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SOUTH AFRICAN PSYCHIATRY

ISSN 2409-5699

ABOUT the discipline FOR the discipline

issue 26 • FEBRUARY 2021



MOTHERING IN
CHILDHOOD:
THE IMPLICATIONS AND
CHALLENGES

PSYCHOSOCIAL
OUTCOMES
IN CHILDREN WITH
S H O R T
S T A T U R E

PREMENSTRUAL
DYSPHORIC
DISORDER (PMDD):
THE MONSTER OF
“ P M S ”

PUBLISHED IN ASSOCIATION WITH THE SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

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S E Q U E L A E
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Features

MOTHERING IN
CHILDHOOD:

14

THE IMPLICATIONS
AND CHALLENGES

PREMENSTRUAL
DYSPHORIC DISORDER
(PMDD):

23

THE MONSTER OF
"PMS"

PSYCHOSOCIAL
OUTCOMES
IN CHILDREN WITH
SHORT STATURE

34

NEUROPSYCHIATRIC
SEQUELAE
IN POST COVID-19
ILLNESS

41

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Acknowledgement: Thanks to Lisa Selwood for assistance with proof reading

Advertising: The Source Public Relations, Pharmapreneurs

Design and Layout: Rigel Andreoli

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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.

"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."

S
T
I
N
T
E
N
T
S
O
N
E

FEBRUARY 2021

- 8 FROM THE EDITOR
- 10 **IN MEMORIAM PROF DAN LAMLA MKIZE**
- 12 **PHARMA DYNAMICS** SPONSORS NEW PSYCHIATRY PROCEDURAL CODING WEBINAR
- 14 **MOTHERING IN CHILDHOOD: THE IMPLICATIONS AND CHALLENGES**
- 18 **PUTTING POLICY INTO PRACTICE: DISTRICT MENTAL HEALTH AND COMMUNITY PSYCHIATRY IN GAUTENG PROVINCE**
- 23 **PREMENSTRUAL DYSPHORIC DISORDER (PMDD): THE MONSTER OF "PMS"**
- 31 **THE HEALTHCARE WORKERS CARE NETWORK (HWCN): SUPPORTING SOUTH AFRICAN HEALTHCARE WORKERS DURING THE COVID-19 PANDEMIC AND BEYOND**
- 34 **PSYCHOSOCIAL OUTCOMES** IN CHILDREN WITH **SHORT STATURE**
- 38 **DISCOVERY COVID-19 WEBINARS AND PODCASTS**
- 41 **NEUROPSYCHIATRIC SEQUELAE IN POST COVID-19 ILLNESS**
- 48 **WPA NEWS**
- 50 **CHERRYMED UPDATE**
- 52 **DR REDDY'S WEBINARS**
- 57 **BELIEF SYSTEMS** AND THE ROUTINE BIOPSYCHOSOCIAL (BPS) **CLINICAL ASSESSMENT**
- 59 OF NECESSARY INVASION, **BROKENNESS AND BRAVERY**
- 62 **ADDICTION TREATMENT** AND DUAL DIAGNOSIS IN SOUTH AFRICA
- 63 **DEPARTMENTS OF PSYCHIATRY**
- 71 **MEDICAL PRACTICE: THE MINEFIELD OF SAVING LIVES**
- 73 **MADNESS** STORIES OF UNCERTAINTY AND HOPE
- 76 **THE PERSUASION CODE: HOW NEUROMARKETING CAN HELP YOU PERSUADE ANYONE, ANYWHERE**
- 78 **CONSCIOUSNESS RISING**
- 81 **NUTT UNCUT & DRINK?**
- 82 **MOVIES**
- 83 **WINE FORUM: PEAS IN A POD - TWO ROCKSTAR WOMEN WINEMAKERS**
- 85 **FORESTS, BEACHES, AND THE OVERSTRESSED CLINICIAN: AN ANALYSIS OF KNYSNA AS CHILL SPOT**
- 88 **SASOP**

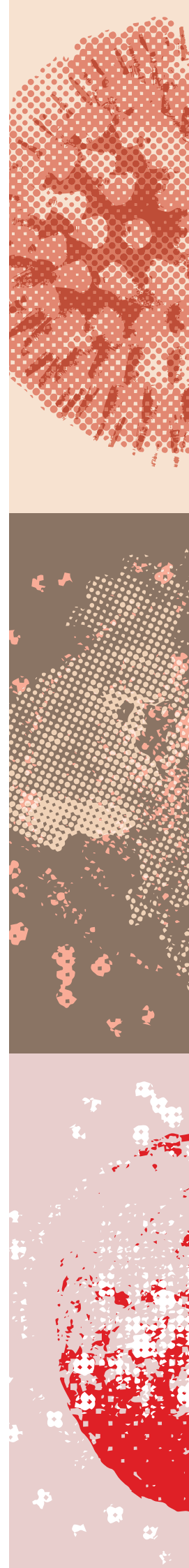
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Dear Reader,

Welcome to the 1st issue of 2021. Strangely 2021 feels no different to 2020. It is as if there has been no new year, but simply a continuation of time as we find ourselves living through a pandemic whose waves wax and wane but seemingly will continue well into this next year. There is much chatter about the Great Reset (conspiracy theory related to a new world order or a process unfolding in plain sight that will enhance lives for all? https://en.wikipedia.org/wiki/Great_Reset) and taking a leaf out of the French Revolution's book where the past was cast into oblivion, or at least was destined to be, and the world begun anew – we are now in year 2 <https://daily.jstor.org/why-the-french-revolutions-rational-calendar-wasnt/>.



I decided, in writing this piece, to return to the February 2020 issue of *South African Psychiatry*. Reading it I was struck by how naively quaint it was – acknowledging the content, which included the article on an African approach to mental health and illness by Jan Chabalala (since deceased) as well as looking forward to the National Congress...which never happened. These have indeed been tumultuous times, generally, and aside from COVID related content in the subsequent issues of *South African Psychiatry* during 2020 I have had no impression of how the situation has impacted psychiatric practice from fellow clinicians – albeit that I had suggested in the May 2020 issue that such sharing of personal experience would have been welcome and certainly published. So, I wonder how everyone is doing? How you are coping? How have you adapted? As for myself – as you see...I am here, writing this piece, involved with the publication and continuing to see patients with a blend of in-person and Zoom/Skype. The latter has established itself as a useful adjunct albeit lacking the qualitative experience of in person consulting. Whilst certainly an option for established therapeutic relationships, I have reservations regarding use for initial assessments.

Based on *evidence* the publication moved forward and evolved during 2020, and has made it to 2021. Each issue is a journey, and I am always humbled by the contributors who take time to write – without content there is no publication. I am grateful to industry, whose involvement and support is vital. Finally, the readership – why else have a publication. Speaking of readership, we undertook a survey some months ago and I was pleased that we actually received responses. Surveys are notorious in this regard. Although the sample of respondents was limited it does appear that in the main the experience of *South African Psychiatry* is overwhelmingly favourable. It was heartening to note that content was regarded as *very* or at least *somewhat* informative with the majority of respondents reading *most* if not *all* of it, with *Features, Perspectives and Reports* viewed as *very interesting* or *interesting*. Whilst being in our seventh year of existence one might assume that we are getting something right, it is always reassuring to obtain direct feedback. As a publication we are constantly evaluating our product and based on responses we have already introduced a *Book Review* section and are considering how to further develop our online offerings, noting that hardcopy remains our preferred means of publication – specifically noting that respondents reported keeping their copies of each issue for more than a month.

As much as I have waxed a bit philosophical I now need to mention a few hard facts. Throughout 2020 I was struck with the extent of loss of colleagues, friends and family. It was not a good year. Alas, 2021 begins no differently in terms of colleagues and I need to acknowledge the passing of Dan Mkize, the former Head of Department at UKZN and one of the elder statesmen of South African psychiatry (see SASOP content which follows), as well as the passing of Fred Kigozi, a Ugandan psychiatrist and colleague who was an active member of the World Psychiatric Association as a zonal representative. Sad losses, and our condolences to family and loved ones.

Finally, I am pleased to announce that Renata Schoeman has agreed to join the board of *South African Psychiatry* as an Associate Editor. Renata is no stranger to our readership, and I have no doubt that her enthusiasm and “can do” approach will serve the publication well. Welcome Renata. In addition, and as has been tradition for Heads of Departments to be members of the advisory board, we are pleased to have Funeka Sokudela join following her appointment as Head of Department at the University of Pretoria – congratulations on the latter, and welcome aboard. Speaking of HoDs – thanks to those who submitted content for the *Department News* section. It is the first time we have five Departments represented in one issue.

As always, I hope you enjoy the issue. Stay safe.

A handwritten signature in black ink, appearing to read 'C. Kigozi'. The signature is stylized and fluid.

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IN MEMORIAM PROF DAN LAMLA MKIZE



We are deeply saddened to inform you of the untimely death of Prof Dan Lamla Mkize on the 17th of January 2021.

As his successors in the Department of Psychiatry at the University of KwaZulu-Natal, we are humbled and honored to pay tribute to this visionary leader, outstanding doctor, respected mentor and friend.

Dan was born and bred in Umzimkhulu and his roots remained deep in this region of KZN. Umzimkhulu is on the borderland of KZN and the Eastern Cape, and it is therefore fitting that he left his mark on the mental health care of KZN and Eastern Cape. He matriculated in 1966 from St John's College in Mthatha and entered medical school at the then University of Natal, graduating with an MBChB as a doctor in 1972. He returned to his birthplace, working as a Family Practitioner and District Surgeon from 1975 to 1984. He obtained Diplomas in Child Health and Forensic Medicine as well as the MFGP from the Colleges of Medicine during the period 1978 to 1983. Dan then returned to the University of Natal to specialize as a psychiatrist, graduating with an MMed Psych in 1989.

ALWAYS DRAWN TO SERVE WHERE THERE WAS NEED, DAN MOVED BACK TO MTHATHA TO WORK AS A PSYCHIATRIST, ESTABLISHING THE DEPARTMENT OF PSYCHIATRY IN MTHATHA AND BECOMING ASSOCIATE PROFESSOR AT THE UNIVERSITY OF TRANSKEI FROM 1992 TO 2000.

He served in many administrative roles at UNITRA, including as Vice Dean of the Faculty of Medicine and Health Sciences from 1996 to 1997. During this period, he was involved in the National Department of Health's programme to recruit medical practitioners from Cuba and he recruited an esteemed colleague to the Department as his successor. In 2001, Dan was appointed Professor and Head of the Department of Psychiatry at UKZN, a position he held for almost ten years until his retirement in 2010, when he became Emeritus Professor of Psychiatry.

As HOD of Psychiatry at UKZN and Chief Specialist Psychiatrist for the Province, Dan drove the



development of mental health services across KZN and his impact was huge. Mental health care services were greatly expanded and particularly in areas traditionally starved of specialist and academic involvement. As a direct result of his efforts, senior level psychiatrist posts were established in Pietermaritzburg, Ngwelezane, Madadeni and Port Shepstone. At a Provincial level, Dan chaired the drafting of the first mental health care policy in KZN – the KZN Strategic and Implementation Plan and later, in 2018, was appointed by the National Minister of Health as Director of Mental Health for the Eastern Cape Province.

HE WAS A PIONEER ALSO OF DECENTRALIZING THE REGISTRAR TRAINING PLATFORM, WITH PSYCHIATRY BEING ONE OF THE FIRST DISCIPLINES TO SEND REGISTRAR TRAINEES TO PORT SHEPSTONE AND NGWELEZANE HOSPITALS.

Nationally, he was a member of the Ministerial Committee on Mental Health and Substance Abuse from 1994 to 1995, chaired the first National Health Research Committee from 2007 to 2010, and served as President of the College of Psychiatrists of South Africa for the period 2009 to 2011. These roles were a testament to his great leadership abilities that were recognized by his peers and leaders of the Department of Health. In addition he served on the Boards of numerous organisations – professional, academic, governmental and non-governmental – at local, national and international levels. He was also a key resource person for the leadership of SASOP, both nationally and in KZN subgroup.

DAN'S ACADEMIC AND RESEARCH INTERESTS WERE WIDE AND HIS GREATEST CONTRIBUTIONS WERE IN RELATION TO THE FIELD OF TRANSCULTURAL PSYCHIATRY, AND SPECIFICALLY AFROCENTRIC PSYCHIATRY. HE WAS GREATLY INTERESTED IN THE ROLE THAT CULTURE, SPIRITUALITY AND RELIGION PLAY IN THE EXPRESSION OF OUTCOMES, PATHWAYS TO CARE, AND OUTCOME.

Remarkably he was interested in this area very early on in his career as he was awarded the coveted RWS Cheetam Award for an article he wrote at the end of his registrar training in 1989. He was still interested in this area in the last few years as he sought to navigate the ethical dilemmas in forensic psychiatry through the African spiritual lens. He

supervised many registrar research theses and presented in national and international congresses. He was also invited to examine undergraduate and postgraduate students at a number of universities across our country.

Since Dan's untimely passing, we have asked some of his colleagues what they remember best about him and we would like to share a few common themes that emerged.

Firstly, Dan was a humble, unassuming and approachable man, a down to earth and genuine man of integrity and warmth. Bonga relates: *"I remember him coming to my home in Hillcrest after several of us had passed our final specialist exams to celebrate with us ... eat some meat ... and drink some whisky."*

Secondly, Dan was deeply committed and unwavering in his vision and dedication to training more African psychiatrists and he achieved this without doubt. *"Yet"* said one colleague, *"he did so by respecting those of us who are not African"*. Jonathan adds: *"In 2006 I joined the Department – a young white man from a privileged background and Dan didn't just accept me, he actively supported and mentored and befriended me every inch of the way, to the point where I could follow him as HoD. That had a huge impact on my life – one I won't ever forget."*

And thirdly, a registrar in psychiatry speaks very fondly of a chance meeting with Prof Mkize as a medical student. After rotating in psychiatry, he thought THAT is the kind of doctor I would like to be! We are certain that he inspired many more medical students to specialize in psychiatry.

While Dan saw many successes in his academic and professional life, he was always, first and foremost a loyal and deeply committed man to his family, his community and his country. He had a deep and serious faith and a humble but firm passion for bettering the lives of others, especially those less fortunate than himself. We have lost a legend and while we mourn, we celebrate this true leader and servant. Rest in peace, Dan, you have done a great job and lived a life to be proud of. We will miss you but will try always to follow your example.

Hambe Kahle Mkhulu!

Prof's Bonga Chiliza & Jonathan Burns ■



PHARMA DYNAMICS COMMITTED TO WORKING WITH CLINICAL PARTNERS TO IMPROVE MENTAL HEALTHCARE FOR ALL IN 2021 -
SPONSORS NEW PSYCHIATRY PROCEDURAL CODING WEBINAR



As direct support to clinicians and other relevant personnel, Pharma Dynamics provides ongoing CPD training through the SmartDoc portal and we work with multiple bodies and professionals within the discipline to provide topical and instructive webinars available more widely.

Clinicians stand at the forefront of the twin epidemics of COVID-19 and non-communicable lifestyle diseases, none more so than mental health illness.

Pharma Dynamics, as a leading provider of psychiatric medication and advocate of mental health in the country, is committed to stepping up alongside our clinical partners and the industry for better mental healthcare for all in 2021 and beyond. This includes providing more affordable psychiatric medication through the provision of effective generic medicines.

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Our patient support programmes stand alongside our wide portfolio of CNS medications – including for depression, bipolar disorder, anxiety and panic disorders, schizophrenia, chronic pain, epilepsy and common mental health concerns in children and adolescents, amongst others – in offering comprehensive mental health support and patient empowerment. The new year also sees the expansion of our digital patient education platform, Let’s Talk, and its integration into our wider My Dynamics platform. Additionally, the QR codes on our new product packaging allows clinicians to send patients to a trusted source of health information to ensure easier and continuous patient education and lifestyle support for overall wellness “beyond the pill”.

Our latest webinar series, run in conjunction with PsychMG and presented by Dr Eugene Allers, is focused on updating clinicians and practise staff on the new the procedural coding system in the 2021 Medical Doctors’ Coding Manual (MDCM). PsychMg has been in consultation with relevant role-players to make these changes that were implemented at the start of the year. Changes have been made to attempt to address the guarantee of payment of prescribed minimum benefits by medical aid schemes for patients with psychiatric disorders who have seen significant increases in costs and reduced benefit coverage over the years, putting mental health treatment out of range for many. Some important changes are in relation to clinicians who may have been up-coding certain conditions as PMBs as an attempt to assist patients to access scheme risk benefits, but who may have had administrative difficulty therefore. This was particularly concerning as previously bipolar mood disorder was eligible for PMB coverage, but other forms of depression were excluded; it is alleged that many patients are subsequently coded as having BMD.

ALL CLINICIANS ARE ENCOURAGED TO ATTEND THE WEBINAR FOR TRAINING IN THE NEW CODING AND ITS IMPLEMENTATION IN PRIVATE PRACTICE.

The next webinar is scheduled for Wednesday, 10 February, 18h30-20h00, with plans to present workshops in the major centres in the latter half of 2021, dependent on the COVID-19 situation. The webinar can be accessed on ZOOM.

If you would like more information about the webinar or SmartDoc registration, or any Pharma Dynamics CNS products, you can contact: a.kenny@pharmadynamics.co.za.

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MOTHERING IN CHILDHOOD: THE IMPLICATIONS AND CHALLENGES

Alexandra Maisto

Adolescent pregnancy is defined as pregnancy that occurs from the age of 10 to 19 years. It is a global social and health problem accounting for 11% of all births worldwide, the majority of the burden occurs in developing countries. South Africa has a very high burden with estimates ranging from 15% of all pregnancies occurring between the ages of 15-19 years and 19% of pregnancies in the 12-19 year age group.

WHY IS IT A PROBLEM?

Adolescent pregnancy is associated with significant adverse health outcomes, including effects on mental and physical health in both the adolescent and her child. Indeed one of the leading causes of adolescent girl mortality is pregnancy and delivery related complications. Adolescents are at a high risk of developing eclampsia, infections and anaemia in pregnancy. Additionally, there is an increased risk of HIV infection and sexually transmitted infections and medical complications arising from attempts to terminate the pregnancy, especially when unsafe/ backstreet abortions are sought.

MENTAL HEALTH IMPACTS INCLUDE HIGHER RATES OF DEPRESSION COMPARED TO BOTH NON PREGNANT PEERS AS WELL AS PREGNANT AND POSTPARTUM ADULTS. DEPRESSION SYMPTOMS ARE MORE LIKELY TO EXTEND INTO THE POSTPARTUM PERIOD, AND MAY BECOME CHRONIC.

Adolescents may also be at a higher risk for suicidal ideation and behaviours during the peripartum period. Pregnancies resulting from rape may also increase the risk of trauma related responses including PTSD, and are associated with high rates of comorbid substance use.



Alexandra Maisto

Adolescent childbearing traps these girls in a cycle of poverty. Adolescent pregnancy is a primary risk for school dropout. Pregnant school goes face stigma and poor support from their peers and the school, and may be forced to leave by school administrators.

THE RETURN TO SCHOOL FOLLOWING CHILDBIRTH MAY ALSO BE IMPAIRED BY LIMITED OPTIONS FOR CHILD SUPPORT AND FINANCIAL PRESSURES TO SUPPORT THE CHILD. THIS IN TURN REINFORCES THE POVERTY CYCLE BY LIMITING FUTURE ECONOMIC OPPORTUNITIES AND RESULTING IN INCREASED RELIANCE ON SOCIAL SERVICES.

An increased risk of birth complications including premature rupture of membranes, very preterm delivery (before 32 weeks gestation) and the delivery of very low birth weight infants increases the risk of stillbirth and mortality and morbidity in the neonate. The presence of depression in pregnancy poses potential additional intergenerational effects. Intrauterine prenatal stress exposure is associated

with intrauterine growth restriction, low birth weight and microcephaly. Adolescent mothers may in addition lack the cognitive, social and emotional skill to provide the sensitive and appropriately responsive parenting necessary to ensure secure attachment and may provide less stimulating home environments than their adult mother counterparts. Infants born to adolescents are at an increased risk of developing neuro-behavioural disorders including Autism spectrum disorder, pervasive developmental disorder, ADHD, Mood disorders, cognitive difficulties – including learning disorders, anxiety and psychotic disorders.

WHO IS AT RISK?

Children born to parents with lower educational achievement and low income are more likely to experience pregnancy in adolescence. Adolescents living in the context of poor supervision and limited social support such as in child headed households, informal foster care and single parent households may be especially at high risk. Food insecurity and economic pressures in impoverished environments may distract from school performance and attendance, leading to school failure and early school dropout. Chaotic home environments characterised by abuse and difficult interpersonal relationships represent another factor in the development of adolescent pregnancy; along with serving as a risk for mental health complications secondary to interpersonal violence, abandonment and poor social support. Gender based violence is common in South Africa, with adolescents being particularly vulnerable to becoming victims of sexual coercion and rape.

A STUDY BY AJAYI ET AL ILLUSTRATED THAT SEXUAL VIOLENCE RESULTS IN HIGH RATES OF UNINTENDED PREGNANCY. THEY HYPOTHESISED THAT PERPETRATORS ARE UNLIKELY TO USE CONTRACEPTIVES AND VICTIMS OFTEN UNDER REPORT EPISODES AND DELAY ACTING ON THE POTENTIAL IMPACTS OF ASSAULT, SUCH AS UNINTENDED PREGNANCY.

Unprotected sexual activity is associated with a risk of HIV exposure. A South African study shows that almost a third of attendees under 20 years of age presenting to antenatal care were HIV positive. The rates of infection amongst young women are up to eight times greater than their male counterparts, with young women acquiring the infection on average 5-7 years earlier. The marked disparity in risk highlights gender inequality and inequity in access to sexual and reproductive health. High rates of HIV infection are especially common in transactional arrangements, age disparate relationships and in the context of gender based violence. The gender power dynamics in these interactions limit the adolescents' capacity to negotiate safe sex and pose an aggregated risk for exposure to HIV infection.

Adolescents who face significant psychosocial risk factors may experience limited access to health and reproductive information and have unreliable access to contraception. A nationwide household study (2012) assessing contraceptive coverage found alarmingly low knowledge about risks of pregnancy and contraception use amongst adolescents aged 15-19 years. This is a cause for concern regarding the effectiveness of current school based integrated programmes. In addition, despite termination of pregnancy becoming legal in 1997 with the implementation of The Choice on Termination of Pregnancy Act (1997) utilization is still low despite the high number of unwanted pregnancies. Many adolescents still opt for unsafe backstreet abortions. Barriers to the use of legal termination of pregnancy have been described as lack of knowledge regarding legality and fears regarding the cost, especially in young and rural adolescents. Additional concerns include fears of judgement and stigma from people becoming aware of termination procedures and disclosure to parents.

THE ASSOCIATED MENTAL AND PHYSICAL HEALTH CONSEQUENCES OF EARLY CHILDBEARING AS WELL AS IMPACTS ON THE INFANT MAY BE EXPLAINED BY THE COEXISTENCE OF ADVERSE LIFE EXPERIENCES AND SOCIO-ECONOMIC DISADVANTAGE.

In fact, a review of the literature by Hodgkinson S et al (2014) found that controlling for confounding sociodemographic factors diminished the association between adolescent pregnancy and mental health difficulties.

CHALLENGES AND BARRIERS TO CARE

Adolescents have unique health needs and require interventions which address their individual concerns. Integrated interventions that target community, school, family and individual levels of care are required.

PRIMARY AND SECONDARY PREVENTION NEEDS TO FOCUS ON ADDRESSING THE SOCIAL DETERMINANTS OF HEALTH AT A SOCIETAL LEVEL. THE CURRENT LEGISLATION OF SOUTH AFRICA PROTECTS THE RIGHTS OF PREGNANT ADOLESCENTS.

In terms of Article 9 (3) of the Constitution of the Republic of South Africa, 1996, "the state may not unfairly discriminate, whether directly or indirectly, against anyone on one or more grounds, including race, gender, sexual inclination and pregnancy" and The SA National Adolescent Sexual and Reproductive Health and Rights Framework Strategy 19 promotes the availability of adolescent Reproductive Health Policy to guide government

agencies in recognising the rights of adolescent's access to services and information regarding reproductive and sexual health; however, this doesn't necessarily translate into adolescents' lived experiences.

According to the constitution every child in South Africa has the right to education, however policy documents are ambiguous and have been variably implemented. For example the national Integrated School Health Policy recommends school health services provide sexual and reproductive health services, including the distribution of contraception and condoms, however; individual school bodies have ultimate decision making powers in choosing whether these services are to be provided despite any child of 12 years being legally able to access contraception without parental consent.

FURTHERMORE, THE DEPARTMENT OF EDUCATION'S POLICY ON MEASURES FOR THE PREVENTION AND MANAGEMENT OF LEARNER PREGNANCY IS VAGUE AND NONSPECIFIC.

The document lacks clarity on when learners should leave school during their pregnancy and when to return post-delivery. It has moreover provided school administrators the option to "request" a learner leave and not return for a period of up to two years following a pregnancy. This constitutes impinging on the learners right to education.

Sexual and reproductive education also needs to be evidence based and informative with reference to elements of delaying sexual debut as well as promoting the correct and consistent use of contraceptives, including the right to termination. The alarmingly low knowledge about risks of pregnancy and unmet need for contraception amongst adolescents aged 15-19 years found in the aforementioned household survey further questions the effectiveness of current curricula. The myths and prejudice amongst administrators and educators needs to be addressed so as not to interfere with girl children's rights to comprehensive sexual and reproductive education as well as privacy. Improved collaboration and consultation between adolescents, health care providers, parents, and teachers on comprehensive sexual and reproductive content could be helpful in this regard.

LEGISLATION AND POLICY AROUND AGE OF CONSENT AND PARENTAL CONSENT REQUIREMENTS ALSO HAVE A DIRECT IMPLICATION ON ACCESS TO CARE AND DECISION MAKING AUTHORITY.

Current inconsistencies are confusing, including a younger age of consent (12 years) for contraception

and termination of pregnancy (any age) than for sexual intercourse (16 years).

In the management of adolescent pregnancy access to health services may be determined by dependence on parents/others for money for transport and payment of medical services as well as the opportunity costs of missing school to attend appointments or of guardians missing work. Making services available at community and primary level overcomes this barrier.

ENSURING SERVICES ARE YOUTH FRIENDLY PLAYS A PIVOTAL ROLE IN ENSURING ADOLESCENTS MAKE USE OF SERVICES.

Adolescents have described hostile health care worker attitudes and stigma as barriers to care, particularly around contraception and termination of pregnancy services. This results in delays of service with resultant complications. Training of health care staff in approaching adolescents sensitively may be of value to overcome this.

The integration of mental health services into routine antenatal care and infant well visits in the form of screening with appropriate referral to counselling and psychiatric services will serve to improve mental health outcomes. In addition, post-partum programmes focusing on addressing parenting behaviours may serve to improve long term child outcomes. The involvement of social services and parents/ guardians as well as partners throughout the pregnancy in garnering social support for the adolescent is vital at all levels of care.

CONCLUSION

We need to find more effective interventions in the prevention and management of adolescent pregnancy due to the extensive and far-reaching health and socioeconomic consequences on this generation and the next. In keeping with the sustainable development goals, the aim of interventions are to reduce the incidence of unintended pregnancy, maternal and infant morbidity and mortality, sexually transmitted infections and HIV, as well as improving adolescents' health, wellbeing and ensuring their socio economic future

References are available from the author

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PUTTING POLICY INTO PRACTICE:

DISTRICT MENTAL HEALTH AND COMMUNITY PSYCHIATRY IN GAUTENG PROVINCE

Lesley Robertson

On 25 October 2020, newly created public health sector mental health professional posts in Gauteng province were advertised in the Sunday Times. The posts were advertised according to three human resource teams, District Specialist Mental Health Teams (DSMHTs), Clinical Community Psychiatric Teams (CCPTs), and NGO governance compliance teams (NGCTs). One DSMHT was allocated to each district and posts for the CCPTs and NGCTs were allocated according to district population size. The teams are as those developed by the GDoH, with the support of a Mental Health Technical Advisory Team (MHTAT), in response to the Life Esidimeni tragedy and recommendations made by the

Health Ombud, arising from his investigation, and by the Arbitrator of the Life Esidimeni Arbitration.



Lesley Robertson

The teams are part of a new organogram for district mental healthcare services in Gauteng (Figure 1). The organogram was developed for a recovery plan, as recommended by the Arbitrator, 'to achieve systemic change and improvement in the provision and delivery of mental health care by the Department of Health in the Province of Gauteng'. The recovery plan, 'the Gauteng Province Mental Health Strategy and Action Plan

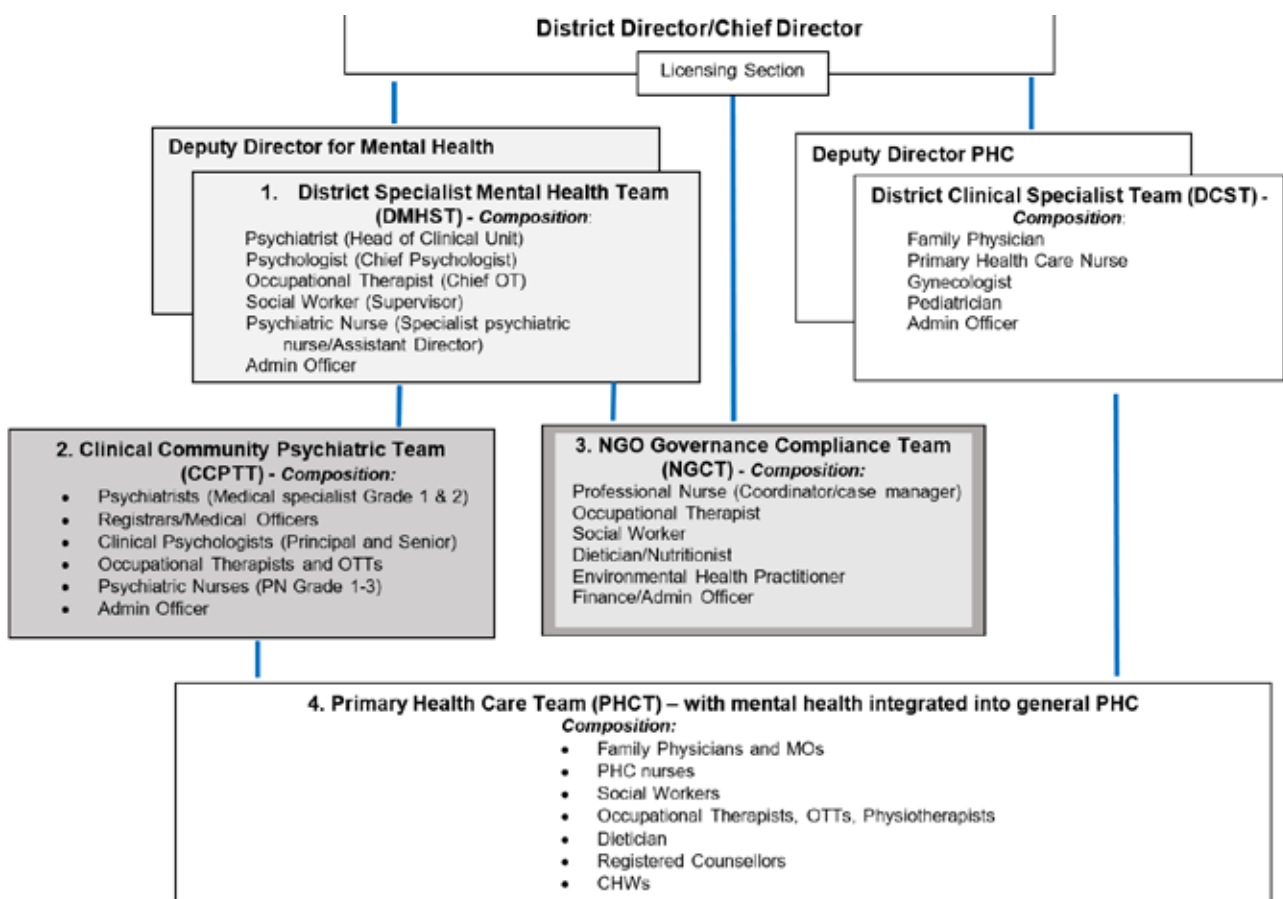


Figure 1. Organisational structure for Gauteng District Mental Health Services. Source: Gauteng Province Mental Health Strategy and Action Plan 2019- 2023

2019- 2023', is largely based on the National Mental Health Policy Framework and Strategic Plan 2013 – 2020 (NMHPF) and the World Health Organisation's (WHO) optimal mix of services for mental health (Figure 2).

