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issue 39 • May 2024

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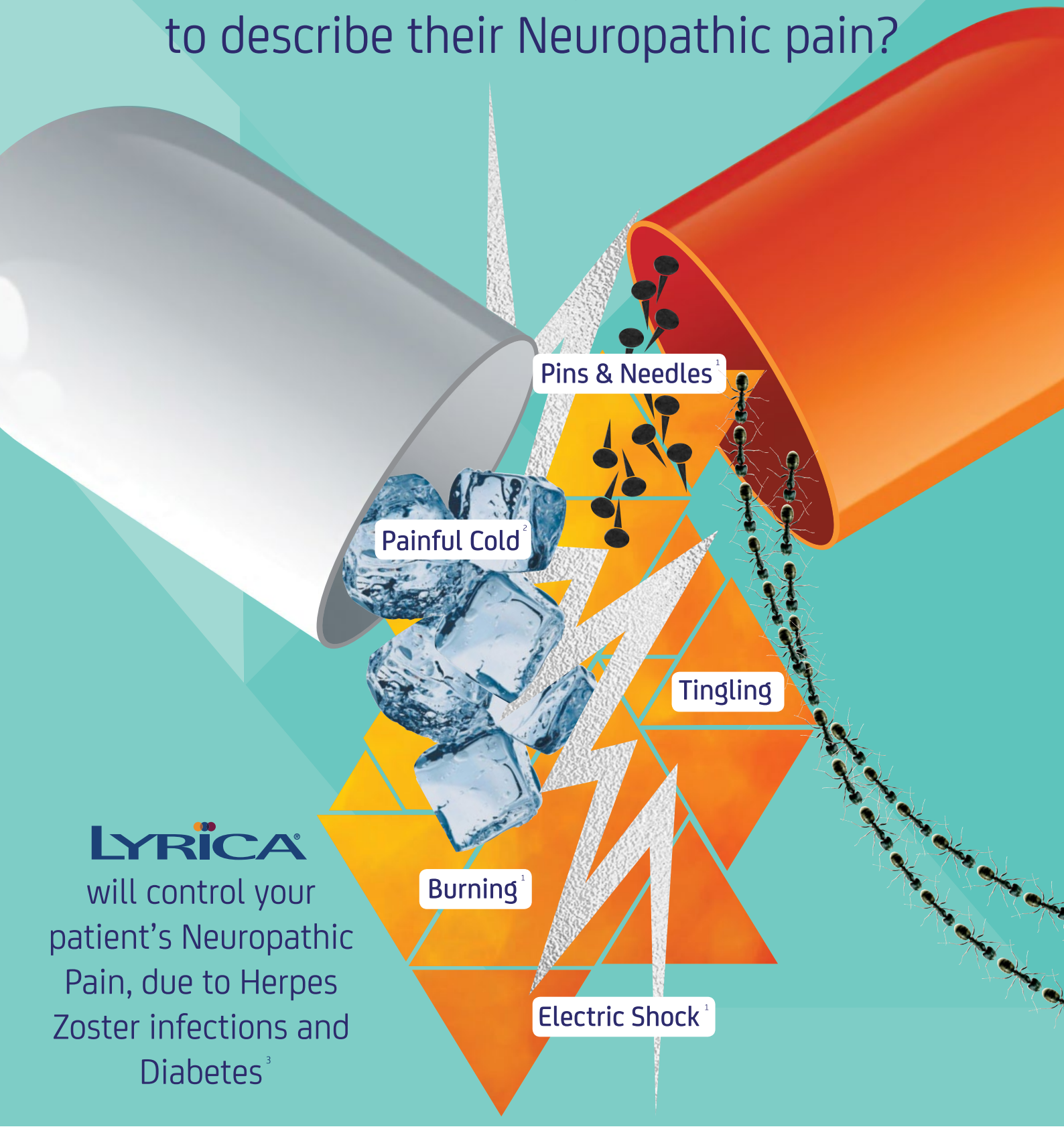

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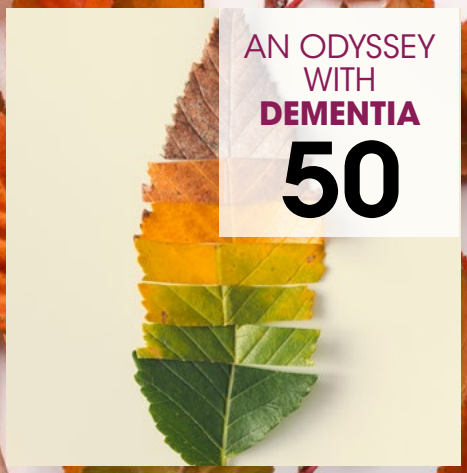

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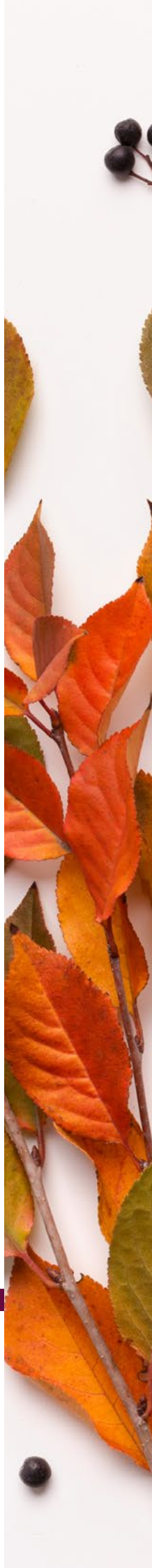

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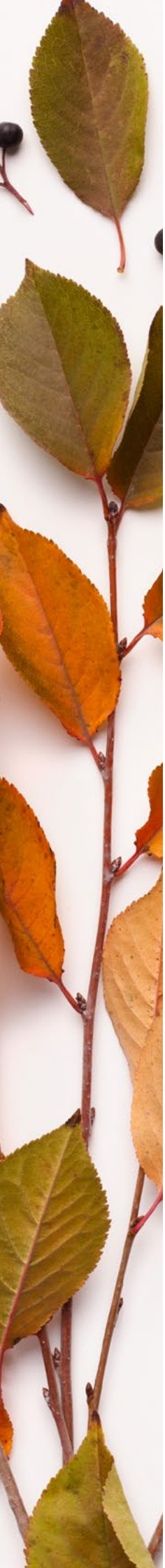

Dear Reader,

welcome to the May 2024 issue. Autumn has arrived and with it the coolness, shorter days and the changing colours of the leaves. A time of change. Speaking of which, I decided to stop clinical practice and by the time you read this I will no longer be an "active" psychiatrist. There comes a time to step back, to reflect…a time for change. For the August 2024 issue of *South African Psychiatry* Renata Schoeman has curated a series of articles dealing with "Retirement" - an interesting coincidence - so I will likely contribute my own *Perspective*…am I retiring or simply opening up space for different activities ? A friend sent me David Whyte's poem *Mameen* – it resonated, and I would recommend it be read as you might contemplate change.

Following publication of the February 2024 issue we sent a survey to the publication's database, to establish how readers experience *South African Psychiatry*. We will be sharing the responses in the August 2024 issue but for those who have not yet participated but wish to do so here is a QR code which you can scan and do so from your phone – the cellular one 😊 …

The current issue features a series of *Reports* converting presentations from an academic meeting into content accessible to a wider audience. As always, I am pleased to have the publication provide a platform for dissemination of such content which also provides an illustration of how industry contributes to the discipline in a way that is purely educational.

In closing, I came across an article in the BMJ which gave me pause to reflect hence I thought I would share it: "Prescribing isn't a single act – getting it right requires time and effort" (Rammya Mathew; *BMJ* 2024; 384:q279 ; http://dx.doi.org/10.1136/bmj.q279).

I hope you will enjoy this issue.

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OPPOSITIONAL DEFIANT DISORDER AND CO-MORBID PSYCHIATRIC CONDITIONS

Saeeda Paruk

THIS ARTICLE IS A REVIEW OF A PRESENTATION AT THE DR. REDDY'S PSYCHIATRY ACADEMIC WEEKEND MEETING HELD 9TH TO 11TH JUNE 2023. THE MEETING, SPEAKERS AND WRITING ASSISTANCE WERE SPONSORED BY DR. REDDY'S LABORATORIES PTY. LTD. THE SPEAKER ACKNOWLEDGES DR DAVID WEBB FOR WRITING ASSISTANCE. ***dawebb@mweb.co.za***

Oppositional defiant disorder (ODD) is a recurrent pattern of negativistic, defiant, disobedient and hostile behaviour that is persistent for at least 6 months. It is characterised by temper tantrums, arguments, refusal to listen to adults and comply with rules, and annoying behaviour towards siblings, peers and adults. It is a milder form of conduct disorder (CD), and the behaviours associated with ODD do not meet criteria for a diagnosis of CD. According to DSM5, a diagnosis is made based on the presence of at least 4 of the following criteria:

Angry/irritable mood

1. Loses temper
2. Easily annoyed by others
3. Angry and resentful

Argumentative/defiant behaviour

4. Argues with adults
5. Defies/refuses adults' requests
6. Annoys others deliberately
7. Blames others for their own mistakes

Vindictiveness

8. Spiteful or vindictive.

It is not uncommon for individuals with ODD to show symptoms only at home and only with family members. However, the pervasiveness of the symptoms (number of settings in which symptoms are present, e.g., home, school, with peers, etc) is an indicator of the severity of the disorder.

Saeeda Paruk

IT IS IMPORTANT TO DISTINGUISH BETWEEN ODD AND CD, BECAUSE TREATMENT MAY VARY AND OUTCOMES OFTEN ARE DIFFERENT. CONDUCT DISORDER IS CHARACTERISED BY A PERSISTENT PATTERN OF VIOLATION OF RIGHTS AND MAJOR SOCIAL RULES OR NORMS.

It is often manifested by aggression to animals or people, deceitfulness or theft, destruction of property and serious violation of rules. There is impairment of social functioning, and childhood

onset before the age of ten is associated with a poorer prognosis and greater likelihood of progressing to antisocial personality disorder.

ODD IS A CONTROVERSIAL DIAGNOSIS. SOME CONSIDER IT TO BE A REBELLIOUS PHASE WITHIN A NORMAL CHILDHOOD AND BELIEVE THAT THE BEHAVIOUR SHOULD NOT BE PATHOLOGISED.

Others consider it to be a milder form of CD and therefore on the spectrum of CD and not a distinct category in its own right. Others do consider it a distinct disorder (and hence its inclusion in DSM5) with its own developmental trajectory, independent risk factors and distinct long-term health implications. Nevertheless, CD remains a common reason for referral to child and adolescent mental health services. It impacts on education and may be a reason for premature dropping out of school. Management involves multiple agencies, including social work, the educational system, psychology and occupational therapy.

