BRIVOR 5, 10, 20 mg. Each film coated tablet contains vortioxetine hydrobromide equivalent to 5, 10, 20 mg vortioxetine respectively. S5 A55/1.2/0105, 6, 7. For full prescribing information, refer to the professional information approved by SAHPRA, February 2023. **1)** Evren, C., 2021. Vortioxetine: a comprehensive update on a new generation antidepressant. *Dusunen Adam*, 34(1), pp.1-13. **BVRB905/09/2023**

pharma dynamics
EFFECTIVE AFFORDABLE HEALTHCARE

CUSTOMER CARE LINE **+27 21 707 7000**
www.pharmadynamics.co.za

NEW

PROLONG THEIR POSITIVITY

PRODYNA 150 mg 300 mg XR

BUPROPION HYDROCHLORIDE

PATIENTS EXPERIENCING SYMPTOMS OF **LOSS OF POSITIVE AFFECT** CAN BE RETURNED TO NORMAL FUNCTIONING WITH AN AGENT THAT HAS A **DOPAMINERGIC** AND/OR **NORADRENERGIC** COMPONENT.[1]

EFFECTIVE AFFORDABLE HEALTHCARE

PRODYNA 150, 300 mg XR. Each tablet contains 150, 300 mg bupropion hydrochloride respectively. S5 A54/1.2/0181,0182. For full prescribing information, refer to the professional information approved by SAHPRA, March 2023. **1)** Nutt, D.J., 2008. Relationship of neurotransmitters to the symptoms of major depressive disorder. *The Journal of clinical psychiatry*, 69, pp.4-7. **PDAA914/10/2023**

CUSTOMER CARE LINE **+27 21 707 7000**
www.pharmadynamics.co.za

ISSN 2409-5699

SOUTH AFRICAN PSYCHIATRY

ABOUT the discipline FOR the discipline

issue 40 • AUGUST 2024

READERSHIP SURVEY 2024

POLYVAGAL THEORY & ITS RELEVANCE TO PSYCHIATRY

TECHNOLOGY IN PSYCHIATRY

MEDICAL INFLUENCERS, OPINION LEADERS AND SHARING HEALTHCARE INFORMATION ON SOCIAL MEDIA

PUBLISHED IN ASSOCIATION WITH THE SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

RETIREMENT

www.southafricanpsychiatry.co.za

Are these the words your patients use to describe their Neuropathic pain?

Pins & Needles[1]

Painful Cold[2]

Tingling

Burning[1]

Electric Shock[1]

LYRICA®

will control your patient's Neuropathic Pain, due to Herpes Zoster infections and Diabetes[3]

LYRICA®
PREGABALIN
Rapid onset.[4] *Sustained relief.*[4, 5]

References: **1.** Chetty S, Baalbergen E, Bhigjee AI, et al. Clinical practice guidelines for management of neuropathic pain: expert panel recommendations for South Africa. SAMJ. 2012;102(5):312-325. **2.** Bouhassira D, Attal N, Alchaar H, et al. Comparison of pain syndromes with nervous or somatic lesions and development of new neuropathic pain diagnostic questionnare (DN4). Pain. 2005;114:29-36. **3.** Lyrica Package Insert, 21 December 2022. **4.** Freeman R, Durso-DeCruz E, Emir B. Efficacy, Safety, and Tolerability of Pregabalin Treatment for Painful Diabetic Peripheral Neuropathy. Diabetes Care. 2008 July; 31(7): 1448-1454. **5.** Satoh J, Yagihashi S, Baba M, et al. Efficacy and safety evaluation of pregabalin treatment over 52 weeks in patients with diabetic neuropathic pain extended after a double-blind placebo controlled trial. J Diabetes Invest. 2011 December; 2(6): 457-463.

S5 **LYRICA®** 25 mg, 75 mg and 150 mg capsules (Reg. nos.: A39/2.5/0264, 0266, 0268). Each capsule contains 25 mg, 75 mg and 150 mg pregabalin respectively. **LICENCE HOLDER:** Viatris Healthcare (Pty) Ltd. Reg. No. 1949/035112/07. 4 Brewery Street, Isando, Gauteng, 1609. Tel.: +27(011) 451 1400. For full prescribing information, refer to the professional information approved by the medicines regulatory authority. **LYR-2023-0471.** Exp. 04/2025.

Features

READERSHIP SURVEY 2024 10

THE POLYVAGAL THEORY 13 & ITS RELEVANCE TO PSYCHIATRY

RETIREMENT 25-34

TECHNOLOGY IN PSYCHIATRY 36

MEDICAL INFLUENCERS, OPINION LEADERS AND SHARING HEALTHCARE INFORMATION ON SOCIAL MEDIA 44

NOTE: "instructions to authors" are available at www.southafricanpsychiatry.co.za

Disclaimer: *No responsibility will be accepted for any statement made or opinion expressed in the publication. Consequently, nobody connected with the publication including directors, employees or editorial team will be held liable for any opinion, loss or damage sustained by a reader as a result of an action or reliance upon any statement or opinion expressed.*

© South African Psychiatry This magazine is copyright under the Berne Convention. In terms of the South African Copyright Act No. 98 of 1978, no part of this magazine may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopying, recording or by any information storage and retrieval system, without the permission of the publisher and, if applicable, the author.

CONTENTS

AUGUST 2024

7 FROM THE EDITOR

9 SAFE CARE OF PSYCHIATRIC PATIENTS IN REHAB CENTRES

10 READERSHIP SURVEY 2024

13 THE POLYVAGAL THEORY & ITS RELEVANCE TO PSYCHIATRY

25 RETIREMENT REFLECTIONS THE PONDERINGS OF A PENSIONER

27 LEGACY, WINDING DOWN OR SELLING YOUR PRACTICE IN PREPARATION FOR RETIREMENT

29 THE ELEPHANT IN THE ROOM

32 WEALTH MINDSHIFT: WHAT ENTREPRENEURS IN PSYCHIATRY NEED TO KNOW ABOUT PRESERVING THEIR WEALTH FOR RETIREMENT

34 PSYCHIATRISTS AND RETIREMENT

36 TECHNOLOGY IN PSYCHIATRY

40 WHEN I GROW UP...

43 BRIDGING MINDS FROM ACROSS THE WORLD

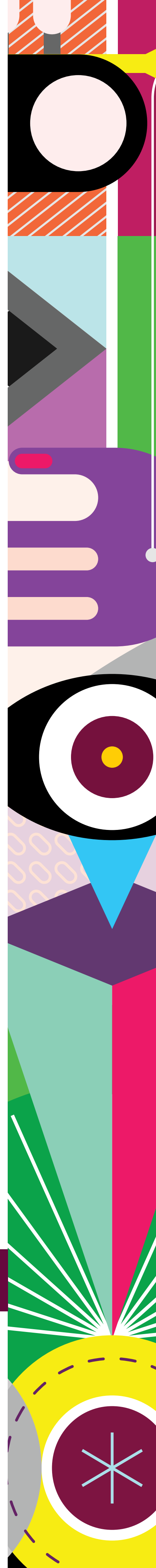
44 MEDICAL INFLUENCERS, OPINION LEADERS AND SHARING HEALTHCARE INFORMATION ON SOCIAL MEDIA

46 DEPARTMENTS OF PSYCHIATRY NEWS

52 MOVIES

53 WINE FORUM: A JOURNEY WITH A VINTNER

57 SASOP



CPD questions are available at: **www.southafricanpsychiatry.co.za**

* **PLEASE NOTE:** *Each item is available as full text electronically and as an individual pdf online.*

Advertising: The Source Events and Marketing
Design and Layout: Rigel Andreoli
Web: www.southafricanpsychiatry.co.za
Contact Person: Vanessa Beyers - *vanessa@thesourcepr.co.za*

South African Psychiatry is published quarterly by The Source Public Relations Group.
Its mission is to communicate the latest news and developments in the area of South African Psychiatry.

COVER IMAGE: 'Music Festival Background' by ' danjazzia' on AdobeStock

Design and layout: The Source • Printers: Raptor Print

Dear Reader,

Since the last issue of *South African Psychiatry* an important event of direct relevance to South African Psychiatry took place – the judgement in the Life Esidimeni inquest. The inquest was established in July 2021 and it took almost 2 years for the 196 page judgement to be handed down by Judge Mmonoa Teffo. A monumental task, and long overdue given that the events leading to the death of 144 psychiatric patients took place in 2016. In her judgement, Judge Teffo found that the Gauteng MEC for Health at the time, Qedani Mahlangu, and the then Director for Mental Health, Dr Makgabo Manamela, could be held accountable for a number of the deaths (https://www.sanews.gov.za/south-africa/lesufi-fully-accepts-judgement-life-esidimeni-inquest). A report issued by AfriForum specifically noted that at least nine of the deaths were attributable to the negligence of both Mahlangu and Manamela with specific detail of one the deaths being given i.e. that one of the victims (whose family were being represented by AfriForum's Private Prosecution Unit) was believed to have starved to death (https://afriforum.co.za/en/life-esidimeni-the-ball-is-back-in-the-npas-court-its-time-to-reconsider-decision-not-to-prosecute/). Whilst the NPA had declined to initially prosecute, both AfriForum and the DA's Jack Bloom (DA Gauteng Shadow MEC for Health) believe the NPA needs to revisit their initial decision. Jack Bloom further noted that charges should also be considered against David Mabuza, the then Gauteng Premier (https://www.da.org.za/2024/07/npa-should-broaden-esidimeni-charges). It should be noted that an initial Report by Professor Malegapuru W Makgoba – in his capacity as HEALTH OMBUD: Republic of South Africa - was released in February 2017. One of the 18 recommendations was that *"The Ombud fully supports the ongoing SAPS and Forensic investigations underway. The findings and outcomes of these investigations must be shared with appropriate agencies so that appropriate action where deemed justified can be taken."* . There were further, additional recommendations to the Gauteng Department of Health (https://www.politicsweb.co.za/documents/the-life-esidimeni-disaster-the-makgoba-report). Subsequent to the HEALTH OMBUD report, an arbitration process led by the retired Deputy Chief Justice Dikgang Moseneke was established in 2018, leading to an arbitration award to victims (https://www.saflii.org/images/LifeEsidimeniArbitrationAward.pdf; https://www.sanews.gov.za/south-africa/lesufi-fully-accepts-judgement-life-esidimeni-inquest). At the time of writing, it was not clear whether the NPA would indeed prosecute.

The Life Esidimeni Tragedy has been covered in the pages of *South African Psychiatry* and it might be appropriate, and timeous, for readers to revisit the articles in question (Mbele, November 2018; Trotter, February 2019; Eriksson, February 2022; all available at www.southafricanpsychiatry.co.za). Each one provides a unique and impactful perspective. Reflecting on the Life Esidimeni Tragedy I came across an editorial in the June 2024 issue of World Psychiatry entitled "Dehumanization and mental health" (Haslam, 2024; https://www.researchgate.net/publication/380509892_Dehumanization_and_mental_health). The author notes how dehumanization leads to people being seen as less than human, and consequently suffering deprivation and dispossession, as well as violence and exclusion. I would recommend you read it, within the context of the Life Esidimeni Tragedy, and specifically what appears to be a key observation i.e. *"..failures to fully humanize people with mental illness…have significant consequences."*

On that sombre note, I hope you will enjoy the current issue which features a *Report* on the recently undertaken 'Reader Survey' as well as *Features* related to 'retirement' - with thanks to Renata Schoeman for curating this content.

Editor-in-Chief: Christopher P. Szabo - *Department of Psychiatry, University of the Witwatersrand*

Associate Editor: Renata Schoeman - *University of Stellenbosch Business School*

Advisory Board:
Ugash Subramaney - *Head, Department of Psychiatry, University of the Witwatersrand*
Soraya Seedat - *Head, Department of Psychiatry, Uiversity of Stellenbosch*
Dan Stein - *Head, Deprtment of Psychiatry and Mental Health, University of Cape Town*
Taiwo Akindipe - *Head, Department of Psychiatry, Sefako Makgatho Health Sciences University*
Funeka Sokudela - *Head, Department of Psychiatry, University of Pretoria*
Janus Pretorius - *Head, Department of Psychiatry, University of The Free State*
Bonga Chiliza - *Head, Department of Psychiatry UKZN; President South African Society of Psychiatrists*

Acknowledgement: *Thanks to Lisa Selwood for assistance with proof reading*

"The views expressed in individual articles are the personal views of the authors and are not necessarily shared by the editor, associate editor, advisory board, advertisers or the publisher."

GROWING ANTIDEPRESSANT PORTFOLIO

SSRI
DynaSertraline sertraline hydrochloride 50 / 100
zytomil ESCITALOPRAM 10 mg | 20 mg
serrapress PAROXETINE 20 mg

SNRI
DULTA DULOXETINE 30 / 60 mg
EXLOV XR DESVENLAFAXINE 50 / 100
illovex XR VENLAFAXINE

SEROTONIN MODULATOR
BRIVOR VORTIOXETINE 5 mg / 10 mg / 20 mg

NDRI
PRODYNA 150 mg 300 mg XR BUPROPION HYDROCHLORIDE

For further product information contact **PHARMA DYNAMICS**
Email info@pharmadynamics.co.za **CUSTOMER CARE LINE** +27 21 707 7000

BRIVOR 5, 10, 20 mg. Each film coated tablet contains vortioxetine hydrobromide equivalent to 5, 10, 20 mg vortioxetine respectively. S5 A55/1.2/0105, 6, 7. **DULTA 30, 60 mg.** Each tablet contains 30, 60 mg duloxetine respectively. S5 A46/1.2/0889, 890. NAM NS3 18/1.2/0126, 0127. **DYNA SERTRALINE 50, 100.** Each tablet contains 50, 100 mg sertraline respectively. S5 A43/1.2/0339, 0340. NAM NS3 14/1.2/0627, 0628. **EXLOV XR 50, 100 mg.** Each extended-release tablet contains desvenlafaxine benzoate equivalent to 50, 100 mg desvenlafaxine respectively. S5 A51/1.2/0009, 0010. **ILLOVEX XR 37,5, 75, 150, 225, 300 mg.** Each extended release film coated tablet contains venlafaxine hydrochloride equivalent to 37,5, 75, 150, 225, 300 mg venlafaxine respectively. S5 A48/1.2/0910, 0911, 0912, 0913, A53/1.2/0467. **PRODYNA 150, 300 mg XR.** Each tablet contains 150, 300 mg bupropion hydrochloride respectively. S5 A54/1.2/0181,0182. **SERRAPRESS 20 mg.** Each tablet contains 20 mg paroxetine. S5 A38/1.2/0069. NAM NS3 08/1.2/0101. **ZYTOMIL 10, 20 mg.** Each film coated tablet contains 10, 20 mg escitalopram respectively. S5 A42/1.2/0912, 0914. NAM NS3 10/1.2/0479, 0481. For full prescribing information, refer to the professional information approved by SAHPRA. **NSCRA941/02/2024**

pharma dynamics
EFFECTIVE AFFORDABLE HEALTHCARE

www.pharmadynamics.co.za

SAFE CARE OF PSYCHIATRIC PATIENTS IN REHAB CENTRES

Dear Member,

The Boards of SASOP and PsychMg note with concern the recent unfortunate circumstances involving the care and support of patients with Psychiatric illnesses and dual diagnosis at Rehabilitation Centres, most recently in KZN.

We would like to assure the membership that we will be acting on the following to address this concern:

- Engage in Public Awareness and Advocacy regarding the safe care of Psychiatric Patients in Rehab Centres.
- Raise our concern formally through channels via HPCSA and the Health Ombudsman.
- Liaise with the Department of Health and the Department of Social Development next regarding the regulation of Rehab Centres.

We will keep members updated.

Dr Anusha Lachman
On behalf of SASOP

Life Path Health is a group of private mental health hospitals with inpatient facilities in the Western Cape, Soweto and Kwazulu-Natal. We assist psychiatrists in launching their private practices to meet the high demand for quality mental health care in South Africa. To find out more, please contact COO Dr Karen Olckers at **karen@lifepathgroup.co.za**

www.lifepathgroup.co.za

READERSHIP SURVEY 2024

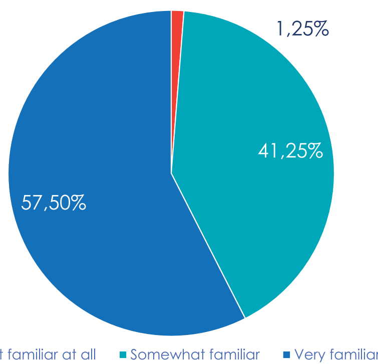
Christopher Paul Szabo

The November 2024 issue of *South African Psychiatry* will mark 10 years of the existence of the publication. At the beginning of April 2024 we undertook a readership survey, something one might argue was long overdue. An email invitation to participate was sent to all those registered in our electronic database. At the time of the survey, the database comprised 622 readers registered for access to full content. An email reminder was sent in early May. In addition, there was also mention of the survey in the May 2024 issue's "From the editor" content - together with a QR code to access the survey for readers accessing content via hardcopy.

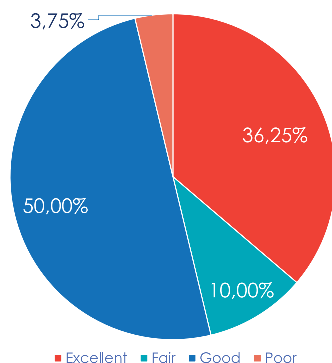
RESULTS

There were 79 respondents. It was difficult to determine a response rate insofar as it is not clear that all respondents were exclusively from the electronic database, although certainly the overwhelming majority were. Using that number as a baseline of respondents would have given a response rate of just under 13%. As response rates go for this type of survey – using the method described: it was average. On that basis one might question the data, but even with a limited sample there were some clear indicators of what respondents thought. Each of the 10 items which comprised the questionnaire are noted below. A broad statement is provided for each and rather than specific numbers of respondents per response option for each item, percentages are presented.

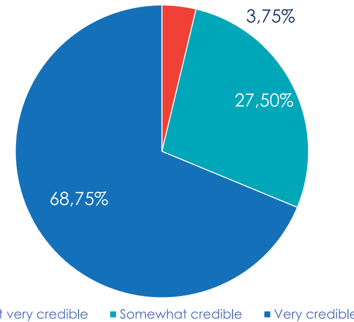
- *Familiarity with the pubication:* most respondents were "very familiar", a smaller percentage "somewhat" familiar and a minority being "not familiar".



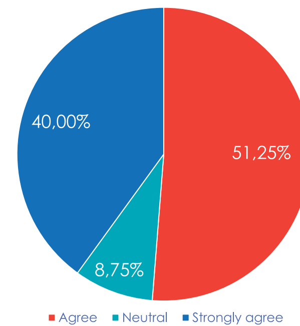
- *Quality of the publication:* most respondents rated the quality as either "good" or "excellent" with only a minority rating content "poor".



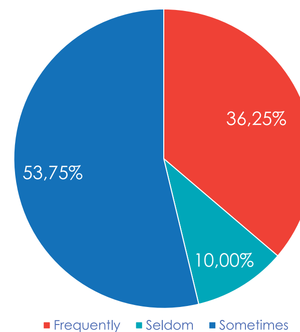
- *Credibility:* most respondents rated the content as "very" credible, a smaller number "somewhat" with a minority responding, "not very".



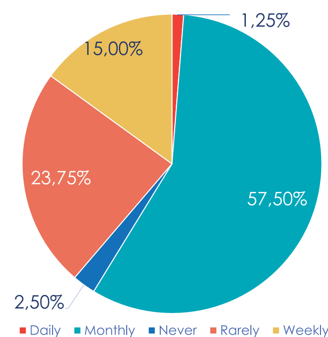
- *Effective coverage of relevant topics:* the majority responded either "strongly agree" or "agree" with a minority responding "neutral".



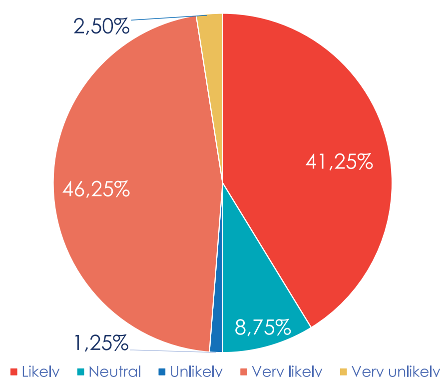
- *Access of content:* the majority reported "frequent" access, a smaller number "sometimes" and a minority "seldom".



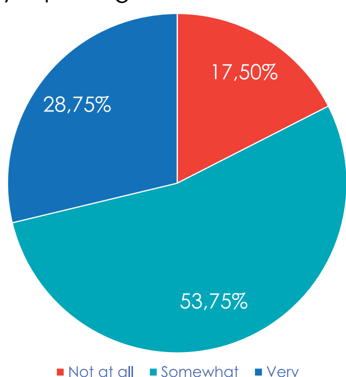
- *Engagement with content:* the majority reported "monthly" with "daily" and "weekly" next in frequency with a minority responding "rarely/ never".



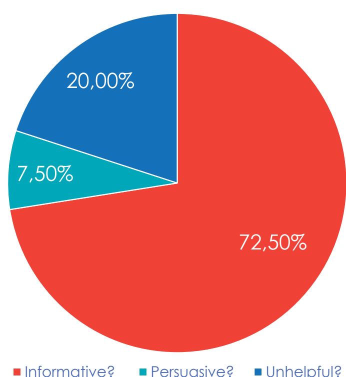
- *Likely to recommend the publication:* the majority were "likely" or "very likely" to recommend with a minority "unlikely" or "very unlikely" to do so.



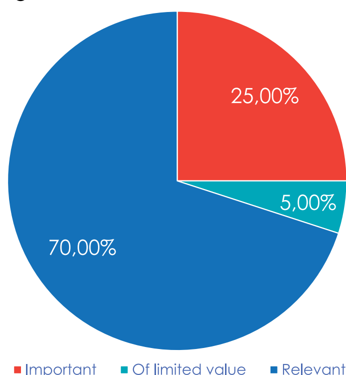
- *Awareness of adverts:* the majority were either "somewhat" or "very" aware of adverts, and a minority reporting "not at all".



- *Impact of adverts:* the majority experienced the adverts as "informative" with a smaller number experiencing adverts as "persuasive" with a minority noting them to be "unhelpful".



- *Overall:* the majority found the publication to be both "relevant" and "important" with a minority reporting that it was of "limited value".



DISCUSSION

It appears that the readership/audience is generally very familiar with the publication, accessing content frequently and engaging with content at least monthly. Most respondents experience the content positively in terms of quality and credibility. They believe there is effective coverage of topics and are generally likely to recommend the publication, viewing it overall as both relevant and important. Finally, most respondents were not only aware of adverts but viewed them as both informative and persuasive albeit more informative than persuasive. Clearly this is of relevance to our advertisers, who together with our readers and contributors, are key primary stakeholders.

In addition to the questionnaire, respondents were also able to provide additional comments. In general, these were positive and highlighted specific aspects that were liked most, but also noted issues in relation to a specific article or questioning the relevance of certain content. There were single mentions of preference for hardcopy and the desire to share opinions more directly via a "comments" section.

THERE IS ALWAYS A CONCERN THAT A SURVEY OF THIS NATURE WILL BE SUBJECT TO SELECTION BIAS WHEREBY THOSE WITH NOTHING GOOD TO SAY MAY SAY NOTHING OR THAT THE GENERALLY POSITIVE SENTIMENTS EXPRESSED MIGHT SIMPLY REFLECT A HARDCORE OF DEDICATED READERS. IT IS NOT CLEARLY EITHER, BUT WHATEVER ONE'S CONCERNS MAY BE IN TERMS OF LIMITATIONS OF SUCH DATA THE SURVEY PROVIDES IMPORTANT FEEDBACK, ALBEIT TO A SPECIFIC SET OF QUESTIONS, FOR THE FIRST TIME IN ALMOST 10 YEARS.

CONCLUSION

South African Psychiatry has always embodied a collaborative spirit captured in the statement ***"ABOUT the discipline, FOR the discipline"***. Approaching the end of the first decade of existence, a reader survey was long overdue.

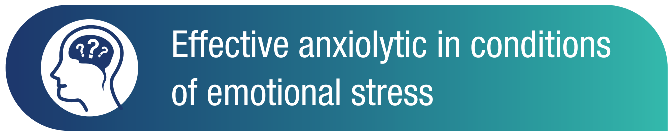
It was important to reflect and gain some understanding of sentiment towards and experiences of the publication. Based on the data, it appears both are positive. However, aside from responses to a finite set of questions for a specific survey, direct comments are (and always have been) welcome at any time. Many thanks to all who participated!

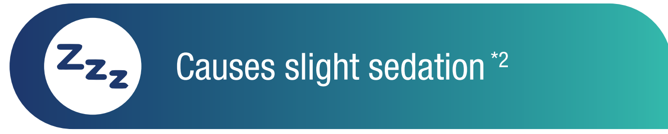
Acknowledgement: many thanks to Rigel Andreoli for assistance with graphics

Christopher Paul Szabo Editor-in-Chief, South African Psychiatry **Correspondence: christopher.szabo@wits.ac.za**

S5 Aterax SYRUP TABLETS
Hydroxyzine Hydrochloride 10 mg/5 ml | 25 mg

When times of intense stress triggers a storm, restore the calm with ATERAX[1]





* Compared to lorazepam

REFERENCES: 1. Chu B, Marwaha K, Sanvictores T, *et al.* Physiology, Stress Reaction - StatPearls - NCBI Bookshelf 2022. Available from: https://www.ncbi.nlm.nih.gov/books/NBK541120/?report=printable (Accessed 12 March 2024). **2.** Święcicki Ł. Therapy of anxiety disorders – the problem of choosing a drug in the primary health care physician's practice. *Paediatr Fam Med* 2015;2(1):82–91.