The NGCTs were formed in response to the National Policy Guidelines for licensing of residential and/ or day care facilities for persons with mental illness and/or severe or profound intellectual disability.

The staffing of the DSMHTs is based on the terms of reference for these teams in the NMHPF and the composition of the CCPTs is based on Lund and Flisher's model for community mental health services (available at <https://doi.org/10.1111/j.1365-3156.2009.02332.x>).

THE NUMBERS OF PERSONNEL USED FOR THE CCPTS WERE THOSE MODELLED FOR MINIMUM POPULATION COVERAGE, AIMING TO ACHIEVE 30% AND 50% COVERAGE OF 'COMMON' AND 'SEVERE' MENTAL DISORDERS, RESPECTIVELY.

A paper discussing the functions of each team has been submitted to the South African Medical

Journal. The implications for psychiatric practice and training of the two specialist level teams (the DSMHTs and CCPTs) are discussed in this article. It must be noted though, that while interviews and appointments are in process for the CCPTs and NGCTs, they are still to occur for the DSMHTs. In addition, the Head of Clinical Unit Psychiatrist post for the DSMHT has yet to be advertised.

REASONS FOR THE DELAY IN DSMHT INTERVIEWS AND ADVERTISEMENT OF THE PSYCHIATRIST POST ARE NOT KNOWN.

IMPLICATIONS FOR PSYCHIATRIC PRACTICE AND TRAINING

While the NGCTs are of non-specialist personnel, the DSMHTs and CCPTs are specialist mental health professionals employed by District Health Services to work in the Primary Health Care (PHC) setting. Although they represent implementation of national policy, the core competencies required for these teams are somewhat new to public health sector psychiatric practice in Gauteng, as they differ from hospital-based psychiatry. For DSMHTs, practical implementation of public mental health skills is necessary; for CCPTs, clinical skills in preventative

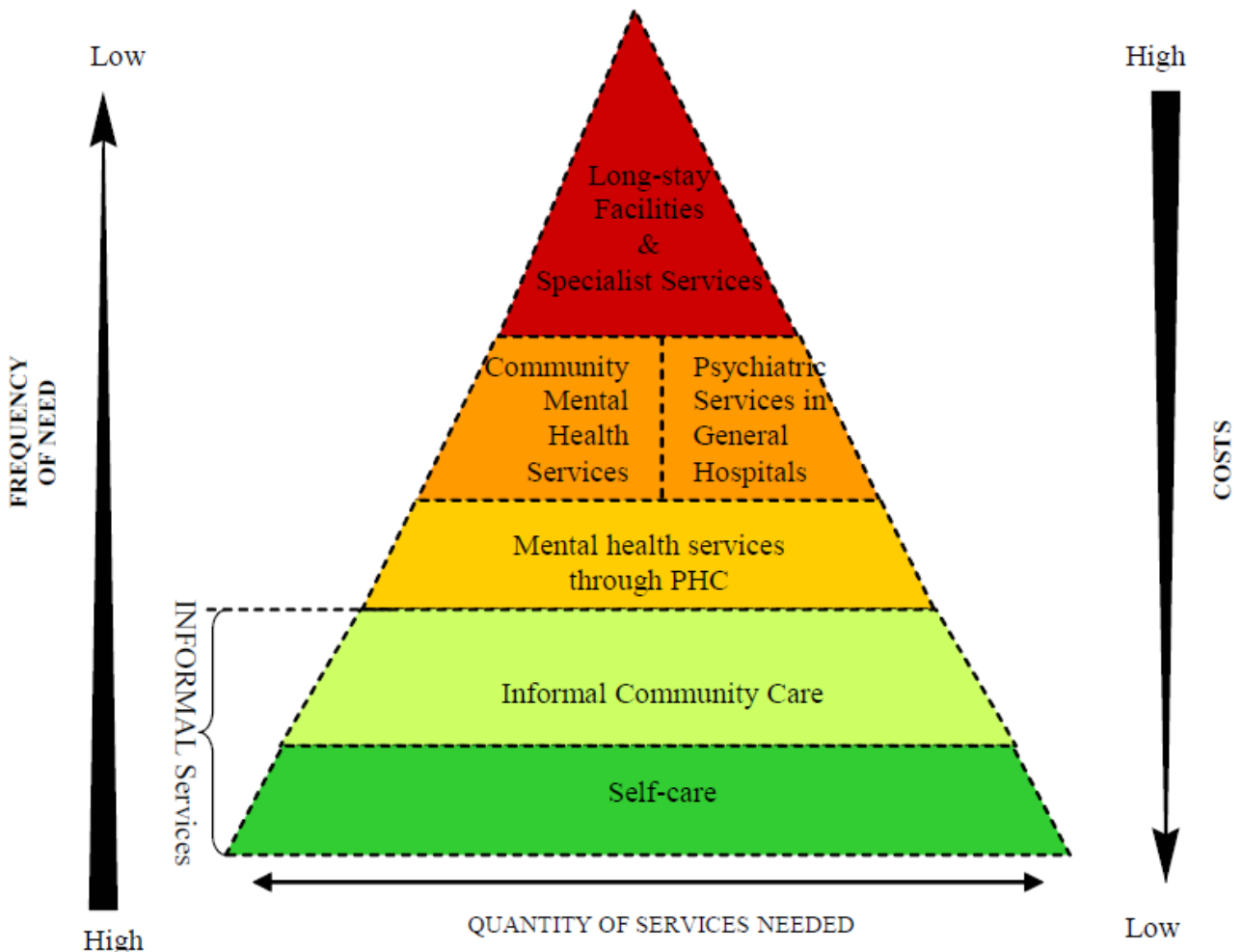


Figure 2. WHO Optimal Mix of Services for Mental HealthSource: Gauteng Province https://www.who.int/mental_health/policy/services/2_Optimal%20Mix%20of%20Services_Infosheet.pdf

psychiatry are needed as well as district-based consultation liaison. Both teams need competency in intersectoral engagement.

DISTRICT SPECIALIST MENTAL HEALTH TEAMS

As stated in the NMHPF, the DSMHTs are to take a public health approach, conducting a situational analysis and developing an action plan for mental healthcare service delivery within a recovery orientated preventative framework. The focus of DSMHTs is population mental health, considering the WHO definitions of health, 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity', and of mental health, 'a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.'

Therefore, the situation analysis must consider the full range of mental health conditions in the population, from non-specific psychological distress to psychosis and including neurodevelopmental, neurocognitive, personality, and substance use disorders.

THE ACTION PLAN SHOULD AIM FOR OUTCOME-DRIVEN UNIVERSAL HEALTH COVERAGE, WITH PHYSICAL, MENTAL, AND SOCIAL WELLBEING AS THE GOAL FOR PEOPLE WITH ANY MENTAL HEALTH CONDITION, WHETHER DIAGNOSABLE OR NOT.

It is however not appropriate to address all mental health conditions from the healthcare platform; most will be more effectively addressed from the population and community platforms using health and non-health interventions. Hence the situation analysis and action plan would incorporate legislation, policy, and practice of all stakeholders in the district who affect population mental health. The DSMHTs, positioned in the healthcare platform, are required to engage with and provide expert input into programmes driven by the non-health sector as well as the health sector.

MENTAL HEALTH PROMOTION INVOLVES BUILDING RESILIENCE AMONG THE DISTRICT POPULATION.

Typically, the healthcare platform provides mental health educational talks and awareness campaigns. However, reducing access to recreational substances, interpersonal violence, and trauma would likely be more effective in improving resilience. Other activities would be to increase access to 'green spaces' for safe community recreation, encourage social cohesion, develop parenting programmes and support, and improve employment opportunities.

Such fundamental social and cultural activities are already on the agenda of district municipalities and other stakeholders. DSMHTs may play an advocacy role and assist with monitoring and evaluation from a mental healthcare perspective.

Primary prevention builds on mental health promotion, including the identification of at-risk groups with appropriate psychosocial intervention. Again, it is multi-sectoral, predominately from the community platform. Healthcare platform primary prevention may include promoting maternal and child health care to prevent peri-natal complications and childhood illnesses which may predispose to intellectual or behavioural disorders. Strategies for secondary prevention, with early detection and care, treatment, and rehabilitation of mental disorders, and tertiary prevention, with mitigation of impairment and disability, must also be developed.

THE HEALTHCARE PLATFORM PLAYS A LARGER ROLE IN SECONDARY AND TERTIARY PREVENTION, INCLUDING MUTUALLY SUPPORTIVE REFERRAL PATHWAYS AND CONTINUITY OF CARE ACROSS SERVICE LEVELS. HOWEVER, COMMUNITY-BASED DE-STIGMATISATION AND SOCIAL INCLUSION TO STRENGTHEN EARLY DETECTION, INFORMAL CARE, AND SOCIAL SUPPORT, ARE PIVOTAL.

Finally, the skill set required for optimal DSMHT functioning is broad. Specialised knowledge in psychiatry and a comprehensive understanding of the roles and limitations of all stakeholders is needed. These must be brought together using public health science to implement interventions, develop and monitor outcome measures, and further inform policy and practice. However, for them to be successful, full co-operation by all stakeholders, including healthcare and community platforms, is needed.

CLINICAL COMMUNITY PSYCHIATRIC TEAMS

The CCPTs are named 'clinical' to differentiate their role from that of DSMHTs, 'community' to distinguish them from 'hospital' care, and 'psychiatric' to separate their scope of practice from that of PHC mental health services. While PHC is to provide care for people with uncomplicated conditions, CCPTs provide a specialist level community mental health service, at the same service level as general hospital psychiatric units (Figure 2). Their function differs from hospital-based psychiatry as the care is preventative, encompassing secondary and tertiary prevention with primary prevention outreach education.

The aim is to provide thorough multidisciplinary psychiatric assessment early in the course of illness with the goal of treatment being to optimise

function and well-being. This means subtle signs of illness and impairment must be evaluated and addressed. For those with severe illness and dysfunction, the goal of treatment is the same. Treatment is person-centred, in that the person's needs are prioritised, and the goal of care is tailored to the individual's abilities.

THE IMMEDIATE MULTIDISCIPLINARY TEAM STRETCHES BEYOND THE HEALTHCARE SECTOR, TO INCLUDE FAMILY MEMBERS, NGOS, AND COMMUNITY-BASED STAKEHOLDERS.

For example, an NGO social welfare officer may be the predominant official carer and may be included in family sessions conducted by a psychiatrist, with consent of the user. Within the healthcare platform, PHC and psychiatric services in general and specialised hospitals would engage with the CCPTs to ensure streamlined continuity of care. Ideally, for people with complex mental disorders, the CCPTs should evolve to be their main psychiatric service, with hospital services providing care when ambulatory care is not feasible, with feedback to the CCPTs. According to the WHO's optimal mix of services, this should allow for MHCUs to be community-dwelling, able to participate in their communities.

A CAVEAT FOR CCPT FUNCTIONING IS THE LACK OF EVIDENCE FOR PREVENTATIVE PSYCHIATRIC CARE. MOST THERAPEUTIC INTERVENTIONS ARE BASED ON STUDIES WITH ACUTE REDUCTION OF SYMPTOMS AS THE PRIMARY OUTCOME.

There are only a few high quality studies which evaluate prevention of relapse and these often use hospitalisation as the main outcome measure rather than emergence of symptoms. Even fewer studies use quality of life or level of functioning as outcome measures. Hence, the degree to which preventative psychiatric care may be successfully implemented is still not clear.

HUMAN RIGHTS CONSIDERATIONS

Notwithstanding the lack of evidence on which to base preventative psychiatric care, the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) makes it imperative that we do so. Unlike the Mental Health Care Act No. 17 of 2002, substitute decision-making in the face of mental incapacity is not acceptable. People with disabilities have the right to 'equal recognition before the law' as those without disabilities (Article 12 of the UNCRPD) and legal capacity (or autonomy) may not be compromised. Those who lack mental

(or decision-making) capacity are to receive support in making a decision for themselves.

Of note, South Africa signed and ratified the UNCRPD in 2007, and the UNCRPD supersedes previous international human rights treaties for people with disabilities. The purpose of the UNCRPD is to 'promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity' and persons with disability are defined as 'those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others' (Article 1). Informed strongly by the social model of disability, the UNCRPD promotes societal and environmental change to accommodate an individual's impairment. Therefore, the healthcare system needs to accommodate an individual's mental, intellectual, or psychosocial impairment in order to provide care.

HOW THE UNCRPD IS TO AFFECT CURRENT PSYCHIATRIC PRACTICE AND DISTRIBUTION OF RESOURCES STILL HAS TO BE DETERMINED.

However, there will need to be an adaptation of mental health services in South Africa, which are heavily weighted towards specialised hospital care. The difficulty with emphasising hospital-based care is that it tends to be accessed only in late presentation of severe illness. Attempting to support decision-making during episodes of severe mental incapacity is unlikely to be feasible. Possibly, our best option is to improve promotive and preventative care, hopefully, in time, reducing the numbers of people requiring restraint and involuntary admission, thereby reducing opportunity for infringement of the UNCRPD. While preventative care may still require some limitations to autonomy, these would be in the context of public health ethics, consistent with principles of relational autonomy, and less specific to MHCUs.

CONCLUSION

Three new human resource teams have been integrated into the Gauteng district health system in order to strengthen services and improve accessible, quality mental health coverage. For psychiatry, an opportunity to hone public mental health skills and to develop expertise in delivering accessible recovery orientated, preventative psychiatric care has been provided. In addition by complying with the MHCA, it is envisaged that implementing public health principles and community psychiatry will also facilitate compliance with the UNCRPD.

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PREMENSTRUAL DYSPHORIC DISORDER (PMDD): THE MONSTER OF “PMS”

Lavinia Lumu

Pre-menstrual syndrome (PMS) has afflicted women for centuries. In fact, for centuries women have had to quietly suffer with these debilitating symptoms that lead to emotional distress and physical symptoms that result in functional impairment. Women are often described as ‘pms-ing’ because of being moody or irritable in the premenstrual period and some attribute their affective symptoms to be present because it is “that time of the month”. PMS has a long history and finally this debilitating condition is being acknowledged.

Premenstrual disorders are a spectrum of disorders including premenstrual syndrome, premenstrual dysphoric disorder, and premenstrual debilitating of another medical condition.² Premenstrual dysphoric disorder (PMDD) is often referred to as a more severe form of premenstrual syndrome (PMS).⁵

PMDD IS CHARACTERISED BY IMPAIRMENT IN COGNITION, MOOD, AND ASSOCIATED PHYSICAL SYMPTOMS IN THE WEEK PRECEDING MENSTRUATION. PMDD AFFECTS MILLIONS OF WOMEN WORLDWIDE AND AS A RESULT HAS LED TO THE RECOGNITION OF PMDD AS A PSYCHIATRIC DISORDER IN THE DSM-5.^{1, 6}

PMDD VS. PMS

On the premenstrual disorders’ spectrum, PMDD is classified as the most severe. PMS would be classified as a ‘mild’ variant of PMDD. The PMS criteria have been described by both the International Society for Premenstrual Disorders (ISPMDD) and the Royal

College of Obstetricians and Gynaecologists (RCOG). The PMS criteria does not dictate a minimum number of symptoms, whereas the DSM-5 criteria for PMDD are more stringent. Due to the stringent criteria for PMDD more women are likely to meet criteria for PMS than PMDD. PMS and PMDD criteria have some features in common including premenstrual symptoms in the week preceding menstruation and impairment in functioning associated with the disorder.^{2,11} Researchers have reported PMDD prevalence rates for premenopausal women at 2 - 5% in contrast to PMS (30 - 75%).^{1, 5}



Lavinia Lumu

PMDD AS A DISORDER: THE CONTROVERSY

Criteria that need to be met for a disorder to be classified in DSM-5 include the following: a distinct pattern and similarities in family history and risk factors occurring across multiple population groups. Cognition and mood predictors and clinical comorbidity must be present. The disorder must be diagnostically stable and have a predictive disease course, and similar therapeutic response across various populations.^{6,12}

In the DSM-III-R, PMDD was referred to as a “late luteal phase dysphoric disorder” and was included as a provisional diagnostic category for further research and remained as an appendix in DSM-IV. Researchers then concluded that the available data was convincing enough to make PMDD an official diagnosis in the DSM-5 in 2013, published in the depressive disorders chapter. This was groundbreaking for women’s mental health.⁶

The World Health Organization's International Statistical Classification of Diseases and Related Health Problems also acknowledged the inclusion of PMDD as a stand-alone disorder in the ICD-11.⁵

THERE WAS MOUNTING OPPOSITION FROM FEMINIST LOBBYISTS WHO RAISED CONCERN ABOUT THE EFFECTS OF A "PSYCHIATRIC" DIAGNOSIS AND TREATMENT APPROACHES FOR PMDD WOULD RESULT IN DISCRIMINATION AND WOULD FURTHER STIGMATISE THIS GENDER-SPECIFIC CONDITION.

The pathologizing of physiological cyclic and hormonally related emotional distress was of great concern.⁵

Another issue were the potential consequences of such a diagnosis for women including the forensic implications, where PMDD could be utilised to successfully mitigate responsibility and the additional surge in overdiagnosis and overprescribing, specifically by general practitioners. An increasing number of women could be labelled with this mental disorder which would carry more stigma than if they were diagnosed with "premenstrual syndrome" and other premenstrual spectrum disorders, which are more socially accepted.^{1,5}

EPIDEMIOLOGY

Prevalence studies estimated rates of PMDD in adults to be 5% and is even higher in adolescents. Community population studies have estimated prevalence rates for PMS at 20-30%. Prevalence studies across several continents and ethnicities demonstrated similar findings.^{2,3}

RISK FACTORS

A potential risk factor for PMS/PMDD includes racial disposition. Research to corroborate this was conducted in a United States population sample where it was demonstrated that PMS had a higher prevalence in White women than African American women. Cultural differences may explain findings that are synonymous with research on other psychiatric illnesses. Other risk factors across various premenopausal age groups were the same. Dietary factors seem to play a role in the risk of PMDD and PMS symptoms. High potassium intake, metabolic syndrome, and an increased Body Mass Index (BMI) (greater than 27.5 kg/m²) were all associated with an increased risk for PMS/PMDD.^{2,14}

AETIOPATHOLOGY

Reproductive hormonal fluctuations that occur with the normal menstruation and serotonin deficits have both been implicated in PMDD.² Aetiopathological factors include the central nervous system sensitivity to reproductive hormones, genetic and

psychosocial factors. The cyclic timing of the PMDD symptoms and the temporal reproductive hormonal fluctuations is the pinnacle in the pathogenesis of PMDD. This would imply that women with PMDD have abnormal sensitivity to 'normal' reproductive hormonal fluctuations or variations throughout the menstrual cycle.¹

PROGESTERONE AND ALLOPREGNANOLONE

Women with PMDD have been postulated to have a pathological response to either withdrawal from or exposure to the progesterone metabolite, and gamma aminobutyric acid (GABA) agonist, allopregnanolone (ALLO), which is also a neuroactive steroid. Progesterone levels are low during menstruation, specifically during the follicular phase and again just before menses and so too are the levels of progesterone's key metabolite, ALLO. The effects of ALLO on the GABA-A receptor results in anxiolytic, anaesthetic, and sedative effects. In women with PMDD, it is postulated that they are "resistant" to the GABA-enhancing effects of ALLO. This chronic physiological increase followed by rapid withdrawal of progesterone may be a key factor in the aetiology of PMDD.

THE PHYSIOLOGICAL WITHDRAWAL OF PROGESTERONE AND DECREASED ALLO MAY RESULT IN SOCIAL WITHDRAWAL AND ANHEDONIA, SYMPTOMS CHARACTERISTIC OF PMDD AND OTHER DEPRESSIVE DISORDERS.^{1,2}

OESTROGEN

Oestradiol is a potent neuromodulator of the serotonin system and results in the regulation of mood, cognition, sleep, and other neuro-vegetative functions. The therapeutic effects of the selective serotonin reuptake inhibitors (SSRIs) in PMDD, implicates the temporal relationship between oestradiol and serotonin in PMDD pathogenesis.¹

BRAIN-DERIVED NEUROTROPHIC FACTOR (BDNF)

BDNF is produced in various parts of the brain related to learning, memory and mood regulation and is crucial for neurogenesis. Lower BDNF levels may be associated with a greater risk for depression as well as other neuropsychiatric conditions. BDNF levels are potentiated by antidepressants that increase serotonin transmission and these levels are further modulated by oestradiol. In turn, these BDNF levels have cyclic sensitivity throughout the menstrual cycle.^{1,15}

IMMUNE ACTIVATION AND INFLAMMATION

Research has indicated that depression is strongly associated with dysfunction of the immune system. Although PMDD differs from MDD, inflammation may also seem to have a role in the pathophysiology of PMDD. The luteal phase is associated with increased production of proinflammatory markers interleukin 6R (sIL-6R) and tumour necrosis factor alpha (TNF-α) compared to the early follicular phase. A study confirmed that C-reactive protein (CRP) levels varied throughout the menstrual cycle.

A tenfold increase in progesterone was associated with an increase in CRP of 20 to 23%. Women with premenstrual symptoms had increased proinflammatory markers compared to controls.^{1,16} These proinflammatory markers also have cyclic sensitivity.

HYPOTHALAMIC-PITUITARY-ADRENAL AXIS

Studies in women with PMDD have shown evidence of aberrant hypothalamic-pituitary-adrenal (HPA) axis function, including lower cortisol levels during periods of stress and higher baseline cortisol levels during the luteal phase compared to controls.¹

STRESS

Significant stress has been associated with PMDD. A potential mechanism linking stress and PMDD may be related to ALLO. ALLO enhances GABAergic transmission and increases in response to acute stress. Women with PMDD do not exhibit this typical ALLO increase.¹

BRAIN IMAGING

Brain imaging has implicated the amygdala and prefrontal cortex in PMDD. Research in women with PMDD has demonstrated an increase in amygdala reactivity in the follicular phase compared to controls resulting in increased anxiety symptoms.^{1,2}

GENETICS

The estrogen receptor alpha (ESR1) gene may potentially contribute to the genetic susceptibility

to PMDD.^{1,2,3,17} Polymorphism of the 5HT1A gene responsible for the decreased serotonin neurotransmission in major depression, has also been found in PMDD. The serotonin transporter (SERT) gene length polymorphism (5-HTTLPR) allele is associated with a reduction in transcriptional efficiency of SERT and therefore decreased serotonin neurotransmission.¹⁷ More research is required to find more gene associations with PMDD.⁸

COMORBIDITY

PMDD is strongly linked to mood and anxiety disorders. Comorbidity rates between PMDD and other psychiatric disorders are as high as 47.4% for anxiety disorders and 29.8% for mood disorders.^{3,18}

STUDIES HAVE ASSOCIATED A LINK BETWEEN TRAUMA AND PMS/ PMDD. STUDY PARTICIPANTS WITH A HISTORY OF TRAUMA OR PTSD WERE REPORTEDLY MORE LIKELY TO HAVE PMDD COMPARED WITH WOMEN WITH NO TRAUMA HISTORY.

Personality disorders do not seem to significantly be associated with PMDD, although research has been inconclusive.^{3,19}

Research on the association between PMDD and postpartum depression (PPD) has yielded mixed results. A study focused on 23 women with PPD and

Diagnostic Criteria for Premenstrual Dysphoric Disorder

- A. In the majority of menstrual cycles, at least five symptoms must be present in the final week before the onset of menses, start to improve within a few days after the onset of menses, and become minimal or absent in the week postmenses.
- B. One (or more) of the following symptoms must be present:
 1. Marked affective lability (e.g., mood swings; feeling suddenly sad or tearful, or increased sensitivity to rejection).
 2. Marked irritability or anger or increased interpersonal conflicts.
 3. Marked depressed mood, feelings of hopelessness, or self-deprecating thoughts.
 4. Marked anxiety, tension, and/or feelings of being keyed up or on edge.
- C. One (or more) of the following symptoms must additionally be present, to reach a total of five symptoms when combined with symptoms from Criterion B above.
 1. Decreased interest in usual activities (e.g., work, school, friends, hobbies).
 2. Subjective difficulty in concentration.
 3. Lethargy, easy fatigability, or marked lack of energy.
 4. Marked change in appetite; overeating; or specific food cravings.
 5. Hypersomnia or insomnia.
 6. A sense of being overwhelmed or out of control.
 7. Physical symptoms such as breast tenderness or swelling, joint or muscle pain, a sensation of "bloating," or weight gain.

NOTE: The symptoms in Criteria A–C must have been met for most menstrual cycles that occurred in the preceding year.

- D. The symptoms are associated with clinically significant distress or interference with work, school, usual social activities, or relationships with others (e.g., avoidance of social activities; decreased productivity and efficiency at work, school, or home).
- E. The disturbance is not merely an exacerbation of the symptoms of another disorder, such as major depressive disorder, panic disorder, persistent depressive disorder (dysthymia), or a personality disorder (although it may co-occur with any of these disorders).
- F. Criterion A should be confirmed by prospective daily ratings during at least two symptomatic cycles. (NOTE: The diagnosis may be made provisionally before this confirmation.)
- G. The symptoms are not attributable to the physiologic effects of a substance (e.g., a drug of abuse, a medication, other treatment) or another medical condition (e.g., hyperthyroidism).

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143 women in the control group, the prevalence rates for PMDD were 34.8% (8/23) and 4.9% (7/143), respectively. The study found a correlation between PPD and PMDD.^{2,3,9}

Although more prospective longitudinal studies are required, women with PMDD are more predisposed to mood symptoms during the postpartum period and the menopausal transition due to synonymous vulnerability to reproductive hormonal fluctuations.³

DIAGNOSIS

A careful medical history and prospective daily symptom monitoring across two menstrual cycles is key in confirming the diagnosis of PMDD. The American Psychiatric Association published criteria in the DSM-5 for the first time in 2013.¹³

THE DIAGNOSTIC CRITERIA FOR PMDD REQUIRES THE PRESENCE OF AT LEAST 5 OF 11 SYMPTOMS. THESE SYMPTOMS MUST RESULT IN A MARKED DISRUPTION AND DYSFUNCTION.

Symptoms must not also be aggravated by another disorder, such as major depressive disorder.^{7,13}

DIFFERENTIAL DIAGNOSIS

- Mood disorders
- Anxiety disorders
- Bulimia Nervosa
- Substance use disorders
- Endometriosis
- Combined oral contraceptives
- Thyroid disease
- Diabetes Mellitus

SCREENING TOOLS

Rating scales of premenstrual symptoms include the Daily Record of Severity of Problems (DRSP) (most commonly used), Calendar of Premenstrual Experiences and Premenstrual Assessment Form.

PROSPECTIVE RATINGS CONFIRM THE CYCLIC TIMING OF THE SYMPTOMS AND RULE OUT UNDERLYING PSYCHIATRIC DISORDERS THAT MAY BE MORE APPARENT PREMENSTRUALLY.^{3,4}

PMDD TREATMENT

ANTIDEPRESSANTS

Pharmacotherapy is the recommended first-line intervention for PMDD. The American College of Obstetricians and Gynecologists (ACOG) endorses the SSRIs as the first-line treatment for PMDD and severe mood-related PMS.^{1,10}

SELECTIVE-SEROTONIN REUPTAKE INHIBITORS (SSRIS)

Research has shown that antidepressants with strong serotonin neurotransmission are superior to antidepressants in the treatment of premenstrual symptoms. Studies have evaluated intermittent dosing, symptom-onset dosing and/or continuous dosing of the following SSRIs: sertraline, fluoxetine, paroxetine, escitalopram, and citalopram. The conclusion of these studies confirm that the use of SSRIs during the luteal phase and the continuous use of SSRIs are both equally effective in reducing the physical and psychological symptoms of PMDD/PMS.^{2,7,20}

• Intermittent Dosing

SSRIs have a short onset of therapeutic action in PMDD. SSRIs have an onset of action with therapeutic effect within hours to days, in contrast to the weeks often required for response to SSRIs in depression.

THIS RAPID ONSET OF ACTION IS POSSIBLY DUE TO THE SSRIS' ABILITY TO ENHANCE FORMATION OF ALLO. SSRIS INCREASE CONVERSION FROM A PROGESTERONE TO ALLO WITHIN MINUTES OF EXPOSURE.

This short onset of action makes intermittent dosing (administering during the luteal phase, from the time of ovulation until menstruation begins/ day 14) possible. Intermittent dosing is efficacious for irritability, lability, and mood swings, while having weaker effects on depressed mood and physical symptoms. Depressed mood and somatic symptoms may benefit more from continuous SSRI therapy.^{1,21}

• Symptom-onset therapy

In symptom-onset therapy, SSRIs are taken as soon as PMDD symptoms have initiated, then stopped at menstruation. This method has been well-researched using fluoxetine, citalopram, paroxetine, and escitalopram. Relatively low doses (e.g., 25 to 50 mg sertraline) were found to reduce symptoms.^{1,21}

• Continuous dosing

Research has endeavoured to compare continuous versus intermittent/symptom-onset dosing of SSRIs. So far, findings have concluded that both dosing approaches are equally effective in reducing PMDD symptoms.^{7,22}

SEROTONIN NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)

Multiple studies have concluded that venlafaxine is significantly effective in reducing PMDD symptoms. Research has demonstrated that extended-release venlafaxine administered based on flexible dosing, ranging from 75 to 112.5 mg/d, was found to be effective in reducing PMDD symptoms.

Duloxetine has also been evaluated and determined to be efficacious, with 50% or greater reduction in baseline premenstrual symptoms.^{7,23}

TRICYCLIC ANTIDEPRESSANTS

Clomipramine has strong serotonergic activity and is therefore effective treatment for irritability and mood lability in PMDD. Two studies evaluated the efficacy of clomipramine (25 to 75 mg) in women experiencing severe irritability and mood lability and results noted a significant decrease in irritability and depressed mood.^{7,24}

ANXIOLYTICS

Alprazolam has been demonstrated to be effective in numerous studies, although the prolonged use of benzodiazepines can result in dependence.⁷

Buspirone, a 5HT agonist has demonstrated some efficacy in treating PMDD.⁷

MOOD STABILISERS AND OTHER PSYCHOTROPICS

MOOD STABILISERS HAVE BEEN MINIMALLY STUDIED. THERE HAVE BEEN POSITIVE CASE REPORTS WITH LAMOTRIGINE AND LEVETIRACETAM.

Other small studies have demonstrated that adjunctive quetiapine was reported to be helpful in SSRI- 'non-responders'.³

HORMONAL TREATMENT

Oral contraceptives (OCs), which contain oestrogen and progestin, and prevent ovulation are commonly used to treat PMDD.⁷

THERE IS A PAUCITY OF RESEARCH ON THE EFFECTIVENESS OF HORMONAL TREATMENT FOR PMDD.