ODD IS ASSOCIATED WITH SUBSTANTIAL COMORBIDITY, INCLUDING BOTH THE DESTRUCTIVE DISORDERS (E.G., ADHD) AND INTERNALISING DISORDERS, INCLUDING MAJOR DEPRESSIVE DISORDER (MDD) AND ANXIETY DISORDERS, AND IT MAY PROGRESS TO PERSONALITY DISORDERS AND OTHER ADULT PSYCHOPATHOLOGY. IT CARRIES A SIGNIFICANT BURDEN TO BOTH THE PATIENT AND FAMILY.

EPIDEMIOLOGY OF ODD

The estimated prevalence of ODD varies from 2% to 11%, but it may be as high as 28-65% in the clinical setting among children attending a mental health service. It affects boys and girls equally and prevalence peaks around age 7 coinciding with entry into the formal schooling system and the necessity to conform to structure and rules. It peaks again at around age 14-15 when adolescents are seeking autonomy and they may have difficulty in expressing themselves.

RISK FACTORS

Risk factors for ODD include the following,

(1) Genetic predisposition. The estimated heritability is approximately 50%. There is substantial genetic overlap with CD, ADHD and depressive disorders, but whether the exact genetic contribution is the same is unknown.

(2) Gene-environment interactions. Children who may be biologically vulnerable and who also suffer environmental stresses may be particularly vulnerable to developing ODD. Studies have shown that individuals with a low activity level of the neurotransmitter-metabolizing enzyme monoamine oxidase-A and who were exposed to childhood abuse may be at higher risk.

(3) Maternal smoking may increase the risk of ODD, and some studies have suggested that a child with the *DAT* gene and a mother who smokes may be at increased risk.

(4) Lower cortisol levels and higher androgen levels have also been implicated.

(5) Neuroimaging suggests involvement of the prefrontal cortex, amygdala and insula.

(6) Individual factors include temperament, cognitive ability to deal with problems, and problem solving. Often children with ODD tend to be inflexible when faced with challenges and they have poor problem-solving skills, leaning on aggression and irritability as a coping mechanism.

(7) Family dysfunction (e.g., parental separation and hostility, poor parenting, substance use disorders) is very important and common, although it is not invariably present.

(8) Environmental factors are also common and include neglect, abuse, low socioeconomic circumstances, and poor social support.

ASSESSMENT

The child is usually young and must be assessed together with his/her parents. In the absence of diagnostic tests, history is critical and should be taken from multiple sources and across multiple settings. Particular attention should be paid to the following:

- Symptoms
- Family history, parenting techniques
- Medical history (e.g., seizures, developmental problems)
- Developmental history:
  - child having a difficult temperament
  - being difficult to soothe as a baby
  - having high motor activity
  - a propensity toward extreme emotional reactions
  - periods of different care givers
  - history of disruptive behaviour from age 6-7 years, but can be younger

A PHYSICAL EXAM SHOULD BE PERFORMED TO EXCLUDE ANOTHER MEDICAL DISORDER.

COMORBIDITIES ARE COMMON AND MUST BE EVALUATED. IN PARTICULAR ONE SHOULD EXCLUDE NEURODEVELOPMENTAL DISORDERS, SUCH AS ADHD, LEARNING DISORDERS, AND MDD.

A risk assessment is also necessary to identify risk of abuse (physical and psychological) to the child and to others who might be impacted on by the child's behaviour and who require care (e.g., siblings, peers, and parents).

In conjunction with a full assessment, diagnosis may be augmented by screening tools, which help to provide an objective assessment of symptoms and symptom severity, and provide a longitudinal measure of the evolution of symptoms. Screening tools that might be useful include the Swanson, Nolan, Pelham (SNAP) questionnaire, Child Behaviour Checklist, and Connor's rating scale.

ODD AND COMORBIDITIES

ODD shares risk factors with, and may act as a risk factor longitudinally for, other psychiatric conditions and carries a substantial risk of comorbidity. A large study that assessed lifetime prevalence and correlates of ODD in more than 3 000 American adults estimated the lifetime prevalence of ODD to be approximately 10%.

Of those with lifetime ODD, 92% met criteria for at least one other lifetime DSM-IV disorder, including mood (46%), anxiety (62%), impulse control (68%) and substance use (47%) disorders. Early onset of ODD before age 8 and comorbidity predicted slow speed of recovery of ODD.

COMMUNITY AND EPIDEMIOLOGIC STUDIES ALSO SHOW A CONSIDERABLE RISK OF DEPRESSION (PREVALENCE 15-45%) AND ANXIETY DISORDERS (7-55%) IN CHILDREN WITH ODD.

ODD is also highly comorbid with CD. The Great Smoky Mountains Study included a representative sample of 4 500 children aged nine, eleven and thirteen years resident in western North Carolina, USA who were followed up until the age of 21 years.

BETWEEN THE AGES OF 9 AND 16 YEARS CD WAS DIAGNOSED ON AT LEAST ONE OCCASION IN 8.6% OF YOUTH AND ODD IN 9.7%. ODD PREDICTED LATER CD IN BOYS (ODDS RATIO 6.5), BUT NOT IN GIRLS.

Atypical family structure was an important factor in the transition between ODD and CD in boys, but transitions between ODD and CD were less common than anticipated (approximately 9% in the overall sample with ODD at baseline). CD largely predicted behavioural outcomes, whereas ODD showed stronger prediction to emotional disorders in early adult life. Irritable and headstrong dimensions in ODD symptoms predicted later behavioural and emotional disorders.

THERE IS SOME OVERLAP BETWEEN DISRUPTIVE MOOD DYSREGULATION DISORDER (DMDD) AND ODD. IRRITABILITY IS COMMON TO BOTH. HOWEVER CHILDREN WITH ODD ARE MORE LIKELY TO HAVE COMORBID ADHD, EXHIBIT DELINQUENT BEHAVIOUR AND TO HAVE DIFFICULTY WITH AUTHORITY FIGURES. CHILDREN WITH DMDD ARE MORE LIKELY TO HAVE IRRITABILITY THAT IS GENERALISED AND PERVASIVE, WITHOUT PROBLEMS WITH AUTHORITY.

MANAGEMENT OF ODD

Care for the child with ODD has to be highly individualised taking into consideration the individual and their contextual circumstances (e.g., place of residence; support structures; access to, and availability of care; family structure, socioeconomics and available resources). It is important to consider not only deficits, but also the innate strengths of the child and what is already available to support them.

Guidelines recommend starting with non pharmacological treatment. The care plan includes child and family-based interventions, based on severity, age, developmental level, risk and resources, starting with parent management training, school-based interventions and family therapy. Older children (from 11 years) benefit from individual therapy (e.g., play therapy), although it is uncertain whether this will prevent future psychopathology. Comorbidities must be addressed, and treatment of comorbidities often results in a commensurate improvement in symptoms of ODD.

STRATEGIES FOR OPPOSITIONAL CHILDREN NEED TO FOCUS ON THE POSITIVE, RATHER THAN INSTRUCTING THE CHILD ON WHAT NOT TO DO. THEY SHOULD BE ENCOURAGING AND PLAY TO THE CHILD'S STRENGTHS AND POSITIVE BEHAVIOURS. ALL ADULT CAREGIVERS NEED TO BE INFORMED AND ALIGNED IN THEIR APPROACH TO MAINTAIN A CONSISTENT APPROACH TO THE CHILD'S BEHAVIOUR.

Parents need to be informed that over-the-counter medications and popular diets do not have a scientific evidence base.

PHARMACOLOGICAL THERAPY IS NOT FIRST LINE AND IS NOT WELL STUDIED. IN THE MULTIMODAL TREATMENT STUDY OF ADHD (MTA), CHILDREN WITH ADHD AND COMORBID ODD BENEFITTED MORE FROM A COMBINATION OF BEHAVIOURAL THERAPY AND MEDICATION COMPARED WITH EITHER MODALITY ALONE OR IN COMPARISON WITH COMMUNITY ROUTINE CARE.

However, the very high cost associated with combined treatment, means that the presence of ODD in ADHD patients makes the cost of treatment higher, and the response rate to medication alone is not sufficient when ODD is co-morbid with ADHD. It can be speculated that early and effective interventions for behavioural problems in patients with ADHD, before the establishment of a full picture of ODD, may represent savings in healthcare delivery to these patients.

A large systematic review and meta-analysis evaluated the efficacy of pharmacotherapy for ADHD, ODD and CD. The medications evaluated included psychostimulants, alpha-2 agonists, atomoxetine, antipsychotics and traditional mood stabilizers. The investigators concluded that, when severe disruptive or aggressive behaviour occurs with ADHD, medications for ADHD (psychostimulants) should be used first. Atomoxetine and alpha-2 agonists received conditional recommendation.

Risperidone was the only medication recommended for treating disruptive or aggressive behaviour in the absence of ADHD, although, given its association with potential adverse effects, it received only a conditional recommendation in favour of use. Other medications are not well tolerated and are not recommended.

RECENT CANADIAN GUIDELINES ON PHARMACOTHERAPY FOR DISRUPTIVE AND AGGRESSIVE BEHAVIOUR IN CHILDREN AND ADOLESCENTS WITH ADHD, ODD AND CD MADE SIMILAR RECOMMENDATIONS.

In a subgroup of 439 adolescents with a primary diagnosis of MDD who also had ODD (13%), fluoxetine monotherapy, cognitive behavioural therapy (CBT) and fluoxetine combined with CBT all reduced oppositionality. However, fluoxetine monotherapy and fluoxetine combined with CBT were more effective in reducing symptoms of ODD than CBT alone, with no significant difference between the two. The study indicates that, in adolescents with MDD, treating depression improves symptoms of ODD.

PROGNOSIS

ODD resolves within 3 years in approximately two thirds of children. However, in a minority it can progress to CD, and 10% progress to antisocial disorder.

RISK FACTORS FOR PROGRESSION TO CD INCLUDE CHILDREN WITH GREATER PHYSICAL AGGRESSION, PARENTAL HOSTILITY, FAMILY INSTABILITY, LOWER SOCIOECONOMIC CIRCUMSTANCES AND MORE SEVERE ODD. ESPECIALLY IN THOSE WITH MORE SEVERE ODD AND THOSE WHO'S ODD WAS PRESENT AT A YOUNGER AGE, THERE IS AN INCREASED RISK OF LATER PSYCHOPATHOLOGY, INCLUDING MOOD AND ANXIETY DISORDERS.

Children with ODD are not only at increased risk of being a bully, but are also at increased risk of being bullied, and both require appropriate intervention.

FINAL THOUGHTS

It is easy to dislike a child who is oppositional, defiant and 'badly behaved'. However, it is important to remember that behind that behaviour is a human being who frequently is struggling to cope in a difficult world, often under adverse personal circumstances. Under those conditions it would be understandable to feel misunderstood and uncared for.

