. I was also admitted into a rehabilitation centre twice but suffered relapses and I could not change my behaviour.

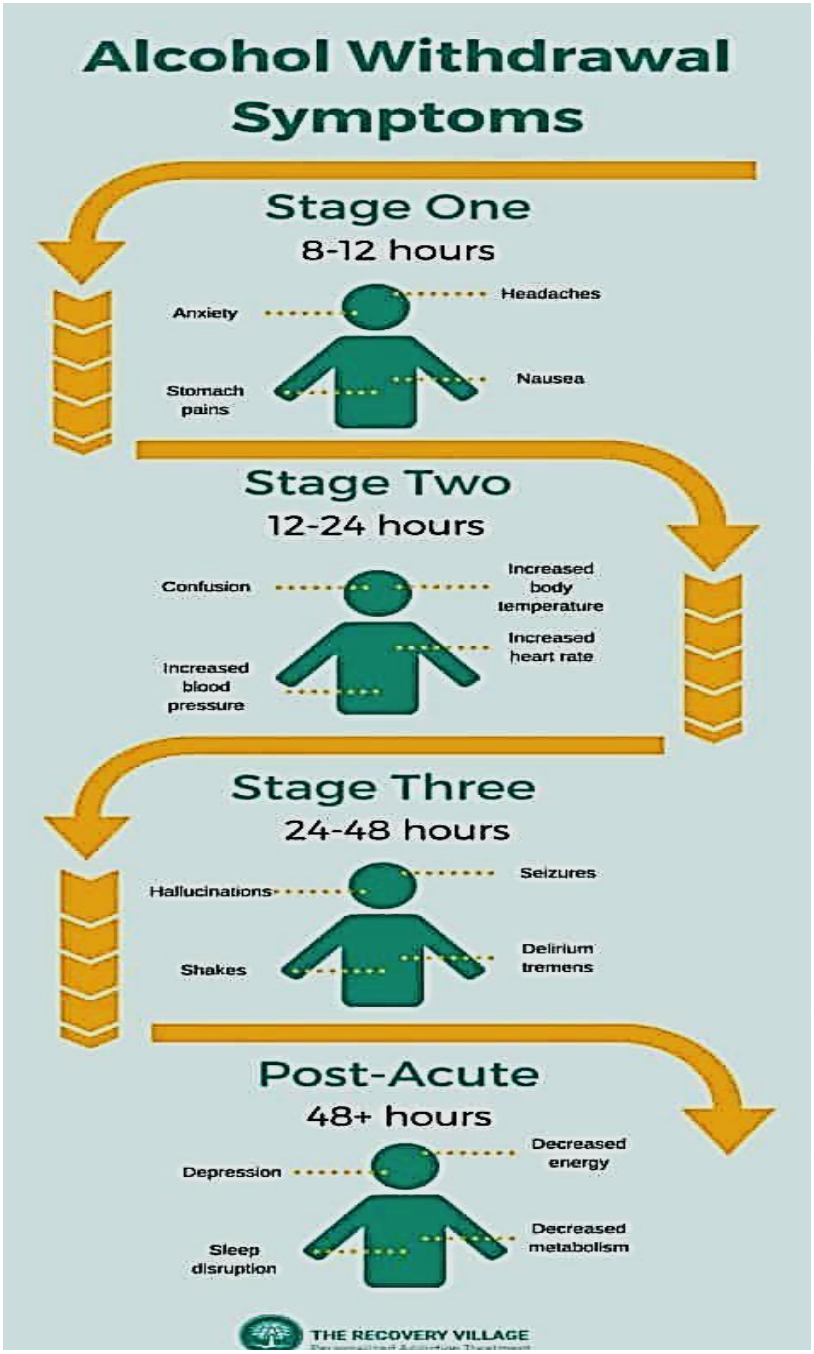
4.2: *My Recovery*

Once again during my latest admission to the rehabilitation centre, I had undergone therapy sessions and gained support from the mental health professionals. It was not until I took upon myself to be determined in changing my lifestyle did I manage to make real progress in my journey towards living a non-alcohol dependent life. Equipped with tools learned during the sessions, I was able to cope with my alcohol problem better. I hope that I can resume my old life which I have left especially with regards to my role as a husband and a father. To the others who are currently facing issues with alcoholism, I hope that they would accept the reality of their given situations and seek professional help soon as everyone deserves a better life. They should also accept their own, personal recovery journey and be genuine, patient, as well as resilient in their effort to heal themselves.

Overview by Psychiatrist

Alcohol is a psychoactive substance with dependence-producing properties that has been widely used in many cultures for centuries. The harmful use of alcohol causes a large disease, social and economic burden in societies. The harmful use of alcohol can also result in harm to other people, such as family members, friends, co-workers and strangers.

Some of the indicators of harmful alcohol use include, the need to drink more or longer than you intend, inability to cut down or stop drinking, having to drink more than you once did to get the effect you want, continuing to drink even though it makes you feel depressed or anxious or adds to another health problem and spending a lot of time drinking or thinking about alcohol. Usually people with alcohol use disorders will find that drinking interferes with work, daily activities, family and friends. When stopping alcohol it may cause withdrawal symptoms such as shakiness, sweating, tremors, headaches, anxiety, irritability and insomnia.



Source: ***Pinterest***

Treatments for alcohol use disorders include medications that may help to control cravings or medications such as Naltrexone or medications used as aversive treatments such as Disulfiram. Psychological therapies include motivational interviewing, cognitive-behavioural therapy, coping skills and relaxation techniques. Other effective therapies include self-help programs like Smart Recovery or Alcoholics Anonymous (AA). AA focuses on a 12-Step approach facilitated by recovered peers. These therapies can help people boost their motivation to stop drinking, identify circumstances that trigger drinking, learn new methods to cope with high-risk drinking situations and develop social support systems within their own communities.

Story 5: Borderline Personality Disorder and Drug Addiction

5.1: *My Journey*

I am 32 years of age with a degree in Bachelors of Law and was working as a clerk prior to my present admission into the mental health facility. Previously, I lived at home with my parents and younger cousin. I have a history of substance addiction such as cannabis and alcohol which began shortly after college. My relationship with my family had been bad as I had poor academic performances in high schools and it deteriorated after my involvement with drugs and alcohol. I was charged a few times for driving under the influence but was lucky enough not having spent time in prison. I dealt with the condition for approximately 12 years now. I was diagnosed with Borderline Personality Disorder with Substance Use Disorder when I was admitted in a psychiatry unit during this period. Looking back, I realised that I had problems coping with stress and feelings of abandonment for a long time. I was impulsive and that led me to my substance use and also sabotaging success by suddenly quitting a good job. I did the same with the last job. I have been hospitalised multiple times and have been admitted into rehabilitation centre on two occasions for which I have been prescribed antidepressants and mood stabilizers. Currently, my primary affliction remains solely in that of addiction and Borderline Personality and it is for this that I am taking an antidepressant, anti-anxiety medication and anti-craving medication.

