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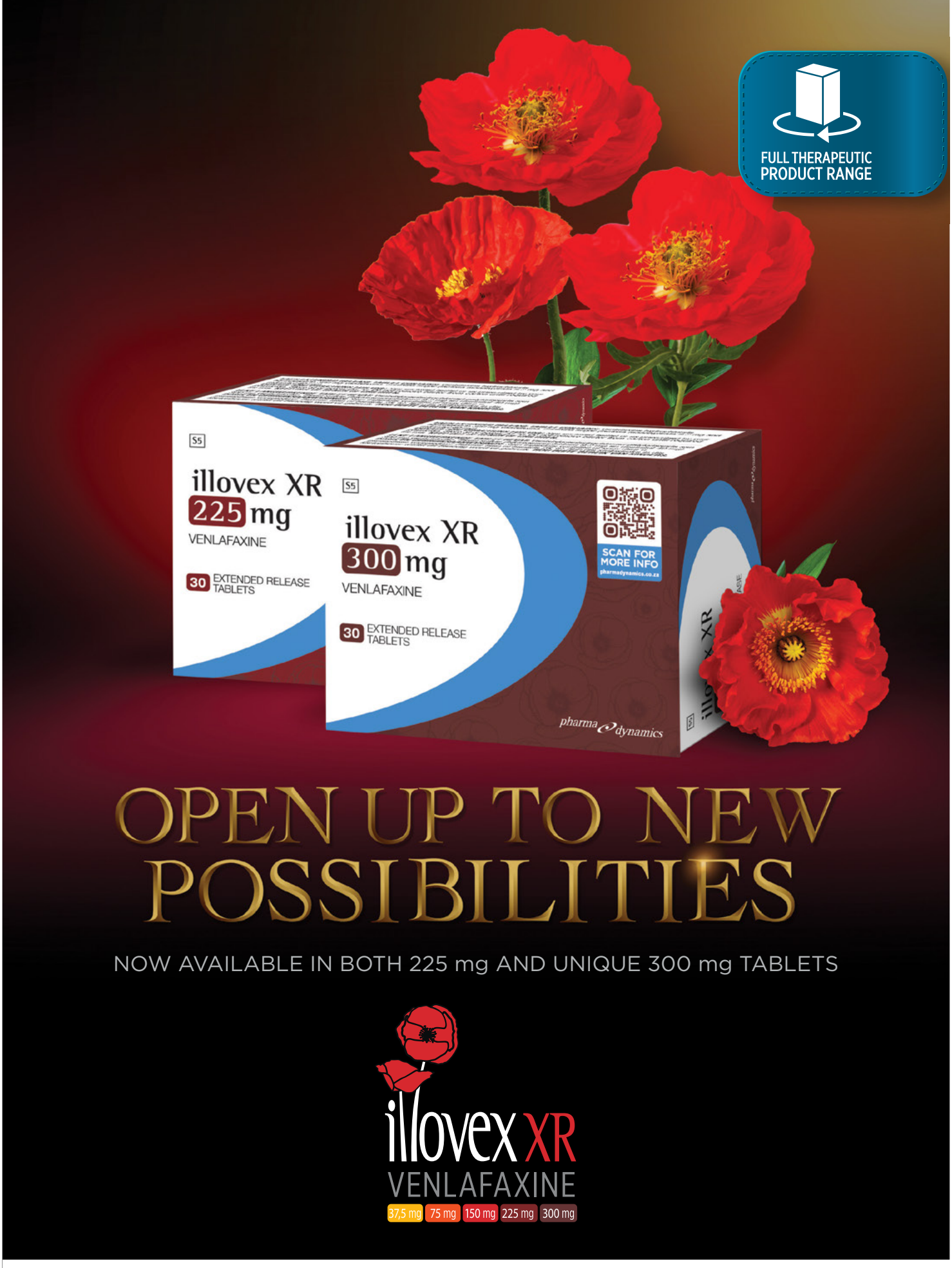

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SOUTH AFRICAN PSYCHIATRY

ABOUT the discipline FOR the discipline

issue 31 • MAY 2022

EXERCISE AS TREATMENT FOR CHILDREN DIAGNOSED WITH ADHD

THE BIG & SMALL OF ADHD: WEIGHT RELATED MATTERS

DIGITAL HEALTH INTERVENTIONS & ADHD MANAGEMENT

CIVIL CLAIMS & COMPENSATION

CAESAREAN KIDNAPPING IN THE CONTEXT OF FORENSIC PSYCHIATRY. MADNESS VS METHOD?

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Features

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

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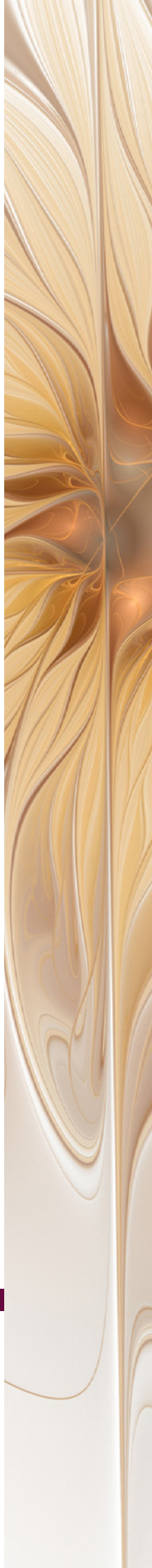

*** PLEASE NOTE:** *Each item is available as full text electronically and as an individual pdf online.*

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EFFECTIVE AFFORDABLE HEALTHCARE

PHARMA DYNAMICS UNVEILS NEW BRAND IDENTITY TO MARK 20 YEARS IN BUSINESS

Pharma Dynamics – one of the fastest growing pharmaceutical companies in South Africa, celebrates its 20th anniversary with a new corporate identity to better reflect the company's people, passion and purpose.

The rebrand, which encompasses a new logo, serves to connect all the company's divisions as it works in unison to meet customer needs through the accessibility of its people and products.

Wilmi Hudsonberg, Marketing and Business Development Executive at Pharma Dynamics says while healthcare continues to evolve, their slogan: "effective, affordable healthcare", has and will always be at the heart of everything they do.

"For the last twenty years, we have stayed true to this motto, which has made it possible for people of all walks of life to access affordable medicine."

PHARMA DYNAMICS OPENED ITS DOORS IN THE SAME YEAR THE SA GOVERNMENT PASSED A LAW WHICH ALLOWED GENERIC MEDICINES TO BE SUBSTITUTED FOR BRANDED MEDICATION.

It was an exciting time, says Hudsonberg. "Today generic medicine makes up more than 80% of prescriptions worldwide and the national market has also shown significant growth. Since those early days, the company has established itself by sourcing molecules worldwide to feed the local demand, always with the purpose of serving various customers by increasing choice and access. Today we have 19 leading brands in 30 therapeutic areas and we are also the biggest provider of cardiovascular medicines in the country. "

To coincide with Pharma Dynamics' 20th anniversary, a simpler and sleeker logo has been designed to take the company into the next decade.

"In a world where things have become more intricate and complex, we have chosen to go for a simpler, bolder emblem that resembles our purpose to deliver on more than just medicine in a newer, nimbler way."

"The recognisable, yet reimagined nexus at the centre of the logo both acknowledges our history and honours the original visual mark. It represents our focus on healthcare through patient and customer centric solutions. Staying close to the care journey and moving beyond the pill, through preventative care remains an important part of our value offering," she says.

"The choice of blue hues visually expresses our commitment to science and patients, and the trust that exist between us and our customers.

DARK BLUE represents our clinical efficacy and dedication to the highest quality standards. We remain focused on being a thought leader in our industry.

LIGHT BLUE is symbolic of simplifying the care journey through digital innovation. Supporting patients' post-script by linking the physical product to disease education and lifestyle adjustment programs through the use of on-pack technology.

The use of a cleaner and modern font not only denotes our company tone and manner in letter form, but also signals the company's ongoing expansion", she adds.

Hudsonberg says as the healthcare environment advances, so is Pharma Dynamics. "To transform the future, we need to think and act differently today. Our goal is to do so justly, sustainably and responsibly".

"Our new branding encompasses our vision for the future, while acknowledging our past that has moulded us into the company we are today. As we celebrate 20 years in business, we are excited about the opportunities that lie ahead."

Issued by Meropa Communications on behalf of Pharma Dynamics. For further information, contact Brigitte Taim from Meropa on 021 683 6464, 082 410 8960 or brigittet@meropa.co.za

PSYCHMG/SASOP ROADSHOW 2022

PROUDLY SPONSORED BY PHARMA DYNAMICS

SASOP/PsychMg with the kind sponsorship of Pharma Dynamics, will be embarking on a Roadshow for the third year in 2022. These events have proven to add value to the practice of psychiatrists in private practice as they are an opportunity for the leadership to connect with members locally.

Psychiatrists have had to keep up with rapid changes over the past few years – COVID-19 and the way that it impacts how we practice, a barrage of admin that is generated by funders, and a new coding system being implemented on top of dealing with patients on a day to day basis. Private practice can be a lonely and stressful experience, and from recent feedback the leadership has noted that many colleagues are feeling frustrated and disempowered.

WE HAVE THEREFORE DECIDED THIS YEAR TO FOCUS ON ADDRESSING THE NEED TO **EMPOWER PSYCHIATRISTS IN PRIVATE PRACTICE.**

Psychiatrists are the professionals who take primary responsibility for patients receiving psychiatric treatment. As leaders of the multidisciplinary team we often don't know how to take the lead and increasingly this is being taken by other professionals. We will look at practical ways to re-establish that lead, whilst also addressing emergent issues related to the new coding system, implementation of value based care etc.

There will be an open discussion following group work that will be an opportunity to discuss private practice related emergent issues that are specific to that region.

The format of the events will be as follows:

15h30-16h00	Registration
16h00-18h30	Workshop
18h30-19h00	Cocktails
19h00-21h00	Dinner

SAVE THE DATES!

06.04.2022	Gauteng - Johannesburg
07.04.2022	Gauteng - Pretoria
11.05.2022	Free State - Bloemfontein
22.06.2022	Western Cape - Cape Town
20.07.2022	KwaZulu Natal - Durban
03.08.2022	Eastern Cape - Port Elizabeth
07.09.2022	Limpopo - Polokwane

Inivites and registrations will be done regionally so please be on the lookout for these!

Looking forward to seeing you on the road!

Kind Regards

PsychMg, SASOP & Pharma Dynamics

Dear Reader,

welcome to the May 2022 issue. You will notice that we have a focus on Attention Deficit Hyperactivity Disorder (ADHD), with *Feature* articles emanating from the last ADHD Congress – noting the next one is imminent (September) with full details noted in the pages of this issue. A big thanks to Renata Schoeman for curating the articles, and of course to the authors for converting presentations into articles. I am hoping the next ADHD Congress will likewise yield such contributions that can serve a wider audience.

Speaking of Congresses, September is a busy month and there is the Biological Congress too with details also in the pages of this issue. In this regard I have a similar hope, as for the ADHD Congress, that presenters will convert presentations into articles… *South African Psychiatry* is your platform. The fourth of our *Feature* articles deals with a strange, fascinating but shocking phenomenon – "caesarean kidnapping". Aside from our *Feature* articles we have Claudia Campbell's *Perspective* with her unique and personal take on patient issues that always provide food for thought. Whilst I don't ordinarily comment on the *Book Review*, Koffi Kouakou"s choice for this issue is one that I think deals with an issue we cannot ignore – "surveillance capitalism". Finally, *Beyond Madness*…the podcast series, was extended for a further 14 episodes following the initial 15. It has been a fascinating journey into the world of podcasting, and I have been privileged to host leading figures to discuss a wide variety of issues related to our discipline of psychiatry. We publish the public relations content in the current issue, which provides the full schedule of the next podcasts.

Enjoy the reads and wishing you warmth, as winter approaches.

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NEW EPISODES OF BEYOND MADNESS PODCAST SERIES OFFER VALUABLE INSIGHTS INTO PSYCHIATRY AND MENTAL HEALTH

In October 2021 the first of 15 weekly podcast episodes aired on CliffCentral. After a short break, 14 new podcast episodes of **Beyond Madness** hosted by Professor Christopher Szabo will begin airing on CliffCentral from Tuesday, 3rd May – in association with Adcock Ingram OTC Sponsors of Brave.

Mental health issues and psychiatry have, until relatively recently, been subjects which were not discussed openly. Thanks to the advent of forums focused on lifting the 'shroud' around understanding mental health issues - such as the **Beyond Madness** podcasts – vital information has become accessible, empowering not only mental health professionals but also the community at large.

KNOWLEDGE IS AFTER ALL POWER BUT WITHOUT TRUE UNDERSTANDING IT CAN BE MEANINGLESS.

Why name a podcast **Beyond Madness**? Professor Szabo sheds light on the rationale behind this: *"These episodes are not about 'madness' per se, however one understands and defines 'madness'. Certainly, psychiatry would refer to 'mental illness' whereas madness might be seen as somewhat pejorative in describing someone who is indeed ill, and the term might be better suited to someone whose behaviour, whilst disturbed, is not the product of mental illness. And yet, there is madness in mental illness and maybe one should be less sensitive to the use of the term. It captures a quality that the term 'mental illness' does not. In a sense the title is not explicit in what it means, maybe a little provocative, but whatever it might mean it is likely associated with some degree of discomfort or suffering so it is not a term used frivolously. This is a serious podcast, one that takes you 'beyond madness' by delving into issues that are beyond the immediate clinical reality of psychiatry but integral to its practice. In a sense, it will take you behind the scenes through the voices of selected individuals, and whilst their work may appear to have specific relevance to psychiatry, each issue raised will ultimately be understood to have broader societal implications."*

Beyond Madness began as a natural extension of a publication founded in November 2014 by Professor Szabo, *South African Psychiatry www.southafricanpsychiatry.co.za,* with the goal of reaching beyond patient care and in a sense converting the written word of the publication into the spoken word of the podcast. The interactive and easily accessible format of the podcasts highlights the intention to provide content not only for psychiatrists and other mental health professionals but the families, friends and colleagues of those who are impacted by emotional difficulties and mental illness. Psychiatry is complex. As a bio-psycho-social discipline it is the only medical discipline that has such an ethos embedded in its practice. These podcasts are intended to humanise psychiatrists, and psychiatry, and what they do beyond diagnosing or treating in a one-dimensional way.

The initial **Beyond Madness** podcasts were so well-received, that it made perfect sense to continue making them and in these new episodes some topics which were covered previously will be explored once again, with the intention of creating greater awareness and understanding about the discipline of psychiatry.

BEYOND MADNESS PODCAST SCHEDULE

Episode 1: 3 May - Smart Food for the Brain
Episode 2: 10 May - Living with Eating Disorders
Episode 3: 17 May - Photographers in war zones
Episode 4: 24 May - Living with Dementia
Episode 5: 31 May - Pregnancy and Psychiatry
Episode 6: 7 June - Divorce and Child Custody
Episode 7: 14 June - Social Media: Youth and emotional well-being
Episode 8: 21 June - The Psychology of Serial Killers
Episode 9: 28 June - Trauma of Loss
Episode 10: 5 July - Living with ADHD
Episode 11: 12 July - Assisted Dying
Episode 12: 19 July - Living with learning disabilities
Episode 13: 26 July - Ketamine: depression and beyond
Episode 14: 2 Aug - What's in a Dream?

New episodes are available every Tuesday at 10am from the 3rd of May on cliffcentral.com and are also available on *Spotify* as well as the *Apple* and *Google* podcast platforms.

Any questions relating to scheduled topics can be emailed to contact@cliffcentral.com

Beyond Madness is available on http://cliffcentral.com/podcasts/beyond-madness/

ABOUT ADCOCK INGRAM OTC

Adcock Ingram OTC, engineered a campaign to acknowledge Health Care Professionals (HCPs) for their bravery. This drive has its origins even before the advent of the pandemic and has since grown in stature. Pharmacists, Pharmacies, Doctors, Nurses and other frontline HCPs have been acknowledged through this campaign. Using this platform, Adcock Ingram OTC Sponsors of Brave celebrates full-time HCPs and healthcare students whilst empowering consumers towards Self-Care as a Human Right. The "Beyond Madness" Podcast is yet another avenue to equip every South African resident with mental health nuances that contribute to each of our Self-Care. Adcock Ingram OTC are proud to be associated with Professor Christopher Paul Szabo and CliffCentral in bringing this Mental Health Self-Care series to life.

This release is distributed on behalf of CliffCentral and Beyond Madness by ANGELFISH PR & EVENTS. Any media enquiries can be sent to Annie Hodes on annie@angelfishpr.co.za

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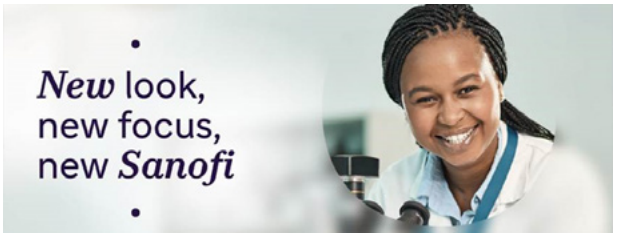

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Our efforts are driven by the clear determination to develop breakthrough medicines and vaccines and get them to the people who need them. We are also elevating our commitments to society, putting environmental sustainability and affordable access at the center of our vision for the future.

View our new identity video here:
https://www.youtube.com/watch?v=UWTfMHzKT10

THIS IS AN EXCITING TIME FOR US AND WE INVITE YOU TO JOIN US ON THIS TRANSFORMATIONAL JOURNEY.

CAESAREAN KIDNAPPING

IN THE CONTEXT OF FORENSIC PSYCHIATRY.

MADNESS VS METHOD?

Ugash Subramaney[1] & Larissa Lala Mohan[2]

[1] Department of Psychiatry, School of Clinical Medicine, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa
[2] Department of Paediatrics, School of Clinical Medicine, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa

The first case of caesarean kidnapping as reported by Porter in 2010 occurred in the United States in 1987 (*Porter, 2010*).[1] 19-year-old Darci Pierce kidnapped Cindy Ray from a prenatal clinic in New Mexico. They were strangers and it appears that Pierce chose Ray at random from among the many other pregnant women at the clinic that day. Pierce drove down the road and called for an ambulance, claiming that she had just given birth and claiming the infant as her own. At the hospital, Pierce refused to allow the physicians to perform a routine examination and then changed her story, claiming that the baby was delivered from a surrogate mother. As word reached police of a missing pregnant woman, they looked more closely at Pierce and she was arrested (*Porter, 2010*).[1]

AN ACCUMULATION OF CASES

Since then, there have been at least 30 incidents worldwide of pregnant women being kidnapped and their foetus forcibly removed via caesarean section, 4 in South Africa. *(National Centre for Missing and Exploited Children (NCMEC),2021; Unknown Gender History, 2021)*[2, 3]

In 2012 and 2013, 2 isolated cases occurred in Johannesburg, South Africa. A 30-day observation period was conducted at Sterkfontein hospital and both women were found to have no mental illness or defect (Section 77a of the CPA). They were found fit to stand trial (section 77b), and responsible for the offences on both legs (section 77c (able to appreciate the wrongfulness of the act and able to act in accordance with such appreciation).

They were subsequently found guilty of murder (x1 in the first case as the baby survived and x2 in the second case as both mother and foetus were killed) and imprisoned.

Ugash Subramaney

COMMONALITIES

ABDUCTION OF CHILDREN IS RARELY COMMITTED BY WOMEN. WHEN THEY DO, MENTAL ILLNESS OR INTELLECTUAL DISTURBANCE IS OFTEN AT PLAY.[7]

The abduction of unborn children, by forced caesarean section accounted for 6% of the total amount of infant abductions reported to NCMEC (2021).[2] Since 1987, in the USA alone, 23 cases were recorded.[8] All known cases of caesarean kidnapping have several things in common. Of the cases reported thus far, most perpetrators faked a pregnancy for many months, padded their clothes and convinced others of their pregnancies.[1, 6] Most purchased baby clothes and other items needed for a nursery, while many, like Jacqueline Williams and Effie Goodson, were given baby showers.[1]

Most of them used a confidence trick or deceit to manipulate their victims. (Josephina Saldana told Margarita Flores that she had a large supply of

diapers she was willing to donate to the pregnant woman. When Flores went to Saldana to pick up the diapers, she was killed and her baby removed;[1,9] Charnetta Simmons-Abduel met Elsa Kaiser at a medical clinic and claimed to be doing a survey, thus convincing Kaiser to go with her.[1]

In Laura Lugo's case, sisters Rosa and Paulyna Botello met her at a social event and persuaded her to drive from Texas to Mexico with them, where they claimed their obstetrician would treat her for free. At the clinic she was sedated and woke up with her baby and the sisters missing.[1]

Some of these women stalk their victims. Michelle Bica noticed pregnant Teresa Andrews while shopping and stalked her, eventually killing Andrews and burying her in a shallow grave.[1] Others simply abduct their victims. Peggy Jo Conner went to Valerie Oskin's home and beat her with a baseball bat then put the unconscious woman in a car, drove to a secluded area and performed the caesarean kidnapping.[1]

IN SEVERAL CASES, THE PERPETRATOR KILLED THE VICTIM'S OTHER CHILDREN TO ELIMINATE POTENTIAL WITNESSES.

Jacqueline Williams killed Lavern Ward's 2 young children. Tiffany Hall drowned Jimella Tunstall's 3 children after cutting her fetus from her womb.[1]

These perpetrators generally planned well, having duped their family and friends using fake sonograms and padded clothing, choosing a pregnant victim and extracting the infant safely.[1] Many did not know how to remove the umbilical cord. And several sought medical assistance, not thinking that a physician could tell whether or not a woman had just delivered a baby.[1]

MAKING SENSE OF IT ALL

So how do we understand these cases? What could make a woman murder another woman and rip her baby from her womb?