Research on OCs containing synthetic progestin and drospirenone found that Yaz® (drospirenone 3 mg plus ethinyl estradiol 20 µg) somewhat reduced severe PMDD symptoms, despite a large placebo effect. Drospirenone-containing OCs are associated with an increased risk of venous thromboembolism. Due to this risk, drospirenone-containing OCs require individualised prescribing and careful patient selection.²⁵ Continuous dosing strategies of OCs, where there is no week of placebo pills, instead active pills are taken throughout, thereby preventing hormonal fluctuations is recommended.^{1,3}

HORMONE MONOTHERAPY MAY BE LESS EFFECTIVE THAN COMBINED ORAL CONTRACEPTIVES. THIS STRATEGY IS OFTEN RECOMMENDED WHEN WOMEN WITH PMDD HAVE FAILED TRIALS OF SSRI TREATMENT.¹

GNRH AGONISTS

GNRH agonists (leuprolide, goserelin, buserelin, and histrelin) cause downregulation of the hypothalamic-

pituitary-ovarian axis. This results in decreased levels of luteinizing and follicle-stimulating hormone, as well as decreased oestrogen and progesterone production by the ovaries. This in turn, results in anovulation, amenorrhea, and a medical menopause state or a "chemical oophorectomy", which then clinically eliminates the physical and emotional symptoms. Common adverse effects such as vaginitis, vasomotor symptoms, and decrease in bone density may occur. For this reason, and the high costs, GnRH agonists are usually reserved for severe cases of PMS and PMDD or as third-line agents. The long-term use of GnRH agonists and safety has not been fully established.^{1,2,7}

DANAZOL

Danazol is a synthetic steroid with androgenic and anti-gonadotropic properties. Danazol has been found to improve physical and mood symptoms, when administered at doses that suppress ovulation (200 to 400 mg/d). The long-term use of danazol is limited due to side effects - increased weight, abnormal cholesterol metabolism, hirsutism, and acne. Due to these adverse effects, the use of danazol is not recommended as a first-line treatment.⁷

OTHER MEDICATIONS

BROMOCRIPTINE AND CABERGOLINE

Bromocriptine is a dopamine agonist that inhibits prolactin and has been found to be efficacious for premenstrual mastalgia. Cabergoline is a newer dopamine agonist that has demonstrated similar efficacy as bromocriptine in the treatment of premenstrual mastalgia but with fewer side-effects. Compared with cabergoline, bromocriptine was associated with significantly more nausea, vomiting, and headaches.⁷

SPIRONOLACTONE

Spironolactone is an aldosterone receptor antagonist that may be considered in the management of PMDD. Spironolactone 100 mg/d from day 14 of the menstrual cycle to the first day after onset of menstruation is effective in decreasing physical symptoms and mood symptoms, including irritability and depression.

BECAUSE SPIRONOLACTONE IS A POTASSIUM-SPARING DIURETIC, IT IS RECOMMENDED THAT PATIENTS BE MONITORED FOR HYPERKALAEMIA; AND IT IS THEREFORE NOT RECOMMENDED FOR LONG-TERM USE.⁷

SUPPLEMENTS

CALCIUM

Calcium may be a factor in the pathophysiology of severe PMS because calcium influences neuromodulation. Studies have shown low calcium in women with PMS. Research on calcium supplementation administered at 1200 mg/d resulted in a significant reduction in PMS symptoms compared with placebo.^{1,2,7}

OTHER SUPPLEMENTS

Other dietary supplements such as omega-3 fatty acids, myo-inositol, magnesium, Vitamin B6, and Vitamin E have thus far shown limited benefit in treating premenstrual symptoms.¹

HOMEOPATHIC OPTIONS

Research on alternative/homeopathic treatments have reported that the strongest evidence for Chasteberry (*Vitex agnus-castus*), St John's Wort (SJW) (*Hypericum perforatum*), Evening Primrose Oil, Saffron (*Crocus sativus*) and Gingko biloba in the treatment of severe PMS and PMDD symptoms.^{2,3,7}

PSYCHOTHERAPY

Cognitive-behavioural therapy (CBT) for PMDD may be therapeutic by reconceptualising perceived negative cognitions or improving coping mechanisms. Both pharmacotherapy and CBT are effective in symptom reduction of PMDD. A meta-analysis suggests no added benefit from combined treatment.^{2,26} A rigorous trial compared CBT to fluoxetine and found no difference between groups or additive effects of both CBT and fluoxetine.^{1,26}

THE USE OF INTERNET-BASED CBT HAS BEEN RESEARCHED AND MAY RESOLVE THE ISSUE OF LIMITED MENTAL HEALTH RESOURCES.^{1,2,3,7}

SURGERY

Hysterectomy and bilateral salpingo-oophorectomy are considered as a last resort in the management of severe PMS and PMDD and should only be considered for patients who have failed pharmacotherapy trials and are suitable candidates for sterilisation. As this is an irreversible procedure, it is recommended that at least 6 months of continuous effective GnRH agonist medication be administered before surgery. GnRH agonist administration is essentially a "chemical oophorectomy" and can help determine whether surgical oophorectomy would be beneficial.⁷

DIET

Lifestyle modifications for PMS/PMDD include dietary recommendations (i.e., Frequent snacks/small meals, decreased caffeine and decreased refined sugar and artificial sweeteners intake, and an increase in complex carbohydrates).^{3,7}

EXERCISE

The ACOG non-pharmacological guidelines for PMS/ PMDD include exercise strategies that may improve physical symptoms including yoga and aerobic exercise.

EXERCISE MAY ALLEVIATE OR REDUCE PREMENSTRUAL SYMPTOMS THROUGH THE MECHANISM OF INCREASED BETA-ENDORPHIN LEVELS AND A RESULTANT IMPROVEMENT IN OVERALL WELL-BEING.^{1,3}

CONCLUSION

PMDD can be a debilitating disorder affecting millions of ovulatory women worldwide that can result in significant impairment. The categorisation of PMDD in the DSM-5 through extensive research and awareness has created an opportunity for more women to finally access the complex treatment modalities available.

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THE HEALTHCARE WORKERS CARE NETWORK (HWCN): SUPPORTING SOUTH AFRICAN HEALTHCARE WORKERS DURING THE COVID-19 PANDEMIC AND BEYOND

Rita Thom, Antoinette Miric, Thriya Ramasar



**HEALTHCARE WORKERS
CARE NETWORK**

Caring for the Carers by the Carers

The Healthcare Workers Care Network (HWCN) was established at the start of the COVID-19 pandemic to support frontline healthcare workers, through providing information on the promotion of good emotional mental health and the prevention of mental distress, as well as to provide an easily accessible counselling resource for healthcare workers in distress. This initiative also built on the vision and work of Professor Bernard Janse van Rensburg (before his untimely death) on behalf of SASOP, who in collaboration with SAMA and SASA (South African Society of Anaesthesiologists) and SADAG, were planning to establish a mental health support network for doctors in South Africa.

THE HWCN IS AN ENTIRELY VOLUNTEER-RUN INITIATIVE, WHICH HAS BEEN SUPPORTED BY, AND HAS BEEN WORKING CLOSELY WITH THE SOUTH AFRICAN DEPRESSION AND ANXIETY GROUP (SADAG).

Since its inception, over 500 mental health professionals have volunteered their time and expertise to assist healthcare workers in both public and private sector health services (this includes non-clinical staff in healthcare settings, who are also exposed to high risks of infection as well as the trauma related to the pandemic).

IN THE INITIAL MONTHS OF THE PANDEMIC, MUCH OF THE EFFORT WAS DEVOTED TO PREPARING FRONTLINE WORKERS AND THEIR MANAGERS FOR WHAT TO EXPECT AND HOW TO PRACTICE GOOD SELF-CARE.

So, the initial work involved training clinical and nonclinical leaders in health services to support their teams during the pandemic, and these healthcare managers also facilitated webinars for their staff. In the latter half of 2020, SADAG and other organisations facilitated webinars for healthcare workers, which focused on a range of topics, including how to build resilience, aspects of moral injury, and burnout. There were a total 4058 attendances at these webinars, with positive feedback from attendees.



HEALTHCARE WORKERS, PARTICULARLY DOCTORS, ARE RELUCTANT TO SEEK HELP FOR EMOTIONAL DISTRESS AND MENTAL DISORDER. THIS IS A GLOBAL PHENOMENON, AND THE "HERO" NARRATIVE SURROUNDING THE PANDEMIC MAY MAKE IT EVEN MORE DIFFICULT FOR THESE "HEROES" TO REACH OUT FOR SUPPORT WHEN THEY ARE STRUGGLING.

A recent publication in the JAMA by Jaklevic¹, describes the establishment of volunteer networks in the United States of America, with very similar approaches to the HWCN in South Africa (one of which is appropriately called the "Emotional PPE project"). The figures cited in this publication mirror the situation in South Africa. Three organisations in the United States have merged to form the Therapy Aid Coalition, and prior to their merger, together, they had provided counselling to just over 1000 healthcare workers (total number of doctors and nurses in USA population approximately 5,6 million²). The HWCN has to date provided counselling to over 200 healthcare workers (total number of doctors and nurses in SA population approximately 331000³).

THIS WOULD SUGGEST THAT THE HWCN IS AT LEAST AS EFFECTIVE (IF NOT MORE SO) THAN THE ORGANISATIONS IN THE USA, IN TERMS OF BEING ACCESSIBLE TO HEALTHCARE WORKERS IN SOUTH AFRICA.

Nevertheless, with the surge in COVID-19 cases in the second wave, we are extremely concerned about the impact this is having on healthcare workers and anticipate that there will be immediate as well as long-term mental and emotional sequelae as a result of this. At this point, our sense is that healthcare workers are in survival mode and doing their best under extremely difficult circumstances. What they need now is practical support –

additional human resources, food, drink, adequate PPE, rest and of course, access to vaccination as soon as it becomes available. As a network, we call on government, the private sector and NGOs to urgently intervene to address these needs.

THE HWCN IS PLANNING TO FOCUS ON WORKING WITH MENTAL HEALTH PROFESSIONALS AT THIS POINT IN TIME.

Monthly webinars are planned. The first webinar in February will focus on "how to keep on keeping on", and the March webinar will focus on the vaccine. Of course, the confidential pro bono counselling service continues to be available, and help can be accessed online through the HWCN website www.healthcareworkerscarenetwork.org.za as well as through the helpline hosted by SADAG (0800 21 21 21).

PLEASE SPREAD THE WORD ABOUT THE HWCN AMONGST YOUR MEDICAL, NURSING AND ALLIED HEALTH PROFESSIONAL COLLEAGUES. HELP IS AVAILABLE.

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PSYCHOSOCIAL OUTCOMES IN CHILDREN WITH SHORT STATURE

David Webb

Healthy physical and psychological development during childhood and adolescence is essential to become a well-adjusted and socially functional adult. Any abnormality during this time can be detrimental to normal development. In addition to the physical limitations associated with being shorter than average, social stigma may affect self-perception and social integration.

THEREFORE, HOW INDIVIDUALS PERCEIVE THEIR HEIGHT AND APPEARANCE AND THEIR ABILITY TO COPE WITH THEIR OWN ATTITUDES AND THOSE OF OTHERS CAN DETERMINE THE SEVERITY OF IMPAIRMENT.

Consequently, although short stature among healthy children is most commonly not associated with any psychosocial disadvantage, children with poor coping skills or a maladaptive personality type and height that is substantially below the norm for age group may be at risk for emotional and behavioural problems (Table 1).

Table 1. Psychological attitudes to height that indicate referral for counselling

<ul style="list-style-type: none"> • Personal: e.g., "My appearance is my own fault. It's only me that feels this way - I am not as worthy as my peers." • Pervasive: e.g., "The consequences of my short stature will affect all areas of my life and everything I try to do." • Permanent: e.g., "My short stature is not only a problem at school, but will disadvantage me for the rest of my life."
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Factors that might be important in influencing how well a child or adolescent copes with being shorter than peers are listed in Table 2.



David Webb

Table 2. Factors that may influence coping skills in children and adolescents with short stature¹⁻⁹

Risk factors for poor coping skills	Protective factors for positive coping skills
<i>Individual factors</i>	
<ul style="list-style-type: none"> • Health status and aetiology of short stature (medical cause of short stature vs. idiopathic short stature) • Perceived shorter height/personal dissatisfaction with height • Older age • Male gender • Poor coping strategies 	<ul style="list-style-type: none"> • Good physical health • Personality • Sense of humour • Good self-esteem • Personal skills and competencies • Positive body image
<i>Social environment</i>	
<ul style="list-style-type: none"> • Family situation; e.g., having a younger, but taller sibling 	<ul style="list-style-type: none"> • Socioeconomic status

<ul style="list-style-type: none"> • Lack of support from parents and siblings • Lower socioeconomic status • Negative beliefs about the importance of height • Poor social integration and prejudice; e.g., being teased or juvenilisation • Other psychosocial stresses (major life events or day-to-day problems; e.g., bullying) • Cultural stereotypes regarding short stature (e.g., tall men are successful) 	<ul style="list-style-type: none"> • Social support & friends • Parental support • Normal integration and treatment at school • Positive cultural influences
Academic performance	
<ul style="list-style-type: none"> • Lower intellect and cognitive ability 	<ul style="list-style-type: none"> • Academic achievement • Intelligence • Mature behaviour
Participation	
<ul style="list-style-type: none"> • Physical limitations of daily activities • Lack of functional independence 	<ul style="list-style-type: none"> • Appropriate sport and other activities • Association with children of similar age • Self-esteem

DO SHORT CHILDREN HAVE WORSE QUALITY OF LIFE?

Some of the psychosocial impairments that have been reported in relation to children who are shorter than average include physical limitations, behavioural problems, below average academic performance, lower visual-motor skills, less social support from teachers, low self-esteem, overprotectiveness from parents and teachers, being teased and bullied, avoidant behaviour, feelings of guilt, anxiety, depression and difficulty establishing interpersonal relationships.^{1,3,11,13,15,17-20}

However, studies do not consistently show that children diagnosed with idiopathic short stature will be psychosocially impaired. On the contrary, many epidemiological, cross-sectional population studies indicate that short children are not disadvantaged, either academically or socially.^{3,4,11,14-19}

The Wessex Growth Study was a prospective longitudinal cohort study, which recruited an unselected population of short, but otherwise healthy children from a wide range of socioeconomic backgrounds and followed them from age 5-6 years throughout childhood and adolescence to age 18-20 years. It failed to demonstrate any evidence of serious psychological or academic disadvantage before or after puberty.^{4,14} Furthermore, in the follow-up of young adults with short stature during childhood, neither childhood nor adult stature was associated with an increase in high risk behaviours, such as alcohol or drug abuse or severe violence.⁴ Another larger study of 712 school children with a mean age of 12 years found no difference between short children and their peers in social, emotional or behavioural outcomes, including depression, optimism, social support or victimisation, by either self- or teacher-reported findings.¹⁵

Results from studies investigating quality of life in short adults are also variable. Some studies associate short stature with reduced chance of marriage, higher unemployment and self-reported problems in social functioning, whereas others reveal no differences between short adults and those of normal stature.¹

A LARGE HEALTH SURVEY INCLUDING MORE THAN 14 000 ADULTS LIVING IN PRIVATE HOUSEHOLDS IN ENGLAND CONCLUDED THAT SHORTER HEIGHT IN ADULT LIFE IS ASSOCIATED WITH A SIGNIFICANT REDUCTION IN HEALTH-RELATED QUALITY OF LIFE.²¹

However, the main subscales that lowered quality of life scores were problems with 'mobility', 'usual activities' and 'pain/discomfort', suggesting that other confounding health issues rather than height *per se* might have influenced the assessment.

WHY DO SOME STUDIES OF SHORT PEOPLE SUGGEST PSYCHOLOGICAL PROBLEMS AND OTHERS NOT?

Psychosocial problems may be reported by the children themselves, teachers, parents or healthcare providers. This is important, because there are often inconsistencies between different reporters and depending on how the information is gathered. Parents may report significant impairment of quality of life measures for their child, whereas questioning the child themselves reveals no apparent impairment; patients referred for medical assessment of short stature may report psychosocial stress, whereas short individuals in general population-based studies do not. Even the order in which questions are asked may influence the outcome on psychosocial quality of life tests. Therefore, results from psychosocial studies of individuals with short stature need to be interpreted with caution, taking care to consider potential confounding biases.^{1,4,5,10-17} For example, parental

attitudes may be influenced by concern for the child's future or their own past experiences of being short, whereas the child may be too young to adequately assess their own functioning, or have a tendency towards denial.¹

Two contributing factors may help to explain discrepant results among psychosocial studies of short children, adolescents and adults. The first is that where there is an underlying medical condition responsible for the short stature, such as a genetic condition, chronic illness or intrauterine cause of small for gestational age, this condition and possibly the need for chronic interventions may also be responsible for associated developmental problems, such as low intellect and poor academic performance.^{17,19} In turn, these may influence behavioural and emotional adjustment (including self-concept) during childhood and outcomes in adulthood, such as employment, income and marital status.^{3,11} The unusual appearance associated with conditions like Turner's syndrome may further serve as an independent source of stigmatisation.

MEDICAL REASONS FOR SHORT STATURE MIGHT ALSO HELP TO EXPLAIN THE DISCREPANCY BETWEEN THE CLINIC-BASED IMPRESSION THAT INDIVIDUALS WITH SHORT STATURE ARE SEVERELY DISADVANTAGED BY THEIR HEIGHT AND COMMUNITY-BASED STUDIES OF HEALTHY CHILDREN THAT FIND LITTLE OR NO DIFFERENCE BETWEEN SHORT AND NORMAL STATURE.⁵

Secondly, and perhaps more importantly, especially among individuals with idiopathic short stature, environment, and in particular the family environment, may play a significant role in how the child or adolescent experiences their short stature.¹³ For example, overprotective parents, low self-esteem, introverted personality type and differential treatment by teachers may predispose to apparent low intellect, poor academic performance, poor coping skills and social immaturity. The tendency to treat a child according to their size, rather than their chronological age (juvenilisation) may be associated with exclusion from age-appropriate activities, or lower expectations of these children than from children of the same age and normal height.⁶ Similarly, being the only individual with short stature in a family of average height may lead to differential treatment. Family support is extremely important.

A POSITIVE, CONFIDENT AND MOTIVATED CHILD WITH GOOD PROBLEM SOLVING SKILLS IS LESS LIKELY TO EXPERIENCE ADVERSE PSYCHOLOGICAL AND SOCIAL OUTCOMES.

Furthermore, the child's perception of his/her height appears to be more important than the

actual height itself and children with a positive body image and personal satisfaction may be less affected by their height as they grow up.⁶ Children with short parents or siblings tend to present with lower indices of anxiety, depression and difficulty establishing social relationships and with higher indices of good adjustment.¹³

In the Wessex study, stature did not predict psychosocial or academic outcome. However, measured intelligence and psychological development were significantly associated with social class.¹⁴ The same was demonstrated among young adults. While adult height was not associated with poorer psychosocial adaption, there was a significant association of female gender and lower socioeconomic status with personality functioning, education, employment and coping with everyday living tasks, such as managing finances.⁴

Whatever the reason for maladjustments in short individuals, these studies highlight the importance of psychological support during growth and development.¹³

PSYCHOSOCIAL ASSESSMENT

Thorough psychological evaluation should be performed during the assessment of children with short stature and should include both emotional effects, such as wellbeing and adaptation, and social effects, such as the presence of psychosocial stressors, peer integration and social support. Where necessary children and their families should be referred for professional psychological counselling, which is focussed on improving assertiveness and coping skills (Table 3).

Table 3. Psychosocial management of children with short stature^{7,8}

<ul style="list-style-type: none"> • Promotion of assertiveness and resistance to juvenilisation • Promotion of self-reliance and age-appropriate behaviour • Encouraging the development of strengths <ul style="list-style-type: none"> o Abilities and interests o Physical activities and sports where size is not especially important (e.g., hockey, soccer, cricket, gymnastics, boxing & martial arts, cycling, swimming, dancing) • Development of coping skills for healthy peer relationships; involvement in youth groups or clubs • Problem solving where height may pose an obstacle to activities; e.g., using a step to reach high objects; choosing age-appropriate clothing

CONCLUSIONS

Accurate measurement of height and growth should be performed regularly in all children and meticulously documented for future comparisons. It allows early identification of medical disorders

that may be amenable to treatment, facilitating timeous individualised intervention. Furthermore, although short stature itself is not an independent predictor of a poor psychological outcome, it indicates consideration of a thorough psychosocial assessment to help identify children who may be at risk, but in whom counselling and social support may foster a well-adjusted and happy member of society.

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OUT-OF-HOSPITAL MANAGEMENT OF COVID-19 DURING THE SECOND SURGE

The COVID-19 second surge is upon us. Once again, we are faced with many new clinical dilemmas. Recognising the need for sound clinical guidance among the profession at this critical time, Discovery, SAMA, UFFP and SAPPF are reinstating the COVID-19 Clinical Brief webinar series. This CPD accredited series, launched in 2020, will continue to support doctors on the frontlines with credible, practical information about a range of COVID-19 related topics from local and international experts.

You are invited to attend the next webinar:

Date: Thursday, 14 January 2021

Time: 19:00

Topic:

Out-of-Hospital Management of COVID-19 during the second surge

This webinar will be led by:

Dr John Tilley and **Dr Pradaruth Ramlachan**

Dr John Tilley is a specialist physician and intensivist. He is currently the Director of the Medical Intensive Care Unit at the Donald Gordon Medical Centre. Dr Tilley completed his undergraduate degree at Wits University, followed by his specialisation in internal medicine and completed his sub-specialist training in critical care. He has a special interest in clinical informatics and decision support systems. His most recent publication appeared in the Wits Journal of Clinical medicine titled 'Respiratory failure – Review of basic sciences and application in COVID-19'.

Dr Pradaruth Ramlachan is the Director of, and practices at, the Newkwa Health and Wellness Centre. He is also a part-time lecturer and examiner for undergraduate and postgraduate students at the Department of Family Medicine at the Nelson R Mandela School of Medicine in KwaZulu-Natal. He completed his undergraduate studies at the University of Natal and holds a master's degree in Health Sciences (Sexual Health) from the University of Sydney. In 2012, he received the Fellow of the European Committee of Sexual Medicine Specialist (FECSM) from the European Union of Medical Specialists. He is the past president of the Durban Doctors Guild practicing as the Durban Independent Practitioner Association (IPA), he is the chairperson of the Pharmaceutical and Therapeutic Committee of the KwaZulu-Natal Doctors Healthcare Coalition (KZNDHC) and serves as a member of the Developing Countries Committee of International Society of Sexual Medicine. Dr Ramlachan is also internationally recognised as the past president of the African Society for Sexual Medicine. He has provided leadership as the principal investigator and completed several clinical trials on sexual dysfunction, erectile dysfunction, HIV, diabetes mellitus, hypertension, cardiovascular disease, gout and infectious diseases. He is a well-published clinician with contributions including online learning resources.

The webinar will be accredited for CPD points.

Medical Practice Consulting has partnered with Discovery to make the webinars aired in the first series viewable for CPD points. If you missed the opportunity to earn CPD points at live webinars, register here:

<https://www.mpconsulting.co.za/products/online-cme/1520/covid-19-mental-health-resilience-for-health-care-professionals>.

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All previous webinars and podcasts are available for viewing and listening here: <https://www.discovery.co.za/portal/provider/coronavirus-webinar>

Wishing you strength and ensuring you of our ongoing support during these challenging times.

Warm regards,

Dr Maurice Goodman

Chief Medical Officer: Discovery Health

IN-HOSPITAL MANAGEMENT OF COVID-19 DURING THE SECOND SURGE

Date: Thursday, 4 February 2021

Time: 19:00

Topic: **In-Hospital Management of COVID-19 during the Second Surge**

This webinar will be led by: **Professor Graeme Meintjes**

Professor Graeme Meintjes is an infectious diseases physician, the second chair and deputy head of the Department of Medicine at the University of Cape Town. He also holds the SARChI chair of poverty-related infections. He was previously the joint head of a busy infectious diseases referral service at GF Jooste Hospital in Cape Town and currently carries out consultant clinical duties at the Khayelitsha and Groote Schuur hospitals.

Professor Graeme Meintjes has contributed to the development of management guidelines for HIV and TB at a provincial, national and international level. His research focus areas include HIV-associated TB, the immune reconstitution inflammatory syndrome, cryptococcal meningitis and drug-resistant TB. He has 280 publications in peer-reviewed journals and has been an author or co-author on 12 book chapters. Over the last year, he and colleagues at Groote Schuur Hospital have been managing patients admitted with

COVID-19.

The webinar will be accredited for CPD points.

Medical Practice Consulting has partnered with Discovery to make the webinars aired in the first series viewable for CPD points. If you missed the opportunity to earn CPD points at live webinars, register here: <https://www.mpconsulting.co.za/products/online-cme/1520/covid-19-mental-health-resilience-for-health-care-professionals>.

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All previous webinars and podcasts are available for viewing and listening here: <https://www.discovery.co.za/portal/provider/coronavirus-webinar>

Wishing you strength and ensuring you of our ongoing support during these challenging times.

Warm regards,

Dr Maurice Goodman

Chief Medical Officer: Discovery Health ■

UPDATE FOR THE CLINICIAN ON LABORATORY DIAGNOSTICS FOR COVID-19

Although the number of infections is dropping, we nevertheless, still need to consider ourselves in the grip of the COVID-19 second surge, with its attendant novel clinical challenges and dilemmas.

Recognising the need for sound clinical guidance during this important time, Discovery, SAMAs, UFPF and SAPPF have reinstated the COVID-19 Clinical Brief webinar series. This CPD-accredited series (launched in 2020) will continue to support doctors on the frontlines with credible, practical information from local and international experts about a range of topics related to COVID-19.

Reserve this 19:00 time slot on Thursdays for this informative series.

To help you plan your attendance, please reserve the time slot between 19:00 and 20:15 on Thursday evenings in your calendar for the ongoing series: **'COVID-19: The Second Surge'**.

Date: Thursday, Thursday, 11 February 2021

Time: 19:00

Topic: **Update for the clinician on laboratory diagnostics for COVID-19**

This webinar will be led by:

Professor Lucille Blumberg

Professor Lucille Blumberg will lead this webinar alongside a panel of experts:

Professor Lucille Blumberg is the Deputy Director of the National Institute for Communicable Diseases (NICD), a division of National Health Laboratory Service (NHLS), and a specialist in clinical microbiology and infectious diseases.

Professor Anne von Gottberg is the laboratory Lead of the Centre for Respiratory Diseases and Meningitis at the NICD, an Associate Professor in the School of Pathology at Wits University's Faculty of Health Science and an Honourary

Professor in the Department of Pathology at the University of Cape Town's (UCT) Faculty of Health Science.

Professor Simnikiwe Mayaphi is a specialist virologist and the Head of the Department of Medical Virology at the University of Pretoria and Tshwane NHLS.

Dr Jeremy Nel is a physician, infectious diseases specialist and the Head of Infectious Diseases at Helen Joseph Hospital and Wits University.

Dr Marvin Hsiao is a consultant virologist at University of Cape Town/Groote Schuur Complex of the National Health Laboratory Service (NHLS) and currently leads the diagnostic subgroup of 501Y.V2 MRC consortium.

The webinar will be accredited for CPD points.

Register here: <https://www.mpconsulting.co.za/products/online-cme/1520/covid-19-mental-health-resilience-for-health-care-professionals>.

For any CPD-related queries please email: cpd@discovery.co.za

All previous webinars and podcasts are available for viewing and listening here: <https://www.discovery.co.za/portal/provider/coronavirus-webinar>

We look forward to interacting with you on these webinars. Wishing you strength and assuring you of our ongoing support during these challenging times.

Warm regards,

Dr Maurice Goodman

Chief Medical Officer: Discovery Health ■

NEUROPSYCHIATRIC SEQUELAE IN POST COVID-19 ILLNESS

SANDRA FERNANDES

The world changed as of the 30th of December 2019 after the WHO received a report from Wuhan Jinyintan Hospital, Hubei Province, on the collection of three bronchoalveolar lavage samples from a patient with pneumonia of unknown origin. Real-time PCR (RT-PCR) identified these samples as being positive for the pan Beta-coronavirus. This virus was initially named 2019-nCoV, but later renamed as SARS-CoV-2 (COVID-19).

This virus, highly infectious, has spread rapidly across the globe resulting in widespread panic and devastation. We have surpassed the 1.9 million mark in global deaths and almost 90 million infections. South Africa as of today (9th January 2021) has 1.2 million infections and 32 425 deaths. This pandemic has certainly affected us all. It has become a 'shared experience' and has affected us in unimaginable ways. This experience includes psychological, psychiatric, medical and social/economic factors.

PAST WARNINGS

We have received warnings over the centuries of what was to come. There has been documentation of both the physical and economic impacts of various pandemics. Certainly the mental health effects have not escaped historical accounts.

Since the beginning of time, human civilization has had to live with viruses, bacteria and parasites. As far back as 430 BCE, Athens was devastated by Typhoid Fever. This epidemic resulted in the Spartans gaining a military advantage during the Peloponnesian War. The Plague and Black Death devastated huge parts of Europe decimating a third of the European population.

We have learnt about how people during the Spanish Flu in 1918-1919 had to contend with serious mental health effects. Not only did people back then have to deal with the devastating

impact of the First World War, but also with the effects of a global pandemic. The world saw the spread of this virus (an H1N1 virus of avian origin) from the shores of the USA right through to Europe and subsequent spread across the globe. The USA in fact had 4 waves: the first in spring 1918; a second wave in August 1918; followed by winter 1918-1919; and a final smaller surge in early 1920.



Sandra Fernandes

AS FAR BACK AS 1918, THE MENTAL HEALTH EFFECTS OF THIS PANDEMIC WERE BEING NOTED, RANGING FROM SLEEP DISTURBANCES, ANXIETY, DEPRESSION AND VARIOUS NEUROPSYCHIATRIC SYMPTOMS. PEOPLE STRUGGLED TO COPE AT WORK EVEN AFTER THE END OF THE OUTBREAK.

This pandemic primarily affected the younger generation from their early 20s to their 40s, which had significant consequences for the economy.



An emergency hospital at Camp Funston, Kansas during 1918 pandemic. <https://nantuckettodayonline.com/archives/the-pandemic-of-1918/>

First-time hospitalisations from influenza were recorded as having mental health effects. These hospital admissions increased annually by a factor of 7 for up to 6 years post-pandemic. Physicians in the UK noted that a pronounced increase in neurological and 'nervous' symptoms was on the rise. Suicide rates were positively correlated to the effects of the pandemic.

Numerous other outbreaks have also affected many people. This was seen during the SARS epidemic in 2003 and MERS in 2009. Varied neuropsychiatric presentations were found.

There is a paucity of research in this area because it is a novel virus. However, research is growing and developing.

THE DIFFICULTY IS TRYING TO ESTABLISH WHAT SYMPTOMS ARE PRE-EXISTING. THIS INFORMATION IS OFTEN NOT AVAILABLE.

SARS-COV-2 PROGRESSION AND MECHANISMS OF ACTION

SARS-COV-2's natural progression is via an early infective phase, followed by a pulmonary phase and a hyperinflammatory phase. During this progression the general innate immune response to any infection takes effect. It is possibly during this phase that SARS-COV-2 subverts the innate response. This may explain the protracted asymptomatic or pre-symptomatic period. The subsequent adaptive immune response allows for both cellular and antibody response which is longer lasting. In this area of antibody response, there is research taking place, looking at potential dangers of suboptimal antibody response, especially in a milder form of the disease of COVID-19.

Viral shedding of SARS-COV-2 starts even during the asymptomatic/pre-symptomatic phase. Viral shedding of mRNA has been used before as a marker of infectious coronaviruses. SARS-COV was shown to shed for up to 4 weeks post-infection. SARS-COV-2's viral shedding is much more poorly documented than SARS-COV-1, although the median range of viral shedding has been noted to be from 8-20 days in survivors and up to 37 days in post-mortem studies.