5.2: *My Recovery*

I am now working with my therapist and other mental health professionals in the rehabilitation centre and have been making some progress in improving my self-destructive behaviour. I have managed to work at a decent job and my relationship with my family also improved. I also have a sister who lives abroad whom I admire greatly. She is someone who I can lean on for support during distressing times. Gradually, I feel that I have come to terms with the things that triggered my addictive behaviour. Presently, I am working on changing my mindset and aiming to change my negative thoughts as well as lifestyle into one that is more productive and meaningful. More than anything, I am looking forward to understanding myself better so that I can be better equipped to handle life and pursue those things which are dearest to me, which include a career as a clerk.

Overview by Psychiatrist

Personality is generally fixed by the age of 18. *Borderline Personality Disorder (BPD)* is a condition that typically has difficulties regulating emotion. This means that people with BPD feel intense emotions especially after a triggering event but not long enough to be classified as Depression or Mania. They can suffer impulsivity, poor self-image, stormy relationships and

intense emotional responses to stressors. Struggling with self-regulation can also result in dangerous behaviours such as self-harm (e.g. cutting) and drug or alcohol use.

People with BPD experience mood swings and a great sense of instability and insecurity. They can also experience real or imagined abandonment by friends and family and employ frantic measures to avoid this. The term Borderline is to describe symptoms that can be psychotic or neurotic but unlike other psychotic and neurotic disorders, they do not last as long.

Treatment options include psychotherapy, medications and group, peer and family support. Psychotherapy includes dialectical behavioural therapy (DBT), cognitive behavioural therapy (CBT) and psychodynamic psychotherapy. Learning ways to cope with emotional dysregulation is often the key to long-term improvement for those experiencing BPD. Mood stabilisers and antidepressants can help with mood swings and dysphoria.

Source: ***Pinterest***

Story 6: Obsessive Compulsive Disorder

6.1: *My Journey*

I had an amazing career in the oil industry back in 2012. However, one fine day at work, I had these intrusive thoughts and was gripped with anxiety. Since then, I had been having these repetitive thoughts which triggered a feeling of great distress. I did not understand the reason I was obsessing over these thoughts even though it clearly made me so uncomfortable and afraid. Each time I tried to reason with it, I would be pulled much deeper into it which just made it worse for me to deal with. Every day was a struggle until it took a toll on my career. I found it to be extremely difficult to focus at work as I was afraid of my own thoughts. Being a Geophysicist meant having the utmost attention in order to scrutinise every single detail of seismic data. This was a task that now seemed impossible for me to perform as I no longer had the concentration I once had. I tried coping with this on my own for many years by trying to forget it yet I still failed. Fast forward to 2018, I was still gripped with fear and anxiety over these intrusive thoughts. I was very afraid to wake up every morning as I would be actively worrying and ridden with anxiety. I knew I needed help when one day I was crying profusely in my bedroom. I knew this was not normal as I was days away from starting my new job which I have always wanted and was supposed to be happily enjoying the rest of my holidays at home. Instead, my thoughts just kept spiralling out of control and I was feeling so depressed. That was when I decided that I had to seek professional help. Although I was well aware that I was going to sound crazy to a total stranger, I just had to tell all of this to a professional in order to get better. I wanted a better life for myself and for that to happen I had to be well again.

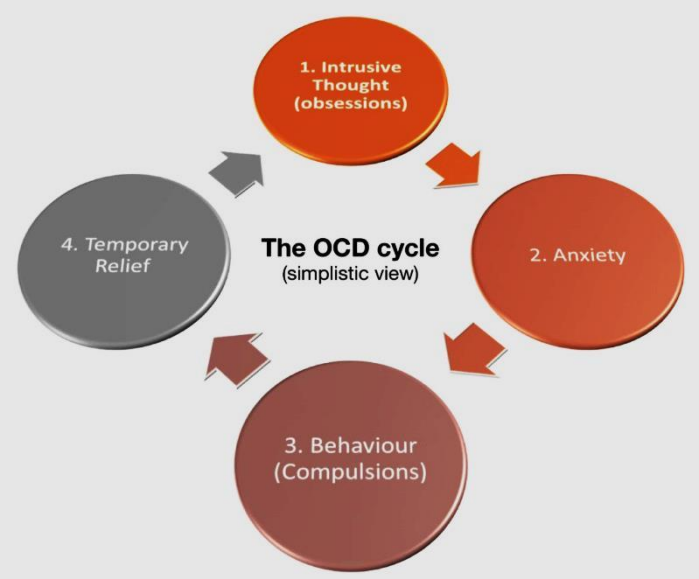
6.1 *My Recovery*

When I was diagnosed with Obsessive Compulsive Disorder (OCD) with Depression by a psychiatrist, it just made it so much easier to deal with. I am happy to report that I am slowly but surely getting better each day through medication and talk therapy. It is very comforting to know that I am not alone in this struggle and that there are professionals out there who can help me. It certainly comes with a price but it is really worth investing in your mental health. It is always going to be hard to take that first step to seek help but once we do it, it will be really worth it. Never did I ever imagine that I would one day see a psychiatrist. Nonetheless, sometimes life throws us some unexpected curve balls and we have to decide if we want to sink or swim. These professionals are there to help us and it is no shame in seeking their assistance. As human beings, we are not perfect and it is possible to live well, feel well and also find happiness with any sort of mental illnesses that we may be struggling with.

Overview by Psychiatrist

Obsessive-compulsive disorder (OCD) is an anxiety disorder where people have recurring, unwanted thoughts or ideas (obsessions) that make them feel driven to do something repetitively (compulsions). The thoughts and repetitive behaviours such as hand washing, checking on things or cleaning can significantly interfere with a person's daily activities and social life.

Many people have focused thoughts or repeated behaviours. However, these do not disrupt daily life and may add structure or make tasks easier. For people with OCD, thoughts are persistent and unwanted and resisting or trying to not think them triggers immense anxiety. Similarly, routines and behaviours are rigid and not doing them causes great distress. Many people with OCD know or suspect their obsessions are not true and insensible but are unable to stop them.