Resnick (1990) believes these abductions are due to "the maternal instinct run amok" a theory echoed by Stone (2000), who claimed that "motherhood is a prime function that mothers carry out -- that women carry out." In other words, these women have a biologically based drive to be a mother, at any cost. It is their reason for existing.[1]

Porter, however, finds this theory is problematic for several reasons. First, the infertility rate in women is rather high; about 9% of women of childbearing age worldwide. If the sole motivation for these acts was the uncontrollable desire for a baby, then this high infertility rate should mean widespread baby snatching by infertile women. Yet while infant kidnapping is a problem, it simply isn't a pandemic. Millions of infertile women worldwide adopt, engage in reproductive medical assistance or come to terms with their infertility without murdering other women and kidnapping their babies.[1]

The second problem with this argument is the concept of "maternal instinct". The terms "instinct" and "prime function" are suggestive that women are mere primates, subject to an oestrus cycle and hard wired for maternity. Instincts are fixed action patterns that control and define every member of a species. They are inherited, irresistible and unlearned.[1]

While humans are born with some reflexes, Porter believes we do not have drives that cannot be over-ridden; we do not have instincts, maternal or otherwise. Unlike lower mammals, we can choose our behavior and the use of the term "instinct" cannot be used in reference to human behavior. (Porter, 2020)[1]

The final problem with the above theory is the fact that many of these women were already mothers. 11 of the perpetrators had living children. Luzmilla Fierra was the mother of 6 children. Julie Corey was the mother of 5 children, Lisa Montgomery was the mother of 4 and Jacqueline Williams was the mother of 3 children.[1]

In the very first South African case (in Cape Town), the woman, now deceased, was actually pregnant at the time she abducted a baby girl. She spent years at Valkenberg as a state patient, one of the few that were found not fit and/or not responsible for the murder.

THE DESIRE FOR MOTHERHOOD COULD NOT HAVE BEEN THE ONLY MOTIVATING FACTOR IN THESE CASES.[10]

One of the most common reactions to reports of caesarean kidnapping is the presumption that the perpetrator must be insane. One might presume the perpetrator suffered from Pseudocyesis, a non-psychotic belief that one is pregnant. Symptoms can include abdominal and mammary swelling, amenorrhea, nausea and vomiting, and weight gain. Pseudocyesis was noted as far back as Hippocrates and generally is seen in women who are psychologically and medically naïve or are a member of a group that focuses on childbearing as the primary role for women.[1]

For these women, pregnancy becomes an idealized value to their sense of self and their bodies begin to react, sometimes even showing hormonal changes such as an increase in levels of Luteinizing hormone and Prolactin.[1]

There is no evidence that any of these women truly thought themselves pregnant.

When arrested, most of them admitted to the police that they were not pregnant, despite having consciously manipulated their friends and family into thinking they were.[1]

Michelle Bica forged a doctor's note instructing her to have complete bed rest. Lisa Montgomery, Katherine Smith and others printed images of

ultrasounds off the internet to convince people of their respective "pregnancies".[1]

Felicia Scott previously had a hysterectomy; Lisa Montgomery had a tubal ligation. These women were not under the delusion that they were pregnant but were consciously attempting to convince others that they were.[1]

For most of these women, there is little or no indication of insanity. On analysis, in 8 of the cases the perpetrator was given a psychiatric diagnosis; however further scrutiny showed only 2 cases involving psychotic symptoms.[1]

FEW OF THESE WOMEN HAD ANY HISTORY OF DOCUMENTABLE MENTAL ILLNESS. MOST PLOTTED THEIR CRIMES WELL AND MADE CONSIDERABLE EFFORT TO HIDE THE EVIDENCE OF THEIR CRIMES AND AVOID DETECTION. THEIR BEHAVIOR, WHILE HORRIFYING, WAS ORGANIZED AND GOAL DIRECTED, WHICH IS NOT SUGGESTIVE OF INSANITY.[1]

Porter considers how these women come to be this way. Did they develop such an extreme need for attention that they would kill in order to win the intangible brief rewards of new motherhood? Were they trying to make up for neglected childhoods?[1]

Few of their pre-crime stories have been made public and those that are available lack clear explanations to help us understand. The forensic observation process allowed us some insight into 2 of these women.

Most of them appear to have outwardly functional lives, had partners, friends, jobs, children. But it wasn't enough. They needed to be special, to be admired, even at the cost of another woman's life.

These women don't simply want a baby; they ***need*** one in order to secure all the rewards and privileges of motherhood.

These women so desired the attention, care and love that society gives pregnant women and new mothers that they were willing to kill to obtain it.

- *"Caesarean Kidnapping is a disturbing topic and the women who perpetrate these crimes appear beyond our comprehension. However, as we have seen, most of these women are neither insane nor hysterically pregnant. They so covet one stereotyped aspect of western female identity that they are willing to kill to obtain it. As long as some women view infants as a means towards obtaining this end role, these crimes are likely to continue." (Porter, 2010)*[1]

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EXERCISE AS TREATMENT FOR CHILDREN DIAGNOSED WITH ADHD

Eileen Africa

Attention Deficit Hyperactivity Disorder (ADHD) is one of the most commonly diagnosed heterogenous developmental disorders in childhood which persists into adulthood (Boshomane, 2020; Den Heijer *et al.*, 2020; Zang, 2020). In countries such as America, Australia and Africa, the prevalence of ADHD is not significantly different.

THE GLOBAL PREVALENCE IS AROUND 5.3% WITH APPROXIMATELY 1 IN EVERY 20 SCHOOL-AGED CHILDREN DIAGNOSED WITH ADHD IN SOUTH AFRICA (BOSHOMANE, 2020).

According to the Centers for Disease Control and Prevention (CDCP), ADHD is predominantly diagnosed in boys with the prevalence among boys being 12.9% compared to 5.6% among girls (CDCP, 2018).

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5); inattention, impulsivity, impaired inhibition, and hyperactivity are the most well-known symptoms of ADHD and must be present within a variety of settings. Inattention can refer to actions such as wandering off task, lacking perseverance, having difficulty sustaining focus, forgetfulness, and being disorganised, which affects everyday life. Impulsivity can include characteristics such as fidgeting, inability to engage in activities calmly and quietly, talking excessively, and finding waiting a big challenge (APA, 2013).

Eileen Africa

Children diagnosed with ADHD are often socially awkward, show signs of low self-esteem and self-confidence, are easily frustrated, and struggle in the schooling environment or system (Boshomane, 2020). These children struggle with low muscle tone, poor postural control, overall poor execution of motor tasks, and difficulties in both perception and self-regulation which affects their ability to control their emotions (Mehren, 2020).

EARLY INTERVENTION IS KEY IN TREATING ADHD SYMPTOMS; IN ADDITION, THERE ARE A VARIETY OF EFFECTIVE TREATMENTS AVAILABLE.

Prescribed stimulant medication has been accepted as the most popular applied medication to control the symptoms of ADHD. Research shows that it increases attentiveness and academic performance, as well as reduces anti-social behaviour and impulsivity. However, long-term and potential side-effects of these medications are still unclear. Non-pharmacological treatments such as cognitive training, neurofeedback, behavioural therapy, diets, and combined interventions exist, however research conducted on these treatments is limited (Lara, 2012; Den Heijer *et al.*, 2017; Vysniauske et al., 2020).

THERE IS THUS AN EMERGING NEED FOR A COST-EFFECTIVE AND EASY TO ADMINISTER APPROACH AS AN ALTERNATIVE OR A SUPPLEMENTARY TREATMENT METHOD FOR CHILDREN DIAGNOSED WITH ADHD.

The Exercise is Medicine® (EIM)'s global health initiative promotes physical activity (PA) as a requirement in clinical care for everyone, regardless of their capabilities (ACSM, 2021). Exercise and medicine are very similar in nature, given that they must both be explicitly prescribed in an exact dosage specific to the individual (Swisher, 2010). Exercise is, nevertheless, not a miracle cure for ADHD, but a promising method with the potential to reduce the need for prescribed stimulant medications (Klil-Drori & Hechtman, 2020). To reap the benefits, you need to exercise in the correct manner and engage in the appropriate treatment dose (Lara, 2010). Furthermore, the social, cognitive, and coordinative demands of PA serve as an excellent facilitator in dealing with the motor difficulties in children diagnosed with ADHD (Den Heijer *et al.*, 2017).

The health benefits of PA and exercise are well known and include better planning and problem-solving ability, decreased impulsivity, reduced anxiety and improved attention. (Lara, 2012; Den Heijer *et al.*, 2017; Rassovsky, 2019; Vysniauske et al., 2020). It is therefore a worthy option to be added as part of the holistic treatment process for children with ADHD.

Activity type, however, is very important and careful consideration needs to be paid towards the programme selection for each individual child. These activities ought to be part of the child's daily routine. A variety of old and new functional skills should be included, and detailed and quantifiable goals must be specified (Lara, 2010).

It is worth noting that for exercise to be an effective treatment method, it needs to be scientifically prescribed to meet the needs of the individual and their corresponding outcome goals. It is not just simply the movement of the body in an organised way, but a well-structured and planned programme that uses PA as a means to contribute to the individual's quality of life and alleviate symptoms that suppresses the quality thereof. Complex and controlled movements have a greater impact on functional outcomes in children diagnosed with ADHD when being compared to generic and repetitive aerobic activities such as treadmill exercises. Activities that strive towards this optimal balance between complex and controlled movement include martial arts, ballet, gymnastics, rock climbing, and mountain biking (Lara, 2012).

The most beneficial form of PA, however, involves a combination of both aerobic and anaerobic activities through a variety of movements and motor skill opportunities (Vysniauske *et al.*, 2020; Zang, 2020). This combination has been shown to yield better results than exclusively performing only aerobic or only anaerobic activities in isolation. Examples of aerobic activities include running, swimming, and cycling; all of which require long bouts of oxygen intake. On the other hand, anaerobic activities rely on alternative energy sources in order to achieve movements denoted by strength and power. Examples of this activity type include push-ups, pull-ups and jumping.

According to the World Health Organisation (WHO), children between the ages of 5 and 17 years are advised to engage in a minimum of 60 minutes of daily moderate PA. A further addition of vigorous activity, no less than 3 times per week, is also recommended (WHO, 2021). In addition, it has been seen that greater benefits are achieved when PA is maintained for a continuous period of a minimum of 20 minutes (Chang *et al.*, 2012).

There is however, still not enough research being done regarding PA and exercise for children with ADHD, along with the best possible intervention method for them. Nevertheless, doing any form of PA is better than engaging in sedentary behaviours. Until further research is conducted on this topic, having a child moving, playing, and learning new motor skills will be more beneficial than not.

PHYSICAL ACTIVITY IS A SAFE AND EFFECTIVE ADHD SYMPTOM MANAGEMENT METHOD, IS EASY TO IMPLEMENT AND FOLLOW, HAS ESSENTIALLY NO SIDE EFFECTS, AND IS MORE AFFORDABLE THAN MOST OTHER INTERVENTION METHODS.

However, the following needs to be taken into consideration when planning future research: participants in most of the literature reviewed were predominantly boys, which might direct the research to biased gender findings, most intervention programmes within the literature differ in both duration and frequency, leading to varied PA and fitness responses and the study samples' ages also varied widely which makes generalisations difficult due to the presence of different natural abilities and skill development across ages (Neudecker *et al.*, 2019). Further research done on ADHD and PA

in children needs to be age-specific and cover all developmental age ranges to get a more accurate result of intervention affects.

CURRENT RESEARCH ALSO OFTEN FAILS TO DECLARE MEDICATION STATUS OR COMORBIDITY PRESENCE IN THEIR PARTICIPANTS.

It is important to take this into consideration as well, not only to understand the body's adaptions and the relevant timeframe thereof, but also to avoid any serious side effects throughout the intervention period.

"The truth is, there is no such thing as 'normal', there are just a series of spectrums on which we all fall and how 'normal' we are is largely determined by how well our strengths and weaknesses match the social norms of the times we live in".
– R Boyce

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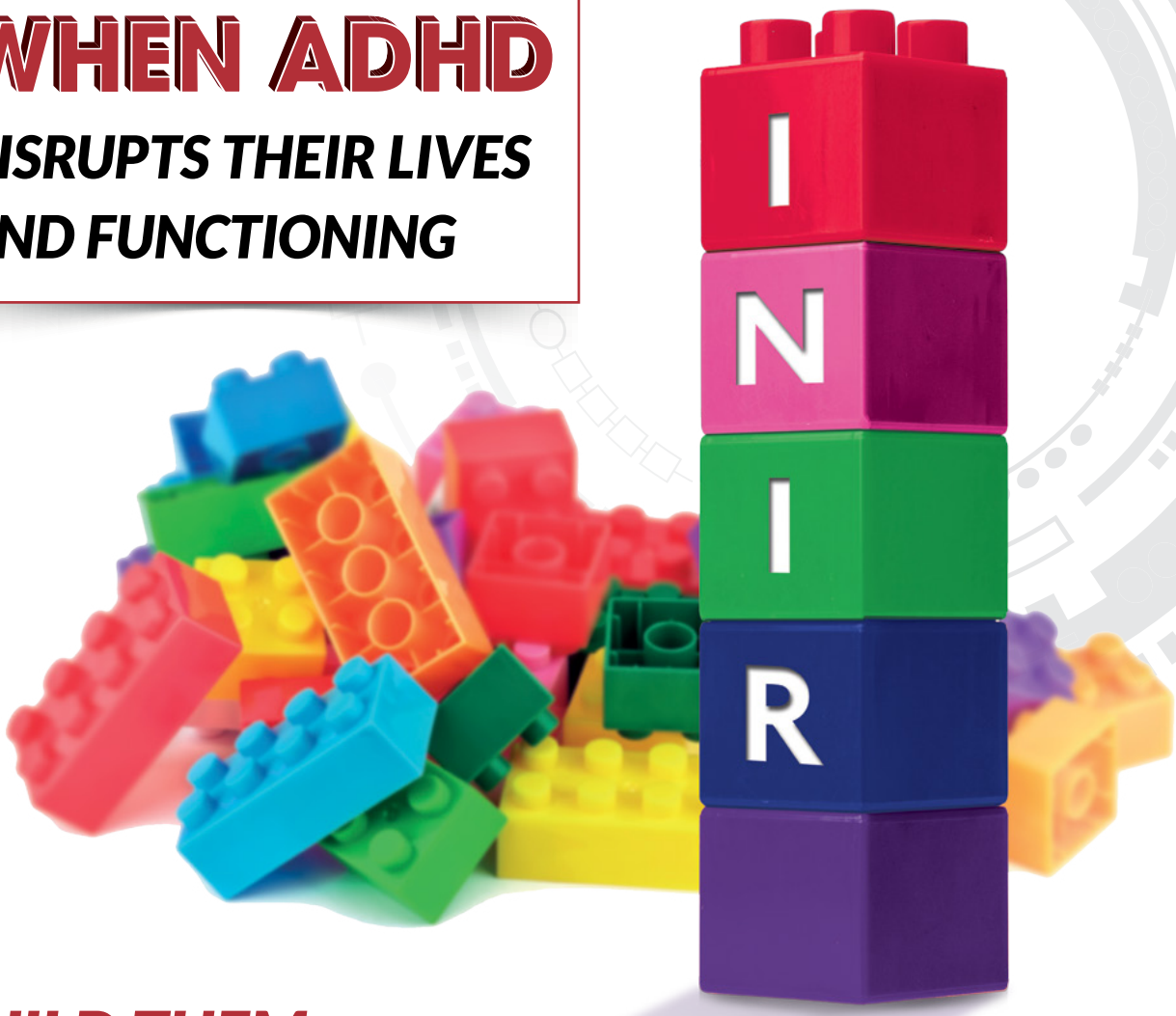
A PERSONAL WORD FROM EILEEN:

I received my PhD in Sport Science in December 2006 from Stellenbosch University and began my career in January 2007 at the same University. I started my research journey in the field of gross and fundamental movement skills development in 2004 and continued in the field of adolescent health. I made a U-turn in 2007 where I re-directed my focus to early childhood development, physical activity, gross and fundamental movement skills for all children and became increasingly interested in and fascinated with special needs. In 2009, I initiated the Honours Kinderkinetics programme at the Department of Sport Science, Stellenbosch University. I am currently still the coordinator of the programme and delivered 109 honours, 13 Masters students and 1 PhD student since the programme started.

I am a member of the International Motor Development Research Consortium (IMDRC) as well as the South African Professional Institute for Kinderkinetics (SAPIK). I am also the co-founder and –president of the International Motor Behaviour Society (IMBS). In addition, I serve on the panel of experts for Virgin Active South Africa. Furthermore, I have 5 social impact projects servicing the traditionally underserved communities in and around Stellenbosch, giving students the opportunity to strengthen connections and empower communities

WHEN ADHD

DISRUPTS THEIR LIVES AND FUNCTIONING



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DIGITAL HEALTH INTERVENTIONS AND ADHD MANAGEMENT

Hugo Theron

This article explores the possibility of using digital health interventions (DHI) to manage Attention Deficit Hyperactivity Disorder (ADHD). According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), ADHD is defined as inattention and hyperactivity/impulsivity which is present in more than one setting (e.g. home and school) and which leads to various negative outcomes in terms of social, educational and work achievements (APA, 2013). The condition is associated with negative outcomes for individuals, families, and society (Păsărelu, Andersson & Dobrean, 2020). ADHD is one of the most prevalent paediatric mental health disorders (Kollins et al., 2020).

The updated practice guidelines of the American Academy of Pediatrics (AAP) stipulates that the current treatment option for children (6-11 years) with ADHD is medicine and/or behaviour therapy with preferably a combination of both (Danielson et al., 2018). There are, however, challenges involved in the preferred treatment, including difficulty in accessing healthcare services, unequal service delivery, medication side effects that may lead to non compliance and a shortage of trained paediatric mental health practitioners who can deliver behavioural interventions (Kollins et al., 2020; Danielson et al., 2018; Davies, 2014). Digital Health Interventions (DHI) may be a possible viable alternative in the treatment of ADHD.

Hugo Theron

DHI can be grouped into three categories: (i) game-based digital therapeutic devices (games), (ii) smartphone applications (apps), and (iii) wearable technologies like augmented reality glasses, virtual reality headsets and fitness wearables (e.g. Apple watch, Samsung Gear watches and Fitbits).

Currently there are not enough empirical studies to support the use of DHI for managing ADHD, but evidence in favour thereof looks promising (Pandian, Jain, Raza & Sahu, 2021; Păsărelu et al., 2020).

NEUROPATHOLOGY OF ADHD

UNDERSTANDING THE NEUROPATHOLOGY OF ADHD IS VERY IMPORTANT WHEN CONSIDERING THE EFFECTS OF DHI FOR ADHD. THE BRAIN CHANGES OBSERVED IN ADHD PATIENTS CAN BE CATEGORISED AS (I) ANATOMICAL, (II) FUNCTIONAL, AND (III) CHEMICAL.

Anatomically, a 5 to 10% reduction/loss of brain volume in the prefrontal cortex and basal ganglia can be observed in ADHD patients (Seidman et al., 2006; Makris et al., 2007; Shaw et al. 2006, Dickstein et al., 2006) leading to an asymmetry of the brain (Giedd et al., 2001; Castellanos et al., 2002; Sowell et al., 2003; Jacobson et al., 2018). Furthermore, decreased blood flow to the striatum is also observed (Kliegman & Geme, 2019).

ON A FUNCTIONAL LEVEL, FMRI STUDIES HAVE INDICATED THAT ADHD AFFECTS HIGHER-LEVEL COGNITIVE AND SENSORY-MOTOR FUNCTIONS (CORTESE ET AL., 2012; THAPAR & COOPER, 2016).

In terms of chemical changes, catecholamine metabolism (dopamine and epinephrine) plays a key role in ADHD pathology. It is an imbalance between these neurotransmitters (i.e. increased epinephrine and decreased dopamine) that leads to ADHD (Thapar & Cooper, 2016; Arnsten & Pliszka, 2011). Current treatment of ADHD mainly involves drugs that target this chemical imbalance (Pandian et al., 2021).

DHI AND THE BRAIN

VIDEO GAMES

It has been shown that video games can improve cognitive functioning by increasing working memory, processing speed and attention (Lenartowicz et al., 2015; Shams et al., 2015).

PLAYING VIDEO GAMES CAN LEAD TO AN INCREASED DOPAMINE RELEASE (SHAMS ET AL., 2015). FURTHERMORE, IT HAS BEEN INDICATED THAT VIDEO GAMES CAN ALTER REWARD PROCESSING (SHAMS ET AL., 2105).

Various studies have shown that video games can change the structure of the brain by (i) increasing the volume of grey matter in the hippocampus, dorsolateral prefrontal complex, and cerebellum (Shams et al., 2015; Kuhn et al., 2014), (ii) increasing blood flow to the cerebral cortex (Shams et al., 2015; Voss et al., 2012), and (iii) increasing the plasticity of white matter (Shams et al., 2015).

Apart from these brain changes, video games may also have motivational, social, and emotional benefits (Granic et al., 2014). The wider medical community is also interested in the benefits of video games, and it has been tested in the field of oncology with a game called *Re-Mission* (Granic et al., 2014). Children who played this game showed increased compliance with treatment, greater self-efficacy, and increased knowledge about cancer (Kato et al., 2008).

A video game called *EndeavorRx* is the first of its kind for ADHD treatment in 8- to 12-year-old children. The treatment is delivered through an immersive video game experience on iPhone or iPad devices. It uses sensory stimuli and simultaneous motor challenges to target areas of the brain that play a key role in attention function. The game requires cognitive focus and flexibility, along with the ability to filter out distractions. The difficulty level adapts in real-time to ensure that the child is continuously challenged. *EndeavorRx* is an FDA-approved medical device and must be prescribed by a healthcare professional.

IT IS NOT INTENDED AS A SUBSTITUTE FOR MEDICATION WHERE A CHILD IS ALREADY ON MEDICATION.

SMARTPHONE APPLICATIONS

Digital innovations in the forms of games, wearables and apps have become new promising paths in dealing with a diversity of mental health problems in both adult and child/adolescent populations (Mohr et al, 2013). Mental health apps can be cost-effective (Powell, Chen & Thammachart, 2017) as well as impact-effective. Research regarding the effectiveness of mobile apps designed for ADHD is, however, still scarce (Păsărelu et al, 2020).

WHEN CONSIDERING APPS TO TREAT ADHD, IT IS IMPORTANT TO REMEMBER THAT NOT ALL THESE APPS WILL TARGET THE SAME THING AND NEITHER DO ALL OF THEM HAVE THE SAME QUALITY, DESIGN, OR SCIENTIFIC BASE.

Păsărelu and colleagues (2020) reviewed 109 ADHD apps that can be divided into two categories: (i) apps for screening or assessment of ADHD, and (ii) apps that aim to be treatment strategies. The latter category includes apps for monitoring pharmacological treatment as well as self-help and psychosocial treatment apps.