ALL CHILDREN SHOULD BE APPROACHED WITH COMPASSION AND A POSITIVE OUTLOOK. LABELS DESCRIBE BEHAVIOUR, NOT THE CHILD, AND TERMS ARE USED TO DESCRIBE PATTERNS OF BEHAVIOUR AND NOT CHILDREN. SO INSTEAD OF 'HE IS AN ODD CHILD', CONSIDER HIM AS 'A CHILD WITH ODD'.

References available on request.

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CLIMATE CHANGE & MENTAL HEALTH

Ugash Subramaney

THIS ARTICLE IS A REVIEW OF A PRESENTATION AT THE DR. REDDY'S PSYCHIATRY ACADEMIC WEEKEND MEETING HELD 9TH TO 11TH JUNE 2023. THE MEETING, SPEAKERS AND WRITING ASSISTANCE WERE SPONSORED BY DR. REDDY'S LABORATORIES PTY. LTD. THE SPEAKER ACKNOWLEDGES DR DAVID WEBB FOR WRITING ASSISTANCE. ***dawebb@mweb.co.za***

Increasing CO_2 levels as a consequence of global industrialisation has led to rising temperatures, extreme weather events (droughts, floods, storms and heat waves) and rising sea levels. In turn these are associated with fatalities, injuries and significant damage to property and infrastructure. Climate change threatens food and water security, health and well-being and may result in displacement of vulnerable populations, affecting specifically those in lower socioeconomic circumstances. Climate change is also associated with significant effects on both physical and mental health. Rising temperatures lead to increased incidence of cardiovascular, cerebrovascular and respiratory illnesses. Associated increases in ozone increase exacerbations of respiratory illnesses, such as bronchitis, asthma and chest pain. Adverse effects on farming and food production in some parts of the world cause migration from rural areas to urban centres placing pressure on already constrained healthcare systems and limited food resources.

A GROWING URBAN POPULATION IS ASSOCIATED WITH AN INCREASED RISK OF INFECTIOUS AND DIARRHOEAL DISEASES, AND NUTRITIONAL DISORDERS. FURTHERMORE, SOUTH AFRICAN STUDIES HAVE SHOWN THAT HIGH TEMPERATURES ARE POSITIVELY ASSOCIATED WITH AGGRESSION, VIOLENT BEHAVIOUR AND HOMICIDES.

Ugash Subramaney

It is unsurprising that under conditions of such environmental hazards, food insecurity, displacement, threat to livelihood, and adverse effects on physical health and well-being, that mental health should also suffer. Indeed, climate change may be positively associated with various psychiatric conditions, including posttraumatic stress disorder (PTSD), anxiety disorders, sleep disorders, affective/mood disorders, substance use disorders and suicide.

PTSD

Life threatening situations due to the effects of climate change (rampant floods, droughts and fires), may increase the risk of developing acute stress disorder or posttraumatic stress disorder (PTSD). Losses due to increased infection can also lead to the symptoms of PTSD, such as flashbacks of the event, increased arousal and avoidance of cues to the memory of the event. This was borne out in the immediate aftermath of the California wildfires in 1991, as well as after Hurricane Katrina in 2005.

ANXIETY AND SLEEP DISORDERS

In the context of climate change concerns, the manner in which a person responds to anxiety may produce beneficial or harmful outcomes.

Beneficial outcomes include greater awareness of individual choices and actions and their impact on the environment. This then translates to individual action that is aimed at reducing harmful effects, and may improve wellbeing. A harmful outcome is one where there are increased levels of anxiety experienced in the face of feelings of helplessness and gloom and concerns about the future. This anxiety may worsen over time.

Climate change and acute climate events may be a direct and immediate cause of anxiety and anxiety disorders (such as generalized anxiety disorder, panic disorder with or without agoraphobia, and social anxiety disorder).

ANXIETY MAY ALSO DEVELOP MORE CHRONICALLY IN RESPONSE TO THE CLIMATE CRISIS AND MIGHT LEAD TO ANXIETY DISORDERS INDIRECTLY IN THE SHORT OR LONG TERM.

Anxiety about the future in the context of climate change and destruction of the environment ('eco-anxiety') is increasing, and may be associated with other emotional reactions including anger, guilt, despair and grief. 'Solastalgia' describes a feeling of distress and isolation caused by the negatively perceived changes associated with climate change and the gradual removal of solace from the present state of one's home environment. Young people, including those living in high-income countries, are believed to be especially vulnerable to these syndromes. As part of an anxiety response individuals may experience changes in sleep patterns, which can further impact mental health outcomes.

PSYCHOSIS

Acute traumatic climate events can precipitate acute psychiatric outcomes, including psychotic episodes. This may be especially relevant in individuals with a pre-existing history.

Acculturation has been studied in its relation to psychotic disorders such as schizophrenia and psychotic like experiences (PLEs). Acculturative stress has been shown to be associated specifically with hallucinatory symptoms among immigrants to the United States, particularly those from Asian countries. Hence the stress from migrating due to climate change effects might be implicated in the onset of PLEs and psychotic disorders.

OCD

As anthropogenic climate change dominates present day culture through youth movements, legislature, media, global health summits, etc., it is likely to influence OCD symptomatology. A study published in 2008 found that 28% of 50 patients with OCD in Australia had symptomatology related to climate change. Obsessions among these individuals were related to increasing temperatures causing evaporation of pets' water, depleting power and water sources by leaving lights and taps on, and global warming leading to infrastructural damage. Compulsions centred around these obsessions and included checking pets' water bowls, repeatedly checking light switches and taps, and visually checking for damage to buildings.

The coronavirus disease-19 (COVID-19) outbreak in 2019 was associated with a significant increase in prevalence rates of OCD. Pre-COVID-19, the estimated lifetime prevalence globally of OCD was 2-3%. A systematic review published in 2021 demonstrated that the prevalence of OCD in multiple countries was significantly higher post COVID-19; for example in Wuhan, China (18.0%) and Germany (21.5%). A worsening of pre-COVID-19 OCD symptoms was also noted in this review.

AFFECTIVE/MOOD DISORDERS

The relationship between mood disorders and climate has long been identified, with a "seasonal pattern" specifier, for both bipolar and related disorders and major depressive disorders (MDD), appearing in the DSM-5. Traditionally, seasonal patterns have typically been associated with autumn or winter months, but a recent scoping review published in 2021 identified multiple studies where an increase in temperature was associated with mental illness. A study in Taiwan, included in the review, found a 7% increased incidence of MDD per 1°C rise in regions with an annual average temperature above 23°C. Fifteen studies in the review demonstrated the association between heat waves and psychiatric hospital admissions, including mood disorders.

Wildfires have also been significantly associated with MDD, with a Californian study identifying 33% of victims having symptoms of MDD. A 2014 study comparing lifetime prevalence rates of mood disorders from 17 countries found a statistically significant association between mood disorders and average annual rainfall, as well as monthly rainfall differences.

ANOTHER SYSTEMATIC REVIEW PUBLISHED IN 2021 FOUND THAT 20% OF FLOOD VICTIMS WERE CLINICALLY DEPRESSED. THE RESULTANT CONSEQUENCES OF CLIMATE CHANGE, SUCH AS LOSS OF LIFE, HOUSING, RESOURCES, COMMUNITIES AND SO ON ALSO PLACE INDIVIDUALS AT RISK FOR MOOD DISORDERS.

SUBSTANCE USE DISORDERS

Substance use has been associated with both the direct and indirect effects of climate change. The direct effects refer to reactions following acute weather events while indirect effects relate to financial loss, displacement, homelessness, forced migration, a lack of resources and collective

violence. A Canadian-based population survey found that 35% of homeless youth reported at least 1 drug overdose requiring hospitalisation. Patients with substance misuse were victims of significantly higher heat-related mortality, and air pollution also has the potential to exacerbate cardiorespiratory illnesses in patients with substance use disorders who smoke.

SUICIDE

Climate change has been linked to suicide via air pollution, rising temperatures and drought. One study found that daily poor quality air increased suicide rates by 1-2%. The pathophysiology of air pollution and suicide risk is theoretically neuroinflammatory, with air pollutants acting as irritants.

Studies in India, Finland, Italy, the United States of America and Mexico have all found an association between higher temperatures and increased suicide rates. In Finland, temperature changes contributed to the variance in suicide rates by more than 60%.

IF CLIMATE CHANGE CONTINUES AT ITS CURRENT RATE, IT IS EXPECTED TO RESULT IN AN ADDITIONAL 21 770 SUICIDES BY 2050 IN THE US AND MEXICO ALONE.

Studies demonstrating the association between drought and suicide are mostly Australian. One study done between 1964 to 2001 demonstrated an 8% increased risk of suicide for every 300 mm decline in rainfall.

CLIMATE CHANGE IN SOUTH AFRICA

In South Africa, climate change is predicted to exert significant effects on mental health and well-being. It has been shown that high temperatures are positively associated with aggression, violent behaviour and homicides, which could increase by 18% with temperatures above 30°C. It is further predicted that with every one-degree Celsius increase in warming, displacement due to flood events will rise by 50%. Displacement affects psychosocial well-being, livelihood, and access to essential services. A study on climate change migration in an informal urban settlement found that people who migrated due to climate-induced reasons faced non-economic losses including self-identity, sense of belonging, and honour.

GOING FORWARD FOR BETTER MENTAL HEALTH

The United Nations Framework Convention on Climate Change convened the 26th Climate Change Conference of the Parties (COP 26) in the United Kingdom in November 2021. The meeting was convened to accelerate the progress of the Paris Agreement, where every country agreed to work together to limit global warming, aiming to stay below two degrees Celsius by the end of the century (UK government COP 6). However, present levels of warming are currently at 1.1 degrees Celsius, the health ramifications of which are already being seen worldwide. The recent COVID-19 pandemic taught us the importance of building resilient health systems, which include health workforce, financing, information systems, and governance structures. Like COVID-19, the climate change crisis is expected to amplify weaknesses and inequalities in the health system. Mental health, a key component of health, will be severely impacted. To safeguard against this, the six prescriptions published by the WHO in 2020 must be adhered to, for a healthy and green recovery to preserve human health (Box 1).

Box 1. Six Prescriptions for a Healthy and Green Recovery

1. Protect and preserve the source of human health: Nature.
2. Invest in essential services, from water and sanitation to clean energy in healthcare facilities.
3. Ensure a quick and healthy energy transition.
4. Promote healthy, sustainable food systems.
5. Build healthy, liveable cities.
6. Stop using taxpayers' money to fund pollution.

In South Africa a new Climate Change Bill (B9-2022) was brought into legislation in 2022. This new Bill will provide an overarching response to ensure the protection of lives and property and tackles the control of greenhouse gas emissions to prevent further harm.