Source: ***OCD UK***

OCD is typically treated with medication, psychotherapy, social treatments and the best results is a combination of all three. Sometimes people with OCD also have other co-occurring mental disorders such as depression and substance use disorder. Medications used for OCD include antidepressants like SSRI's (Selective Serotonin Reuptake Inhibitors). Psychological treatments include, Cognitive Behavioural Therapy and Exposure and Response Prevention (EX/RP). An example of EX/RP is spending time in the very situation that triggers compulsions (e.g. touching dirty objects) but then being prevented from doing the usual resulting compulsion (e.g. handwashing).

Story 7: Panic Disorder

7.1: *My Journey*

I was sitting by the pool chatting with my friend on a nice evening when suddenly I felt nauseous, started coughing and felt numb in my arms and legs. My stomach started to churn and I felt giddy. We went back to the apartment and I tried lying down. However, not long after that, I started trembling and an hour later, I was at the clinic. It felt as if I had some form of seizure. A week later, I went for a thorough medical check-up and was told that I may have had a panic attack. I was then asked to see a Psychiatrist but was not convinced. I remembered feeling this way five years ago. I dealt with it by ignoring it and forcing myself to continue what I was doing until the feeling went away. Unfortunately this time, that did not work. I took some relaxants but avoided them whenever I could. The anxiety worsened thereafter. I was not able to go on a train and could not bear to wait at the cashier or eat properly. I recalled one day that I was terrified of the rain and thunder. I stopped working because I would get an attack whenever I am rushing out to work or even attending a meeting. The hardest thing for me was when I started to hyperventilate and it would spiral out of control. I felt so odd and out of place when I am panicking in situations where normal people would have no problems with. It was very tiring and I wished that there was hope for me to get better. My partner was feeling helpless and was worried of me.

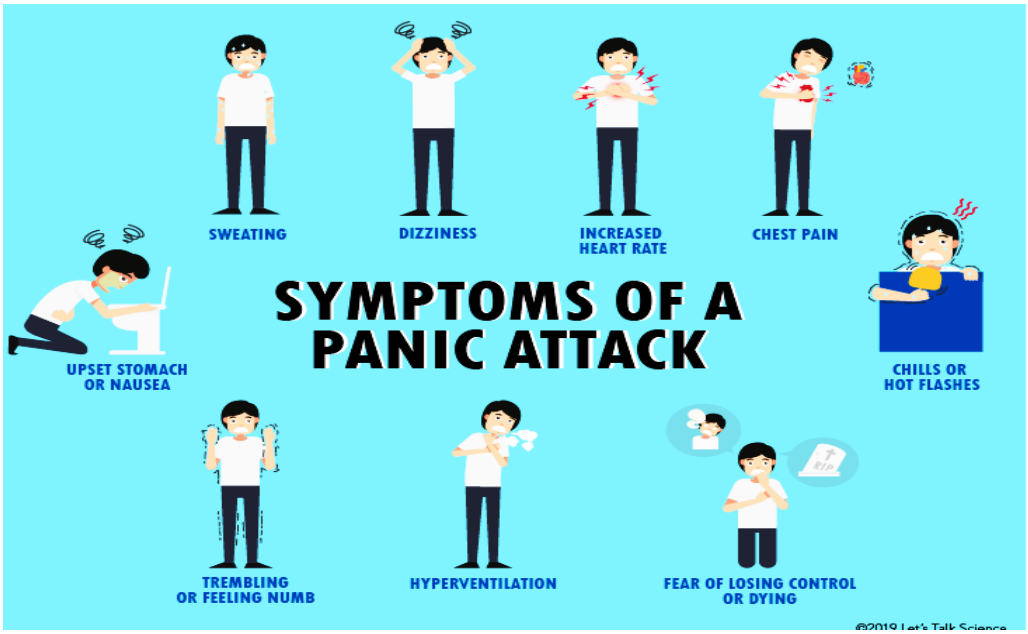
7.2: *My Recovery*

It took some time before I was convinced that I would need medication. I saw the Psychiatrist and he prescribed Fluoxetine which is an SSRI because it was something that is tried and tested. Initially, it was a little difficult but as time passed, I could feel that I have built my confidence with every fear that I have managed to overcome. I took up yoga and started playing a musical instrument. I also took up a temporary job to get back into the swing of things. In a month, I was feeling so much better that I even went for a holiday and had a great time. I preferred having the guidance of the Psychiatrist over reading books on anxiety as it was easier when the doctor taught me one skill every fortnight to master. Books, on the other hand are loaded with lots of information which was overwhelming for me at that time. During the therapy sessions, I learned to use positive self-talk and to challenge my negative thoughts. Having faith in knowing that I will get better in time was the key to recovery. The support given by the mental health professionals during my recovery journey had helped me and my partner to understand my condition better. I am now confident that I can avoid getting another attack in future.

Overview by Psychiatrist

A *panic attack* is a sudden episode of intense fear that triggers severe physical reactions when there is no real danger or trigger. Panic attacks can be very frightening. When panic attacks occur, you might think you're losing control, having a heart attack or even dying. Many people have just one or two panic attacks in their lifetimes and the problem goes away, perhaps when a stressful situation ends. If they are recurrent and at least 4 attacks in one month or one attack with 4 weeks of fear of having another (anticipatory anxiety), then it is a *panic disorder*. Although panic attacks themselves aren't life-threatening, they can be frightening and significantly affect your quality of life. But treatment can be very effective.

Panic attacks typically begin suddenly, without warning. They usually peak within minutes and slowly subside but you can feel fatigued and worn out after an attack. Panic disorder causes an intense fear of having another attack. You may fear having panic attacks so much that you avoid certain situations where they may occur. Panic attack symptoms can also resemble symptoms of other serious health problems such as a heart attack, so it's important to get evaluated by your doctor. Once a medical condition is ruled out, it is then more confirmatory of a Panic Disorder.



Source: ***Lets Talk Science***

The treatment for Panic Disorder is medication such as antidepressants or anxiolytics combined with Cognitive Behavioural Therapy. Anxiolytics, however, must be used cautiously as they can cause tolerance and dependence if used for long periods (usually if longer than 2 weeks). Relaxation techniques such as breathing exercises and progressive muscle relaxation are also helpful and so too is mindfulness and meditation.