Of the apps designed for screening/assessment, the authors identified several promising ones. *ADHD Self Test* is an app designed for adult ADHD self-assessment, while *ADHD Test* is designed for parental rating of ADHD symptoms. *The Attention Deficit ADHD Test* can be used by parents to rate their child's symptoms or their own symptoms. *ADHD Medtest* is an assessment app that is designed to be used by parents and teachers to rate ADHD symptoms. Lastly, *Diva 2.0 V2* is an app designed for clinicians who assess ADHD. It is a semi-structured interview that is based on DSM-IV criteria for ADHD.

Regarding the apps that can be used to monitor pharmacological treatment, the authors mention *ADHD Health Storylines* (an app used

by adults with ADHD to track their symptoms, moods, and medication treatment), ADHD Psychopharmacology (a complex app covering diagnosis and treatment that can be used by specialists), and ADHD Doctors (an app designed for professionals for ADHD assessment and patient tracking).

WITH REGARDS TO THE SELF-HELP APPS AND THOSE USED FOR PSYCHOSOCIAL TREATMENT, THE AUTHORS DIFFERENTIATE AMONG APPS INTENDED FOR PSYCHOEDUCATION, ORGANISATIONAL SKILLS TRAINING, AND COGNITIVE TRAINING.

In the psychoeducation category they recommend apps like *ADHD* and *ADHD in Children* that provide information about the disorder, causes and treatment options via animated videos. *ADHD Treatment* provides information about ADHD symptoms, causes and treatments. The authors recommend it for information about causes and symptoms but identified some shortcomings regarding the treatment options provided.

Other psychoeducation apps that are recommended by the authors are *ADHD Angel*, *ADHD Guardian Angel* and *Jumpy car* (a gamified app about ADHD symptoms, causes and treatment).

In the organisational skills training category, the authors mention apps like Visual Schedule and *ADHD Notebook* and in the cognitive training category, *ADHD Trainer* and *ADHD Adult Trainer*.

Tracto, a new app developed in South Africa, allows parents of children with ADHD, their teachers, as well as their clinicians, to collaborate on information pertaining to the child and ADHD. This information provides much-needed assistance to parents in managing their child's behaviour and treatment. The app also enables clinicians to access invaluable longitudinal data on their patients that can be used for more integrated decision-making in so far as treatment is concerned (https://www.tracto.app).

CHALLENGES AND LIMITATIONS

DIGITAL INEQUALITY IS STILL A BIG PROBLEM WHEN IT COMES TO THE USE OF DHI FOR TREATING MENTAL DISORDERS IN GENERAL, AND ADHD SPECIFICALLY.

Further research is also needed to assess the viability of treating ADHD with DHI. Studies that include larger sample sizes and longer follow-up periods may provide valuable insights, as could randomised blind studies.

LASTLY, THE REAL-WORLD EFFECTIVENESS OF GAMES AND APPS IN THE TREATMENT OF ADHD REMAINS TO BE PROVEN.

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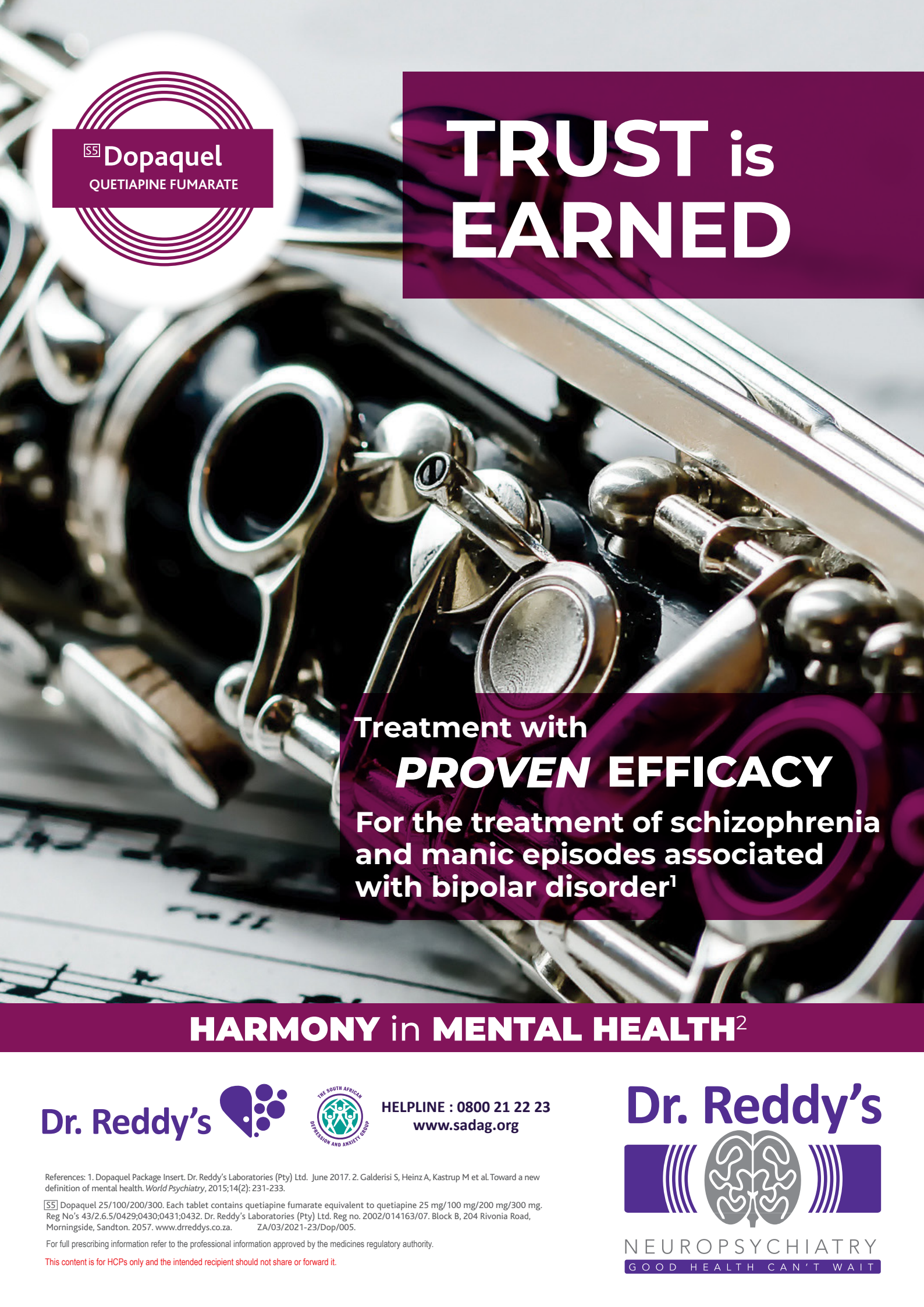

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THE BIG AND SMALL OF ADHD: WEIGHT RELATED MATTERS

Richard Sykes

In 2002, Altfas *et al*., published the first scientific data indicating the probable relationship between ADHD and obesity.[1] Subsequent research that occurred in the following 19 years, has established that there is a significant association between ADHD and overweight/obesity.[2,3]

RESEARCH HAS SHOWN THAT HAVING ADHD IS ASSOCIATED WITH A 3.8 TIMES HIGHER RISK OF OBESITY.[2]

The Swedish national register in 2018, which included over 2.5 million people, showed that the risk of obesity was three times higher in individuals with ADHD than their non-ADHD siblings and cousins.[4]

THE INCIDENCE OF COMORBID ADD/ADHD IN RELATION TO SEX/GENDER

A national longitudinal study of adolescent to adult health was conducted in the USA in 2019. The study included a large sample of 13 332 participants, between the ages of 12 to 34 years. It was found that ADHD presenting as hyperactive/impulsive, both males and females, had a significantly higher BMI, but in the inattentive type, only females had a significantly higher BMI.[5]

Richard Sykes

WHY DOES THE AVERAGE INDIVIDUAL STRUGGLE TO REACH/MAINTAIN A HEALTHY WEIGHT?

Weight management is challenging for most individuals, regardless of their mental health status. The three most common factors attributed to this challenge are: an obesogenic environment, behaviour of the individual, and individual biology.[6,7,8]

A SUCCESSFUL WEIGHT LOSS STRATEGY IS HIGHLY DEPENDENT UPON THE PATIENT'S/PARTICIPANT'S MOTIVATION AND COMMITMENT (EXECUTIVE FUNCTIONS) TO THE WEIGHT LOSS PLAN.[9,10,11]

Reward processing has long been known to be essential to the reinforcement learning cycle, i.e., when rewarded for a specific behaviour, that behaviour is linked with a reward value which inspires repetition in future.[12]

WHY IS IT HARDER FOR ADHD INDIVIDUALS TO ATTAIN AND MAINTAIN A HEALTHY WEIGHT?

NEURO-BEHAVIOURAL DYSFUNCTIONS IN ADD/ADHD

In 2015, Faraone *et al.*, identified four dysfunctional areas of neuro-behaviour that overlapped in ADHD, obesity and binge eating. These neuro-behavioural areas included: reward processing; response inhibition; emotional processing, and emotional/self-regulation, all of which are integral to adopting and maintaining a healthy diet and exercise program.[13]

Reward processing:

In ADHD, the ventral striatum,[14] prefrontal cortex,[14] caudate nucleus,[13,14,15,16] globus pallidus,[14] and cortico-basal ganglia,[14,16] in the brain that are involved in reward processing, are smaller than normal.

THERE IS A HIGH DENSITY OF DOPAMINE RECEPTORS IN THE CAUDATE NUCLEUS, GLOBUS PALLIDUS AND THE BASAL GANGLIA, IN THE AVERAGE INDIVIDUAL.[15] THE REDUCED SIZE OF THESE STRUCTURES IN ADHD RESULTS IN SIGNIFICANTLY FEWER DOPAMINE RECEPTORS IN THESE AREAS OF THE BRAIN THAT ARE ESSENTIAL TO THE OPTIMAL FUNCTIONING OF THE DOPAMINE REWARD PATHWAY.[13,15]

Furthermore, impaired dopamine signaling is present in ADHD and leads to delayed reinforcement sensitivity in response to a reward.[14,17]

The decreased number of dopamine receptors combined with the lower sensitivity of the dopamine receptors/markers that are present in ADHD, lead to the need for a higher level of stimulus for the ADHD individual to attain the same reward as would be experienced in normal individuals.

Response inhibition:

Response inhibition, otherwise known as impulse control is the ability of an individual to resist an innate urge to respond to a stimulus in a certain way and deliberately suppress an action or behaviour to achieve a set goal.

THE AREAS OF THE BRAIN THAT CONTROL SUCH IMPULSE CONTROL ARE SMALLER IN ADHD THAN NORMAL. SUCH DIMINISHED AREAS CONTROLLING RESPONSE INHIBITION ARE THE PREMOTOR AND PREFRONTAL CORTEX,[13,14] STRIATAL AND SUBCORTICAL AND FRONTOTEMPORAL REGIONS OF THE CEREBELLUM.[13,14,16]

The levels of gamma-aminobutyric acid (GABA) – the neurotransmitter that controls inhibition – are significantly lower in ADHD.[18] Adequate levels of GABA facilitate one's ability to resist behaviour that could be detrimental in the long-term, despite immediate or short-term reward/pleasure.[18] In ADHD, practicing such resistance is substantially more difficult because of the effects of inadequate GABA levels combined with the impaired dopamine reward pathway.[13,14,15,17]

IT CAN THUS BE ASSERTED THAT THE INDIVIDUAL WITH ADHD DOES NOT RECEIVE APPROPRIATE SIGNALS ALERTING HIM/HER TO POTENTIAL LONG-TERM HARM AND IS DRIVEN BY THE SHORT-TERM REWARD WHEN MAKING DECISIONS ABOUT EATING AND PHYSICAL ACTIVITY.

Emotional processing and regulation:

Appropriate interpersonal behaviour, optimal academic achievement and effective adaptive skills are all dependent upon effective emotional processing.[19] Emotional processing and regulation are the core neuro-behavioural functions that enable an individual to adapt his/her emotional state in such a way as to promote behaviour/s that will facilitate a personally important specific goal.[19]

When the individual is placed in a position where he/she is not able to adapt emotional dysregulation occurs, which leads to behaviour which is incongruent with the individual's intended goal/s and best interests.[19,20,21]

Areas of the brain, responsible for emotional processing and regulation that have decreased volume in ADHD are the: prefrontal cortex,[13,14] ventral striatum,[13,14] amygdala,[13,16] basal ganglia,[13,14,16] and cerebellum.[13,14]

PATHOLOGICAL EATING BEHAVIOURS

Due to the decreased inhibitions and seeking immediate reward,[13,18] those with ADHD are vulnerable to the temptation of comfort eating. Comfort food is simple food that reminds one of past times that evoke feelings of happiness and calm. An extension of eating for comfort is the phenomenon of "*nostalgic*" eating.

EATING CERTAIN FOODS CAN BE A NOSTALGIC EXPERIENCE WHICH BRINGS BACK MEMORIES OF POSITIVE PAST EVENTS. THIS NOSTALGIC EATING ELEVATES FOOD FROM SIMPLY JUST A COMFORT IN THAT IT FOSTERS A SOCIAL, COGNITIVE AND EMOTIONAL REPRESENTATION OF SIGNIFICANT INDIVIDUALS AND PAST EVENTS.

In some instances, consumption of certain foods is associated with "*loved ones*", such as: valued family members, friends and social acquaintances.[22] When feeling isolated, these individuals attempt to feel closer to "loved ones" through consumption of comfort foods.[22]

Roberto Olivardia coined the term: "*Procrastin-eating*". The theory behind this term is that eating is a form of avoidant behaviour, which is used to take up time and delay addressing an undesirable/ unpleasant activity.

POOR INTEROCEPTIVE AWARENESS

Interoceptive awareness is the individual's interpretation of the body's cues to its physiological needs, for example: hunger, thirst tiredness, discomfort due to hot/cold, etc.[23] An individual's interoceptive awareness is closely related to his/ her ability to successfully tackle life challenges and adapt to the unpredictable nature of life.[24]

IN ADHD, THE INTEROCEPTIVE INTERPRETATION OF INTERNAL CUES IS EASILY IMPAIRED, LEADING TO THE MISINTERPRETATION OF A PHYSIOLOGICAL CUE, OFTEN AS HUNGER, AND THUS THE INDIVIDUAL TURNS TO FOOD TO FULFILL THE CUE THAT HAS BEEN MISREAD.[23]

DISRUPTED CIRCADIAN RHYTHM

Adults with childhood-onset ADHD present with a delayed circadian rhythm combined with increased alertness in the evening.[24] Up to 75% of adults with childhood-onset ADHD exhibit a delayed circadian rhythm phase, presenting with: a rise in salivary dim-light melatonin onset (DLMO); an altered core body temperature; altered actigraphy-measured sleep-related night-time movements (+/- 1.5 hours later); delayed rise in early morning cortisol, than healthy controls later than healthy cohorts.

IN ADDITION, ADULTS WITH CHILDHOOD-ONSET ADHD EXHIBIT A DELAYED CIRCADIAN RHYTHM WHICH IS ASSOCIATED WITH A DIFFICULTY INITIATING AND MAINTAINING SLEEP; THE ACCUMULATED SLEEP DEBT; DAYTIME SLEEPINESS AND THE DISRUPTION OF THE TIMING OF MEALS AND ROUTINE ACTIVITIES.[25]

GENETICS

Research in this field has indicated that ADHD-related genetic alterations may foster an obesogenic environment and contribute to behaviour that leads to weight gain. The genetic correlation between ADHD and obesity/overweight should, however, not be interpreted in isolation, but rather within the context of situational and environmental factors of the individual ADHD patient.

Research by Barker *et al.* (2019), has found significant associations between the phenotypes (and their respective polygenic risk scores) between the trait of impulsivity specific to ADHD and BMI.[27] Karhunen *et al.* (2021), found a genetic link between ADHD and obesity. The risk of obesity needs to be considered when treating ADHD symptoms and ADHD screening is advisable for children and adolescents seeking care for obesity, due to the shared genetic liability.[28]

ONGOING RESEARCH TO TRY AND DETERMINE THE RELATIONSHIP BETWEEN THE LEVEL TO WHICH GENETICS LINKS ADHD AND OBESITY/OVERWEIGHT IS EXTENSIVE, THE CORRELATION IS COMPLEX AND THERE IS MUCH NEED FOR FURTHER RESEARCH IN THIS FIELD.

THE RISK OF OBESITY IN UNTREATED ADHD

A meta-analysis untertaken in 2016, included a large sample of nine studies of adults with ADHD (> 45 000 participants) and 15 studies of children and/or adolescents (> 400,000 participants).[29] It was found that adults with ADHD that were not treated were 50% more likely to be overweight or obese. Unmedicated children and/or adolescents with ADHD were 20% more likely to be overweight or obese.

ADHD MEDICATION IN RELATION TO WEIGHT

Stimulants are the first-line pharmacological treatment for ADHD and their effectiveness has been widely demonstrated.[30] One of the most common side effects of stimulant medication is diminished appetite. One would thus expect that most stimulant-treated ADHD patients would be either underweight or normal weight.[30]

IN CONTRAST TO THIS ASSUMPTION, SCIENTIFIC RESEARCH HAS SHOWN THAT MOST ADHD-INDIVIDUALS ARE LESS PHYSICALLY ACTIVE, EAT LESS HEALTHY FOODS, AND HAVE HIGHER BMIS THAN HEALTHY COHORTS.[31]

In addition, a positive correlation between long-term treatment with stimulants and negative effects of growth trajectories and an increase in both weight and body-mass index (BMI) has been shown in the research.[30,31]

PRACTICAL ADVICE FOR MEDICAL PRACTITIONERS AND THEIR PATIENTS

The following guidelines may offer some insight for ADD/ADHD patients:

1. Planning:
   - Set a time aside on one day, each week to write a meal plan for each day of the week.

2. Breakfast:
   - Commit to a "break the fast" plan, to fire up your metabolism.
   - Include proteins at breakfast (Proteins help satiate appetite until lunchtime).

3. Preempt "night owl" behaviour:
   - Anticipate the high likelihood of your nighttime binge eating.
   - Plan other activities that you enjoy, for times when you may be tempted to eat at night.

4. Be conscious and present at mealtimes:
   - Take time to be present when you are eating to be more conscious of how much you are consuming and try to recognize when you are full.

5. The food in your environment:
   - Don't let your pantry sabotage you.
   - Avoid having tempting high fat/sugar snacks in your home/kitchen.
   - Keep tasty, healthy snack foods in your kitchen (ready for when you want a snack).

CONCLUSION

- The association between ADHD and overweight/obesity has been clearly established.
- The relationship between ADHD and overweight/obesity is bidirectional, not simply unidirectional.
- ADHD AND OVERWEIGHT/OBESITY ARE INTIMATELY CONNECTED, FORMING PARTS OF A VAST AND INTRICATE MULTIFACTORIAL NETWORK.
- The genetic links between ADHD and obesity/overweight and eating disorders are at the early stages of scientific research. Future research in this field may offer valuable insight into this complex dynamic.
- Future (evidence-based) research is needed, regarding associations between ADHD and overweight/obesity, especially in the fields of genetics and neuro-behaviour to optimise the treatment and management of these patients.

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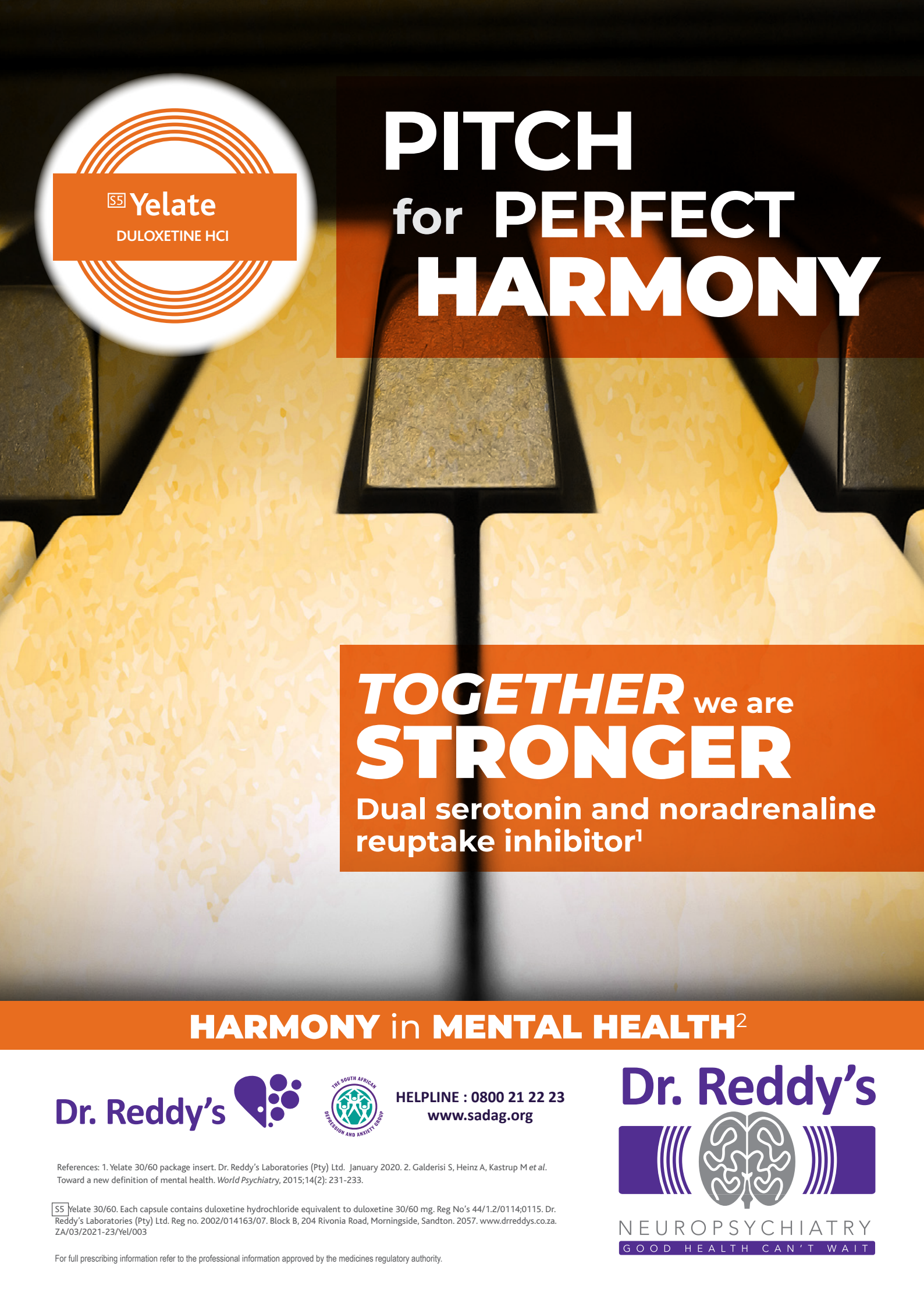

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CIVIL CLAIMS AND COMPENSATION

Volker Hitzeroth

In this article, the fourth of a medicolegal series of articles, Dr Volker Hitzeroth will explain and clarify the events and processes relating to a claim in alleged clinical negligence.