S5 ATERAX Syrup. Ref. No.: B785 (Act 101 of 1965). Each 5 ml of ATERAX Syrup contains 10 mg hydroxyzine hydrochloride. S5 ATERAX 25 mg (tablet). Ref. No.: B787 (Act 101 of 1965). Each film-coated tablet contains 25 mg hydroxyzine hydrochloride. For full prescribing information refer to the professional information approved by the medicines regulatory authority (03/2010). Trademarks are owned by or licensed to the Aspen Group of Companies. © 2024 Aspen Group of companies or its licensor. All rights reserved. Marketed by Pharmacare Limited t/a Aspen Pharmacare. Co. Reg. No. 1898/000252/06 Healthcare Park, Woodlands Drive, Woodmead, 2191. ZAR-HHYD-04-24-00001 08/2024 MEATE3115

aspen PHARMACARE

Healthcare. We Care.

Marketed by Aspen Pharmacare
www.aspenpharma.com
Medical Hotline 0800 118 088

THE POLYVAGAL THEORY & ITS RELEVANCE TO PSYCHIATRY

Marc Roffey

SUMMARY

'The Polyvagal Theory' (PVT) has gained considerable traction over the last couple of decades, and is espoused by a range of mental and allied health professionals. It is in the field of trauma that the idea has gained the most prominence. PVT is seen by some as a helpful way of understanding responses to trauma, and as a useful way to treat trauma-induced psychopathology using psychological approaches.

PVT HAS ALSO GAINED ATTENTION BECAUSE OF THE ROLE THAT THE VAGUS NERVE PLAYS IN HEALTH, AND BECAUSE OF THE THERAPEUTIC POTENTIAL OF VAGUS NERVE STIMULATION.

An overview of PVT's conceptual foundations will be provided, and thereafter it will be argued that the foundations of PVT are flawed, and that it lacks validity as a scientific theory. Responses to trauma are neurophysiologically well understood and do not require a polyvagal explanation.

Key words: polyvagal theory • vagus nerve • autonomic nervous system • dorsal vagal complex • ventral vagal complex • dorsal motor vagus nucleus • nucleus ambiguus • vagal brake • evolution • dissolution • neuroception • social engagement system • trauma • triune brain theory • heart-rate variability • respiratory sinus arrythmia.

Abbreviations: PVT = polyvagal theory • DVC = dorsal vagal complex • VVC = ventral vagal complex • DMVN = dorsal motor vagal nucleus • NA = nucleus ambiguus • HRV = heart rate variability • RSA = respiratory sinus arrythmia • ANS = autonomic nervous system

[1]Polyvagal Institute | Stephen Porges

INTRODUCTION

Marc Roffey

Medical undergraduates are taught that the vagus nerve, which is the tenth cranial nerve, is functionally a single nerve (there are of course two of each of the twelve cranial nerves, but by convention the cranial nerves are referred to in the singular). The vagus nerve's contribution to the ANS is entirely parasympathetic, and is mediated by the neurotransmitter acetylcholine. Efferent innervations are supplied to the respiratory system, the myocardium, cardiac pacemaker nodes, striated (voluntary) muscles of the pharynx and larynx, and smooth (involuntary) muscles and glands of the gastrointestinal system. Parasympathetic activation of the ANS leads to a decrease in heart rate, bronchoconstriction, and a relaxation of smooth gastrointestinal muscle (popularly referred to as a state of 'rest and digest', as opposed to the sympathetically mediated 'fight or flight' states).

PVT was first proposed in 1994 by Stephen Porges, who is a professor in the Department of Psychiatry at the University of North Carolina, and founder of The Polyvagal Institute.[1] PVT's primary proposition is that the vagus nerve has two neuroanatomical and neurophysiological components.

THE THEORY

Polyvagal theory proposes that there are two functional components to the vagus nerve, which is conventionally considered to be one nerve. It suggests that an evolutionary perspective is essential to understand how humans respond to threat; the two components of the vagus nerve are

proposed as mediating different parasympathetic responses to threat, which are respectively ancient and modern.

Full descriptions of PVT, and of the concepts outlined below, can be found in Porges, 1995, 2009, 2021, 2022, and Porges, in Porges & Dana, 2018.

PVT's view of the vagus nerve derives from its assertion that social mammals evolved from asocial reptilian ancestors. Because the vagus nerve has different neuroanatomical features in mammals and reptiles, members of these species have evolved different vagally-mediated mechanisms of cardiac and respiratory regulation. Mammals have inherited an ancient, reptilian vagal complex which is dorsally situated in the brainstem. It is responsible for the bradycardia which occurs in response to neonatal distress, and for the immobilisation and bradycardia which can occur in response to threat (these are 'reptilian' responses, according to PVT). It is called the '*dorsal vagal complex*' (DVC), and is mediated by the parasympathetic part of the ANS.

ACCORDING TO PVT, MAMMALS HAVE A MORE 'SOPHISTICATED' VAGAL MECHANISM WHICH IS UNIQUE TO THEM, AND WHICH ENABLES THE COORDINATION OF BREATHING, FEEDING AND SWALLOWING, VITAL ACTIVITIES IF MAMMALIAN NEWBORNS ARE TO SURVIVE.

It is the most recently evolved autonomically mediated response to threat, and mediates this by downregulating the ancient dorsally mediated bradycardic threat response, and by enabling sociality to thrive. It is ventrally placed in the brainstem, and is called the '*ventral vagal complex*' (VCC). It also dampens sympathetically driven 'fight or flight' responses, which are intermediate with regard to evolutionary age. Finally, the DVC and VVC are broadly represented in the brainstem by the dorsal motor ventral nucleus (DMVN) and the nucleus ambiguus (NA) respectively. The following table shows the various components of the ANS, as proposed by PVT.

Autonomic neural platform	Evolutionary age	Function
Dorsal vagal complex (DMVN)	Ancient	Immobilisation
Sympathetic nervous system	Intermediate	'Fight or flight'
Ventral vagal complex (NA)	Recent	Sociability

The VVC promotes sociality through the '*social engagement system*'. This is envisaged as an emergent system which, through the midbrain connections between the vagus and other cranial nerves, and between the vagus and heart and lungs, facilitates social engagement. Cues of threat and safety (comprised of external, environmental, and also internal, interoceptive information) are detected by the body, without conscious awareness, and result in different autonomic responses. This process is called '*neuroception*'. Safe cues will facilitate prosocial interactions with others via the social engagement system.

When a mammal is overwhelmed by threat its autonomic nervous system responds with responses which occur sequentially, as determined by their evolutionary age. This is a process of 'evolution in reverse' and is called '*dissolution*'. Accordingly, a failed prosocial parasympathetic response will be replaced with a sympathetically mediated fight/flight response, and if this is not an option then ancient, parasympathetically mediated responses such as freezing, and immobilisation, will occur.

THERE ARE THEREFORE TWO COMPONENTS OF THE PARASYMPATHETIC NERVOUS SYSTEM, AND HENCE THE TERM 'POLY'-VAGAL. ONE IS ANCIENT, THE OTHER MODERN, AND THEY ARE MEDIATED BY DIFFERENT VAGAL CIRCUITS, WHICH ARE RESPECTIVELY THE DORSAL AND VENTRAL VAGAL COMPLEXES.

Although the vagus can respond to threat it is also greatly implicated in maintaining health. Heart rate variability (HRV) is the variability in beat-to-beat heart rate which normally occurs in health, and it is recognised as a valuable marker of healthy cardiac functioning. It is reduced post-myocardial infarction, is compromised in chronic medical conditions such as diabetes, and declines with age. These opposing effects - bradycardia in fetal distress and threat response, but maintenance of health through HRV - is called '*the vagal paradox*'. The vagal paradox is solved by the fact that different vagal pathways mediate them.

The vagus reduces heart rate through a '*vagal brake*'. Respiratory sinus arrythmia (RSA) is a form of HRV which occurs during respiration, in which the heart rate accelerates slightly during inspiration and then slows during expiration. RSA is relevant to PVT as it views it as an index of general vagal tone (Porges, 1995, 2023), which is overall parasympathetic nervous system activity. It is considered by PVT to be a psychophysiological variable (Porges, 2007) and has been used as a purported measure of emotional regulation (Beauchaine et al, 2019).

NEUROSCIENCE CHALLENGES TO PVT

Most of PVTs assertions are arguably scientifically inaccurate, implausible, simplistic, or self-evident. In the first instance, mammals did not evolve from reptiles, nor from a reptilian ancestor common to both of them, and this therefore amounts to a foundational flaw in the theory. Mammals and

reptiles evolved along two separate evolutionary lines, about 300 million years ago (Brocklehurst et al., 2022). PVT derives from the triune brain theory (Porges, 2003), a model of brain functioning which arose in the 1960s, and which suggested that the modern brain has a reptilian core. This in an outdated theory which has been discredited (Cesario et al, 2020; Steffen et al., 2022).

The essential neuroanatomical and physiological features of the control of cardio-respiratory interactions are common to both reptiles and mammals, which amounts to an additional critical flaw in the theory (Grossman & Taylor, 2007, Taylor et al., 2010; Taylor et al., 2022, and Grossman 2023).

BOTH SPECIES POSSESS DORSAL AND VENTRAL VAGAL COMPLEXES WHICH MEDIATE THESE, AND THE DORSAL COMPLEX IS THEREFORE NOT OLDER IN REPTILES THAN IT IS IN MAMMALS, AND NEITHER IS THE VENTRAL COMPLEX MORE RECENT IN MAMMALS THAN IT IS IN REPTILES.

Dissolution, or 'evolution-in-reverse', is a speculative and implausible mechanism to explain the bradycardia which is observed in distressed fetuses and neonates, and physiological mechanisms provide a more parsimonious explanation for this (Ban, 2017; Heuser 2020; Jaeggi et al., 2016, Caruso et al. 2021). The mammalian diving and trigeminocardiac reflexes are other parasympathetic responses in which profound bradycardia occurs, and are vagally mediated by both the DMVN and NA (Panneton and Gan, 2020; Gutierrez et al., 2023; Singh and Chowdhury, 2017). It would be unlikely for the neural circuitry involved in bradycardia during fetal distress to be uniquely different from that involved in these responses. This partly resolves the vagal paradox, and vagal contributions alone do not account for heart rate variability (Draghici & Taylor, 2016; Shaffer & Ginsberg, 2017), which is the other component of the paradox.

The role of the social engagement system in mammals has been overstated, as reptiles and other vertebrates display social behaviours (Doody et al., 2023). The anatomical and functional features of the ventral vagal complex, as formulated by PVT, have been challenged, and PVT incorrectly attributes control of facial movements, which are essential for social behaviours, to it (Neuhuber & Berthoud, 2022; Manzotti et al., 2023). The constructs of the social engagement system, neuroception, and the vagal brake, are arguably not saying anything new.

Finally, respiratory sinus arrythmia is likely a poor marker of cardiac tone and overall vagal tone, which are respectively parasympathetic activity in regard to cardiac functioning, and parasympathetic nervous system activity (Grossman, 2023, 2024; Farmer et al., 2016; Mammerstein et al., 2021).

TRAUMA RESPONSES AND PVT

1. Responses to threat occur across vertebrates, and are not older in mammals (and therefore humans) than they are in other species.

2. In humans such responses include 'fight/flight', vasovagal syncope, freezing, immobilisation, and dissociation.

3. Vasovagal syncope and freezing are the only two responses which have predominantly parasympathetic components (mediated by the vagus nerve).

3. PTSD provides a useful perspective from which to understand the neural and physiological pathways involved in the fear response.

4. The dorsal vagal state is a speculative construct in PVT, and describes a state which is dominated by a dorsal, and therefore allegedly ancient, vagal response. It may be chronic and contains symptoms such as hypoarousal, fatigue and emotional flatness.

Responses to trauma such as vasovagal syncope, freezing, immobilising, and dissociation, are proposed by PVT to be ancient reptilian responses which are mediated through dorsal vagal structures.[2] There is a robust knowledge of how these responses are neurophysiologically mediated, and both the DMNV and NA provide vagal input (Jardine et al., 2018; Roelofs, 2017; Krause-Utz & Elzinga, 2018; Lamotte et al., 2021; Lebois et al., 2022).

CONTEMPORARY NEUROSCIENCE DOES NOT CONSIDER THEM TO BE REPTILIAN RESPONSES, OR TO BE MEDIATED THROUGH A PROCESS OF DISSOLUTION. THEY OCCUR ACROSS VERTEBRATE SPECIES, INCLUDING MAMMALS, REPTILES, BIRDS AND FISH.

The amygdala–hippocampus–medial prefrontal cortex neural circuit is well-elucidated, and is robustly implicated in fear and threat-related behaviour, as exemplified in PTSD (Ressler et al., 2022). PVT proposes that a speculative 'dorsal vagal state' , which may be acute or chronic, contains an array of physical, emotional, and cognitive symptoms.[3] These can be better explained as symptoms of physical or mental illness.

[2] stephen_porges_interview.pdf (complextrauma.uk)
[3] Understanding the Polyvagal Ladder: A Brief Overview - Trauma Therapist Network; Dorsal Vagal Shutdown: How to Identify Shutdown (neurodivergentinsights.com)

THE POLYVAGAL THEORY – IS IT A MYTH?

The polyvagal theory arises from the construct that autonomically mediated responses to threat are older in reptiles than they are in humans. This is then used to support and legitimise the construct that humans have 'new' vagal pathways which are used to downregulate responses to threat. The fact that humans can to a degree learn to consciously mediate responses to threat is then inferred as evidence for these supposedly new vagal responses, and therefore as validation of the polyvagal theory. All of the aforementioned are contestable and thus in its current formulation the PVT is scientifically questionable.

Trauma responses, discussed in the above section, evolved as responses to predator threat. They are therefore old strategies, and they occur across vertebrate classes, including reptiles. Across species, such strategies are therefore equally old.

PVT recognises that such responses are old, but states, mistakenly, that mammals have evolved from reptiles. It therefore deduces, incorrectly, that mammals have inherited reptilian threat responses which are older than theirs, and that they resort to them under threat by the mechanism of 'evolution-in-reverse'.

PVT ATTEMPTS TO SUPPORT ITS POSITION BY ALLEGING THAT REPTILES AND MAMMALS HAVE DIFFERENT CARDIOREGULATORY VAGAL CIRCUITS AND THAT BRADYCARDIA IN REPTILES IS PRIMARILY MEDIATED DORSALLY. BECAUSE DORSAL CIRCUITS ARE ALSO FOUND IN MAMMALS, IT IS INCORRECTLY INFERRED THAT THIS THEREFORE IS THE PRIMARY VAGAL CIRCUIT WHICH IS RECRUITED IN BRADYCARDIC MAMMALIAN RESPONSES TO THREAT, THROUGH THE PROCESS OF DISSOLUTION.

However, dorsal *and* ventral vagal circuits participate in mammalian threat responses, and these circuits are present in both mammals and reptiles. Dissolution is an unlikely mechanism to explain responses to trauma, and parasympathetically mediated bradycardia is provided by a functionally single vagus nerve, and not selectively by its dorsal circuits.

THE VENTRAL VAGAL STATE

According to PVT, the allegedly 'new' and uniquely mammalian ventral vagus mediates a ventral vagal state. This, in opposition to the dorsal state, is characterised by calm, safety, and connection, and supports optimal physical health.[4] It can be cultivated and accessed in various ways, including through trademarked PVT interventions, physical movement practices, grounding techniques, and vagal nerve stimulation.

Its attainment is important in a therapeutic context. Co-regulation, which is the dynamic interplay of emotion between members of a dyadic relationship (Butler & Randall, 2013), is emphasised as an important therapeutic approach by PVT informed therapists.

From a PVT perspective, expressive and autonomic components are accessed and regulated through the social engagement system and ventral vagus. In this way a client will attune to a calm therapist, and will therefore in turn feel calm and safe; grounding techniques are often used to facilitate this (Geller, in Porges & Dana, 2018).

A THERAPEUTIC PRESENCE THEREFORE ARISES WHICH IS SIMULTANEOUSLY IN THE PRESENT AND EMERGENT, AND WHICH IS ALSO INDIVIDUAL, YET SHARED (IBID., GELLER & PORGES, 2014).

Nevertheless, empathy, connection and safety have long been established as psychotherapeutic principles, and do not require polyvagal constructs to be understood. It is inaccurate and misleading to attribute these principles, and optimum psychophysical health, to allegedly 'new' vagal circuits, which apparently only exist in mammals.

THE VAGUS NERVE IN HUMAN HEALTH

The vagus nerve, like all other nerves, is involved in maintaining health. It has received especial attention in this regard because it is the longest cranial nerve. Its many branches provide an intricate and expansive parasympathetic neural network between most of the viscera in the body and the brain (hence its name in Latin, meaning 'wandering'), and it is crucially involved in the physiological process of homeostasis. The solitary nucleus, which is the main sensory vagal brainstem nucleus, plays as essential role in this (Yuan & Silberstein, 2016).

LIKE ALL SENSORY BRAINSTEM NUCLEI, IT IS A *DORSAL* STRUCTURE (BAKER AND LUI, 2019), AND THEREFORE IS NOT PART OF THE VENTRAL VAGAL COMPLEX. THE ENTIRE VAGUS NERVE CONTRIBUTES TO MAINTAINING HEALTH, AND EVIDENCE FOR THIS DOES NOT TRANSLATE AS EMPIRICAL SUPPORT FOR PVT. IN ADDITION, AS DISCUSSED EARLIER, RSA IS REGARDED AS A POOR MEASURE OF VAGAL TONE.

Regarding vagus nerve stimulation (VNS), anticonvulsant, antidepressant, analgesic,

[4] Polyvagal Theory — Rhythm of Regulation

cognitive, cardiac, and anti-inflammatory effects of VNS have been reported. It has been used to treat a range of physical and mental illnesses, including epilepsy, depression, autism spectrum disorders, migraine, Parkinson's disease, and Alzheimer's disease (Vonck & Larsen, 2018; Wang et al., 2021). The solitary nucleus, because it is the largest gatherer of visceral information, is regarded as the primary relay for centrally mediated effects of VNS (Vonck & Larsen, 2018). VNS is not informed by PVT, and again, evidence for the effectiveness of VNS does not provide empirical support for PVT.

PVT AND MENTAL ILLNESS

PVT predicts that autonomic dysregulation, and reduced HRV, can occur in severe mental illness. No PVT informed therapies (including for PTSD) are listed in widely used clinical guidelines.

PVT suggests that the ANS is dysregulated in psychiatric disorders where there is flattening of affect, and diminished reactivity, and such illnesses include ASD (autism spectrum disorder), schizophrenia, anxiety, depression, PTSD, and eating disorders (Porges, 2007; Cabrera et al., 2017). Mechanisms include maintaining autonomic states that foster defensive rather than social behaviours, and compromised components of the social engagement system (Porges, 2007; 2003). These illnesses will therefore be associated with poor vagal tone and will display reduced HRV (Porges, 2003).

Reduced emotional reactivity is often present in these illnesses, and in schizophrenia, occur as one of the cluster of 'negative symptoms' which is present in this illness. Such symptoms are conventionally thought of as arising from disrupted neural networks and dysregulation of the neurotransmitters dopamine and glutamate (Correll & Schooler, 2020). However, disturbed autonomic reactivity also occurs in schizophrenia, and is associated with the psychopathological features of the illness and its metabolic comorbidities (Stogios et al., 2021). ASD displays dysregulation of neural excitation vs. inhibition in cortical networks implicated in sensory, learning, social and emotional systems, rather than autonomic dysregulation (Rubenstein & Merzenich, 2003; Satterstrom et al., 2020).

AS THE ASSOCIATION BETWEEN REDUCED HRV AND PHYSICAL DISEASE IS WELL-RECOGNISED, AND PSYCHIATRIC ILLNESSES ARE PRIMARILY BIOLOGICAL DISEASES, IT DOES NOT SURPRISE THAT HRV REDUCTION HAS BEEN MEASURED IN SCHIZOPHRENIA, MANIA, AND DEPRESSION (STOGIOS ET AL., 2021; REED ET AL, 2020; GREGÓRIO ET AL., 2020; PIZZOLI ET AL., 2021; GALIN & KEREN, 2024).

Defensiveness can be present in such illnesses, and is likely caused by the presence of symptoms which are distressing or cause paranoia, lack of insight and resistance to treatment, and as a response to societal stigma.

Emotion is often discussed in PVT, usually in the context of its regulation by the social engagement system, and neuroception (Porges, 1998; 2009).

No PVT informed therapies are listed in widely used clinical guidelines, which provide evidence-based recommendations for treating mental illness. These include the British NICE (National Institution for Health and Care Excellence) guidelines, and the APA (American Psychiatric Association) guidelines.

POLYVAGAL CONTRIBUTIONS

Trauma therapists have lauded PVT as a valuable explanatory model for therapists, and their clients who have endured trauma. The latter are comforted that their freeze, immobilisation and dissociative states are old and involuntary responses to severe threat.

CONVERSELY, IT IS VALUABLE FOR PEOPLE WHO HAVE UNDERGONE TRAUMA TO KNOW THAT THEY ARE BIOLOGICALLY EQUIPPED TO RECOVER FROM IT; AND THAT THEY CAN LEARN TO PROCESS AND UNDO THE DAMAGE THAT CHRONIC OR SEVERE TRAUMA CAN IMPOSE ON THEIR PHYSIOLOGIES. THEY ALSO LEARN THAT AUTONOMIC STATE, WHICH MAY BE DYSREGULATED, WILL INFLUENCE HOW THEY SEE THE WORLD AND INTERPRET THREATS, TRIGGERS AND CUES, AND ALSO CUES OF SAFETY; AND THEREFORE HOW THEY RESPOND TO THEM.

Autonomic states which are prevailing, recurring or distressing can be modulated and regulated through an array of interventions. PVT has disseminated an awareness and appreciation of this amongst trauma therapists. Such interventions can be taught, and calm and safety can be modelled in a therapeutic space. Parasympathetic modulation will largely be mediated through the vagus nerve, although it is argued that this is not because it has 'new' features. Clients deserve better explanatory models than PVT for how their nervous systems function, and none of what has been said above requires a polyvagal explanation.

PVT places great emphasis on safety, within and outside of therapeutic relationships, and in wider social contexts (Porges, 2022). Feeling unsafe is a prominent aspect of persisting responses to trauma. PVT's emphasis that safety can be therapeutically cultivated, and harnessed, is valid and valuable,

although this is not new information (Foa et al., 2000; Najavitz, 2002; Elliott et al., 2005; Hobfoll et al., 2007).

CONCLUSION

It has been argued that polyvagal theory is scientifically flawed, based on legitimate challenges to its foundational constructs.

IN SPITE OF THIS PVT IS A POPULAR APPROACH TO UNDERSTANDING TRAUMA, AND ALSO TO VIEWING OVERALL WELL-BEING. THERE ARE NUMEROUS REASONS FOR THIS. IT IS EASY TO UNDERSTAND, AND MAKES INTUITIVE SENSE. CATCHY NEOLOGISMS AND 'SOUNDBITES' ARE ASSOCIATED WITH IT, INCLUDING THE NAME ITSELF, AND OTHERS SUCH AS 'NEUROCEPTION', 'VAGAL BRAKE', 'DISSOLUTION', 'DORSAL VAGAL SHUTDOWN', 'THE VAGAL PARADOX', ET AL. SUCH TERMS ADD A SHEEN OF SCIENTIFIC RESPECTABILITY TO PVT.

Polyvagal ideas can easily be accessed on the internet, and PVT's message that distress can be addressed through autonomic regulation appears (and to some extent is) plausible and feasible. It especially appeals at a time when the burden of trauma and emotional distress in the world is increasing at an accelerated pace.

Nevertheless, it misleadingly attributes psychosocial wellbeing to supposedly 'new' vagal pathways which apparently only exist in mammals, and makes exaggerated claims that such wellbeing can be achieved through parasympathetic activation, using interventions informed by PVT.

AT THE SAME TIME, FEELINGS OF DISTURBED WELLBEING ARE SUBSUMED WITHIN ITS SPECULATIVE PSYCHOPHYSIOLOGICAL 'DORSAL VAGAL SHUTDOWN' CONSTRUCT, AND IN SOME CASES THESE COULD BE SYMPTOMS OF ACTUAL BUT UNDIAGNOSED PHYSICAL OR MENTAL ILLNESS.

It is argued that polyvagal theory is centred upon a false construct of old vs. new vagal nerve circuits in mammals, which respectively mediate old and new autonomic responses to distress. It has been referred to here as 'the polyvagal myth'. It is formulated from the following erroneous ideas: that mammals evolved from reptiles; that autonomic stress responses (such as freezing) are therefore older in reptiles than in mammals; and that they are activated in mammals through a speculative mechanism of dissolution, or 'evolution-in-reverse'. However, autonomic responses to threat are equally old across vertebrate species, and are neurophysiologically mediated by dorsal and ventral vagal circuits.

The second core PVT theme is that the vagus nerve plays an important role in human sociality by down-regulating sympathetically driven 'fight or flight' responses, and other responses including vasovagal syncope and dissociation, which may be driven by either parasympathetic, or sympathetic activation, or by both simultaneously. It does so via the 'social engagement system', which promotes behaviours which are soothing, and which encourage feelings of calm, warmth, safety, empathy and connectedness.

This idea, and its emphasis on safety, constitutes PVT's strength. It offers a humanistic approach, and promotes that these emotional states foster healthy sociality. Interventions which support parasympathetic modulation of sympathetically driven states of anxiety, anger, agitation or distress are especially valuable within a psychotherapy context, and can be facilitated through co-regulation and therapeutic presence.

HOWEVER, IT IS ARGUED THAT THE HUMAN ABILITY TO DOWNREGULATE THREAT IS NOT BECAUSE THERE IS A 'NEW', UNIQUELY MAMMALIAN VAGUS WHICH ENABLES THIS, BUT BECAUSE HUMANS CAN CONSCIOUSLY MODULATE DISTRESS TO A SIGNIFICANT DEGREE, AND ALSO HAVE A UNIQUE CAPACITY TO CREATE STRATEGIES WHICH CAN FACILITATE THIS TOO. THIS COULD BE VIA SAFE AND SUPPORTIVE SOCIAL INTERACTIONS, OR THROUGH DELIBERATE PRACTICES WHICH UPREGULATE PARASYMPATHETIC ACTIVITY. PVT IS NOT REQUIRED FOR THIS TO BE UNDERSTOOD OR EXPLAINED.