Story 8: Bipolar Disorder Type I

8.1: *My Journey*

My secondary school life had been great as I was good in my studies and actively involved in extracurricular activities. It all started when I went to college to do my pre-university studies. Initially, everything was going well and smoothly. I had made new friends and my social life was expanding. However, one night, my life was changed forever when I was ridiculed by my friends offensively. The next morning, I woke up with strong anxious feeling. I immediately knew that something was not right. From there on, my life went downhill all the way. I felt depressed most of the time with recurring moments of anxiety. My studies and social life deteriorated but I somehow managed to pass my examinations slightly well. I continued my studies overseas. It was quite a disaster over there as this was when my mania first surfaced. It was like I had new powers. I had an amazing focus, developed a new kind of confidence and was able to have excellent conversations. However, this power would only last for a few days. Then, it would disappear and be replaced by the darkest depression. The depression too would last for a few days and replaced in turn by the mania. This cyclic change in moods went on for a few months. I returned home to my family as I could not take it and I decided to see a psychiatrist who diagnosed me with Bipolar Disorder Type I.

8.2: *My Recovery*

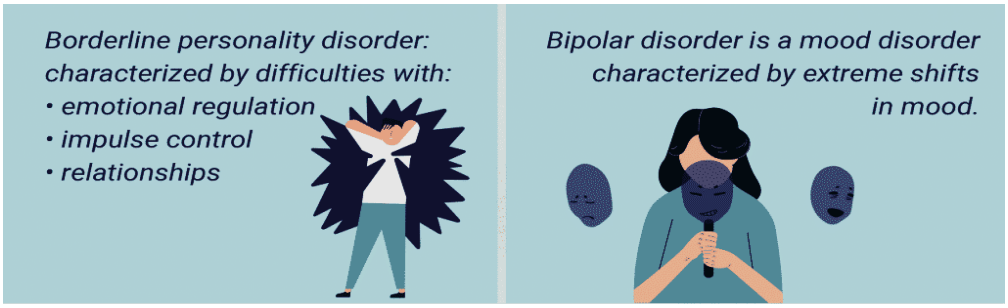
I would take the medications prescribed to me but not when mania surfaced. This was because during the times of depression, I believed that something was wrong and I needed help but not when I was in manic episode in which I believed I was alright. Somehow, I have managed to complete my tertiary education before going on to work. The cyclic change in mood was no longer as frequent as it previously was. Instead, depression prevailed most of the time. However, mania would still surface about every 1 to 1.5 years during which I would go on spending sprees, become very irritable and frequently visited nightclubs in search of female companionship and eventually would end up in psychiatric ward. During these periods of being hospitalized, I had lost many jobs, friends and money. Along the way, I have put a lot of people, especially my immediate family through so much stress. After about 13 years with this condition, I finally realized that I am ill with Bipolar Disorder Type I and I need to take medication even during the manic episode. My psychiatrist played a big role in helping me getting back on my feet. I tell myself that I have this illness which is like any other physical illness and when I take my medication, I will be normal again.

Overview by Psychiatrist

Bipolar disorder which was previously called manic depression is a mental health condition that causes extreme mood swings that include emotional highs (mania or hypomania) and lows (depression). When you become depressed, you may feel sad or hopeless and lose interest or pleasure in most activities. When your mood shifts to mania or hypomania (less extreme than mania), you may feel euphoria, increased energy or unusually irritable. These mood swings can affect sleep, energy, activity, judgment, behaviour and the ability to think clearly. The depressed phase usually will last 2 weeks or more and the manic phase for at least 1 week. There are 2 main types of Bipolar Disorder;

1) ***Bipolar Disorder Type I.*** You've had at least one manic episode that may be preceded or followed by hypomanic or major depressive episodes. In some cases, mania may be associated with psychosis which is loss of touch with reality.
2) ***Bipolar Type II.*** You've had at least one major depressive episode and at least one hypomanic episode but you've **never** had a manic episode.

Although bipolar disorder can occur at any age, typically it's diagnosed in the teenage years or early 20s. It occurs in males and females almost equally. In Malaysia, it is estimated to afflict approximately 3% of the population. Though this may not be a huge number but Bipolar Disorder ranks among the top 10 most disabling disorders in adults worldwide (The World Health Organization 2002).



Source: ***The Recovery Village***

Optimum management of bipolar disorder needs the integration of medication with targeted psychosocial treatments. Medications include mood stabilisers to prevent episodes of mania and depression. They need to be taken every day and for a long-term depending on the advice of your doctor. Then, there are medicines to treat the main symptoms of depression and mania when they happen and these may include atypical anti-psychotics and antidepressants.

Psychoeducation is important not only for patients but also for families. It is a form of training for patients and their families to help them cope with the illness and to avoid relapses by understanding the way treatment works. It also emphasises the need for absolute treatment compliance and most importantly, to identify early warning signs of relapse as well as to help them develop well-structured daily habits. Other forms of therapy such as Cognitive Behavioural Therapy and Group therapy are useful too.

Story 9: Postpartum Depression

9.1: *My Journey*

I had always been an active, outgoing and sporting person but all this took a turn for the worse after the birth of my first child. My problem started during my pregnancy. I started feeling increasingly moody during this period. There would be moments where I would be extremely happy and another moment of feeling totally miserable. My husband noticed these emotional changes but we took it as normal behaviour during pregnancy.

It worsened after the birth of my baby. Instead of feeling happy, I felt burdened by the birth of my child which made me feel guilty. I did not understand the reason I could not welcome our newborn with joy and happiness. Relationship with my husband became increasingly tense. I became hot-tempered; screaming at people and throwing whatever things that were within my reach. At work, I was suffering with the workload and found it hard to juggle between home, work and the baby as I was pretty much alone and had very little assistance. In addition to that, I also rarely had good sleep and my blood pressure was low. To make things worse, I started getting suicidal thoughts and that was when I finally went to see a psychiatrist who diagnosed me with postpartum depression.

9.2: *My Recovery*

I was told that I would be on a course of medication in order to get better and to take a break from work to concentrate on my recovery for a while. Initially, I was in denial but eventually decided to give it a try after much persuasion and assurance from my doctor and my husband. All my life I have known depression to be a sense of feeling when a person feels very sad but now I realized that depression was an illness and medication is needed. I was started with lowest dosage which made it easier for me to cope with. The side effects that I had in the beginning of the treatment had disappeared after some time.