The practice of medicine entails assessing, treating, and caring for the unwell. This endeavor is not without risk and unfortunately adverse incidents and unpropitious outcomes are part and parcel of our daily clinical practice. Health Care Practitioners (HCPs), by the nature of their profession, are engaged in a risky occupation where much remains unknown, and many aspects are little understood. Similarly, many clinical trajectories are unpredictable, and outcomes are unforeseeable. Sadly, patients occasionally also experience unexpected and unfortunate complications. Of course, if the ultimate outcome is serious and a patient has suffered a harm or an injury, they or their family may seek financial redress by instituting a claim in clinical negligence.

CLAIM IN ALLEGED NEGLIGENCE:

A patient who believes that the treatment they received was negligent and caused them harm or injury has very few options available to receive financial redress. Whilst attempts to incorporate a culture of early mediation into the South African discourse are in their infancy, they show signs of promise and may alleviate significant delays, frustrations, and heartache in the future. In the absence of a firmly established alternative dispute resolution framework the current process to access monetary compensation involves the patient having to institute a claim in alleged clinical negligence against the relevant and implicated service providers which may include, but are not limited to, the treating practitioner, the hospital group, the pathology service, or radiology group.

The law of delict refers to civil actions brought by, and against, individuals or corporates to seek compensation for an alleged harm or injury. A civil claim in alleged negligence is therefore an attempt by the injured party to protect their interests and enforce their rights.

Volker Hitzeroth

A claim in negligence is initiated by the patient or their family (now referred to as plaintiffs) issuing a "Letter of demand" and/or a summons in which they set out the background facts of the matter, the allegations of negligence and finally a list of injuries or harms that have resulted from the alleged negligent conduct. The list of injuries and harms is usually converted into a monetary value of damages which the practitioner (referred to as the defendant) is expected to pay within 10 working days. Upon receipt of a summons or "Letter of Demand" the HCP would be wise to seek urgent legal advice.

IF THE PRACTITIONER MAINTAINS THAT THEIR CONDUCT WAS NOT NEGLIGENT THEN THEIR LEGAL REPRESENTATIVE WOULD ISSUE A "NOTICE OF INTENTION TO DEFEND".

Thereafter a formal response to the allegations is filed (a plea) and several further clarifications and communications may occur to flesh out particulars and other relevant information while each side investigates the issues, positions themselves, assesses the opposition's position, and decides on the most appropriate strategy going forward.

To succeed with their claim in alleged negligence the plaintiff must satisfy several legal hurdles. These are:

1. **Duty of care:** they must prove that the HCP had a duty of care towards the plaintiff.
2. **Breach:** they must prove that the HCP breached the reasonable standard of care that can be expected from a reasonable practitioner in a similar situation.
3. **Causation:** they must prove that the injuries sustained due to the HCP's alleged negligence were in fact caused by the acts or omissions of the HCP.
4. **Quantum:** it is also prudent to investigate the monetary demands and hence ensure that the claim has been correctly quantified and is not overvalued.

As it is difficult to establish what a reasonable HCP in the same situation would have done the courts have to rely on the opinion of an appropriately qualified and experienced colleague (the expert) in order to determine whether an HCP acted negligently. It is therefore not unusual for both parties to the dispute to instruct an expert to review the whole matter and opine on the HCP's conduct. An expert is deemed to be objective and serves the court and not either of the two parties.

IT MAY BE THAT DURING THIS LENGTHY PREPARATORY PROCESS THE PLAINTIFF DECIDES TO ABANDON THE CLAIM, IN WHICH CASE IT IS WITHDRAWN OR NOT PURSUED.

Alternatively, the HCP in conjunction with their legal advisers, decides that they are vulnerable to criticism and may make an offer of settlement which in turn may be accepted or rejected by the plaintiff. Such an offer of settlement is usually made without an admission of liability, includes a clause that brings the matter to a finality and would usually also include a confidentiality clause.

Ultimately, if both parties remain confident in their position and firm in their views the matter would proceed to trial where the two parties argue their case before a judge. Each party is provided an opportunity to state their case, present their expert opinion, be cross examined, and make closing arguments before the judge reaches a conclusion based on the balance of probabilities. To be successful at a civil trial the parties must prove, on the balance of probabilities (at least a 51% of probability), that their version of events is true and correct. There are no degrees of clinical negligence. An HCP is either negligent or not - they are either guilty of negligence or not. Any "degree of negligence" may only become relevant and might count in mitigation and / or sentencing.

If an HCP is found guilty of negligence and the negligence is responsible for the harm claimed for, they are obliged to pay for the damages claimed, the plaintiff's and their own legal costs which would usually be defrayed to the HCP's medicolegal indemnity or insurance provider. If the HCP does not have appropriate or adequate medicolegal indemnity or insurance the amount payable would be for their own account. Such a financial burden may easily reach into multiple million rands. In high claims this amount could reach ten or twenty million Rands. In such an event, any HCP without adequate indemnity or insurance is likely to face financial ruin. Alternatively, if an HCP is found not guilty of negligence, they are not obliged to pay any damages or costs to the plaintiff and may reclaim their own legal spend from the plaintiff.

IN ESSENCE THEREFORE A CLAIM IN ALLEGED CLINICAL NEGLIGENCE IS ABOUT AN HCP (NOT) KNOWING AND (NOT) CONDUCTING THEMSELVES ACCORDING TO THE REASONABLE AND EXPECTED STANDARD OF CARE AND (NOT) TAKING REASONABLE AND EXPECTED STEPS TO PREVENT HARM OR INJURY.

A claim is not an assault on the HCP's integrity or moral values. Neither is it a punitive process. Rather, it is a convoluted legal conduit for reparations to be passed to the plaintiff to compensate for an injury or harm.

Unfortunately, a claim in negligence often becomes a long and drawn-out affair where the initial summons or "Letter of Demand" is issued a few years after the alleged injury while the whole tortuous legal process takes a further few years before completion. It is no surprise that many HCPs experience such a legal assault on their clinical acumen as extremely traumatic and suffer from elevated stress levels during, and even long after, the claim and trial have faded into the shadows of legal history. Many HCPs have, understandably and not unreasonably, compared this process to the peril of the proverbial sword of Damocles hanging above their head – constantly in their mind, burdening their clinical practice and affecting their interpersonal relationships. While there is little that can be said to ease this burden, it is worth reminding all HCPs that none of it is personal.

Additionally, having appropriate indemnity in place can provide an HCP with peace of mind that they would not face such an experience alone.

It is worth once again making the point that an HCP should contact their indemnifier immediately for advice if they receive a "Letter of demand" or if they have any concern about a potential claim.

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OF CARS AND CURVEBALLS, PLAYLISTS AND PATIENCE

Claudia Campbell

You know those good days – not spectacular ones, just good ones? Maybe a mid-month Wednesday, where the weather is fine, your family is well, your to-do list is perfectly manageable, your playlist is marvellous, and the traffic is smooth? At 16:30 you might have even briefly thought 'what a great day' – then, boom! A curveball happens and dominos the rest of your day into chaos. Your car engine breaks down in the middle of an intersection, you are crowded by tow-trucks, traffic police painfully labour through paperwork, your car is loaded on a truck, and you watch in horror as it disappears over the hill with your wallet and phone-charger. You cannot contact your spouse who was expecting you home an hour ago, your head is pounding from being under the hot sun, you have no transport. You are stranded, with no wallet and no cellular lifeline (your phone is now powerless). You are surrounded with strange people you must trust can help you, but whom you don't know.

ONE CURVEBALL AND YOUR DAY, YOUR WEEK, HAS SIMULTANEOUSLY EXPLODED AND IMPLODED INTO A MESSY HEAP. HAVE YOU EVER HAD ONE OF THESE DAYS?

Something metaphorically similar happened to me. Medically, unexpected curveballs were thrown my way over the last few months - with extensive repercussions. Smooth sailing tumbled into a cascade of falling dominos. The experience has again highlighted a human is so much more than the sum of its parts. Perhaps, a human should never be viewed as a set of parts, but always as one entity – a human. The singular 'Claudia' is more than a collection of my biological systems.

Claudia Campbell

I say this because the root cause of my recent ill health is endocrinological, however the most devastating symptoms are psychiatric and psychological – thank you PTSD. I can without doubt say that over the last 6 months I have experienced some of the worst physiological, PTSD and related symptoms in comparison to the last decade.

When an anaphylactic response to a non-allergenic substance arises, terms such as 'allosteric' are used, and peer-reviewed research leaves me feeling increasingly uncertain about what is happening, despondency can set in. Usually, I face medical challenges head on and manage to maintain a spirit of grit and resolve. As soon as I have a plan of action and clarity regarding who I need to be dealing with for the current situation, I'm quite calm. I know often treatment will be unpleasant, but that is okay when it is part of a plan with a fair chance of a hoped-for outcome.

For a long time, uncertainty was the certainty when it came to my body. However, over the last few years, we've learnt to predict much of what was previously unpredictable. I, for my part, think I may have become complacent – a little too confident in the relative physical and mental stability I've been enjoying. However, the curveball threw so much on its head. Not only did uncertainty and paradoxical reactions return, but they also came from new directions – areas that had never really been of much concern before.

Because of the root cause, suddenly symptoms my psychiatrist has treated for the longest time had to be addressed by my endocrinologist. However, it is my psychiatrist with the experience regarding the manifestation of my mental health symptoms – he is the one who knows how my brain handles situations, my emotional resolve, and frailties. It's been such a long psychiatrist/patient relationship that many aspects of 'me' don't need discussion, he simply knows. On the 21st of March 2010, I wrote: "Trust no one until they have proved trustworthy". My psychiatrist proved trustworthy. However, in my entirely subjective opinion, it is a bit unclear where he fits in now, and it has knocked my trust, out of no fault of his own. All this newness has disturbed the 'natural order' of things.

After numerous attempts to reach each other my psychiatrist and endocrinologist eventually managed to have a meeting about my situation. It highlighted again, how important doctor-to-doctor collaboration is, and how challenging the specialisation silos of private health care make collaboration. However, I feel it's essential to everyone's understanding of each other. Taking a patient's history is a critical part of any initial consultation, no matter the medical discipline. It is vital to understand why and how to treat, as well as why and how a patient might feel and react towards their diagnosis and treatment. In my view, doctor-to-doctor collaboration is the same, except it goes a step further. Any conclusions from the conversation about the patient need to be communicated to the patient. This goes a long way in building necessary trust and neutralising possible misgivings the patient might have; and I would venture to add, that the doctors might have.

MY HEAD HAS BEEN A VERY DANGEROUS PLACE RECENTLY, BUT RIGHT NOW IT SEEMS MY ALLOSTERIC REGULATION IS THE MOST DANGEROUS THING.

As mentioned, the horror of PTSD has been my primary presenting symptom of an endocrinological issue. My days and nights have often been filled with terrifying and grotesque flashbacks, accompanying overwhelming obsessive thoughts, and mental exhaustion from figuring out how to attempt to manage a functional life amid totally dysfunctional thoughts and feelings – or should I say peculiar allosteric reactions?

It took a long time for my psychiatrist's office to become a safe space for me to be vulnerable and feel secure enough to describe these types of experiences. My trust in his space is not only in being able to speak but also in knowing my psychiatrist will be able to react to what I'm saying, but not overreact. I have previously written about how, at times, it feels as if I am walking a tight rope, over a gorge, in a tornado. When PTSD episodes take up residence in my mind, my psychiatrist and I have learnt to walk the tightrope together. When paradoxical reactions and allergies surface, we've had to co-walk the tightrope, communication forming the foundation of semi-confident footsteps. On my part this requires total transparency about the events in my mind, those that for survivors of abuse are often saturated with shame and failure. It's hard to do that, and it's harder to be convinced that shame and failure have no place in this situation.

I tell you this, because recently I have had to find the resolution to be as transparent about the 'ugly' with my endocrinologist as I am with my psychiatrist – and quickly. I've had to find the resolve to expose that which I know is not shameful failure, but which feels that way when I tell a person I have not had to walk the mental-illness tightrope with. I trust my endocrinologist and his knowledge of my biological body but shining a spotlight on the darkest parts of my mind has felt excruciating. I don't think it's been easy for him either. I have felt lost sometimes, metaphorically stranded without a working phone, after my car has been towed, because my regular tight-rope cowalker is not next to me.

For years I have not really thought about whether it was right or appropriate to speak with my psychiatrist about whatever might have been going on. It is a strange and disorientating thing to wonder if I should be using up my psychiatrist's time for what might land up just being a conversation not a consultation, because he very well may not be the most appropriate doctor to treat me now. A conversation about symptoms, which clearly belonged in my psychiatrist's office may now belong in my endocrinologist's office – at least that's how it is if you look at the parts of the situation and not the one human entity, 'me'.

I don't think there is one thing which is going to settle the discomfort I feel. I think it is probably a process, that time, in its usual way, will prove the essential key. Time requires patience. Patience is tricky to find in a storm of psychiatric symptoms, or should I say a storm of odd allosteric reactions?

I've free-associated this writing with no specific goal in mind. I now wonder of what use it is to you the reader. I'm not sure. It is simply my story, my experience as a patient and nothing more. I hope perhaps it has stayed true to the name of this column: "Perspective". I hope too that by the time you read my next "Perspective" I will be in possession of my metaphorical charged phone, phone charger, wallet, and car again, driving down a smooth road, listening to a marvellous playlist.

Claudia Campbell holds a post-graduate degree in psychology and has 10 years experience in the field of corporate transformation strategy. Claudia has worked 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**

DEPARTMENTS OF PSYCHIATRY

UNIVERSITY OF THE WITWATERSRAND

Compiled by **Prof. Ugash Subramaney** Correspondence: Ugasvaree.Subramaney@wits.ac.za

BJVR MEMORIAL LECTURE

It has been business as usual at Wits, and the Department hosted Professor Catherine Burns who delivered the 2022 annual BJVR memorial lecture.

She spoke beautifully on "The bricolage of health and healing traditions in South Africa"

PSYCHIATRY UNIT CLOSURE

As we enter the second quarter of the year, the mood has been somewhat sombre due to the ongoing challenges in mental health care, and in particular the closure of the psychiatry unit at one of our hospitals, Charlotte Maxeke Johannesburg Academic Hospital

DEPARTMENT RESPONDS TO TIMESLIVE QUERY

The Department of Psychiatry at Wits recently responded to a Timeslive media query, that came from the WITS communications office. Prof. Subramaney, together with Dr Thuli Mdaka, the current SASOP Southern Gauteng branch Chairperson compiled a report in response to the questions that follow. Noting that full content is due to be published as a standalone journal article, with some modifications, below is an edited version of the responses:

What is the state of psychiatric care provided to patients at State medical facilities and how did the situation become like it is?

The provision of psychiatric care would encompass resources from **human capital** (psychiatrists, medical officers, registrars -these are trainee specialists; allied health care practitioners such as psychologists, social workers, Occupational therapists as well

as nurses) to **infrastructure** availability (clinics, hospital beds in acute facilities and hospital beds in specialised psychiatric hospitals and step down facilities and chronic care), **medication**, a reliable **information system** and an adequate **budget**.

We will comment mainly on the situation in Southern Gauteng, where the issue of availability of beds for psychiatric patients, acute and chronic, general, and forensic has been a challenge for a long time. We will also draw on publications relating to South Africa.

Of late, acute bed shortages i.e., need for admission as an acute admission - either voluntarily or involuntarily is rife and this has recently attracted media attention. There are many reasons for this situation, ranging from a historical perspective (previous Mental Health Act and the governance of how psychiatric patients were admitted; stigma (across all levels) infrastructure challenges at various sites; staff shortages; to current issues such as the closure of a major site that provides acute admission, recurring infrastructure challenges, an overwhelmingly increased need for mental health care with an additional influx of patients needing care from other African countries, ongoing stigma, international pandemic etc.

How many psychiatric specialists are there in SA, is there a shortage, what numbers should we have and what is the current ratio of state/private psychiatrist to psychiatric patient and what should the ratio be?

Publications related to this e.g., Janse Van Rensburg et al (2021) and the World Health Organization Global Health Observatory Data Repository have consistently found that this is a dynamic, everchanging number. Drawing from the national data base from the South African Society of Psychiatrists (SASOP) as well as the Health Professions Council of SA (HPCSA), Janse Van Rensburg et al (2021) reported thus:

In April 2019, there were 850 qualified psychiatrists actively practicing in the country and based on the national population figure of 55.6 million people (2016 Census), the psychiatrists per 100 000 ratio was 1.53. This indicates no improvement between 2016 to 2019. From the South African Society of Psychiatrists database, it was determined that about 80% of psychiatrists are working in the private sector—a much higher proportion than is usually quoted. As most psychiatrists are practicing in urban areas in two provinces, Gauteng (n = 350) and Western Cape (n = 292), the ratio of psychiatrists per 100 000 in these areas is relatively higher at 2.6 and 5.0, respectively, whereas rural areas in South Africa are largely without specialist mental health expertise at a rate of 0.03 per 100 000 population. This was considered based on the national population figure of 55.6 million people based on the 2016 Census. The World Health Organization Global Health Observatory Data Repository reports South Africa with 1.52 psychiatrists per 100 000 of the population among other countries in Africa with 0.01 psychiatrists per 100 000 (Chad, Burundi, and Niger) to more than 30 per 100 000 for some countries in Europe.

Data related to South African prevalence rates of mental disorders are limited, but previously high rates (about 1 in 3) South Africans will develop a mental health condition in their lifetimes - reported by The South African Stress and Health (SASH) Study, the only nationally representative study of its kind in South Africa, documented a 30.3% lifetime prevelance of common mental disorders in the country (Williams et al. 2007) (Stein et al. 2008).

The good news is that in SA, there appears to have been a 9.3% increase in funded specialist psychiatry training posts (150 in 2008 to 164 in 2018). During the same period though the occupancy of funded posts when using comparable data had not increased (138 in 2008 to 136 in 2018), with an increase in vacant posts.

Would you say the number of people presenting psychiatric conditions has risen in SA since 2019 and if so what has led to this rise and are the conditions patients are presenting with becoming more and more severe?

This is a complex issue with the burden of mental illness reflected by those that present for treatment only. Firstly, it is important to note that mental disorders often affect, and are affected by, other diseases such as cancer, cardiovascular disease, and HIV infection/AIDS, and as such require common services and resource mobilization efforts. More recently we have also seen the COVID-19 pandemic and consequences of a national lockdown contributing to the burden of mental health issues.

Whether cases presenting since 2019 are more severe is a difficult question to answer definitively.

Would you say that there has been a collapse of both state and private psychiatric services in SA and if so what has led to this collapse?

In post-apartheid South Africa (SA), there has been clear awareness that mental health has been neglected and that the transition to democracy requires paying much more attention to it. At a national level the Mental Health Act of 2002 made an important advance as it emphasised the human rights of those with mental illness, including access to care. After a major consultative process including provincial and national mental health summits between February and April 2012, a further important step forwards was taken in 2013 when the National Health Council adopted the Mental Health Policy Framework (MHPF) for SA and the Strategic Plan 2013 – 2020, which contained eight key objectives: 'district-based mental health services and primary healthcare re-engineering; building institutional capacity; surveillance, research and

innovation; building infrastructure and capacity of facilities; mental health technology,- equipment and medicines; intersectoral collaboration; human resources for mental health; advocacy, mental health promotion and prevention of mental illness'. However, despite this there has been a somewhat inconsistent effort to meet the needs indicated in these documents. Acknowledgement must be made to the efforts that have been made, but for mental health care practitioners there is a sense of pleas falling on deaf ears, a lack of faith in ethical leadership which unfortunately contribute to challenges and perpetuation of perceived collapses. Immigration of psychiatrists and psychologists and others with skills in mental health care, due to feelings of despondency and an increasingly burdened state with trauma, stress, load shedding, high taxes and other reasons abound.

How many dedicated state psychiatric beds are there in SA and how many should there be?

Simply put, what we have is not enough. What we do have might be utilised differently.

The numbers of beds should align with the population in need, which we have seen is increasing. We are mindful of the management of less serious or less severe pathology needing to be managed in outpatient setting, and of course preventative mental health care in the public context is vital.

How many private psychiatric beds are there in SA and how many should there be?

SASOP (PsychMg) reflects the following in SA: 2346 beds available (across all provinces).

Are state psychiatric patients receiving the necessary care that they should be and if not why and what is the impact on patient care if they are not receiving the necessary care?

Different layers of care, promulgated by specific needs at that level, as well as psychiatric pathology must be considered. Care includes attention from correct personnel, with issues of task shifting, managing symptoms before they worsen (which amounts to recognising symptoms) then providing adequate treatment plans that include medication, psychosocial inputs which includes social work intervention, psychological therapies, and OT services. Each case is individual, for hospitalised patients nursing staff that are trained to manage patients ranging from PTSD sufferers to manic and psychotic patients are vital. Adequate training e.g., in calming and restraint, management of aggression in patients, with a consideration for adequate security and/or orderlies to assist is important. The impact of untreated mental illness has been shown to result in dire consequences such as suicide, homicide, aggression, criminal offences, and dysfunction leading to job loss and relationship difficulties, to name a few.

What is the impact from the closure of certain state hospitals and their psychiatric wards on other medical facilities whose psychiatric wards are either full or who do not have psychiatric facilities?

This is dire!! Examples of this are starkly seen in Gauteng where the closure of CMJAH emergency Department and the unit for psychiatric treatment has led to marked increases in numbers presenting to other hospitals i.e. Helen Joseph Hospital, Chris Hani Baragwanath Academic Hospital, as well as district and regional services (clinics and hospitals). At specialised hospitals for further involuntary care under the MHCA for example, a waiting list has been slowly developing over the last two years or so, with a distinct and noticeable effect since the closure of CMJAH. Specialised hospitals with specific programmes e.g. TARA hospital also report waiting lists for admission. Increases at HJH have been noted with consequences of adverse events.