DESPITE ALL THESE PROGRESSIVE CLIMATE CHANGE LEGISLATION, POLICIES, AND RENEWABLE ENERGY PROGRAMMES, SOUTH AFRICA'S RESPONSE HAS BEEN PLAGUED BY POOR INFRASTRUCTURE MAINTENANCE, THEFT OF COPPER CABLES, POOR LEADERSHIP AND GOVERNANCE, AND CORRUPTION, ALL LEADING TO THE COLLAPSE OF THE COAL-DRIVEN POWER-PRODUCING STATE-OWNED ENTITY, ESKOM.

While this grey cloud does have a silver lining, having forced those who can afford solar energy to switch over, the bleak outlook regarding the number of failed state-owned entities and rampant corruption has painted a dark future for South Africa and has most certainly affected the mental health and well-being of many South Africans.

References available on request.

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1. Dopaquel [Professional Information]. Sandton, South Africa. Dr. Reddy's Laboratories (Pty) Ltd; 2017. **2.** Yatham LN, Kennedy SH, Parikh SV et al. Canadian Network for Mood and Anxiety Treatment (CANMAT) and International Society for Bipolar Disorders (ISBD) 2018 guidelines for the management of patients with bipolar disorder. *Bipolar Disorders. 2018*; 97-170.

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1. DOPAQUEL [Professional Information]. Sandton, South Africa. Dr. Reddy's Laboratories (Pty) Ltd; 2017. **2.** YELATE [Professional Information]. Sandton, South Africa: Dr. Reddy's Laboratories (Pty) Ltd; 2021. **3.** REDILEV [Professional Information]. Sandton, South Africa: Dr. Reddy's Laboratories (Pty) Ltd; 2016. **4.** INIR [Professional Information]. Sandton: South Africa: Dr. Reddy's Laboratories (Pty) Ltd; 2023. **5.** LAMITOR [Professional information]. Sandton: South Africa: Dr. Reddy's Laboratories (Pty) Ltd; 2022. **6.** COGNIMET 10 [Professional information]. Sandton: South Africa: Dr. Reddy's Laboratories (Pty) Ltd; 2015.

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CHILD MENTAL HEALTH: WHAT'S PLAY GOT TO DO WITH IT?

Anusha Lachman

THIS ARTICLE IS A REVIEW OF A PRESENTATION AT THE DR. REDDY'S PSYCHIATRY ACADEMIC WEEKEND MEETING HELD 9TH TO 11TH JUNE 2023. THE MEETING, SPEAKERS AND WRITING ASSISTANCE WERE SPONSORED BY DR. REDDY'S LABORATORIES PTY. LTD. THE SPEAKER ACKNOWLEDGES DR DAVID WEBB FOR WRITING ASSISTANCE. ***dawebb@mweb.co.za***

Play is to engage in activity for enjoyment and recreation rather than a serious or practical purpose, and it is one of the most important aspects of a child's life. Many parents intuitively know that play is important for healthy child development, but despite its many benefits, we don't always associate play with learning. For most people, learning involves acquiring a specific new skill, such as memorising alphabets, counting, writing, and so on. We often believe that playing is only for fun and involves no actual learning. However, playing is learning and children learn through play experiences.

IT IS IMPORTANT TO REMEMBER, HOWEVER, THAT PLAY IS NOT ONLY ABOUT THE CHILD; IT IS ABOUT RELATIONSHIPS.[1] INFANT-CAREGIVER RELATIONSHIPS ARE THE CONDUIT THROUGH WHICH INFANTS EXPERIENCE AND LEARN ABOUT THE ENVIRONMENT, PROTECTED FROM, AND LEARNING HOW TO NAVIGATE ENVIRONMENTAL HAZARDS.

Regardless of the diversity of family structures (i.e., who the influential adult/s is/are – mother, father, grandparent, crèche, teacher), what is most important is the quality of care that the child receives.

Anusha Lachman

It is evident that a child's interaction with their caregiver is perhaps the most powerful determinant of their future health and wellbeing. This is because early childhood experiences matter. They can change the structure of the brain, alter the expression and regulation of genes and hormones, and inform how the child perceives the world and relates to self and others (e.g., facial affect recognition). These can be buffered by a caring environment, nurturing relationships and emotional and physical support.

NURTURING RELATIONSHIPS

Nurturing care is essential for children to survive and to thrive.[2] Nurturing interactions include attentive responses to young children's efforts to connect to and learn about their world, and involve efforts to present children with age-appropriate stimulating learning experiences in a safe and mutually enjoyable way.

This means physically interacting, face to face, with appropriate attention and emotional responses to the child. A developing brain is activated and

patterned by the nurturing care of trusted adults and such interactions are crucial in mitigation of early risks. Unfortunately, in modern society, devices and screen time are all too often substituted for nurturing care, to the detriment of healthy emotional and social development.

RECIPROCAL INTERACTIONS ARE ESSENTIAL FOR HEALTHY DEVELOPMENT. FROM AS EARLY AS TWO MONTHS OF AGE, INFANTS DEMONSTRATE SKILLS THAT SUPPORT ENGAGEMENT AND INTERACTION WITH THEIR CAREGIVERS AS PART OF A SOCIAL INTERACTION. AMONG THESE BIOLOGICALLY DETERMINED SKILLS, THE ABILITY TO INITIATE AND MAINTAIN EYE CONTACT AND THE USE OF FACIAL EXPRESSIONS TO ENGAGE THE CAREGIVER SERVE AS PART OF EARLY SOCIAL COMMUNICATION.

Face-to-face interactions elicit a positive effect on both the infant and the mother. Positive affect leads to synchronicity (i.e., synchronised behaviour; doing things together). Synchronised behaviours, including mutual gaze and gaze following, create the foundation of early social connectedness and regulation with positive emotions shared in meaningful relationships. Sharing positive affect in parent-infant interactions fuels the organisation of early infant experiences of socialisation and helps infants develop socially and emotionally.

PLAY

Although researchers tend to characterise play and types of play according to their specific research focus (gross versus fine motor skills development), discipline (e.g., physiotherapy, occupational therapy), and ideology, play is also a fun activity for the children involved. It is important to note that the ways play is observed and described might differ in different cultures, such that the definition of play might very accordingly. Consequently it is difficult to establish a single overarching, clear acceptable definition of play.

NEVERTHELESS, THE IMPORTANT THING TO REMEMBER IS THAT PLAY IS FUN. IT IS THE DIRECT ROUTE TO SOCIAL JOY – TO A HEALTHY PERCEPTION OF, AND RELATIONSHIP WITH OTHERS, AND IT IS GOOD FOR US. POSITIVE EMOTIONS SUCH AS JOY FROM PLAYING INCREASE THE CHILD'S CAPACITY TO LEARN.

They help them to be more open minded, and support them as they learn new skills and develop new ways of seeing things. One of the most critical functions of play is to facilitate social development, usually in positive ways.

Play increases joy and decreases distress. Studies of university students have found that those who were "playful", those who, for instance, acted spontaneously and joked around, had lower levels of perceived stress than their less playful counterparts. By increasing positive emotions, playfulness helps us cope with stress and improve life satisfaction.

DEVELOPMENTAL SCIENCE

DEVELOPMENTAL SCIENTISTS HAVE UNDERLINED THAT PLAYING AFFECTS COGNITIVE PROCESSES. IN THE FIRST HALF OF THE TWENTIETH CENTURY PIAGET OBSERVED THAT DIFFERENT STAGES IN THE PSYCHOLOGICAL DEVELOPMENT OF CHILDREN CORRESPOND TO DIFFERENT STAGES IN PLAY DEVELOPMENT, AND THAT THE PASSAGE FROM SYMBOLIC TO RULED GAMES CREATES PLAY THAT BECOMES LESS SPONTANEOUS AND MORE RULE BASED, WITH DEVELOPMENT OF MORAL VALUES.

He observed that, during the first months of life, play is perceptual with the child seeking eye contact and making physical attempts to connect with their caregiver. This gives way to combined perceptual and motor pleasure; for example peek-a-boo, reaching out for contact, hiding behind the curtains, laughing at repetitive behaviours. From the toddler stage play becomes symbolic, relying on fantasy and imagination, whereas in older children it starts to take the form of rule-based games.

THERE IS AGREEMENT ON WHAT IS FAIR, WHO GETS MORE POINTS, AND THAT THERE MAY BE A WINNER. CHILDREN START TO IMITATE THE WORLD AROUND THEM, AND GAMES BECOME COMPETITIVE.

When symbolic fantasy play changes to rules based play, there is an emergence of appropriation of moral values, i.e., Who decides what the rules are? Who said you should follow the rules? Why are you not following the rules? What defines a cheat? Who decides who is a cheat?

In the late 1960s, another psychologist, Lev Vygotsky further developed this distinction between imagination and rules in play. He claimed that the effects of culture are visible even in the early phases of symbolic play, as every imaginary situation includes social rules of behaviour.

HE SAID THAT CHILDREN ARE LIKE SPONGES, ABSORBING WHAT IS GOING ON AROUND THEM, SOCIAL AND PHYSICAL INPUTS FROM THE ENVIRONMENT, WHAT THEIR PARENTS SAY AND HOW THEY TREAT OTHERS, AND THIS IS HAPPENING CONSTANTLY. FOR EXAMPLE, CHILDREN WILL PLAY MOM, REPRODUCING THE PRACTICES OF WHAT CAN BE CALLED A "MATERNAL BEHAVIOUR".

Neuroscience helps explain how playful experiences can support learning. Brain processes involved in learning include reward, memory, cognitive flexibility, mood and stress regulation pathways that are activated during learning and serve to prepare a child to deal with the world. Again this highlights the importance of the quality of early experience and nurturing play for healthy development.

PLAYFUL LEARNING EXPERIENCES

Playful learning experiences can offer multimodal inputs that stimulate interconnected networks involved in learning. There are five components of a playful learning experience.

(1) Joy. To adapt is to learn, and joy exists to motivate us to continue adapting to our environment and learn from it. The experience of joy is associated with network changes in the brain (e.g., increases in dopamine levels) that result in positive emotions and reward responses. The resulting positive affect is linked to a series of cognitive benefits, such as enhanced attention, working memory, mental (task) shifting, and improved stress regulation that are useful to learning

(2) Meaningful exchange. Learning usually involves moving from the unknown to the known, or from effortful to automatic processing. Meaningful experiences can provide a space for these progressions, with opportunities for contextual learning, analogical reasoning, metacognition, transfer, and motivation. When we find learning and experiences meaningful, gained knowledge in one domain may be transferred to new and real-world settings.

(3) Active engagement. Active engagement demands both attention and response, and when the engagement is between two people, the attention and response must be reciprocal. For an experience to affect our awareness and thought it has to be able to captivate us first. Engagement increases brain activation related to decision making, agency and flow. It enhances memory encoding and retrieval processes that support learning. Children learn important life skills (e.g., social skills) from active engagement with their caregivers.