In addition to medication, I was also given therapy during which I learned relaxation techniques and ways to challenge my negative thoughts. I noticed a lot of improvement after just a few weeks as I was able to relax and sleep better. Apart from that, my relationships with my husband as well as my other family members improved tremendously. I was so grateful for my doctor for all the encouragements and advice given as I managed to strengthen the relationship with my husband which could have nearly ended in divorce. I began to enjoy this period of motherhood and I now realised that my baby has brought me so much of joy in my life.

Overview by Psychiatrist

Having a baby can be one of the biggest and happiest moments in a woman's life but it can also be hard and stressful at times. Many physical and emotional changes can take place in a woman after she gives birth and sometimes these changes can leave new mothers feeling sad, anxious, afraid or confused. For many mothers, these feelings (called the baby blues) go away quickly. However when these feelings do not go away or get worse, a woman may have postpartum depression.

Postpartum depression (PPD) can happen a few days or even months after childbirth. PPD can happen after the birth of any child, not just the first child. A woman can have feelings similar to the baby blues – sadness, despair, anxiety, irritability – but she feels them much more strongly. It also lasts longer than Baby Blues. PPD often keeps a woman from doing the things she needs to do every day. People with Postpartum depression usually report feeling restless, feeling sad, depressed or crying a lot, having no energy, having headaches, chest pain, heart palpitations, numbness or hyperventilation. They may suffer insomnia, being very tired, not being able to eat and weight loss. Some may have instead, overeating and weight gain. It is associated with trouble focusing, remembering, making decisions, being overly worried about the baby and not having any interest in the baby. This can lead to feeling worthless and guilty, being afraid of hurting the baby or yourself and no interest or pleasure in activities that you used to enjoy doing.

Feeling depressed doesn't mean that you're a bad person, or that you did something wrong or that you brought this on yourself. It is important to know that postpartum depression (PPD) is treatable and that it will go away. The type of treatment will depend on how severe the PPD is. PPD can be treated with medication (antidepressants) and psychotherapy. Those with severe postpartum depression benefit from a treatment called Electroconvulsive Therapy. This will be decided by your treating doctor. Women with PPD are often advised to attend a support group to talk with other women who are going through the same thing or who have recovered from PPD.

Table 2. Distinguishing Between "Baby Blues" and Postpartum Major Depression

Characteristic	*Baby blues*	*Postpartum major depression*
Duration	Less than 10 days	More than two weeks
Onset	Within two to three days postpartum	Often within first month; may be up to one year
Prevalence	80 percent	5 to 7 percent
Severity	Mild dysfunction	Moderate to severe dysfunction
Suicidal ideation	Not present	May be present

Source: ***AAFP***

Story 10: Major Depressive Disorder

10.1: *My Journey*

I was married for 30 years and have 3 grown up children. I was a home maker, wife and mother. I enjoyed traveling, meeting people as well as learning about cultural and spiritual beliefs, traditional crafts, environment and nature. However, things changed after marital problems surfaced. My husband was having an affair and he moved out leaving me on my own. My whole life and career crumbled. I felt like failing in everything I tried to do. I felt lost, empty and betrayed. It became an effort to do everyday activities. I tried to believe that I can manage on my own and that I am a very capable person. Unfortunately, I still felt so empty that I didn't have the energy to go on. I was confused and couldn't focus on what I wanted for my future. I talked to my children and friends for support but didn't find relief. I was constantly tired and listless. I only did daily activities when I had to. I knew I had to persevere and be patient but the pain was severe and relentless and nobody understood.

10.2: *My Recovery*

I had previous experiences with emotional disorders when I worked as a nurse so I was very receptive to receiving help and believing in the doctor to be able to help. Nevertheless, I still found it to be extremely difficult to fight any negative thoughts and self-doubt. I had always been prioritizing others but now I needed to put myself first. I distracted myself by walking, reading, crafting and meeting a friend for a coffee. I also read up emotional and religious books to gain knowledge on developing and maintaining a positive attitude. I found it to be very distressing listening to others' stories of hard times. Everyone has bad times and I knew there were many worse than mine. Yet, it doesn't give any immediate solution to my problems. They just expect me to 'snap' out of by telling me of their experiences. It does not work that way. It took time and eventually, I learnt to make a new lifestyle along with shedding the negativity. This recovery was aided by the medication even though it took time to have its full effect. Slowly, I was strong again, be able to do much more for myself and finally be able to move on.

My advice for people struggling with depression is to believe in and follow medical advice. This is certainly not an easy task but make it your priority in life to take medication strictly as directed. Don't expect immediate results, just take it and go on with other activities. You need to find some activities to occupy your time and thoughts. Keep looking and if it doesn't work, try something else. Exercise as much as possible; force yourself to walk and to make commitments to do things with active people. This is vital as engaging in activities leaves less time for negative thoughts, discussions and dwelling in the past. You can also offer to help people with some activities or join groups, particularly with children or animals as they don't dwell in the past and always want to enjoy your company.

Overview by Psychiatrist

Major depressive disorder is reported to affect about 10 to 15% of most populations around the world including developing nations like ours. Depression is an illness, just like hypertension, diabetes and cancer. The suffering, however, is not evident to the eye unlike in a fracture or a swelling. The suffering is largely internal. It is an illness because there are biological changes in the brain that occur in people suffering depression. These changes include a change in the neurochemicals which work as important messengers in the areas for thought, emotion and feeling. There are also psychological, behavioural and social changes that are a result of the depression. The World Health Organization and the World Bank studied the disability that diseases bring and found that Depression is the fourth most disabling disease in the world. It is predicted that in this year, it will rise to being the second most disabling disease.

Depression occurs more in women than in men in a ratio of 1:2. There are many postulates to this and some of them include that women may be more willing to discuss their emotional issues. Women have hormonal changes that may increase the risk of depression. Also, men may self-medicate their depression with alcohol or drug use. The central features of depression include a low mood or feeling sad and anhedonia. Anhedonia is the inability to derive pleasure from pleasurable activities. An example of this is when a person who enjoys gardening, just can't find the mood to do anymore gardening. Other symptoms include a general feeling of tiredness, loss of appetite, sleep disturbance, inability to concentrate, a feeling of hopelessness, uselessness, worthlessness, guilt feelings and suicidal thoughts.

Depression is different from normal sadness as a diagnosis can only be made if a patient has at least five of the symptoms described above and it has lasted continuously for at least two weeks. The symptoms are significant enough to cause social and occupational impairment as well. There are various medical conditions that can also cause or that may occur concurrently with depression and these need to be ruled out. Assessment often includes an interview with family members as well.