We have received reports that there has been a marked increase in all forms of state medical staff, including cleaners, being attacked by psychiatric patients because they are unable to be held in psychiatric wards because state hospitals psychiatric wards are full. The result is these patients are held in general wards and often emergency rooms which are suited for such patients. Are you aware of such situations, are you aware of how many medical staff and patients have been attacked or killed by psychiatric patients because they are not held in the correct wards and are these attacks of concern to you?

The impact of mental illness and disruptive behaviours due to serious mental illness is indeed cause for concern. It is simplistic and rather short sighted to indicate that the reasons for the attacks are due to patients unable to be held in psychiatric wards because state hospitals psychiatric wards are full. This is a serious problem. The official number of staff assaulted in the last year is 32, however, many incidents have gone unreported. According to hospital psychiatry staff, the Department of Health has conducted site visits, and protocols for the management of the aggressive patient are in place. Of great concern are the attitudes and tones of stigma linked with reporting, and indeed management of psychiatric patients in the ED. Issues of judgement and culpability always follow such reports. If aggression is due to acting out based on psychiatric pathology such as hallucinations (psychotic patients might have command hallucinations to harm for example) or delusions of persecution, then this calls for action based on medical (psychiatric) need. With human rights violations, and non-attendance to basic needs, the likelihood of behavioural disturbances increases.

What needs to be done to improve the treatment state psychiatric patients receive?

The number of specialized and general health

workers dealing with mental health in low-income and middle-income countries is grossly insufficient and this is relevant to us in SA. Almost half the world's population lives in countries where, on average, there is one psychiatrist to serve 200 000 or more people. Health systems have not yet adequately responded to the burden of mental disorders; consequently, the gap between the need for treatment and its provision is large all over the world. Between 76% and 85% of people with severe mental disorders receive no treatment for their disorder in low-income and middle-income countries; the corresponding range for high-income countries is also high: between 35% and 50%. Hospital units that are closed must be prioritised urgently. All issues pertaining to why there is a delay in this must be urgently addressed. Attention to requests for adequate staffing ratios must be addressed, noting that norms and standards for our country is a moving target.

Compiled by Ugasvaree Subramaney (Academic HOD, Dept of Psychiatry) and Nokhuthula Mdaka, Chairperson, Southern Gauteng branch of SASOP; with contributions from Ralf Brummerhof, Lesley Robertson, Kagisho Maaroganye, Gagu Matsebula and Peet Kotze

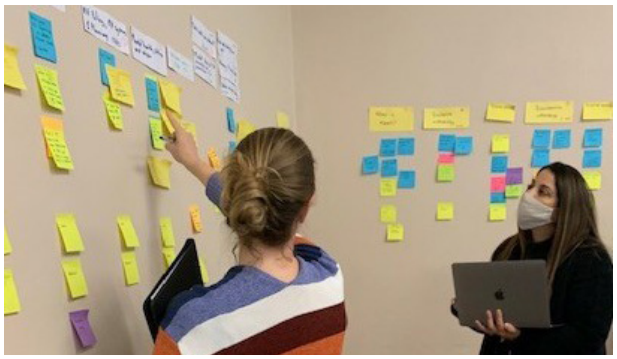
UNIVERSITY OF CAPE TOWN

Compiled by **Toni Abrahams** and **Cebokazi Mtati**

INSPIRING AND EQUIPPING AFRICAN PUBLIC MENTAL HEALTH RESEARCHERS AND PRACTITIONERS

BY CLAIRE VAN DER WESTHUIZEN

Programme ARISE (African mental health Researchers InSpired and Equipped) is a new capacity building programme funded through Fogarty International at the US National Institutes of Health. ARISE was initiated by the Alan J. Flisher Centre for Public Mental Health, which is a collaboration between the University of Cape Town (UCT) Dept of Psychiatry and Stellenbosch University Dept of Psychology. The programme builds on the Centre's track record of capacity building and the existing Masters and PhD programmes, with the aim of strengthening and extending the postgraduate pipeline. To this end, ARISE will develop and deliver a PGDip in Public Mental Health tailored for clinicians, policymakers, NGO staff and academics on the continent. ARISE draws on the existing, diverse global mental health community to accomplish this goal.



The exploratory formative and initial learning design work has been undertaken with African public mental health stakeholders, assisted by the Centre for Innovation in Learning and Teaching (CILT) at UCT. Part of this work has included a four-day workshop with faculty from five African countries, representing multiple disciplines, to develop content and delivery strategies for the PGDip in public mental health. This unique learning opportunity will be delivered remotely to increase accessibility and engage a diverse student body. The PGDip will deliver public mental health content, including research and soft skills, using learning design techniques to engage students and develop our public mental health colleagues. Through this programmme, the ARISE team plans to strengthen our global mental health community and ultimately contribute to addressing the large mental health treatment gap in Africa

FAREWELL TO WILLEM DE JAGER

EXTRACTED FROM ARTICLE BY JOHN-JOE DAWSON-SQUIBB

Willem, a clinical psychologist in the department retired in December 2022. He initially qualified as a psychometrist in 1985, and then Clinical Psychologist in 1987. He worked at Alexandra Care and Rehabilitation Centre from 1985 to 1989 before working at William Slater and then Valkenberg in the Neuro-Clinic. Since 1994 he has been a permanent fixture at the Division of Child and Adolescent Psychiatry (DCAP) (previously the Child and Family Unit). At DCAP headed up the in-patient focused Therapeutic Learning Centre and

since 2011, and was working in the Outpatient Unit. He also took a sabbatical to work in the UK, in a child inpatient setting, bringing many learnings back with him. He was the Principal Clinical Psychologist at DCAP. Long hours at DCAP have hinted at the breadth of his efforts. Since 2017 he has been Chairperson of the Centre for Group Analytic Studies, and since 2001 he has been Chairperson on the Governing Body of the Red Cross Children's Hospital School Board. He has also spent over 15 years as Treasurer of the South African Association for Child and Adolescent Psychiatry and Allied Professionals. He was an associate editor of the Journal of Child and Adolescent Mental Health for 23 years. He has authored a number of chapters and articles, in addition to being a regular presenter at local and international Child and Adolescent Psychiatry conferences. On top of all this, he has assisted many groups and NPOs with his expertise in organisational dynamics, not least of which being The Empilweni Project, where he sits on their advisory board. We were gifted with his service for many years, and wish him well for the next chapte

A REVIEW OF PSYCHOTROPIC DRUG PRESCRIPTION FOR PATIENTS WITH ID AT ALEXANDRA HOSPITAL OUTPATIENT CLINIC

EXTRACTED FROM AN ARTICLE BY IDORENYIN AKPABIO

Individuals with Intellectual Disability are more likely than the general population to be prescribed psychotropic medication with the most common indications including treatment of a psychiatric disorder or managing behaviours that challenge. Concerns include inappropriate prescribing, polypharmacy, increased sensitivity to medication thus the development of adverse effects and clinician competence when prescribing. In the absence of locally developed prescribing guidelines, International Guidelines such as by NICE (National Institute for Health and Care Excellence) or WPA (World Psychiatric Association) may help guide a clinicians' prescribing techniques.

A retrospective folder and prescription chart review of new patients seen between January 2018 and August 2019 at Alexandra Hospital outpatient clinic was undertaken. The study aimed to review how closely clinicians were following prescribing guidelines. A total of 103 new patient folders were reviewed. The results indicate that psychotropic medication was prescribed to 88% of patients reviewed. Antipsychotics accounted for the most commonly prescribed agent, and at higher rates than psychotic disorders were diagnosed, in line with various international studies. Doctors at Alexandra followed the guidelines closely in areas such as noting diagnosis, following appropriate management protocols for the diagnosed disorder, using the lowest effective dose of chosen agent and making use of allied health services. There were gaps in consistently documenting rationale for medication used and recommending behavioural strategies for managing of behaviours that challenge. There was no medication review schedule or a standardized instrument for monitoring of side effects in any of the reviewed folders. These can be addressed by improving clinician competence and confidence in dealing with individuals with ID, through specific ID-related training and familiarising them with relevant guidelines. Standardised forms e.g. for reviewing side effects or medication, could be developed and put in patient files to make it easier to comply to guidelines. It would be interesting to conduct such a study on a larger scale, perhaps through similar facilities across South Africa, to accurately assess what is being done and determine whether adaptations to international guidelines may be indicated for the local setting. There is also a need to conduct clinical research into developing contextually appropriate and effective behavioural interventions in the South African context

DIVISION OF PUBLIC MENTAL HEALTH OFFICIALLY LAUNCHES MOSAIC BENCH IN HANOVER PARK

EXTRACTED FROM AN ARTICLE BY SIMONE HONIKMAN AND RITA STOCKHOWE

Above: The mosaic bench and performers, Sinovuyo Balintulo (left) and Siyasanga Mpondo (right).

On 3 December 2021, the division hosted an event in the garden at its service site at Hanover Park Midwife Obstetric Unit.

The division celebrated its wide range of supporters and gave thanks to the Ebrahim family, Lovell Friedman and her team of mosaic artists for a beautiful new bench. The mosaic bench is the latest addition to the garden at the division's Hanover Park service site, which has been a sanctuary for facility staff and women using the service. The event also acknowledged the staff at Hanover Park MOU and CHC for their outstanding work, commitment and support, especially during the challenges of the COVID pandemic. After nearly 10 years of being on site, the division is deeply grateful for the many local partners who continue to support their work

STUDENT PSYCHIATRY SOCIETY UPDATE

EXTRACTED FROM AN ARTICLE BY IAN OLIVIER

2021 presented both challenges and opportunities for expanding our presence in an ever-evolving virtual world. Online platforms have improved access to events organised by student-run societies, and despite the lack of in-person events, our committee has organised several talks and workshops which were well attended.

At the start of the year, student recruitment took place virtually, featuring videos and descriptions of our society on an online plaza forum – a vastly different experience from the lively hustle and bustle on plaza day that usually occupies campus in mid-February. Still yet, sign-ups were successful, although numbers were less than seen in pre-covid times.

We continued to engage with our members via social media, and grew our Facebook page following to 347, with over 50 engagements per posts, and our Instagram page to 355 followers. In addition to expanding our audience, we also added new inter-societal collaborations to our portfolio, including UCT PaedSoc, SCORA, and SHAWCO Health.

Psych Soc organised several engaging and relevant talks over the course of the year, thereby maintaining the presence of psychiatry and related themes amongst student circles in the health sciences. Our first event took the form of an online discussion on Autism Spectrum Disorder, a collaboration with UCT PaedSoc, hosted to commemorate World Autism Awareness Day on the 2nd of April 2021 with speakers including Prof Petrus de Vries, Sue Struengmann, Professor of Child and Adolescent Psychiatry, and founding director of the Centre for Autism Research in Africa (CARA), as well as Dr Moodley, senior registrar in developmental paediatrics at Red Cross War Memorial Children's Hospital.

The second event hosted and organised by the society (including SCORA) was an online talk entitled "Transgender Mental Health and being a Trans-friendly Healthcare Provider", presented by Dr Pickstone-Taylor, a child and adolescent psychiatrist and founder of the Gender Identity Development Service within Red Cross Hospital and UCT's Division of Child and Adolescent Psychiatry.

In addition, we hosted a talk entitled "When are women especially vulnerable to mental health disorders?", given by Dr Gordon, Head of Undergraduate Teaching in the Department of Obstetrics and Gynaecology at UCT.

The society ended off the events for the year by hosting workshops aimed at assisting students in developing anxiety and depression recognition skills and establishing management techniques for these disorders. This was hosted in collaboration with SHAWCO, with Dr Henderson as the host

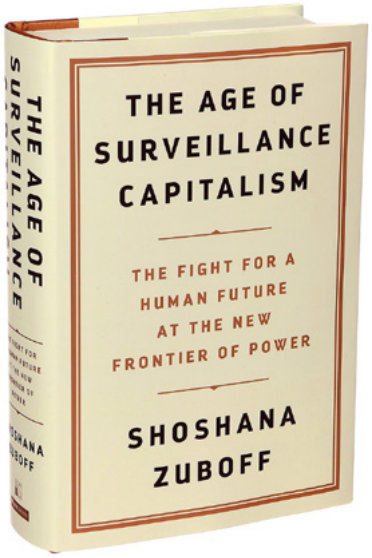
Finally, we held our annual general meeting in October, where the new committee for 2022 was elected.

For the full articles above and more news, read our departmental newsletter which is available for download on http://www.psychiatry.uct.ac.za/

THE AGE OF SURVEILLANCE CAPITALISM

THE FIGHT FOR A HUMAN FUTURE AT THE NEW FRONTIER OF POWER

Koffi Kouakou



Title: The Age of Surveillance Capitalism
The Fight for a Human Future at the New Frontier of Power
Publisher: PublicAffairs
Author: Shoshana Zuboff
ISBN: ISBN-13: 978-1610395694

This book is about the freedom of our deep humanity, hijacked and wrapped around the ideological metaphors of two key words - *surveillance* and *capitalism.* Those words conjure a creeping feeling of unease and profiteering. Strangely, they do have an impact on our psychology, our mental health, sanity and wellbeing.

Furthermore, their combination brings about a conflicting sense of manipulative tyranny. Even worrisome, Shoshana Zuboff, who coined them, and the author of *The Age of Surveillance Capitalism,* tells us that we are already willing participants and cogs in this age of surveillance. She captures well the paradoxically dreadful opportunities that digital technologies usher onto society.


Koffi Kouakou

However, she warns us and calls our attention to the challenges they pose. How the exploitative and absolutist custodianship, by powerful corporations to govern our behaviours and threaten the future of humanity. Actually, she has opened a vivid window on the tip of the iceberg that George Orwell, Edward Snowden and others - freedom lovers of liberty - have warned us about for decades.

This is serious. Is Zuboff being dramatic, playful in order to sell her book or somber about the nefarious role of surveillance capitalism and its use of digital technologies to control our lives while making huge profits?

NO JOKES, SHE IS SERIOUS. THIS BOOK IS UNCOMFORTABLE YET NECESSARY.

But what is *surveillance capitalism* anyway? She has eight definitions for it. Here are the first four: (1) "a new economic order that claims human experience as free raw material for hidden commercial practices of extraction, prediction, and sales; (2) a parasitic economic logic in which the production of goods and services is subordinated to a new global architecture of behavioural modification; (3) a rogue mutation of capitalism marked by concentration of wealth, knowledge, and power unprecedented in human history; (4) the foundational framework of a surveillance economy."

This is already a lot and concerning. Yet, she piles it up.

In another long, windy, elitist and complicated sentence of seventy-four words (74), Zuboff offers

a summary of what the book is all about. It is the "idiosyncratic economic imperatives defined by extraction and prediction, its unique approach to economies of scale and scope in raw-material supply, its necessary construction and elaboration of *means of behavioural modification* that incorporate its machine-intelligence-based "means of production" in a more complex system of action, and the ways in which the requirements of behavioural, modification oriented operations forward totalities of information and control, creating the framework for an unprecedented *instrumentarian power* and its societal implications."

GOODNESS! WHY WOULD ANYONE TAKE THEIR READERS INTO THIS TORTUOUS DEFINITION AND MEANING?

Well, for one, Zuboff belongs to the class of US Ivy league narrators that must convince her academic tribes with an impressive language about technology she understands better than most. Then after gaining their endorsements, she needs no more convincing from the masses, it seems. In short, she knows her audience and panders to it well, with suitable language.

Although praised, rightly so, for this deep scholarship by a long list of social scientists, economists, celebrities and media personalities, the book has occupied mostly the preferred conversations of the global elite, data, privacy and advocacy groups who are worried about authoritarianism, totalitarian corporations and governments, freedom and human rights.

But one wonders why she couldn't write in a simpler vocabulary for the masses. Well, she doesn't need to, as the digital technology ecosystems she talks about deal with a sophisticated language of their own. Her erudite tone and expressions of digital futures belong to a special crowd of digital technology head gurus.

This new age is also defined by a new language, Zuboff tells us. She invents a new vocabulary whenever "existing terms fail to capture new phenomena". And the book is full of them. Among many others, here are a few mind-numbing ones: gothic algorithmic daemons, metadata, behavioural modification, behavioural surplus, instrumentarian, instrumentation collective, reality business. Intimidating and impressive.

Indeed, Zuboff's impeccable academic and technical credentials, as the Charles Edward Wilson Professor emerita at Harvard Business School, are vindicated with the brilliant quality of her narrative about surveillance capitalism. Furthermore, her earlier book *In The Age of the Smart Machine: the Future of Work and Power* has cemented her unparalleled credibility as a unique chronicler of smart and digital machines, their deep impact and danger to humanity.

Here, she lays bare the dire consequences, hope and the fears of the new economic order of surveillance capitalism of our age, the state we are in and how we can change it to our advantage. However, it seems many of us have not paid much attention to her warnings. Now, we may be paying the heavy price of our shackled liberty in digital prisons that continue to feed on the lucrative data mines that govern our behaviours.

This comprehensive work of scholarship is not an easy read, as it requires considerable patience. Nonetheless, most of us should not feel intimidated by it and give up.

More important, Zuboff cautions us about the nefarious role and tentacles of surveillance capitalism, and its digital colonisation consequences that are proving to be a hindrance to democracy, human rights, freedom of expression and privacy. The dreadful description of the oppressive nature of surveillance capitalism reminds the reader of the Orwellian nightmare of George Orwell's famous science-fiction novel, *Nineteen Eighty-Four* also named *1984*, where an entire society is under mass surveillance and a repressive regimentation by an omnipresent, totalitarian government, run by a dictatorial leader called Big Brother. Zuboff's compelling warnings make real Orwell's prescient dystopian novel into a 21st century well managed, manipulated, and overt private public partnership between corporations and government digital thought-police nightmares.

Surveillance capitalism power assimilates and dominates the social order that shapes our digital economic present and future. The new market economy it dictates is founded on the concentration of data, extreme inequalities of knowledge and power of the digitisation of our society.

The digital cult of personality, the manipulated information choices and the depersonalised psychologies it harnesses through social media digital giants like Google, Apple, Facebook, Amazon, LinkedIn, Twitter, WhatsApp and other platforms are a stark reminder of Zuboff's warnings. These platforms are the ecosystem frontiers of the new age of surveillance capitalism. Incidentally, most of us are the protagonists in a digital world that controls us, with our opt-in consent.

Our privacies and democratic agencies are at stake against business models that harvest and grow on our 'every move, emotion, utterance and desire'. Zuboff stresses that, 'It is not OK' And something must be done to resist and establish acts of digital self-defense to regain our digital sovereignties. Some form of rebellion will be needed to escape or keep surveillance capitalism digital tyranny at bay today and tomorrow. But what can we really do?

Will her call to re-own the control of our digital sovereignty be heeded in an age of incoherent soundbites, the search for misplaced publicity, cultish celebrity, anti-democratic threats and undue online vulnerabilities that digital technologies hoist on us, before it is too late? I doubt it, in the near future.

Koffi M. Kouakou is MD of Stratnum Futures, a foresight consulting and advisory company in Pretoria
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THE ARTIST'S WIFE

IMAGINATION AND COURAGE IN THE FACE OF INEVITABLE LOSS

Kim Laxton

During the South African Society of Psychiatrists' (SASOP) congress, held from 20 – 24th October 2021 in the Drakensburg, delegates were fortunate to have the opportunity to attend a preview screening of *The Artist's Wife*, a film by Tom Dolby. The event was organized by Dr Leverne Mountany and Dr Kim Laxton, bringing a different element to an academic event. Refreshments were kindly sponsored by Lundbeck in a lunch box, with every single box donated to an underprivileged school in the area.

L-R: Leverne Mountany, Lisa Selwood, Hendrik Odendaal

Lundbeck lunch boxes

The film tells the story of a woman, Claire Smythson (portrayed by Lena Olin) redefining herself, as a wife, and as an artist, as she learns to navigate the treacherous pathway of dementia. Richard Smythson (played by Bruce Dern), Claire's husband, begins to exhibit subtle signs of early neurocognitive deterioration, as his artistic career is in full bloom.

Kim Laxton

THIS IS NOT A STORY ABOUT THE PATIENT HIMSELF BUT GIVES A VOICE TO THOSE WHO, EVEN WITHOUT THE DIAGNOSIS SUFFER NONE-THE-LESS, THE PAIN OF GRIEF AND DESPAIR.

Despite the enormity of Claire's responsibilities as she shares a home with her ailing spouse, she finds herself in new territory of unfamiliar choice. She faces questions of personal, sexual, and professional identity. As her husband forgets his wife, Claire begins to discover her own unique unopened doors, who she is and who she might become.

However, Claire is not only experiencing an internal question of identity, but she also faces the inevitability of eternal loss. She is called to choose to become the outstretched hand for her deteriorating husband. This hand, she recognizes, is her act of desperation to reunite Richard with his estranged family. The story calls into question: "How, and should, we say goodbye to those who have harmed us?" For Claire the answer is not simple, but her choice is of critical importance.

It is a gentle story. The dementia canvas is untouched. The direction is fresh, wholesome, and artistically beautiful. A new perspective of dementia is told through the eyes of a caregiver, the character often chosen to be a shadow of the diagnosed patient. The thunderous mood swings, frustration of memory impairment, unbeknownst to the patient, physical outbursts, confusion, self-harm, and frightening periods of fleeting fragments of lucidity, are the core to stories told about the destruction of dementia.

YET, THIS STORY HAS THE FINEST BRUSHSTROKES OF HOPE. THE DISEASE IS LOUD AT TIMES, YET CLAIRE'S QUIETNESS, GENTLE ACCEPTANCE OF PAINFUL CHANGE, EVEN HER SILENT LAUGHTER AS SHE CLEARS THE DUST FROM HER OWN UNTOUCHED PAINTINGS, IS THE ESSENTIAL CONVERSATION BETWEEN STORYTELLER AND AUDIENCE.

Bruce Dern plays a character who externalizes his internal confusion with outward force. Richard is brash and obnoxious; but one feels the desperation and pain of unrequited family and sympathizes with both Richard and Claire.

The story is centered around Claire, who she is, who she was, and what she might become. It is a story without an ending. As with art, one embraces the overall 'look', the immediate impression. However, *The Artist's Wife* calls for the audience to search for the nuances, to listen to the colours, to question oneself as if one were forcibly thrust into a world of shattered reality. The canvas appears complete, the paintbrushes placed aside, yet the story of Claire continues.

The Artist's Wife asks its audience to continue the journey of personal discovery. Each audience member is presented with a piece of this canvas, and we will need to complete the painting for ourselves; with Claire Smythson as our inspirational teacher.

The film will be released on DStv BoxOffice on 13 June 2022.