(4) Iterative experiences (repetitive engagement). This is characterised by repetition of activity or thought, to build memory of experiences and to potentially discover new insights with each round. Engaging in and building upon this cognitive skill is a critical step to forming memory and early and lifelong learning. With practice, iteration engages networks related to taking alternative perspectives, flexible thinking and creativity.

(5) Social interaction. Positive caregiver interactions lay the neural foundation for developing healthy socio-emotional regulation. Early social interaction promotes plasticity in the brain, encouraging adaptive learning and by extension better coping later in life.

IS PLAY UNIVERSAL?

PLAY HAS BEEN OBSERVED IN EVERY SOCIETY WHERE CHILDREN WERE STUDIED AND IT CAN BE CONSIDERED A UNIVERSAL TRAIT OF HUMAN PSYCHOLOGY. HOWEVER, LIKE EVERY HUMAN ACTIVITY, IT IS AFFECTED BY CULTURAL CONTEXT, WHICH MAY VALUE OR REACT DIFFERENTLY TO PLAY, PLAY PARTNERS OR PLAY INVOLVEMENT. CHILDREN AT PLAY REPRODUCE AND ALSO RECREATE THE SPECIFICITIES OF THEIR CULTURAL ENVIRONMENT, AND CULTURE FLOWS THROUGHOUT PLAY ACTIVITIES.

Culture cannot be separated from play. Frequency, nature and duration of play may contextually depend on a number of factors:

- Financial status
- Adult role models and attitudes
- How available the caregiver is, how often the child is with them, and who they allocate that transitional time to
- Availability of time and space
- Objects and playmates
- Urban versus rural settings
- Access to manufactured toys versus reliance on imagination
- Safety and accessibility of toys

Therefore, what is appropriate and healthy play in one society may differ in another, and comparisons between societies and cultures may not be appropriate.

GENDER DIFFERENCES

Preference for companions of the same gender appears to arise around age 3 years of age. It is usually attributed to processes of social identification, of which gender identity is one of the main aspects, and tends to increase as children deepen their understanding of gender differences. Gender preferences, as expressed in the imitation of same gender activities, are resistant to adult encouragement to inter-gender imitation. These preferences tend to occur even when there are few available same age partners and it implies interacting with varied age companions.

Boys tend to occupy larger spaces, play in larger groups and farther away from home, and engage in activities with gross motor movements. In contrast, girls occupy internal or more restricted spaces and play in smaller groups. Play among girls is often related to domestically exposed activities. Pretend play themes are more varied amongst girls than boys, but are likely entirely due to context and parenting models. There is some evidence that sexual hormones may contribute to gender differences in play behaviour, but also of strong cultural & gender stereotypes. However, choice of play activities closely mirror adult practices.

Children imitate what they experience and see in the environment around them, and quality play experiences are created and nurtured when adults are involved in the process.

ADULT PLAY

BECOMING AN ADULT OFTEN SEEMS TO MEAN LEAVING PLAY BEHIND. IN FACT THE TERM 'ADULTING' HAS BEEN COINED TO DESCRIBE DOING THINGS THAT ARE JOYLESS, BORING AND TIRESOME - THE OPPOSITE OF PLAY.

Nevertheless, we can (and should!) embrace adulthood while still finding joy through play and being playful. Play helps us to be able to think through possibilities so that we can anticipate outcomes and respond more creatively. It helps us react flexibly and without excessive fear and judgment to situations we find threatening.

PLAY IS AN ACTIVITY THAT WE CHOOSE TO DO BECAUSE WE WANT TO DO IT – IT IS NEVER FORCED.

Play is low stakes, and we do it because it feels good. Tips to cultivate play in adulthood include the following:

(1) Learn how you like to play
One of the easiest ways to become more playful as an adult is to tap into our childhood play patterns. Revisit what you liked to play with and how you liked to play. Perhaps you like competitive games, or maybe you prefer to play through movement, like dance. Maybe you like to collect things or explore new places.

FINDING YOUR PERSONAL PLAY IDENTITY WILL HELP YOU DISCOVER THE KINDS OF PLAY ACTIVITIES THAT YOU ARE LIKELY TO GET MOST ENGAGED IN, AND THE ONES THAT WILL TAP INTO YOUR EMOTIONS AND HELP YOU EXPERIENCE JOY.

(2) Plan to play
Making a plan to play might seem counter-intuitive, but scheduling time for things that are important is valuable.

(3) Make a "playlist"
Write a list of playful activities or hobbies you have enjoyed doing or would like to try. Take your time and keep adding to your playlist over a few days. Reach out to others who might want to join you. And then, start playing – even if it's just for five minutes.

(4) Reflect on play
As adults we don't always have the time to play or be playful. But just taking some time to reflect on past playful moments, or times others were playful with us, can help improve wellbeing.

FINAL THOUGHTS

Playing is a universal phenomenon, a basic motivation and a legitimate right of children (and adults!). Cultural contexts highlight both universal features of play and performance and cultural variability. Play is important because it provides a primary foundation for learning, exploring, problem-solving, and building an understanding of the world and the role of the individual within it.

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LIVED EXPERIENCE PERSPECTIVE: VALUE OF PARTNERSHIP & SHARED DECISION-MAKING

Charlene Sunkel

THIS ARTICLE IS A REVIEW OF A PRESENTATION AT THE DR. REDDY'S PSYCHIATRY ACADEMIC WEEKEND MEETING HELD 9TH TO 11TH JUNE 2023. THE MEETING, SPEAKERS AND WRITING ASSISTANCE WERE SPONSORED BY DR. REDDY'S LABORATORIES PTY. LTD. THE SPEAKER ACKNOWLEDGES DR DAVID WEBB FOR WRITING ASSISTANCE. ***dawebb@mweb.co.za***

MY JOURNEY

After I left school I started working. That was amazing, I bought my own flat and a car. My life was just as I wanted it to be. But it soon unravelled a couple of months later when I started experiencing symptoms. It first started with complete withdrawal from everything. I used to be a very sociable person, went out with my friends all the time. All of a sudden I had absolutely no interest. I saw people more of a threat. I did not want to speak to people or look at them. I avoided people at all costs.

THAT IS WHEN PEOPLE STARTED NOTICING THAT EVERYTHING WAS NOT ALRIGHT. AFTER THAT I STARTED HEARING VOICES AND HAVING DELUSIONS. IT WAS A COMPLETE MESS FOR ME.

At the time, my boss was a medical doctor and she was very supportive and encouraged me to seek help. I reluctantly did so, because in 1991 there was a lot of stigma and shame attached to going to a psychiatrist. Since then I have seen a number of psychiatrists and was diagnosed with paranoid schizophrenia. Over a period of 9 years I have been on numerous psychiatric medications, struggled with side effects and have spent a total of 4 years in psychiatric hospitals. I had voluntary and involuntary admissions. And that entire situation of navigating the mental health system was worse than experiencing the symptoms of schizophrenia. The system back then was broken and it broke me. Still to this day I do not believe it is fixed yet. Hence the importance of including people with lived experience - I think we can help fix the system.

Charlene Sunkel

In the beginning I was completely independent and my life was good. For me independence was extremely important. That is what I valued the most. After all of this I lost my job; my family relations were damaged. I lost everything, and through that my decision-making and my independence was completely taken away from me. That was really really bad for me. Everything was so much about what I could not do.

I WAS TOLD I WOULD NEVER BE ABLE TO WORK AGAIN, I COULD NEVER LIVE ON MY OWN, I COULD NEVER GO ANYWHERE UNACCOMPANIED, I COULD NEVER DRIVE A CAR. NOBODY EVER SAID TO ME WHAT I COULD DO.

I think that was what was lacking – that positive encouragement to develop what you can – your abilities and the potential that you have to regain your life back. That was what I was looking for. I had to discover my own pathway towards recovery. In South Africa we don't use the word recovery very much. People misunderstand that you completely recover, so they can't make the connection that recovery in mental health is based on the individual's need to be happy and to have wellbeing.

IT DOES NOT MEAN THAT BECAUSE I HAVE A MENTAL HEALTH CONDITION THAT I DON'T HAVE MENTAL HEALTH. I ACTUALLY DO, BECAUSE I AM ABLE TO FUNCTION DAILY.

MY RECOVERY

My recovery involved key aspects that I had to find myself. Unfortunately in those days, Google was not around, it might have been very helpful in getting information. I had to sneak into the library to look up what schizophrenia was because I was not informed about it at all. That is how I learned.

(1) Mental Healthcare

Medication is important. It is a choice to take it, because it is a choice between living with symptoms, or taking medication despite side effects and adapting to the side effects and having quality of life.

THE RELATIONSHIP BETWEEN ME AND MY PSYCHIATRIST HAS TO BE A PARTNERSHIP, WITH NO POWER IMBALANCES. I NEED TO BE LISTENED TO AND HEARD. THE 'HEARD' PART IS VERY IMPORTANT – TO TAKE MY CONCERNS AND POINT OF VIEW AND CHOICES ON BOARD.

(2) Self-care

I struggled quite a bit in finding how to navigate that. Structure and routine are extremely important to me. The moment something is thrown out of order, I become confused. I still live with difficulties, so I have to put routines in place. Balance is important. I need at least 8 hours of sleep, with some time after I wake up for me to become alert in the morning due to the medication. Exercise is important; walking helps me. I try to balance work and making time to relax.

I had to discover coping mechanisms. Working from home gives me time flexibility and helps me to manage my time. If I feel I need a break because I can't focus, I am able to take one. A crisis plan is essential. I have a very strong support system. I do not need to say a word – my friends and colleagues can easily see from how I write a WhatsApp message that something is wrong. They ask me what I need and how they can support me – they don't make assumptions.

I am also lucky to have strong support from a large number of peers through the Global Mental Health Peer Network (GMHPN). It's amazing to see how we are all able to support each other.

PARTNERING WITH PEOPLE WITH LIVED EXPERIENCE

THERE ARE TWO ASPECTS TO PARTNERING WITH A PERSON WITH LIVED EXPERIENCE (PWLE). THE FIRST IS THE RELATIONSHIP BETWEEN THE TREATING TEAM AND THE PERSON. THE SECOND IS TO INCLUDE PEOPLE WITH LIVED EXPERIENCE IN POLICY AND PRACTICE IN THE BROADER SCHEME OF THINGS.

I want to know as much information as I can about the diagnosis. What to expect, management tools, and options and additional support available. Understanding about the medication and potential side effects helps me to better manage the condition. Human rights information is also important.