COULD THIS LONG-TERM VIRAL SHEDDING BE RESPONSIBLE FOR NEUROPSYCHIATRIC SYMPTOMS?

There are 7 human coronaviruses that infect humans and cause primarily mild respiratory illness. Three viruses have been shown to directly infect neurons. These are HCoV-229E, HCoV-OC43 and SARS-COV-1.

There is much debate about whether neurotropism may cause post-infectious neuropsychiatric complications. Within the coronaviruses, SARS-COV

and SARS-COV-2 share a 79.5% genome sequence. Also, SARS-COV-2 has a structure replication that is similar to various viruses such as the mouse hepatitis virus which has been shown to persist in the CNS during acute infections and causes chronic demyelinating disease.

EVIDENCE HAS SHOWN THAT SARS-COV-2 VIRAL PARTICLES ARE FOUND IN THE CYTOPLASM OF FRONTAL LOBE NEURONS AND BRAIN ENDOTHELIAL CELLS.

There are various proposed mechanisms explaining how SARS-COV-2 could invade the CNS. There are both direct and indirect mechanisms that this virus uses to invade the CNS.

The direct mechanisms involve haematogenous spread via endothelial cells in the blood brain barrier (BBB) or via the epithelial cells of the blood-CSF choroid plexus. The haematogenous spread is potentially via the infection of leukocytes that cross the BBB into the CNS. This mechanism is termed the Trojan Horse Mechanism. The infected leukocytes release pro-inflammatory cytokines and further recruitment of leukocytes takes place. This creates a neuroinflammatory loop.

Direct invasion also involves the retrograde axonal transport of the virus such as through the olfactory bulb or sensory afferents such as the vagus nerve. This mechanism was studied during the SARS epidemic when transgenic mice were inoculated intranasally with the SARS-COV virus and direct spread to the CNS took place. Further, these mice had their olfactory bulbs ablated, and inoculated with the virus intranasally. No direct spread to the CNS was found.

WE KNOW THAT ACE 2 RECEPTORS ARE UBIQUITOUS THROUGHOUT THE BODY AND CERTAINLY PREVALENT IN PARTS OF THE CNS SUCH AS IN NEURONS, ASTROCYTES, OLIGODENDROCYTES, SUBSTANTIA NIGRA, VENTRICLES, MIDDLE TEMPORAL GYRUS, POST CINGULATE CORTEX AND OLFATORY BULB.

Indirect invasion presents multiple possibilities. Host anti-SARS-COV-2 responses make the BBB permeable with inflammation and stress auto-immunity; there is secondary immune dysregulated response via the HPA axis activation causing stress and resulting in the release of various steroids; gut microbial translocation (gut-brain axis) occurs; lymphatic drainage from microglia through the perivascular spaces along the olfactory system to nasal mucosa also takes place. Infection of endothelial cells lining brain vasculature is also presumed to occur. We know that up to 40% of patients with GIT symptoms have viral shedding in stools for more than 5 weeks post-infection. This

may explain some of the long term effects from COVID-19.

NEUROPSYCHIATRIC EFFECTS OF SARS-COV-2

Neuropsychiatric presentations may differ in their effects in both the public at large and HCWs (Health Care Workers). The psychological presentations are well documented and have been experienced by many, especially during the hard lockdown. The ongoing ramifications pose challenges. In particular, HCWs and those on the frontline have been documented to be at high risk. This is largely due to ongoing exposure and the stress of working in the frontline with high levels of work intensity, fears of personal safety, lack of PPE, and burnout.

DURING THE SARS EPIDEMIC, FRONTLINE WORKERS HAD HIGH RATES OF PTSD, DEPRESSION AND BURNOUT 2-3 YEARS POST OUTBREAK.

There are still many unanswered questions and neuropsychiatric presentations are still evolving. We do not know how common these are, and we do not know the proportion of neurological and psychiatric presentations. There is a lack of comprehensive and epidemiological characterisation and there is a need for a multidisciplinary team-work approach. Despite the literature growing at a fast pace, there are many gaps in our knowledge.

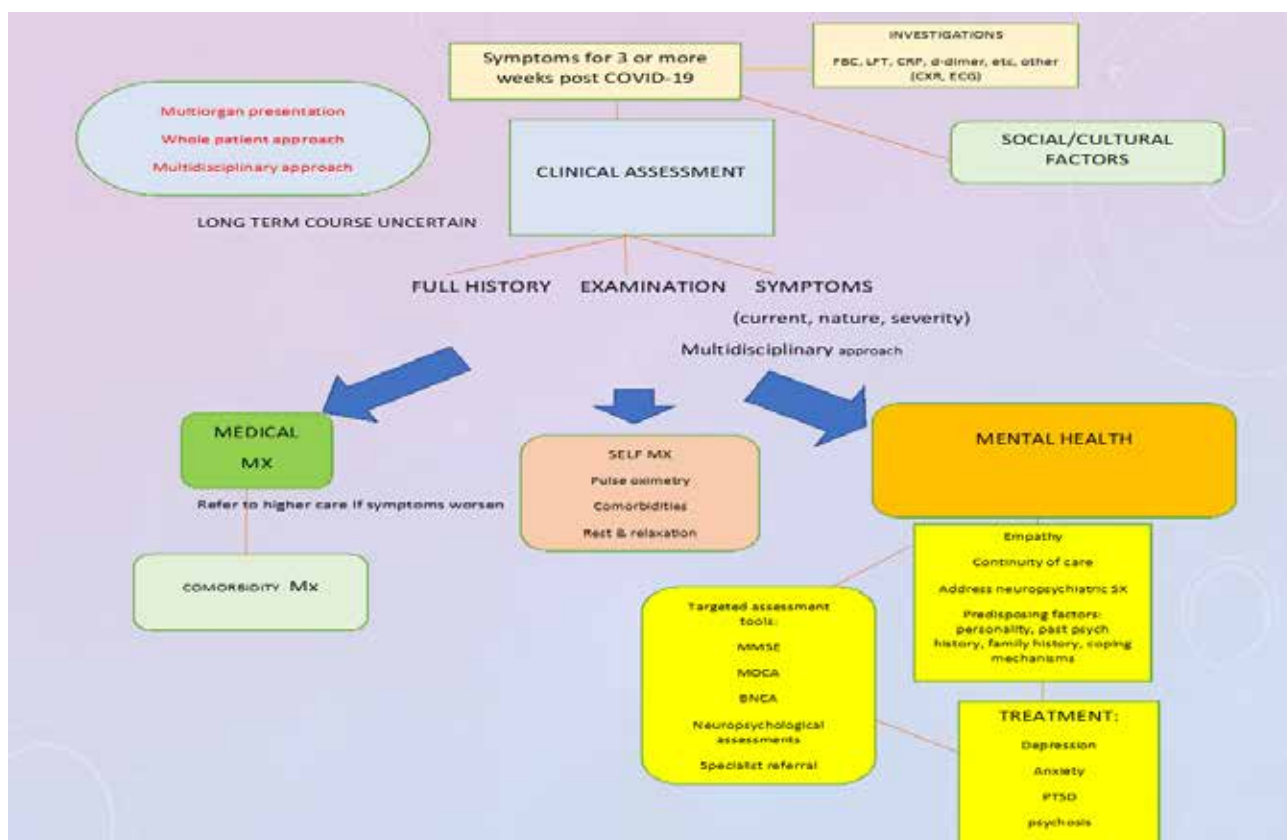
As far as neurological presentations are concerned, a Spanish study (ALBA COVID REGISTRY) cites at

least 57% of patients admitted to hospital presented with a neurological symptom.

Other studies, including a large, multi-centre European study, have shown varying rates of mild to moderate presentations from headaches (13%), altered sensorium (8%) and sleep disturbances (3.8%), to name a few.¹⁷ There are also some disagreements with the WHO definition of neurological presentations, of what constitutes probable versus possible illness. These are distinguished by PCR positivity in CSF and, if no other causative factors are found, to other commonly associated causes.

This field is ever-developing. Recently, a newly reported presentation of COVID-19 is sensorineural hearing loss (SSNHL) in both symptomatic and asymptomatic cases. This hearing loss is of 30 dB or greater in at least 3 consecutive frequencies over a 72-hour period. We know that hearing loss is common to viral infections as the result of an inflammatory response, but in the case of COVID-19, it is thought that the mechanism of action is either via direct damage to the organ of Corti, the stria vascularis or the spiral ganglion. Asymptomatic cases have shown cochlear hair cell function abnormalities.

OVER AND ABOVE ALL THESE CAUSES, ONE NEEDS TO BEAR IN MIND THE EXISTING ROLE OF OTOTOXIC SIDE EFFECTS OF VARIOUS MEDICATIONS USED IN THE TREATMENT OF COVID-19 SUCH AS AZITHROMYCIN AND FUROSEMIDE.



Author's own diagram

Acute neuropsychiatric presentations have shown some differences despite this information coming from a small number of case series and limited data. Cerebrovascular events such as vasculopathy and endotheliitis in various organs seem to be more common in older people. Altered mental states are especially common in those with critical illness and among ICU admissions.

A widespread UK surveillance study has shown a preponderance of neuropsychiatric presentations, such as psychosis, neurocognitive disorders and other psychiatric disorders, in younger people. This will require more detailed prospective and longitudinal studies in order to understand this fully. Collaborative work being undertaken under the Coronerve Study Group, in conjunction with the Brain Infections Global Neuro Network, hopes to answer some of these questions and characterise novel neuropsychiatric syndromes.

IMMUNE RESPONSES AND PRO-INFLAMMATORY CYTOKINES IN THE CNS CAUSE DEPRESSION IN ANY SYSTEMIC INFECTION. THIS IS PARTICULARLY PRONOUNCED IN THE ELDERLY DUE TO THE IMMUNE HOMEOSTASIS BEING REDUCED.

In fact, inflammatory markers such as TNF α , IL-2 and 6 correlate with various psychiatric presentations. These factors may also be primary regulators of an immune response in the brain. All of this may be responsible for chronic neuropsychiatric presentations. So are we potentially seeing a similar post-viral syndrome as is seen with EBV (Epstein-Barr Virus)?

POST-COVID-19 SYNDROME

Post-COVID-19 Syndrome (“Long Haulers”) is a newly described syndrome that is characterised by chronic fatigue, myalgia, depression and anxiety, sleep disturbance and brain fog with ongoing concentration difficulties. The CDC reported that up to 35% of people infected with COVID-19 have ongoing symptoms or develop symptoms after a brief convalescence period. There is, however, lack of clarity on the agreed definitions of what constitutes Post-COVID-19 Syndrome. There has also been a lack of agreement on the requirement of a positive test for COVID-19. This is largely due to the fact that during the first wave in various countries, people were often not able to access testing. Chronic COVID-19 has loosely been defined as occurring from 3-12 weeks post infection. So is this a post-infectious process similar to chronic fatigue syndrome (CFS)?

THE DIFFICULTY WITH SOME OF THESE ANECDOTAL AND SMALL CASE SERIES REPORTS ARE THAT PRE-EXISTING HISTORIES OF AFFECTED PEOPLE ARE NOT AVAILABLE.

Often PCR tests are not positive and no abnormalities are seen on blood/biomarkers of COVID-19.

So how can we approach the management of post-COVID-19 presentations? A holistic and multidisciplinary approach is of the utmost importance. We know that COVID-19 is a multiorgan presentation. A clinical assessment that is comprehensive in history-taking, examination and symptom documentation is essential. Medical management needs to ensure that all aspects are thoroughly assessed and comorbidities are dealt with. Patients can themselves manage various areas, such as doing pulse oximetry at home and managing diabetes and hypertension and ensuring that they rest adequately.

THE MENTAL HEALTH EFFECTS ARE EXTREMELY IMPORTANT. MENTAL HEALTH PROFESSIONALS NEED TO TAKE HISTORIES THAT INCLUDE COPING MECHANISMS, PERSONALITY TRAITS, PREDISPOSING FACTORS AND FAMILY HISTORIES OF PSYCHIATRIC ILLNESS.

These need to be done with empathy and the provision of continuity of care. Targeted assessment tools can also be used, especially where neurocognitive impairment may be suspected. The adequate treatment of psychiatric presentations such as depression, PTSD and anxiety needs to follow.

So what is the way forward with regards to Post-COVID-19 Syndrome?

We are faced with an unprecedented number of long term effects of COVID-19 infection. We are most likely going to see an increased number of disability claims and workplace assessments. This requires the collaboration between various disciplines in order for research to move forward. Agreed structured criteria for the diagnosis of Post-COVID-19 Syndrome is essential. It is important to keep in mind that the majority of people do not develop this syndrome, so not over-pathologizing is crucial. However, empathically acknowledging this presentation remains a necessity.

THE ROLE OF A VACCINE ON NEUROPSYCHIATRIC PRESENTATIONS

As of January 2021, two novel mRNA vaccines and one adeno-viral vector-based vaccine have been developed and approved for emergency use and distribution. The UK became the first in this race to roll out the vaccine to some of its HCWs and the elderly in care centres. This was quickly followed by the USA, where almost simultaneously the rolling out of a second vaccine across the country took place.

How will a vaccine impact on the neuropsychiatric presentations documented so far?

Not much is known about post vaccine immunity and the role it will play in the long-term post-inflammatory response from COVID-19. Could any side-effects from a vaccine potentially contribute to post-infectious inflammatory response? If vaccines are rolled out successfully, then will a post COVID-19 syndrome rapidly dissipate?

IT IS INTERESTING TO NOTE THAT THE FIRST RECORDED 'SIDE-EFFECT' FROM TWO OF THE VACCINES UNDER TRIAL WERE IN FACT NEUROPSYCHIATRIC PRESENTATIONS.

COVID-19 VARIANTS

After all the world has been through in 2020, yet another complication has arisen. What seemed to be a light at the end of the tunnel (the vaccines), is now being obscured by uncertainty as variants of the virus have developed. As a result, it seems we may have to live with this virus indefinitely, much like the influenza viruses. However, this one is more severe and has a far greater impact worldwide.

So perhaps neuropsychiatric presentations are here to stay. The variant results in higher viral loads in the respiratory tract, suggesting greater transmissibility and possibly infectiousness, but not necessarily disease severity.

HOWEVER, INCREASED VIRAL LOAD DOES PREDICT HOSPITALISATION. SO WOULD THIS NOT EQUATE TO INCREASED SEVERITY?

South Africa soon documented its own unique variant, named 501.V2. Research is currently looking at how this variant may affect hospitalisations and how it could be affected by the existing vaccines.

It has taken a couple of months for the first UK variant to spread across the globe inevitably the South African variant will follow suit.

VARIOUS QUESTIONS ARE RAISED: WHAT IS THE IMMUNE RESPONSE TO THIS NEW VARIANT AND HOW WILL A VACCINE AFFECT ITS RESPONSE?

We have learnt much about this virus. We have learnt how to treat it more effectively. We will have to live with this virus for much longer even with the advent of a vaccine. Perhaps a lesson not learnt from the Spanish Flu in 1918 is that up to four waves were seen across the globe. Back then, people relied upon mask wearing, social distancing and hand washing. With the technological breakthroughs that we have seen with vaccine development and production it is certainly hoped that we may mitigate subsequent waves. But a rough road lies ahead even with the roll-out of the current vaccines.

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Sandra Fernandes is a Neuropsychiatrist and Head of Clinical Unit Neuropsychiatry at Tara Hospital. A Wits graduate (1996), she qualified as a psychiatrist in 2002 and has been employed at Tara since 2004. She is a registered neuropsychiatrist subspecialist with HPCSA since 2016. She has managed a specialist neuropsychiatric ward and outpatient clinic.

From March 2020, Dr Fernandes set up policies and protocols for COVID-19 management of patients and staff at the hospital. She also set up a designated COVID-19 ward for psychiatric inpatients, providing oxygen and treatment protocols as per CMJAH. During this time she completed courses on respiratory support for COVID-19 patients as part of upscaling her skills. She has been managing two isolation wards for PUIs and one COVID-19 ward. Her team has managed mild-moderate COVID-19 disease with comorbidities and psychiatric illness. Dr Fernandes also chairs the surveillance hospital COVID-19 committee and co-chairs the Tara COVID-19 response committee. She also chairs the PILIR committee and is responsible for making recommendations on alternative accommodations for staff with comorbidities during this pandemic. **Correspondence: sandra@sfernandes.co.za** ■



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WPA

MESSAGE FROM THE PRESIDENT

FEBRUARY 2021

Dear friends,
Greetings for the new year! It is difficult to believe it is already February – these first months of my presidency have gone by quickly with a substantial amount of work on our 2020-2023 Action Plan already underway. The new Executive Committee has met several times since the General Assembly in October and has finalised changes made at that time to the WPA Statutes & Bylaws, and Manual of Procedures. Updated versions of both documents are now available on our website.

We have also established 16 Working Groups to tackle our six key priorities: Capacity Building; Public Mental Health; Child, Adolescent and Youth Mental Health; Addressing Co-Morbidity in Mental Health; Partnerships with other Professional Organisations and NGO's; and Continuation and Completion of the previous Action Plan's work. Each of these groups has brought together its members to develop terms of reference and agree on projects for the future. A list of the groups is available here: <https://www.wpanet.org/action-plan-2020-2023> and each of them will soon have a page on the website through which we will keep members informed of their work.

Meanwhile, WPA's Advisory Council on Response to Emergencies (ACRE), established last year to respond to the COVID-19 pandemic and other emergencies, continues its excellent work in support of children in Nepal. Through ACRE, we have been able to arrange professional support from the Royal College of Psychiatrists UK to train mental health

professionals in Belarus; while the Royal Australian & New Zealand College of Psychiatrists (RANZCP) has provided a generous grant to Papua New Guinea in support of ongoing work on COVID-19.



Dr Afzal Javed

Our meetings program is in full swing. Planning for the 2021 WPA World Congress of Psychiatry in Cartagena is well-underway and we are excited to have an in-person meeting scheduled.

CERTAINLY, AS COVID-19 VACCINATIONS ARE ROLLED OUT ACROSS MUCH OF THE GLOBE, OUR HOPE IS THAT THE OPPORTUNITY TO SAFELY TRAVEL WILL ONCE AGAIN BE RESTORED.

In December last year, we hosted a virtual thematic congress on Intersectional Collaboration "Psychological Trauma: Global burden on mental and physical health". Presentations from the meeting are available via our website and a full report of the meeting is available here: https://3ba346de-fde6-473f-b1da-536498661f9c.filesusr.com/ugd/e172f3_d53720fbbfd545f7a3514565753e2b5a.pdf.

We also co-sponsored a number of online events, including the 2020 WISH Summit and, more recently, a joint webinar with the World Health Organization (WHO) on "The COVID pandemic in



Europe: Lessons learnt". WPA is now exploring with WHO, the possibility of arranging similar meetings in other WHO zones.

Work also continues on our first-ever virtual World Congress of Psychiatry which is now less than two months away. We have a wonderful program of interactive sessions and world-class speakers, and our team is busy putting the final touches on what is sure to be an engaging and fulfilling Congress experience.

IF YOU HAVEN'T ALREADY REGISTERED TO PARTICIPATE, I ENCOURAGE YOU TO DO SO – ESPECIALLY AS WE NOW HAVE A VERY EXCITING ADDITION TO THE PROGRAM! THIS YEAR, ALL PAYING CONGRESS REGISTRANTS WILL RECEIVE COMPLIMENTARY ACCESS TO WPA'S WCP ONLINE LEARNING PROGRAM.

Many of you will already be familiar with the courses we usually run the day prior to a World Congress – attendees can register and pay to attend an expert-led session on a topic of their interest. To celebrate the launch of WPA's new Education Portal – all paying WCP 2021 registrants will be eligible to register FREE for any of the ten WCP Online Learning courses, scheduled to take place throughout the coming year. Just like our in-person courses, there will be activities, discussion and opportunities for interaction, with participants who successfully complete the course receiving a Certificate of Participation. This opportunity is a valuable addition to an already outstanding scientific agenda, and we are very grateful to our colleagues who are contributing their time and expertise to this new program. Our first Course, directed by Dr Davor Mucic on the topic of Telepsychiatry, will take place later this month. The full course schedule is available here: <https://www.wpanet.org/education-portal>.

All courses from the WCP Online Learning Program will eventually be available on the WPA Education Portal. A key part of our Educational Program led by WPA Secretary for Education, Roger Ng, the portal was established last year under the leadership of my predecessor, Professor Helen Herrman. It now houses WPA's many educational resources – including our COVID-19 Resource Library and well-regarded Comorbidity and Depression series.

This year, a selection of new and updated resources has also been added. One program we are especially excited about is a course on Evidence-based Psychotherapies, which has been developed to help psychiatrists in all countries, in particular trainees and early career psychiatrists, improve competency in this area. Produced by WPA's Psychotherapy Section under the leadership of Professor César A. Alfonso, the course materials are divided into eight modules, and include articles, presentations, videos and self-assessment tools. You can read more about it on the portal.

ALSO AVAILABLE ON THE PORTAL, IS OUR VERY POPULAR INTIMATE PARTNER AND SEXUAL VIOLENCE AGAINST WOMEN CURRICULUM. THE ENGLISH LANGUAGE VERSION HAS NOW BEEN UPDATED TO BE MORE INTERACTIVE THAN EVER BEFORE WITH PRESENTATIONS, READING LISTS, TEACHING POINTS AND QUIZZES.

We will be working over this next year to update the other language versions as well. In the meantime, the original PDFs remain available on our website and via the portal.

GOING FORWARD, IT IS OUR HOPE THAT THIS NEW PORTAL WILL NOT ONLY FACILITATE FURTHER EDUCATION IN PSYCHIATRY BUT ALSO THAT IT WILL ENCOURAGE AND INSPIRE LEARNING AMONG COLLEAGUES AND TRAINEES AROUND THE WORLD.

If you have a course or resources you would like to see included on the portal, please contact WPA's Education Coordinator, Catherine Devine.

2020 will be remembered by many of us as one of the most challenging years in our lifetime. But it was also a year that provided us with an unparalleled opportunity to learn, adapt, educate and inspire. I look forward to continuing those philosophies into 2021 and beyond.

Dr Afzal Javed
President
World Psychiatric Association ■



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FORENSIC PSYCHIATRY

DATE PRESENTED: **29 OCTOBER 2020**

Clinical practice in psychiatry often places psychiatrists at the interface of medicine and law. It is inevitable that at some point a clinician will be faced with a request or demand from the legal fraternity when psychiatric input is required in the adjudication of a legal issue.

Behaviour and cognitive functioning are two important domains that come under scrutiny by psychiatrists. These domains have a significant impact on an individual's ability to engage in legal acts or to function within the confines of the law. There are various scenarios in both civil and criminal law where a psychiatrist may be called upon to assist, either by providing clinical reports or by conducting independent assessments.

This webinar will focus on three important areas where psychiatrists may be called on to assist and which may be medicolegal processes from the outset or which may have the potential to become medicolegal processes:

- **Dr Tando Melapi** will focus on the psychiatric considerations in a fitness to work assessment. This is an area frequently under scrutiny in psychiatric practice.
- **Dr Rodhie Sapinoso** will speak on psychiatry in the digital age, a topic that is especially

pertinent in current times.

- **Dr Mirriam Close** will focus on various aspects of medical negligence and the legal obligations placed on clinicians.

These are three important areas where legal processes may require psychiatric input in the determination of an outcome. It is therefore necessary that clinicians are familiar with both the professional and legal requirements attached to patient care and assessments in these areas.

MENTAL HEALTH OF CHILDREN AND ADOLESCENTS IN 2020

DATE PRESENTED: **12 NOVEMBER 2020**

CHAIRPERSON: Ms Jasmin Kooverjee

SPEAKERS: **Dr B. Belsham**, Child Psychiatrist
Treating ADHD during COVID-19 pandemic

Dr Venera Stancheva, Child Psychiatrist
Disorders in Children and Adolescents in 2020 - New insights

Dr Helen Clark
The Psychosocial Impact of COVID-19 on child Mental Health

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STRONGER TOGETHER



DUAL ACTION & CONTROL FOR DEPRESSION & DPNP*¹

Dr. Reddy's



HELPLINE
0800 21 22 23 www.sadag.co.za

Dr. Reddy's



NEUROPSYCHIATRY
GOOD HEALTH CAN'T WAIT

* Depression, as defined by DSM-IV Criteria; DPNP = Diabetic peripheral neuropathic pain
Reference: 1. Yelate 30/60 package insert. Dr. Reddy's Laboratories (Pty) Ltd. December 2012

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

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

TO ACCESS WEBINARS

You will need to register at: www.medeapro.co.za to access the site. The webinars are available on the menu. Alternatively to just view, you can go to <http://medeapro.co.za/webinars/>

DIGITAL DETOX

DATE PRESENTED: **26 NOVEMBER 2020**

We spend an inordinate amount of time in front of and staring at our black rectangles, our screens. People spend around six hours a day in front of a screen and on average about two to three hours on our phones. And during the pandemic our screen use has skyrocketed.

Our eyes hurt, our backs ache, and our attention span aspires to be that of a goldfish. We need a digital detox. We live completely disconnected from our own bodies, living out our lives on social media platforms and glued to screens.

This 30 min presentation (online or in-person) teaches you and your team the importance of



stepping away from the screen. It includes a guided Body Meditation/Practice which everyone can use as part of your daily rhythm, to help you and your team detox, reconnect to their bodies and be all round healthier and happier people

Dr. Reddy's  **Good Health Can't Wait.**

Get the *most value* from CPD's with MEDePRO

Dear Healthcare Professional,

Earn 2 CPD Ethics points

Get **CPD Ethics points** for the webinar.
Follow the link to register and login:

“Attract More Patients to Your Practice with Digital Media” >

presented by
Rohit Uttamchandani,

a leading digital marketing and transformation consultant.

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Yours, in digital communication,

Dr. Reddy's 

Dopaquel
QUETIAPINE FUMARATE

**HARMONY
IN MENTAL HEALTH**

**Dopaquel
PERFORMANCE**

The
SOUTH AFRICAN

No. 1

**ANTIPSYCHOTIC
OF CHOICE!²**

Dear Healthcare Practitioner

We are excited to release a series of short, sharp Dopaquel videos to keep you in the picture about Dopaquel's role in the treatment of schizophrenia and manic episodes associated with a bipolar disorder.³

Please use the link below to start the first educational video to stay up-to-date with Dopaquel:

<https://www.medeapro.co.za/dopaquel/>

Yours, in staying ahead of the changing educational arena.



Dr. Reddy's

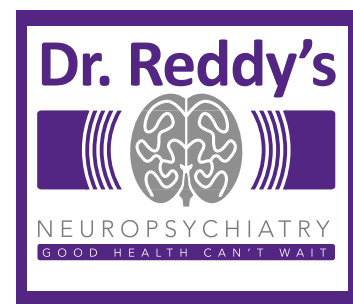


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- Galderisi S, Heinz A, Kastrup M et al. Toward a new definition of mental health. *World Psychiatry*, 2015;14(2):231-233.
- IQVIA, TPM data, Nov Mat 2019; Impact RX, Mat. November 2019.
- Dopaquel Professional Information. June 2017.

☐ Dopaquel 25/100/200/300. Each tablet contains quetiapine fumarate equivalent to quetiapine 25 mg/100 mg/200 mg/300 mg. Reg No's 43/2.6.5/0429;0430;0431;0432. Dr. Reddy's Laboratories (Pty) Ltd. Reg no. 2002/014163/07. Block B, 204 Rivonia Road, Morningside, Sandton. 2057. ZA/02/2020-22/Dopaquel/021.

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



SR Dopaquel
QUETIAPINE FUMARATE

HARMONY IN MENTAL HEALTH

The
SOUTH AFRICAN

No.1

ANTIPSYCHOTIC OF CHOICE!¹



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Dr. Reddy's



NEUROPSYCHIATRY
GOOD HEALTH CAN'T WAIT

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

SR Dopaquel 25/100/200/300. Each tablet contains quetiapine fumarate equivalent to quetiapine 25 mg/100 mg/200 mg/300 mg. Reg No's 43/2.6.5/0429;0430;0431;0432. Dr. Reddy's Laboratories (Pty) Ltd. Reg no. 2002/014163/07. 204 Rivonia Road, Block B, Morningside, Sandton. 2057. www.drreddys.co.za. ZA/01/2020-22/Dopaquel/003

For further information refer to the website of the medicines regulatory authority.

BELIEF SYSTEMS

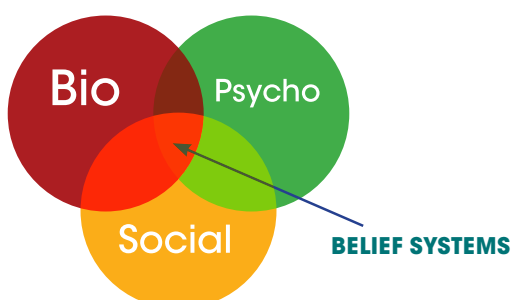
AND THE ROUTINE BIO PSYCHO SOCIAL (BPS) CLINICAL ASSESSMENT

Lennart Eriksson

This personal perspective is to highlight the need to add enquiry of our patient's belief systems into our routine clinical history. The broader term of belief systems – rather than only focusing on spiritual and religious beliefs – is intended to speak to a more inclusive enquiry relevant to our multicultural and multiethnic society. Many of our patients do not hold any spiritual or religious beliefs but have a wide variety of strongly held belief systems. An understanding of a patient's personal belief system may significantly impact on our final diagnostic formulation and may also influence our chosen management options.

TO MAKE THE AREA OF BELIEF SYSTEMS RELEVANT IN OUR CLINICAL ASSESSMENT I PROPOSE THAT THE ENGELS BPS MODEL BE EXPANDED TO FORMALLY INCLUDE THE PATIENT'S BELIEF SYSTEMS.

The "radical centre" of the BPS intersecting Venn diagram would then be the focus for exploring a patient's belief system.



A belief system may be defined as a set of principles or tenets which together form the basis of a religion, philosophy, or moral code. In a broad sense it may be understood to refer to the framework of ideas and beliefs through which an individual interprets the world and interacts in it.



Lennart Eriksson

Listed belief systems are numerous. A quick search will list 45 recognised belief systems. Persons may even have their own belief system. A person may hold the belief that "Fairies at the bottom of my garden protect me from harm"!

THE ROLE AND PLACE OF SPIRITUALITY, RELIGION AND PSYCHIATRY ARE THE FOCUS OF A GREAT DEAL OF ATTENTION.

The World Psychiatric Association, Royal College of Medicine and South African Society of Psychiatrists (SASOP) have all published Position statements on the relationship between Spirituality, Religion and Psychiatry. A summary of these three position statements would include:-

- An acknowledgement of the importance of spiritual and religious experiences in the lives of our patients
- The important role of scientific information on mental health and its interface with spirituality and religion

- The role of culture is acknowledged
- The role of training of psychiatrists in the field of spirituality and religion is emphasised.
- Public information on the importance of spirituality and religion is encouraged
- Clinical practice must be aware of the ethical and professional boundaries associated with spirituality and religion
- Competent, sensitive, respectful and appropriate management of spiritual and religious beliefs is highlighted by the Royal College.
- All faith traditions and belief systems are to be recognised and treated as equal - SASOP

THE SA COLLEGE OF PSYCHIATRISTS CURRICULUM REQUIREMENTS FOR PART 1 AND PART 2 INCLUDES RELIGION AND SPIRITUALITY UNDER THE SECTION "SPECIAL TOPICS". "SPECIAL TOPICS" ALSO INCLUDES TRANSCULTURAL ISSUES.