Polyvagal constructs might be better conceptualised as existing in a framework which is something other than a 'theory'. In spite of scientific flaws, relevant therapeutic ideas in treating trauma through psychological approaches have been promoted by PVT. These might not be new, but they have been made widely accessible through PVT. This may be its legacy, and such approaches might be more usefully accommodated within a polyvagal model, or paradigm, rather than a theory.

REFERENCES

Baker E. and Lui F. (2019): Neuroanatomy, Vagal Nerve Nuclei, Study Guide from StatPearls Publishing, Treasure Island (FL), 20 Aug 2019. Neuroanatomy, Vagal Nerve Nuclei - Abstract - Europe PMC.

Ban, J. (2017): Neonatal arrhythmias: diagnosis, treatment, and clinical outcome, *Korean J Pediatr* 2017;60(11):344-352. https://doi.org/10.3345/kjp.2017.60.11.344.

Beauchaine, T.P., Bell, Z., Knapton, E., McDonough-Caplan, H., Shader, T., Zisner, A. (2019): Respiratory Sinus Arrhythmia Reactivity across Empirically Based Structural Categories of Psychopathology Among Adults: A Meta-Analysis, *Psychophysiology*. 2019 May ; 56(5): e13329. https://doi.org/10.1111/psyp.13329.

Brocklehurst, N., Ford, D.P., Benson,R.B.J. (2022): Early Origins of Divergent Patterns of Morphological Evolution on the Mammal and Reptile Stem-Lineages, *Syst. Biol.* 71(5):1195–1209, 2022. https://doi.org/10.1093/sysbio/syac020.

Butler E.A., Randall A.K. (2013): Emotional Coregulation in Close Relationships, *Emotion Review* Vol. 5, No. 2 (April 2013) 202 –210. https://doi.org/10.1177/175407391245163

Cabrera A., Kolacz J., Pailhez G., Bulbena-Cabre A., Bulbena A. Porges S.W. (2017): Assessing body awareness and autonomic reactivity: Factor structure and psychometric properties of the Body Perception Questionnaire-Short Form (BPQ-SF), *Int J Methods Psychiatr Res*. 2018;27:e1596. DOI: 10.1002/mpr.1596.

Caruso, E., Farruggio, S., Agati, S. (2021): Fetal Bradyarrhythmias: Etiopathogenesis, Diagnosis and Treatment: Between Literature Review and Experience of a Tertiary Center, *Congenital Heart Disease 2021*, vol.16, no.4. DOI: 10.32604/CHD.2021.015470

Cesario, J., Johnson, D.J., Eisthen, H.E. (2020): Your Brain Is Not an Onion With a Tiny Reptile Inside, *Current Directions in Psychological Science 2020*, Vol. 29(3) 255–260. https://doi.org/10.1177/0963721420917687.

Correll C.U. and Schooler, N.R.(2020): Negative Symptoms in Schizophrenia: A Review and Clinical Guide for Recognition, Assessment, and Treatment, *Neuropsychiatric Disease and Treatment*, 519-534. DOI: 10.2147/NDT.S225643

Doody, J.S., Burghardt, G., Dinets, V. (2023): The evolution of sociality and the polyvagal theory, *Biological Psychology 180* (2023) 108569. DOI: 10.1016/j.biopsycho.2023.108569

Draghici, A.E., and Taylor, J.A. (2016): The physiological basis and measurement of heart rate variability in humans. *Journal of Physiological Anthropology* (2016) 35:22. DOI: 10.1186/s40101-016-0113-7.

Elliott D.E., Bjelajac P., Fallot R.D., Markoff L.S., Reed B.G. (2005): Trauma-Informed Or Trauma-Denied: Principles And Implementation Of Trauma-Informed Services For Women, *Journal Of Community Psychology,* Vol. 33, No. 4, 461–477 (2005). DOI: 10.1002/jcop.20063.

Farmer, D.G.S., Dutschmann, M., Paton, J.F.R., Pickering, A.E., McAllen, R., M. (2016): Brainstem sources of cardiac vagal tone and respiratory sinus arrhythmia, *JPhysiol* 594.24(2016)pp7249–7265. https://doi.org/10.1113/JP273164.

Foa E.B., Keane T.M., Friedman, M.J. (2000): Guidelines for Treatment of PTSD, *Journal of Traumatic Stress*, Vol. 13, No. 4, 2000. https://doi.org/10.1023/A:1007802031411.

Galin S. and H. Keren (2024): The Predictive Potential of Heart Rate Variability for Depression, *Neuroscience 546* (2024) 88–103. https://doi.org/10.1016/j.neuroscience.2024.03.013.

Geller S.M. (2018): Chapter 7, Therapeutic presence and Polyvagal Theory: Principles and practices for cultivating effective therapeutic relationships. In S. W. Porges & D. Dana (Eds.), *Clinical applications of the polyvagal theory: The emergence of polyvagal-informed therapies* (pp. 106–126). W. W. Norton & Company.

Geller S.M. and Porges, S.W. (2014): Therapeutic Presence: Neurophysiological Mechanisms Mediating Feeling Safe in Therapeutic Relationships, *Journal of Psychotherapy Integration* Vol. 24, No. 3, 178–192. https://doi.org/10.1037/a0037511.

Gregório, M.L., Wazen G.L.L.W., Kemp A.H., Milan-Mattos J.C., Portae, A., Cataid A.M., Fernandes M.F. (2020): Non-linear analysis of the heart rate variability in characterization of manic and euthymic phases of bipolar disorder, *Journal of Affective Disorders,* Volume 275, 1 October 2020, Pages 136-144. DOI: 10.1016/j.jad.2020.07.126

Grossman, P. (2023): Fundamental challenges and likely refutations of the five basic premises of the polyvagal theory, *Biological Psychology 180* (2023) 108589. DOI: 10.1016/j.biopsycho.2023.108589.

Grossman, P. (2024): Respiratory sinus arrhythmia (RSA), vagal tone and biobehavioral integration: Beyond parasympathetic function, *Biological Psychology 186* (2024) 108739. DOI: 10.1016/j.biopsycho.2023.108739.

Grossman P. and Taylor, E.W. (2007): Toward understanding respiratory sinus arrhythmia: Relations to cardiac vagal tone, evolution and biobehavioral functions, *Biological Psychology 74* (2007) 263–285. DOI: 10.1016/j.biopsycho.2005.11.014

Gutierrez, V., Coverdell, T., Abbott, S., Campbell, J. (2023): Disambiguating control of the diving reflex by the nucleus ambiguus, American Physiology Summit 2023, Meeting Abstracts, May 2023. https://doi.org/10.1152/physiol.2023.38.S1.5729637.

Heuser, C.C. (2020): Physiology of Fetal Heart Rate Monitoring, *Clinical Obstetrics and Gynecology.* Volume 63, Number 3, 607–615, September 2020. doi: 10.1097/GRF.0000000000000553.

Hobfoll S.E., Watson P., Bell C.C., Bryant R.A., Brymer M.J., Friedman M.J., Friedman M., Gersons B.P.R., de Jong J.T.V.M., Layne, C.M., Maguen S., Neria Y., Norwood, A.E., Pynoos R.S., Reissman D., Ruzek J.I., Shalev A.Y., Solomon Z., Steinberg A.M., Ursano R.J. (2007): Five Essential Elements of Immediate and Mid–Term Mass Trauma Intervention, Empirical Evidence, *Psychiatry,* 70:4, 283-315. https://doi.org/10.1521/psyc.2007.70.4.283.

Jaeggi, E. and Öhman A. (2016): Fetal and Neonatal Arrhythmias, *Clin Perinatol* 43 (2016) 99–112. http://dx.doi.org/10.1016/j.clp.2015.11.007.

Jardine, D.L., Wieling, W., Brignole M., Lenders, J.W.M., Sutton, R., Stewart J. (2018): The pathophysiology of the vasovagal response, *Heart Rhythm,* Vol 15, No 6, June 2018. DOI: 10.1016/j.hrthm.2017.12.013.

Krause-Utz A., Elzinga B. (2018): Current Understanding of the Neural Mechanisms of Dissociation in Borderline Personality Disorder, Current Behavioral *Neuroscience Reports* (2018) 5:113–123. https://doi.org/10.1007/s40473-018-0146-9.

Lamotte G., Shouman, K., E. E., Benarroch (2021): Stress and central autonomic network, Autonomic *Neuroscience: Basic and Clinical* 235 (2021) 102870. https://doi.org/10.1016/j.autneu.2021.102870.

Lebois L.A.M., Baker J.T., Kumar P., Palermo C.A., Lambros A.M., O'Connor L., Wolff J.D., Gruber S.A., Lewis-Schroeder N., Ressler K.J., Nickerson L.D., Kaufman M.L. (2022): *Neuropsychopharmacology* (2022) 47:2261–2270. DOI: 10.1038/s41386-022-01468-1

Mammerstein J.T., McCallum G.A., Durand D.M. (2021): Direct measurement of vagal tone in rats does not show correlation to HRV, *Nature Scientific Reports* | (2021) 11:1210 DOI: 10.1038/s41598-020-79808-8

Manzotti A., Panisi C., Pivotto M., Vinciguerra F., Benedet M., Brazzoli F., Zanni S., Comassi A., Caputo S., Cerritelli F., Chiera M. (2023): An in-depth analysis of the polyvagal theory in light of current findings in neuroscience and clinical research, *Developmental Psychobiology.* 2023;66:e22450. DOI: 10.1002/dev.22450

Najavits, L. M. (2002): Seeking safety: A treatment manual for PTSD and substance abuse (book). Guilford Press.

Neuhuber W.L. and Berthoud H-R. (2022): Functional anatomy of the vagus system: How does the polyvagal theory comply?, *Biological Psychology* 174 (2022) 108425. DOI: 10.1016/j.biopsycho.2022.108425

Panneton W.M. and Gan Q. (2020): The Mammalian Diving Response: Inroads to Its Neural Control, Front. Neurosci., 05 June 2020 Sec. Autonomic *Neuroscience* Volume 14 - 2020 DOI: 10.3389/fnins.2020.00524

Pizzoli S.F.M., Marzorati, M., Gatti D., Monzani D., Mazzocco K., Pravettoni G. (2021): A meta analysis on heart rate variability biofeedback and depressive symptoms, *Nature: Scientific Reports* (2021) 11:6650. DOI: 10.1038/s41598-021-86149-7

Porges, S.W. (1995): Orienting in a defensive world: mammalian modifications of our evolutionary heritage. A Polyvagal Theory, *Psychophysiology.* 1995 Jul;32(4):301-18. DOI: 10.1111/j.1469-8986.1995.tb01213.x

Porges, S.W. (1998): Love: An Emergent Property Of The Mammalian Autonomic Nervous System, *Psychoneuroendocrinology,* Vol. 23, No. 8, pp. 837-861, 1998. DOI: 10.1016/s0306-4530(98)00057-2

Porges, S.W. (2003): The Polyvagal Theory: phylogenetic contributions to social behavior, *Physiology & Behavior* 79 (2003) 503–513. DOI: 10.1016/s0031-9384(03)00156-2

Porges, S.W. (2007): The Polyvagal Perspective, *Biol Psychol.* 2007 February ; 74(2): 116–143. DOI: 10.1016/j.biopsycho.2006.06.009

Porges, S.W. (2009): The polyvagal theory: New insights into adaptive reactions of the autonomic nervous system, *Cleve Clin J Med.* 2009 April ; 76(Suppl 2): S86–S90. DOI: 10.3949/ccjm.76.s2.17

Porges, S.W. (2018): Chapter 4, Polyvagal Theory: A Primer, Clinical Applications of the Polyvagal Theory: The Emergence of Polyvagal-Informed Therapies. New York: WW Norton, Edited by Porges SW & Dana D (2018).

Porges, S.W. (2021): Polyvagal Theory: A biobehavioral journey to sociality, Comprehensive *Psychoneuroendocrinology* 7 (2021) 100069. DOI: 10.1016/j.cpnec.2021.100069

Porges, S.W. (2022): Polyvagal Theory: A Science of Safety, *Frontiers in Integrative Neuroscience* May 2022 | Volume 16 | Article 871227. https://doi.org/10.3389/fnint.2022.871227

Porges, S.W. (2023): The vagal paradox: A polyvagal solution, *Comprehensive Psychoneuroendocrinology* 16 (2023) 100200. DOI: 10.1016/j.cpnec.2023.100200

Reed A.C., Lee, J., Green M.F., Hamilton H.K., Miller G.A., Subotnik K.L., Ventura J., Nuechterlein K.H., Yee C.M. (2020): Associations between physiological responses to social-evaluative stress and daily functioning in first-episode schizophrenia, *Schizophrenia Research* 218 (2020) 233–239. https://doi.org/10.1016/j.schres.2019.12.040.

Ressler K.J., Berretta S., Bolshakov V.Y., Rosso I.M., Meloni E.G., Rauch S.L., Carlezon Jr W.A. (2022): Post-traumatic stress disorder: clinical and translational neuroscience from cells to circuits, *Nature Reviews Neurology* Volume 18 May 2022. DOI: 10.1038/s41582-022-00635-8

Roelofs, K. (2017): Freeze for action: neurobiological mechanisms in animal and human freezing, *Phil. Trans. R. Soc.* B 372: 20160206. DOI: 10.1098/rstb.2016.0206

Rubenstein J.L.R., and Merzenich M.M.(2003): Model of autism: increased ratio of excitation/inhibition in key neural systems, *Genes, Brain and Behavior* (2003) 2: 255–267. https://doi.org/10.1034/j.1601-183X.2003.00037.x

Satterstrom F.K., Kosmicki J.A., Wang J., Roeder, K., Daly, M.J., Buxbaum J.D. et al. (2019): Large-Scale Exome Sequencing Study Implicates Both Developmental and Functional Changes in the Neurobiology of Autism, *Cell*. 2020 Feb 6; 180(3): 568–584.e23. https://doi.org/10.1016/j.cell.2019.12.036.

Shaffer F., Ginsberg J.P (2017): An Overview of Heart Rate Variability Metrics and Norms, Front. Public Health, Sec. F*amily Medicine and Primary Care* Volume 5 - 2017. DOI: 10.3389/fpubh.2017.00258

Singh G.P. and Chowdhury T. (2017): Brain and heart connections: The trigeminocardiac reflex!, 2017 *Journal of Neuroanaesthesiology and Critical Care*. DOI: 10.4103/jnacc.jnacc_24_17.

Steffen P.R., Hedges D., Matheson R. (2022): The Brain Is Adaptive Not Triune: How the Brain Responds to Threat, Challenge, and Change, *Front. Psychiatry,* 01 April 2022 Volume 13. 2022. DOI: 10.3389/fpsyt.2022.802606.

Stogios N., Gdanski A., Gerretsen P., Chintoh A.F., Graff-Guerrero A., Rajji T.K., Remington G., Hahn M.K., Agarwal S.M. (2021): Autonomic nervous system dysfunction in schizophrenia: impact on cognitive and metabolic health, *npj Schizophrenia* (2021) 7:22. https://doi.org/10.1038/s41537-021-00151-6.

Taylor E.W., Leite C.A.C., Skovgaard N. (2010): Autonomic control of cardiorespiratory interactions in fish, amphibians and reptiles, *Brazilian Journal of Medical and Biological Research* (2010) 43: 600-610. DOI: 10.1590/s0100-879x2010007500044.

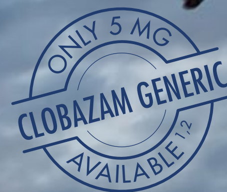
Taylor E.W., Wang T., Leite C.A.C. (2022): An overview of the phylogeny of cardiorespiratory control in vertebrates with some reflections on the 'Polyvagal Theory', *Biological Psychology* 172 (2022) 108382. DOI: 10.1016/j.biopsycho.2022.108382

Vonck K.E.J. and Larsen L.E. (2018): Neuromodulation, 2nd Edition, Chapter 18, 211-220. Published by Elsevier Ltd. 2018. https://doi.org/10.1016/B978-0-12-805353-9.00018-8.

Wang Y., Zhan G., Cai Z., Jiao B., Zhao Y., Li S., Luo A. (2021): Vagus nerve stimulation in brain diseases: Therapeutic applications and biological mechanisms, *Neuroscience and Biobehavioral Reviews* 127 (2021) 37–53. DOI: 10.1016/j.neubiorev.2021.04.018.

Yuan H., and Silberstein S.D. (2016): Vagus Nerve and Vagus Nerve Stimulation, a Comprehensive Review: Part I, Headache 2016;56:71-78. doi: 10.1111/head.12647.

Marc Roffey is a forensic psychiatrist. He recently retired from his position as Senior Lecturer in the Division of Forensic Mental Health, Department of Psychiatry and Mental Health, University of Cape Town and Valkenberg Hospital. He is also a certified mindfulness teacher, and has a postgraduate Certificate in Mindfulness Interventions through IMISA (the Institute of Mindfulness of South Africa) and the University of Stellenbosch. He has authored this article in his personal capacity.
Correspondence: medical@marcroffey.co.za



Take the helm to restore the calm in life's storms

NEW

S5 Qlocam

CLOBAZAM CAPSULES 5 mg TABLETS 10 mg

- For the treatment of anxiety in neurotic patients and for pre-operative medication; may be effective in relieving the acute symptoms of alcohol withdrawal syndrome.
- Convenient dosing to suit your patient's needs.

References: 1. DOH Price file, 25 June 2024. **2.** Medikredit Pricing Report, 15 April 2024.

S5 QLOCAM 5 mg Capsules. Reg. No.: 51/2.6/0566. Each capsule contains 5 mg clobazam. S5 QLOCAM 10 mg Tablets. Reg. No.: 51/2.6/0567. Each tablet contains 10 mg clobazam. For full prescribing information refer to the professional information approved by the medicines regulatory authority (03/2024).

Trademarks are owned by or licensed to the Aspen Group of companies. © 2024 Aspen Group of companies or its licensor. All rights reserved. Marketed by Pharmacare Limited t/a Aspen Pharmacare Co. Reg. No.: 1898/000252/06. Healthcare Park, Woodlands Drive, Woodmead, 2191. ZAR-CLM-05-24-00004 07/2024 MEQLO3116

Healthcare. We Care.

Marketed by Aspen Pharmacare
www.aspenpharma.com
Medical Hotline 0800 118 088

5th Southern African Multidisciplinary ADHD Congress

SAVE THE DATE

4 - 7 September 2024

Virtual Format
Earn CPD Points (clinical and ethical)
World-class local- and international speakers
Competition prizes and entertainment

For further information, please contact
Londocor Event Management: Marida Kroukamp
marida@londocor.co.za

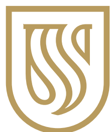
Congress Convenor: Prof Renata Schoeman
renata@renataschoeman.co.za

www.adhdcongress.co.za

Presented by

Goldilocks and The Bear Foundation

In partnership with



Stellenbosch Business School
STELLENBOSCH UNIVERSITY

ADHD

When **ADHD** disrupts their **lives** & **functioning.**[4,5]

Build them up again.[1-3]

INIR is indicated for: The treatment of Attention-Deficit/Hyperactivity Disorder (ADHD) in children from 6 years of age or older, adolescents and adults[6]

1. Savill NC, et al. CNS Drugs. 2015; 29(2):131–151. **2** Michelson D, et al. Biol Psychiatry. 2003; 53(2):112–120. **3.** Wilens TE, et al. J Pediatr. 2006; 149(1): 112–119. **4.** Ramos-Quiroga JA, et al. Curr Med Res Opin. 2013; 29(9): 1093–1104. **5.** Chan E, et al. JAMA. 2016; 315(18):1997–2008. **6.** INIR [Professional Information]; Sandton, South Africa: Dr Reddy'sLaboratories (Pty) Ltd; 2023.

S5 INIR 10. Reg.No.: 43/1.2/0809. Each capsule contains atomoxetine hydrochloride equivalent to atomoxetine 10 mg.
S5 INIR 18. Reg.No.: 43/1.2/0810. Each capsule contains atomoxetine hydrochloride equivalent to atomoxetine 18 mg.
S5 INIR 25. Reg.No.: 43/1.2/0811. Each capsule contains atomoxetine hydrochloride equivalent to atomoxetine 25 mg.
S5 INIR 40. Reg.No.: 43/1.2/0812. Each capsule contains atomoxetine hydrochloride equivalent to atomoxetine 40 mg.
S5 INIR 60. Reg.No.: 43/1.2/0813. Each capsule contains atomoxetine hydrochloride equivalent to atomoxetine 60 mg.
For full prescribing information please refer to the professional information approved by the Medicines Regulatory Authority.
Dr. Reddy's Laboratories (Pty) Ltd., 204 Rivonia Road, Block B, Morningside, Sandton, 2057.
Reg.No.: 2002/014163/07. Tel: +27 11 324 2100. www.drreddys.co.za
R1169991-ZA-CO-24052023-0904-30 June 2025
THIS INFORMATION IS INTENDED FOR HEALTHCARE PROFESSIONALS ONLY.

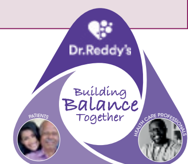
HELPLINE:
0800 21 22 23
www.sadag.org

Help your patient **put the pieces back together again.**

Dopaquel is indicated for the treatment of **adult patients with schizophrenia** or for the treatment of **manic episodes associated with bipolar disorder.**[1]

Quetiapine is recommended as a **first-line treatment** in the management of **acute mania** associated with bipolar disorder[2]

1. Dopaquel [Professional Information]. Sandton, South Africa. Dr. Reddy's Laboratories (Pty) Ltd; 2017. **2.** Yatham LN, Kennedy SH, Parikh SV et al. Canadian Network for Mood and Anxiety Treatment (CANMAT) and International Society for Bipolar Disorders (ISBD) 2018 guidelines for the management of patients with bipolar disorder. *Bipolar Disorders, 2018*; 97-170.
S5 Dopaquel 25. Reg.No.:25: 43/2.6.5/0429. Each tablet contains quetiapine fumarate equivalent to quetiapine 25 mg. Contains sugar (lactose).
S5 Dopaquel 100. Reg.No.: 43/2.6.5/0430. Each tablet contains quetiapine fumarate equivalent to quetiapine 100 mg. Contains sugar (lactose).
S5 Dopaquel 200. Reg.No.: 43/2.6.5/0431. Each tablet contains quetiapine fumarate equivalent to quetiapine 200 mg. Contains sugar (lactose).
S5 Dopaquel 300. Reg.No.: 43/2.6.5/0432. Each tablet contains quetiapine fumarate equivalent to quetiapine 300 mg. Contains sugar (lactose).
For full prescribing information refer to the professional information approved by the Medicines Regulatory Authority.
Dr. Reddy's Laboratories (Pty) Ltd., 204 Rivonia Road, Block B, Morningside, Sandton, 2057. Reg.No.: 2002/014163/07. Tel: +27 11 324 2100. www.drreddys.co.za.
FOR HEALTHCARE PROFESSIONALS ONLY



RETIREMENT REFLECTIONS

THE PONDERINGS OF A PENSIONER

Rykie Liebenberg

"SUCCESS IS WHEN A MAN GETS UP IN THE MORNING AND GOES TO BED AT NIGHT AND DOES WHAT HE WANTS IN BETWEEN" BOB DYLAN

After having worked very hard for many years, it is a big decision to stop or even just reduce working hours. The reasons for making the decision could be many and varied, but it often coincides or is directly due to other life events. Retirement is therefore not a single decision or life event. The consequences are far reaching and many and affect so many aspects of our life. Everything changes, as a matter of fact. Do we know this when we make the decision? Of course, we don't, as we can never really know what the consequences of any decision will be.

If you work for an employer and retirement is enforced because of an age limit, I suppose that is one thing, but if you work for yourself as an independent practitioner, the decision rests with you and you alone. I have had recent personal experience of a complete change of circumstances, personally and professionally.

I left my very busy, complex, longstanding, diverse private practice in an urban setting to move to a different country and a small town. I also decided to take a sabbatical from work. This was supposed to last three months, and then I wanted to start work, albeit at a much slower pace.

At the time I stopped working I felt emotionally and physically drained. I had to pack up my houses in South Africa, and that meant throwing away, giving away, and selling many things that I had gathered around myself through the years. More importantly, it was very difficult to leave people behind.

Rykie Liebenberg

I HAD WORKED WITH MY COLLEAGUES FOR MORE THAN TWO DECADES, I HAD PLAYED TENNIS WITH A FRIEND FOR 18 YEARS EVERY WEEK, AND MY TRAINER WAS MORE OF A THERAPIST THAN A TRAINER.

Although I had moved many times in my life, this would be the first time that I had left my work behind. If I can summarize, there are so many losses involved in making the decision to retire, that it catches one unawares. It certainly overwhelmed me at some point. I felt as if I was being drowned in this tsunami of things and people lost to me. When I was younger, it seemed somehow less permanent.

The counterweight to this feeling of loss, was relief and some anticipation of a better lifestyle to come. What I did not expect, was to miss the security of a regular income. Even if the finances are planned, and your financial advisor says reassuringly that it is safe for you never to work again, as long as you don't buy a Ferrari every year, it is a strange situation to check your bank account and see no incoming funds.

These feelings of loss were not immediately as pronounced for me, as I went travelling for a while to new places, watched some World Cup Rugby in Paris, and had some adventures. The move itself involved three days of driving in 40 degrees heat in two cars, towing a boat. There was not a lot of time to consider existential questions about the future.

Arriving at the destination was exciting, and enjoying a holiday for a month or so was really an indulgence. It was a honeymoon period of sleeping until I woke up, walking on the beach every day and eating at leisure. Mostly, it meant not watching the clock and not feeling constantly pressured for time. I could read as much as I wanted, watch the occasional movie, and go to bed late if I wanted to. This holiday feeling coincided with the December holiday period, so although I had done some of the administration to get my qualifications approved in a foreign country, it was not a priority then.