Paternalism is very disempowering, so the relationship between the treating team and the person must be a partnership. That means involvement in your own treatment plans and supported decision-making. Supported decision making means giving the person all the information that they need to make an informed decision, and if they are unable to make an informed decision, that they are able to appoint someone who could help them to make a decision. This is in line with the United Nations Convention on the Rights of People with Disabilities (UNCRPD) and is in contrast to a substitute decision-making approach, which means the treater decides what they think is in the best interests of the person.

ADVANCE DIRECTIVE IS ANOTHER OPTION. THIS DIRECTIVE CONTAINS INFORMATION SUCH AS WHAT TRIGGERS ME, AND A DESCRIPTION OF MY NORMAL BEHAVIOUR; IF I AM UNWELL AND I SAY I REFUSE TO GO TO HOSPITAL, DON'T LISTEN TO ME, PLEASE DO TAKE ME. IT LISTS MEDICATION THAT I SHOULD NOT RECEIVE, BECAUSE I HAVE NOT TOLERATED IT IN THE PAST.

Give hope, not doom. We must focus on the positive and highlight the person's abilities and what opportunities are available to them. The recovery approach is person-centered according to the individual person's needs. It is goal orientated (short-term, medium and long-term) and facilitates community integration and support.

Places of care, especially hospitals, psychiatric hospitals and clinics should provide a dignified and conducive environment for recovery.

IF I WERE TO RELAPSE NOW, I WOULD RESIST GOING TO HOSPITAL, BECAUSE IT IS NOT A PLACE THAT IS PRESENTED AS CARING, COMFORTABLE AND SAFE – IT LOOKS LIKE A PRISON. INSIDE THE WALLS ARE BARE. IT IS NOT HOMELY AND IT IS NOT A PLACE I CAN SEE MYSELF RECOVERING IN.

This is something simple that can be rectified. The interior needs to be painted and decorated, there should be plants and gardens. It makes an enormous difference. Patients are very creative – they could be involved in some of those activities.

When service users are involved in their own care they are listened to and heard, valued and empowered. They are able to take a lead in their own treatment and recovery and they are able to make informed choices based on all the information on their diagnosis, treatment options and support. This facilitates an individualised approach to management of their condition.

WHEN SERVICE USERS ARE PARTNERS IN POLICY AND SERVICES IT HELPS TO STRUCTURE SYSTEMS AND SERVICES THAT CAN DELIVER A COMPREHENSIVE CARE PACKAGE ALIGNED WITH WHAT SERVICE USERS ACTUALLY NEED IN ORDER TO THRIVE, DESPITE THEIR DIAGNOSIS.

The result is that services and policies are based on and respect and protect human rights; services are high quality and support is available; it builds trust and confidence in the system, which improves engagement with care. This approach is cost-effective, because it facilitates development of services that can optimise outcomes for the majority of people with lived experience.

Involving PWLE in designing clinical trials helps to identify outcomes that are meaningful. In contrast to the usual outcomes, such as access to treatment, symptom reduction and other clinical outcomes, clinical trials need to demonstrate that an intervention improves quality of life. Quality of life means:

- Basic needs are met (e.g., accommodation, food);
- Healthy relationships and repair of relationships damaged by symptoms;
- Belonging to a community;
- Personal growth, resilience and empowerment;
- Identifying a purpose, being able to pursue an education and to work;
- Ability to be independent and self-sufficient.

The GMHPN has developed guidelines for including PWLE meaningfully and authentically in their own care (Table 1).

IT IS IMPORTANT THAT WE ARE SEEN AS EXPERTS IN OUR OWN RIGHT, NOT ONLY BECAUSE OF OUR SPECIFIC INDIVIDUAL EXPERIENCE, BUT ALSO BECAUSE OF OUR COLLECTIVE EXPERTISE.

Table 1. GMHPN CONSULT Guidelines for integrating PWLE in discussion and decision-making

C	**C**reate an engaging, safe and supportive space to enable quality contributions
O	**O**btain diverse representation of persons with lived experience to enhance equality and inclusion
N	**N**o to power imbalances, paternalistic approaches, tokenism, discrimination and stigmatization
S	**S**ustain a mutually respectful partnership
U	**U**phold the principles of effective engagement and consultation
L	**L**everage lived experience expertise through meaningful and authentic inclusion
T	**T**ransform policy and practice that is an accurate reflection of lived experience values

THE GLOBAL MENTAL HEALTH PEER NETWORK

I launched the Global Mental Health Peer Network in 2018 to strengthen the voice of PWLE, especially those in low and middle income countries, because higher income countries seem to be a bit more advanced in including PWLE.

The Network has two main aims:

(1) To provide an engaging and safe platform for peer sharing, learning and support. This is achieved through member collaboration, networking, discussion platforms and webinars.

(2) To empower members to become leaders in mental health and advocacy at local and global levels. This is achieved through peer-to-peer mentorship, peer-to-peer knowledge exchange, an Experts by Experience Consultancy Service, and opportunities for members for engagement and public speaking.

Currently, we are represented in 6 world regions (Eastern Mediterranean, Europe, Western Pacific, South East Asia, Americas and Africa), including more than 50 countries with over 150 PWLE experts representing these countries.

Activities during the past year provide examples of the services delivered by the Experts by Experience Consultancy Service. They include the following:

- Workshops in the corporate sector (4 GMHPN members involved);
- Engagement sessions and lectures in academia and design of research, implementation and dissemination of findings (35 GMHPN members involved);
- Workshops in the non-profit sector (19 GMHPN members involved);
- Consultancy meetings with government in various countries on policies and laws (2 GMHPN members involved);
- Consultancy meetings with international agencies including the United Nations and World Health Organisation (23 GMHPN members involved);
- In-person appearances at international conferences and workshops (13 GMHPN members involved);
- International webinars (70 GMHPN members involved);
- Author/co-author on 12 publications (19 GMHPN authors involved).

LAST THOUGHTS

I have a dream of an ideal world in which PWLE will form an integral part of the mental health system – a Community Experts by Experience Peer-Led Centre (Figure 1). This is a centre completely run and managed by people with mental health conditions. From the management to the communications, to the services coordination component and provision of peer support. In high income countries, peer support worker is a formal occupation and they provide a very important part of the metal health team. It is a cost-effective way in which services and support can be provided at community level. However, in South Africa, there is little formal integration of peer support into the mental health system.

OFTEN AFTER DISCHARGE FROM HOSPITAL THERE IS LACK OF COMMUNITY SUPPORT, WHICH CONTRIBUTES TO THE REVOLVING DOOR SYNDROME. PEER SUPPORT CAN BE PROVIDED IN PERSON AND VIRTUALLY.

A training unit would be able to train people in peer support and train supervision of peer support workers. Recovery navigation assists PWLE to navigate the system faster and more effectively so that they can get the help that they need. It takes a lot of courage to seek help in the first place, and it is very discouraging to be sent backwards and forwards without receiving the help you need and often receiving no help at all. A human rights resource hub will enable service users to be aware of their human rights, and help refer people to avenues of redress if their human rights have been violated. Peer consultants can advise on policy and service development and monitor and evaluate mental health and social support services.

I hope that one day we will see this come to fruition in South Africa.

References available on request.

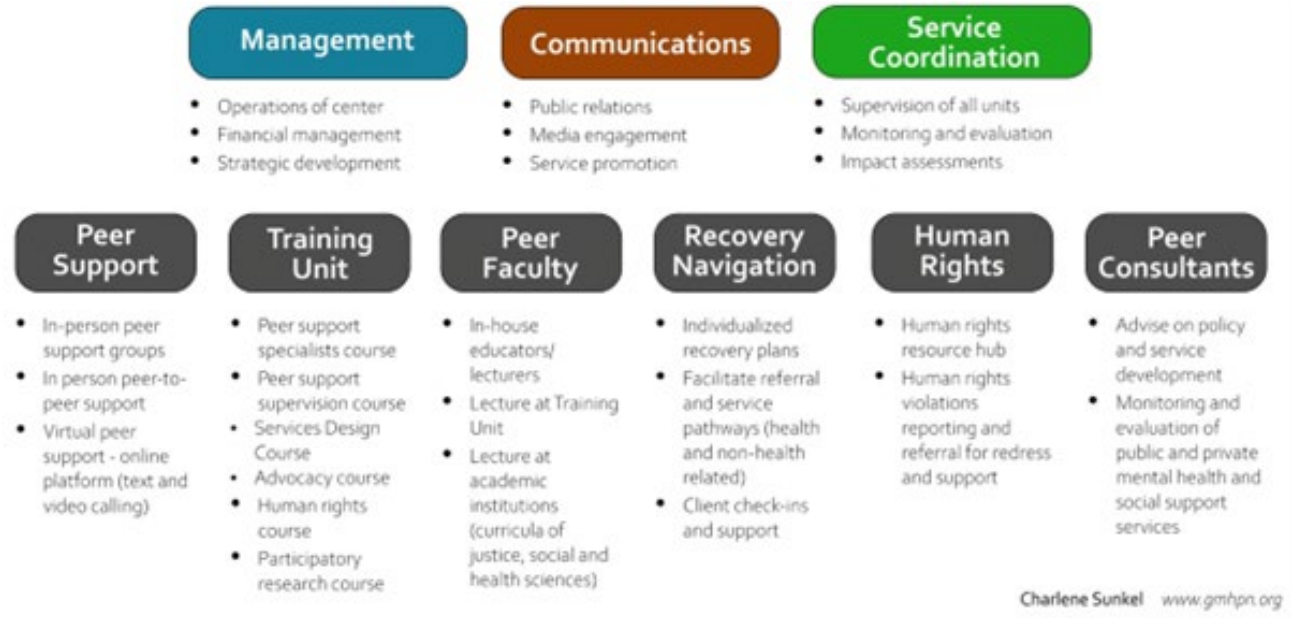

Figure 1. Community Experts by Experience Peer-Led Center

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STRUCTURAL RACISM, ECONOMIC INEQUALITY & STIGMA: HOW DO THEY IMPACT MENTAL HEALTH?

Christopher P Szabo

THIS ARTICLE IS A REVIEW OF A PRESENTATION AT THE DR. REDDY'S PSYCHIATRY ACADEMIC WEEKEND MEETING HELD 9TH TO 11TH JUNE 2023. THE MEETING, SPEAKERS AND WRITING ASSISTANCE WERE SPONSORED BY DR. REDDY'S LABORATORIES PTY. LTD. THE SPEAKER ACKNOWLEDGES DR DAVID WEBB FOR WRITING ASSISTANCE. ***dawebb@mweb.co.za***

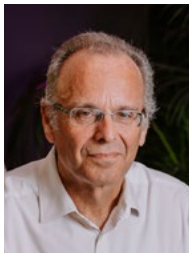
MENTAL HEALTH

Mental health is an integral part of health; indeed, there is no health without mental health. It is more than the absence of mental disorders, and is determined by a range of socioeconomic, biological and environmental factors. Accordingly the approach to a patient with mental illness should be a biopsychosocial one. *According to the World Health Organisation, "mental health is a state of mental well-being that enables people to cope with the stresses of life, realise their abilities, learn well and work well, and contribute to their community. It is an integral component of health and well-being that underpins our individual and collective abilities to make decisions, build relationships and shape the world we live in. Mental health is a basic human right. And it is crucial to personal, community and socio-economic development.*

Throughout our lives, multiple individual, social and structural determinants may combine to protect or undermine our mental health and shift our position on the mental health continuum. Individual psychological and biological factors such as emotional skills, substance use and genetics can make people more vulnerable to mental health problems. Exposure to unfavourable social, economic, geopolitical and environmental circumstances – including poverty, violence, inequality and environmental deprivation – also increases people's risk of experiencing mental health conditions."