Depression is treatable. Close to 85% of people suffering from depression recover and go back to a level of functioning before the start of their illness. Treatment for depression is often multidimensional including antidepressants, counselling, cognitive behaviour therapy, family therapy, psychotherapy and social therapy. Antidepressants are useful in treating mild, moderate and severe depression. Psychotherapy alone may be useful only for mild depression. Combination treatments, however, have the best results. It is vital that people suffering from this disabling illness shed their fear and prejudice from seeking treatment that is effective and which is now widely available. Depression is not a personal weakness. It can strike anyone at any time and has no preferences. Families and communities have a responsibility to help their members to seek appropriate help. The earlier the onset of treatment, the higher the chances of recovery are.

Story 11: Schizophrenia

11.1: *My Journey*

I still remember how it all happened. The time I saw my life from a normal robust spiralling into something bizarre, something that no one in my family ever imagined could happen to me. I was the fun loving, young, vibrant and vivacious 23 years old, graduate of Bachelor of Law, waiting to do my Certificate in Legal Practice (CLP). I had a real promising life ahead of me but all that came to a slow halt. My mind was disintegrating from a very logical and healthy one into one that you would now call schizophrenic.

My thinking became more bizarre and unacceptable as I thought I was able to walk on water, call on the clouds and that I could communicate directly with God in the most audible and succinct way. I began to hear rumbling in my ears as though the heavens were responding to me and saw shadows of different deities. I also started to be very suspicious of others and believed that they were plotting against me. I even thought that strangers were talking bad about me and I only felt comfortable in the confines of my home.

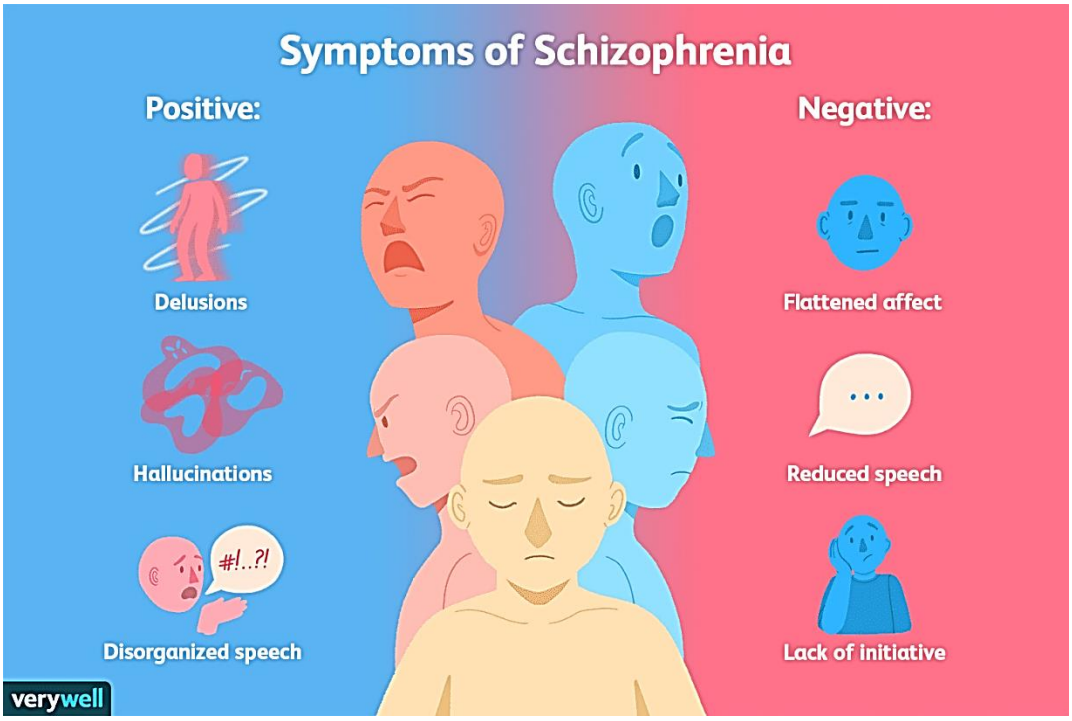
11.2: *My Recovery*

I sought treatment with the support of my family and with medication, my positive symptoms of schizophrenia such as delusions and hallucinations tapered off rather quickly - within about a month but not without going back to the psychiatrist many times. There were side-effects and they were disruptive but I eventually found that they wore off. My life is now more regimented as I try to apply more routine healthy patterns and find that routine prevents my anxiety to spiral and then also prevent future relapses. I am still working and have a very supportive, loving and caring family. I also still have a roof above my head, good friends, good music, food and ample supply of books to keep me occupied. I am now able to laugh and joke in the midst of it all. My Psychiatrist says I am in recovery and I am starting to believe him. People with Schizophrenia can recover.

Overview by Psychiatrist

Schizophrenia is one of the most severe and debilitating forms of mental disorders with lifetime prevalence of around 1% across all populations. It is characterized by a variety of symptoms such as thought disturbances, disturbances in feelings and emotions, hallucinations and delusions. It can also cause cognitive impairments especially in the areas of memory, attention and perception. ***Positive symptoms*** in schizophrenia include thought disorders, hallucinations, delusions and disturbed behaviour. ***Negative symptoms*** of schizophrenia include lack of motivation, reduced speech, social withdrawal and reduced activity. Approximately 10% of people with schizophrenia will die by suicide. This is because schizophrenia commonly starts

during early adulthood and can be a lifelong disorder. It results in significant functional, social and economic impairment.



Source: ***Very Well Mind***

Management of schizophrenia involves hospitalization, pharmacological, physical, social and psychological measures. Pharmacotherapy is important in the treatment of schizophrenia but it is better enhanced in combination with psychosocial treatment. The atypical antipsychotics or newer antipsychotics offer hope as they are effective and have much less side-effects. They are as effective as the typical antipsychotics for both the positive and negative symptoms of schizophrenia. These treatments get people with schizophrenia stable and well but they need to be instituted early. Early detection and assertive intervention can improve first episode patients. This is of special concern in countries like ours, where the onset of symptoms and contact with the mental health specialist is often delayed. This is related to the stigma associated with mental illness and its treatment as well as local cultural and religious beliefs. Better awareness, de-stigmatization and making treatment accessible are essential in helping these people live normal lives.