The CMSA Curriculum Content Blueprint elaborates on the competences required with respect to Culture and spirituality. Personal growth and self-reflection are encouraged. Most importantly, and relevant is an emphasis on the clinical assessment, interventions and professional practice. Professional practice includes ethics and boundaries.

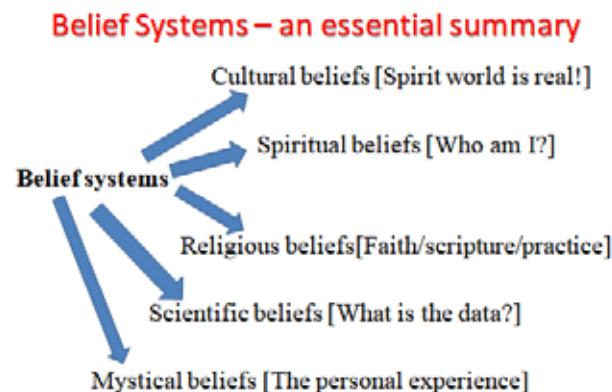
LITERATURE EXPLORING THE RELATIONSHIP BETWEEN PSYCHIATRY, SPIRITUALITY AND RELIGION ARE AVAILABLE TO ALL WHO WISH TO PURSUE THIS OFTEN DIFFICULT TOPIC. IT IS NOT THE INTENTION OF THIS PERSONAL PERSPECTIVE TO EVEN ATTEMPT TO SUMMARISE ALL THAT IS WRITTEN ON THIS INEXHAUSTIBLE, AND OFTEN EXHAUSTING, SUBJECT.

Belief systems in the context of culture and mental health has also been given a fair amount of attention in the literature.

Science – as a practice and a belief system – is discussed from a range of perspectives. These range from evolutionary psychology (including the evolution of consciousness), Neurotheology, neuroanatomy using fMRI images (e.g., brain changes using meditation), drug induced mystical experiences (e.g., Psilocybin) and even

neurochemistry (serotonin receptor density). Science therefore has some evidence for understanding the nature of spirituality. Culture as an area of focus is included in treaties of cultural psychiatry.

Broadly speaking – and again not wishing to pursue elaborate detail – a personal perspective. An essential summary of belief systems will, in my opinion, include the following:



Thus, in summary and again from a personal perspective, I have highlighted the importance of this area of the human experience.

IT IS AN AREA DESERVING OUR FULL ATTENTION. A PHYSICAL EXAMINATION, A ROUTINE CLINICAL HISTORY, A MENTAL STATUS EXAMINATION, AN ASSESSMENT OF PERSONALITY AND INTELLIGENCE AND MUCH MORE IS NOT COMPLETE WITHOUT ALSO GATHERING INFORMATION ABOUT A PERSON'S BELIEF SYSTEMS. WHETHER THE BELIEF SYSTEM IS CULTURAL, SPIRITUAL, RELIGIOUS, SCIENTIFIC, OR MYSTICAL WILL CONTRIBUTE TO OUR SUMMARY FORMULATION AND FINAL DIAGNOSTIC PROFILE.

Management and care of the patient - and very often the family - may be strongly influenced by our having included information on the patient's belief systems.

References are available from the author.

Lennart Eriksson is a retired psychiatrist attached to the University of KwaZulu Natal. He is the past convenor of the SASOP Spirituality and Religion Special Interest Group. **Correspondence: lennarte@iafrica.com** ■

OF NECESSARY INVASION, BROKENNESS AND BRAVERY

Claudia Campbell

I've been trying to figure out my concurrent wish and reticence to have the letter contained in this article published. I've spent time analysing the certainty that, at least for some readers, it will serve its intended purpose and not be viewed as a curious little anecdote. Additionally, I would hate it to read as an overreaction instead of a useful opinion.

This article is not a passive reminder for professional empathy, but a direct request for action. Really it is a plea for psychiatrists (or any other practitioners) to be aware of moments you could be your patient's advocate and voice when her trauma might silence her - to bolster her courage. With that caveat I would be very grateful if you continue reading and don't page on by.

So, here we go...

I WAS DIGGING THROUGH PAST WRITING IN SEARCH OF SOMETHING UNRELATED TO THIS ARTICLE, AND CAME ACROSS THE 2014 LETTER BELOW. IT IS NOT ADDRESSED TO A PSYCHIATRIST BUT A GYNAECOLOGIST. SO WHY THEN AM I ASKING PSYCHIATRISTS TO PAY ATTENTION TO IT? I BELIEVE THE LETTER WILL SPEAK FOR ITSELF.

When proposing the idea of this article and my concern about its very personal nature, it was suggested that perhaps I use my current voice to speak to excerpts of the letter. After much consideration I decided that it should be published as originally written. Using a few excerpts to insert into a 'new' article felt as if the intent of the letter became a diluted academic exercise. I realise it's a very direct piece of writing, and honestly

if I were the gynaecologist, I would not have wanted to be its recipient. It's harsh, but I would argue not disproportionate to my experience. Perhaps that is the point? This letter was not written with any intention of it being published one day. It was written with the hope that another woman might be helped to manage the potential terror associated with the necessary physical invasion during a gynaecological consultation - to help that woman feel believed and not broken.



Claudia Campbell

POST TRAUMATIC STRESS DISORDER (PTSD) IS A TRAGIC CONDITION. ITS REALITY, IN THIS INSTANCE, BEING THE RE-EXPERIENCING OF SEXUAL ASSAULT IN SUCH A COMPLETE WAY, SO MANY YEARS LATER.

Even today, touch can be a trigger for me, and essentially that is the biggest thing a woman deals with during a gynaecological appointment. The contents of my letter is not something women generally speak about. Yet, because sexual abuse is so common, many of us need to muster up the courage to trust gynaecologists, and hope they will gently manage our vulnerabilities with care. However, it's not just gynaecological consults that require one to breathe through chilling vulnerability born of past tragedy, it may also be operating theatres, radiology, gastroenterology, dermatology... the list goes on. Also, when trying to contain the awfulness of resurgent trauma, it becomes really tough to stand up to an insensitive doctor and request accountability for experiences similar to that in my letter. And so, with that said, I ask you to read my letter:

Dear Dr,

It is with utter respect and concern that I write this email.

I have reflected a lot on my consultation with you yesterday and questioned my responses over and over. As someone with psychiatric diagnoses and a fairly unreliable body I tend to place all the responsibility for painful emotions and messy reactions on myself and my own weaknesses. However, as I calmed down and gained perspective, I felt that to a large degree my discomfort was connected to the manner in which I felt you approached me. Given that a large percentage of women will experience some kind of sexual assault and that a significant number of people are at some time diagnosed with a mental disorder, I imagine that I will certainly not be the last patient with a complicated emotional make-up to see you. Taking this into account I felt that perhaps I owe it to you to explain how I experienced our consultation.

HOW WOULD YOU EVER KNOW HOW A PATIENT FEELS UNLESS THEY TELL YOU?

I understand that presenting the history of my body and mind to a practitioner must smell somewhat of 'unstable hypochondriac' - funny thing is I have questioned whether this label does in fact belong to me. Medically there is so much complexity, so often, that I begin to wonder if it's all fiction or reality. Those treating me need to repeatedly remind me that it's not an imagined situation, that my body was horribly violated, that I had head injuries, that the chemicals in me, which should support my body, brain and emotions are off-kilter. It's a truly unpleasant situation to accept and acknowledge. This is not something I have chosen, and I fight everyday to be functional, add to society and move as far away as possible from the traumatized woman of five years ago who barely knew her name. This immensely hard work has, to an extent, begun to pay off.

However, one is not given psychiatric diagnoses for no reason, and the existence of PTSD does not happen in the absence of symptoms. The physical responses my body renders are very unpleasant, as is the psychiatric dread my mind can serve up. My reality is that I have to deal with the dark reactions in my heart and mind continually, this takes commitment and hard work. Having the most intimate parts of you violated due to abuse unfortunately can leave very deep and painful scars.

For most women a gynaecology appointment renders some anxiety, even more so when you have never met the doctor. Having to visit a new gynaecologist when you have PTSD is terrifying. Even though I can rationally reason that a gynaecologist appointment is not a place I should be terrified of, it is unfortunately a trigger for my panic attacks, flashbacks, and dissociation that don't always respond to rational thought. Vulnerability, and the feeling of being exposed and unsafe in any way

can prove to be a strong trigger. Being seen by a gynaecologist requires me to position myself in the most exposed way and accept the paralyzing examination. It is one of the hardest things and generally renders a dissociated 'me' attempting to exit the situation. Even though the reactions occurring are of absolutely no fault of a well-intentioned gynaecologist, I can only imagine that it is an unpleasant experience to see a patient in this kind of distress.

Mental illness and abuse unfortunately come with a loaded amount of stigma. As a patient, when you disclose your diagnosis or experiences you have to continually deal with the awkward silences or obvious attempts to ignore what you have just divulged. Ironically, the lack of acknowledgement simply engenders a feeling that all the person, or doctor, before me sees is my diagnosis, suddenly the 'real' me is invisible. Couple this situation with various medical anomalies and you have a state moulded by embarrassment.

Yesterday when I told you I was terrified and that I have PTSD, I really needed you to acknowledge it and help me feel safe. I needed you to 'see' me and help me know that I wasn't going to be hurt and that you didn't view me as a patient over-reacting to something ridiculous. When I reflect on my demeanor yesterday it must have been apparent that I was awash with fear. But you didn't acknowledge that part of me, the part that is the cause of my greatest daily struggles and immense terror as I sat across from you.

THE WAY I FELT WHEN I ENTERED YOUR ROOMS WAS ABSOLUTELY NOT YOUR FAULT, EVEN SO, THOSE FEELINGS NEEDED ACKNOWLEDGEMENT AND GENTLE CARE. IF YOU DIDN'T KNOW HOW TO HANDLE ME OR WHAT YOU SHOULD HAVE DONE YOU COULD HAVE SIMPLY ASKED WHAT I NEEDED.

Instead I felt foolish and humiliated. When I stood by your desk crying and trying to gather both myself and my things I felt so guilty and ashamed of who I am. When you chose to rather take a phone call from Mrs X and not face me I felt deeply humiliated.

I understand and acknowledge that none of this must have been easy or pleasant for you. I must have made you feel uncomfortable, but as my healthcare-provider I needed you to help me. In that moment there was nobody else to help me. Although what I was experiencing was in a manner 'all in my head' it didn't make it less real or terrifying. Acknowledgment of my fear and the irrational responses to those stigma inducing parts of me was really important.

Sexual assault doesn't only leave one feeling ashamed and dirty, it leaves one feeling alone in vulnerability. It helps immensely to be reminded

that one is not alone, that there is someone there who won't let you get hurt again, even if they need to ask how to help. Being invisible and solitary are some of the most painful experiences and residues of both sexual assault and mental illness.

I do not in any way intend for this email to be destructive or to make you feel as if I am berating you. I simply hope that perhaps if you understand what was happening inside me yesterday, you'll be able to metaphorically 'hold the hand' of your next patient whose fear threatens to overtake her.

Sincerely,

Claudia Campbell

PSYCHIATRY IS A MEDICAL SPECIALTY WHICH REQUIRES VERY LITTLE PHYSICAL CONTACT WITH ONE'S PATIENT. HENCE MY QUESTIONING WHETHER A PSYCHIATRY PUBLICATION IS THE RIGHT PLATFORM TO PUBLISH THIS LETTER AND ARTICLE.

I have found one very motivating reason. How many female patients do you consult with who are victims/survivors of sexual abuse? I assume a rather devastating number. I also imagine that it's not uncommon for some of these women to have to consult with other doctors who will require them to be touched - require them to be and feel exposed.

I have an amazing mental health care team. There is no doubt in my mind that my wellbeing matters to them, and we have retrospectively spoken about the theme of this article on various occasions. However, on reflection there has been a relative absence on the part of my mental healthcare providers to proactively, and preemptively initiate conversation about how to deal with, quite frankly, the necessary physical invasion expected when seeing some other doctors. I think it would have been immensely helpful if we had those conversations. I believe I would have been able to find a little extra courage and reasonableness.

I STATE THE OBVIOUS THAT AS A PSYCHIATRIST, YOU WOULD OFTEN KNOW ABOUT A PATIENT'S HISTORY OF SEXUAL TRAUMA, HOWEVER THAT FACT DOES NOT NECESSARILY MAKE IT EASIER FOR YOUR PATIENT TO RAISE THE MATTER AND HER FEARS.

So I believe it would be kind and supportive for you to possibly initiate a conversation about potential triggers and how to handle them before

a consultation with a gynaecologist (or any other doctor requiring a measure of vulnerability); perhaps suggesting a consult or phone call to check in after the appointment.

Psychiatrists (and often psychologists) are best positioned to have these conversations with patients - frankly and safely. It would probably have been very helpful if I had been able hand a referral letter from my psychiatrist to the gynaecologist instead of blustering an inadequate account of my situation. Trying to explain my abuse and its subsequent PTSD, whilst standing in front of the gynaecologist for the first time was terrifying, embarrassing, and probably incoherent. What's worse was believing I was not being taken seriously.

IT'S SAD, BUT OFTEN DOCTORS TAKE REFERRAL LETTERS FROM OTHER DOCTORS MORE SERIOUSLY THAN A PATIENT'S ACCOUNT OF THEIR OWN EXPERIENCE. I FEEL A REFERRAL NOTE WOULD HAVE HELPED ME NOT FEEL QUITE SO ALONE. IT'S EASIER TO BE BRAVE WHEN YOU'RE NOT ALONE.

What would I want written in that referral letter? Maybe, "*Claudia has PTSD, she is a survivor of sexual abuse. Although strong, Claudia is also fragile. Your examination will require her to be most vulnerable. So, please be present, listen, observe and be kind. Claudia needs you to help her feel brave and not broken*".

Almost seven years on I feel the letter I wrote is as important now as it was then - not just for me, but for other sexual assault survivors. I feel this way because my letter is not a retrospective opinion, but a real letter to a real doctor. It is about a very distressing experience, which should not have happened, because I explicitly informed them about my trauma and PTSD. But, it did happen. Mine is a common experience, but it doesn't make it okay - ever.

I never received an acknowledgment of this letter, even less a reply. Honestly, I didn't really expect one, but the silence did amplify my shame. I am a much more confident woman today than I was then: the woman who felt saturated with fear, embarrassment, brokenness and stupidity. However, those feelings still lurk beneath the surface, the difference now is that I'm confident enough to preemptively ask for help.

So please help quiet your patient's fear and summon her courage.

Claudia Campbell holds a post-graduate degree in psychology and has 10 years experience in the field of corporate transformation strategy. Claudia works in a voluntary capacity as a psychosocial facilitator, public speaker, and consultant. Due to various health challenges, Claudia's personal life includes many experiences from the patient's side of the consultation room. **Correspondence:** claudia@redbench.co.za ■

ADDICTION TREATMENT AND DUAL DIAGNOSIS IN SOUTH AFRICA

Flicky Gildenhuys

The history of addiction treatment in South Africa is rooted in the philanthropic and later keen business eye of addicts who found that others like themselves had nowhere to go for help in overcoming their addiction to alcohol, drugs, and prescription medication.

What started out as 'mom and pop' halfway houses, providing hands on inspiring 12 Step psycho-education and practice (utilising the Minnesota model of addiction treatment) was over time formalised as the Department of Social Development took on the task of trying to licence the addiction treatment facilities that were springing up all over South Africa, with implementation of the developing legislation.

AS IT STANDS NOW ADDICTION TREATMENT FALLS UNDER THE RESPONSIBILITY OF THE DEPARTMENT OF SOCIAL DEVELOPMENT.

However, many of the demands of addiction treatment fall under the scope of the Department of Health - namely safe and effective medical detox, management of drug induced psychosis, and the clinical management of dual diagnoses of depression, anxiety and other mental disorders. This means that substance dependent persons presenting for treatment at many of the registered substance abuse treatment facilities have no access to detox medication, adequate nursing supervision, medical, psychological or psychiatric assessment. Unregistered and many faith-based facilities provide even less professional care and admissions are often left in the care of those recently 'recovered' and unpaid, rather than receiving any form of adequate social welfare care.

After working in the field of addiction care for over 20 years in Cape Town in all the leading facilities, it is apparent to me that substance abuse treatment should fall under the responsibility of the Department of Health and that registration of facilities should require detox facilities as well as medical, psychological and psychiatric supervision and treatment.

There is extensive co-morbidity of many forms of mental illness but predominantly depression and anxiety and PTSD. There are also health challenges such as HIV, diabetes, heart and liver disease and STDs, as well as the current challenges of COVID-19 infections. For those presenting for addiction treatment these co-morbidities must be attended to in order to in anyway begin an effective treatment process.



Flicky Gildenhuys

The effectiveness of treatment, in my experience, is also largely dependent on access to effective post-treatment aftercare programs. The dearth of such support in local communities, especially for those unable to access ongoing out-patient treatment suggests that the utilisation of free community-based structures are often the key for sustainable recovery from substance and alcohol dependency. The medical model of substance abuse treatment whilst attending to the physical and psychological needs of the patient do need to incorporate the benefits of the clinically proven 12 Step programme. Experience has shown that presentation of these programmes by those living their lives according to the 12 Step principles of abstinence plus behavioural and thought change (basic CBT) offer inspiration and hope, and cost-free support to what many consider an existential illness.

When considering where to refer patients ensure that:

1. The facility is registered with both the Department of Social Development, as well as the Department of Health.
2. Detox is medically supervised in a registered Detox unit.
3. Your patient is provided with the benefit of an introduction to the 12 Step programme

Flicky Gildenhuys has an Hons. Clinical Social Work (Substance Abuse) UCT. **Correspondence:** info@ixande.co.za ■

DEPARTMENTS OF PSYCHIATRY

UNIVERSITY OF THE WITWATERSRAND



MMed GRADUANDS



Standing left to right: Drs Prinesh Miseur, Sheila Lutaaya, Yumna Minty and Vuyani Nxumalo. Seated: Prof. Ugash Subramaney (HOD) and Dr Peaceemaker Mngomezulu. Not in the photo but to note that Dr Corinne Johnson and Dr Spongile Nkhahle also graduated

FCPsych PART 2

The following passed the examinations in October 2020: the below mentioned MMed graduands (besides Drs Miseur, Lutaaya and Johnson who had all passed previous exams) as well as Drs Zuma, O'Brien and Mondlana.

NAME	TITLE OF MMED REPORT
P Miseur	Childhood trauma exposure and adherence to antiretroviral therapy (art) among patients attending a public neuropsychiatry health facility
S Lutaaya	Effectiveness of a structured behavioural communication intervention programme in enhancing adherence amongst outpatients with mental illness at Tara OPD
Y Minty	Mental illness attitudes and knowledge in non-specialist medical doctors working in state and private sectors

C Johnson Factors associated with attention deficit hyperactivity disorder in children presenting to the child, adolescent and family unit at Charlotte Maxeke Johannesburg Academic Hospital

S Nkhahle Comorbidities of children and adolescents with intellectual disabilities or specific learning disorders attending specialized psychiatric clinics

CONSULTANT APPOINTMENTS

Dr V Nxumalo (Sterkfontein hospital)
Dr Y Minty (CHBAH)

THE DEAN'S AWARD FOR EXCEPTIONAL SERVICE

Bestowed upon Prof Bernard Janse Van Rensburg, (posthumously) at a special online Faculty honours celebration.

2019 LOUIS FRANKLIN FREED PRIZE FOR THE BEST MMED

Dr Sanushka Moodley

COVID AND MENTAL HEALTH: TRAUMA AND RESILIENCE

On the 21st October the Department hosted a webinar sponsored by Sanofi. The speakers were Dr Andrew Wim (Harvard University), and Drs Thriya Ramasar and Alicia Porter from the National Healthcare Workers Care Network.

CHAIRPERSONS OF COMMITTEES FOR 2021

The Department is pleased to announce the following staff members as Chairs:

Undergraduate committee: Dr Wendy Friedlander

Postgraduate committee: Dr Ralf Brummerhof

Research committee: Dr Belinda Marais

Psychotherapy training committee: Dr Craig Bracken

Registrar committee: Dr Michelle Hungwe ■



UNIVERSITY OF CAPE TOWN

WELCOME

The Division of Child and Adolescent Psychiatry warmly welcomes two International sub-specialist registrar trainees currently doing their sub-specialist training in Child and Adolescent Psychiatry, namely Dr Khalid Abdalhai, from Sudan, and Dr Tigest Zerihun Kebede from Ethiopia.

Dr Kebede is an advocate for and active participant in obtaining affordable and accessible mental health development in a resource-limited setting.

Dr Abdalhai worked as a lecturer in the department of psychiatry at the International University of Africa



Dr Tigest Zerihun Kebede

Dr Khalid Abdalhai

in Sudan. The Division of Psychotherapy is very excited to welcome a new PhD Candidate, **Daniel Rabinowitz** (pictured right), a clinical psychologist, who is supervised by Dr Helena Thornton.



His proposed research intends to (i) investigate the feasibility of task-shifting DBT to community workers, and (ii) to investigate the acceptability of task-shifted DBT for street dwellers with alcohol-related disorders.

The Division of Psychotherapy is also looking forward to working with **Dr Kader** as an honorary appointment to our Division. She graduated with a PhD at the Department of Psychiatry, University of Stellenbosch in 2013. Dr Kader trained as a Global Master Trainer for the Colombo Plan (ICCE) since 2014, has extensive teaching and training experience in substance abuse prevention and treatment, and addiction science. She also has several research publications in peer reviewed journals.

Dr Nada Lagerstrom, who previously trained at UCT, is joining our Department as our Registrar Teaching Programme Coordinator.

We welcome five new registrars that were appointed from the 1st of February, namely **Drs Mpho Mahlakametsa, Hassina Sablay, Syed Nadvi**, as well as, **Dr Inette Swart** (1st March), and **Dr Michelle Swartz** (from 1st August) ■

GOODBYE TO STAFF

The Department will be bidding farewell to **Dr Wendy Vogel**, Head of the Division of Child & Adolescent Psychiatry, and **Prof Sean Kaliski**, Head of the Division of Forensic Psychiatry. The legacy they leave behind, their immense contribution and support to our department and province has been phenomenal.

The Division of Psychopharmacology and Biological Psychiatry bids farewell to **Associate Professor Fleur Howells**. In the years past Fleur excelled as a leader and manager.

Farewell to **Dr Kirsten Reid** who was affiliated with the Division of General Adult Psychiatry. Thank you for her contributions.

The Division of Neuropsychiatry bid farewell to **Carl Freeman** and **Lena Andersen** at the end of 2020. Dr Freeman has played an absolutely pivotal role in teaching. Dr Andersen has done ground-breaking work in the area of psychotherapy research, focused on individuals with HIV ■

CONGRATULATIONS

Congratulations to **Carol Dean**, our lead manager in mental health in the Province, on graduating with the Oliver Tambo PG Diploma PGDip in Leadership. Carol has increasingly integrated UCT and WCG visions, working to ensure that "we learn while we serve, and we serve while we learn". This contribution promises to make a substantive difference to mental health locally.

Dr Lisa Dannatt on the successful completion of her MPhil in Addictions. Lisa's thesis is titled "The views of healthcare providers on providing a brief treatment to address methamphetamine use among patients with a dual diagnosis".

Dr Adam Fakrooden was awarded MMed Psychiatry Part 3 in a ceremony that was held virtually in December 2020.

A third year registrar, **Dr Jasper van Zyl**, who published his MMed thesis in the South African Journal of Psychiatry titled "Motives for deliberate self-harm in a South African tertiary hospital", was awarded the best UCT Registrar research 2020 by the SASOP: Western sub-group during a virtual meeting held on 31st October 2020.

We congratulate the following registrars, namely, **Dr Kavi Naidu** and **Dr Kathryn Grobler**, who despite being the first group of candidates to be examined in the SBA written format in the first semester, and virtually for the oral part in the second semester, passed the Part 2 final exit CMSA examinations.

Congratulations to the following persons on having been awarded research funding:

- **Siyabulela Mkabile** on being awarded a UCT Research Development grant to cover publication costs for his PhD outputs.
- **Babalwa Tyabashe-Phume, Cole Goldberg** and **Siphesihle Zihlazi**, on being awarded Vera Grover scholarships for their PhD and master's studies.
- **Toni Abrahams** for receiving an NRF Thuthuka award and UCT Research Development grant for her PhD study ■

WORLD MENTAL HEALTH DAY 2020 WEBINAR

To commemorate this year's World Mental Health Day, the Centre for Public Mental Health (CPMH) and the South African Depression and Anxiety Group (SADAG) co-hosted a webinar on 9 October 2020 with the following theme "What Mental Healthcare in South Africa should look like".

Prof Crick Lund, a professor in Global Mental Health at the CPMH at the University of Cape Town, as well as at King's College, London, spoke on the strong investment case for mental health in South Africa.

Cassie Chambers, Operations Director at SADAG, then spoke on their experience over these last past months of moving their system completely online.

The highlight of the webinar was when two service users, **Dr Sindi van Zyl** and **Thabo Xaba**, shared

INTERNATIONAL ONLINE CPD EVENT

Professor Sean Kaliski and Maryam Abbas presented to over 400 delegates at an international online CPD event titled "Where Human Sexuality, Sexual Offending and the Law Collide", organised by the Southern African Sexual Health Association.



and assist jurist bodies in their deliberations.

Professor Sean Kaliski presented on "The Nexus between Personality Disorders, Sexuality and the Law", focusing on how personality disorders and patterns of aberrant sexual behaviour are managed within the Criminal Justice system, and how clinical experts can make management recommendations



Maryam Abbas presented on "Balancing Legislative Requirements and Human Rights in Supporting the Rehabilitation of People with Intellectual Disability who Commit Sexual Offences: A South African forensic perspective" ■

their experiences of living with mental illness in South Africa ■



WMHD (from top left to bottom right): Prof Crick Lund, Dr Sindi van Zyl, Thabo Xaba, Prof Katherine Sorsdahl, Cassie Chambers and Dr Marliese Richter.

ALAN J FLISHER MEMORIAL LECTURE: IMPLEMENTING AND SCALING UP INTEGRATED PRIMARY MENTAL HEALTH CARE IN THE REAL WORLD

The Alan J Flisher Memorial Lecture on 3 November 2020 was delivered by Prof Inge Petersen on implementing and scaling up integrated primary mental health care in the real world.

In this lecture, Professor Inge Petersen, public mental health psychologist and Principal Investigator of the Southern African Mental health Integration (SMhINT) research consortium, shares the use of a three-pronged approach that adopts

implementation science, technical support and systems strengthening, to bring evidence-based task sharing interventions for common mental disorders into routine primary health care services in the province of KwaZulu-Natal in South Africa.

She is the Director of the Centre for Rural Health, College of Health Sciences, University of KwaZulu-Natal; and a Research Professor in the College of Health Sciences, UKZN ■

VIRTUAL SYMPOSIUM: NETWORKING FOR INTELLECTUAL AND DEVELOPMENTAL DISABILITY (IDD) RESEARCH IN AFRICA

Prof Colleen Adnams, Emeritus Professor in the Division of Intellectual Disability, assumed the Presidency of the International Association for the Scientific Study of Intellectual and Developmental Disabilities (IASSIDD) in January 2020. At the IASSIDD World Congress held in August 2019 in Glasgow, Scotland, Prof Adnams convened an informal special meeting of congress delegates working in IDD in Africa, to discuss developments in IDD research in Africa.

The meeting was convened on the 1st of December and was attended by 20 researchers, clinicians and post-graduate students in the field of IDD from South Africa, Namibia, Zambia, DRC, Uganda, Ethiopia and the Seychelles, as well as, 3 researchers from the Netherlands, Ireland and the UK working in Africa.

Brief presentations on the service and research situation in three of the African countries set the scene for discussions which echoed a need for research to inform and advocate for service developments which support families in their communities, as they are the primary carers of their children and adult relatives with IDD in Africa.

In addition, a need for multisectoral involvement in this research, particularly in the areas of health, education, social services, housing and employment; and the need to address poverty experienced by families through research to support contextually appropriate poverty alleviation programmes.

The value of a regular forum for online discussion to promote collaborative work was supported by the group, and the Division of ID's offer to provide logistical support to future meetings was well received ■



Prof Colleen Adnams

PERINATAL MENTAL HEALTH PROJECT (PMHP) HIGHLIGHTS

In the last quarter of 2020, there are various highlights to note from the PMHP, a few of which are reflected below.

PMHP set up and chaired a virtual workshop with a range of South African stakeholders from the academic, policy and development sectors to provide comment on the costing research draft report of the Global Economics in Maternal Mental Health (GEMMH) project. This project aims to develop the economic case for improving maternal mental health in low- and middle-income settings and South Africa was chosen as the first case study.

The workshop provided invaluable feedback for improvement to the costing component of the work, as well as guidance for the return-on-investment component, which is to follow in 2021, as well as translation and uptake considerations for national government.

Director, **Simone Honikman**, together with British-Sudanese obstetrician colleague, **Dr Saadia Noreldeen**, was invited to give a workshop on maternal mental health at the Africa regional congress of The International Federation of Gynecology and Obstetrics (FIGO).

The event became virtual and Simone and Saadia were able to use a range of media to engage participants from Rwanda, Brazil, Côte d'Ivoire, Zimbabwe, and the Philippines towards their own strategic development of maternal mental health services in their settings.

The Messages for Mothers (M4M) coalition, of which PMHP is a founding member, recently translated all their Physical Health, Mental Health and Child Health content regarding COVID-19 into additional languages. The PDFs and infographics (for social media sharing) are now available in English, Afrikaans, isiXhosa, isiZulu, Sepedi and Sotho ■

SOCIALLY RESPONSIVE PSYCHIATRY AND MENTAL HEALTH IN THE TIME OF COVID-19

Prof Petrus de Vries, on behalf of the Social Responsiveness Committee recently compiled an inspiring report on the social responsiveness activities and initiatives undertaken in the department during the COVID-19 pandemic. He highlighted the resourcefulness and resilience of the department by outlining the varied socially responsive activities,

some of which are mentioned here:

- Psychological support was provided to a wide range of healthcare staff in hospitals and clinics.
- Practical ways to support children, families, people with disabilities, and local communities,

were found (e.g., registrars at Groote Schuur Hospital donated cell phones to inpatients without phones so that they could remain connected with their families during lockdown; and the Lentegeur Spring Foundation led a 'Food Drive' that raised over R100,000, enabling the Foundation to support more than 200 households with food hampers, to support over 1,000 people in their local community).

- A range of collaborative efforts were stimulated (e.g., the Division of Child & Adolescent Psychiatry linked up with the International and South African Associations for Child & Adolescent Psychiatry and Allied Professions - IACAPAP and SA-ACAPAP - to produce 'Tips for Parents and Carers in the time of COVID-19' in an easy-read WhatsApp format, translated into six South African languages).
- Staffed or participated in research on COVID-19, e.g., an article appeared in *Aids & Behaviour* on the increased risk to the mental health and safety of women living with HIV in South Africa because of the COVID-19 pandemic (**Prof John Joska and colleagues** from the Division of Neuropsychiatry).
- The department went virtual for teaching, seminars, workshops and conferences, e.g., **Prof Katherine Sorsdahl and the Centre for Public Mental Health** arranged a webinar in collaboration with the African Mental Health Initiative on 'mental health aspects of the COVID-19 crisis in Africa'.
- There was a shift towards digital mental health for clinical consultation and intervention, e.g., **Dr John-Joe Dawson-Squibb** led the creation of South African guidelines for psychiatric/psychological telehealth consultations with children, adolescents, and their families, in partnership with SA-ACAPAP (South African Association for Child & Adolescent Psychiatry and Allied Professions).
- Communities were empowered through media, e.g.:
 - Various departmental members contributed to printed media such as *Daily Maverick* and *News24* with writings on mental health, wellbeing, and self-care in the time of COVID-19. Local radio stations such as KFM, RSG, and hospital radio stations approached many departmental members for talks on mental health, parenting, or supporting people with disabilities during lockdown.
 - A special section was created for COVID-19 resources on the departmental website, while Dr John-Joe Dawson-Squibb, Senior Lecturer in the Division of Child & Adolescent Psychiatry, collated and curated relevant and freely available resources for staff, patients, families, and the broader community.