WHO, 2023[1]

STRUCTURAL RACISM



Christopher P Szabo

"Structural racism involves interconnected institutions, whose linkages are historically rooted and culturally reinforced. It refers to the totality of ways in which societies foster racial discrimination, through mutually reinforcing inequitable systems (in housing, education, employment, earnings, benefits, credit, media, health care, criminal justice, and so on) that in turn reinforce discriminatory beliefs, values, and distribution of resources, which together affect the risk of adverse health outcomes."

Bailey, *et al;* 2014.[2]

THIS DEFINITION OF STRUCTURAL RACISM HIGHLIGHTS THE NEED FOR CONSIDERATION OF WIDER SOCIETAL ISSUES WHEN ADDRESSING MENTAL HEALTH.

The chronic stress of structural racism and discrimination damages brain circuits and mental health. Experiences of racial discrimination have been associated with mental health issues such as depression, anxiety, substance use and posttraumatic stress disorder (PTSD), as well as physical ailments including diabetes, hypertension and obesity. Black Americans, for instance, are about twice as likely as White Americans to develop dementia.

The South African Constitution prohibits discrimination……but allows for it! Chapter 2 of the Bill of Rights states that:

(3) The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.

(4) No person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of subsection (3). National legislation must be enacted to prevent or prohibit unfair discrimination.

(5) Discrimination on one or more of the grounds listed in subsection (3) is unfair unless it is established that the discrimination is fair.[3]

While there is no doubt that structural racism is a part of South Africa's history, is there still evidence that it remains in 2023? Some believe that there is. For example, the Democratic Alliance has claimed that the Employment Equity Act violates the key constitutional value of non-racialism.[4]

SOCIOECONOMIC DEPRIVATION

Poverty is generally characterised by the inability of individuals, households, or entire communities, to command sufficient resources to satisfy a socially acceptable minimum standard of living and perceived inability to make ends meet. In South Africa in 2019, the poorest 40% comprised just under 50% of the population and accounted for 11% of income (19 million people).[5] The ultra-poor, the poorest 20%, comprised 27% of the population (10 million people). The richest 10% comprised 7% of the population and accounted for 40% of the income. These figures highlight the gross inequality in terms of wealth in SA. According to the Gini coefficient, in 2021 SA had the greatest inequality of any country in the world with a score of 0.63, where 0 indicates perfect equality and 1 indicates perfect inequality.[6]

In the 2019 survey, South Africans were asked about their subjective perception of poverty. More than half of respondents (57%) said that they earned less than the absolute minimum to make ends meet.

MENTAL HEALTH ISSUES WERE REPORTED BY 8.3% OF THOSE CLASSIFIED AS ULTRA-POOR, 6.5% OF THOSE WHO WERE POOR, AND 2.5% OF THOSE RATED NON-POOR. POVERTY WAS ASSOCIATED WITH BEING 'LESS HAPPY'.

Two pathways have been postulated to account for the association between poverty and mental disorders.[7] Poverty may directly increase the risk of mental illness (social causation), in particular depression, and especially where it is associated with stress, exclusion, violence and gender-based violence, trauma (including adverse childhood experiences), obstetric risks and malnutrition.

IN ADDITION, MENTAL ILLNESS ITSELF, FOR EXAMPLE SCHIZOPHRENIA OR INTELLECTUAL DISABILITY, AND THE REDUCED OPPORTUNITY FOR EMPLOYMENT AND STIGMA ASSOCIATED WITH IT, COULD DIRECTLY CAUSE POVERTY (SOCIAL DRIFT).

In terms of intervention, poverty alleviation (giving people money in the form of grants) has not been shown to improve mental health outcomes, whereas improving mental health interventions can help to improve independence, earning potential and economic outcomes.

STIGMA

Erving Goffman (1963) classically defined stigma as an "attribute that is deeply discrediting." A discredited attribute could be readily discernible, such as one's skin colour or body size, or could be hidden but nonetheless discreditable if revealed, such as one's criminal record or struggles with mental illness. Types of stigma include the following:

- Public stigma involves the negative or discriminatory attitudes that others have about mental illness.
- Self-stigma refers to the negative attitudes, including internalised shame that people with mental illness have about their own condition.
- Institutional stigma, is more systemic, involving policies of government and private organisations that intentionally or unintentionally limit opportunities for people with mental illness. Examples include lower funding for mental illness research or fewer mental health services relative to other health care.

STIGMA AND DISCRIMINATION CAN CONTRIBUTE TO WORSENING SYMPTOMS AND REDUCED LIKELIHOOD OF GETTING TREATMENT.

A recent extensive review of research found that self-stigma leads to negative effects on recovery among people diagnosed with severe mental illnesses.[8] A 2017 study involving more than 200 individuals with mental illness over a period of two years found that greater self-stigma was associated with poorer recovery from mental illness after one and two years.[9]

CONCLUSION

The explosion of research delving into the neuroscience underlying mental illness and pharmacological approaches often means that a biopsychosocial approach to the management

of mental health problems is subjugated to pharmaceuticals. However, social determinants of mental health must not be forgotten.

SOCIAL SCIENCE STUDIES HOW PEOPLE INTERACT WITH ONE ANOTHER, EXPLORING EVERYTHING FROM THE TRIGGERS OF ECONOMIC GROWTH AND THE CAUSES OF UNEMPLOYMENT TO WHAT MAKES PEOPLE HAPPY.

Findings can help to improve patient management, inform public policies and improve overall public mental health.

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SAN ROCK PAINTINGS

This is a most significant San Rock Art painting. It has been called the Rosetta Stone of San Rock Art. This is because the painting makes particular reference to the belief system of the San people.

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IS THE RIGHT TO CONFIDENTIALITY AN ABSOLUTE RIGHT?

Indhrin Chetty

THIS ARTICLE IS A REVIEW OF A PRESENTATION AT THE DR. REDDY'S PSYCHIATRY ACADEMIC WEEKEND MEETING HELD 9TH TO 11TH JUNE 2023. THE MEETING, SPEAKERS AND WRITING ASSISTANCE WERE SPONSORED BY DR. REDDY'S LABORATORIES PTY. LTD. THE SPEAKER ACKNOWLEDGES DR DAVID WEBB FOR WRITING ASSISTANCE. ***dawebb@mweb.co.za***

Unlike the relationship between a legal practitioner and client, in medical practice, the right to confidentiality is not an absolute right.

In bioethics, there are four principles on which decisions are based to inform what is and what is not ethical. These are

(1) Autonomy: an individual's right to make decisions for themself. These include decisions about treatment and information management (patient data).

(2) Beneficence: to do what is in the patient's best interests.

(3) Non-maleficence: striving to do no harm.

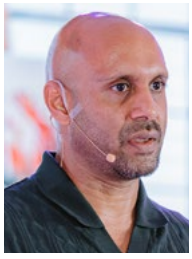
(4) Justice: while making decisions in the patient's best interests, taking into account how that impacts on others.

THE RIGHT TO PRIVACY

An individuals' right to privacy is a fundamental human right and is laid down in section 14 of the Constitution.

IT INCLUDES THE RIGHT TO BE FREE FROM INTERFERENCE AND INTRUSION, INCLUDING DIVULGENCE OF INFORMATION THAT MIGHT HAVE BEEN GIVEN WITHIN THE DOCTOR-PATIENT RELATIONSHIP. DIVULGING SENSITIVE INFORMATION IS AN INTRUSION OF THE PATIENT'S RIGHT TO PRIVACY AND IT HAS (SOMETIMES HARMFUL) CONSEQUENCES.

For example, it is uncertain how that information might be used by insurance companies, third parties, family members and legal systems. However, the Constitution does allow for a limitation of rights if that limitation can be justified.



Indhrin Chetty

CONFIDENTIALITY

Confidentiality finds its grounding in the right to privacy and is transactional in nature. It refers to the act of keeping another person or entity's information private, and is most commonly expected in medical and legal fields.

When a patient consults a medical practitioner, they usually do so with an expectation that their information will be kept confidential, and they need to trust the medical practitioner to do so. Furthermore, medical professionals are required by law to keep certain information private, although there are exceptions. This places a duty on clinicians to refrain from sharing information without consent.

PROTECTION OF PERSONAL INFORMATION (POPI) ACT

The POPI act came into force in 2013 and it is one of the main acts relating to privacy and confidentiality. According to the act, the aims are to promote the protection of personal information processed by public and private bodies. It is based on the recognition that section 14 of the Constitution provides that everyone has the right to privacy. The right to privacy includes a right to protection against the unlawful collection (consultation), retention (record keeping), dissemination (who has access to the information, and who the clinician shares the information with) and use of personal information, which places additional responsibilities on clinicians to safeguard patient information. If patient information has been obtained from a third party (e.g., medical aid or another clinician), then the

treating medical practitioner must inform the patient of this and the purpose of having that information. Failure to comply with the POPI act can potentially lead to a civil claim.

DISCLOSURE

Clinicians must take precautions to prevent unintentional disclosure. For example, clinicians must ensure consultations cannot be overheard. Disclosure, when permitted, must be proportional to a valid request, including only minimum information necessary for purpose. It is not permissible, for example, to write a general report at the request of the patient (or anyone else) when the recipient of the report is unknown to the doctor writing the report. If possible, information must be anonymised. Information provided by the patient about a third party may not be divulged to anyone else.

THE NATIONAL HEALTH ACT

The National Health Act No. 61 of 2003 states that all patients have a right to confidentiality, and this is consistent with the right to privacy in the South African Constitution.

WHEN IS DISCLOSURE LAWFUL?

Rule 13 of the Ethical and Professional Rules of the HPCSA states that a practitioner may divulge information regarding a patient only if this is done:

1. In terms of a statutory provision;
2. At the instruction of a court;
3. In the public interest (e.g., based on a risk assessment);
4. With the express consent of the patient (if the patient is deemed competent to give consent to divulge that information at that time);
5. With the written consent of a parent or guardian of a minor under the age of 12 years;
6. In the case of a deceased patient, with the written consent of the next of kin or the executor of the deceased's estate.