After the holiday, when everybody went back to work and the town settled down to ordinary small-town activities after the holiday, the reality of not working began to materialize. I have never enjoyed domesticity, so keeping house is not my chosen occupation. My life was still in boxes, as I was buying a new property, and the frustration began to rise with the red tape and bureaucracy involved in getting registered, getting a practice number, setting up a consulting room and a computer system. I had to register with all sorts of Government Ministries, including registering as a taxpayer, before I could get a practice number. Every step took weeks longer to complete than I thought it would, and I could not contain my frustration and feelings of helplessness on some days. I would still exercise and read and even cook, but now my mind was not occupied enough. I had a sense of everything being pointless, and I missed the stimulation of seeing patients and using knowledge and experience to make diagnoses and decide on treatment, and hearing people's stories. The worst feeling was not being in control of the situation and waiting for some outside agency to make decisions about your fate. I suppose in summary, I felt frustrated and useless and out of control. My sleeping patterns were very disrupted, food tasted strange, and I had a very deep fatigue that seemed completely physical. I could sleep all day and still be tired. Maybe this was accumulated fatigue from decades of little sleep and overwork, but it improved after three months of rest and walking by the sea, and quiet time. I realize now that I was in mourning.

However, life goes on and issues are resolved. The practice was registered, and the computer systems installed, the script pads printed, the property transaction settled, and life settled down. I could go to work again every day, while still walking three times a week. I can still read, and still choose better how to spend my time. I just hope to keep it low key, but the work is already gathering momentum and it might be a challenge. The resources are limited where I work now, so I hope I have the resilience to balance the demand with my own resources.

I am not ready to retire completely, but I am thankful to be in a less intense and demanding environment. I think everybody's circumstances are different, so I would not like to give advice. maybe I can share some themes and thoughts based on my own experience.

I WAS NOT PREPARED FOR THE INTENSITY OF FEELINGS OF LOSS I EXPERIENCED. I AM NOT SURE HOW ONE WOULD PREPARE FOR THIS, BUT IT HITS HARD. I WAS NOT SOME IMPORTANT CEO OF A LISTED COMPANY, BUT I HAD MY OWN LITTLE QUEENDOM WHERE EVEN THE AIRCON AND THE TYPE OF COFFEE WAS UNDER MY CONTROL, AND I MADE THE DECISIONS.

It was much harder than I ever thought possible. I miss the presence of my colleague in the rooms every day, who greeted every patient cheerfully and said "I make it my business to be well"! I miss collegial support and chats in the corridor, and I miss my tennis and gym and even my accountant!

The second theme of relief and excitement and enjoyment of a new phase in life is what I had hoped for, but it soon became clear that one must fill your time with some meaningful activity, not just leisure. To be honest, I will probably never stop working. I had a conversation with my beloved father on his 60th birthday. I wish I had paid more attention, but we never do, do we? He was being asked about retirement and being a much wiser man than I will ever be, he discussed the loss involved in taking such a step. In the end, he only retired fifteen years later. He was not the same man after retirement, although he was gracious as always. We decided that if you felt confident that you could still do the job well, it was good to carry on working, especially if you love what you do. I think with time comes experience and hopefully more insight, more wisdom and tolerance and understanding.

The last theme for me has been acceptance, and realizing what is right for me as an individual. I have to work in the profession that I love. I just have to keep focused on maintaining a balance between what other people demand from me, and what I need.

I hope I have enough work, and enough time to read.

I hope I have enough time to sleep, and enough time to walk by the sea.

I hope I have enough time to think about why the sea has tides, and enough time to spend with loved ones.

I hope I can age gracefully into wisdom and peace and never lose my joy in small things of great beauty.

I hope life is always exciting and new, and that I never run out of books to read!

Rykie Liebenberg Psychiatrist in private practice, Swakopmund, Namibia **Correspondence: medical.rml@global.co.za**

LEGACY, WINDING DOWN OR SELLING YOUR PRACTICE

IN PREPARATION FOR RETIREMENT

Nicolene Schoeman-Louw

As a medical professional, retirement is often a daunting prospect. For many, it is something put off until the proverbial "last minute," usually resulting in unintended consequences, chaos, and unforeseen mounting costs that can be avoided.

HOWEVER, IT IS A TIME WHEN WE NEED TO BE MOST STRATEGIC.

First and foremost, it is a question of intent - whether it is time to close the practice or preserve and transfer the values and objectives you upheld during your time in practice. Either process could prove to be an intense exercise where legacy planning needs to be the cornerstone of the decision-making process.

Complying strictly with healthcare laws and regulations is essential. Therefore, it is advisable to verify the status of your licenses, certifications, and adherence to guidelines set by the Health Professions Council of South Africa (HPCSA) during and after any transitionary period. This will help ensure that you remain compliant with the relevant professional rules and code of conduct, including the provisions of the Health Professions Act 56 of 1974 as amended.

Where the objective is to transition out and leave the care and continuance of your practice to your partners or professionals in your team, here are some of the steps and processes to consider:

1. Develop a comprehensive succession plan that outlines the transition of leadership and responsibilities. Identify potential successors within your practice, whether they are existing partners, associates, or other qualified individuals. Ensure that the chosen successors share your values and commitment to patient care.

2. Clearly define and institutionalise the core values that have guided your practice. Communicate these values to your team and successors, emphasising the importance of maintaining a patient-centric approach, ethical standards, and a commitment to excellence in healthcare delivery.

Nicolene Schoeman-Louw

3. Ensure that your practice stays abreast of technological advancements in the healthcare industry. Implement and integrate relevant technologies that enhance patient care, streamline operations, and improve efficiency. A technologically advanced practice is more likely to attract and retain healthcare professionals who are committed to providing high-quality care.

4. Document standard operating procedures, best practices, and any unique insights gained over the years. Create a knowledge transfer plan to ensure that critical information is passed on to the next generation of healthcare professionals. This documentation can serve as a valuable resource for maintaining continuity and preserving your practice's legacy.

5. Retain patient records for 6 years in the case of adult patients (after becoming dormant) and until they reach the age of 21 in the case of children. Records should be kept for at least six years after they become dormant. The records of patients who are mentally impaired should be kept until the patient's death. Records pertaining to illness or accident arising from a person's occupation should be kept for 20 years after treatment has ended.

6. Develop a plan for transparent communication with patients regarding the transition. Assure them of the continued commitment to their care and introduce them to the new leadership

or healthcare providers. Patient trust is a crucial aspect of any successful medical practice, and maintaining open communication helps to ease the transition.

If, however, you want an exit or are looking to wind down instead, consider these points:

1. Review all existing contracts and agreements associated with your medical practice, including property leases, equipment agreements, and service contracts. See when these lapse and what the termination procedure entails.

2. Develop a comprehensive plan for the secure transfer or retention of patient records in compliance with the Protection of Personal Information Act 4 of 2013 (POPIA). Notify patients about the transition, their rights concerning medical records, and the procedures for obtaining copies or transferring records to another healthcare provider. The rules of retention of records will still apply.

3. If your practice employs staff, it is essential to explore reduction as an option to terminate the relationship. It is also vital to maintain transparent communication with staff regarding these changes and to look for ways to assist staff in seeking alternative employment while ensuring they have the required resource support to help with the practical administration of winding down.

4. Where you are seeking to sell your share in the practice or the practice as a going concern, it is essential to engage legal professionals who are well-versed in South African healthcare transactions. Address critical components such as the purchase price, liabilities, patient notifications, non-compete clauses, and indemnification, ensuring legal compliance.

In the case of all the aforementioned objectives, evaluate potential tax consequences, address outstanding debts and liabilities, and consider the optimal financial structure for your retirement.

CONCLUSION:

TRANSITIONING YOUR MEDICAL PRACTICE IN SOUTH AFRICA AS YOU APPROACH RETIREMENT REQUIRES A METICULOUS APPROACH TO LEGAL CONSIDERATIONS.

Seek guidance from tax and financial experts as well as legal professionals to ensure a smooth and legally sound retirement process, prioritising the well-being of your patients, staff, and the legacy of your practice.

Nicolene Schoeman-Louw Managing Director, Attorney, Conveyancer, Notary Public and Mediator SchoemanLawInc
Correspondence: nf.schoeman@schoemanlaw.co.za

Rwanda's gorillas in the mist. Walking in the footsteps of Diane Fossey we went to experience the behaviour and magnificence of our divergent ancestors. In 2014 - after a climb up the mountains of the Rwanda Volcanos National Park - these peaceful primate ancestor allowed us into their family gathering. The 234kg silver-backed male gorilla played with his son and the mothers suitably corrected the behaviour of a mischievous youngster. A bucket list must!

Dr Lennart Eriksson Psychiatrist, Pennington KZN **Correspondence: lennarte@iafrica.com**

THE ELEPHANT IN THE ROOM

Anton Kruger

There are things in life that we all often wonder about, but yet it seems and feels miles away till one day, when all of a sudden, it pops into our mind and becomes real. Some of us have been casually giving it some thought, others have been preparing for it for years and a large number have been in some form of denial about it.

The realisation that "retirement" is creeping up and can't be cognitively "side-stepped" anymore conjures up many different ideas for people. For some, it is a long-awaited reward for a lifetime of work. To others, it is a signal of the end of one's usefulness and relevance in the world. Depending on the point of view taken, retirement can raise feelings of relief and happiness or of anxiety and sadness.

It's complicated!. When moving from work to non-work, everything about your daily schedule changes. You may be more relaxed, and your life may slow down. Loss of work-related stress may be a great relief and good for your health, but losing the daily structure and your work relationships can also be stressful and harmful to your wellbeing.

AFTER SPENDING DECADES OF YOUR LIFE FOCUSED ON YOUR MEDICAL CAREER AND PROFESSIONAL ADVANCEMENT, IT CAN BE VERY CHALLENGING TO CONTEMPLATE RETIREMENT. DECIDING ON EXACTLY WHEN TO RETIRE, AND MAKING A SPECIFIC PLAN FOR RETIREMENT IS DAUNTING. SO MUCH EMPHASIS IS GIVEN TO FINANCIAL PLANNING AND HOW MUCH MONEY YOU WILL NEED TO SUPPORT YOUR LIFE-STYLE AND THERE ARE ALL SORTS OF EXPERT ADVICE ABOUT THAT, WHETHER OR NOT YOU CHOOSE TO TAKE IT. HOWEVER WHAT IS CONCERNING, IS THE LACK OF PSYCHOLOGICAL PLANNING THAT NEEDS TO RUN PARALLEL WITH THESE CREATIVE FINANCIAL PLANNING INITIATIVES.

Retirement is a time that marks the passage from a life of work, to a life of accomplishment, leisure and choice. As most people feel defined by their job and professional achievements, that transition is not always easy. Throughout the stages of retirement planning, one can enhance an awareness of how to "budget" and what to expect and how to navigate this new chapter in your life.

To gain an understanding of this inevitable life process, one must look at the common **stages of retirement** that most people experience at some point in their own journey.

FIRST STAGE: PRE-RETIREMENT

The stage before you actually retire involves imagining and visualising your new life and planning for it. This initial stage can start from five to thirty or more years before actual retirement date. Most people shift their focus from building their careers to focusing on the financial planning aspect of retirement. Many don't do any forward planning for their "psychological portfolio" when reaching retirement.

This stage can be a time of excitement and anticipation but it can also be a time of worry and anxiety, especially in the year or two before retirement.

SECOND STAGE: FULL RETIREMENT

The liberation or "honeymoon" phase of retirement occurs at the official beginning and can last from one to two years after commencement. It features feelings of excitement, relief, and freedom from your day-to-day work responsibilities and professional demands. People in this stage are usually busy reconnecting with family,friends,and spouses, and spending time on hobbies, travelling and other leisure activities. There are however some that are realising that their life has been "one-dimensional" and the glaring gaps in their living day is becoming more obvious.

THIRD STAGE: DISCONTENTMENT

Once the emotional "euphoria" of retiring has worn off, and the honeymoon phase is over, many people feel a sense of disappointment and disillusionment. They have spent so much time anticipating and

looking forward to the "bliss" of retirement, that once it sets in, it can feel less exciting than it was hyped up to be. Feelings of boredom, loneliness, being useless and a depressed mood can surface.

FOURTH STAGE: REORIENTATION

This stage is often viewed as the most challenging phase which usually occurs after the retiree has rapidly gone through their retirement "to-do-list "and a feeling of loss of purpose is starting to appear with a need to evaluate their retirement experience and path. Reorientation demands creating a new identity, and it can take some time and conscious effort to accomplish.

ONCE THIS RE-CALIBRATION PROCESS CAN HAPPEN THE PERSON CAN GAIN A SENSE OF CLOSURE FROM THEIR WORKING DAYS AND MOVE ON TO ENJOY RETIREMENT AS IT IS MEANT TO BE ENJOYED.

FIFTH STAGE: RECONCILIATION AND STABILITY

This final stage may start up to ten years after the official start of retirement. The retired individual in this stage is content and hopeful in their transition. They are settling into a fun and rewarding retirement lifestyle, simplifying their lives and feeling content. Health conditions may be more prevalent during this stage, so retirees' focus will shift more on maintaining their health and independence, sometimes by moving to retirement communities where they can age in a place with access to healthcare, amenities, activities, and friends nearby.

For some, the process and stages of retirement don't lead to a final phase of contentment and stability and they will experience a life of perpetual financial, social and psychological challenges and failures.

These **psychological challenges** can be sudden, unexpected and significant.

UNCERTAINTY

One of the most disconcerting aspects about retirement is the sheer amount of uncertainty experienced ,compared to the predictable life when at one's peak of your profession. On a micro level, a difficulty in knowing what to do on a given day becomes a reality. On a broader level, uncertainties about the future, one's identity, the meaning of life, your purpose, the success of new ventures to name a few, coupled with an overall lack of clarity, is hugely psychologically challenging.

IDENTITY

The loss of identity can easily be viewed as one of the most difficult psychological challenges experienced when transitioning into retirement. How do you explain who you are without explaining what you do? Who are you when you are no longer a clinician? After being someone who had been in a clearly defined role in society and adding a considerable amount of value to people's life's, retirement can "rob" you of that certain profile and status in societal terms." I am a doctor, but I don't practice anymore" None of this describes one's identity now, since it refers to what you did in the past. It's likely much more complex and harder to articulate what your identity is in the present.

MEANING

THROUGHOUT YOUR LIFE, YOU WERE PREOCCUPIED WITH, INITIALLY YOUR EDUCATION, TRAINING AND THEN CAREER, RAISING CHILDREN OR BEING INVOLVED IN OTHER WORTHWHILE PROJECTS, VENTURES AND ACTIVITIES. IT BROUGHT A SENSE OF PURPOSE WHICH PROVIDED MEANING TO ONE'S LIFE.

In retirement, many of these things are now finished and accomplished, contributing to one feeling a void in life. A fear of this next step and an inability to see what comes next may keep some people in their careers much longer with a degree of denial of the reality that, eventually everyone must retire. A lack of acceptance of this inevitable life "fact" leads to inefficient planning and preparation causing a more stressful and unhappy retirement experience.

IRRELEVANCE

One of the most rewarding features of being a successful professional with decades of experience is the feeling of being relevant. People in society view and value one's expertise, opinions, leadership, decisions and interventions that made huge differences in their lives. Immediately after retirement, these inputs and engagements may still be highly sought after, but either swiftly or gradually the feeling of relevance diminishes.

LOSS OF WORK ROUTINES, SOCIALISING AND SOCIAL CONNECTIONS

For decades the daily work routine, structure and interacting with colleagues became the norm and default setting which then one day abruptly ends.

THIS IS A DIFFICULT REALITY TO GET USED TO FOR MANY RETIREES, FOR SOME HOWEVER IT IS A BLESSING IN DISGUISE AS IT LEGITIMISES TERMINATING CERTAIN SOCIAL CONNECTIONS THAT WERE BURDENSOME.

CHANGES IN RELATIONSHIPS AT HOME

Retirement can be similar to getting married and having children again in the sense that it can cause

a significant shift in relationship dynamics at home. For years both partners have been occupied on a variety of levels and being used to their own space and time. Spending all their time together at home on a daily basis can be a big adjustment.

HEIGHTENED SENSE OF MORTALITY

So many things get taken for granted as we navigate our way through life, one of them is an awareness of our own mortality. The cold and harsh reality of significant "others" in our life passing away, forces the retiree to confront their own mortality.

FOR SOME INDIVIDUALS THAT HAVE BEEN VERY SUCCESSFUL AND LEAD IMPRESSIVE PROFESSIONAL CAREERS THESE AFOREMENTIONED PSYCHOLOGICAL CHALLENGES CAN ADVERSELY IMPACT ON THEIR MOOD (DEPRESSED MOOD, ANXIETY, PANIC, DOUBT, GUILT AND ENVY TO NAME A FEW), COGNITIVELY (BLEAK VIEWS OF THEMSELVES, OTHERS AND THE FUTURE WITH CATASTROPHIC ELEMENTS IN THEIR THINKING STYLES) AND UNHEALTHY BEHAVIOURAL HABITS (AVOIDANCE, ISOLATING, ADDICTIVE BEHAVIOURS ETC).

These manifestations can be experienced as atypical for the individual and cause marked levels of distress.

Retirement is a reality that all of us must face and is proving to be more challenging and requiring adjustments on a variety of personal levels, but all is not lost, and a renewed level of resilience and curiosity can be achieved.

REMEDIES

The range of techniques, strategies and other interventions that are proposed as preventative, protective and enhancing seem endless on a variety of platforms and academic publications, all designed to make this transition as constructive as possible.

A few "remedies" however, can be considered to develop and refine the process of resilience and empowerment, contributing to one's unique psychological portfolio.

PHYSICAL

Physical activity and exercise, balanced diet, weight control, regular health checks, moderation in alcohol intake, non- smoking, good sleep habits etc.

SOCIAL

Rekindle and maintain friendships, be creative in planning regular social events and forming new social memories, joining groups with shared interests etc.

SPIRITUAL

Exploring new spiritual interests, places and activities, refresh neglected religious practices etc.

SPORT/HOBBIES

Starting or expanding new participations in sport or hobby- like activities and venues.

PLANNING

Deliberate daily planning, with weekly, monthly, quarterly and annual setting of leisure goals.

TRAVELLING

Regular short breaks and planned longer vacations.

COGNITIVE/MENTAL

TO UTILISE ALL THE AVAILABLE APPS AND OTHER MEDIUMS TO GET INVOLVED WITH DAILY MENTAL EXERCISES E.G. WORDLE. TO START LEARNING A NEW MUSICAL INSTRUMENT AS IT WILL STIMULATE FURTHER COGNITIVE BENEFITS AND SKILLS.

COMMUNITY

To get involved in community initiatives and non-profit organisations.

PSYCHOLOGICAL

To equip oneself with knowledge regarding psychological preventative concepts such as acceptance and commitment, mindfulness, cognitive behavioural therapeutic principles whether it's through self-study or engaging more formally by seeing a mental health practitioner.

So now that we have faced the elephant in the room…there is hope!

SUGGESTED READING:

Dychtwald, K. & Morison, R. (2020). What retirees want: A holistic view of life's third age. John Wiley & Sons.

Haley, J. (2023). "Psychology Works" Fact Sheet: Retirement. Canadian Psychological Association.

Rosenthal, D. & Moore, S. (2018). The Psychology of Retirement. Routledge.

Anton Kruger Clinical psychologist, Bellville/Somerset-West
Correspondence: drantonkruger@gmail.com

WEALTH MINDSHIFT: WHAT ENTREPRENEURS IN PSYCHIATRY NEED TO KNOW ABOUT PRESERVING THEIR WEALTH FOR RETIREMENT

Nic Horn

CITADEL DIRECTOR AND REGIONAL HEAD FOR KWAZULU-NATAL, NIC HORN SHARES ADVICE WITH ENTREPRENEURS IN PSYCHIATRY ON HOW TO MAKE THE MINDSHIFT FROM GENERATING WEALTH TO ALSO PRESERVING IT FOR THEMSELVES AND THEIR FAMILIES.

Entrepreneurs typically devote decades to building up their businesses and company's balance sheets but rarely put the same care and attention into managing and preserving their wealth. Citadel Director and Regional Head for KwaZulu-Natal, Nic Horn has four tips to share with entrepreneurs in psychiatry who want to get to a place where they can provide for themselves and their families even if their practice has closed.

TIP 1: DON'T TIE ALL YOUR WEALTH UP IN YOUR BUSINESS

Not putting all your eggs in one basket is easier said than done for most entrepreneurs, who work tirelessly for decades to create stable and successful businesses. "Many entrepreneurs are motivated to build solid and resilient businesses that can provide the passport to financial freedom, which will allow them to live their hopes, dreams, and aspirations. It is an investment of personal time and effort that can pay off handsomely. If an entrepreneur's wealth is fully tied to one business or industry, it can however put them at significant risk when the unthinkable or the unexpected happens.

WE ALL REMEMBER WHAT HAPPENED TO MANY BUSINESSES DURING THE COVID-19 PANDEMIC. IT'S ABOUT CONCENTRATION OF RISK."

"What you want to do is to take some of that risk off the table over time. This is counterintuitive for entrepreneurs, because they may reason that they would rather keep the money in their business which builds their wealth – this is however riskier. To minimise risk, it's better to transfer some funds to a different pool where it can be diversified and preserved," says Horn.

Nic Horn

Horn recommends that entrepreneurs or business owners with psychiatry practices get into the habit of extracting some money from their businesses consistently over time and diversify it across different investment classes and jurisdictions for long-term financial security and with the guidance of an experienced and trusted wealth manager.

"THEN NO SINGLE EVENT CAN DESTROY YOUR WEALTH. WE WITNESSED FIRST-HAND HOW THIS HAPPENED JUST A FEW YEARS AGO."

TIP 2: BUILD PERSONAL FINANCIAL FREEDOM

For entrepreneurs who have worked hard for their success in psychiatry, perhaps without much help over the years, it can be difficult to relinquish full

control of their personal finances. "It's a big moment in an entrepreneur's life when they realise that a qualified expert can make unemotional decisions that will enable them to gain financial freedom away from the business. It's almost like appointing a personal Financial Director."

"What an independent expert can do firstly, is to take the emotion out of any investment decision because emotion is the most dangerous element in the investment decision-making process. They can then help entrepreneurs in the industry to build a separate wealth pool which is accessible and liquid. Liquidity is something that entrepreneurs may not always have."

"ALL THEIR WEALTH IS OFTEN TIED UP IN THEIR BUSINESS. LIQUIDITY ULTIMATELY MEANS HAVING SOME MONEY TUCKED AWAY THAT YOU CAN ACCESS IMMEDIATELY IN TIMES OF CRISIS OR AS YOUR CIRCUMSTANCES CHANGE – AT NO COST. BUSINESS ASSETS ARE HIGHLY ILLIQUID AND SUBJECT TO RISK – AND THEREFORE CAN'T ALWAYS BE USED AS A CATCH NET IN A CRISIS OR AS A PENSION IN OLD AGE. DO NOT ASSUME THAT YOUR BUSINESS CAN BE YOUR PENSION."

"Similar to how you'll seek the advice of the best psychiatrist to assist with your mental health, it's advisable to do the same with your money and seek the advice of a professional, reputable wealth manger to work with you and place your money in a safe place where the power of compound interest can do its magic at an acceptable level of risk."

TIP 3: DIVERSIFICATION, DIVERSIFICATION, DIVERSIFICATION

If you are a South African business, along with your other assets like houses and cars, it means you are almost exclusively exposed to South Africa. It therefore makes sense to diversify your wealth into other countries and currencies. Citadel's current Houseview indicates an optimal offshore exposure of over 50% of one's financial assets, says Horn. "South Africa is less than 1% of the world in global economic terms so it makes no sense to allocate 100% of your wealth here. Offshore markets give you exposure to asset classes and companies you cannot access here as well as other currencies."

TIP 4: CREATE FINANCIAL SAFETY FOR YOUR DEPENDENTS

"Many entrepreneurs in psychiatry have successful businesses, but their children and other dependents don't have financial security because there is no resilient structure around their wealth. It's as basic as ensuring your will is in place. Have you done estate planning? You can destroy what you've built and impact the lives of your family and employees if you don't have the right financial structures and processes around them in place, to protect what you've built. If you have a trust, the trust administration must be above reproach – for example, it's important to hold meetings with accurate minutes. Decisions must be made by the trustees, so the trust is not seen as your alter-ego. Your family must know where to access everything and what to do when the time comes, with the assistance of trusted advisors. This is very important for everyone's financial safety."

HORN SAYS IT IS IMPORTANT FOR ENTREPRENEURS IN THE INDUSTRY TO REALISE THAT PROPER FIDUCIARY STRUCTURING CAN HELP THEM AS WELL, AS IT CAN ENABLE THEM TO ENJOY THEIR OWN LIFE AND RETIREMENT, FREE FROM FINANCIAL STRESS.

"If you keep working into your old age you should do so because you want to, not because you have to. Plan to put enough away or be brave enough to let go of your business so that – even if everything goes away tomorrow – you can continue living a quality life into your later years and everything you've worked for is kept safe for yourself and your family."

Nic Horn Citadel Director and Regional Head for KwaZulu-Natal

MORE ABOUT CITADEL

Far more than specialist wealth managers, we're here to secure and grow your wealth, so that you have the freedom to choose the size of your dreams and the content of your next chapters.

Wherever you are on your wealth journey, we have the people and solutions in place to take you beyond remarkable:

- Investment advice
- Family office
- Asset management
- Fiduciary services
- Foreign exchange and treasury
- Offshore structuring
- Philanthropy
- Investment administration
- Private client securities

Discover more at citadel.co.za, or email Citadel Partner, Rebecca Harvie, at rebeccah@citadel.co.za

PSYCHIATRISTS AND RETIREMENT

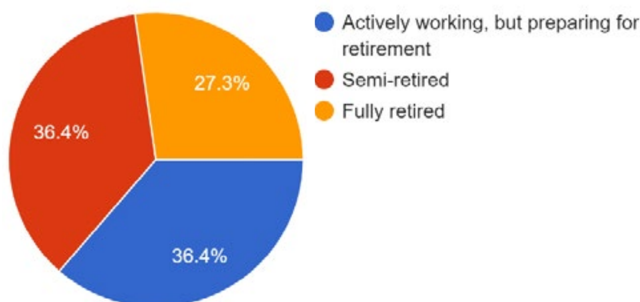
Renata Schoeman

Retirement marks a significant transition in the life of any professional, including psychiatrists whose careers have been dedicated to understanding and improving mental health. As psychiatrists, we are intimately acquainted with the intricacies of human behaviour, yet when it comes to our own retirement, we often find ourselves traversing unfamiliar terrain. In this survey, we have delved into the experiences of 11 of our colleagues as they contemplate, navigate, and/or embrace retirement. Our aim is not only to shed light on the individual experiences of psychiatrists, but also to offer insights that may inform psychiatrists who will also embark on their own retirement journeys in the future.