The contributions of staff across all divisions in the department are acknowledged and celebrated ■

UNIVERSITY OF KWAZULU NATAL



ACADEMIC PROMOTION

Suvira Ramlall is the Clinical Head of Psychiatry at King Dinuzulu Hospital Complex (KDHC) and a member of the Joint Medical Establishment. She obtained her MBChB at the University of Natal in 1990, and her Fellowship in Psychiatry in 1996 (CMSA), completed her PhD (UKZN) in 2013 and was promoted to Associate Professor in 2020.

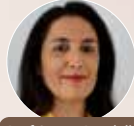
Prof Ramlall is active on many platforms: the Department of Health, UKZN, CMSA and various community organizations. In addition to her clinical duties at KDHC, she is a member of the multi-disciplinary specialist team of KZN's Memory Clinic established in 2007 and based at Inkosi Albert Luthuli Central Hospital. She serves on numerous provincial and national mental health task teams, works with the Provincial Mental Health Directorate informing policy and service delivery as well as



Prof Suvira Ramlall

Congratulations!

Congratulations on your promotion to Associate Professor



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Prof Ramlall is the Principal Investigator for the mental health stream on the College of Health Science's DRILL Programme- an NIH/Fogarty Medical Education Partnership Initiative (D43) International Research Training Award.

As the first academic leader of the Registrar Training Programme in the CHS, Prof Ramlall champions the clinical, academic, research and wellbeing needs of registrars across three Schools and on both DOH and UKZN platforms. She is also a member of the KZN Registrar Programme Steering Committee. By partnering with the private sector, the CHS hosted its first Registrar Awards Evenings, comprehensive orientation programmes and Registrar Workshops in 2018 and 2019.

As a board member of The Association for the Aged (TAFTA) since 2011 and patron of the Bessie Makatini Foundation, which renders dementia care services in Lamontville, Prof Ramlall has been rendering support to these and several NGOs in the province, especially but not exclusively related to mental wellbeing. She has been instrumental in advocating for mental health in KZN by co-founding the KZN Mental Health Advocacy Group in 2015 and inaugurating the Annual Mental Health Walk in the province in 2016. In 2018, she opened the KZN branch of the South African Depression and Anxiety Group (SADAG) - a platform that promotes mental wellbeing in the community and is providing service, training and research partnerships with the students and staff of UKZN and other tertiary institutions in KZN. She was the recipient of SASOP-KZN Community Service Excellence Award in 2016.

After serving three terms as its Secretary, Prof Ramlall was elected as the President of the College of Psychiatrists for the triennium 2020-2023 and is a member of the Senate of the CMSA. She is a member of the Public Sector Executive Committee of the South African Society of Psychiatrists and serves on the editorial boards of the South African Journal of Psychiatry and Frontiers in Psychiatry. Prof Ramlall has graduated Masters and PhD students, is widely published in local and international journals and has co-edited the first South African psychotherapy textbook, Talk Therapy Toolkit.

Despite the many hats she wears, Prof Ramlall identifies herself foremost as a clinician and mental health advocate who is passionate about promoting a holistic approach to wellbeing on community, clinical and academic platforms.



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FCPsych EXAMINATIONS 2020



Dr Megan Schultz passed the FC Psych Part II Examinations in the 2nd half of 2020 with a distinction and is the recipient of the Novartis medal for obtaining the highest overall marks in the FCPsych Part II 2020 examinations.

There are plans to retain Dr Schultz in the Eastern Cape public health sector in Port Elizabeth.



Dr Rhiyaaz Neff passed the FC Psych Part II Examinations in the 2nd half of 2020 and there are plans to retain Dr Neff in the Eastern Cape public health sector in Port Elizabeth.



Dr Carmenita Groves passed the FC Psych Part II Examinations in the 2nd half of 2020 and there are plans to retain Dr Groves in the Eastern Cape public health sector in Port Elizabeth.



Dr Nombulelo Madala-Witbooi passed the FC Psych Part II Examinations in the 2nd half of 2020 and there are plans to retain Dr Madala-Witbooi in the Eastern Cape public health sector in East London.



Dr Vuyisa Matshaya passed the FC Psych Part II Examinations in the 2nd half of 2020 and there are plans to retain Dr Matshaya in the Eastern Cape public health sector in Grahamstown ■

DISCOVERY AWARDS 2020



Dr Illana Links, 3rd year registrar, has been awarded the Discovery Rural Fellowship Award to complete her MMed Studies in HIV and Mental illness. She is conducting the study at the Dora Nginza Hospital Mental Health Unit in Port Elizabeth.



Dr Sara Boschhoff, 2nd year registrar, has been awarded the Discovery Rural Fellowship Award to complete her MMed Studies in the lived experience of patients admitted to ICU. She is conducting the study at the Livingstone Tertiary Hospital in Port Elizabeth.



Dr Nokwazi Mtshengu, final year registrar, has been awarded the Discovery Rural Fellowship Award to complete her MMed Studies in postnatal depression in the Eastern Cape, focusing on the screening tools and validation thereof.



Prof Zukiswa Zingela, Head of Department, has been awarded the Discovery Rural Institutional Award for advancing and promoting the mental health of initiates through training and upskilling of healthcare workers in primary health ■

BOARD APPOINTMENTS

Prof Zingela has been appointed to the International Narcotics Board (INCB) till 2025. The INCB is an independent United Nations entity responsible for monitoring the control of substances in relation to the three United Nations control conventions governing this. It supports and assists member states to implement these conventions.

Prof Zingela has been appointed to the Health Professions Council of South Africa, Medical and Dental Board, to serve for a period of 5 years ■

SETTING UP A LIFE SKILLS PROGRAM FOR JUNIOR DOCTORS

The medical internship rotation has been amended to a new program in 2021 with medical interns now rotating for two months in Psychiatry instead of the previous one month.

The Department of Psychiatry has complimented Internship training at Nelson Mandela Academic Hospital and Mthatha Regional Hospital by adding a life skills program over and above the usual training program. This comprises of content focused on self-care and self-help skills. Two to three sessions are offered a week on identifying

stress early and knowing what action to take when starting to feel overwhelmed, how to practice relaxation techniques and mindfulness, dealing with grief, addiction and bullying, professionalism in health, career pathways in medicine and financial management and avoiding debt traps. All though the program is only a few weeks in existence the feedback from Interns who have taken part in it so far has been overwhelmingly positive. A formal audit of the program will be undertaken throughout 2021 to track the feedback from Interns more efficiently ■

UNIVERSITY OF PRETORIA



Funeka Sokudela was promoted to Associate Professor, and appointed the Head of Department of Psychiatry as of November 2020, Faculty of Health Sciences, University of Pretoria and Weskoppies Psychiatric Hospital, Gauteng Dept. of Health. She is a forensic psychiatrist and heads the forensic mental health unit at the same institution.

She holds a medical degree (MBBCh) from the University of Witwatersrand; a Master in Medicine degree in psychiatry (MMed Psychiatry), a Postgraduate Diploma in Health Systems Management (PDHSM) and a Doctor of Philosophy degree (PhD) in psychiatry from the University of Pretoria.

She teaches and supervises undergraduate and postgraduate students at UP and elsewhere in topics that include forensic psychiatry, legislation, diversity, leadership and public mental health.

She is an avid advocate for diversity training and anti-bias sensitization in post-apartheid South Africa and is passionate about improving access to good quality health care, especially mental health care services for all – including students and staff at universities.

She is the chairperson of the Faculty of Health Sciences Transformation Com; and thus a member of the Institutional Transformation Com at UP.

She is a Fellow of the **Albertina Sisulu Executive Leadership Programme in Health (ASELPH)** and

Kalaivani Naidoo and **Gerhard Grobler** were promoted to Adjunct Professor as of 01 January 2021.



Dr Kalaivani Naidu graduated with a MBChB from the University of Pretoria in 2002, and post community service, spent 2 years working in psychiatry in the UK. She returned to SA and began specialising in psychiatry at Wits University in 2007. She qualified in March 2011, from the University of Pretoria, with an MMed in Psychiatry as well as the FC Psych (SA). Her MMed study was published internationally, in a Biomed Central Journal and presented at the Royal College of Psychiatry Congress in Birmingham. Dr Naidu graduated with a PhD from the University of Pretoria in 2018. The PhD entitled, "Asymptomatological study of syndromal and undifferentiated anxiety comorbidly to acute phase schizophrenia", was presented at the Schizophrenia International Research Society Congress in Orlando, Florida in 2019, and was published internationally in Annals of General Psychiatry in June 2020. Dr Naidu



a fellow of the **Africa Leadership Initiative - South Africa (ALI-SA)** and a member of the **Aspen Global Leadership Network**.

She is a member of various professional bodies including the South African Society of Psychiatrists (SASOP) and the Africa Global Mental Health Institute. She was a previous chairperson of the South African Society for Mental Health and Deafness (SASMHD), of which she is still a member ■

has supervised both MMed and PhD candidates and has several other international publications to date. She is a senior psychiatrist at Weskoppies Hospital and heads the Schizoaffective Disorder firm. She has been the overall convener of the FC Psych Part 1 exam for 2020 and again for 2021. She is an active member of the Department of Psychiatry, and has been the block chairperson for the SIC medical students as well as block chair for the Occupational Therapy students for many years. Dr Naidu is the chairperson of the Infection Control Committee for the Department of Psychiatry and was the chairperson for the steering committee, a committee tasked in the management of the Covid-19 pandemic at Weskoppies Hospital. She was recently elected as a member of the academic advisory committee in the School of Medicine.



Gerhard Grobler is the Head of the Clinical Unit - Psychiatry at Steve Biko Academic Hospital. Besides clinical service delivery, he is involved in pre- and postgraduate training and research on transgender care, psychopharmacology, and relapse prevention.

MEDICAL PRACTICE: THE MINEFIELD OF SAVING LIVES

Merlita Kennedy, Jared Ishmael

The recent move to charge a medical practitioner with murder rather than culpable homicide for the death of a patient after surgery is alarming, because it could deter innovation and new entrants to the profession

Media reports suggest that South African medical practitioners are increasingly being criminally charged when patients pass away under their care.

WHILE THIS MAY APPEASE THOSE CLOSE TO THE DECEASED, WHAT EFFECTS WILL THIS TREND HAVE ON SOUTH AFRICAN MEDICAL PRACTITIONERS AND MEDICAL PRACTICE IN SOUTH AFRICA?

It has been reported by various South African media outlets that the National Prosecuting Authority of South Africa ("NPA") has changed the charges against a prominent medical practitioner, aged 73, from culpable homicide to murder following the death of a patient after surgery.¹ The NPA has not advanced any reasons for amending the charges. It must be noted that the anaesthetist who worked

alongside this medical practitioner was killed in 2020 at the age of 56 and to date, no arrests have been made.²

MURDER IS DEFINED AS THE INTENTIONAL KILLING OF ANOTHER HUMAN. CULPABLE HOMICIDE IS DEFINED AS THE NEGLIGENT UNLAWFUL KILLING OF ANOTHER HUMAN BEING.³

The charges of culpable homicide and murder, while both relate to the killing of a human being, differ in the way that they address fault or culpability.

THE FORMER CENTRES ON NEGLIGENCE WHILE THE LATTER CENTRES ON INTENTION IN ITS VARIOUS FORMS.

The nature of medical practice is that practitioners often carry out procedures on people whose health is already compromised (which is why they need medical assistance) and this often happens under immensely stressful conditions.

THE MINEFIELD OF SAVING LIVES

THAT A MEDICAL PRACTITIONER WILL PRODUCE THE DESIRED RESULT CANNOT BE GUARANTEED, GIVEN THE NUMBER OF VARIABLES ASSOCIATED WITH MEDICAL PRACTICE.

Consequently, medical practitioners cannot be compelled to provide the desired result but to diligently apply themselves in a manner similar to that of a reasonable practitioner, regardless of the consequences.

THE THREAT OF HARSH SANCTION, MAY, IN THE EYES OF THE NPA, DETER MEDICAL PRACTITIONERS FROM DEVIATING FROM THAT STANDARD. HOWEVER, THE PROSPECTIVE IMPLICATIONS ARE SEVERE: MEDICAL PRACTITIONERS WILL BE CONFLICTED BETWEEN PERFORMING PROCEDURES TO ASSIST PATIENTS AND THE THREAT OF CRIMINAL SANCTION IF THOSE PROCEDURES PRODUCE AN UNINTENDED ADVERSE RESULT.

In addition, given the risky nature of medical innovation, practitioners will be reluctant to carry out what may be medically innovative procedures, for fear of criminal sanction.

The criminal sanction of medical practitioners for conduct undertaken in the performance of their duties will have a chilling effect on new entrants to medical practice because the profession itself will carry the risk of criminal sanction for procedures performed on every patient in the normal course of the medical practitioner's career, without time limitations.

AS A RESULT, COLLOQUIALLY SPEAKING, A MEDICAL PRACTITIONER COULD FACE CRIMINAL SANCTION FOR "A HARD DAY'S WORK".

This must be viewed in the context of South Africa's low doctor-patient ratio of approximately 40.7

doctors per 100 000 people⁴ and the poor socio-economic conditions of the majority of South Africans.

While the grievances of those who have lost loved ones following medical procedures deserve to be heard and addressed, a balance must be struck between holding medical practitioners accountable and allowing them the freedom to practise and innovate in a profession that is pivotal to human existence and wellbeing.

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3. James Grant *Critical Criminal Law* RS 02 of 2018 at page 14.
4. <https://www.medicalbrief.co.za/archives/africa-check-puts-together-numbers-doctor-patient-ratios/> ■



From Webber Wentzel, Left to right: Merlita Kennedy (partner) and Jared Ishmael (Associate)

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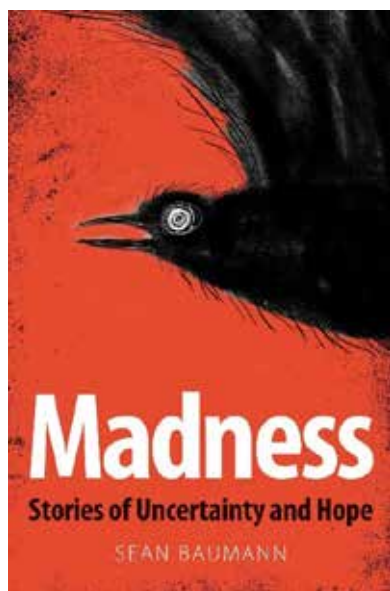
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MADNESS

STORIES OF UNCERTAINTY AND HOPE



Author: Sean Baumann
Illustrator: Fiona Moodie
Publisher: Jonathan Ball, Cape Town, 2020
EBOOK: 9781776190140

A patient is standing in the middle of the river, his back turned to the hospital. The nurses are waiting for him patiently on the riverbank. He seems uncertain whether to cross the river or to return. There is no danger. He is in an in-between space, as is the hospital where I have worked as a specialist psychiatrist for over twenty-five years.

FOR MANY OF US, WHAT LIES BEYOND CONVENTIONAL PORTRAYALS OF MENTAL ILLNESS IS OFTEN SHROUDED IN MYSTERY, MISCONCEPTION AND FEAR.

Dr Sean Baumann spent decades as a psychiatrist at Valkenberg Hospital and, through his personal engagement with patients' various forms of psychosis, he describes the lived experiences of those who suffer from schizophrenia, depression, bipolar and other disorders.

The stories told are authentic, mysterious and compelling, representing both vivid expressions of minds in turmoil and the struggle to give form and meaning to distress. The author seeks to describe

these encounters in a respectful way, believing that careless portrayals of madness cause further suffering and perpetuate the burden of stigma.

Baumann argues cogently for a more inclusive way of making sense of mental health. With sensitivity and empathy, his enquiries into the territories of art, psychology, consciousness, otherness, free will and theories of the self reveal how mental illness raises questions that affect us all.

Madness is illustrated by award-winning artist Fiona Moodie.



'This book has irrevocably changed my understanding of madness. Through succinct and often poetic accounts Baumann carefully mediates access to glimpses of the brave, fearful, lonely and vulnerable humanities of those suffering from psychiatric disorders, especially schizophrenia. The text, illuminated by extraordinary artwork, compels one to believe that beyond all the distress and despair, there is, and always should be, hope.'

– Antjie Krog

ABOUT THE AUTHOR

Dr Sean Baumann worked for twenty-five years as a consultant to the male acute service at Valkenberg Hospital in Cape Town and was a senior lecturer in the Department of Psychiatry and Mental Health at UCT, where he holds an honorary position. He is the editor of *Primary Care Psychiatry: A Practical Guide for Southern Africa* (1998, 2007, 2015). His cantata *Madness: Songs of Hope and Despair* was performed at the Baxter Theatre in Cape Town in 2017.

Ebook available from Amazon, Kobo, Snapplify and ITSi.

Pre-order your physical copy:
<http://jonathanball.6.evlink.net/servlet/link/4215/50576/28343575/818770> ■

MADNESS

STORIES OF UNCERTAINTY AND HOPE

Sue Hawkrige

Title: Madness – Stories of Hope and Uncertainty

Author: Sean Baumann

Publisher: Jonathan Ball, Cape Town, 2020

Dr Sean Baumann’s most recent book was one of the few good things to emerge from the year 2020. In a time of isolation, grief, and crushing workloads, it became for me a solace, a quiet space in which to think about what I was doing, and a comforting companion on what sometimes seemed like a very dark road with no clear destination. I think that the most important thing that it gave me was hope. Hope that there still existed a better world, past and future, where we would practice our discipline in a way that bore some resemblance to the oath that we once took. Hope that one day we would be able to restore the non-emergency mental health services that COVID-19 had ripped away from our patients and hope that once the pandemic had passed, we would indeed be able to attend to the wounds inflicted by its rampage.

SO MY COPY OF MADNESS IS ALREADY TATTERED AND DOG-EARED, INTERMITTENTLY ANNOTATED, OCCASIONALLY TEAR-SPLOTCHED, AND PROFUSELY COFFEE-STAINED. IT HAS SERVED ME WELL.

I have known the author as a close friend and colleague for all of his working life in South Africa, and then some, and have long admired his tireless efforts to represent to the public mind, in an authentic and respectful manner, the experiences of people living with psychiatric illness. However, even more of his time has been spent in the actual provision of compassionate and intelligent care to his patients and their families, in a society which does not make it easy. This book is a distillation of his years spent at what we used to like to call “the rock face” but which increasingly resembles a cliff edge. Written with fluid elegance, the book is accessible to layperson and professional alike,

neither over-simplified nor needlessly complicated. It is a privileged glimpse into the minds of a healer and his patients, and, complemented by some hauntingly insightful illustrations by Fiona Moodie, becomes an anthology to treasure and return to.

Those of us familiar with “the other side of the river” will recognise places and situations, sometimes with nostalgia, but more often with that state of heightened vigilance that accompanies the anxiety and indecision of having to choose between evils, and doing the best we can with the little we have. Baumann reminds us throughout that certainty in psychiatry is rarely found, and that this applies not only to our concept of the causes of mental illness but also to our treatments of it, not just in the theory of how to help those afflicted to feel better, but also in how to navigate situations in which our medical treatment may be the least significant factor in the ocean of social chaos that surrounds the individual. Baumann’s accounts repeatedly underline the fact that inefficient or non-existent support systems can make an already complex clinical decision almost completely futile. But not always, and it can be hard to predict which interventions will “work” for a particular patient, and which will not.

LIVING WITH UNCERTAINTY IS ONE OF THE FIRST NECESSARY SKILLS OF THE MENTAL HEALTH PROFESSIONAL, AND IT IS WELL THAT MOST OF US ACQUIRE IT RAPIDLY.

But alongside the often traumatic accounts of trying to practice good medicine in a far less than perfect environment, is a silver thread of hope that runs throughout the book. I wondered at first whether this was a singular attribute of the author, but came to recognise as I read that it probably is found to some degree in most of us in the mental health field. There can be no other reason for our persistent presence in the field, in which our reward lies more often in the relationships we are privileged to have with our patients than in the actual outcomes of our interventions. The sense of hope seems most often to emanate from the resilience, the courage, and sometimes the grace, with which the patients face their worlds.

PERHAPS THERE IS ALSO A HOPE THAT, WITH ENOUGH ADVOCACY, THE BATTLE FOR APPROPRIATE MENTAL HEALTH SERVICES WILL ONE DAY BE WON.

Baumann takes us through a vast and fascinating selection of topics, each covered in a readable chapter, eminently suitable for short sittings due to decreased attention span as the exhaustion of the plague years drains our energies. But the brevity of the chapters belies the volume of thinking that follows each one. We are made to consider and reconsider our ideas, preconceptions, practices and beliefs about mental illness and mental health.

The science is not ignored; indeed, there are many informative and sometimes provocative journeys through published findings and current theories but there is a balancing of the scientific with the philosophical, moral and ethical, and all are grounded in a searingly honest account of the author's own very human responses to experiences and dilemmas that will resonate with all health care workers, not just those in mental health care.

We travel through the meanings of "madness", societal responses to the mentally ill, the biology of psychiatric disorders, the limits of psychotropic medication, the medicalisation of daily life, the use and misuse of psychiatric diagnoses in the courts, the role of traditional healers in the mental health care team, the ethics of involuntary care and treatment, public misunderstanding and misrepresentation of mental illness, the emotional challenges faced by mental health clinicians, the implications of "disability", and many other routes, detours and destinations.

THE WORK IS WIDE-RANGING AND EXPLORES EXPERIENCES OF DEPRESSION, ANXIETY AND ADDICTION AS WELL AS THE SCHIZOPHRENIA AND BIPOLAR MOOD DISORDER SPECTRA. THESE TOPICS ARE NOT NEW TO THE PSYCHIATRIC LITERATURE, BUT THE IMPORTANCE OF THIS ACCOUNT IS THAT IT COMES FROM ONE OF US, IN AFRICA, IN SOUTH AFRICA.

However universal the frustrations of being a mental health professional (or patient, for that matter), the sometimes rather abstract meanderings of our colleagues on the other sides of the various ponds may not always seem relevant to our own day to day struggles to help our patients. Baumann's accounts are relevant to us. They are us. These are not "first world problems".

However, it is not only the voice of the clinician that we hear in this book. Intrinsic to Baumann's approach to helping people is listening, and from

that intensive and wide-minded listening has come a collection of the words of our patients themselves. Baumann has stressed in his writing, here and elsewhere, the centrality of how we experience the self. He explores how patients are often able to make meaning of the things that happen to them, in a way that is perhaps more healing than the medications that we can provide. The title of one chapter, "Odd ideas, and rarely a strange beauty", neatly sums up the sense of humility and curiosity with which Baumann approaches the subjective experience of patients. And the caregivers and family members have a voice too, a powerful one. The pain, suffering and occasionally, the relief and pride, of those living with mentally ill family members, often recorded in their own words, is a constant accompaniment of the patients' and the clinician's accounts of their attempts to navigate the maze of the illness itself. The patients themselves are a cross-section of Cape Town and surrounds, from businessmen to buskers, farmers to fruit sellers. Medical aid cover for psychiatric illness is generally somewhat limited, and private sector facilities able and willing to manage involuntary patients are few and far between. Valkenberg is indeed a leveller.

OVERALL, THIS BOOK IS A RARE AND INSIGHTFUL ACCOUNT OF THE CHALLENGES FACING MENTAL HEALTH PROFESSIONALS IN DEVELOPING COUNTRIES.

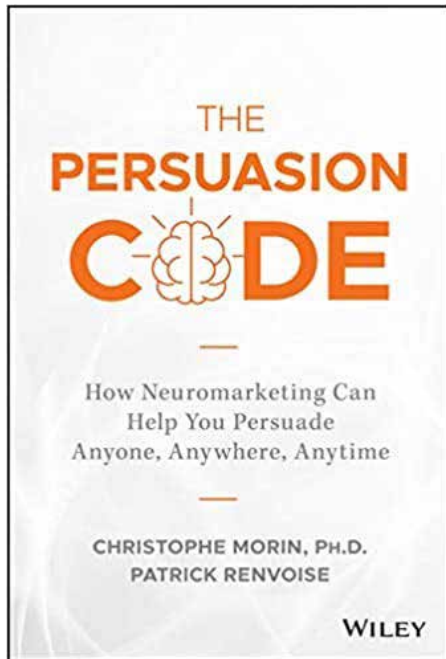
A great deal of the frustration we sense between the lines comes from the sheer inadequacy of the support available in the community to people with psychiatric disorders but the book is full of respect and hope. The justifiable anger is there, although very civil and polite in its expression, as well as a perplexity that mental health services should be so perpetually and corrosively underfunded and under-resourced, when it is so very clear to us that this is a false economy. It is inexplicable, and it should make us angry but Baumann reminds us that we need to "hush the noise" of our struggles and listen to the people we are trying to help.

OUR STRUGGLES ARE NOT NECESSARILY THEIRS, AND OUR SOLUTIONS MAY MISS THE MARK IF WE DO NOT PAY ATTENTION.

I recommend this book to all students and practitioners of mental health care, specialised or not, and to anyone who has any interest in understanding or helping people afflicted with mental illness. In the author's words, it is "an attempt to change our harmful ways of thinking about mental illness" and "also seeks to pay tribute to those who live with these mysteriously altered states of mind and ways of being in our shared world". I think that he succeeds in both. I keep it on my desk so as to remind myself in moments of seeming therapeutic futility that I should first seek meaning, and not necessarily my own ■

THE PERSUASION CODE: HOW NEUROMARKETING CAN HELP YOU PERSUADE ANYONE, ANYWHERE

Koffi Kouakou



Title: The Persuasion Code: How Neuromarketing Can Help You Persuade Anyone, Anywhere

Publisher: Wiley

Author: Christophe Morin, Patrick Renvoise

ISBN: ISBN-10 : 111944070X
ISBN-13 : 978-1119440703

The business of persuasion is booming. We are bombarded with all sorts of enticing books, seminars and webinars on how to influence and persuade. This book is no different. But what makes it unique is its ability to integrate many domains and techniques of the science of persuasion. Persuading is no longer an art form, it is a science. That's why it demands attention.

A couple of years ago, I stumbled upon a boastful book and dismissed it as the usual publisher gimmick. The cover strapline screamed "How Neuromarketing Can Help You Persuade Anyone, Anywhere, Anytime".

I did not give it my usual utmost curious attention and refused to read it. But then, I came across one of my favourite opinion-maker's weekly rant about mind hackers and what they do to influence, persuade

and manipulate us to behave the way they want us to. Then I started to pay more attention to the book.

So I bought two copies and gifted one to a colleague.

Finally the authors of the book, Christophe Morin and Patrick Renvoise, had my attention. They had laid out compelling, scientific and persuasive techniques that help to convince consumers to change their behaviours and buying decisions as orchestrated by marketers. They have used a brain science called neuromarketing to achieve their goals. The book, The Persuasion Code details an extensive list of tested techniques, evidence based and prominent case studies on how successful persuasion sciences work.



Koffi Kouakou

In three parts - decoding persuasion science, decoding persuasion theory and decoding your persuasive narrative - the authors tell us about neuromarketing, its powers, why use it to change the behaviours of customers against their will and show how to apply it persuasively beyond the traditional nudging approach to sway decision-making. They offer four steps to maximize the chances to persuade systematically, six persuasion elements and seven persuasion catalysts that scientifically explain the chemistry of persuasion via the understanding of "only 6 persuasive stimuli that communicate directly with the primal brain".

WE LIVE IN A NOISY SOCIETY WHERE ATTENTION IS CONSTANTLY DISRUPTED AND DIFFICULT TO MANAGE. MOST ATTEMPTS TO PERSUADE FAIL BECAUSE OF THE FRAGMENTATION OF AUDIENCE ATTENTION THAT SHIFTS CONSTANTLY.

What this book seems to have achieved is the integration of well-known persuasion theories and their applications to seize the attention and manage it effectively. It simplifies the complex science of persuasion and helps to develop proven and successful NeuroMap strategies of influence through practical means with remarkable results.

However, it is impressive yet concerning to experience the language of the science of persuasion. It is full of intimidating expressions such as Neuroinsights,

the Triune Ethics ZModel, NeuroMap, Cognitive Bias Codex, Neurobenchmarking and Persuasion Catalysts.

The authors assert that neuromarketing is a game changer and with enormous supporting evidence. They provide undeniable proof for their statement. Over years of research and the combination of techniques of science of persuasion, private companies and governments have employed brain-based persuasion systems and strategists to unlock and control the wills and choices of the public. Sometimes these methods seek the complete control of the cognitive maps of their targets, thus making neuromarketing mapping a preferred instrument of marketers, advertisers, politicians and other dictators of the mind.

The book provides step by step scientific evidence based methods and case studies. The cases range from "Which Animal Images Grab the Most Attention", "Understanding How Consumers Feel About Banks in Morocco", "The Effectiveness of Public Health Campaigns" to "Neurobenchmarking Multiple Ads".

The book builds on the long legacy of behavioural science success stories. Of note are the works of Robert Cialdini, Sigmund Freud, Abraham Maslow, Amos Tversky, Nobel Prize recipients such as Daniel Kahneman, Richard Thaler and other modern social science writers such as Malcolm Gladwell and other social behavioural science experts.

Morin and Renvoise make a most persuasive point when addressing the design, decoding and deliberate applications of persuasive narratives via what is called the science of stories. Of convincing importance is the "huge body" of research evidence that shows the powerful effects of stories on the brain and how "narrative persuasion" can create a "mental transformation" and have long-lasting impacts on listeners to "the point of changing their opinions or beliefs". In other words, telling a compelling story creates emotional feelings, resonates and transforms the audience.

It stresses that "stories have the power to reshape the beliefs and behaviours of the listeners because they fool the story receiver's primal brain in believing the story is real. Stories typically put the listener in the middle of the action." In addition, the authors say that "stories work because they transport the mind of the audience and create a pseudo-real experience." And they continue to sell us with persuasion the benefits and secrets of storytelling and ask: "What is the secret of good storytelling?" Their answer is emphatic. "The storyteller needs to create visual, auditory, kinesthetic (movement), and possibly taste and smell clues that will make the primal brain of her audience believe that the story is actually happening to them." Therefore, storytelling becomes a powerful and essential arsenal in the toolbox of persuaders when applied properly.

Koffi Kouakou is a senior lecturer at the Wits School of Governance, where he teaches strategic government communications and scenario planning. He is the former director of the Unilever Mandela Rhodes Academy for Communications and Marketing (UMRA), a Storyteller, Social Commentator, Business Strategist, Author and Futurist. He specialises in information communications technologies for development and telecommunications adapted to environmental issues in Africa. He has been a regular contributor to international, local media and business magazines on the BBC, VOA, Deutsche Welle, The People Daily, eNCA, Africa 360 degrees, SAFM, 702 Radio, Power FM, China, Brainstorm, The Media, CIO.COM and Intelligence in South Africa. He co-authored a book titled AfricaDotEdu: IT Opportunities and Higher Education in Africa, 2003. **Correspondence:** koffizulu@gmail.com ■

I was also pleasantly intrigued by the role and use of smile as a tool of persuasion next to storytelling. Understanding a "Duchenne smile", otherwise known as "a genuine smile" helps to influence, break the stubborn defenses and resistances of customers and people in general.

Neuromarketing, a sophisticated technique, can "precisely anatomise such smiles, show how to spot them, and discusses the 'construction' of sincerity and 'genuineness'", according to George Monbiot.