Kim Laxton qualified as a psychiatrist in 2016 and is currently in private practice at Akeso Crescent Clinic, Johannesburg. She works within the life insurance industry in addition to teaching, academia and clinical practice. At SASOP 2021, she assisted in coordinating a parallel session: "The Art of Psychiatry and the Therapy of Play". This included the movie evening at the conference. She is an avid movie-goer, Funko-Pop collector and wildlife fanatic!
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References: 1. Baune BT et al. *Int J Neuropsychopharmacol* 2018; 21 (2):97-107.2. Fagiolini A et al. *Journal of Affective Disorders*. Nov 2020. **South Africa**: S5 Brintellix® 10 mg film-coated tablets. Each tablet contains vortioxetine hydrobromide equivalent to 10 mg vortioxetine. Reg No. 48/1.2/0430 **Namibia**: NS3:15/1.2/0071 **Botswana**: S2: BOT 1502705 **Mauritius**: PB/13008/04/2018. Lundbeck SA (Pty) Ltd. Unit 9, Blueberry Office Park, Apple Street, Randpark Ridge Extension 114 Tel: +27 11 699 1600. For full prescribing information refer to the professional information approved by the medicines regulatory authority.
ZA-BRIN-0143 July 2021

MOVIES

Title: Operation Mincemeat
Release Date: 6 May 2022
Age Restriction: PG - 13
Genre: War / Drama
Director: John Madden
Stars: Matthew MacFadyen, Colin Firth, Kelly Macdonald

During WWII, two intelligence officers use a corpse and false papers to outwit German troops.

Title: The Black Phone
Release Date: 24 June 2022
Age Restriction: 18
Genre: Horror / Thriller
Director: Scott Derrickson
Stars: Ethan Hawke, Jeremy Davies James Ransone

Finney Shaw is a shy but clever 13-year-old boy who's being held in a soundproof basement by a sadistic, masked killer. When a disconnected phone on the wall starts to ring, he soon discovers that he can hear the voices of the murderer's previous victims -- and they are dead set on making sure that what happened to them doesn't happen to Finney.

Title: Men
Release Date: 3 June 2022
Age Restriction: 18
Genre: Folk horror
Director: Alex Garland

In the aftermath of a personal tragedy, Harper retreats alone to the beautiful English countryside, hoping to find a place to heal. However, someone or something from the surrounding woods appears to be stalking her. What begins as simmering dread soon becomes a fully formed nightmare, inhabited by her darkest memories and fears.

Title: Elvis
Release Date: 24 June 2022
Age Restriction: PG - 13
Genre: Musical/Drama
Director: Baz Luhrmann
Stars: Austin Butler, Tom Hanks, Luke Bracey, David Wenham Kelvin Harrison Jr., Kodi Smit-McPhee, Gary Clark Jr., Richard Roxburgh

The film chronicles the life and career of singer and actor Elvis Presley, from his early days as a child to becoming a pop star and movie star, as well as his complex relationship with his manager Colonel Tom Parker.

ALL ABOUT RADFORD DALE INDIVIDUALITY

David Swingler

It's an exquisite autumn day in the winelands and, as I write, soft sunlight pads through the windows onto my keyboard as those-in-the-know are streaming into the Elgin Cool Wine Festival. It's an underplayed, classy weekend without the teetering crowds when the wine growers of this super cool vineyard basin – better known for apples, of course – open their doors for food and wine exploration.

Apart from individual cellar visits and the *Elgin Railway Market,* my highlights this year are the single vineyard wine tastings at *Oak Valley* (see my justifiably effusive review in the 2022 edition of *Platter's South Africa Wine Guide*) and a Quail Day at Iona up the Highlands Road. What's not there, for the moment, is the valley's next big thing: *Radford Dale Organic* (RDO).

The sun rises over RDO

Fast-rewind some 28 years, almost to the day, when I was cutting-&-pasting – literally! – articles and pictures from newspapers onto A4 bond for facsimile transmission to Beaune, France. 'Facsimile?' I hear you gasp. Home fax machines were quite trendy on 27 April 1994, and the WWW was only of interest to Rhodes University academics of the day…

The recipient of these 'Pritt-y' efforts was Alex Dale, a young Englishman already steeped in the Burgundy trade whom I had met in calamitous circumstances three years prior (another story, another day). He wanted to know everything about the New Democracy being ushered in here, for the opportunity it provided as well as a chance to be part of it. This, while everybody was rushing to leave…

David Swingler

Dale resigned his prestigious position on the spot on the basis of his intuition and my 'electoral feed', and decamped to Stellenbosch, first working for Longridge and then, having seen the lie of the land, establishing *Radford Dale* in 1998 with partner Ben Radford, an Australian winemaker living in South Africa who was Head Winemaker at Longridge.

WITH A SUITABLE LEASE OF VINEYARD AND CELLAR SITES ON THE HISTORIC PAUL ROOS FARM, DALE AND PARTNERS ADOPTED THE NEW MODEL OF FORGING RELATIONSHIPS WITH GRAPE GROWERS RATHER THAN THE HEAVY CAPITAL-COST PROCUREMENT OF LAND.

Capital and labour intensive

Dale – 'Founder & Locomotive' in his own words – is nothing if not a maverick, and the very flat structure (three other managing partners look after wine, operations and finance respectively) with indulgent stakeholder directors, meant that 'stuff' often happened off the hip and, as the business got older so, well, did its drivers… An opportunity to clean it up was required.

The deep grey of the clouds masked the silver lining at the time, but Covid-19, State of Disaster restrictions and bans on alcohol sales threatened death knells not just for producers, but also resellers like restaurants. Dale and colleagues leaped to business by means remote, the first priority being to save Radford Dale. They kept on producing wine as they had to, but couldn't sell any.

WITH A GROWING INVENTORY, RD LAUNCHED PROJECTS TO MOVE WINE WITH OODLES OF GOODWILL.

One such was a substantial discount on offer to health care workers for shipping the moment regulations allowed. Another was a Dale masterstroke: The Restaurant Rescue Project. Customers could buy a voucher for a meal to be enjoyed when restrictions eventually allowed, and were rewarded with a substantial parcel of high quality wine from the winery supporting the particular eatery. It started with Radford Dale and Grub and Vine, but spread like wildfire as other wineries wanted to help. Numerous hospitality outlets and livelihoods were saved by the resultant cash flow.

Simple Cellar

RD also took the opportunity to strategize. The future is organic, and they wanted to control their own vineyards entirely. This meant a seismic shift in model, and the purchase of vineyards and land. Having been in the Cape business for a quarter of a century by now, Dale and his partners knew what was out there and it wasn't long before they secured the only fully certified organic and biodynamic farm in Elgin, the 20ha former Elgin Ridge. It will be renamed RDO when regulators allow, and a further 6ha will be planted to add to the extant 6ha in the short term. It will be home, not just for RDO, but with a tasting room to boot.

Hand-sorting grapes

Chenin Blanc

The RD range gets clarified. Bearing the flag will be the Organic wines, a once-off 2020 Chenin Blanc out of Stellenbosch followed by the maiden 2021 Elgin Chardonnay and Pinot Noir, with more to follow (think Dale-fave gamay) from this organic-only cellar. The RD Terroir range houses the bulk of the fine wines made from diverse vineyards in the Stellenbosch cellar allowing – most exciting – resuscitation of the Vinum tier. Originally home to only Chenin Blanc and Pinotage, it has taken on the waifs and strays and is now neatly and tightly focussed as a sextet of two whites – Chenin Blanc and Chardonnay – and four reds including a lip-smackingly delicious Pinot Noir, a wonderfully clean-fruited Grenache and true-to-type Gamay and Pinotage.

Chardonnay

New wave grenache

Mixing metaphors with Dale, they are at the confluence of quality, individuality and value. The whites are R179 each, the reds R198. You will fail to get more bang for your buck anywhere.

The red quartet

Dale is known for pounding pavements to meet customers around the world. After being grounded for two years, he's off soon for three months of living out of a suitcase. But, armed with a RD brand bristling with clarity, the future promise of organicity, and the joyous drinkability of Vinum, it'll be worth it.

https://elgingrabouw.co.za/elgin-event/elgin-cool-wine-festival-2/

https://www.elginrailwaymarket.co.za/

https://www.radforddale.com/

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**

Ketamine Clinics of South Africa (Pty)Ltd

THE NEW WAY TO TREAT DEPRESSION, ANXIETY AND CHRONIC NEUROPATHIC PAIN

KETAMINE, MDD AND CIRCADIAN ACTIVITY - HOW RESPONSE IS LINKED TO SLEEP PATTERNS

A fascinating article in the Handbook of Experimental Pharmacology examines how glutamate regulates circadian rhythms, and how a favourable response to ketamine infusion in individuals with MDD might be predicted by pre-existing sleep disturbances.

At KCSA clinics, we note variability in the effect of ketamine on sleep and wakefulness from patient to patient, and this piece sheds light on the why's and wherefores. In contrast to those with MDD who respond to sleep deprivation (SD) therapy, when only 5-10% remain euthymic after recovery sleep, most ketamine-responders do not relapse following the night's sleep after an infusion.

"Recent research has identified both sleep homeostatic (sleep slow waves) and circadian components that both modulate and mediate the antidepressant and anti-suicidal effects of ketamine."

Read about ketamine, MDD and sleep patterns:
https://ketamineclinics.co.za/wp-content/uploads/2022/04/Glutamatergic-mechanisms-of-sleep.pdf

SOCIAL ANXIETY DISORDER (SAD) RESPONDS WELL TO KETAMINE INFUSION...

A review and meta-analysis of several RCTs of ketamine in the treatment of refractory anxiety disorders, found that it performed best for Social Anxiety Disorder (SAD).

While ketamine as a treatment for depression has enjoyed the spotlight, the role of ketamine in treating resistant anxiety disorders has often been understated.

GLUTAMATE REGULATES THE STRESS RESPONSE AND PLAYS A KEY ROLE IN FEAR EXTINCTION.

A review published in Therapeutic Advances in Psychopharmacology last year sheds light on ketamine's role in TR-anxiety disorders.

Read more here:
https://ketamineclinics.co.za/wp-content/uploads/2022/04/Ketamine-for-refractory-anxiety.pdf

KCSA OFFERS OUTPATIENT KETAMINE INFUSIONS AT THE FOLLOWING LOCATIONS:

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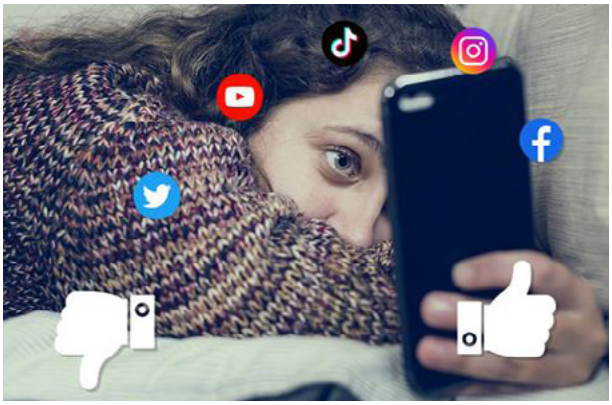
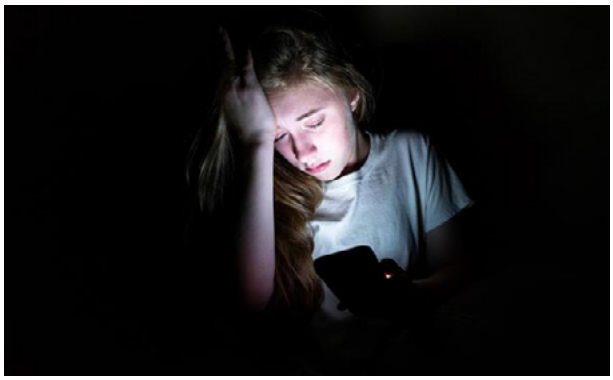


Time spent on social media and watching television. particularly involving 'upward social comparison', is linked to development of depression in adolescence.

Based of a study of 3826 adolescents, a JAMA Pediatrics investigation highlights why parents should be warned.

In a previous newsletter (http://createsend.com/t/y-2CEAF4335F69F6182540EF23F30FEDED) the tragedy of teen suicide and the 'ketamine safety-net' are discussed. We also link to a testimonial (https://ketamineclinics.co.za/wp-content/uploads/2021/08/Belindas-story.pdf) from the mother of a suicidal 14-year-old treated at a KCSA clinic.

SCREEN-TIME, DEPRESSION AND SUICIDALITY IN ADOLESCENCE...

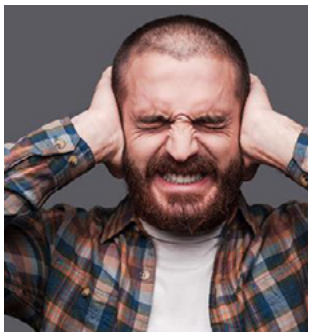


There is a worrying upward trend in child and teenage suicide rates. In the US, between 2010 and 2020 the rate increased by 50% in 13-18 year-olds, and more than doubled in the 10-12 year-old group. A Medscape Review highlights the causative effect of social media and television.

The COVID-19 pandemic has dramatically accelerated rates of depressive symptoms among children and adolescents

Read the JAMA Pediatrics investigation:
https://ketamineclinics.co.za/wp-content/uploads/2022/04/Screen-time-and-depression-in-adolescence.pdf

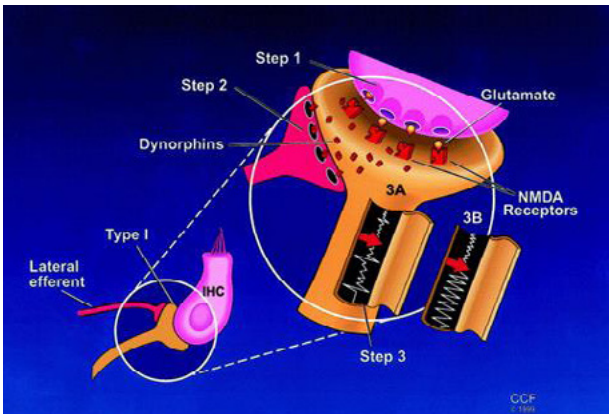
TINNITUS AFFECTS THE MENTAL HEALTH OF UP TO 64% OF SUFFERERS - CAN KETAMINE INFUSION HELP?



The short answer is 'yes' in about 50% of cases. Interestingly, not only by alleviating the associated depression and anxiety so prevalent in tinnitus-sufferers, but because the NMDA receptor plays a key role in the pathophysiology of tinnitus in the cochlea, limbic system and cerebellum. Published in Otolaryngol Head Neck Surg 2020, a review of nearly 10 000-tinnitus sufferers found that 33% were depressed.

THE FAILURE OF THE AURIS TRIAL IS CONSIDERED BY SOME A FAILURE OF THE DELIVERY MECHANISM (ESKETAMINE GEL INJECTION INTO THE MIDDLE EAR).

There is ample justification to offer a trial of ketamine infusion to patients battling tinnitus and depression.



Addressing glutamatergic circuitry by infusion to alleviate tinnitus in an animal model, was shown to provide a sustained benefit, according to an SIUSM study.

Read about the SIUSM study:
https://ketamineclinics.co.za/wp-content/uploads/2022/04/NMDAR-blockade-and-tinnitus-in-an-animal-model.pdf

IN THE NEXT NEWSLETTER - HOT OFF THE PRESS...

Increase in thalamic cerebral blood flow is associated with antidepressant effects of ketamine in Major Depressive Disorder (MDD).

Using Arterial Spin Labelling (ASL) to measure thalamic cerebral blood flow (CBF), researchers in Germany have linked their findings to improvement in depressive symptoms after ketamine.

The fact that changes in CBF are present 24h after ketamine treatment, suggests that these effects are a consequence of neurofunctional plasticity. CBF might potentially be used to inform treatment decisions for depression.

MDD can turn people into shadows of their former selves.

Up to 30% of MDD patients don't respond to traditional antidepressants,[1,2] and even among those that do, as many as two-thirds don't recover fully and continue to experience residual symptoms.[1,3] What's more, the proportion of MDD patients who achieve remission decreases significantly after each treatment failure, from 31% with a second treatment to 13% with a fourth.*[3]

It's time to step out of the shadow of MDD.

*From a report comparing acute and longer-term treatment outcomes associated with each of four successive steps in the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) trial. Remission was defined as a score of ≤5 on the Quick Inventory of Depressive Symptomatology–Self-Report (QIDS-SR16) (equivalent to ≤7 on the 17-item Hamilton Rating Scale for Depression [HRSD17])[3]

References: 1. Al-Harbi K et al. Patient Prefer Adherence 2012; 6: 369-388. 2. Keller MB. J Clin Psychiatry 2005; 66(Suppl 8): 5-12. 3. Rush AJ et al. Am J Psychiatry 2006; 163(11): 1905-1917.

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RESISTANCE TO MEDICATION ADHERENCE: A BETTER SOLUTION

LONG ACTING THERAPY FOR MORE EFFECTIVE SCHIZOPHRENIA MANAGEMENT - PROF L. CITROME ON LAT IN THE TREATMENT OF SCHIZOPHRENIA

Des Brown

Imagine, for a moment, that you could get your patients to adhere more consistently to their antipsychotic regimen while reducing their relapse rate.

In a recent online presentation, Professor Leslie Citrome, MD, MPH, Clinical Professor of Psychiatry and Behavioural Sciences at New York Medical School, highlighted some of the most prominent points underlying treatment non-adherence – and some simple solutions.

The issues, says Professor Citrome, are not abstract: they're practical and immediate, and they can almost all be attributed to common human behavioural patterns. And, he says, it makes sense to consider the simplest and most effective solution.

DRILLING DOWN: THE HIDDEN FACTORS INFLUENCING PATIENT NON-ADHERENCE

As a professional, it's easy (and understandable) to attribute a lack of response or progress to one of two things:

- Genuine ineffectiveness of a prescribed antipsychotic, or
- Patient non-cooperation due to resistance or habitual forgetfulness.

In many cases, you're relying on patient feedback in order to establish adherence – and that isn't always helpful or objective.

A PATIENT MAY ALSO BE IN A POSITION WHERE THEY FEAR JUDGEMENT OR RECRIMINATION – A PERCEPTION OFTEN EXAGGERATED BY THE VERY CONDITION THEY'RE STRUGGLING TO CONTROL.

Professor Citrome makes the point that the greatest obstacles – by far – are the often-intangible influences exerted by circumstance and society itself.

LACK OF PATIENT INSIGHT

Patients are often prone to poor insight into their condition. Add in factors like substance abuse or cognitive impairment, and it's easy to see why patients often struggle to self-monitor (or even remember where they've put their medication, for example).

ENVIRONMENTAL OBSTACLES

Unfortunately, many families still fail to see mental illness as a real condition and view it as a moral failing or weakness. Support groups are also not always readily accessible, and patients (especially those in less affluent communities) are frequently marginalised. Then, there are practical obstacles: financial issues, transport limitations, delays in having prescriptions filled, and inadequate storage of medication, to name a few. There is also the issue of stigma: a patient suffering from an adverse reaction to medication – tardive dyskinesia, for example – may experience social embarrassment or shame to the degree where the psychosis itself is actually less stressful.

THE NORMALISATION OF LAT ANTIPSYCHOTICS

So, is there a practical way to ensure better treatment with fewer relapses? Professor Citrome says there is.

Long Acting Therapy, in the form of injectable antipsychotics, can play a key role in ensuring adherence and eliminating diagnostic grey areas. There are several immediate benefits:

- Adherence is guaranteed – there's no guesswork or relying on patient assurances. You know that they've either had their injection, or not.
- Physiological responses can be better identified and isolated.
- It reduces the psychological pressure on the patient by no longer having to remember to take daily medication.

To underscore the reliability and efficiency of the LAT approach, Professor Citrome refers to a recently completed study that surveyed 75,274 patients hospitalised with schizophrenia over a 10-year period between 2008 and 2017. LAT reduced readmission rates by 29% compared with oral medication in real world settings. Moreover, LAT reduced the readmission rate by 58% in patients with repeated admissions![1]

So, why isn't LAT more frequently presented to patients as a preferred form of therapy? There are factors like cost, of course. But according to Professor Citrome, the key to more widespread acceptance lies in the way the option is presented.

BE CONSULTATIVE, NOT PRESCRIPTIVE

Patients are remarkably receptive to LAT treatment if they're properly informed. In fact, in a survey of 206 patients with >3 months of LAT antipsychotic experience, injectable antipsychotics were the preferred formulation, and 70% of those patients felt better supported in their illness.[2]

So, how should you frame that discussion with your patients? Professor Citrome suggests adopting a consultative, non-judgmental approach. Instead of asking: "Have you been taking your medications?", you could lead with:

"Everyone misses doses of their medicines. Can you give me some idea of how many doses you usually miss in any given week? I just need a ballpark figure; you don't have to be exact

Then follow this with:

"Which doses do you miss most? Morning, Evening? With meals? In between meals?

THIS WAY WE CAN FIGURE OUT THE BEST TIME OF DAY TO USE THESE MEDICATIONS SO WE CAN MINIMISE THE NUMBER OF TIMES YOU MAY MISS THEM".

Ideally, you want to humanise the process. Make adherence issues normal. Give patients permission to admit that they miss taking their medicine, and that it's okay.

Now, instead of saying: "Let's give you a shot!" (usually not that well received!), you could say: "How would you like taking your medicines once a month instead of every day?"

Follow this with: "Yes, it is an injection, just like a flu shot. It's simple and easy, and if you want to try it, it's completely voluntary. If you don't want the second shot, we can go back to pills".

Include the patient as an active and willing participant in the decision – and see what happens. The results may just surprise you.