Eleven psychiatrists partook in the survey which was shared on the various SASOP/PsychMg WhatsApp groups. Six male (54.5%) and 5 female (45.5%) colleagues completed the survey. The mean age of respondents was 69 years (2.4 years), with the mean number of years of professional experience being 32 years (5.3 years). Only psychiatrists from Gauteng (63.3% of the sample) and the Western Cape (36.4% of the sample) participated in the survey.

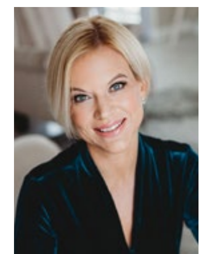
NOT ALL RESPONDENTS WERE ALREADY FULLY RETIRED (SEE FIGURE 1), WITH MOST PSYCHIATRISTS PARTICIPATING HAILING FROM SOLO PRIVATE PRACTICES (SEE FIGURE 2).

Figure 1: Current phase of retirement



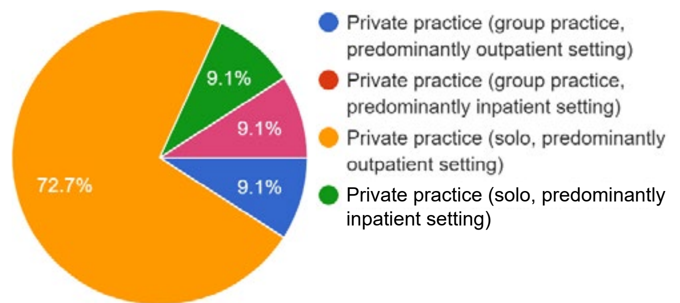
The mean age at retirement or planned retirement was 71.8 years (4.6 years), ranging from 64 to 80 years. Four participants were already fully retired, with the others planning to follow suit in an average of 4.5 years (2.9 years).

The main drivers for retirement were the desire for more personal time and age (see Figure 3). Other reasons included the desire to work on other things.



Renata Schoeman

Figure 2: Practice setting



Most respondents emphasised the importance of financial planning and lifestyle planning when considering retirement (see Figure 4). One respondent was still considering future psychiatric work.

Seven of the respondents found sound financial advice of utmost importance and indicated the value of discussions with colleagues, family, and friends. If health issues played a role in retirement, medical advice was also considered helpful. One participant also highlighted the value of online resources, books, and certification in a related field of work.

Five (45.5%) of the respondents found the loss of professional identity the most challenging after retiring. Other significant challenges were financial issues for three (27.3%) and difficulty finding meaningful activities (3; 27.7%). One participant indicated health issues.

But how do colleagues spend their time after retiring? The majority enjoyed spending time with family and friends, while a significant portion still engage in working part-time. One indicated writing. See Figure 5.

Engaging in the above activities was contributing to making retirement fulfilling – with an emphasis on the luxury of time – for relationships, hobbies, travelling and exercise. Two of the colleagues specifically mentioned the meaning they find in activities such as sharing experience and wisdom, engaging in leadership and management roles, and investing in spirituality.

Some words of wisdom from the participants (in addition to advanced financial and lifestyle planning):

- "Don't stop working if you still can."
- "Continue part time or volunteer work in your field of specialty."
- "Keep busy"
- "Retire when you're no longer finding your work fulfilling."
- "Learn to reflect regularly on where you are at in your life (physically, mentally and spiritually) and what remains on your bucket list…"
- "Know that you are not defined by your current occupation."

Colleagues also mentioned that they wished, before retiring, that they should have considered going into private practice earlier, that they would have become involved in activities besides medicine, that retirement can be traumatic, but also that it can be rewarding to live life at a slower pace. It is important to bear in mind that health challenges might occur, and that the loss of a life partner can change the retirement you have envisioned.

Some final words? Have an open mind: "Enjoy learning about a new world.",

INVEST IN RELATIONSHIPS: "MAINTAINING RELATIONSHIPS IS KEY TO A SATISFYING RETIREMENT."

Know yourself: "Retirement (as a choice) is probably not for everyone. That said, always think of retirement as a novel way of being and meaningfully living the winter of your life!"

Renata Schoeman Psychiatrist, Bellville **Correspondence: renata@renataschoeman.co.za**

Figure 3: Drivers for retirement

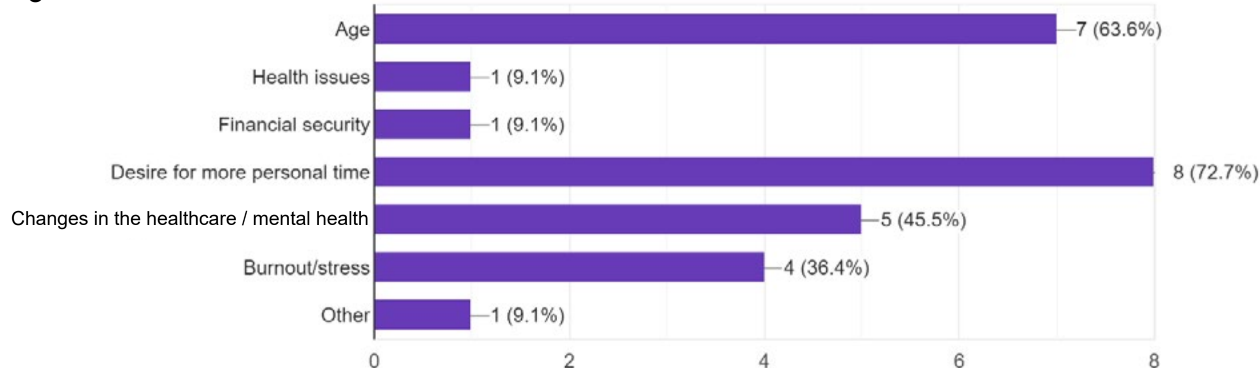


Figure 4: Aspect to consider in preparation for retirement

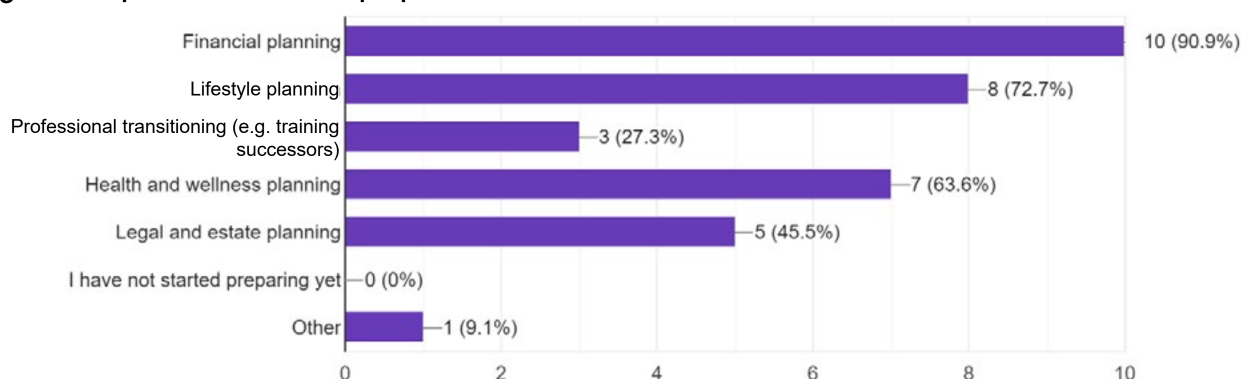
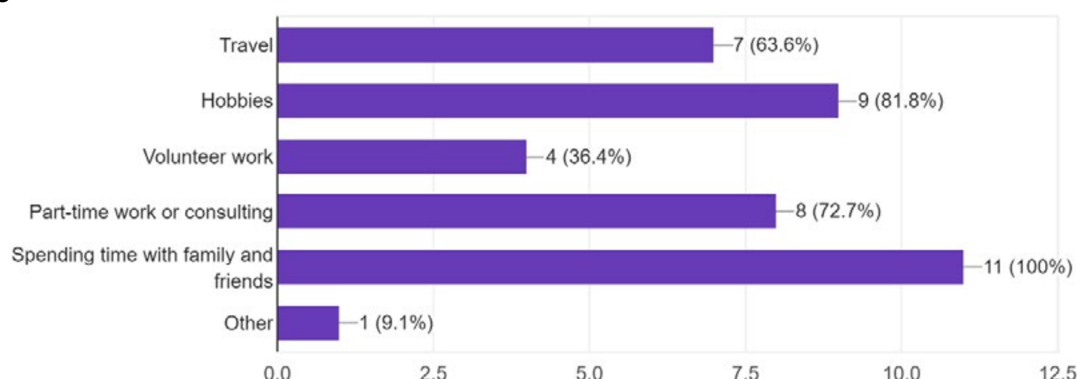


Figure 5: Post-retirement activities



TECHNOLOGY IN PSYCHIATRY

Renata Schoeman

In the May 2021 issue of *South African Psychiatry*, a Feature article entitled "The big move: from paper to digital" was published. It was based on interviews with colleagues who shared their experience and expertise (Drs Marcelle Stastny, Chris van den Berg, Pierre Malherbe, Jow'hara Chundra, Melane van Zyl, Shaun Janki and Eugene Allers) and it was argued for the inevitable (or not) move to digital practices (Schoeman; pg. 6-17). In another article from the same issue the following benefits were emphasised: convenience, simplicity and timesaving, security, accessibility (Szabo; pg. 18-19).

According to the **Technology adoption curve**, we can divide people as follows:

Innovators (2.5%) – Innovators are the first individuals to adopt an innovation (or change). Innovators are willing to take risks, often are the youngest in age, tend to be more social and have closest contact to scientific sources. They are risk tolerant, as they are often less invested in the history of the organization, or the status quo.

Early Adopters (13.5%) – This is the second fastest category of individuals who adopt an innovation. These individuals have the highest degree of opinion leadership among the other adopter categories. Early adopters are typically younger in age, have a higher social status, more advanced education, and are more socially forward than late adopters. They are more discrete in adoption choices than innovators. They realise that the judicious choice of adoption will help them maintain a central communication position.

Early Majority (34%) – Individuals in this category adopt an innovation or change after a varying degree of time. Early Majority tend to be slower in the adoption process, have above average social status, contact with early adopters, and seldom hold positions of opinion leadership in a system. They are often comfortable in the status quo, but still willing to improve.

Renata Schoeman

Late Majority (34%) – Individuals in this category will adopt the change after most of the organization. Their resistance may be seated in uncertainty, or in deep-rooted habits and "the way of doing" (history in the organization). They often are not in opinion leader positions – or often feel they do not have a voice – and can only passively resist.

Laggards (16%) – Individuals in this category are the last to adopt an innovation. Unlike some of the previous categories, individuals in this category show little to no opinion leadership. These individuals typically have an aversion to change-agents and tend to be advanced in age. Laggards typically tend to be focused on "traditions", likely to have lowest social status, lowest financial fluidity, be oldest of all other adopters, in contact with only family and close friends, very little to no opinion leadership. They will most likely actively resist change.

THE COLLEAGUES PARTICIPATING IN THE INITIAL INTERVIEWS, DO NOT NECESSARILY CONFORM TO THE CLASSICAL CHARACTERISTICS OF "EARLY ADOPTERS" (ESPECIALLY IN TERMS OF AGE – NO INTENTION TO OFFEND!). IT IS NOW THREE YEARS LATER, AND THE TOPIC OF "GOING DIGITAL" HAS RECEIVED PLENTY OF AIRTIME AT CONGRESSES, ON WHATSAPP PLATFORMS AND IN "CORRIDOR AND COFFEE" DISCUSSIONS. BUT WHERE ARE WE AS A PROFESSION IN SOUTH AFRICA?

A SURVEY

A follow up survey was conducted in February 2024 to obtain an overview of the lay of the land, but also to (hopefully) assist you in your decision to go paperless – or not. Thank you to everyone who participated!

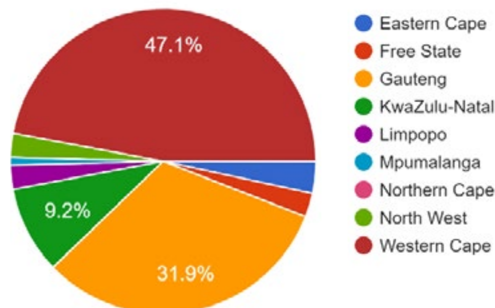
DEMOGRAPHICS

One hundred and nineteen psychiatrists completed the survey. Although the exact number of psychiatrists in South Africa remains an elusive number, we can deduce that roughly 20% of psychiatrists participated in the survey – which is deemed a good response rate for electronic surveys (especially since no incentive for participation was offered!).

The mean age of participants was 50 years (sd 8.4 years), with the youngest participant being 33 years, and the eldest 79 years (Figure 1). This diversity suggest that the discussion of technology adoption is relevant across different age groups.

Participants in the survey ranged from those who are newly qualified, to those with more than 30 years of experience (Figure 2). This may have contributed to differences observed in technology adoption and related attitudes amongst psychiatrists.

The majority of participants were from the Western Cape (47.1%), followed by Gauteng (31.9%). [Figure 3]



Most of the participants were working in the private sector (n=110; 92,4%), and practicing as solo practitioners (n=103; 86.6%). [Figure 4]

Figure 1: Age distribution of participants

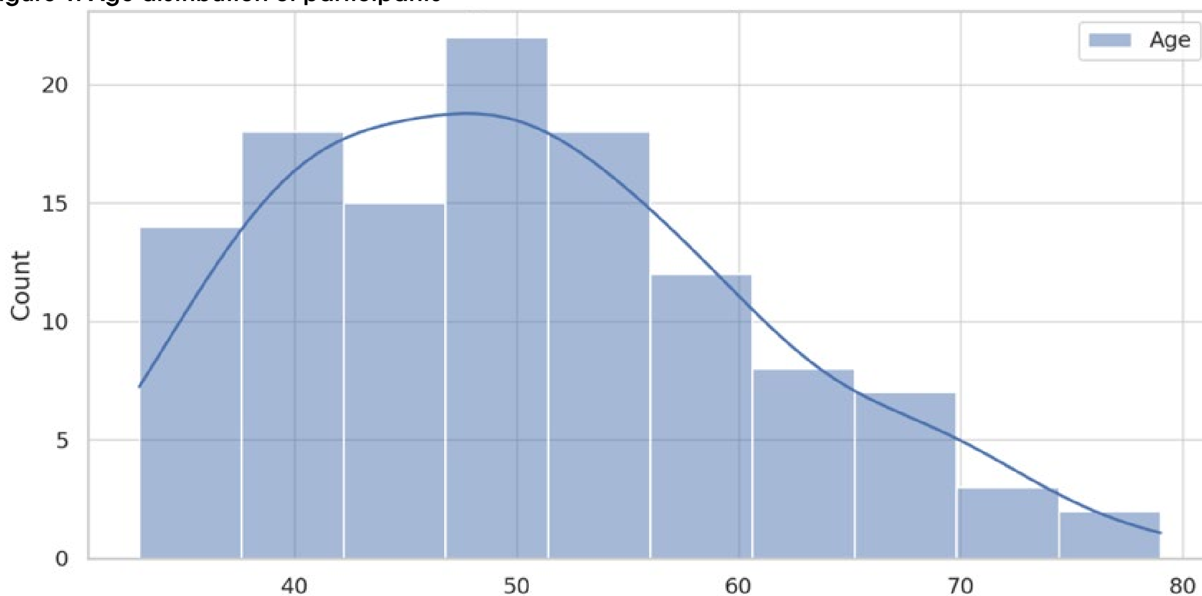


Figure 3: Provincial representation of participants

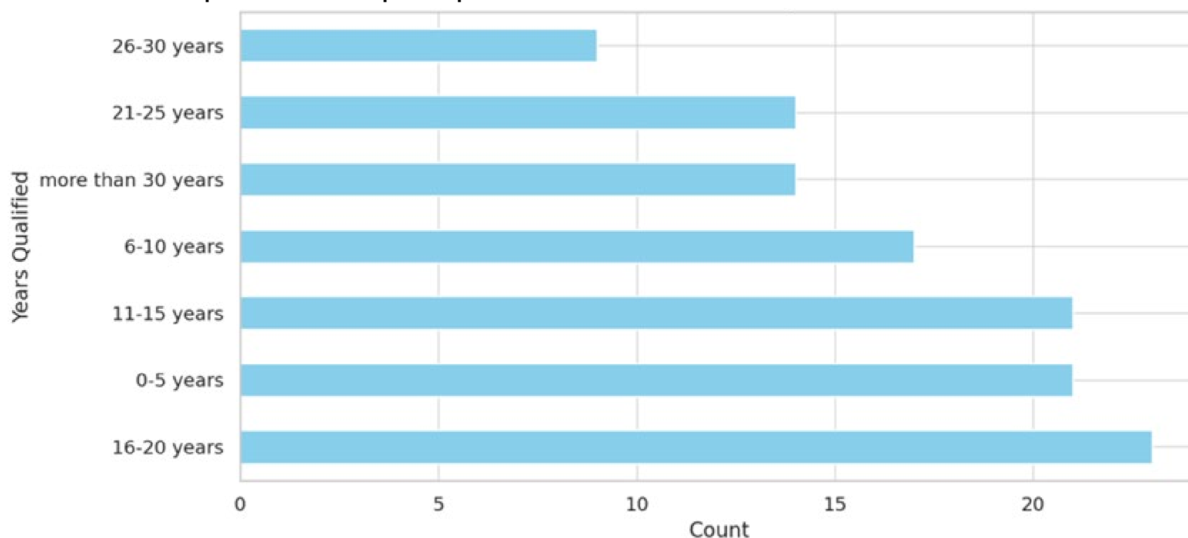
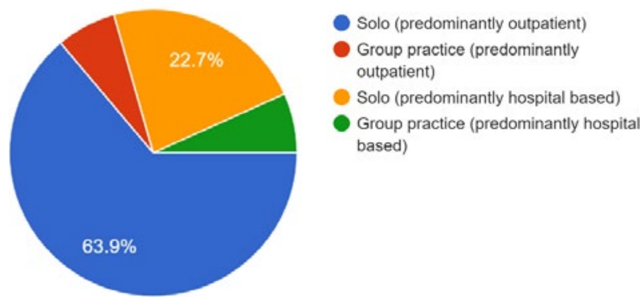


Figure 4: Tpe of practice



TECHNOLOGY ADOPTION

A minority of participants (n=56; 47%) were currently making use of electronic records. Of those not making use of electronic records, the majority (n=28; 41%) were seriously considering transitioning, while 21 (31%) were contemplating transitioning, and 19 (28%) were not considering transitioning to electronic records.

Only 38 (32%) of participants were currently making use of digital scripting. Of those not making use of digital scripting, the majority were seriously considering it (n=40; 49%), with 26 (32%) contemplating transitioning, and only 15 (18%) of participants not considering making use of digital scripting.

PREFERRED HARDWARE AND SOFTWARE

Although some participants (10%) were confused between "hardware" and "software", most participants (71%) who transitioned to digital were making use of Apple products (iPads and Macbooks), while the remainder (19%) made use of a combination of Dell, Samsung, HP, and other android devices with Microsoft operating systems. This preference underscores the value placed on mobility/portability, user-friendliness, and the versatility of iPads in clinical settings. The Apple environment was also considered a more secure environment, with ease of secure backups. However, the (successful) use of other devices and laptops underscored the individual preferences and needs of practices.

THE WIDE RANGE OF SOFTWARE USED REFLECTS THE DIVERSE REQUIREMENTS OF PSYCHIATRIC PRACTICES AND THE ABSENCE OF A ONE-SIZE-FITS-ALL SOLUTION IN THE MARKET.

Most participants opted for software that is not exclusively designed for medical or psychiatric use – which facilitated adapting the general-tools to fit their clinical workflow and personal preferences and needs. However, of the software used, Goodnotes (n=16; 29%) was in the lead, closely followed by OutcomesIT (n=15; 27%). One user expressed a specific preference for OutcomesIT as "The best on the market. You can write effortlessly on an iPad. After working for years on various electronic platforms which were inadequate, I switched to a psychiatric specific system with all the necessary South African forms, can coordinate care and measure outcomes and is value-based care enabled". However, for another, OutcomesIT's drawback was "if I can't access it via the cloud and on my cell phone and iPad and if it does not allow handwritten notes to easily upload it does not work for me, I need an app based handwritten note taking software". Other software used included Notability, One Note, and platforms/packages such as Healthbridge and Practice Perfect. Various participants noted their preference to use software of which they are the owner of (e.g. a once off fee to Goodnotes, or a monthly subscription fee to Microsoft), as it is more financially sustainable.

Of the participants making use of digital scripting, the majority (n=16; 42%) made use of Prescribit (EMGuidance) platform, followed by OutcomesIT (n=12; 32%), and GoodX (n=6; 16%). Benefits of electronic scripting mentioned include timesaving, cost-saving, responsiveness, less dispensing mistakes, prevention of fraud, pre-programming abilities of schedule 6 scripts (Prescribit), access to drug formularies and interaction alerts, and ability to see what other psychiatrists have scripted previously (OutcomesIT).

IT IS IMPORTANT FOR PRACTITIONERS TO REMEMBER TO GET WRITTEN CONSENT FROM PATIENTS TO SHARE INFORMATION WITH OTHER PSYCHIATRISTS/ CLINICIANS TO BE POPIA COMPLIANT.

THE BENEFITS OF MAKING USE OF ELECTRONIC RECORDS

The responses highlighted that the primary benefits of electronic records were centred around improving efficiency, accessibility, and managing space effectively.

- Space saving: Electronic records reduce the need for physical storage space.
- Ease of access: Electronic records can be easily accessed from anywhere, provided you have a device and internet connection available.
- Convenience: Storing records electronically simplifies data management and can enhance the organization (and sharing) of information.
- Ease of use: Electronic systems are generally user friendly, can be customised, and simplify processes that would be more complex if done manually.

CHALLENGES IN ADOPTING TECHNOLOGY

While electronic records offer significant benefits, they also pose challenges related to technology dependence, cost, user adaptability, and security concerns (amongst others). Respondents noted the following drawbacks and challenges:

- *Technology dependence:* If the system goes down, access to records is completely halted, highlighting a reliance on consistent technological functionality. This includes concerns about software crashes, hardware malfunctions, loadshedding, and internet connectivity issues.
- *Cost:* The expense associated with acquiring necessary technology like decent tablets, appropriate software, and the implementation of the most suitable systems and configurations for specific needs can be challenging and time-consuming. Concerns about sunk costs – should you invest in a solution that causes frustration rather than joy – were also raised.
- *User adaptability:* Transitioning to digital tools requires time and effort to learn new systems. Some psychiatrists pointed out the challenge of becoming familiar with electronic systems, especially for those more accustomed to, and preferring, paper-based records.
- *Security concerns:* There were concerns about the security and privacy of sensitive information stored electronically and the sharing of information without explicit patient consent.

NOT ALL SOFTWARE PASSED THE STRINGENT FAST HEALTHCARE INTEROPERABILITY RESOURCES CRITERIA.

- *Patient acceptance and understanding:* A challenge specifically mentioned was the difficulty in getting patients to understand and accept electronic records and scripts. This includes concerns about patients' ability to access electronic scripts and their preference for traditional paper-based methods, as well as pharmacies' buy-in.

SUGGESTIONS FOR SUCCESSFUL IMPLEMENTATION

Many noteworthy recommendations were made by respondents emphasizing the importance of personalization and flexibility in the adoption of technology in psychiatric practice but also suggested areas where further standardization or guidance could benefit practitioners, especially those transitioning to digital systems.

- Careful selection of tools. Psychiatrists advised on the importance of carefully selecting hardware and software based on personal and practice needs. This involves considering factors such as ease of use, reliability, and the specific features that are most relevant to psychiatric practice.
- Embrace change with caution. Some advice centred around the notion of not following trends blindly. Psychiatrists emphasised the importance of evaluating whether digital transitioning will genuinely add value to their practice and benefit their patients before making any changes.
- Seek peer recommendations. Leveraging the diverse experiences and recommendations of peers who have already adopted technology in their practices was suggested as a valuable way to find reliable solutions and avoid common pitfalls.
- Patient communication and education. To address patient acceptance issues, some psychiatrists recommended investing time in communicating with patients about the benefits of electronic systems and educating them on how to interact with these processes. Managing expectations is also important (e.g. boundaries regarding requests and communications).

CONCLUSION

While there is a clear trend towards digitalization in psychiatric practice, there is also a need for guidance and information on the best practices and tools to facilitate the transition. The diversity in software use and the consideration for transitioning to electronic systems underscores the potential for more standardised recommendations and training to optimise technology use in psychiatric care. However, a balanced view and consideration for individual preferences and needs are crucial.

ALTHOUGH THERE IS ENTHUSIASM FOR THE BENEFITS THAT TECHNOLOGY CAN BRING TO PSYCHIATRIC PRACTICES, ESPECIALLY AMONGST INNOVATORS AND EARLY ADOPTERS, RESPONDENTS CAUTIONED AGAINST UNDERESTIMATING THE CHALLENGES INVOLVED. A THOUGHTFUL APPROACH, INCLUDING CAREFUL HARDWARE AND SOFTWARE SELECTION, ADEQUATE PREPARATION FOR CHANGE, AND OPEN COMMUNICATION WITH PATIENTS IS ADVISED.