What this book does brilliantly is to give away the secrets of these accumulated techniques and their step-by-step theory and clear applications through well-presented and simply told narratives. Even better, the authors challenge the perceived wisdom that customers must be left to decide what they want. Rather, they argue that influencers must be the ones to change the way customers feel about their offerings, and that the absolute customer ownership agency of decision-making must be subordinated to that of the persuaders.

That's a non-politically correct approach to dealing with the choices of others. This approach borders on manipulation and propaganda. Yet it's a very appealing and persuasive way to win over people and also sell the book.

THE AUTHORS SMARTLY SKETCH THEIR IRRESISTIBLE PERSUASION METHODS AND CONVINCE US THROUGH THEIR WELL-CRAFTED STORYTELLING TECHNIQUES TO BUY THEIR BOOK. INDEED THEY SUCCEED WELL.

This fascinating account about the science of persuasion is frankly also a perfect manipulator's handbook and is a must-have for anyone in the influence business.

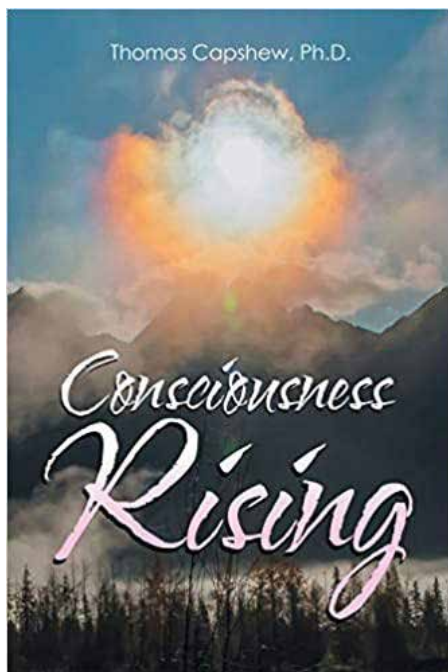
This book is a dangerous proposition to hold in our hands. It peels away the value proposition design layers of the sciences of persuasion. It is a how-to book for influencers, manipulators, propagandists and all people in search of power over others. While its contents seem almost abject and repugnant, it is a good tool to help understand the power of the influence industry. It helps also to design one's own defense to resist such influences wherever possible.

But how do we challenge and resist these manipulative neuromarketing techniques, if we must?

Perhaps there is no better ways to do so but to understand and learn more about neuromarketing. Get a copy of the book. It has a beautifully NeuroMap chart on the backflap, ready to use.

CONSCIOUSNESS RISING

Koffi Kouakou



Title: Consciousness Rising
Publisher: Balboa Press
Author: Thomas Capshew, PhD
ISBN: 978-1-9822-4610-5 (softcover);
 978-1-9822-4612-9 (hardcover);
 978-1-9822-4611-2 (e-book)

“Choosing love is an inside job”, asserts Thomas Capshew, the author of this brilliant yet mind-stretching book which is littered with titillating expressions that tell us about consciousness and its rising.

Capshew makes a series of bold propositions throughout the book about consciousness rising. At the outset and most important, he begins with the human value proposition. He contends that “each human life has immeasurable inherent value or no value at all.” He later and beautifully makes the

link between the value of human life and the consciousness that underlies it. He then starts to peel away human consciousness and what makes it so important, why the reader should care about it and use it well.



Koffi Kouakou

I MUST SAY UPFRONT THAT THIS BOOK IS DENSE. IT ALSO GOES BEYOND THE UNDERSTANDING OF CONSCIOUSNESS AND ITS RISING. IT PUTS THEM INTO PRACTICE.

What is consciousness and *Consciousness Rising*? Where does it arise from and why? Before Thomas Capshew answers in his own words, let us understand what consciousness is all about. Capshew boldly claims that there is no real need to search too far away to understand consciousness and its rise. Being aware of ourselves and the environmental reality we experience, should be enough to understand it. Yet, he also suggests a basket of practical ways to raise and realise consciousness for those who want to deepen their experience of it. By practicing specific and deliberate realisation and mindful techniques such as meditation, Yoga, contemplative Christian exercises, self-inquiry and many other altered states, one can develop deeper awareness and experiences of consciousness and allow it to arise both around and within us to shape our lives.

The study of consciousness while a new and modern 20th century subject, is older than the creation of the world.

HOWEVER, THERE IS A GREAT DEAL OF MISUNDERSTANDING ABOUT CONSCIOUSNESS BECAUSE OF ITS COMPLEX NATURE.

Consciousness is a difficult concept to explain and it requires complex answers. More so, it forces us to ask deep questions.

In general, consciousness is an etheric concept with which modern science is struggling to grapple, difficult to explain, accept and a hard-to-measure phenomenon. It is also viewed as an eclectic subject that embraces new age terminology of spirituality, esoteric topics, religious experiences, the sciences of the heart, intuition and extra-body experiences among others.

Consciousness can be defined also as the field of the substance of everything. It is known as the underlining reality in everything that exists. It assumes that reality is self-awareness and humans are part of it as it unfolds. According to many, reality begins with consciousness. Strangely, I have always believed that altered states of mind were consciousness on demand.

IN TRYING TO UNDERSTAND CONSCIOUSNESS MANY SERIOUS THINKERS, ANCIENT AND MODERN, SECULAR AND MYSTIC, HAVE ATTEMPTED TO DEFINE IT. BUT IN MODERN TIMES, THERE HAS BEEN A WAR ON CONSCIOUSNESS AS SCIENCE HAS ALMOST REJECTED THE IDEA OF CONSCIOUSNESS WITH MECHANISTIC NEWTONIAN VIEWS.

Consciousness activists such as Sanusi Credo Mutwa, Helena P. Blavatsky, Rupert Sheldrake, Graham Hancock and many more have been making bold arguments about a conscious universe and that modern science is failing to recognise and study consciousness as an imperative inquiry. Capshaw is part of this eclectic group yet he follows his own path. He is an all-in-one philosophical, religious and mystical consciousness activist. He brings to the reader the complex religious understanding of human potential value of consciousness rising through a plethora of daily life examples.

However, his way of telling the complex story of *Consciousness Rising* is compellingly mind-stretching but should not be a put-off. He asks us to be diligent, tolerant, patient and daring with ourselves as we deal with consciousness because we are part of it, and we are it. He makes the case that consciousness helps us to be deeply aware of who we are and the reality we experience and shape.

Koffi Kouakou is a senior lecturer at the Wits School of Governance, where he teaches strategic government communications and scenario planning. He is the former director of the Unilever Mandela Rhodes Academy for Communications and Marketing (UMRA), a Storyteller, Social Commentator, Business Strategist, Author and Futurist. He specialises in information communications technologies for development and telecommunications adapted to environmental issues in Africa. He has been a regular contributor to international, local media and business magazines on the BBC, VOA, Deutsche Welle, The People Daily, eNCA, Africa 360 degrees, SAFM, 702 Radio, Power FM, China, Brainstorm, The Media, CIO.COM and Intelligence in South Africa. He co-authored a book titled AfricaDotEdu: IT Opportunities and Higher Education in Africa, 2003. **Correspondence:** koffizulu@gmail.com ■

He also takes the reader into an extraordinary journey of exploring the understanding of consciousness and its rising. This journey is challenging, enjoyable and illuminating. For the most part and through an extensive list of practical experiences, he shows that the universe is conscious, alive, self-aware, that everything is consciousness and we must realise it and take it seriously.

WE MUST BE ALSO GRATEFUL FOR IT AND CONTINUOUSLY ALLOW CONSCIOUSNESS TO RISE WITHIN AND AROUND US AS WE LIVE.

At the heart of the book, springs the idea that consciousness is also love. Capshaw writes "*the intelligence that created the universe as 'Consciousness' and the energy used by such Consciousness to conceive and maintain the seen world as 'Love'*".

While the author adopts an absolute creationist view of the universe and consciousness that embodies it, he also tries to support his account with some scientific arguments. Whilst he fails to do so consistently throughout the book with hard science, each chapter ends with useful reference sources.

I ENJOYED MANY OF THE EXPRESSIONS SUCH AS "CHOOSING LOVE IS AN INSIDE JOB", "INVESTMENT THINKING", "FILLING UP THE SPIRIT WHEN WE RISE IN CONSCIOUSNESS".

Consciousness Rising deals with the role of the human heart in our life experiences. Here Capshaw masterfully lists a number of expressions involving the heart. Among my favourites are "*the heart of the matter*", "*heart-to-heart talk*", "*half-hearted*", "*get to the heart of it*", "*she has lost heart*", "*her heart is in the right place*", "*she found it in her heart to...*" and "*he knows it by heart*".

The book attempts to answer the fundamental question of the nature of consciousness rising while it provides ways and means to understand and co-create a collective human consciousness that benefits all humans.

It is a philosophical and metaphysical book with well-articulated insights. It is a mind stretcher.

Available at the Balboa Press Online Bookstore, Amazon and Barnes & Noble.

CONSCIOUSNESS RISING

BY THOMAS CAPSHEW, PHD

A FEW WORDS

Christopher Paul Szabo

I am not given to writing book reviews. To me the idea of reviewing a book renders the process of reading somewhat technical and thus detracts from the purpose of reading – to immerse oneself, hopefully...and to reflect and enjoy without having to make notes to use in a review. I had received an email promoting the book in question, together with some promotional material and an offer of a copy – nothing requested in return. The title seemed to imply that the content would be of a spiritual nature, which the promotional material confirmed. Experiencing the world through the lens of a pandemic at the time of being made aware of the book, I requested a copy. It seemed to me that the physical world needed a dose of spirituality, for sustenance at a time of extreme challenge.

I have never heard of the author, Thomas Capshew, PhD, but based on what I came to understand of who he might be through reading his work – he appears to have his heart in the right place. His biography is not explicit regarding his professional background but within the content he reveals snapshots – he is a lawyer, who subsequently moved into social work... the source of his PhD it seems, an unusual progression.

HE WORKS WITH SUBSTANCE ABUSE, AND PRACTICES REIKI... HE IS ALSO FOND OF STEEL GUITAR...SNATCHES OF THE PERSON BEHIND THE WORDS.

I liked the fact that not too deep into the book he states that he does not claim that his work is anything more than his interpretation of existing truths, or that his work usurps them – honest. In spite of that acknowledgement he certainly does introduce ideas and concepts that gave me pause to think e.g. the concept of the “dominator consciousness” linked to comparison and a source of fear...fear being understood by Capshew as an absence of love, with love being an important theme throughout the book – not specifically within the romantic context. In terms of fear he highlights three that are key – loss of security/control, aloneness/disconnection and unworthiness. He

emphasises the idea of the “creator” as the source, without specifying who or what “the creator” is, that we should strive to connect with...spiritually. Seemingly something each of us will experience uniquely...and not specifically within a religious context and whilst having a background as a pastor – there is no religious dogma.

Capshew is very clear on the need to focus our energies on attaining oneness through the unseen, spiritual realm which is contrasted to the separateness he believes exists in a preoccupation with the seen, physical realm. Throughout the book Capshew touches on many interesting issues e.g. the types of relationships, attempting to weave them into a cohesive narrative that ultimately calls for a shift in consciousness. The book has a very hopeful, optimistic quality...and not surprisingly provides certain insights and observations that would comfortably be useful in a psychotherapeutic context...sitting, as the author seems to do, at the cross roads of spirituality and psychotherapy...as complementary processes.

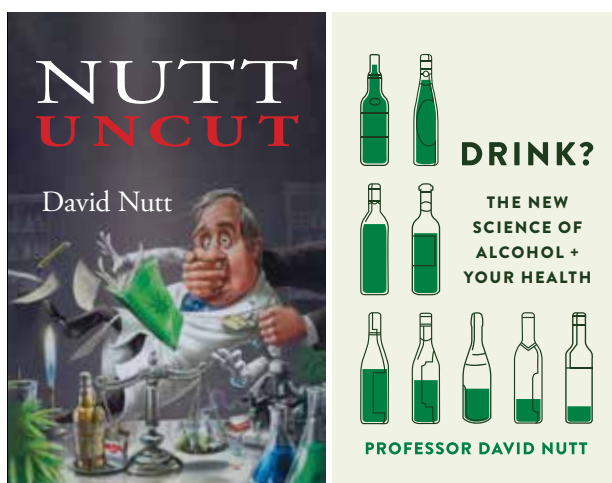
WHILST MUCH OF THE CONTENT I FOUND AGREEABLE, THERE WERE INSTANCES THAT I FOUND MYSELF QUESTIONING AND CHALLENGING CERTAIN OF THE POSITIONS TAKEN BY THE AUTHOR.

I think this is as it should be, and certainly did not diminish the book in my eyes. In some ways the book is also quite political, with some interesting observations in relation to economic systems and government. Does the book have all the answers, no. Is everything always neatly explained, no. Is the sense of optimism naïve, maybe...but that is not a criticism. Aside from a few minor editorial issues that slipped through the net e.g. the repetition of a figure and some missing page numbers – neither of which detract from the content.

I found *Consciousness Rising* a very easy read, providing some food for thought that ultimately encourages us to look beyond the obvious...in pursuit of fulfilment ■

NUTT UNCUT & DRINK?

Christer Allgulander



David Nutt took advantage of the pandemic quarantine to share his expertise in how the brain works and what psychedelics and alcohol can accomplish: *Nutt Uncut* (Waterside Press 2020), and *Drink?* (Yellowkite Books 2020). Few researchers explain so clearly.

THIS IS FOR READING IF YOU WANT THE BEST CURRENT UNDERSTANDING OF ALCOHOL, CANNABIS, PSILOCYBIN, LSD, SEROTONIN AND HOW THE BENZODIAZEPINES WORK.

Having started his training in Medical Sciences at Cambridge University in 1969, David's passion for research found a haven in Bristol where he lives with Di and 3 labradors. He edits the *Journal of Psychopharmacology* since 1989. He keeps lecturing from his busy residence.

Speaking truth to power, David Nutt tells his story of ignorant drug policy in the UK, and the delay in critical research into psychedelics as they were made illegal. He believes that there could be a psychedelic treatment revolution if proper research is allowed.

The Home Secretary became so upset that in 2009 he sacked David Nutt from the Advisory Council on the Misuse of Drugs, a sacking that created shock waves in the scientific community, and a long debate in parliament. He became fair game for right-wing tabloids that even published on three of his children by hacking their Facebook accounts.



Christer Allgulander

In recent years, David Nutt managed to cut red tape and get funding to perform pivotal research on the benefits of psilocybin in depression.

HE ORCHESTRATED AN INNOVATIVE SCALE FOR MEASURING DRUG HARM TO THE INDIVIDUAL AND TO THE COMMUNITY, A SCALE THAT HAS BECOME THE GOLD STANDARD FOR POLICY MAKERS AND EVEN FOR MAGISTRATE'S COURTS (THE LANCET 2007;369:1047-53).

In *Drink?* You will be enlightened about the health harms of alcohol, about children, hormones, fertility, mental health and much more. I have not seen another such comprehensive and accessible review of the effects of alcohol to the body and to society. David does not shy away from pointing out the influence of the powerful brewery and distillery lobby.

Nutt Uncut (autobiography) available at this site <https://www.drugscience.org.uk/get-your-copy-of-nutt-uncut/> or via the author d.nutt@imperial.ac.uk

Drink? should be available from all good booksellers!

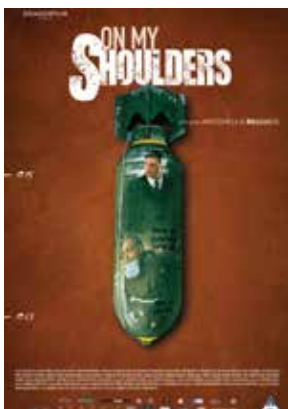
Christer Allgulander is a psychiatrist affiliated to the Department of Neuroscience, Uppsala University, Uppsala, Sweden and an Honorary Professor, Department of Psychiatry and Mental Health, University of Cape Town, South Africa.
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M O V I E S



The Mauritanian, directed by Kevin Macdonald and based on the New York Times best-selling memoir "Guantánamo Diary" by Mohamedou Ould Slahi, is an inspiring true story of Slahi's fight for freedom after being detained and imprisoned for years without charge by the U.S. Government. Alone and afraid, Slahi finds allies in his defence attorney and her associate who battle the U.S. government in a fight for justice that tests their commitment to the law and their client at every turn. Starring Jodie Foster, Tahar Rahim, Shailene Woodley and Benedict Cumberbatch **The Mauritanian** releases at Cinema Nouveau on 12 March.

Academy Award winner Francis McDormand takes the lead in the drama **Nomadland** and follows a woman in her sixties who embarks on a journey through the American West after losing everything during the recession. **Nomadland** releases 16 April at Cinema Nouveau.



Based on a true story **On My Shoulders** tells the story of a man ready to end his life when faced with economic hardship. His soul is saved by Father Leopoldo Mandic, a little Capuchin brother able to touch the lives of an entire city. This drama is written and directed by Antonello Belluco and is now showing at Cinema Nouveau. Book Now at www.sterkinekor.com

Set in 1998, five chess wizards from Miami Jackson High become the first inner-city chess team to win the National Championship. **Critical Thinking** directed

and starring John Leguizamo is a heart-warming drama based on the true story of making the right moves in life and in the game of chess. **Critical Thinking** releases 26 February at Cinema Nouveau.



Certified as "Fresh" on Rotten Tomatoes **The Father**, led by stellar performances from Anthony Hopkins and Olivia Colman, tells the story of a feisty 80-year-old father with dementia who refuses all assistance from his daughter as he ages. As he tries to make sense of his changing circumstances, he begins to doubt his loved ones, his own mind and even the fabric of his reality. **The Father** releases at Cinema Nouveau on 26 March



For more on what's showing and coming soon visit www.sterkinekor.com

PEAS IN A POD

TWO ROCKSTAR WOMEN WINEMAKERS

David Swingler

Let's play a word-association game. I'll ask you to react to ... 'winemaker'. Most, unguarded, will respond with elements of the stereotype: muscular male (showing an early paunch, perhaps), dressed in a two-tone, short-sleeved shirt, blue rugby shorts, rigger socks and veldskoen (or equally unstylish, pull-on ankle boots) leaning up against his hardbody bakkie with a trusty Boerboel or Ridgeback at heel.

Winemaking does indeed entail tossing lug-boxes of grapes into the press, punching down 'caps' (of matted skins, back into the fermenting wine) and hauling large, heavy pipes and pumps around the cellar. But it is so much more than that. Knowing how to farm the grapes for the quality and style envisaged – many say wine is grown, not made – when to harvest (often based on tasting the grape rather than laboratory readings), what natural processes to encourage, checking progress by tasting, and blending the final cuvee, again by tasting. All of which require a fine sense of nuance, rather than mere strength.

WHILE WOMEN HAVE LONG BEEN RECOGNISED AS BETTER WINE TASTERS THAN MEN, AND WHILE THEY ARE WELL REPRESENTED IN THE RANKS OF WINE MASTERS, WINE JOURNALISTS AND JUDGES, IT'S ONLY RECENTLY THAT WOMEN HAVE COME TO BE CELLARMASTERS IN THE CAPE.



The Zoo Cru

And part of the new wave of young, rock-star winemakers storming the traditional ramparts in a modern Cape 'natural wine' revolution – the Zoo Cru that grew out of the Zoo Biscuits is a good example – is a contingent of women winemakers. Two – in the stable of Jeanette and David Clarke's *Ex Animo* – are peas out of the same pod.



David Swingler

Jocelyn Hogan Wilson gained her BSc in Viticulture and Oenology from Stellenbosch University in the mid-2000s and, after stints locally – chiefly at Franschoek's *La Bri* – and abroad, she took a career break to have two children with husband Nicholas, who farms proteas and fruit in Banhoek. She burst back onto the scene at *Cape Wine 2015* with a Hogan Wines 2014 Chenin Blanc that was the talk of the show. I tasted it at a press preview and knew a new star was born.



Jocelyn Hogan



Trizanne Barnard

After gaining her BSc in Viticulture and Oenology from Stellenbosch University and working vintages in Australia, France and Portugal, Trizanne Barnard also went the 'corporate' route at first, working for *Klein Constantia* before having the opportunity to launch the *Anwilka* Firgrove collaboration between KC and fabled Bordeaux heavyweights Bruno Prats and Hubert de Bouard, in 2004. Four years later she was ready to launch Trizanne Signature Wines, based in Kommetjie where she – an avid surfer – lives with husband Malan and their two young boys.

BOTH JOCELYN AND TRIZANNE BUY IN GRAPES, SEEKING FRUIT OF OLDER VINEYARDS AND WORKING WITH THE GRAPE GROWER TO DELIVER THE REQUISITE BUILDING BLOCKS FOR QUALITY AND STYLE.

Both practice 'traditional vinification', allowing natural processes to occur with minimal intervention and without the addition of chemicals or enzymes to manipulate the end product. Both seek elegance, finesse and style in the poured wine.

BOTH CELEBRATE THE EXPRESSION OF EACH VINEYARD AND THE DETAIL OF VINTAGE VARIATION. NEITHER ARE CHEAP; BOTH ARE EXCELLENT VALUE FOR YOUR MONEY.



Jocelyn's foundation stone remains a Swartland Chenin Blanc – the 2017 is finely chiselled and athletic, the 2018 more generous – with a rich Galvanised 2018 Chardonnay completing the white duo. Her Mirror for the Sun Cabernet Franc is in short supply while the Divergent – a cabernet/cinsaut blend now sporting Wellington's *Welgegund's* carignan since her meeting with Serge Hochard of Lebanon's legendary Chateau Musar – is plush and regal in bearing.



Hogan range



Trizanne has a broader palette. Her bedrock is sauvignon blanc and semillon from Elim and Swartland syrah – the whites encapsulate the scrubby, windswept nature of Elim and the reds a white pepper spice of tough dryland farming – but she has more recently added a duo from Stanford's Sondagskloof (White and Syrah), and a Barbera from Darling. The latter is housed in an Alternative Range with a pure Elim Semillon.



Reserve - red TSW - white

Her TSW Sauvignon Blanc and Syrah (and, shortly, Cinsault) are meant for wine-by-the-glass on-consumption and good value home enjoyment, with the Reserve Range variants under cork closure.

Trizanne also collaborates with a leading off-trade UK agent in a larger volume *World of Wine* venture and, never far from the surfboard and sea, is part of *Dawn Patrol Wines* and embraces the *Waves for Change* initiative.

Jocelyn and Trizanne are athletic rather than brawny, neither wear two-tone short-sleeve shirts, nor do they have rugby shorts and socks in their cupboards. And their footwear is somewhat more elegant than their male peers. They do pilot bakkies however but hey, winemakers need to.

<https://hoganwines.co.za/>

<https://www.trizanne.co.za/>

<https://www.exanimo.co.za/>



David Swingler is a writer and taster for Platter's South African Wine Guide for over 21 years to date. Dave Swingler 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, he's intrigued by language in general, and its application to wine in particular. Correspondence: swingler@telkomsa.net

FORESTS, BEACHES, AND THE OVERSTRESSED CLINICIAN: AN ANALYSIS OF KNYSNA AS CHILL SPOT

ABSTRACT:

If a short walk in a forest can make you measurably happier, imagine what a breakaway to South Africa's premier forest destination could do.

INTRODUCTION:

Our study considered a possible mitigation of the internet age's deleterious effects on the attention-spans of an intergenerational cohort of stress bunnies whose time was self-reported to have been far too fractured.

We argue that subjects can expect to experience a reversal of symptoms - coupled to heightened effects of happiness, family bonding, salty skin, adrenaline, and smiley faces - when subjecting themselves to removal to the wilds, the forests, and the sea of the Garden Route's premier natural destination: Knysna.

METHODOLOGY:

WE BEGAN OUR RESEARCH WITH A META-ANALYSIS OF THE DESTINATION. THE REGION INCLUDES BOTH THE SMALL TOWN OF KNYSNA AND THE VILLAGE OF SEDGEFIELD, AS WELL AS THEIR WILD AND NATURAL, RURAL AND COASTAL SURROUNDS.

The town of Knysna spreads out over the northern shore of one of the most important estuaries on the South African coast (so important, in fact, that it's a major focus of the country's largest unfenced wilderness preserve: the 160,000 ha Garden Route National Park), while the village of Sedgefield is surrounded both by sections of the National Park, and by the 2,500 ha Goukamma Nature Reserve and Marine Protected Area, which carries World Heritage Site status.

This sets the stage for an unparalleled selection of activities and attractions whose efficacy in addressing the reversal of symptoms mentioned has been widely discussed in the literature: Song et al (2018), and Li (2018), for example, point to the fact that spending time among the trees helps us feel less stressed, less hostile, less fatigued, and more alive than, say, attending to our time in the urban jungle

While these esteemed authorities choose to label this activity, "forest bathing," the authors of the current study prefer the term, "having a jol in nature."

It's an activity best performed in Knysna - and there are many reasons why:



3 km Jubilee Creek Forest Walk to a small water fall and swimming hole - Photo credit Visit Knysna

1. Garden Route National Park

Unique amongst national parks in South Africa, the Garden Route National Park is made up of a mosaic of conservation areas covering mountains, beaches, lakes, forests and fynbos - many of which can be visited free of charge.

The defining feature of the Park is the Knysna Forest - the country's largest indigenous evergreen forests - which researchers can explore by car (see the self-drive 'Rooted in Time' tour on the SANParks website), by bicycle (kilometre after kilometre of awesome MTB trails and single-track - but don't forget your permit!), or on foot (for data on short walks, day hikes, overnight trails, or braai spots, see visitknysna.co.za, or sanparks.org).

As we've seen, the Knysna River Estuary (the locals call it the Knysna Lagoon) is also managed as part of the National Park.

At 1,633 ha, this is the largest lake in the Garden Route - and since its river mouth is permanently open to the sea, it's a well-stocked laboratory for personal research into the restorative powers of boat-based whale and dolphin watching, luxury sailing charters, chilled lagoon boat tours, SUP-boarding, kayaking, and (for younger participants) splashing in the shallows of the beach at Bollard Bay on Leisure Isle.



Swartvlei Beach in Sedgfield with Gericke's Point in the background - Photo credit Emma Rorke

2. Brenton; Buffalo Bay; Goukamma Nature Reserve; Sedgfield beaches

The region immediately west of the Knysna Lagoon - including Brenton-on-Sea, Buffalo Bay, CapeNature's Goukamma Nature Reserve, and the beaches at Sedgfield (Platbank, Cola Beach, Myoli Beach, Swartvlei Beach, and Gericke's Point) - provides researchers with unparalleled opportunities for coastal tranquility.

In short: there's almost no one around, so this is a good place to chill.

It's also an area for birding, hiking, swimming, and angling, for collecting oysters and eating

them straight off the rocks (remember your license!), and for bass fishing on the Groenvlei (the fresh water lake in the Goukamma Reserve).

Warning: Study subjects reported extreme difficulty tearing themselves away from the beauty of this lightly populated region at the end of each day's activities. A picnic blanket accompanied by the administration of a fine wine or cold lager may be of some help.



Pezula Championship Golf Course with beautiful sea views in the background - Photo credit Pezula

3. Golf, cycling, trail running

Data collected on some of South Africa's favourite sports show that they're extremely well represented in Knysna.

Although the town boasts no less than three 18-hole championship golf courses and two 9-hole mashie courses,

KNYSNA IS CLOSE ENOUGH TO BOTH GEORGE AND PLETTENBERG BAY THAT RESEARCHERS FOUND THEY WERE ABLE TO PLAY ON A DIFFERENT COURSE EVERY DAY FOR ALMOST A FORTNIGHT - AND STILL NOT COMPLETE THEIR EXPERIMENTS.

For cyclists and trail runners, the town is blessed with outstanding routes and trail parks, and since many of the back roads (including the famed 7 Passes Road from Knysna via Rheenendal and Karatara to George) are both scenic and generally quiet, they make for excellent, informal riding.

4. Spas, pampering, shopping, dining

Study subjects identified as desiring a good pampering recorded top-class results during fieldwork in Knysna, with personal reports of 4- and 5-star treatments at local spas, gyms, and beauty salons that exceeded expectations.

As one of South Africa's favourite holiday destinations, the town's shopping and dining experiences are generally concentrated at



Cycling in the SANParks protected Diepwalle forest - Photo credit Wesgro

the water's edge - at places like the Knysna Waterfront and Thesen Harbour Town - although they're also found in many scenic locations both in town and in the countryside.

The data was inconclusive, though. Our researchers are going to have to go back for further sampling of all that goodness. Especially when it comes to those fresh Knysna oysters...

5. Accommodation

Peer-reviewed research (TripAdvisor, visitknysna.co.za, et al) indicate the presence of the widest possible selection of accommodation for singles, couples, and families alike - ranging from luxury hotels and lodges to cosy, home-style B&Bs and self-catering units.

Controlling for selection criteria - including standards of service and amenities, and the

presence of swimming pools, sun decks, and other facilities (where required) - our study found staying over in the Knysna area to be almost as relaxing as visiting its forests, beaches, and other attractions.

CONCLUSION:

Having accepted the benefits of stress reduction through forest bathing and similar therapeutic techniques (such as enjoying a damned good jol), this study has examined Knysna as a breakaway and holiday destination, and has presented representative (but indisputable) data supporting its argument for the quality of the downtime that subjects are likely to experience when visiting.

Our results can therefore be summed up as follows:

"GIVE ME ANOTHER ONE OF THOSE FRESH KNYSNA OYSTERS!"

REFERENCES:

- Song, C., Ikei, H., and others: Psychological Benefits of Walking through Forest Areas. *Int. J. Environ. Res. Public Health* 2018, 15(12), 2804; <https://doi.org/10.3390/ijerph15122804>
- Li, Q.: Forest Bathing: How Trees Can Help You Find Health and Happiness. Penguin Random House, 2018
- Garden Route National Park: www.sanparks.org/parks/garden_route
- Knysna (including Sedgefield, Buffalo Bay, Rheenendal, Noetzie, etc.): www.visitknysna.co.za ■



Arial view of the iconic Knysna Heads and Leisure Isle - Photo credit Elle Photography



SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

SA MRC UNIT ON RISK AND RESILIENCE IN MENTAL DISORDERS,

DEPARTMENT OF PSYCHIATRY STELLENBOSCH UNIVERSITY



Dear Colleague,

We here at the MRC unit on Risk and Resilience in Mental Disorders (SU and UCT) would like to strengthen our ties with mental health professionals in the public and private sectors in South Africa. The reasons are manifold.

First, we would like to cast a wide net when recruiting participants for our research projects to generate results generalizable to the South African patient. We are currently investigating the brain / neuropsychological correlates of OCD in an internationally collaborative NIH funded study (see: <https://global-ocd.org/>).

NOTE THAT THIS PROJECT INCLUDES AN OPTIONAL TREATMENT LEG (I.E. SERTRALINE, FOR 12 WEEKS, UP TO THE MAXIMUM RECOMMENDED OR TOLERATED DOSE), WITH MRI AT BASELINE AND A SECOND MRI SCAN AT WEEK 12. AFTER THAT, TREATMENT WILL PROCEED UNDER NATURALISTIC CONDITIONS, FOR WEEKS 12 – 52.

Other projects focus on the genetic / MRI profiles of people with anxiety disorders in OCD related disorders (including trichotillomania and

skin picking disorder). Please see a part of the information sheet for referral criteria regarding current ongoing studies later in this article.

PARTICIPATION IN THESE PROJECTS WOULD NOT INTERFERE WITH THEIR TREATMENT REGIME EXCEPT IF EXPLICITLY REQUIRED.

Second, we are always keen to maintain good referral channels as our participants (with and without medical aids) often require clinical intervention.