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1. Kim HO, et al. *Ann Gen Psychiatry* 2020;19:1.
2. Caroli F, et al. *Patient Prefer Adherence* 2011; 5:165-171

Des Brown is an author and feature writer covering trends and events for clients across the healthcare and pharmaceutical industries. **Correspondence: des@desbrownwriter.com**

Brown-hooded kingfisher, photo courtesy of Dr Lennart Eriksson, Psychiatrist, Pennington, KZN. lennarte@iafrica.com

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prolonged release suspension for injection

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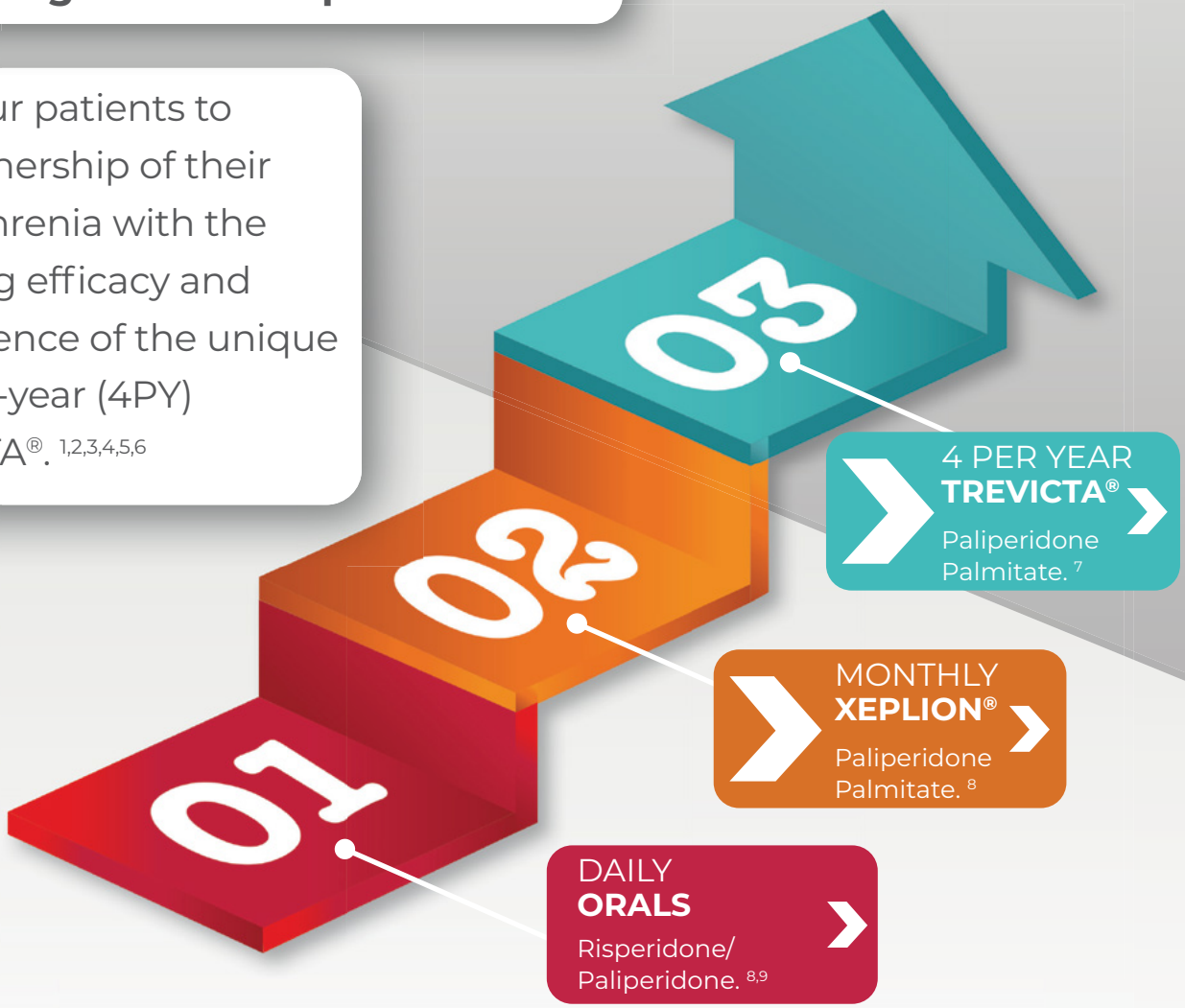
What's your plan for your patients living with schizophrenia?

Help your patients to take ownership of their schizophrenia with the enduring efficacy and convenience of the unique four-per-year (4PY) TREVICTA®. [1,2,3,4,5,6]



* The TREVICTA® Plan is the initiation of XEPLION® then moving to TREVICTA® when stabilised - in line with the approved indications for both treatments.[7] XEPLION® is indicated for maintenance treatment of schizophrenia and for the prevention of recurrence of symptoms of schizophrenia.[8] TREVICTA®, a 3-monthly injection is indicated for the maintenance treatment of schizophrenia in adult patients who are clinically stable on 1-monthly paliperidone palmitate injectable product.[7]

References: 1. Schreiner A, Bergmans P, Cherubin P, et al. A Prospective Flexible-Dose Study of Paliperidone Palmitate In Nonacute But Symptomatic Patients With Schizophrenia Previously Unsuccessfully Treated With Oral Antipsychotic Agents. *Clinical Therapeutics* 2014;36(10):1372-1388e1. 2. Berwaerts J, Liu Y, Gopal S, et al. Efficacy and Safety of the 3-Month Formulation of Paliperidone Palmitate vs Placebo for Relapse Prevention of Schizophrenia. A Randomized Clinical Trial. *JAMA Psychiatry* 2015;72(8):830-839. 3. Savitz A, Xu H, Gopal S, et al. Efficacy and Safety of Paliperidone Palmitate 3-Monthly Formulation for Patients with Schizophrenia: A Randomized, Multicenter, Double-Blind, Noninferiority Study. *International Journal of Neuropharmacology* 2016;19(7):1-14. 4. Hargarter L, Bergmans P, Cherubin P, et al. Once-monthly paliperidone palmitate in recently diagnosed and chronic non-acute patients with schizophrenia. *Expert Opinion on Pharmacology* 2016;17(8):1043-1053. 5. Caroli F, Raymondet P, Izard I, et al. Opinions of French patients with schizophrenia regarding injectable medication. *Patient Preference and Adherence* 2011;5:165-171. 6. Gopal S, Vermeulen A, Nandy P, et al. Practical Guidance for Dosing and Switching from Paliperidone Palmitate 1-Monthly to 3-Monthly Formulation in Schizophrenia. *Current Medical Research and Opinion* 2015;31(1):2043-2054. 7. TREVICTA® Professional Information Leaflet. December 2020. 8. Xeplion Professional Information Leaflet. May 2019. 9. INVEGA® Professional Information Leaflet. January 2010.

S5 TREVICTA® 175 mg, 263 mg, 350 mg, 525 mg prolonged release suspension for injection. 175 mg prolonged release suspension for injection: Each pre-filled syringe contains 273 mg paliperidone palmitate equivalent to 175 mg paliperidone. 263 mg prolonged suspension for injection: Each pre-filled syringe contains 410 mg paliperidone palmitate equivalent to 263 mg paliperidone. 350 mg prolonged release suspension for injection: Each pre-filled syringe contains 546 mg paliperidone palmitate equivalent to 350 mg paliperidone. 525 mg prolonged release suspension for injection: Each pre-filled syringe contains 819 mg paliperidone palmitate equivalent to 525 mg paliperidone. Marketing Authorisation Number/s: EU/1/14/971/007; EU/1/14/971/008; EU/1/14/971/009; EU/1/14/971/010. For full prescribing information, refer to the latest professional information leaflet. December 2020.

S5 XEPLION® 50, 75, 100 or 150mg Prolonged release suspension for intramuscular injection. Each pre-filled syringe contains sterile paliperidone palmitate equivalent to 50, 75, 100 or 150mg of paliperidone respectively. Reg. Nos.:44/2.6.5/0866; 44/2.6.5/0867; 44/2.6.5/0868;44/2.6.5/0870. For full prescribing information, refer to the latest professional information insert. May 2019.

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CP-243117

Perinatal Mental Health Project

Caring for Mothers. Caring for the Future.

SYSTEMS STRENGTHENING IN HANOVER PARK

Liesl with UWC 3rd year nursing students

Our mental health service at the Midwife Obstetric Unit (MOU) in Hanover Park is starting to resemble a working environment similar to that of pre-pandemic. As the Covid-19 restrictions lessen, we have seen many 3rd year nursing students from University of the Western Cape (UWC) and 4th year medical students from University of Cape Town (UCT) return to the site as part of their practical training.

AS PART OF OUR SYSTEMS STRENGTHENING FOCUS AREA, OUR CLINICAL SERVICES COORDINATOR, LIESL HERMANUS, HAS BEEN ORIENTATING STUDENTS TO THE PMHP SUPPORT SERVICE AND MATERNAL MENTAL HEALTH.

Students are keen to engage with this topic and they often reflect on their experiences with clients suffering with mental health problems in facilities they have trained at. This is a great opportunity for us to introduce students to empathic engagement skills, particularly during labour, with vulnerable clients.

SERVICE UPDATES

Tyla Prinsloo joined our team in February 2021 on an initial five month contract as a mental health counsellor.

THANK YOU TO THE LUCKY BEAN TRUST - WHO HAVE FUNDED TYLA'S EXTENDED CONTRACT THROUGH TO DECEMBER 2022.

Tyla Prinsloo

"Since I have been at the PMHP, my professional growth has been tremendous and I have deeply valued working within such a supportive team. My work includes waiting room talks promoting mental well being and normalising service uptake, screening, initial engagements with clients and triaging them to low versus high-intensity care. I provide counselling for the lower risk women as well as case management and supported referrals, as required."

Left to right: Tyla Prinsloo, Liesl Hermanus and Thanya April

Our counsellors have been busy, not only with intensive therapeutic work, but also in case management and time spent liaising with other organisations to ensure appropriate referrals take place. These referrals reflect the complexity of the cases we work with as well as the importance of a multidisciplinary approach.

Thanya April, our Administrator and Mental Health Counsellor, will be moving into a new role within the PMHP as Operations Officer, and is therefore not seeing any new clients, but will, however, continue to provide online support to her current clients.

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LIESL CONNECTS WITH TEENS IN MANENBERG

In view of high rates of teenage pregnancies, Groote Schuur Maternity hosted a Pregnancy Awareness Program at Phoenix High School in Manenberg on 25 February 2022. The aim of the program was to highlight important topics that promote a healthy pregnancy, including maternal mental health.

LIESL WAS INVITED TO BE ONE OF THE PROGRAMME SPEAKERS AND SHE SPOKE BROADLY ABOUT TEENAGE MENTAL HEALTH AND MANAGING MENTAL HEALTH ISSUES.

She initiated a vibrant discussion about schooling and pregnancy, getting support, and the importance of counselling. The learners engaged with the topic and many jumped at the opportunity to discuss mental health.

COMMUNITY HEALTH INTERVENTION THROUGH MUSICAL ENGAGEMENT (CHIME)

Since February 2022, the PMHP research team has been collecting data for the Community Health Intervention through Musical Engagement (CHIME) adaption project in South Africa. The project is a collaboration between the PMHP and researchers from Goldsmiths University, London and Imperial College of London. The CHIME in SA project aims to investigate, develop, and prototype a community-based music intervention for maternal mental health in the South African context.

Our research team facilitated five focus groups to explore the feasibility of the CHIME intervention in SA with: ethnomusicologists, health practitioners, music makers, community health workers, and the management team of a rural, community-based health organisation.

IN EARLY MARCH, OUR JUNIOR RESEARCHER, SIPHUMELELE SIGWEBELA, FACILITATED A WORKSHOP WITH COMMUNITY HEALTH WORKERS TO CO-DESIGN A PROTOTYPE OF THE CHIME IN SA INTERVENTION.

Watch the video recordings of the 14 songs that were composed during the workshop:
https://www.youtube.com/channel/UCjA3_YVCPr7zDcLyFiYiONw

Read more about our CHIME work in this blog post:
https://perinatalmentalhealth.wordpress.com/2022/04/20/community-health-intervention-through-musical-engagement-chime/?ct=t(PMHP-news-feb-2021_COPY_01)&mc_cid=bba3f794f1&mc_eid=aacfa33d76

MATERNAL MENTAL HEALTH TECHNICAL CONSULTATION OUTPUTS

There have been two key outputs arising from the USAID/WHO Maternal Mental Health Technical Consultation that took place late 2021, and for which our director was an invited speaker and advisory committee member.

A report "The Silent Burden: a Landscape Analysis of Common Perinatal Mental Disorders in Low- and Middle-Income Countries" was published on the USAID MOMENTUM website (https://usaidmomentum.org/resource/mmh-landscape-analysis/?ct=t(PMHP-news-feb-2021_COPY_01)&mc_cid=bba3f794f1&mc_eid=UNIQID).

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As our director was a key informant for the document, we were able to inform the content directly drawing on our two decades of experience and research.

The second output has been an open access commentary piece published in the peer-reviewed journal, *BMC Pregnancy and Childbirth*, entitled "Silent burden no more: a global call to action to prioritize perinatal mental health". As a senior author, our director was able to include PMHP's lessons in systems strengthening.

Commentary piece:
https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-022-04645-8?ct=t(PMHP-news-feb-2021_COPY_01)&mc_cid=bba3f794f1&mc_eid=UNIQID

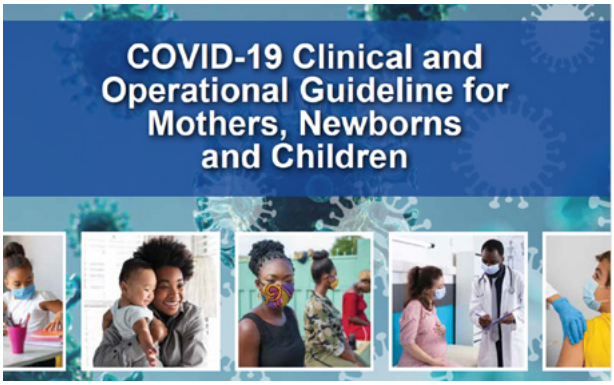
WEBINAR SERIES OF AFRICAN ALLIANCE FOR MATERNAL MENTAL HEALTH AND GLOBAL ALLIANCE FOR MATERNAL MENTAL HEALTH

Both our director, Simone Honikman, and our Clinical Services Co-ordinator, Liesl Hermanus, were invited to present at the first of this three-part webinar series directed at maternal mental health advocates, researchers, practitioners, educators and policy makers, globally. The webinar series is hosted by organisations with which we are working very closely this year: African Alliance for Maternal Mental Health and the Global Alliance for Maternal Mental Health.

SIMONE SPOKE ABOUT THE RATIONALE FOR CAMPAIGNING FOR MATERNAL MENTAL HEALTH IN LOW AND MIDDLE INCOME COUNTRIES AND LIESL SPOKE ABOUT HER LIVED EXPERIENCE OF POSTNATAL DEPRESSION AND HOW THIS INFORMS HER APPROACH IN RUNNING OUR SERVICES.

Attendance was high at 56 participants from countries such as Bolivia, Cameroon, India, Indonesia, Japan, Malaysia, Malawi, Nigeria, Nepal, Senegal, Spain, United Kingdom, United States of America and Zambia. After the presentations, participants engaged in a lively conversation and we look forward to the next in the series on how to run a national campaign for maternal mental health.

NATIONAL COVID-19 CLINICAL AND OPERATIONAL GUIDELINE FOR MOTHERS, NEWBORNS AND CHILDREN



We led the development of the chapter on 'Psychosocial care' for this new iteration of COVID-19 guidelines – approved and published this month.

THE EARLIER EDITION HAD LITTLE MENTION OF PSYCHOSOCIAL HEALTH CONSIDERATIONS.

We convened a team of experts and developed guidance, resource materials and algorithms for a range of issues including: healthworker mental distress and wellness, empathic engagement, communication and messaging, respectful maternity care, mental health conditions, gender based violence, poverty, bereavement, adolescent pregnancy, etc.

GOODBYE RITA

Rita Stockhowe, our fabulous Communication Officer, resigned at the end of 2021 to concentrate on her consultancy work. The extraordinary contributions she made to our advocacy and communications work and her incredible team spirit will be sorely missed. We continue to work with Rita on an ad hoc basis ■

RESEARCH MATTERS. SHARE YOURS.

Behind every innovative psychiatric treatment, there is clinical data. And now, more than ever, it is important to share knowledge and findings that can help us improve patients' lives and mental health care across the world.

That is why we urge you if you have just gotten the results of your clinical study to submit a late-breaking abstract to WCP 2022. You have the weekend to finalize your work and send it for review.

Make an impact with your research, starting today!

Late-Breaking Abstract Submission Deadline: 16 May 2022

THAILAND IS OPEN TO INTERNATIONAL VISITORS

On 1 May the Thai government lifted the RTC-PCR testing requirements for overseas arrivals, opening the kingdom to international visitors!

The latest Covid-19 measures will allow all WCP participants to meet safely in Bangkok & enjoy 4 days of the latest scientific advances in our field, plus many opportunities to network and connect. Start planning your journey and we'll see you there.

INVEST IN YOUR CAREER. WIN A TRAVEL GRANT

The WPA Collaborating Centers are happy to announce the Psychiatric Trainees Fellowship award – a travel grant of USD $2000, allowing one outstanding individual to attend WCP 2022 in Bangkok!

The opportunity is open to all psychiatric trainees, who are invited to submit a 3000–5000-word essay on the topic of "Forced displacement and mental health: challenges and resilience".

All submissions must be sent to kam.bhui@psych.ox.ac.uk (including 'WPA ESSAY PRIZE' in the subject heading), by 16 June 2022, 16:00 pm (BST).

Review our dedicated webpage for more details on submission and apply for our trainee fellowship. The time to invest in your career is now!

WCP 2022 REGISTRATION

ABSTRACT TOPICS

SCIENTIFIC PROGRAM

DISCOVER BANGKOK

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References: 1. Approved professional information October 2007. Full prescribing information. **2.** Inoue Y, Tabata T, Tsukimori N. Efficacy and safety of modafinil in patients with idiopathic hypersomnia without long sleep time: a multicenter, randomized, double-blind, placebo-controlled, parallel-group comparison study. *Sleep Med* 2021;80:315-321. **3.** Ooi T, Wong SH, See B. Modafinil as a stimulant for military aviators. *Aerosp Med Hum Perform* 2019;90(5):480-483. **4.** Billiard M, Broughton R. Modafinil: its discovery, the early European and North American experience in the treatment of narcolepsy and idiopathic hypersomnia, and its subsequent use in other medical conditions. *Sleep* 2018;49:69-72. **5.** Perez-Carbonell L. Treatment of excessive daytime sleepiness in patients with narcolepsy. *Curr Treat Options Neurol* 2019;21:57.

S5 **PROVIGIL® 100** (TABLETS). Reg. No.: 37/1.1/0025. Each tablet contains 100 mg modafinil. For full prescribing information, please refer to the professional information approved by the medicines regulatory authority (10/2007). Further information available on request from the holder of certificate of registration. HCR: Acino Pharma (Pty) Ltd. Reg. No.: 1994/008717/07. 106 16th Rd, Midrand. Tel. No.: 087 742 1860. www.acino.co.za. LP4038 03/2022. Exp. 03/2024.

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Sleep quality [2]

Morning alertness and daytime psychomotor functioning [3,4]

Quality of life WITHOUT
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References: 1. https://www.sahpra.org.za/registered-health-products/ (Online) [cited 2020 July 17]. **2.** Wade AG, Crawford G, Ford I, *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(1):87-98. **3.** Luthringer R, Muzet M, Zisapel N, *et al.* 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. **4.** Lemoine P, Nir T, Laudon M, *et al.* 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.** Otmani S, Demazières A, Staner C, *et al.* Effects of prolonged-release melatonin, zolpidem, and their combination on psychomotor functions, memory recall, and driving skills in healthy middle aged and elderly volunteers. *Human Psychopharmacol Clin Exp* 2008;23(8):693-705. **6.** Zisapel N and Lemoine P. Efficacy and Safety of Circadin® in the Treatment of Primary Insomnia. Touch Brief 2008;53-56. DOI: 10.17925/USN.2008.04.01.53. **7.** Circadin® Package Insert.

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SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

BIOLOGICAL PSYCHIATRY CONGRESS
CALL FOR ABSTRACTS

The Scientific committee invites the submission of abstracts to be considered for Oral or Poster presentation

- The deadline for the submission of abstracts is 30 June 2022
- Registrars and postgraduate students are specifically invited to present.
- All abstracts must be submitted online via the website
- E-mailed or faxed abstracts will not be accepted
- All appropriate abstracts will be reviewed by the Scientific Committee. All abstracts received will be acknowledged, and authors will be sent acceptance or rejection letters by 30 July 2022
- Please note that the presenter of the accepted abstract must register and all costs, including registration fees, are for the author's own expense

INSTRUCTIONS TO AUTHORS:

1. Each abstract must clearly state the following:

- Abstract title (the title of the abstract must not exceed 20 words)
- Name of contributing author(s). The name of the presenting author must appear first in the list of authors.
- Affiliation of all author(s).
- Contact details of the first author (telephone numbers, e-mail address etc)

2. Abstracts must be typed in English, single line spacing.

3 The body of the text must not exceed 350 words (this excludes the information listed in point 1)

4. Please adhere to the following format:

- Introduction: should be brief and informative and state the aim of the study
- Methods: include a description of subjects and research methodology
- Results: outline the findings of the study supported by statistics as appropriate. Do not use figures, graphs or tables in the abstract. The data provided must be sufficient to permit peer review of the abstract
- Conclusion: provide summary and relevance of the main findings

ALL ACCEPTED ABSTRACTS WILL BE PUBLISHED WITHOUT FURTHER EDITING. ABSTRACTS THAT DO NOT ADHERE TO THE SPECIFIC FORMAT WILL NOT BE PUBLISHED.

To submit an abstract, follow this link:

https://medmail.med-bay.com/servlet/link/89469/1168451/99613495/6059990

SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

EARLY CAREER PSYCHIATRISTS

SASOP EARLY CAREER PSYCHIATRISTS' INAUGURAL SYMPOSIUM:

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Date: 4 June 2022

Time: 09:00 – 12:00

Venue: Online Zoom meeting

Each participant will receive a free gift after the event!

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Meeting ID: 847 6851 6129
Security Passcode: 507290

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Time	Title of Talk	Speaker
09:00 - 09:10	Welcome	Dr Tejil Morar: SASOP Early Career Psychiatrists Convener & SASOP ECP Committee
09:10 - 09:25	Mindfulness Exercise	Ms Iram Osman: Clinical Psychologist
09:25 – 09:55 (20 min presentation followed by 10 min for questions)	**Having Tea with Val**	Dr Jade Bouwer: Consultant Psychiatrist & Louis Franklin Freed Prize winner
09:55-10:25 (20 min presentation followed by 10 min for questions)	**Research for ECPs**	Dr Nokukhanya Ngcobo: Atlantic Fellow for Equity in Brain Health at the Global Brain Health Institute
10:25-10:45 (15 min presentation followed by 5 min for questions)	**Speaking & presenting secrets they don't teach you at medical school**	Ms Ursula Botha: Founder of Confident Voices
BREAK	**From Mount Sinai to Integrative Psychiatry, the Road Less Travelled**	Dr Deborah James: Consultant Psychiatrist in Private Practice and Diplomat of the American Board of Psychiatry & Neurology
11:00-11:30 (20 min presentation followed by 10 min for questions)	**Forgiving Us**	Dr Lerato Khatle: Founder of Young MD
11:30-12:00 (20 min presentation followed by 10 min for questions)	Q & A and Closing	Dr Tejil Morar

SOUTH AFRICAN SOCIETY
OF PSYCHIATRISTS
EARLY CAREER PSYCHIATRISTS

MS NAZIA IRAM OSMAN

I am an independent, board-certified clinical psychologist registered with the Health Professions Council of South Africa (HPCSA) and a professional service provider registered with the Board of Health Care Funders (BHF).