The results of the survey highlight the complex nature of integrating technology in healthcare, and the need for both innovation and caution in navigating these changes. To reiterate the aforementioned 2021 article, most of us understand the need to transition, yet will continue to face some barriers – perhaps financial, perhaps time… but hopefully, three years later, with less uncertainty. Creating a paper-free office is an ongoing and incremental process, one which should be adapted and continually improved over time. If you plan to become part of the Early Majority…you should start now. However, it is ok if this is not for you.

Renata Schoeman (www.renataschoeman.co.za) has been in full-time private practice as a general psychiatrist (child, adolescent, and adult psychiatry) since 2008, currently based in Oude Westhof (Bellville). Renata also holds appointments as Associate Professor in Leadership (Stellenbosch Business School), and as head of the Healthcare Leadership MBA specialization stream.
Correspondence: renata@renataschoeman.co.za

WHEN I GROW UP...

Christopher Paul Szabo

On the 25th of April 2024 I closed my limited clinical practice at the Wits Donald Gordon Medical Centre "indefinitely". It was the end of what I might say was a 5 year transitional period from when I resigned from Gauteng Health and stepped down as the Academic Head of the Department of Psychiatry at the University of the Witwatersrand.

A friend encouraged me, in fact told me that I had an obligation to reflect on my "career". I considered what he said, and agreed - it could be a worthwhile exercise. But, how to capture decades in a few hundred or just over a thousand words? Well, you can't but what follows is a stream of consciousness type piece. Make of it what you will but be careful - it could evoke feelings.

And so, *"...the time has come" the Walrus said..."* a line from *Through The Looking Glass, And What Alice Found There* (which follows *Alice's Adventures In Wonderland*), My first consultant when I commenced training was an interesting man, idiosyncratic. A man of epic ward rounds, where he and I would review every single patient, directly and exhaustively interviewing each one. This would last hours, but what an introduction to psychiatry. He had once been to Hungary (to which I owe my surname, amongst other things) and enjoyed it - we bonded. He recommended *Alice* as essential reading - packed with psychopathology and of course the entertainment that the absurdist genius of Lewis Carroll provided. He taught me a lot, and it was during that time I became acquainted with a name – in patient files - my predecessor in the ward.

I was allocated to (the female lock- up ward), at Sterkfontein. In time he and I became colleagues, and then friends. At that time, 1989, he had just defected to the South, Cape Town, to continue his training at that 'other' university - the University of Cape Town. It served him well, and in time he became one of the country's foremost forensic psychiatrists as did another consultant I encountered at Sterkfontein. But it was the late Mike Ewart Smith, the then 'Principal Psychiatrist' at Sterkfontein, who was to have a most powerful impact as did the *capo di capi* - George Hart. To a younger audience these names may not mean much, or anything at all. The lived experience is the most powerful.

Christopher Paul Szabo

MY JOURNEY INTO PSYCHIATRY BEGAN IN 1989, WHEREBY FOLLOWING A 5-MINUTE INTERVIEW WITH GEORGE HART AT THE END OF 1988, AS HEAD OF DEPARTMENT, AND WITH THE NECESSARY PAPERWORK COMPLETING THE PROCESS I WAS APPOINTED AS A REGISTRAR.

Those were different times, times of privilege - to be doing something so pleasing that each morning I would wake up thinking "...and I get paid to do this!". The drive to Sterkfontein was in those days, a drive in the country. Conducive to reflection, introspection…and speeding, with fines and court appearances more than once - to contest a fact, well...to plead mitigation of a fact, but knowing that if the issuing officer didn't show up, I could request the case be thrown out. I can't recall paying a fine, but I do recall securing an unheard-of petrol allowance through lobbying the then Minister of Health - Rina Venter.

Those were indeed different times. Prior to commencing training, I had recently returned from an extended, solo trip around the world having completed 2 years of compulsory national service after concluding my 'house job' as a 'house man' at Bara...a wonderful year. Now of course we speak of 'interns' and Bara evolved into Chris Hani Baragwanath Academic Hospital.

On my sojourn abroad I spent a few weeks doing a Psychiatry locum at St Albans, in England. I needed the money, and it was available. But my interest in Psychiatry stemmed from my Bara days as a 'houseman', and the medical intake ward - Ward 20 - where I began to encounter psychiatric patients, in those days referred to as "MCs" (mental cases – in case you are wondering) ...and usually in pyjamas with a sticker on their back, once admitted to a ward, indicating which one they needed to be returned to (there was no dedicated psychiatric ward in those days).

HERE I ENCOUNTERED THE 'SNAKE MAN' WHO THOUGHT HE WAS ONE – A SNAKE - AND SPENT HIS TIME STEALING ALL THE WARD KEYS. THERE WERE OTHERS. AND YET MY MIND WAS NOT ON SPECIALIZING AT THAT TIME, NOTWITHSTANDING I HAD EXPERIENCED THE WONDERFUL TEACHING OF GEORGE HART AT TARA*, AS A MEDICAL STUDENT.

So, why Psychiatry? Ultimately, it seemed the only fit for me. The only discipline that offered the possibility of creative satisfaction. It was a time when the hegemonic and algorithmic American Psychiatric Association's (APA) Diagnostic and Statistical Manual for Mental Disorders (DSM) driven approach to psychiatry was not fully anticipated. It was the time of DSM III, with DSM IV on the horizon. In fact, I don't recall having a "DSM III". Psychiatry was then, and I believe remains, an art as much as a science...maybe more art, with a dash of science - like a true Macchiato, espresso with a dash of milk?

Of course, there was (and is) science, the basic sciences of neuroanatomy and neurophysiology and the arrival of 'Prozac' in the 1990s, amongst others. Serotonin was the new 'it' neurotransmitter then, SSRIs the drugs of the moment. Psychiatry was arriving. But did we, have we... arrived? What has the discipline become and where is it heading? Artificial Intelligence (AI) comes to mind. Psychiatry, in my humble view is the most vulnerable to AI - if we continue our DSM driven formulaic, algorithmic path. And yet, Psychiatry is the most human of disciplines. The future requires careful consideration of this tension, or else - what are we, as psychiatrists? I return to an earlier theme - art. Art and science.

What is Psychiatry? A discipline dealing with the whole person. A unique discipline. One in the vanguard, of how patients should be treated - as people, not diagnoses. How the practice of medicine should be. We should not be reduced to DSM...technicians, which AI can replace...'script' writers, perceived simply as prescribers.

WE NEED TO OWN WHAT MAKES US SPECIAL, NOT LEAST OF ALL THE MULTI-DISCIPLINARY TEAM. AND SO, AS I BOW OUT OF CLINICAL PRACTICE, I REFLECT ON THE PRIVILEGE OF SERVING BUT ALSO - KNOWING WHEN IT IS TIME TO GO.

I have seen good people stick around past their time and sully their potential legacy. It is now a time for me to open space for possibilities. I will always be a psychiatrist, and what follows will be the next iteration. I have no idea what that is. Is it brave, or reckless? Neither - it is necessary...as part of my ongoing evolution.

Everything ends.

Two words. Very simple. I have encountered many people in my professional life, good and bad, and learned something from everyone. Patients have taught me so much of what I know, but importantly to look at suffering in a different way, to see the struggles and mostly to marvel at humanity.

I've been a clinician, moved into senior management, deinstitutionalised myself from the clinical and academic systems (as a so-called "joint appointee") that were such a major part of my life, returned to being a clinician – in the private sector...never a careerist...more of an adventurer. A classmate, at medical school once told me I'll never grow up. So, did I grow up and if not yet, when? What do I really want to be...when I grow up? What does it even mean? We are always growing up. It stops when you breathe your last...keep going. I can honestly say that up to now I have done everything I never planned to do...and it is my intention to continue.

**Tara Hospital, The H. Moross Centre, Sandhurst, Johannesburg.*

Christopher Paul Szabo is the former: Academic Head, Department of Psychiatry, University of the Witwatersrand & Head of Clinical Department, Charlotte Maxeke, Johannesburg Academic Hospital. He is an Honorary Professor, Department of Psychiatry and an Emeritus Professor, Faculty of Health Sciences, University of the Witwatersrand. **Correspondence: Christopher.szabo@wits.ac.za**

S5

Zolanz

5 mg

10 mg

Tablets

Olanzapine 5 /10 mg

Fast Action, Effective Results

PATIENTS WITH SCHIZOPHRENIA

Up to 50% of patients with schizophrenia do not adhere to treatment in the short term. Approximately 75% experience recurrent relapse and continued disability.[1]

EFFICACY OF OLANZAPINE

Medication discontinuation was mainly due to lack of efficacy rather than intolerability. This highlights olanzapine's favourable efficacy, as evidenced by its sustained treatment use.[1]

LOWER RATES OF DISCONTINUATION

Olanzapine treatment showed better efficacy, with significantly fewer patients discontinuing treatment compared to other antipsychotics.[1]

ALL-CAUSE DISCONTINUATION

Time to all-cause discontinuation is consistently longer for olanzapine compared with other antipsychotics.[1]

zydus

Dedicated To Life

1.Citrome L, McEvoy JP, Todtenkopf MS, McDonnell D, Weiden PJ. A commentary on the efficacy of olanzapine for the treatment of schizophrenia: the past, present, and future. Neuropsychiatric Disease and Treatment. 2019 Sep;15(15):2559–69. S5 ZOLANZ 5 TABLETS (film coated tablets): Each tablet contains 5 mg olanzapine. Reg. No.: A43/2.6.5/0666. S5 ZOLANZ 10 TABLETS (film coated tablets): Each tablet contains 5 mg olanzapine. Reg. No.: A43/2.6.5/0667. For full prescribing information please refer to the package insert approved by the Medicines Regulatory Authority. Zydus Healthcare SA (Pty) Ltd. Block A, Southdowns Office Park, 22 Karee Street, Centurion, 0157. Tel: +27 (0)12 748 6400. 01/ZOL/07/24/ADV

BRIDGING MINDS FROM ACROSS THE WORLD

Kim Madundo

"We need to allow ourselves the space and time to learn and prioritize and decide". Dr. Rachel Oblath spoke these words to me during a 30-minute consultation. We had never met before, but I truly resonated with this sentiment. I not only felt understood and seen but also reassured that a more accomplished professional from a different country could share a similar opinion to mine. This quote helps me summarize my reflections on an expeditious and intensive, yet transformative research training week.

Towards the end of February 2024, I was fortunate enough to attend a week-long gathering of inspirational minds. It was my first time visiting Durban in South Africa. The decision to attend the Psychiatry Research Week at the University of KwaZulu-Natal (UKZN) was somewhat spontaneous. I only knew one person attending this event, who already had connections with many more people there. I did not know what to expect, but I was ready to learn. It is widely known that mental health needs in Africa are under-addressed. It was, therefore, immensely encouraging to be in the company of emerging and established leaders in mental health from across South Africa, Africa, and beyond. Throughout the week, I learned from and interacted with esteemed researchers and mental health professionals, delving into the intricate layers of local, cross-cultural and global mental health phenomena.

One presentation that I found exceptional was by Prof. Xanthe Hunt, who spoke about suicide and mental health among South African youth. It reminded me of the complexity that exists in health systems, and how barriers to care promote creation of opportunities both in research and in improving services. Suicidality is one of my areas of interest in clinical practice and research, and I was inspired to see the expertise and efforts, particularly with the use of technology, to increase access and retention in suicide prevention care.

At UKZN there was an apparent passion amongst the attendees for advancing psychiatric research. Often, too many questions were asked to be answered in session. Trainees and specialists with a wide range of understanding shared their insights, looking to support others in the room. The selected presentations catered to the whole group, from introductory- to more advanced-level topics. The discussions were rich, and the spirit of collaboration was undeniable.

Kim Madundo

Meeting renowned researchers and mental health professionals was an enlightening experience. People who previously existed in my mind only as names on publications were suddenly real people. I was particularly inspired by Professors Saeeda Paruk and Bonga Chiliza, two of the facilitators of the training. Prof. Saeeda shared viewpoints on the preparation for grant writing as a continuous process not bound by any individual grant, which I had never considered before. She explained the importance of intention and a through line in one's work, and managing expectations. Prof. Chiliza emphasized the strength of collaborations that transcend one's geographical location, professional background, and comfort zone. This was evident in the existing UKZN-Boston University collaboration which organized and provided facilitators for the event. The salience of mentorship and collaboration was echoed throughout the week. In my experience, these lessons are often not given priority in traditional psychiatric or research training curricula. This only further underscored the necessity for events such as this one.

AT UKZN I SPENT MOST OF MY TIME LEARNING FROM OTHERS, REGARDLESS OF THEIR LEVEL OF TRAINING, BACKGROUND, OR PRIMARY LOCATION.

I attached myself to a group of five Africa Global Mental Health Institute (AGMHI) mentees and sensed solidarity and unity despite our differences in career choices and values. Of course, humour and sarcasm go a long way in building connections with former strangers. For this invaluable experience, I would like to thank the facilitators, presenters, and other attendees for challenging my preconceptions, practice, and goals.

My week-long experience at UKZN proved to be an enlightening and refreshing one. I made sure each encounter had intention. Through these encounters with inspiring individuals, I can now look back with a heightened awareness of my position as part of the bigger picture. As I continue on my path in the field of psychiatry and mental health research, I carry forward the lessons learned and the connections made. I look forward to our contributions to psychiatry research. I will allow myself the space and time to learn, prioritize and decide.

Kim Madundo is a psychiatrist, lecturer, and early career researcher from Kilimanjaro, Northern Tanzania. He has an interest in trauma, depression and suicidality, intervention development, and psychometric validation. **Correspondence: kimmadundo@yahoo.com**

MEDICAL INFLUENCERS, OPINION LEADERS AND SHARING HEALTHCARE INFORMATION ON SOCIAL MEDIA

Volker Hitzeroth

An increasing number of healthcare practitioners are choosing to become medical influencers on social media. While there are numerous benefits in disseminating healthcare information on social media, there are also many risks. In the sixth and final article in this series of articles we look at the role of medical influencers, the associated risks and what steps can be taken to prevent medicolegal events.

Medical influencers make use of various social media platforms to disseminate healthcare information to the public. Common platforms include Instagram, Facebook, Twitter/X, TikTok, WhatsApp groups, blogs, podcasts, and discussion forums. Most medical influencers are motivated by the opportunity to educate the public, create awareness about specific health issues (e.g. menopause, mental health, cancer screening, healthy eating, cardiac disease, addictions), or to counter misinformation. Occasionally, and sadly, some healthcare practitioners may be driven by fame, fortune, or fashion.

WHATEVER THEIR MOTIVATION MAY BE, EVERY HEALTHCARE PRACTITIONER, ON AND OFF SOCIAL MEDIA, IS OBLIGED TO ABIDE BY THE HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA'S (HPCSA) RULES, REGULATIONS, AND ETHICAL GUIDANCE.

They must always act professionally and use their social media reach responsibly and without bringing the profession into disrepute. It is worth mentioning that a healthcare practitioner is not immune from sanction or prosecution because they are using a social media platform to disseminate health information. Arguably, the risk of a complaint or litigation can increase when active on social media.

Volker Hitzeroth

Prior to embarking on a social media career, the healthcare practitioner must ensure that they have the appropriate education, training, and experience to opine on their area of influence. Practitioners should not stray beyond their scope of practice and the limits of their professional registration. They must be credible and trustworthy in their actions and opinions. Any content that is shared must be scientific, accurate, verifiable, objective and up to date. All references, further reading or links to support services should be live and

up to date as well as evidence based. Be especially cautious about venturing into controversial aspects of healthcare and avoid any contentious topics. Recent examples, resulting in numerous complaints and even litigation include gender reassignment, vaccinations, and Covid-19.

An important aspect that every medical influencer or opinion leader must consider is that of possible conflicts of interest. It is well known that some social media influencers partake in product placement, brand bias or advertising "by stealth". While many such scenarios tend to be overt and relatively clearcut there are also many more subtle situations where an influencer adopts certain views or propagates specific opinions in order to reap benefits (e.g. payments, advertising space, or any other financial or non-financial gain). This is likely to be unprofessional and may invite sanction from the HPCSA. All practitioners must not only be alert to conflicts of interests, but also to the mere perception that a possible conflict of interest may arise. The HPCSA is clear in that healthcare practitioners must ensure that their business dealings are above reproach, do not fall foul of the ethical guidance and do not bring the profession into disrepute.

ALL PATIENTS ARE ENTITLED TO HAVE THEIR MEDICAL INFORMATION REMAIN CONFIDENTIAL. HEALTHCARE PRACTITIONERS MUST NOT DISCLOSE A PATIENT'S PERSONAL INFORMATION WHILE POSTING ON A SOCIAL MEDIA PLATFORM.

If any clinical examples, case discussions or medical vignettes are used, they must be fully anonymised so that the patient's identity is not disclosed, and their confidential information is not disseminated. It would also be very unwise to give direct and personalised advice to any patient on social media. In such circumstances, it is unlikely that a healthcare practitioner would be able to take a full history, complete a detailed physical examination or consider any special investigations or collateral information. Furthermore, it is equally unlikely that contemporaneous records of any such contact have been kept. Without a full clinical consultation any diagnosis or treatment advice could be flawed and put the practitioner at risk of sanction or litigation.

Unfortunately, we have seen several colleagues be accused of defamation. This is especially so when using social media where the online disinhibition effect promotes impulsivity and less restraint. Be especially cautious about commenting or criticising another healthcare practitioner, any organisation, company or business. You should never bring a colleague's clinical acumen into doubt, and you should be cautious about commenting on an apparently adverse outcome. It is likely that you do not have all the relevant information at hand and your views may only have been informed by the patient's explanation without the benefit of the full clinical records, context, and background.

MANY MEDICAL INFLUENCERS AND OPINION LEADERS ON SOCIAL MEDIA HAVE A SEPARATE MEDICAL PRACTICE OR ARE EMPLOYED EITHER IN THE PRIVATE OR THE STATE SECTOR. THIS MEANS THAT THEY WILL NOT ONLY HAVE A CLINICAL AND ETHICAL OBLIGATION TO THEIR EXISTING PATIENTS BUT ALSO A LEGAL OBLIGATION TO THEIR EMPLOYER. THERE MAY BE CERTAIN ASPECTS OF THEIR EMPLOYMENT CONTRACT OR LOCUM AGREEMENT THAT REQUIRE CONSIDERATION PRIOR TO EMBARKING ON A SOCIAL MEDIA CAREER. FOR STUDENTS THERE MAY BE RULES OR REGULATIONS GOVERNING THEIR CONDUCT WHILE ENROLLED AND STUDYING AT A TRAINING INSTITUTION.

It may also be helpful to add a disclaimer to any social media post or video. While it is unlikely to be a guarantee of indemnity and may not prevent someone complaining or litigating it is another layer of caution and evidence of further information to clarify the limits of the shared content or posted messages. Finally, all healthcare practitioners should ensure that their indemnifier or insurer is fully aware of their activities and practice – and that they can request assistance in the event of a medicolegal event brought about by conduct on social media.

Ultimately, a practitioner must be able to justify their decisions, explain their actions and substantiate their reasoning. Sadly, and on occasion, this may be in a medicolegal setting which is likely to be high profile, costly, very stressful and may harm the practitioner's reputation and practice.

Volker Hitzeroth is Medicolegal Consultant at Medical Protection Society in London, United Kingdom. **Correspondence: Volker.Hitzeroth@medicalprotection.org**

DEPARTMENTS OF PSYCHIATRY

UNIVERSITY OF THE WITWATERSRAND

DEPARTMENT OF PSYCHIATRY'S 35TH ANNUAL RESEARCH DAY

BY CADE ANDERSON

The University of the Witwatersrand's Department of Psychiatry held its 35th Annual Research Day on 19/06/2024 at the Killarney Country Club. The Annual Research Day aims to showcase the clinical research endeavours of the Department's staff and students.

Attendees in the Crystal Room at Killarney Country Club

The Annual Research Day was organised by the Department's Research Day Committee, which is led by Dr Belinda Marais. This year, the Committee members were Dr Alexa Fiford, Dr Suvina Gandhi, Dr Muhammed Sheik and Dr Cade Anderson.

The department of Psychiatrys 35th Annual Research Day Committee

From L to R: Cade Anderson, Belinda Marais, Alexa Fiford, Suvina Gandhi, Muhammed Sheik

The keynote speaker, Prof Dayna Ballot, left the audience with a message of encouragement to pursue clinical research, whilst enjoying a full and balanced life through use of effective planning and time management.

Ten MMed Psychiatry students presented their completed research which covered a diverse range of Psychiatry-related topics

Keynote Speaker - Prof Dayna Ballot

- Dr Mokgokong Mathekga - Analysis of Mortality Rate in Patients Admitted in a Long-Term Psychiatric Care Facility in Johannesburg.
- Dr Noluthando Hlongwane - Descriptive Study of Mental Health Care Users 12 Months pre and post COVID
- Dr Marc Stopford - A Description of COVID-19 Related Delusional Thought Content in Admissions to an Acute Psychiatric Unit
- Dr Gemma Purbrick - Burnout Amongst Community Service Doctors in South Africa
- Dr Lerato Masenya - Knowledge of and Attitudes towards Electroconvulsive Therapy in an Academic Psychiatric Department
- Dr Muthumuni Nemavhola - Social, Clinical and Forensic Correlates in Female Observandi Referred for Non-violent Crimes
- Dr Rachel Moshori - Cannabis Use pre and post Decriminalisation in Mental Health Care patients admitted to Chris Hani Baragwanath Academic Hospital in Soweto
- Dr Cherith Herold - Psychedelics as a Novel Treatment: Describing the Awareness and Attitudes of South African Psychiatrists
- Dr Lisha Narayan - The Prevalence of Anxiety Symptoms in Pregnant Women attending the Antenatal Clinic at Chris Hani Baragwanath Academic Hospital
- Dr Luzaan Cooke - The Profile of Adolescent Patients presenting to a Tertiary Maternal Mental Health Clinic

The Head of Department of Psychiatry, Prof Ugasvaree Subramaney, 4th from Left, with the speakers

Best Speaker, Dr Muthumuni Nemavhola, with supervisor Dr Karishma Lowton

Dr Muthumuni Nemavhola, supervised by Dr Karishma Lowton, was awarded the prize for best speaker, which was generously sponsored by the South African Society of Psychiatrists.

A note of thanks must be extended to Ariste Health, Aspen Pharmaceuticals, Janssen and Lundbeck, who made the Annual Research Day possible through their generous donations ■

FORENSIC PSYCHIATRY WEBINAR 2024

2ND AUGUST 2024

Wits Faculty of Health Sciences
Department of Psychiatry

Programme

Registration	8h30-9h00	
Prison Liaison Psychiatry	9h00-9h45	Dr RD Sapinoso
Victim Assessment and Process	9h45-10h30	Ms C Waldeck
Tea Break	10h30-10h50	
Offending Behaviour in the Clinical Setting	10h50-11h35	Dr I Chetty

UNIVERSITY OF CAPE TOWN

EXCITING DEVELOPMENTS AT THE BRAIN BEHAVIOUR UNIT

BY PROF PIETER NAUDÉ

The Brain Behaviour Unit (BBU) has recently been upgraded to a Centre, in recognition of the growth of each of the Unit's Groups (Psychiatric Neuroimaging, Psychiatric Genetics, Translational Neuroscience). Each of the Groups has long had regular meetings. With the appointment of Profs Pieter Naude and Goodman Sibeko as co-Directors of the Centre, we decided that it's also important for postgraduate students and postdoctoral fellows to interact. The primary objectives of these meetings are to foster connections within the Centre and to provide a supportive environment for postgraduate students and non-GOB staff.

We've been delighted with the high attendance of these meetings, with more than 50 students and fellows attending regularly. Students and fellows have presented their work in an informal and engaging way, and have built new friendships and collaborations. The Centre maintains an active social media presence, featuring interesting topics on neuroscience for the layman, led by Mia Lombard. Follow us on Instagram at @neuronerds_bbu and (@NeuronerdsUct) on X (twitter) to stay updated.

Additionally, Centre members have established an active forum on Slack, thanks to Mary Mufford, which serves as a platform for both work-related support and miscellaneous topics. We have also recently formed a social committee, chaired by Anjè Grobler, which organizes social events beyond the work environment.

It is truly inspiring to see how far we have developed in such a short time. The BB Centre hopes to continue to inspire students, and to contribute to South African neuroscience ■

NEW SA MATERNITY CARE GUIDELINES: NDOH KNOWLEDGE HUB AND PERINATAL PRIORITIES CONFERENCE

BY PROF SIMONE HONIKMAN

The National Department of Health (NDoH) launched the new Maternity Care Guidelines in a series of webinars on their online Knowledge Hub. Our director, Simone Honikman, and colleagues presented on the three new chapters that the PMHP developed for these guidelines, in collaboration with teams of experts. Simone also presented these guidelines to attendees at the Perinatal Priorities Conference – the foremost meeting of public sector obstetricians, neonatologists and midwives in the country.

For the first time, pragmatic guidance is provided on Maternal Mental Health, Respectful Maternity Care and Domestic Violence ■

Simone Honikman providing a workshop on the new chapters to obstetricians and midwives.

A DAY-IN-THE-LIFE OF A CLINICIAN-SCIENTIST

BY ANJÉ GROBLER

The UCT Cortex Club, African Research Society (ARS), and Psychiatry Society (PsychSoc) hosted a collaborative event on the 30th of May entitled 'A Day-in-the-Life of a Clinician-Scientist', with sponsorship from the Medical Research Council (MRC) Unit on Risk & Resilience in Mental Disorders.

As student organisations at the UCT, these societies each play a vital role in fostering academic engagement and innovation across diverse fields. The Cortex Club committee endeavours to democratise neuroscience, catering to individuals from various backgrounds, including undergraduates, postgraduates, and learners from schools in and around Cape Town. Similarly, the African Research Society seeks to bridge the gap between students and the world of research, offering a supportive platform for both aspiring and

Cortex Club and African Research Society representatives asking panelists (Prof Mashiko Setshedi, Prof Dan Stein, A/Prof Phumla Sinxadi, and A/Prof Goodman Sibeko) questions following their presentations.

established researchers to explore their interests and contribute to knowledge advancement. Meanwhile, the Psychiatry Society advocates for psychiatry's crucial position in medicine, emphasising its multidimensional advancements and commitment to innovative research and patient-centred approaches. Together, these societies exemplify UCT's commitment to academic excellence and inclusivity, striving to empower students and academics alike in their pursuit of knowledge and discovery.