WE PROVIDE A COMPREHENSIVE DIAGNOSTIC ASSESSMENT AS PART OF OUR DATA COLLECTION PROCEDURES AND SHARE OUR FINDINGS WITH PARTICIPANTS AND (CURRENT/FUTURE TREATING) CLINICIANS. THIS IS HELPFUL ESPECIALLY IN CASES WHERE DIAGNOSTICS AND/OR TREATMENT-RESISTANCE ARE CHALLENGING.

Third, we are commencing an exciting new ICD-11 related study requiring the participation of mental health professionals who make diagnoses in their daily practice; we are testing the first draft



SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

of a comprehensive diagnostic questionnaire, the SCII-11 ("Structured Clinical Interview for ICD-11"). Members of our Unit have been part of the development of this instrument as part of an international group of researchers lead by Prof Michael First, an internationally established expert in diagnostic interviewing based at Columbia University.

IN SUMMARY, WE WOULD LIKE TO ENCOURAGE RELEVANT BIDIRECTIONAL REFERRALS AND ENSURE OPEN CHANNELS OF COMMUNICATION SO THAT LOCAL CLINICAL EXPERIENCE CAN BE TAKEN

INTO CONSIDERATION WHEN DEVISING NEW STUDY PROTOCOLS.

Thanks for your consideration – we look forward to hearing from you.

Yours sincerely

Prof Christine Lochner

SA MRC Unit on Risk and Resilience in Mental Disorders, Department of Psychiatry Stellenbosch University
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Facebook: @OCDRSA

Protocol Version 6, August 2020

IDENTIFYING REPRODUCIBLE BRAIN SIGNATURES OF OBSESSIVE-COMPULSIVE PROFILES

Principal Investigators: Christine Lochner¹, Dan J. Stein²
Co-Investigators: Jonathan Ipser³, Karen Mare⁴, Heidi Sinclair⁴

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³Department of Psychiatry and Mental Health, Faculty of Health Sciences, University of Cape Town

⁴Independent psychiatrist, Bellville

BRIEF OVERVIEW

Obsessive-compulsive disorder (OCD) is a prevalent and disabling disorder, and fewer than half of patients with OCD become well with current treatments (Eisen et al 2013). This is a transnational research project involving one U.S.A. site and four sites in four other countries — Brazil, India, Netherlands, and South Africa **. The goal of the project is to identify brain-based "biosignatures" associated with cognitive and clinical profiles common in individuals with OCD that are reproducible across countries and cultures.

MRI-based brain imaging measures will be collected using standardized protocols across research sites to identify dysfunctional circuits and associate them with clinical and cognitive measures. Identifying brain signatures of measurable behaviors and clinical symptoms will likely provide robust new treatment targets and help pave the way to precision psychiatry

where individual brain signatures can help guide treatment choices. Given variations in culture across the sites, cultural influences on OCD psychopathology may also be identified.

** The 5 study sites and their respective PIs are:
In the U.S.A.: New York State Psychiatric Institute, Columbia University (Dr Blair Simpson)

In Brazil: Department & Institute of Psychiatry, University of Sao Paulo, School of Medicine (Roseli Gedanke Shavitt)

In India: National Institute of Mental Health & Neurosciences (NIMHANS), Bangalore (Dr Janardhan Reddy)

In the Netherlands: VU University Medical Center (VUmc)/Amsterdam (Dr Odile van den Heuvel)

In South Africa: MRC Unit on Risk and Resilience in Mental Disorders (SU and UCT) (Lochner (SU); Dan J. Stein (UCT))



BACKGROUND, SIGNIFICANCE AND RATIONALE

Anxiety and related disorders, including OCD, are leading causes of global disability (Kessler et al 2009). Brain circuit abnormalities have been identified, but important knowledge gaps remain (e.g. (Burguiere et al 2015)). As of yet, it is unclear which abnormalities underlie what symptom profiles, how dysfunction develops and thus which brain abnormalities to target with new interventions (Via et al 2014, Harrison et al 2013, Alvarenga et al 2012, van den Heuvel et al 2009, Gilbert et al 2008). Moreover, circuit abnormalities likely cut across traditional diagnostic categories and, within a diagnostic category, there is individual variability (van den Heuvel et al 2016). Our approach is to identify reproducible brain signatures of measurable behaviors and clinical symptoms; these brain signatures can then be used to reveal trans-diagnostic disease dimensions, to chart their development, and to develop treatments that target these circuit abnormalities directly. The goal of this proposal is to identify reproducible brain signatures associated with cognitive and clinical profiles that are common in individuals with OCD.

To accomplish this, we will study 250 unmedicated OCD, 250 unaffected siblings of patients with OCD and 250 healthy control participants (HCs) at five expert research sites spanning five countries (U.S.A., Brazil, India, Netherlands, and South Africa [SA]). In SA, the research will be done at the MRC Unit on Risk and Resilience in Mental Disorders, a cross-university unit between Stellenbosch University and the University of Cape Town (UCT). Using imaging methods that could ultimately be adapted for clinical use, we will examine multiple brain circuits thought to underlie OCD behaviors, focusing on morphometry (using T1-weighted MRI), structural connectivity (using Diffusion Tensor Imaging [DTI]), and functional connectivity (using resting-state fMRI [rs-fMRI]). We will identify neuroimaging signatures that distinguish individuals with OCD from HCs by analyzing each modality with standardized protocols and by using multi-modal fusion with modern machine learning statistical methods. We will then examine how these imaging signatures are linked to behavioral performance on cognitive tasks that probe these same circuits and to a range of clinical profiles that are common to OCD. Finally, we will explore how specific environmental features (childhood trauma, socioeconomic status, and religiosity) may moderate this brain-behavior relationship. In addition to patients with OCD and HCs, unaffected siblings of OCD participants (50 per site, over 5 years) will also be recruited. The rationale for the addition is that unaffected siblings can be seen as an intermediate group between patients with OCD and HCs, and addition of data

from this additional cohort to analysis will likely assist in identifying endophenotypes or brain signatures of OCD. Recent MRI work in adult and adolescent patients with OCD and their unaffected siblings have, for example, shown that there are similar morphological abnormalities in cortical and subcortical regions of the caudate nucleus, thalamus and the right orbitofrontal cortex in these groups. In addition, both patients with OCD and unaffected siblings, as compared with healthy controls, have shown increased thickness of the right precuneus (Fan et al 2015).

OUR SHORT-TERM GOAL IS TO IDENTIFY BRAIN SIGNATURES OF OCD COGNITIVE AND CLINICAL PROFILES, LEVERAGING OUR GLOBAL COLLABORATION BOTH TO RECRUIT A VERY LARGE UNMEDICATED SAMPLE AND TO PROVE THESE SIGNATURES' REPRODUCIBILITY.

Our long-term goal is to identify brain signatures for measurable behaviors and clinical symptoms that cut across traditional diagnostic categories and to use these signatures to transform how we conceptualize, diagnose and ultimately treat mental illnesses like OCD.

A study embedded in the large project will also be conducted. Through our work with patients with OCD we aim to assess the clinical utility of proposed ICD-11 guidelines for OCD as reported by study clinicians who are doing the assessments. Clinicians will provide information regarding the application of the diagnostic guidelines to their patients and make ratings of their clinical utility with regard to each specific case. This data, collected by the clinicians only, will form part of the WHO Global Clinical Practice Network (GCPN) initiative.

In addition to the first, there will be a second embedded study. Anyone with OCD who completes the parent study, will be eligible for a taking part in a treatment study. Treatment will entail a 12 weeks open-label trial of sertraline (FDA approved for treatment of OCD) up to the maximum recommended or tolerated dose (i.e. titration: 50 mg per week up to 200 mg), with treatment under naturalistic conditions, tailored according to the individual's needs, for weeks 12 – 52. A 2nd MRI scan following the same scan sequences as at baseline, will take place in the week of the week 12 visit, to enable identification of clinical and neurocognitive correlates, as well as neuroimaging variables associated with response to sertraline.

The full version of these protocols is available from the author ■



SOUTH AFRICAN SOCIETY OF
PSYCHIATRISTS

MENTAL HEALTH OF HEALTH WORKERS DURING THE COVID-19 PANDEMIC SURVEY

UNIVERSITY OF THE
WITWATERSRAND
JOHANNESBURG 

Dear Colleague,

We are a team of researchers from the University of the Witwatersrand conducting a survey on mental health experiences of healthworkers during the time of the COVID-19 pandemic in South Africa. This study was approved by the Human Ethics Committee (Medical) at the University of the Witwatersrand (M200461). We would like to invite you to participate in this study.

You may have participated in July, 2020. We are doing a second data collection which will help us better understand your mental health needs.

IF YOU DID NOT COMPLETE THE QUESTIONNAIRE THE FIRST TIME, YOU ARE STILL ELIGIBLE TO PARTICIPATE AND COMPLETE THIS QUESTIONNAIRE.

If you agree to participate, the study will involve completion of a brief demographic questionnaire as well as some questions regarding your mental health experience during this time through an online survey. The survey should take approximately 15 to 30 minutes to complete.

Participation in this study is voluntary and you have the right to decline participation. You will not receive any direct benefits from participating in this study, and there are no disadvantages or penalties for not participating. You may choose not to answer any question. The questionnaire will be completely confidential and your anonymity is ensured.

As there is no identifying information, the researchers will not be able to provide any direct feedback. A summary of the study and its results can be requested using the contact details below. The research may be presented at local/international conferences and published in a journal and/or book chapter.

We aim to conduct a follow up to this study and have therefore asked you to insert the first five digits of a telephone or cellphone number that you will remember. This is the information that we will use to match up responses only for analysis purposes if you choose to participate in the follow up study.

SUBMISSION OF THE SURVEY WILL BE TAKEN AS CONSENT TO USE YOUR RESPONSES IN THIS STUDY.

If you feel vulnerable on completing the questionnaire, please contact the South African Depression and Anxiety Group (SADAG)-0800 567 567 (toll free) (SADAG provides 24-hour telephonic counselling) or contact the Healthcare Workers Care Network Helpline 0800 212 121 or SMS 43001 (toll free). You may also visit www.healthcareworkerscarenetwork.org.za.

If you have any questions about this research, feel free to contact us on the details listed below.

If you have any concerns about the study, you may contact us or the ethics committee secretariat on 011 717 2700/1234 or Zanele.Ndlovu@wits.ac.za and Rhulani.Mukansi@wits.ac.za.

Yours sincerely,

Shona Fraser
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082 746 8865 / 011 535 3212

Prof Sumaya Laher
sumaya.laher@wits.ac.za

Prof Jennifer Watermeyer
jennifer.watermeyer@wits.ac.za

Take the survey at:

<http://healthman.evlink9.net/servlet/link/1774/609630/1886150/2264675> ■



OVERVIEW OF THE CMS ANNUAL REPORT FOR 2019/2020

PREPARED FOR THE BENEFIT OF HEALTHMAN CLIENTS



In its annual report (2019/20) which was only released in December 2020 the Council for Medical Schemes reveals that a total number of 2 829 (2018: 3 808) new complaints were lodged.

1 902 complaints were carried forward from 2018.

Of the 4 731 complaints, 3 006 were resolved. Forty seven percent of all the rulings were in favour of the complainants and 6% of all complaints were invalid. Open and restricted schemes had 42% and 33% rulings in their favour respectively.

THE REPORT CONTAINS THE FOLLOWING:

- The Registrar's review and a synopsis of the council's strategic objectives and their financial affairs;
- **A REVIEW OF MEDICAL SCHEME OPERATIONS WHICH INCLUDES STATISTICS ON MEMBERSHIP, HEALTHCARE AND NON-HEALTHCARE EXPENDITURE INCURRED AND THE FINANCIAL AFFAIRS OF MEDICAL SCHEMES IN GENERAL;**
- An overview of the administrator market and other related issues.

Salient features of the overview can be summarized as follows:

- The number of schemes decreased from 80 to 79 and beneficiaries increased by 0.5% to 8.916 million.
- Approximately 52% of all healthcare benefits was paid in respect of hospitals (37%) and medicines (15%).

- **OVERALL, THE NET HEALTHCARE RESULT IMPROVED FROM R5.01 BILLION TO R7.06 BILLION, AN INCREASE OF 40.9%.**
- The proportion of **beneficiaries** covered by medical schemes as a proportion of the population declined from 16.5% in 2000 to 15.08% in 2019.
- Approximately 40% of beneficiaries were in Gauteng, followed by Western Cape and KwaZulu-Natal with 15% and 14%, respectively
- Schemes reached a solvency level of 29.35% at the end of 2019.
- For every R100 received in 2019, R90.58 was spent on claims, R8.87 was spent on non-healthcare expenditure and R0.55 was allocated towards reserves.
- The average contribution rates increased by 8.2% in 2019 and 7.6% in 2020.
- Expenditure for in-hospital services provided by the "allied" group dropped by 14% from 2018 to 2019, and medical specialists by 11% for out of hospital care.
- The average cost per beneficiary was R19 999, and peaked for the age band 80 to 84 years at R68 944 per average beneficiary.

Medicines continue to make up the largest part of out-of-pocket expenditure (33%), with 14% being to the "allied" disciplines.

Read the Overview at:
<http://healthman.evlink9.net/servlet/link/850/607793/1886150/2250037>



MEDICAL SPECIALIST GRADE 1-3 (X2)

TARA HOSPITAL

- **Reference Number:** refs/007668
- **Directorate:** Medical
- **Number of Posts:** 2

Package : R 1,106,040 per annum – R 1 164 651 per annum (All-inclusive package)

- **Enquiries :** Dr. R Price-Hughes
Tel no: (011) 535 3001

REQUIREMENTS

Appropriate qualification in psychiatry (FC Psych (SA) MMed (Psych) or equivalent qualification recognised by the HPCSA), which allows registration as a specialist psychiatrist with the Health Professions Council of South Africa (HPCSA). Current registration with the HPCSA as a specialist psychiatrist. Sound clinical knowledge and skills in psychiatry. Ability to work in a multi-disciplinary team. Knowledge of legislation, policies and procedures pertaining to mental health care users. Computer literacy. A valid driver's license.

DUTIES:

Provide a direct clinical service and manage a psychiatric inpatient or outpatient unit. The provision of care, treatment and rehabilitation to mental health care users within the framework of the Mental Health Care Act (No 17 of 2002); involvement in other general psychiatry work as needed. Provide outreach services to District Health services and District/ Regional hospitals. Teaching and training of medical students, medical officers and psychiatric registrars, as well as other personnel (e.g. nurses, etc.). To stimulate, assist with and conduct research relevant to the Gauteng Department of Health and Department of Psychiatry. To supervise and manage junior staff, which would include disciplinary responsibilities, if and when necessary. Administrative duties. Active participation in hospital management committees. To assist with the development of policies and protocols of the hospital. Active participation in quality improvement programs including clinical audits, morbidity and mortality meetings and continuous professional development activities. To liaise with external stakeholders when appropriate. To always maintain professional and ethical conduct. This post is a joint appointment with the Division of Psychiatry,

University of the Witwatersrand. The incumbent will be expected to participate in the teaching program of the department and to provide training to a range of students and healthcare workers.

NOTES :

Tara Hospital is committed to the pursuit of diversity, redress and will promote representation in terms of race, disability and gender. Applications must consist of a fully completed and signed Z83 form with a comprehensive CV containing contactable references as well as certified copies of qualifications (including a matric certificate), registration with HPCSA, proof of current registration with HPCSA, driver's license and identity document. The relevant reference number must be quoted in the application form. In terms of the National Qualification Framework Amendment Act 2019 it is an offence for any person to falsely or fraudulently claim to hold a qualification. Any person found to be misrepresenting their qualifications, work experience or facts in their CV will be disqualified and reported to the appropriate authority.

Applications must be delivered to:

Tara the H. Moross Centre, c/o HR Section, 50 Saxon Road Hurlingham 2196,
or be posted to:
Tara the H. Moross Centre, Private Bag x7, Randburg 2125.

Due to technical problems with GPG vacancy website that the institution is consistently facing, applicants are encouraged to apply using hand delivery or postal address.

Employer: Department of Health
Location: Tara, The H. Moross Hospital (Sandton)
Closing Date: 15-01-2021

CRITERIA QUESTIONS:

Do you have current registration with the Health Professions Council of South Africa (HPCSA)?
Do you have a valid Driver's license?
Do you have an appropriate qualification that allows registration with the HPCSA as Specialist Psychiatrist?
Are you computer literate? ■



ADULT PSYCHIATRY CONSULTANT POST TYGERBERG HOSPITAL

A specialist post in Adult Psychiatry will be available at Tygerberg Hospital as from approximately 1 February 2021.

The post is a joint appointment of the Department of Psychiatry, Stellenbosch University, and the Provincial Government of the Western Cape (see attached).

DUTIES INCLUDE:

1. The clinical assessment, management and supervision of adult patients referred to a general adult psychiatry multidisciplinary team including the neuropsychiatry unit at Tygerberg Hospital.
2. In-service training and supervision of pre- and post-graduate students in psychiatry and neuropsychiatry.
3. Clinical governance and administrative organization of a general psychiatry team.
4. Teaching of under- and postgraduate students in relevant degrees and diplomas in psychiatry.
5. Relevant research and publications and supervision of the research of junior colleagues.
6. Support to the Head of the Adult Psychiatry Unit with respect to clinical, management, teaching and administrative matters.

REQUIREMENTS:

1. Specialist registration with the HPCSA to practise as a Specialist Psychiatrist
2. FC(Psych)SA, MMed(Psych) or equivalent recognised by HPCSA
3. Clinical, teaching, research, management and communication skills
4. Ability to serve patients in at least two of three official languages of the Western Cape

EXPERIENCE:

1. At least one year's post-registration experience in clinical psychiatry and management of a mental health care team
2. Experience in the teaching and management of neuropsychiatry would be a recommendation
3. At least one year's post-registration experience in teaching, training, and research of psychiatry at university level.
4. The post comes with 16 hours of overtime per week in psychiatry.

Application submissions closed 15 January 2021. They were to be directed to Veruschka Meyer at veruschka.meyer@westerncape.gov.za or by post/courier to The Chief Executive Officer: Tygerberg Hospital, Private Bag X3, Tygerberg 7505 (For attention: Ms V Meyer).

REQUIRED DOCUMENTS:

1. CV
2. Certified copy of ID and driver's license
3. Z83 completed - use 'as per block advert' for specific post
4. Certified copy of matric certificate and degrees
5. HPCSA registration

ENQUIRIES:

Dr Granville Marinus
Granville.Marinus@westerncape.gov.za

Dr Kerry Louw
kerrylouw@sun.ac.za

Ms Veruschka Meyer
Veruschka.Meyer@westerncape.gov.za
021 938 5194

Prof Soraya Seedat
sseedat@sun.ac.za



VACANCIES IN EKUHLINGENI PSYCHIATRIC HOSPITAL

Telephone: (031) 905 4775
Date: 2021/01/22
Enquiries: Miss E.N. Khwela
Reference: EPH/HRM/4/2/1

CIRCULAR OF VACANT POST

The contents of this Circular Minute must be brought to the notice of all eligible officers and employees on your establishment without delay even if they are absent from their normal places of work.

DIRECTIONS TO CANDIDATES:

1. The following documents must be submitted:
 - o Application for Employment Form (Z83), which is obtainable at any Government Department OR from the website – www.kznhealth.gov.za
 - o Certified copy of Identity Document. Driver's license, highest educational qualifications and professional registration certificate not copies of certified copies.
 - o Updated Curriculum Vitae with full record of service.

NB: CERTIFIED COPIED SHOULD NOT BE THREE MONTHS OLDER

1. The Reference Number must be indicated in the column provided on the Z83, e.g. HRM 2/2013.

NB: Failure to comply with the above instructions will disqualify applicants. Faxed and e-mailed applications will not be accepted.

1. The appointment is subject to positive outcome obtained from NIA to the following checks (security clearance, credit records, qualification,

citizenship and previous experience employment verifications).

2. Please note that applications will not be acknowledged. Correspondence will be limited to short listed candidates only. If you have not been contacted within two months after the closing date of advertisement, please accept that your application was unsuccessful.
3. Ekuhlengeni Psychiatric Hospital is an equal opportunity, affirmative action employer, whose aim is to promote representivity in all occupational categories in the institution.
4. **PERSONS WITH DISABILITY ARE ENCOURAGED TO APPLY.**
5. **Please note that due to financial constraints no S&T payments will be considered for payment to candidates that are invited for interview.**

ALL APPLICATIONS SHOULD BE FORWARDED TO:

The Human Resource Department
Ekuhlengeni Psychiatric Hospital
P.O. Box 3, Umbogintwini 4126

OR

Hand delivery to Ekuhlengeni Hospital
Off old South Coast road, UMBONGINTWINI

Original signed by CEO

MS. N.S. PADAYACHEE
CHIEF EXECUTIVE OFFICER
EKUHLINGENI PSYCHIATRIC HOSPITAL



VACANCIES IN EKUHLENGENI PSYCHIATRIC HOSPITAL

POST: Medical Specialist - Psychiatry

CENTRE: Ekuhlengeni Psychiatric Hospital

REFERENCE NUMBER: EPH 02 / 2021

OTHER BENEFITS: 12% inhospitable Rural Allowance of Basic Salary, commuted overtime, the all-inclusive package consists of 70% basic salary and 30% flexible portion that may be structured in terms of the applicable rules.

REMUNERATION AND MINIMUM REQUIREMENTS:

Grade 1 R 1 106 040.00 – R1 173 900.00 per Annum (all package inclusive)

Grade 12 / National Senior Certificate

Appropriate qualification in Psychiatry that allows registration as a specialist with HPCSA plus current registration with HPCSA (2019)

Grade 2 R1 264 623.00 – R1 342 230.00 per annum (All package inclusive)

Grade 12 / National Senior Certificate

Appropriate qualification in Psychiatry that allows registration as a specialist with HPCSA plus current registration with HPCSA (2019) and 5 years appropriate experience as Medical Specialist after registration with HPCSA in Psychiatry.

Grade 3 R1 467 651.00 – R1 834 890.00 per annum (All package inclusive)

Grade 12 / National Senior Certificate

Appropriate qualification in Psychiatry that allows registration as a specialist with HPCSA plus current registration with HPCSA (2019) and 10 years appropriate experience as Medical Specialist after registration with HPCSA in Psychiatry.

NB: Certificate of service from previous employer is compulsory; please include verification of employment from current employer, which must be endorsed by Human Resource Management

KNOWLEDGE, SKILLS TRAINING AND COMPETENCIES REQUIRED

- Sound Knowledge of clinical concept within the Psychiatry discipline.
- Good Operative skills to carry out advanced clinical services.
- Research and organizational ability
 - o Ability to supervise and teach junior staff
 - o Conflict management

- Management skills

KEY PERFORMANCE AREAS

- Provision of care' treatment and rehabilitation to mental health care users within the framework of the Mental Health Care Act (No 17 of 2002); involvement in other general psychiatry work as needed.
- Conduct mental observations in terms of the Criminal procedure Act (No. 51 of 1977); care, treatment and rehabilitation of State patients in terms of the Mental Health Care Act (No 17 of 2002); involvement in other forensic Psychiatry work as needed.
- Teaching and training of interns and Medical officers as well as other personnel and (e.g. nurse, etc.).
- To stimulate, assist with and conduct research in field of Psychiatry.
- To supervise and manage junior staff, which would include disciplinary responsibilities if and when necessary.
- Administration duties.
- Active participation in hospital committees.
- To assist with the development of policies and protocols of the Hospital.
- Active participation in quality improvement programs including clinical audits, morbidity mortality meetings and continuous professional development activities.
- To liaise with external stakeholders when appropriate.
- To always maintain professional and ethical conduct.
- Participate in formal teaching as required by the department.
- Provide outreach to surrounding PHC clinics and the District Hospitals which refer to Ekuhlengeni Psychiatric Hospital.

FIRST PREFERENCE WILL BE GIVEN TO AFRICAN FEMALE

Enquiries: Ms. NS PADAYACHEE
Nalini.Padayachee@kznhealth.gov.za



SOUTH AFRICAN SOCIETY OF
PSYCHIATRISTS

RWS CHEETHAM AWARD IN PSYCHIATRY

Dear Colleagues,

The award is offered annually (in respect of a calendar year) by the Senate of The Colleges of Medicine of South Africa for a published essay of sufficient merit on trans - or cross - cultural psychiatry, which may include a research or review article.

Medical Practitioners registered and practising in South Africa qualify for the award which consists of

a medal and certificate.

The closing date was 15 January 2021.

The guidelines pertaining to the award can be requested from:

Mrs Evelyn Chetty

Tel: +27 261 8213

+27 261 8518

E-mail: evelyn.chetty@cmsa.co.za ■

WFSBP YOUNG INVESTIGATOR AWARDS

WFSBP is offering Awards to young investigators to attend the WFSBP biennial congress and the special educational sessions. The Award includes free registration to the WFSBP Congress in Vienna, Austria. In addition, the award winner will receive a travel grant of EUR 400 to cover travel expense for attending the meeting in Vienna if WFSBP is able to hold the in-person meeting. Payments will be made in Euros after providing the receipt for travel expenses.

Psychiatrists or basic researchers under the age of 40 are eligible to apply.

The selection is competitive.

The application should include the following:

1. A letter from the candidate applying for the Award with a summary of career goals and interest in biological psychiatry
2. A letter from a mentor or the president of the national WFSBP affiliate Society outlining the candidates' achievements and how the award will support candidate's career in biological psychiatry
3. A Curriculum Vitae

Priority will be given to candidates:

- a) with demonstrated interest in biological psychiatry
- b) with history of interest in research and some track record of publications
- c) that have submitted an abstract for a poster or an oral presentation
- d) from developing countries

The Awardees are expected to attend all five WFSBP educational sessions.

Deadline for submission of application was: 31 January 2021

The submission including all required documents must be sent to the congress office via email: wfsbp2021@cpo-hanser.de

With kind regards,

Prof. Florence Thibaut

Prof. Lakshmi N. Yatham

Co-Chairs WFSBP Committee on Education ■





SOUTH AFRICAN SOCIETY OF
PSYCHIATRISTS

SASOP, PSYCHMG ROADSHOW 2021

- PROUDLY SPONSORED BY PHARMADYNAMICS



**ROADSHOW
2021**

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Although the current situation with the COVID-19 pandemic makes planning for meetings a challenge, we are hopeful that we will be able to proceed with the intended Roadshows for 2021 as planned later in the year. It remains important for us to connect with our membership, and we hope to be able to build on the first round of workshops that were held nationally in 2019.

THIS YEAR THE FOCUS OF THE WORKSHOPS WILL BE ON THE NEW PROCEDURAL CODING SYSTEM THAT HAS BEEN APPROVED AND IS DUE TO BE IMPLEMENTED, AS WELL AS VALUE BASED CARE.

This is a mammoth task and we hope to be able to address issues that arise in real time to ensure a smooth transition for all who work in private practice. The meetings will also be an opportunity to connect with the broader SASOP membership.

We have therefore planned for one more **Webinar (#3)** to introduce the new **Procedural Coding System** to be held on 10 February 2021 which will be facilitated by Dr's Ian Westmore and Eugene Allers. We encourage members to forward questions that they may have in this regard prior to the webinar

already, but there will also be an opportunity to ask questions during the event.

If all goes well and the situation allows, we will be hosting regional meetings in the main centres. The meetings will commence at 16h00 and the workshop will end by 19h00 after which dinner will be served, and an academic talk by a SASOP member will be presented. You are welcome to ask your admin staff to join the workshop.

A DECISION REGARDING THE PHYSICAL MEETINGS WILL BE MADE CLOSER TO THE TIME.

If it seems appropriate, they will be converted to Zoom webinar formats should a physical meeting not be able to proceed. The following dates have been allocated:

SAVE THE DATES:

12.05.2021	Gauteng - Johannesburg
26.05.2021	Gauteng - Pretoria
09.06.2021	Western Cape - Cape Town
23.06.2021	Free State - Bloemfontein
04.08.2021	KwaZulu Natal - Durban
18.08.2021	Eastern Cape - Port Elizabeth
01.09.2021	Limpopo - Polokwane - TBC

Looking forward to see you on the road!

Kind Regards

SASOP, PsychMg & PharmaDynamics ■



SOUTH AFRICAN SOCIETY OF
PSYCHIATRISTS

UCT DEPARTMENT OF PSYCHIATRY & MENTAL HEALTH FIELD TRIAL



Dear Colleagues at SASOP

Structured Clinical Interview for ICD-11 (SCII-11) Field Trial – South African division UCT HREC Ref: 770/2020

I would like to invite you to participate in an international collaborative field trial evaluating the experience of mental health professionals and patients when using the SCII-11, a diagnostic interview based on the clinical descriptions and diagnostic guidelines of the ICD-11. Other participating centres are located in the USA, Canada, the UK and India.

THE SCII-11 WAS DEVELOPED BY AN INTERNATIONAL GROUP OF EXPERTS UNDER THE HELM OF PROF MICHAEL FIRST, WHO IS ALSO THE FIRST AUTHOR OF THE SCID-5.

The group also benefits from the experience of Prof Geoffrey Reed from the WHO, who was responsible

for overseeing the ICD revision from the 10th to 11th edition.

Participants will be asked to interview 5 patients in English over the course of 2021 using the SCII-11. Following the interview both the professional and patient will complete an online questionnaire regarding the acceptability, feasibility and clinical utility of the SCII-11.

BEFORE USING THE INTERVIEW, PARTICIPANTS WILL HAVE TO COMPLETE FREE AND EASY ONLINE ICD-11 AND SCII-11 TRAINING.

This study is unfortunately unfunded, but we are hoping that clinicians see the value of the work, and will be willing to volunteer. Please contact me (details below) if you are interested in participating or have any questions.

Yours sincerely

Dr Karen Maré

Research Psychiatrist

Cell: 076 574 6395

Email: karentmare@gmail.com

UCT Department of Psychiatry and Mental Health

MRC Unit on Risk and Resilience in Mental Disorders (UCT/SU) ■



SASOP

20th National Congress
of the
South African Society of Psychiatrists

20 - 24 October 2021

Champagne Sports Resort
Central Drakensberg

SAVE THE DATE



www.sasop2021.co.za



For further information, please contact the Congress Organisers:

Londocor Event Management

Sonja Du Plessis

Tel: 082 455 7853

email: sonja@londocor.co.za

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@wiits.ac.za



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References: 1. [https://www.sahpra.org.za/registered-health-products/\[Online\]\[cited 2020 July 17\]](https://www.sahpra.org.za/registered-health-products/[Online][cited 2020 July 17]). 2. Wilson SJ, Nutt DJ, Alford C, Argyropoulos SV, Baldwin DS, Bateson AN, et al. British Association for Psychopharmacology consensus statement on evidence-based treatment of insomnia, parasomnias and circadian rhythm disorders. *J Psychopharmacol* 2010;24(11):1577-1600. 3. Wade AG, Crawford G, Ford I, McConnachie A, Nir T, Laudon M, et al. Prolonged release melatonin in the treatment of primary insomnia: evaluation of the age cut-off for short- and long-term response. *Curr Med Res Opin* 2011;27(11):87-98. 4. Lemoine P, Nir T, Laudon M, Zisapel N. Prolonged-release melatonin improves sleep quality and morning alertness in insomnia patients aged 55 years and older and has no withdrawal effects. *J Sleep Res* 2007;16:372-380. 5. Luthringer R, Muzet M, Zisapel N, Staner L. The effect of prolonged-release melatonin on sleep measures and psychomotor performance in elderly patients with insomnia. *Int Clin Psychopharmacol* 2009;24(5):239-249. 6. Wade AG, Ford I, Crawford G, McMahon AD, Nir T, Laudon M, et al. Efficacy of prolonged release melatonin in insomnia patients aged 55-80 years: quality of sleep and next-day alertness outcomes. *Curr Med Res Opin* 2007;23(10):2597-2605.

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