I have extensive work experience as a previous life coach, hypnosis practitioner and within the clinical field in various hospitals within KZN namely; King DiniZulu Hospital Complex, R.K.Khan hospital, Mahatma Gandhi Memorial Hospital and Phoenix Assessment and Therapy Centre.

DR JADE BOUWER

Dr Jade Bouwer completed her MBChB cum laude from the University of Pretoria in 2012. She was awarded the prize for the best student in Internal Medicine and received academic honourary colours for her achievements. Her psychiatry rotation was her final 6th year rotation, and it was then that she fell in love with this speciality.

She moved to Johannesburg where she did her internship at Charlotte Maxeke Johannesburg Academic Hospital, and her community service year at Discoverer's Community Health Centre in Family Medicine. After a further six months as a family medicine medical officer, she began her career in Psychiatry as a medical officer at Chris Hani Baragwanath Academic Hospital in 2016.

Dr Bouwer completed her FC Psych degree in June 2021 and attained her Master of Medicine in the field of Psychiatry through the University of the Witwatersrand. Her research report titled, "Procurement and expenditure on medicines used for mental, neurological and substance use disorders; a secondary analysis of the 2017 – 2018 Gauteng Provincial Pharmaceutical Database", was awarded the Louis Franklin Freed Prize for the overall best MMed (Psychiatry) at Wits and was published in the South African Journal of Psychiatry (Vol 27 2021). She has subsequently worked as a consultant psychiatrist at Helen Joseph Hospital in Johannesburg, overseeing the emergency department and consultation liaison services, while having a limited part-time private practice. Her specific interests include forensic psychiatry, emergency psychiatry, and maternal mental health. She is also passionate about teaching and has been actively engaged in the registrar training program. In June, she will be relocating to Cape Town and joining the Neurodiversity Centre, with the hopes of being able to pursue a sub-specialty in Forensic Psychiatry in the future.

Dr Bouwer enjoys gardening and painting in her free time. She is a wife and a mother to a busy 18-month-old little girl. She believes that there is always an opportunity to be better and do better, and that it is a privilege for us as as doctors to bear witness to our patients' greatest vulnerabilities on their journey to health.

DR NOKUKHANYA NGCOBO

Dr Nokukhanya Ngcobo is a specialist Psychiatrist and honorary lecturer from Durban, South Africa. She obtained her Bachelor of Medicine and Bachelor of Surgery (MBChB) degree from the University of KwaZulu-Natal in 2010 and then later attained her Fellowship in Psychiatry in 2019 (CMSA). She attained her master's degree (MMed-Psychiatry) from UKZN in 2020. She has published in the areas of cognitive decline and adult ADHD.

She has a very keen interest in research and is currently involved in numerous research projects around dementia; looking into locally appropriate person-centred care and interventions that are feasible in their resource-constrained communities; and also, first-episode psychosis projects. She is also involved in mental health and dementia advocacy and outreach and works with a community-based dementia NPOs. Dr. Nokukhanya Ngcobo is currently an Atlantic fellow for Equity in Brain Health at the Global Brain Health Institute, based at Trinity College Dublin, Ireland. The program aims to promote brain health and dementia prevention, reduce stigma, and improve the quality of life of people with dementia by cultivating global brain health leaders.

MS URSULA BOTHA

Ursula Botha teaches professionals to speak with confidence and express their authentic voices. Ursula has over 10-years of experience in the entertainment industry as an actress and voice artist. She has strong academic and teaching skills with over 5-years of experience as an

academic lecturer and skills development coach. Ursula is the founder of Confident Voices, a skills development company that helps professionals to find their confident voices. Confident Voices specialises in offering private 1:1 coaching, small group workshops and live events.

Ursula holds a Master of Fine Arts (with distinction) in screenwriting and social theory construction, an Honours in Live Performance and a BA in drama. Her training in physical theatre and multiple acting disciplines combined with her background in storytelling and social theories makes Ursula a prolific coach to help people express complex ideas with clarity and confidence.

Ursula lives in Johannesburg, South Africa, with her two rescue dogs, Milo and Nala. Her mottos in life are: 'show up' and 'we become the stories we tell ourselves'.

DR DEBORAH JAMES

MBChB UCT
Diplomat of the American Board of Psychiatry and Neurology

I did my psychiatry residency at Mount Sinai Hospital in New York, USA after which I worked at Mount Sinai as a Clinical instructor in Outpatient Psychiatry supervising and teaching psychiatric residents in evaluation and treatment of various psychiatric disorders.

Family commitments resulted in a move back to South Africa and the start of a general adult private practice for 20 years. Within this time, I served on Advisory boards for Cipla and Servier and did a 2-year diploma course in psychodynamic psychotherapy. I spent time doing GP teaching, assisting them in psychiatric evaluation and treatment. I also did my training as an Iyengar yoga teacher after being a student of Iyengar yoga since age 16. This led me to become passionate about the neuroscience of yoga and lectured both psychiatrists and yoga teachers on this topic. Travels to an Ayurvedic and Iyengar Yoga medical centre annually for 4 years further opened my eyes to the role of yoga, nutrition and mindfulness in the healing of mental and physical illness.

At the start of 2020 I decided I wanted to experience teaching in a hospital environment again and took on the position of Associate Professor in Psychiatry Outpatient department at Mount Sinai hospital where I trained. My position was medical director of a partial hospitalisation program overseeing intakes done by 2nd and 4th year psychiatry residents. I was also supervising 3rd year psychiatry resident caseloads, all of which I loved. Covid and family saw me returning back to South Africa in May 2021 after 14 months in the USA.

Upon my return I restarted a private practice and have continued supervising new psychiatrists starting private practice in the USA.

Currently I am enrolled in an Integrative Psychiatry Fellowship with the University of Colorado medical school and am excited about this new phase in my career where I will be exploring various new areas in psychiatry allowing for a holistic and integrative approach to evaluation and treatment.

DR LERATO KHATLE

Dr Lerato Khatle the founder of Young MD (https://www.youngmd.co.za/), a human resource innovations consultancy set out to disrupt the dysfunction plaguing the healthcare system and its human capital. Through this she and her team have led successful projects and programmes empowering clinicians through meaningful learning journeys, exposure and mentorship. Lerato completed her undergraduate medical degree at Stellenbosch University and holds a diploma in Child Health.

She is also an Alumni of the Harvard/MIT Healthcare innovation Bootcamp. Lerato is an emerging leader in the health innovation space, receiving recognition in clinical and non-clinical domains. In 2018, she was awarded the 'Young Professional making a meaningful contribution to the profession' award from the South African Medical Association (SAMA).

In the information and Technology industry (ITC), her company Young MD was the only SMME selected to pitch its IT innovation to the President of the republic, Mr Cyril Ramaphosa at the Telecom ITU world conference in 2018. She is currently the Strategic Stakeholder Senior Specialist at Discovery Health and hopes to continue to make disruptive changes within the healthcare industry as her journey unfolds.

Registration Link:
https://us06web.zoom.us/meeting/register/tZAqceGtrz0rGN3q8jIEkI5PUw4dM6epVrB7

Registration Closes: Friday, 20 May 2022

SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

POSITION

SR CHILD PSYCHIATRY POST TYGERBERG HOSPITAL

PSYCHIATRY

Lentegeur Hospital, Stikland Hospital (includes Karl Bremer Hospital and the Metro), Valkenberg Hospital (includes Alexandra, Groote Schuur, Red Cross Hospitals), Tygerberg Hospital

Participate in clinical governance of a growing integrated district mental health service.

Teaching and clinical supervision of junior and allied mental health practitioners, generalists and medical students within a well-established Rural Training Complex.

REQUIREMENTS:

- MBCHB or equivalent.
- A South African citizen/permanent resident with a valid identity document. Valid registration with HPCSA as an independent medical practitioner.
- Appropriate clinical experience in psychiatry after registration as a medical practitioner.
- A valid driver's licence with minimum code 8.
- Recommendations FC Psych (SA) Part 1, or DMH

GSH: The applicant must have passed at least one of the components of FC Psych (SA) Part 1 or DMH.

Sub-Specialisation: Neuropsychiatry
Consultation Liaison Psychiatry Groote Schuur Hospital Child Psychiatry

FC Psych (SA) and MMed (Psych)
Registered as a Specialist with the HPCSA, on the basis of a MMed (psych) or FCPsych (SA)

Registered as a Specialist (Pschiatrist) with the HPCSA, MMed (psych) or FC Psych (SA)

Division of **Child and Adolescent Psychiatry**
RCWMCH/ UCT; TBH/Stellenbosch

PSYCHIATRIC HOSPITALS:
The Chief Director:
Metro Health Services Bellville Health Park, Private Bag X15, Parow 7500
For attention: Ms B Beukes

TELEPHONE ENQUIRIES:
University of Stellenbosch (US):
Prof L Koen 021 940 8718;
University of Cape Town (UCT):
Dr N Dyalakashe: 021 826 5863

TRAINING OPPORTUNITY

CERTIFICATE IN ADDICTION PSYCHIATRY:

The Department of Psychiatry, Stellenbosch University, would like to invite psychiatrists interested in subspecialist training in Addiction Psychiatry (i.e., completing the Certificate in Addiction Psychiatry), to contact us.

Candidates will either need self-fund or else to apply for external funding (e.g., Discovery Foundation subspecialist funding).

This training can be done full-time or part-time.

Interested candidates can contact Lize Weich to discuss options. (lizew@sun.ac.za)

SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

23RD WORLD CONGRESS OF PSYCHOTHERAPY

CALL FOR PROPOSALS

"PSYCHOTHERAPY AND WORLD MENTAL HEALTH 2023"

9-11 FEBRUARY 2023, FACULTY OF MEDICINE
UNIVERSITY HASSAN II CASABLANCA, MOROCCO

IFPWCP2023.COM

IFP international federation for psychotherapy

WORLD PSYCHIATRIC ASSOCIATION

PRESENTATION FORMATS:

Symposia: 90 minutes duration, with 2 co-chairs, 4 presenters, 15 minutes per presenter, and 30 minutes of Q&A.

Interactive Workshops: 1-hour total duration. There will be 2 Workshop Facilitators who will dedicate the entire time to interact with the audience.

Panel Discussions: 1-hour total duration. Panels will have one Moderator and up to 3 additional panelists. Panelists will interact prompted by the moderator and some time at the end of interaction with audience via the moderator.

Case Conferences: 1-hour total duration. Case conferences will have one moderator, one case presenter (5-15 minutes case illustration), and 2-3 discussants (10 minutes each).

Paper Sessions: 15 minutes presentation of research findings or a clinical topic. Your paper will be placed with others thematically or by topic.

Oral Communications: 10 minutes presentation of relevant research findings or of a description of an innovative program.

DEADLINE FOR PROPOSAL SUBMISSIONS:

Proposals are due October 1, 2022

INSTRUCTIONS TO SUBMIT YOUR PROPOSAL:

Please complete the proposal submission form as instructed in: www.ifpwcp2023.com

PRESIDENTIAL WELCOME

Professor Driss Moussaoui

President, International Federation for Psychotherapy

President, 23rd World Congress of Psychotherapy

Since its foundation in 1934, the International Federation for Psychotherapy organized 22 world congresses, mostly in Europe and Asia. The 23 rd World Congress of Psychotherapy will take place in Africa for the first time, namely in Casablanca, Morocco, from 9 to 11 February 2023.

DESPITE THE COVID-19 PANDEMIC, WE HAVE TAKEN THE CHALLENGE TO ORGANIZE THIS CONGRESS FACE-TO-FACE.

75% of the total population of Morocco has been vaccinated so far, including a third jab for millions. The Omicron wave spreads the virus more rapidly

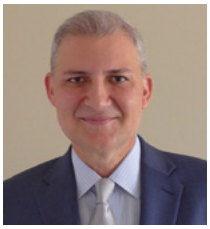
but seems to give less severe clinical situations. The Director General of WHO announced that 2022 will represent the end of the pandemic, and many scientists around the world consider that coronavirus will become endemic with seasonal variations, and that it will become the "new normal" to live with. It is time to have our congress in person again! Moreover, the pandemic, that lasted so far more than two years, showed very clearly the necessity to address mental health difficulties and disorders, including with psychotherapeutic tools.

THE THEME OF THE WORLD CONGRESS IS "PSYCHOTHERAPY AND WORLD MENTAL HEALTH 2023". A SUPERB SCIENTIFIC PROGRAMME IS BEING CONSTRUCTED ON CURRENT CHALLENGES FOR PSYCHOTHERAPY WORLDWIDE, INCLUDING INNOVATIONS IN OUR FIELD, AND THE PATHS AHEAD OF US.

The scientific committee is led by César Alfonso, USA, Tom Craig, UK, Fiammetta Cosci, Italy and Gisele Apter, France.

Casablanca is an appealing city to visit with many beautiful spots, not to mention other Moroccan cities that are worth the visit (Marrakech, Fes, Essaouira...). The National organizing committee, led by Nadia Kadri and Hachem Tyal, along with the professional congress organizer Realize Events, are preparing a nice social and cultural programme.

I do hope that in February 2023, we will have both a world free of Covid-19 and a very successful world congress. Please disseminate the news. See you in Casablanca in 2023!



WELCOMING REMARKS

César A. Alfonso, M.D.

Council Member, International Federation for Psychotherapy

Scientific Executive Committee Co-Chair, 23rd World Congress of Psychotherapy

The International Federation for Psychotherapy invites you to the 23rd World Congress of Psychotherapy, to be held in Casablanca, Morocco on 9-11 February 2023. This conference has as a primary objective to demonstrate the importance of evidence-based psychotherapy in everyday practice across all clinical settings throughout the world.

What are the common curative factors in psychotherapy? Research studies validate the clinical observations that specific aspects of psychotherapy practice are curative. These include: *empathy* (with sub-components of compassion, affective sharing, synchronized mirroring, listening to expressed intense emotions while maintaining composure and serenity), *goal consensus and collaboration, establishing a therapeutic alliance* (through safety, consistency, attunement, properly anticipating and attending to emotional needs), *positive regard and affirmation, mastery, congruence/genuineness, and mentalization* (developing the capacity to understand nuances of emotions, the emotional world of the self, the emotional world of others, and how emotions drive actions and one's actions impact the emotions of others, resulting in either proximity, intimacy or alienation). These factors constitute the main transformative elements in psychotherapy.

In addition, in all psychotherapies affective regulation (regulation of emotional reactions, decreasing amplitude and over reactivity that may interfere with successful relationships) is of essence. In *cognitive behavioural therapies* maladaptive patterns are identified and cognitive distortions corrected, such as catastrophic thinking. Traumatic memories can be remembered in disjointed ways when emotional memories surge and overwhelm the person. Narrative reconstruction has the effect of helping persons who experienced trauma effectively release negative emotions and decrease hyperarousal and avoidance. In *psychodynamic therapies* conflicts that may be outside of conscious awareness are uncovered and verbally processed. Revisiting past experiences, especially traumatic ones, helps understand how to connect past experiences with present concerns or symptoms to forge a better future. Psychotherapy is thus practiced along a past-present-future continuum.

Psychotherapy, in addition to providing symptomatic relief, promotes gains in functioning and improves quality of life. Researchers have demonstrated that psychotherapy not only decreases medical morbidity but also reduces mortality.

A psychotherapy process oscillates from dealing with the here and now, doing retrospective analyses and narrative reconstructions and prospective planning. Psychotherapy pays special attention to the developmental milestones that are relevant to each phase of life, such as trust, autonomy, initiative, industry, identity, intimacy, generativity, integrity, and balancing self-reliance with interdependence.

Neuroimaging findings corroborate that structural changes and changes in metabolic rate in the brain occur as a result of psychotherapy. With

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advances in neuroscience, we now understand that psychotherapy may be considered a biological treatment. As with medication treatments, there is a dose effect with psychotherapy and most individuals obtain greater benefit from either longer-term treatments or rigorous short-term therapies. Episodic psychotherapy could be beneficial when a commitment to long-term therapy or a standardized rigorous short-term protocol is not possible.

THIS CONFERENCE INVITES INTERNATIONAL DELEGATES FROM ALL CONTINENTS WHO ARE MEMBERS OF IFP MEMBER SOCIETIES AND CLINICIANS AND ACADEMICS FROM ALL MENTAL HEALTH DISCIPLINES. WE SEEK TO PROVIDE A FORUM FOR THE COLLEGIAL EXCHANGE OF DIVERSE IDEAS AND THEORETICAL CONSTRUCTS TO ADVANCE THE PRACTICE OF PSYCHOTHERAPY TREATMENTS.

This conference will include Plenary Sessions, Symposia, Panel Discussions, Interactive Workshops, Review Courses and Case Presentations. In addition, there will be two Poster Session tracks, clinical and research, to give opportunities to trainees, researchers, and clinicians from all over the world to present their work in a collegial setting.

IFP is inclusive and all treatment modalities will be featured, including cognitive behavioral and third wave therapies, motivational interviewing, supportive psychotherapy, psychodynamic psychotherapies, provided in individual, group, outpatient and structured settings. Conference participants will be able to compare theoretical approaches and integrate modalities to better tailor treatments. Common factors of all therapies will be discussed, and cultural adaptations will be highlighted.

Plenary speakers, symposia presenters, and workshop facilitators will cover a wide range of relevant topics. These include, among others, *evidence-based CBT and MI treatments of addiction, CBT cultural adaptations, Third-Wave psychotherapies, psychodynamics of psychopharmacology, end of life care, psychotherapy in underserved areas with high volume and low resources, integrating psychotherapy modalities, evidence-based psychotherapies for psychosis, psychotherapy in medical settings, psychotherapy education, religion and spirituality and psychotherapy, psychotherapy and culture, and contemporary psychoanalysis.*

We would like to thank the University Hassan II Casablanca, Faculty of Medicine and Pharmacy, for so graciously hosting the IFP World Congress of Psychiatry, and express gratitude to all the member organizations for their dedication and cooperation to ensure success and academic rigor.

It is with enthusiasm that we invite you to join us Casablanca for this historic conference!

President of the Congress:
Driss Moussaoui (Morocco)

Advisor:
Norman Sartorius (Croatia)

Scientific Executive Committee:
César Alfonso (USA)
Gisèle Apter (France)
Fiammetta Cosci (Italy)
Tom Craig (UK)

National Organizing Committee:
Nadia Kadri (Morocco)
Hachem Tyal (Morocco)
Chaimaa Aroui (Morocco)

South Africa
Gerhard Grobler

INSTRUCTIONS TO AUTHORS

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

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

LETTERS TO THE EDITOR

* Novel experiences
* Response to published content
* Issues

FEATURES

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

REPORTS

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

PERSPECTIVES

* Personal opinions written by non-medical contributors

NEWS

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

ANNOUNCEMENTS

* Congresses, symposia, workshops
* Publications, especially books

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

REVIEW / ORIGINAL ARTICLES

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

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

Acceptance of submitted material will be subject to editorial discretion

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

CNS

Live Today. Brighter Tomorrow!

Introducing NEW Bupropion XR 150 ADCO

- Simple and convenient morning dosing.[1]
- Treats major depressive disorder and associated symptoms.[1-3]
- Offers a therapeutic advantage over serotonergic antidepressants with dual action on monoaminergic receptors.[#*2,4]
- 58 % monthly cost saving vs. originator.[5]

NEW

Bupropion

Bupropion HCl **XR 150 ADCO**

XR - extended release; *Dual action refers to inhibition of neuronal noradrenaline and dopamine re-uptake in the synaptic cleft;[2] #Therapeutic advantage is gained by dual action on noradrenaline and dopamine neurotransmission causing enhanced monoaminergic effects and a reduction in the noradrenergic symptom cluster (decreased positive effect) which include loss of energy and fatigue, loss of self-care and motivation and decreased concentration.[4]

References: **1**. Bupropion XR 150 ADCO Professional Information Leaflet. January 2021. **2**. Stahl SM, Pradko JF, Haight BR, *et al*. A Review of the Neuropharmacology of Bupropion, a Dual Norepinephrine and Dopamine Reuptake Inhibitor. *Prim Care Companion J Clin Psychiatry* 2004;6(4):159-166. **3**. Fava M, Rush AJ, Thase ME, *et al*. 15 Years of Clinical Experience With Bupropion HCl: From Bupropion to Bupropion SR to Bupropion XL. *Prim Care Companion J Clin Psychiatry* 2005;(3):106-113. 4. Bupropion. Medline Plus Information. Available at: https://medlineplus.gov/druginfo/meds/a695033.html. Last accessed: August 2021. **5**. Generics Dictionary [online]. Available at: <http://www.generic.co.za/frontend/generics?utf8=%E2%9C%93&q%5Bactive_ingredient_name_eq%5D=BUPROPION> [Accessed 30 August 2021].

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

S5 Bupropion XR 150 Adco. Each extended-release tablet contains bupropion hydrochloride 150 mg. Reg. No.: 50/1.2/0967.965.

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References: **1**. Deslafore XR 50 and 100, extended-release tablets Professional Information, December 2020. **2**. Osuch E, Marais A. The Pharmacological management of Depression - Update 2017. *S Afr Fam Pract* 2017;59(1):6-16. **3**. Colvard MD. Key differences between Venlafaxine XR and Desvenlafaxine: An analysis of pharmacokinetic and clinical data. *Mental Health Clin* 2014;4(1):35-39. **4**. Database of Medicine Prices, 24 December 2021. Department of Health. Available from: http://www.mpr.gov.za. [Accessed 10 January 2022].

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

S5 Deslafore XR 50 Tablets. Each extended-release tablet contains desvenlafaxine succinate monohydrate equivalent to 50 mg desvenlafaxine. Reg. No.: 52/1.2/0505.
S5 Deslafore XR 100 Tablets. Each extended-release tablet contains desvenlafaxine succinate monohydrate equivalent to 100 mg desvenlafaxine. Reg. No.: 52/1.2/0506.

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