The event aimed to educate, inspire, and connect attendees from diverse backgrounds. We wanted to showcase the unique intersection of clinical practice and scientific research, to motivate individuals interested in clinical science, and to foster interdisciplinary collaboration. The evening addressed challenges faced by clinician scientists, promoted best practices and advocacy efforts, and encouraged diversity and inclusion within the field.

The evening began with a warm welcome from Niamh Ahern, representing the PsychSoc. Her heartfelt welcoming, accompanied by an insightful explanation of the definition of what it means to be a clinician-scientist, set a positive tone for the event. We were fortunate to have a full house, with approximately 75 individuals filling the NI Auditorium. Notably, some attendees travelled all the way from Stellenbosch to join us.

Following this, Tsaiyu Shih guided the attendees through the plan for the evening, providing a detailed introduction to the four presenters' academic achievements and backgrounds. The inclusion of presentations by four clinician-scientists was intentional, designed to showcase their expertise, provide valuable insights into their respective fields, and bring different aspects of their professions to the table. These esteemed individuals, who serve as faculty at the University of Cape Town, included Prof. Dan Stein, A/Prof. Goodman Sibeko, A/Prof. Phumla Sinxadi, and Prof. Mashiko Setshedi.

Prof. Dan Stein, the current Chair of Psychiatry and Mental Health, and Director of the SA Medical Research Council's Unit on Risk & Resilience in Mental Disorders, has a strong track record as a clinician-scientist. Amongst his notable accomplishments are a Lifetime Achievement Award from the World Federation of Societies of Biological Psychiatry and being the holder of one of the highest Google Scholar h-index scores in Africa. He opened the floor with a talk on what it means to be a clinician-scientist, the opportunities for clinician-scientists in South Africa, and the journey from starting as a postgraduate student to becoming a professor. He dispelled common myths about research.

PsychSoc, Cortex Club, and African Research Society members with speakers.

Next, A/Prof Goodman Sibeko took the stage, detailing his personal journey from MBChB to his current role in shaping policy concerning task-shifting and HIV/AIDS. He shared insights into his motivations and the dedication that propelled him to achieve his remarkable accomplishments. A/Prof Sibeko holds several significant positions, including HOD of Addiction Psychiatry, directorship of the South Africa HIV Addiction Technology Transfer Centre, and membership on the steering committee of the International Society of Substance Use Professionals South Africa. His pioneering efforts in integrating traditional health practitioners into primary health and addiction care were also highlighted.

A/Prof Phumla Sinxadi shared her inspiring journey towards becoming a clinical pharmacologist, shedding light on the various research projects and fellowships that shaped her path to completing a PhD. As the Chair of Clinical Pharmacology and the first Black South African female clinical pharmacologist, she has led groundbreaking initiatives, including the first-in-human clinical trial for MMV390048, a novel antimalarial drug. Her exceptional contributions have earned her multiple research awards, including the prestigious "Best Publication" accolade from the South African Society for Basic and Clinical Pharmacology. Through her experiences, A/Prof Sinxadi aims to empower students from similar backgrounds, demonstrating that despite coming from a small town and facing disadvantages, women like her can thrive and excel in the medical field.

Prof. Mashiko Setshedi concluded the presentations with an engaging talk centred on discovering one's passion, actively pursuing opportunities, and achieving a harmonious work-life balance. As the Head of Gastroenterology and soon-to-be Head of the Department of Medicine at UCT, she

brings a wealth of experience and expertise to her discussions. With a distinguished background as an Oxford Nuffield postdoctoral fellow and a pivotal member of the team that executed South Africa's first successful bowel enteroscopy, Prof. Setshedi's insights were invaluable. She emphasised the importance of passion in navigating one's career path, highlighting how it can alleviate challenges and enhance job satisfaction. Furthermore, Prof. Setshedi underscored the significance of rest, advocating for proactive self-care measures to prevent burnout and maintain overall well-being.

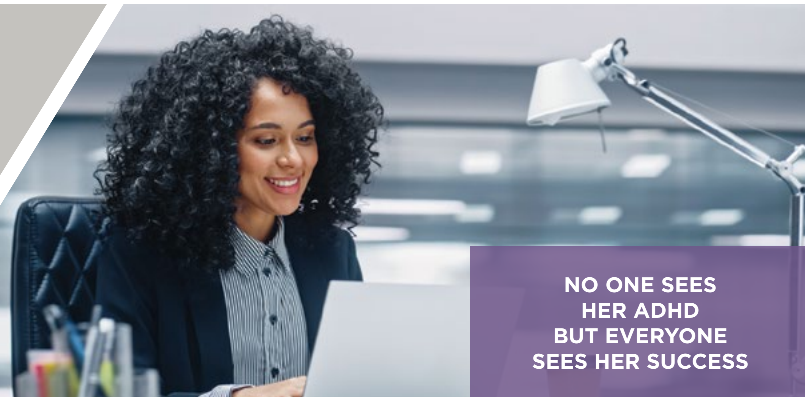
Participants and attendees in the Neuroscience Auditorium

To end off the evening, a panel discussion and question from the attendees ensued, addressing key topics in the field of science. Common tips suggested for achieving work-life balance included setting boundaries, prioritising tasks, and scheduling breaks. To stay focused while researching, panellists recommended breaking tasks into smaller segments and creating a work environment and schedule that work for the individual. Strategies to combat distractions included using tools like phone locks or using timers to break up the workload. Publishing advice emphasised organisation, targeting appropriate journals, and seeking feedback (and not taking it personally!). For those starting their research journey, the importance of mentorship, self-identification of research interests, and active participation in research-related activities were highlighted. Finally, panellists emphasised the role of professional online profiles and engagement with the academic community.

We are grateful for the diverse array of presentations we had, catering to the varied interests and preferences of everyone present in the room, with topics ranging from technical discussions to emotional narratives and inspiring talks.

For more news on the department see our newsletter. https://health.uct.ac.za/department-psychiatry/news/newsletters

BE WHO YOU WANT TO BE



VYVANSE® offers sustained improvement in adult attention deficit hyperactivity disorder (ADHD) symptoms for up to 14 hours[1]

VYVANSE® is the FIRST prodrug stimulant[2,3]

- Offers improvement in real-life executive function deficits and self-reported quality of life[3,4]
- Convenient once-daily dosing with a well-established safety profile[3,5,6]

References: 1. Wigal T, Brams M, Gasior M, Gao J, Squires L, Giblin J, for 316 Study Group. Randomized, double-blind, placebo-controlled, crossover study of the efficacy and safety of lisdexamfetamine dimesylate in adults with attention-deficit/hyperactivity disorder: novel findings using a simulated adult workplace environment design. *Behav Brain Funct.* 2010;**6**:34. Available from: http://www.behavioralandbrainfunctions.com/content/6/1/34 [Accessed 18th August 2021]. **2.** Pennick M. Absorption of lisdexamfetamine dimesylate and its enzymatic conversion to d-amfetamine. *Neuropsychiatr Dis Treat.* 2010;**6**:317-327. **3.** Frampton JE. Lisdexamfetamine: A Review in ADHD in Adults. *CNS Drugs* 2016: **30**(4):343-54.DOI 10.1007/s40263-016-0327-6. **4.** Adler LA, Dirks B, Deas PF, Raychaudhuri A, Dauphin MR, Lasser RA, *et al.* Lisdexamfetamine Dimesylate in Adults With Attention-Deficit/ Hyperactivity Disorder Who Report Clinically Significant Impairment in Executive Function: Results From a Randomized, Double-Blind, Placebo-Controlled Study. *J Clin Psychiatry.* 2013;**74**(7):694-702. **5.** VYVANSE® 30,50,70. SAHPRA approved professional information. Takeda (Pty) Ltd. 24 July, 2020. **6.** Coghill DR, Caballero B, Sorooshian S, Civil R. A Systematic Review of the Safety of Lisdexamfetamine Dimesylate. *CNS Drugs* 2014;**28**:497–511.

S6 VYVANSE® 30. Each capsule contains 30 mg lisdexamfetamine dimesilate. Reg. No: 48/1.6/0407. **S6 VYVANSE® 50**. Each capsule contains 50 mg lisdexamfetamine dimesilate. Reg. No: 48/1.6/0408. **S6 VYVANSE® 70**. Each capsule contains 70 mg lisdexamfetamine dimesilate. Reg. No: 48/1.6/0409. For full prescribing information, refer to the Vyvanse Professional Information as approved by SAHPRA. Takeda (Pty) Ltd, Reg. No.: 1982/011215/07, Building A, Monte Circle, 64 Montecasino Boulevard, Fourways 2191. Tel: +2711 514 3000. Marketed by Acino Pharma (Pty) Ltd. Reg. No: 1994/008717/07. No 106, 16th Road, Midrand, 1686, Gauteng, South Africa. (011) 516 1700. www.acino.co.za C-APROM/ZA/Vyv/0039.

Brain and Mind: Broadening Horizons

BIOLOGICAL PSYCHIATRY CONGRESS

Thursday 28 November - Sunday 1 December 2024

Century City Conference Centre, Cape Town

www.biopsychsa.co.za

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

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

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

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

Register Now

Early bird registration is closing 28 September 2024

REGISTRATION

https://biopsychsa.co.za/registration/

PROGRAMME

https://biopsychsa.co.za/programme/

SUBMIT ABSTRACTS

https://biopsychsa.co.za/abstract-submission/

Call for Abstracts

The deadline for abstract submissions is 30 June 2024

- Registrars are specifically invited to submit their abstracts.
- All appropriate abstracts will be reviewed by the Scientific Committee.
- All submissions received will be acknowledged, and authors will be sent acceptance or rejection letters by 31 July 2024.
- Please note that presenting authors of accepted submissions must be registered delegates.
- Registration costs are at the presenter's own expense.

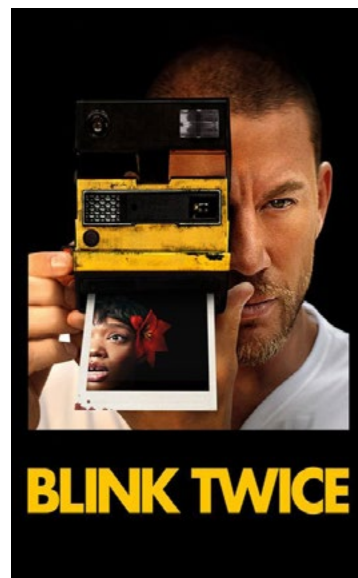
MOVIES

Title: Widow Clicquot
Release Date: 09 August
Directors: Thomas Napper.

The story behind the Veuve Clicquot champagne family and business that began in the late 18th century.

Title: ALIEN: Romulus
Release Date: 16 August 2024
Director: Renny Harlin

While scavenging the deep ends of a derelict space station, a group of young space colonizers come face to face with the most terrifying life form in the universe



Title: Blink Twice
Release Date: 23 August 2024
Director: Zoe Kravits

Frida is a young waitress in Los Angeles who has her eye on tech entrepreneur Slater King. On a dream vacation to his private island, strange things start to happen.

Title: André Rieu's 2024 Maastricht: Power of Love
Release Date: 30 August
Director: NA

André Rieu is ready to blow you away. From his picturesque hometown of Maastricht The King of the Waltz presents a must-see big screen spectacular.

Title: The Wild Robot
Release Date: 20 September 2024
Director: Chris Sanders

After a shipwreck, an intelligent robot called Roz is stranded on an uninhabited island. To survive the harsh environment, Roz bonds with the island's animals and cares for an orphaned baby goose.

Title: Joker: Folie À Deux
Release Date: 4 October 2024
Director: Todd Phillips

Failed comedian Arthur Fleck meets the love of his life, Harley Quinn, while incarcerated at Arkham State Hospital. Upon his release, the two of them embark on a doomed romantic misadventure

A JOURNEY WITH A VINTNER

David Swingler

Of my numerous peculiarities, one particular quirk is a view that Test Cricket is an extended game of chess, enacted by athletes. So, there I was on the Newlands terraces over New Year, absorbed by a match between peerless India and our nail-biting Proteas. I was trying to explain to Leila that, when the opening fast bowler is moving the ball around, either in the air or seaming off the pitch in the 'corridor of uncertainty', sometimes the best shot a batter can offer, is no shot. To 'shoulder arms'. To let the ball flash by without risking contact with the bat and being out 'caught behind'.

Leila is the teenage daughter of Richard Hilton, then an associate and now a friend of mine. She is a talented cricketer with aspirations of playing for the national Proteas Women's cricket team, eager to learn. Out of the blue Richard asked: 'Do you want to come to Spain with me? To tour the Northern winelands in a camper van?' So audacious was the proposal that I'd blurted out 'Yes!' before even thinking. Richard thought I was joking and would surely withdraw, sooner rather than later. I didn't.

Fabulous tapas everywhere

David Swingler

We have just returned from a glorious adventure starting with dinner at Madrid's Botin – the oldest restaurant in the world dating back to 1725 (and where Goya worked as a dishwasher) – on to Valladolid (Ribera del Duero and Toro), Haro (Rioja), San Sebastian (tapas like no other), Bilbao (Guggenheim Museum) and Ponferrada (Bierzo and Galicia). We finished off experiencing the incomparable Prado Museum and Picasso's Guernica back in Madrid. Indescribable in opportunity, we enjoyed overwhelming receptions at top end producers of which many were envious (Numanthia and Vega Sicilia are both world famous) as well as intimate greetings at wineries others had never heard of (like Cantarina and Cabanelas). It was eye watering, and humbling. And we bivouacked in hotels!

1860 vines at Numanthia

BUT THE REAL TREAT FOR ME WAS TO GET TO KNOW RICHARD, WELL, BETTER. AS ONE DOES, ON THE ROAD TOGETHER!

He is something of a polymath. Of British origin, he cut his vinous teeth in France, doing everything from vine growing, wine and barrel making, to marketing and sales. He came to South Africa at the birth of our democracy and contributed to various facets of the wine trade before establishing himself in his

current iteration. The first of his two prongs is that of a boutique wine maker *Richard Hilton Vineyards,* producing an exclusive 15 000 bottles a year. The second is as Hospitality Destination travel facilitator Greatest Africa, 'Luxury African Travel Specialists'. In this guise he attracts and welcomes top end foreign visitors to South Africa and beyond; in particular is his now legendary annual reception of two groups from Scandinavia whose contribution to our GDP is, well, not insignificant.

In the Arzuaga cellar

With Santiago of Cantarinas

Richard is a new wave South African wine producer. Young (ok, if only at heart), he owns neither vineyard nor cellar, sourcing grapes from partner farmers and crafting wines in shared rented cellar space. Winemaking is 'chaperoned' rather than manipulated – 'natural' processes are supported with no additives other than protective sulphur – and volumes are boutique level.

HE SPECIALISED IN VIOGNIER FROM ELGIN BEFORE ADDING A STELLENBOSCH CHARDONNAY TO THE RANGE.

All three whites are half destemmed/half whole-bunch pressed, with an hour's skin contact before gentle pressing to seasoned French oak where 'wild yeast' fermentation take place at cool temperatures, followed by full spontaneous malo-lactic acid transformation. All the wine rounds out 11 months in cask. The 2022 *Clay Shales Viognier* is redolent of the tropical peach-pip varietal character, but with refinement and balance of components. It's big brother, *The Emperor Probus Viognier* 2022 – named for the Roman Emperor who introduced the grape to the Northern Rhone valley in 281AD – is fuller, bolder, deeper, but with the trademark 'fluidity' that marks all the wines. Only 600 bottles were made.

Carolus Magnus Rex Chardonnay 2022 – this time the moniker doffs a hat (via his nickname) to Charlemagne who planted the grape in Burgundy in the 9th century – is from Stellenbosch. As a result, it's more structured but as luxurious and velvet-like as its cellar siblings.

Vineyard reception at Finca La Emperatriz

Richard pins Syrah to the mast as his signature red wine. Cool-climate Elgin's 2019 *Cartref Syrah* is of lighter, more red-berry fruit styling and can be enjoyed cool in the summer months. That's not to say it's slender – far from it – but it has flavour without weight in the mouth. The wine is named for its grapes' soil type, as is the 2019 *Ironstone Syrah* from Stellenbosch vineyards. This is strikingly spicy, with whiffs of pan-fried pimento woven into the mulberry fruit profile. Maturity from more bottle age than equivalent wines on the market make it deliciously accessible now.

Yours truly with the agronomist and export executive and an 1890 vine at famous Vega Sicilia

Finally, the flagship *The Dalmatian Syrah* 2018 does Richard proud. The inspiration for the name is twofold. It refers, first, to the sprinkling of Viognier that is blended with Syrah is the famous Cote Rotie wine (the white spots of the dog) and, secondly, to the Dalmatian Coast of Croatia where Viognier has its origins. The wine is full bodied, deep and broad, its fruit characters well supported by ripe tannins, with an integrated lingering finish. Very satisfying. As were the travels together!

Richard discussing oenology at Condado de Haza

AS RICHARD AND I PARTED AT ADOLFO SUÁREZ MADRID–BARAJAS AIRPORT, WE WERE ALREADY PLANNING THE NEXT VENTURE; A TRIP TO CAMPANIA, SICILY AND SARDINIA. IN A CAMPER VAN, THIS TIME.

https://www.hiltonvineyards.co.za/

https://greatestafrica.com/

Richard is offering 5% discount for orders arising out of this review. Cases can unfortunately not be broken so orders need to be in increments of 6-bottles per label, at website prices BUT emailed to Richard Hilton richard.hilton@icloud.com with 'Doctor' in the subject line.

[The website doesn't offer the discount]

On Calle del Laurel Logrono

David Swingler is a writer and taster for Platter's South African Wine Guide for 26 years to date. He has over the years consulted to restaurants, game lodges and convention centres, taught wine courses and contributed to radio, print and other media. A psychiatrist by day, David is intrigued by language in general, and its application to wine in particular. **Correspondence: ddswingler@gmail.com**

in partnership with:

ASOCIACIÓN PSIQUIÁTRICA MEXICANA A.C.

24th WPA WORLD CONGRESS OF PSYCHIATRY

MEXICO CITY, 14-17 NOVEMBER 2024

#WCP24

NEW HORIZONS FOR GOOD MENTAL HEALTH FOR ALL

ANNOUNCING THE PLENARY SPEAKERS

We are thrilled to announce the exceptional lineup of plenary speakers for WCP24! Join us in welcoming renowned experts such as:

Dr. Nora Volkow
Addiction as a brain disorder

Prof. Mario Maj
The future of psychiatric treatments: beyond new medications and new psychotherapies

Dr. Joshua Gordon
Neuroplasticity and mental health: understanding the neural basis of cognition in schizophrenia

Dr. Prabha Chandra
Global picture – women and girls mental health in comparison with males

Dr. John Mann
Suicide and suicide prevention from genes to public mental health

Prof. Helen Herrman
Evidence-based methods to mitigate mental health effects of crisis, wars and terror attacks

THE EARLY BIRD REGISTRATION DEADLINE IS APPROACHING

With just two months left to avail yourself of the early bird rates for the WCP 2024, we encourage you not to miss this chance to join an influential community of mental health professionals, industry experts, and academia from around the globe. By registering early, you will enjoy a reduced fee and benefit from more time to arrange your travel and accommodation, ensuring a hassle-free experience at the congress.

Early Bird Registration Deadline: 15 July, 2024

REGISTER EARLY

INVITATION TO PRIVATE PSYCHIATRISTS AND PSYCHOLOGISTS

CONDUCT FORENSIC MENTAL ENQUIRIES IN TERMS OF CRIMINAL PROCEDURE ACT

Invitation for submission of details of private Psychiatrists and Clinical Psychologists who are prepared to conduct Forensic Psychiatric Enquiries for the Courts in terms of Section 77, 78, 79 of the Criminal Procedure Act.

According to Section 79(9) of the Criminal Procedure Act (Act No 51 of 1977 as amended) in respect of a panel for the purposes of the enquiry and report under Sections 77 and 78 of the Act, the Director-General: Health will compile and keep a list of Psychiatrists and Clinical Psychologists who are prepared to conduct an enquiry in terms of Section 79 and Section 286A (3) of the Criminal Procedure Act, 1977 as amended, and will provide the Registrars of the High Courts and all Clerks of the Magistrate's Courts with a copy thereof.

The Department hereby invites private Psychiatrists and Clinical Psychologists who wish to conduct forensic mental enquiries in terms of Section 79 as well as Section 286A (3) of the Criminal Procedure Act, to submit their details for inclusion in the national 2024/2025 list.

Interested psychiatrists and psychologists must submit the following information: Full names, contact details, business and residential address and your area of interest (enquiries in terms of Criminal Procedure Act) using a form that is obtainable from the Department of Health website at www.doh.gov.za. The completed form should be accompanied by a proof of current registration with the relevant professional body.

Kindly note that the contracting and remuneration processes for this work will be handled by the Department of Justice and Constitutional Development. Enquiries with regard to tariffs and remuneration should be send to Adv Elisabeth Picara, Chief Director: Court Services @ 012 315 1658 Email:EPicara@justice.gov.za.

Please submit your completed form and attachment by email to the Director-General: Department of Health, Private Bag X828, Pretoria, 0001, for attention: Ms Dudu Shiba, Director: Mental Health and Substance Abuse at Dudu.Shiba@health.gov.za; and copy Bashu.Pule@health.gov.za. Enquiries pertaining to submission of details may be directed to Ms Dudu Shiba at Email: dudu.shiba@health.gov.za or Mr Bashu Pule at Tel 012 395 9533 and Email: Bashu.Pule@health.gov.za

Closing date for submission was: 13 May 2024

SUBMISSION OF DETAILS FOR INCLUSION IN A LIST OF PSYCHIATRISTS AND PSYCHOLOGISTS THAT ARE PREPARED TO CONDUCT FORENSIC PSYCHIATRIC ENQUIRIES IN TERMS OF THE CRIMINAL PROCEDURE ACT, 1977 AND/OR CRIMINAL CAPACITY ASSESMENT IN TERMS OF THE CHILD JUSTICE ACT FOR THE 2024/25 FINANCIAL YEAR

All completed forms together with proof of current registration with the relevant professional board must be submitted to the Director-General, Department of Health and marked for the attention of the Director: Mental Health and Substance Abuse by Email: dudu.shiba@health.gov.za and copy Bashu.Pule@health.gov.za no later than **Monday, 13 May 2024**. Enquiries may be directed to: Mr Bashu Pule at Email: Bashu.Pule@health.gov.za or Dudu.Shiba@health.gov.za

PERSONAL INFORMATION

Title:	Full name/s:	Surname:
Postal address:		
Cell phone Number :		
Land line :		
Email :		
HPCSA Registration number:		

AREA OF INTEREST (Please tick relevant box. Tick both if willing and qualifying to be included in both lists):

☐ Conduct criminal capacity assessment of children in terms of the Child Justice Act, 2008 as amended.

☐ Conduct forensic mental evaluation in terms of the Criminal Procedure Act, 1977 as amended.

Signature of clinician	Date

REVIEW AND CLARIFICATION OF MEMBERSHIP STATUS AND RIGHT

Anusha Lachman

Dear Member

I am writing to you on behalf of the BoD of SASOP to provide some clarification regarding membership rights with the South African Society of South Africa (SASOP).

Following the discussion at the AGM of 2023, and subsequently, concerns have been raised regarding the eligibility of non-psychiatrists to apply to become members of SASOP.

According to the Memorandum of Incorporation (MOI) of SASOP, non-psychiatrists are welcomed and eligible to join as SASOP members as Associate Members, provided that they are registered medical practitioners with the HPCSA.

The current membership fee for Associate Members is R245.00/m.This associate membership right, however, is restricted in terms of voting rights within the society.

SASOP values the diverse perspectives and contributions of professionals from various backgrounds who are interested in the field of psychiatry. Accepting non-psychiatrists as SASOP members speaks to our understanding of the fundamental and essential collaborative relationships we foster with the multidisciplinary team. While non-psychiatrist members may not participate in voting processes, their involvement and contribution to the field of advocacy and support for mental health is still highly values.

Anusha Lachman

Non-psychiatrist members have access to a range of benefits, including networking opportunities, educational resources, and participation in committees and working groups.

If you have any further questions or require additional information regarding membership in SASOP, please do not hesitate to reach out to us. We are committed to ensuring clarity and transparency regarding membership policies and procedures. Thank you for your attention to this matter.

Sincerely,
Dr Anusha Lachman
SASOP President

COMRADES 2024: #MOVEFORYOURMIND

We are excited to announce the official recognition of the Sport and Exercise Psychiatry SIG! to kick off our presence.

SIG! is launching a mental health awareness campaign by celebrating the strength and resilience of Comrades runners.

Not everyone can (or wants to) run an ultramarathon. Yet, staying active in any form is essential for our mental health and well-being.

We encourage our SASOP networks to #Moveforyourmind and #GoMental as we approach the world's largest ultramarathon event on Sunday, 9 June.

Are you running, or supporting the movement? Let us know by visiting the link below and completing the form

MEMBERSHIP TERMS AND CONDITIONS REVIEW SURVEY

At South African Society of Psychiatrists (SASOP), we continuously strive to maintain the highest standards and practices within our community. As part of this commitment, we are currently reviewing our Membership Terms and Conditions to ensure they accurately reflect our values, goals, and the needs of our members.

According to the Memorandum of Incorporation (MOI) of SASOP, non-psychiatrists are welcomed and eligible to join as SASOP members as Associate Members, provided that they are registered medical practitioners with the HPCSA.

The current membership fee for Associate Members is R245.00/m.This associate membership right, however, is restricted in terms of voting rights within the society.

Your input as a valued member is crucial in this process. We kindly request that you take a few moments to complete the following survey. Your responses will help us shape the future of SASOP and ensure that our Membership Terms and Conditions align with the expectations of our members.