Although pharmacology is important in the treatment of schizophrenia, psychosocial interventions can further enhance the clinical improvement. Thus, in managing schizophrenia, the combination of drugs and psychosocial treatment is preferred. Psychosocial therapy entails psychotherapy, cognitive therapy, family therapy, behavioural therapy, occupational therapy and group therapy.

RESOURCES

6.1: Mental Health Services in Malaysia

- ***Malaysian Mental Health Association(MMHA)***

MMHA is a non-profit voluntary organisation formed back in 1967 by mental health professionals from University Malaya Medical Centre (previously known as University Hospital). There are various psychological support therapies provided for individual, couple, family and child as well as psychological assessment. Mental Health First Aid Training is also offered for those with mental health crisis until it resolves or professional help is received. A part from that, MMHA also runs a Day Care Centre, a Charity Shop Project, organises public forums on mental health issues, provides support for carers of the mentally ill, runs Family to Family Education groups, conducts a Depression Support group and advocates for the rights of the mentally ill. MMHA has introduced the Illness Management & Recovery (IMR) Program, line dancing, singing, art painting, gardening, indoor and outdoor games, daily exercising and occasional outings for the clients under its rehabilitation programme.

Contact information:-

The Mind Hub, Malaysian Mental Health Association (MMHA)
TTDI Plaza, Block A Unit 2-8, Jalan Wan Kadir 3, Taman Tun Dr Ismail, 60000, Kuala Lumpur.
Phone: 03-2780 6803 Facebook: Malaysian Mental Health Association
Email: admin@mmha.org.my Website: https://mmha.org.my/

Malaysian Mental Health Association (MMHA)
No. 8 Jalan 4/33 off Jalan Othman, 46000 Petaling Jaya, Selangor, MALAYSIA
Tel: (+603) - 7782 5499 Fax: (+603) - 7783 5432
Email : mmha@streamyx.com

- ***Mental Illness Awareness and Support Association(MIASA)***

MIASA is a non-governmental organization for mental health based in Selangor and has been founded in September 2017. It aims to promote mental health awareness and provide supports for both patients and caregivers through numerous campaigns, forums and videos being uploaded into their website.

Contact information:-
DS 1-07, Block D Retail Lot, Metropolitan Square, Jalan PJU 8/1, Bandar Damansara Perdana, 47820 Petaling Jaya, Selangor.

Phone: 013-878 1322/019-236 2423 Email: miasa.malaysia@gmail.com
Website: https://miasa.org.my/index.html

- ***Malaysian Psychiatric Association(MPA)***

MPA provides vast amount of useful up-to-date information regarding mental health issues for professional, patients and public via its website. It also encourages the public to contribute by sharing stories, news and valuable information which can be submitted through the website.

Contact information:-
Malaysian Psychiatric Association, P.O. Box 12712, 50786 Kuala Lumpur
Email: info@psychiatry-malaysia.org.
Website: http://www.psychiatry-malaysia.org/index.php

- ***Befrienders***

Befrienders is a non-profit organisation which provides free emotional support 24 hours a day, every day to those who are in distress and having suicidal thoughts. The volunteers are trained and each conversation would be kept confidential. This organization provides services through phone calls, e-mails, face to face as well as talks and seminars to groups who are at high risk.

Contact information:-
Phone hotline: 603-76272929, 24-hour (KL) Email: sam@befrienders.org.my (KL)
Website: https://www.befrienders.org.my/

Befrienders Centre	Telefon / Telephone	E-mel / E-mail	Other Services	Waktu dibuka / Service hours
Kuala Lumpur	**03-76272929**	sam@befrienders.org.my	**BefKL Skype 1**	24 jam/hours
Penang	-	pat@befpen.org	WA: **011-56997687** Skype: **BefPen2**	3pm – 12am 3pm - 9pm
Ipoh	-	sam.befriendersipoh@gmail.com	**BeflPOH Skype 1**	2pm - 11pm
Seremban	**06-6321772 / 06-6321773**	-	WA: **018-9691772**	7pm - 10pm
Melaka	**06-2842500**	-	-	2pm - 5pm
Muar	**06-9520313**	sam@befriendersmuar.org	-	2pm - 5pm
Johor Bahru	**07-3312300**	sam@befriendersjb.org	WA: **07-3312300**	1pm - 12am (midnight)
Kota Kinabalu	-	befrienderskk@gmail.com	WA: **016-8036945** FB +Twitter: **"befrienderskk"**	7pm - 10pm
Kuching	-	sam@befrienderskch.org.my	-	

Updated 4 May 2020 WA = WhatsApp

- ***The Mind Faculty***

  It is a private mental health clinic situated in Solaris Mont Kiara. There are over 20 mental health professionals in this clinic who provide various counselling services and therapies.

  Contact information:-
  Phone: 03 6203 0359 / 03 6203 0733 Email: enquiries@themindfaculty.com
  Website: https://www.themindfaculty.com/
  Opening hours: Monday - Friday: 9.00 am - 9.00 pm Saturday: 8.00 am - 7.00 pm (Strictly by appointment only)

- ***The Wave Clinic***

  The Wave Clinic offers residential care facility and is also the first within South East Asia to offer such facility (20 minute drive from KL International Airport). Its treatment programs which are varied and intended to help clients to experience a "lifetime of wellness and recovery" are focused for teenagers, young adults as well as families.

Entrance

  Contact information:-
  The Wave Clinic, Nu Tower 2, Level 23 Jalan Tun Sambanthan KL Sentral, KL, Malaysia
  Phone: +60 32 727 1799 Website: https://thewaveclinic.com/

- ***Eve Psychosocial Rehabilitation Centre***
  This centre which is situated in Petaling Jaya has a comfortable home environment in the effort of helping patients with mental health problems to recover and join the society. Among the services provided by them are psychiatric ambulance service and detox and dependency service.

  Contact information:-
  Eve Psychosocial Rehabilitation Centre, 91, Jalan Templer, Pjs 7, 46050 Petaling Jaya, Selangor.
  Phone: 03-7954 2614 Website: https://evecentre.com.my/index.php

- ***International Counselling Association of Malaysia (PERKAMA International)***
  PERKAMA International (Persatuan Kaunseling Malaysia Antarabangsa) is a non-profit organization that officially represents professional counsellors in various practice settings. It plays a crucial role in empowering individuals and organizations in the counselling field. Currently, it has more than 800 members and regularly organizes counselling training workshops and conferences to be a professional referral source for government or non-government agencies. To enhance its services, PERKAMA International also provides accreditation to organizations who offer counselling services. It also provides plenty of platforms for individuals to acquire knowledge, skills and assistance to perform to their fullest potential in the counselling field.

  Contact information:-
  Pejabat PERKAMA, Lot 3-1B, Jalan Hentian 1C, Pusat Hentian Kajang,
  43000 Kajang, Selangor
  Phone: +603 8734 0735 Email: pr.perkamainternational@gmail.com
  Website: https://www.perkamainternational.org.my/

- ***Relate Malaysia***
  It is an organization established to promote public awareness of mental health and to de-stigmatize mental illness. It also conducts researches on mental illness and develops mental health interventions. This organization also designs policy recommendations which promote access to treatment in order to help Malaysian to live a life with healthy mental state. Online psychotherapy is also offered at affordable price after a client underwent diagnostic assessment test. A 50-minute psychotherapy session will be done through online with either a Masters-level clinical psychology intern or with a qualified professional.

Contact information:-
Email: info@relate.com.my Website: https://relate.com.my/

- ***International Medical University(IMU) Mind Matters Club***
  It is a quite new psychiatric based club in IMU which meant to promote the importance mental health especially among IMU students.
  Facebook page: https://www.facebook.com/IMUMIndMattersClub/

6.2: Online Tools for Mental Health Improvement

- ***Moodgym***

This web-based is like an interactive, online self-help book which intends to assist an individual to learn and practice skills based on cognitive behavioural therapy that can help to keep the symptoms of depression and anxiety to a manageable level. It has been used by people worldwide and the data of the users are kept confidential. Moreover, it can be accessed at anytime, at one's own pace. However, it is not for those who are in crisis or experiencing clinical level of depression for which moodgym would suggest the individual to seek the help of professional based on the depression quiz score. Moodgym costs US $27.00 for 12 month's access.
Website: https://moodgym.com.au/

- ***E-couch***

E-Couch' is a free, self-help, online interactive treatment program which provide several therapies such as cognitive behavioural therapy, interpersonal therapy and relaxation. Various coping skills taught in this program aids people in managing their symptom better. It offers variety of treatment modules such as for depression, anxiety, bereavement and relationship issues.
Website: https://ecouch.anu.edu.au/welcome

- ***Headspace***

Headspace is a mobile application which offers the basics of mindfulness and meditation during the free trial sessions. The paid version includes access to numerous guided meditations and breathing exercises which helps to calm the mind and reduce stress.
Website: https://www.headspace.com/

- ***Sanvello***

This mobile application provides coping skills based on cognitive behavioural therapy for common mental health issues such as depression, anxiety and stress. Among the features included are daily mood tracking, meditation, journaling and self-assessment. Like Headspace, the paid version will enable the individual to gain access to unlimited tools.

Website: https://www.sanvello.com/

- ***Moodtools – Depression Aid***

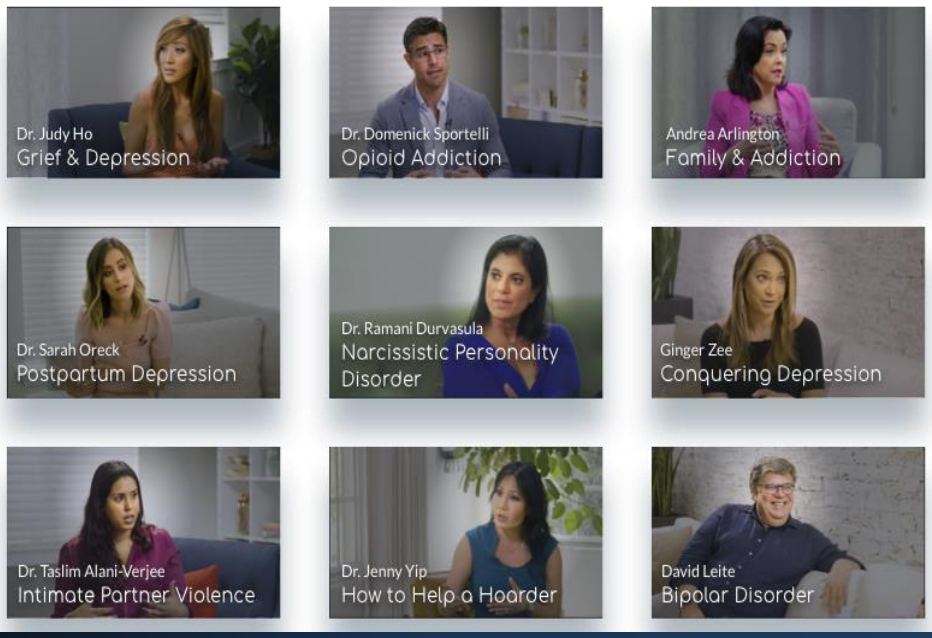
This free mobile application has a variety of tools supported by research which includes thought diary to identify distorted thinking patterns, activities based on Behavioural Activation Therapy, suicide safety plan, and mental health information. It also shows recommended YouTube video ranging from guided meditations to information TED talks to improve one's mood.

Website: https://www.moodtools.org/

- ***MedCircle***

This website is one of the most trusted sources for mental health education. It offers in-depth vetted videos series on mental health topics which can help people to improve their knowledge and understand these topics better. The team consists of passionate psychiatrists and psychologists who discuss various topics related to mental health. There are also a few series on patients who are willing to share their own success stories in their recovery journey in the hope of inspiring others in similar situations. This website offers both free and all-access memberships for everyone and it is easily accessible.

Website: https://www.medcircle.com/



Do you want to know more about common mental illness in Malaysia and the hindrance faced by the sufferers? Do you want to learn about the voices of mental ailments from the mind of the patients which often go unnoticed? Where can you or your loved ones seek help in Malaysia? And, most importantly, can a person recover from a mental illness?

In ***Mental Health Recovery – A Handbook of Case Reviews in Malaysia***, you can find:-

- Stories of real patients in Malaysia and their journey in recovering from various mental illnesses such as schizophrenia, substance use disorder, mood disorders, personality disorder and many more.
- Stories written from the viewpoint of the afflicted individuals which gives the readers an opportunity to learn the experience of living with a mental disorder.
- Overview by a psychiatrist on each illness which can help readers to better comprehend the conditions.

This book is hoped to aid medical students, doctors, other healthcare professionals and the general population to gain better understanding on mental disorders as like other health conditions where recovery is reality.

"One small crack does not mean that you are broken, it means that you were put to the test and you didn't fall apart."

Linda Poindexter

eISBN 978-967-18129-2-1

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