We have included a survey below which will include the following fields:

- Disclaimer
- Email Address
- Name & Surname
- MP Number
- Your opinion on the 'Associate Member" type and any comment

Thank you for taking the time to complete this survey. Your feedback is invaluable to us and will directly contribute to shaping the future direction of SASOP. If you have any further questions or concerns, please do not hesitate to contact us.

Disclaimer: Please note that the purpose of this survey is to gather feedback and consensus from our members regarding the Membership Terms and Conditions. No changes are being made at this stage. Your input will help inform our decision-making process. Thank you for your participation.

Sincerely,

Dr Anusha Lachman

SASOP President

TAKE SURVEY HERE

702 WALK THE TALK IS BACK

In celebration of 30 Years of Democracy this year 702 landers were to be granted the freedom of the Capital City of Tshwane to walk two distances: 6.7km and 8 km in recognition of Mandela Month

The walk will start from Freedom Park Heritage Site, past some of our unique heritage sites, finishing at the Southern Lawns of the Union Buildings.

The Southern Gauteng subgroup sponsored the first 20 members who were interested in participating in the 702 Walk the Talk.

BOOK AN APPOINTMENT

MEDSCHEME OFFERS A CONVENIENT BOOKING PLATFORM THAT ALLOWS YOU TO SCHEDULE AN APPOINTMENT WITH A MEDICAL ADVISOR TO DISCUSS THE FUNDING OF YOUR PATIENT'S CLINICAL TREATMENT, IF NEEDED.

Medscheme offers a convenient booking platform that allows you to schedule an appointment with a Medical Advisor to discuss the funding of your patient's clinical treatment, if needed.

Before booking an appointment, please ensure you have the following information at hand:

- Treating doctor's full name and practice number
- Patient's full name, membership number and dependant code
- Authorisation reference number

THERE ARE TWO WAYS TO BOOK AN APPOINTMENT:

1. Easily access the booking platform by clicking on this link: Book Medical Advisor Appointment
2. Alternatively, visit the Medscheme website at www.medscheme.com:

- Log in as a Provider
- Click on Authorisations
- Select Medical Advisor Appointment

Proceed to add the required information and select a convenient date and time for the appointment. Our Medical Advisor will then call you at the scheduled time.

Please refer to the below User Guide for detailed instructions on booking an appointment.

Remember: This appointment is only for discussing the funding of your patient's clinical treatment. The Medical Advisory Team is not responsible for managing claims-related queries.

We look forward to hearing from you.

Kind regards

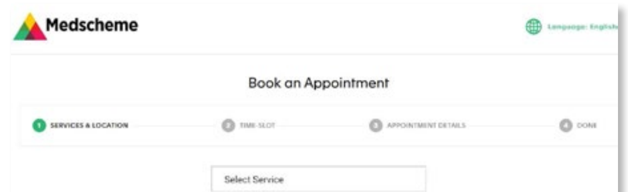
Health Professions Strategy and Medical Advisory Team

USER GUIDE TO BOOK A MEDICAL ADVISOR APPOINTMENT

To access the booking platform directly, click on the following link: Book Medical Advisor Appointment or scan the code below.

2. Alternatively, access the platform via the Medscheme website at www.medscheme.com:

- Log in as a **Provider**
- Click on **Authorisations**
- Click on **Medical Advisor Appointment**
- This will take you to **Book an Appointment**



3. Click on **Select Service**.
4. Choose either **Hospital Event Management** or **Chronic Medicine Management**.
5. Continue to enter the required information.
6. Once complete, you will receive confirmation of your scheduled appointment via email.
7. A Medscheme Medical Advisor will call you at the scheduled time

SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

TRANSFORMING MENTAL HEALTH IN AFRICA

At the AGMHI, we are dedicated to advancing mental health care throughout Africa and the diaspora. With mental health often under-resourced and stigmatized, our Institute aims to foster collaborations, promote inclusive research, and implement sustainable mental health programs that make a real difference in people's lives.

In an effort to increase awareness about the AGMHI to new audiences and to inspire action, we are excited to announce the launch of our latest initiative: new video content!

We have partnered with Boston Medical Center to create two compelling videos that highlight the AGMHI's impact on the mental health of people of African descent no matter where they are in the world. These videos capture the essence of the Institute's mission and the difference each of you are making in the lives of your local and global communities. We invite you to join us in celebrating the launch of this exciting new content by:

1. Watching the videos on our website scanning the QR code below.
2. Spreading the word by liking, commenting on, and sharing our posts on social media.
3. Joining us by signing up for membership and attending the 2024 AGMHI conference.

Your support and engagement are invaluable in helping the AGMHI reach a wider audience and make an even greater impact. Together, we are creating a future where mental health care is accessible, equitable, and effective for all individuals across Africa and the diaspora.

Thank you for your continued support, and we hope you will join us as we foster collaborations and catalyze solutions to improve mental health outcomes ■

Watch video

SASOP AND RCPSYCH DEANS GRAND ROUND

You are invited to attend our collaborative AGMHI, SASOP & RCPsych Dean's Grand Rounds on Thursday 22 August 2024 at 11am ET / 4pm BST / 5pm CAT.

TITLE:

Integrating perinatal and infant mental health services in resource-constrained settings: Creating a "one-stop shop" using a public mental health approach.

Session by by Drs Lavinia Lumu, Bavi Vythilingum and Anusha Lachman ■

Register here

SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

SASOP STATEMENT ON THE ETHICAL AND SAFE USE OF KETAMINE IN THE TREATMENT OF TREATMENT RESISTANT DEPRESSION (TRD)

Ketamine is a new and effective treatment option for the treatment of Treatment-Resistant Depression (TRD).

SASOP released a statement in 2022 that addresses some of the pitfalls of ketamine administration, including:

1. Ketamine is registered in South Africa as an anesthetic agent, and therefore, the use of ketamine for the treatment of depression and suicidality is off-label.
2. Although there is evidence for efficacy in treating TRD, long-term data regarding safety are needed, and its position in treatment algorithms still needs to be established.
3. The recommended route of administration is ivi, and for safety reasons, ketamine should be administered by an anesthetist or suitably qualified general practitioner (diploma in anesthetics).
4. The diagnosis of TRD is in the sole domain/ Scope of Practice of psychiatrists, as only psychiatrists review the efficacy of the previous treatment (and thus diagnose "true" treatment resistance).
5. Patients should, therefore, formally be referred by a psychiatrist to the medical practitioner who administers the ketamine. Psychiatrists should follow up with patients who have received ketamine.
6. Organizations promoting the ethical and safe use of ketamine, such as SASA (South African Association of Anesthesiologists), have released statements that SASOP supports.

As the number of patients receiving ketamine has increased dramatically, the following concerns have been identified:

1. Ketamine has been advertised extensively, e.g., on social media. This has enabled patients with depression to obtain ketamine on demand without an evaluation by a psychiatrist. Thus, the diagnosis of TRD for many patients has not been established. This exposes patients to side effects, possible worsening of their mental health condition, and numerous other adverse effects.
2. As only psychiatrists can diagnose TRD, this implies health practitioners such as psychologists and general practitioners recommending and administering ketamine are practicing out of scope of practice. They are exposing patients to risks and themselves to litigation.
3. The use of ketamine is evidence-based for adults. However, it has been mentioned in the media as a treatment option for children.
4. SAPHRA (South African Health Products Regulatory Authority) has ruled that because the use of ketamine for TRD is off-label, ketamine may not be advertised or even mentioned online. Although factually correct, this stance makes it difficult to educate the public.
5. Due to the increased use of ketamine, the supply of ketamine has become problematic. Fresenius Kabi does not condone the off-label use of ketamine for psychiatric patients, except when under strict supervision of a psychiatrist.
6. Only psychiatrists can diagnose TRD and

SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

prescribe ketamine, while only anesthetists and GPs with diplomas can administer ketamine. This scenario has, unfortunately, created conflict and communication breakdown between the relevant medical practitioners. This is not to the advantage of our patients.

SUMMARY:

The first SASOP statement regarding the use of ketamine for TRD remains applicable.

We anticipate an increased demand for ketamine as a therapeutic modality, which will lead to additional challenges with interpretation and compliance with existing guidelines will likely accompany.

Adherence to the recommendations of the initial SASOP position statement remains critical.

All relevant stakeholders, e.g., psychiatrists, psychologists, general practitioners, anesthesiologists, and patients, should be informed about the ethical and safe use of ketamine in the treatment of TRD

SASOP DIRECTORS:

Dr A Lachman (President), Dr Thuli Mdaka (Public Sector Convenor),

Dr A Pillay (President-Elect), Dr A Porter (Honorary Secretary), Dr S Seape (Past-President),

Dr T Seshoka (Honorary Treasurer), Dr Melane van Zyl (Private Sector Convenor)

REFERENCES:

1. Schwartz J, Murrough JW, Iosifescu DV Ketamine for treatment-resistant depression: recent developments and clinical applications

2. *BMJ Ment Health* 2016;19:35-38. Megan Brooks; Charles P. Vega; The APA Guidelines on Ketamine Use for Depression; https://ketamineclinics.co.za/wp-content/uploads/2021/06/American-Psychiatric-Association-Guidelines-on- Ketamine-use-for-Depression.pdf

3. Kennedy SH, Lam RW, McIntyre RS, Tourjman SV, Bhat V, Blier P, Hasnain M, Jollant F, Levitt AJ, MacQueen GM, McInerney SJ, McIntosh D, Milev RV, Müller DJ, Parikh SV, Pearson NL, Ravindran AV, Uher R; CANMAT Depression Work Group. Canadian Network for Mood and Anxiety Treatments (CANMAT) 2016 Clinical Guidelines for the Management of Adults with Major Depressive Disorder: Section 3. Pharmacological Treatments. *Can J Psychiatry.* 2016 Sep;61(9):540-60. doi: 10.1177/0706743716659417. Epub 2016 Aug 2. Erratum in: Can J Psychiatry. 2017 May;62(5):356. PMID: 27486148; PMCID: PMC4994790.

4. * The Canadian Network for Mood and Anxiety Treatments (CANMAT) Task Force Recommendations for the Use of Racemic Ketamine in Adults with Major Depressive Disorder; Recommandations Du Groupe De Travail Du Reseau Canadien, Pour Les Traitements De L'humeur Et De L'anxiet' e (Canmat), Concernant L'utilisation De La Ketamine Rac' emique Chez, Les Adultes Souffrant De Trouble Depressif Majeur'

5. Jennifer Swainson, Alexander McGirr, Pierre Blier, Elisa Brietzke, Stephane Richard-Devantoy, Nisha Ravindran, Jean Blier, Serge Beaulieu, Benicio N. Frey, Sidney H. Kennedy,Roger S. McIntyre, Roumen V.Milev, Sagar V. Parikh, Ayal Schaffer, Valerie H. Taylor, Valerie Tourjman,Michael van Ameringen, Lakshmi N.Yatham, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7918868/pdf/10.1177_0706743720970860.pdf

6. * Megan Brooks; Charles P. Vega; The APA Guidelines on Ketamine Use for Depression; https://ketamineclinics.co.za/wp-content/uploads/2021/06/American-Psychiatric-Association-Guidelines-on- Ketamine-use-for-Depression.pdf

7. * Roger S. McIntyre, Joshua D. Rosenblat, Charles B. Nemeroff, Gerard Sanacora, James W. Murrough, Michael Berk, Elisa Brietzke, Seetal Dodd, Philip Gorwood, Roger Ho, Dan V. Iosifescu, Carlos Lopez Jaramillo, Siegfried Kasper, Kevin Kratiuk, Jung Goo Lee, Yena Lee, Leanna, Rodrigo B. Mansur, George I. Papakostas, Mehala Subramaniapillai, Michael Thase, Eduard Vieta, Allan H. Young, Carlos A. Zarate, Stephen Stahl, Synthesizing the Evidence for Ketamine and Esketamine in Treatment-Resistant Depression: An International Expert Opinion on the Available Evidence and Implementation; ajp.psychiatryonline.org 1; https://adaa.org/sites/default/files/Banners/APA%20American%20Journal%20International%20Guidelines%20 Ketamine%20Esketamine%20Final%202021.pdf

JOINT STATEMENT ON USE OF KETAMINE AND PSYCHEDELIC AGENTS

The South African Society of Psychiatrists (SASOP) and the South African Society of Anaesthesiologists (SASA) Joint Position Statement on the use of ketamine and psychedelic agents

The South African Society of Psychiatrists (SASOP) and the South African Society of Anaesthesiologists (SASA) jointly note with concern the recent promotion of the use of psychedelic agents for clinical use, and the off-label use of ketamine in South Africa by the healthcare profession.

The recent formation of a new multidisciplinary society in South Africa - The Society of Interventional Practitioners South Africa (SIPSA) - with the stated aims of promoting the professional and legitimate interests of ketamine and psychedelic treatments, and to develop guidelines, uniform protocols and techniques for ketamine and legal psychedelic treatments, has prompted SASOP and SASA to alert membership of the following:

- SASOP has a clear position statement that ketamine for psychiatric indications is a level 3 treatment and should be administered at level 2-7 care pathways and, therefore, should only be prescribed by a psychiatrist, as only a specialist clinician in this field is qualified to decide if an indication for ketamine for mental illness is present[1]

- Then, to note with emphasis, all psychedelics, including psilocybin and MDMA, are currently illegal in South Africa, and SASOP has a clear position statement in this regard[2]. This is still clearly referenced in the Drugs and Drug Trafficking Act 140 of 1992 and the Medicines and Related Substances Act 101 of 1965[3]

- SASOP does not support or endorse the use of psychedlics for any psychiatric conditions and does not currently support the use of ketamine for psychiatric conditions other than Treatment Resistant Depression (TRD). Neither SASOP nor SASA support the treatment of TRD by anaesthesiologists. Further we do not support or endorse the use of psychedlic assisted therapy

- Both SASOP and SASA only endorse practice that is in line with good clinical practice (GCP) guidelines[4]

- Lastly, SASA has clear clinical practice and safety guidelines for the administration of ketamine with respect to pain management in the acute perioperative and chronic pain settings. However, the association of ketamine usage as part of psychotherapy or within ketamine clinics requires that this be strictly under the guidance and prescription of a qualified specialist psychiatrist[5]

SASOP and SASA encourage their members to abide by the existing guidelines of their respective organisations and reiterate that they cannot support any practitioner who engages in illegal behaviour, the prescription or distribution of illegal substances, or clinical practice that is neither evidence-based nor peer-reviewed, and which may contravene existing South African law, the South African Health Act, or the HPCSA Ethical Rules. In addition, this practice may be viewed as being harmful to patients and any practitioner registered with the HPCSA will be mandated to report an offending practitioner engaging in such practice to the HPCSA themselves, as per the Ethical Rules of the HPCSA. SASOP and SASA caution their members of the medicolegal risk inherent in experimental practices, as both short-term insurers and mutual indemnifiers consulted on this topic would not support practitioner cover in the event that a knowingly illegal act was willfully or deliberately committed or off-label or unregistered or unapproved medical intervention was instituted in blatant contravention of South African law.

Off-label usage and prescription of ketamine for indications other than TRD, as well as the illegal usage or prescription of psychedelics within the clinical space, remain in contravention of the HPCSA ethical rules and the South African Law. Research and experimental practice are restricted to those institutions that are both approved for and licensed to partake in such activities and are, therefore, heavily regulated within the legal and ethical boundaries of the State.

SASOP and SASA support the commitment to current and future approved and licensed research and exploration of treatment modalities within the fields of psychiatry, chronic pain management, and perioperative anaesthesiology, respectively. However, this research should be conducted only in appropriately regulated, ethically approved,

and strictly controlled environments and by appropriately qualified and licensed practitioners.

We remain open to further engagement in the best interests of patient safety and the maintenance of professional standards of quality patient care.

REFERENCES

1. SASOP Statement on Use of IVI Ketamine and Intranasal Esketamine for TRD
2. SASOP Statement on the Use of Psychedelic & Empathogenic Agents for Mental Health Conditions https://www.sasop.co.za/_files/ugd/cc5d8c_c374aef5e8f3415590b14b0d7825d8c8.pdf
3. The Medicines and Related Substances Act (previously Drugs Control Act) 101 of 1965 https://www.sahpra.org.za/wpcontent/uploads/2019/09/Medicines-and-Related-Substances-Act_101-of-1965_Act_GG-40869_2017-05-26.pdf
4. SOUTH AFRICAN GOOD CLINICAL PRACTICE GUIDELINES SECOND EDITION https://health.gov.za/wp-content/uploads/2021/10/nhrec-train_gcp.pdf
5. SASA Practice Guidelines 2022. South Afr J Anaesth Analg. 2022; 28(4 Suppl 1) http://sasaweb.com/wp-content/uploads/2022/09/SASA-Practice-Guidelines-2022-Appendices-Combined-Final.pdf

JAPANESE SOCIETY OF PSYCHIATRY AND NEUROLOGY FELLOWSHIP AWARD

The Japanese Society of Psychiatry and Neurology (JSPN) is pleased to invite young psychiatrists from around the world - particularly Asia- to apply for the Japanese Society of Psychiatry and Neurology Fellowship Award.

The purpose of this award is to recognise early-career, outstanding psychiatrists and to encourage academic discussion and personal friendships with early-career Japanese psychiatrists at the 121st annual meeting of the JSPN in June 19th to 21st, 2025 in Kobe, Japan.

Award recipients will receive a waiver of meeting registration fees, accommodation, and a prize (JPY 70,000 for recipients from World Bank A and B category countries, and JPY 140,000 for those from C and D countries). Award recipients will be expected to give a presentation at one of the international sessions, the themes of which are;

1. Natural disasters and mental health, including due to global climate change
2. Case Vignette

Award recipients will also be expected to attend other programs for JSPN Fellowship and to participate in future JSPN Fellowship Award Alumni programs.

APPLICANTS MUST:

1. Be 40 years old or less, or have 10 years or less experience in psychiatry when the JSPN Annual Meeting is held in 2025;
2. Not be previous recipients of the JSPN Fellowship Award; and
3. Belong to a World Psychiatric Association member society.

(To ensure broad participation from around the world, the JSPN accepts nominations from each society up to a maximum of two applicants.)

MEETING INFORMATION

The 121st Annual Meeting of the Japanese Society of Psychiatry and Neurology

- Date: June 19th to 21st, 2025
- Venue: Kobe International Conference Center / Kobe International Exhibition Hall / Kobe Portopia Hotel
- Meeting president: Shu-ichi Ueno Professor, Department of Neuropsychiatry, Neuroscience, Ehime University Graduate School of Medicine, Ehime
- Theme: Enhancing and Developing Psychiatry and Neurology : Issues To Be Addressed

APPLICATION PROCEDURE

For details, please ask the applicants to visit the English website of the JSPN.

https://www.jspn.or.jp/modules/english/index.php?content_id=86

Applicants must submit through On-Line Registration System for the 121st Annual Meeting of the Japanese Society of Psychiatry and Neurology.

Application Deadline: September 25th, 2024 (Japan time)

CONTACT

Secretariat of the Japanese Society of Psychiatry and Neurology

E-mail: jimu-kokusai@jspn.or.jp

Postal address: CIRCLES Ochanomizu Building, 2-3-6, Kandasurugadai, Chiyoda-ku, Tokyo 101-0062 Japan

SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

SASOP PSYCHMG ROADSHOW 2024 EASTERN CAPE

WE HAVE BEEN FORTUNATE IN THAT PHARMADYNAMICS HAS AGREED TO SPONSOR ANOTHER ROUND OF SASOP/PSYCHMG ROADSHOWS IN 2024.

This year we will be focusing on development of the subgroups, and developing leadership at a local level.

PROGRAMME:

15h30-17h30	Workshop for selected/invited colleagues and Subgroup Committee on Leadership
17h30-18h00	Drinks
18h00-19h30	Workshop with SASOP/PsychMg members
19h30-21h00	Dinner with SASOP/PsychMg feedback

Regards,
Dr Ian Westmore
(Convener)

You are free to forward any questions for discussion to me at ianwestmore@icloud.com

DISCLAIMER:

Members who RSVP for the event will be held liable for their cost should they not attend.

DATES FOR ROADSHOW 2024:

Saturday	27.07.2024	Cape Town (morning meeting)
Wednesday	14.08.2024	PE/Gqeberha (afternoon/evening meeting)
Thursday	15.08.2024	The Beach Hotel East London (afternoon/evening meeting)
Saturday	14.09.2024	Blue Lagoon Hotel Gauteng (combined Northern and Southern with Northwest) (morning meeting)
Wednesday	09.10.2024	Southern Cape (George)(afternoon/evening meeting)
Saturday	02.11.2024	Limpopo (morning meeting)

REGISTER HERE

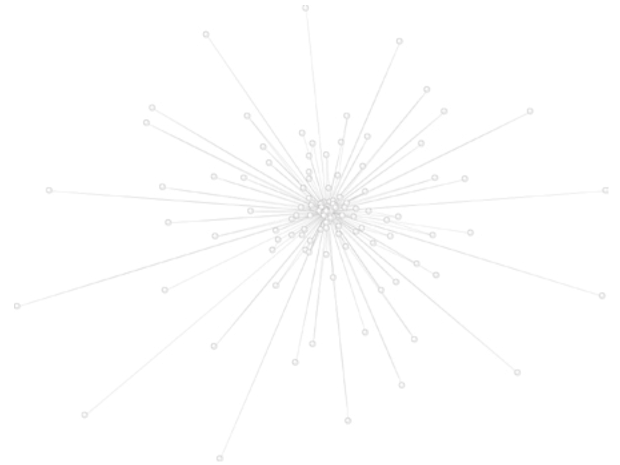
SPONSORED BY:

EFFECTIVE AFFORDABLE HEALTHCARE

INSTRUCTIONS TO AUTHORS

South African Psychiatry publishes original contributions that relate to South African Psychiatry. The aim of the publication is to inform the discipline about the discipline and in so doing, connect and promote cohesion.

The following types of content are published, noting that the list is not prescriptive or limited and potential contributors are welcome to submit content that they think might be relevant but does not broadly conform to the categories noted:



LETTERS TO THE EDITOR

* Novel experiences
* Response to published content
* Issues

FEATURES

* Related to a specific area of interest
* Related to service development
* Related to a specific project
* A detailed opinion piece

REPORTS

* Related to events e.g. conferences, symposia, workshops

PERSPECTIVES

* Personal opinions written by non-medical contributors

NEWS

* Departments of Psychiatry e.g. graduations, promotions, appointments, events, publications

ANNOUNCEMENTS

* Congresses, symposia, workshops
* Publications, especially books

The format of the abovementioned contributions does not need to conform to typical scientific papers. Contributors are encouraged to write in a style that is best suited to the content. There is no required word count and authors are not restricted, but content will be subject to editing for publication. Referencing - if included - should conform to the Vancouver style i.e. superscript numeral in text (outside the full stop with the following illustration for the reference section: *Other AN, Person CD. Title of article. Name of Journal, Year of publication; Volume (Issue): page number/s. doi number (if available).* **Where referencing is not included, it will be noted that references will be available from the author/authors.** All content should be accompanied by a relevant photo (preferably high resolution – to ensure quality reproduction) of the author/authors as well as the event or with the necessary graphic content. A brief biography of the author/authors should accompany content, including discipline, current position, notable/relevant interests and an email address. Contributions are encouraged and welcome from the broader mental health professional community i.e. all related professionals, including industry. All submitted content will be subject to review by the editor-in-chief, and where necessary the advisory board.

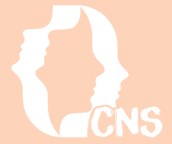
REVIEW / ORIGINAL ARTICLES

Such content will specifically comprise the literature review or data of the final version of a research report towards the MMed - or equivalent degree - as a 5000 word article

* A 300 word abstract that succinctly summarizes the content will be required.
* Referencing should preferably conform to the Vancouver style i.e. superscript numeral in text (outside the full stop with the following illustration for the reference section: *Other AN, Person CD. Title of article. Name of Journal, Year of publication; Volume (Issue): page number/s. doi number (if available);* Harvard style or variations of either will also be acceptable
* The submission should be accompanied by the University/Faculty letter noting successful completion of the research report.

Acceptance of submitted material will be subject to editorial discretion

All submitted content will be subject to review by the editor-in-chief, and where necessary the advisory board. All content should be forwarded to the editor-in-chief, Christopher P. Szabo - Christopher.szabo@wits.ac.za



A calming touch

Introducing CLOBAZAM ADCO

Indicated for the treatment of anxiety in neurotic patients, for pre-operative medication, and it may be effective in relieving the acute symptoms of alcohol withdrawal syndrome[1]

May be used as an adjuvant in epilepsy*[1]

- Unlike other benzodiazepines, **CLOBAZAM ADCO** has less sedative effects[2]
- Mild to moderate adverse events[2]
- Cost saving of 15 % versus originator[3]

NEW

Clobazam ADCO

*The dosage of CLOBAZAM ADCO should be determined by monitoring the EEG and plasma levels of the other medicines.[1]

References: 1. CLOZABAM ADCO 10 & 20 mg tablets Professional Information, 27 June 2023. 2. Faulkner MA. Comprehensive overview: efficacy, tolerability, and cost-effectiveness of clobazam in Lennox-Gastaut syndrome. *Ther and Clin Risk Manage* 2015;11:905-914. 3. Generics dictionary. http://www.generic.co.za/frontend/generics?utf8=%E2%9C%93&q%5Bactive_ingredient_name_eq%5D=CLOBAZAM (Accessed: 03 October 2023).

For full prescribing information please refer to the Professional Information approved by SAHPRA (South African Health Products Regulatory Authority).

S5 CLOBAZAM 10 ADCO. Each tablet contains 10 mg of clobazam. Reg. No.: 55/2.6/0546. S5 CLOBAZAM 20 ADCO. Each tablet contains 20 mg of clobazam. Reg. No.: 55/2.6/0547.

Adcock Ingram Limited. Reg. No.: 1949/034385/06. Private Bag X69, Bryanston, 2021. Customer Care: 0860 ADCOCK/232625. www.adcock.com
20230801103033342. August 2023.

17919

adcock ingram generics