1. STATUTORY PROVISION

Clinicians may be obliged to disclose information to comply with a statutory requirement. The patient must be informed of the requirement to disclose the information and the purpose thereof. Examples include notifiable conditions (e.g., communicable disease); the Domestic Violence Act creates conditions under which information must be reported (e.g., child is the victim of domestic violence); the Older Persons Act requires that abuse of older people must be reported.

2. AT THE INSTRUCTION OF A COURT

A court may order the disclosure of information when the court is of the view that this information is materially necessary in resolving a legal dispute. Practically this disclosure may occur in different ways: (1) clinical notes may be subpoenaed. In this case copies of the notes should be submitted and it is permissible to black out sensitive information that is not relevant to the matter at hand or that relates to third parties; (2) the doctor may be subpoenaed to give oral testimony; and (3) the doctor may be requested to provide a clinical report. In this last case, the patient should be informed that a report is being provided to the court and, if possible, the contents of the report should be discussed with them. This should be documented.

WHILE IT IS PREFERABLE TO OBTAIN CONSENT FROM THE PATIENT TO PROVIDE A REPORT REQUESTED BY THE COURT, IT IS NOT MANDATORY.

3. IN THE PUBLIC INTEREST

Disclosures in the public interest would include, but not be limited to, situations where the patient or other persons would be prone to harm as a result of risk-related contact (e.g., suicidal or homicidal intent). The benefits of disclosure must outweigh the risks of not disclosing (utilitarian), then disclosure may be justified even without consent. Attempts must be made to obtain the patient's consent before divulging the information, and if the patient refuses, then they need to be informed of the intention to disclose.

4. WITH EXPRESS CONSENT OF THE PATIENT

For consent to be valid, the clinician must be certain that the patient has the capacity to consent, and it is their responsibility to make sure that the patient is fully informed about that for which they are providing consent. Consent may be expressed or implied. Except in cases where required by law or in the public interest, express consent (in writing) must be obtained. When sharing information with the treating team it is necessary to first get the patient's consent.

Circumstances under which there may be a lack of capacity to consent include immaturity and mental illness or intellectual disability. Under these circumstances, the order of preference for obtaining consent from a third party is (1) spouse or partner, (2) parent, (3) grandparent, (4) adult child, and (5) adult sibling.

5. MINOR UNDER AGE OF 12

When consent is required for a minor younger than 12 years, written consent must be obtained from the parent or guardian. An adolescent older than 12 but younger than 18 can consent to disclosure if they understand the implications of such disclosure (12 is the age of consent for medical treatment and surgical treatment, with assistance of parent/guardian). If a minor is the victim of abuse but does not have capacity to consent to disclosure, the clinician has obligation to disclose.

6. DECEASED PATIENT

Disclosure of information about a deceased individual requires written consent from the next of kin or executor of the estate. Duty of confidentiality to a patient remains after death, and as far as possible the wishes of the patient expressed before death should be respected. It is important to always be clear to whom the information is being provided and for what purpose.

CLINICIANS AND DUAL RESPONSIBILITIES

Situations arise where healthcare practitioners have contractual obligations to third parties, such as companies or organisations, as well as obligations to patients. Such situations occur, for example when practitioners:

- Provide occupational health services or medical care for employees of a company or organisation;
- Are employed by an organisation, such as an insurance company;
- Work for an agency assessing claims for benefits;
- Provide medical care to patients and are subsequently asked to provide medical reports or information for third parties about them;
- Work as district medical officer or forensic pathologist;
- Work in the armed forces; or
- Work in correctional services.

When there is a request for information by a third party, the clinician must be satisfied that the patient has been told about the purpose of the examination or disclosure; the extent of the information to be disclosed; and the fact that relevant information cannot be concealed or withheld. Written consent to the disclosure must be obtained from the patient or a person properly authorised to act on their behalf.

ONLY INFORMATION RELEVANT TO THE REQUEST FOR DISCLOSURE SHOULD BE DISCLOSED, INCLUDING ONLY FACTUAL INFORMATION THAT CAN SUBSTANTIATED AND WHICH IS PRESENTED IN AN UNBIASED MANNER.

CONCLUSION

The right to confidentiality in the clinician-patient relationship, while protected, is not absolute. Disclosure is legally and ethically sanctioned in specific circumstances. The legal requirements may seem clear at first sight, but there are many grey areas that need careful analysis before a decision on disclosure is made. Whenever the clinician is in doubt, they should seek advice.

References available on request.

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SAN ROCK PAINTINGS

The Eland is dead after having been speared by a group of San men. The position of the head and the raised hair on the mane signify that the Eland is dead. The man on the right is a therianthrope depiction of a Sharman. He has the head of an antelope and has the feet of an antelope. He is making contact with the Eland in order to transfer the spiritual energy from the sacred and venerated Eland to himself.

The beliefs of the San hunter gatherer peoples of Southern Africa are shown in this significant rock art painting. The San people held an Animistic belief system. They held the belief that life was a matter between the ancestral spirits that lived in animals and the environment – rivers, rocks etc.. This belief system was lost with the arrival of peoples to Southern Africa from both Africa, Europe and the Middle East.

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MANAGEMENT OF TREATMENT-RESISTANT ANXIETY DISORDER

Ian Westmore

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Anxiety can be viewed through multiple lenses. Subjectively it is a distressing experience and a symptom that can be reported to a health care professional. Anxiety disorder is a specific diagnosis defined by DSM-5 criteria. Anxiety is also a qualifier that can be added to other DSM-5 diagnoses, such as major depressive disorder (MDD), and it is a key symptom in other psychiatric conditions, including autism spectrum disorders, bipolar disorder (BD) and substance use disorders, where the presence of anxiety may have important prognostic implications. Recent analyses have suggested that in MDD, comorbid anxiety as a symptom has more prognostic value than the presence of a comorbid anxiety disorder.

THE PRESENCE OF ANXIETY ALSO COMPLICATES DIAGNOSIS, BECAUSE INITIALLY IT MAY NOT BE CLEAR WHETHER IT IS THE PRIMARY DISORDER OR WHETHER IT IS A SYMPTOM OF ANOTHER CONDITION.

EPIDEMIOLOGY

The group of anxiety disorders has a combined lifetime prevalence of 28%. When it accompanies other disorders, anxiety predicts a worse course and poorer response to treatment. Most clinical trials of these disorders document response rates of 50% to 60% and remission rates between 25% and 35%. However, refractory anxiety must also include patients who relapse after remission, and this rate is 0% at 1 year, 20% at 5 years, and 30% at 10 years. Thus the prevalence of treatment-refractory anxiety can be sizable.

Ian Westmore

DSM-5 ANXIETY DISORDERS

The DSM-5 anxiety disorders include the following,

- Separation anxiety disorder
- Selective mutism
- Specific phobia
- Social anxiety disorder (social phobia)
- Panic disorder
- Generalized anxiety disorder (GAD)
- Agoraphobia
- Substance/medication-induced anxiety disorder
- Anxiety disorder due to another medical condition
- Other specified anxiety disorder
- Unspecified anxiety disorder

In DSM IV obsessive compulsive disorder (OCD) and posttraumatic stress disorder (PTSD) were listed among the anxiety disorders, but they have been described as distinct entities in DSM5.

DEFINING TREATMENT-RESISTANT ANXIETY

There is neither a universally accepted definition of treatment resistant anxiety (TR-AD) nor consensus

on the definitive number and characteristics of interventions needed to constitute an adequate treatment trial for persistently symptomatic anxiety disorders. However, taking the various definitions into account, TR-AD may be defined as failure of both first-line pharmacological treatment (at least one medication) and one psychological treatment, provided for an adequate duration (at least 8 weeks), with anxiety severity remaining above a specified threshold.

A diagnostic tool, the TR-AD checklist, has been developed based on this definition (Table 1).

TR-AD IS PRESENT IF ALL SIX TREATMENT BOXES CAN BE CHECKED IN ADDITION TO AT LEAST ONE SYMPTOM SEVERITY BOX.

Table 1. TR-AD checklist

Failed pharmacotherapeutic treatment

☐ At least one first-line treatment (SSRI, SNRI)

☐ Pre- to post-treatment difference in HAM-A <50% or post-treatment CGI-I >2

☐ Treatment period of at least 8 weeks

Failed psychotherapeutic treatment

☐ At least one first-line psychotherapeutic treatment (CBT)

☐ Pre-to post-treatment difference in HAM-A <50% or post-treatment CGI-I >2

☐ Provided according to local protocols and for an adequate duration (at least 8 weeks)

Current severity of anxiety symptoms

☐ Generalised anxiety disorder (GAD): HAM-A >15 or CGI-S > 3

☐ Panic disorder (PD): HAM-A >15 or PDSS >3, or any item >1 or CGI-S > 3

☐ Social anxiety disorder (SAD): HAM-A >15 or LSAS ≥ 60 or CGI-S > 3

CBT: Cognitive behaviour therapy; CGI: Clinical Global Impressions score (I-improvement, S-severity); HAM-A: Hamilton Anxiety score; LSAS: Liebowitz social anxiety scale; PDSS: Panic disorder severity scale

IN A 2-YEAR FOLLOW-UP STUDY, RESEARCHERS EVALUATED A DIMENSIONAL APPROACH TO TREATMENT RESISTANCE IN ANXIETY DISORDERS AND THEY IDENTIFIED VARIOUS CLINICAL ASPECTS AS CRITERIA TO DEFINE TR-AD.

These included symptom severity, presence of functional impairments, psychiatric comorbidity, previous duration of symptoms, and number of adequate pharmacological and psychological treatments (Table 2). Each subcategory can be scored and subscores are added to determine a total score. The optimal cut-off for the dimensional TR-AD score is 11 or higher. Thus higher levels of anxiety duration, symptom severity, psychiatric comorbidity and functional impairments contribute to higher levels of TR-AD.

Table 2. Dimensional assessment of the degree of TR-AD

Symptom severity

- Mild: Beck Anxiety Inventory (BAI) <10, Fear Questionnaire (FQ), agoraphobia subscale (Ag) <15 and FQ, social phobia (So) subscale <12
- Moderate: BAI 10 to <30, or FQ (Ag) 15 to <19, or FQ (So) 12 to <18
- Severe: BAI ≥30, FQ (Ag) ≥19, or FQ (So) ≥18.

Score: mild = 1; moderate = 3; severe = 5

Functional impairment

World Health organization Disability Assessment Schedule (WHO-DAS 2.0) general population percentile scores: none <25th; low: 25th to 50th; moderate: 50th to 75th; severe >75th.

Score: none = 0; low = 1; moderate = 2; severe = 3

Psychiatric comorbidity

Major depressive disorder, dysthymia, alcohol dependency.

Score: None = 0; comorbidity present = 2

Previous duration of symptoms

- Short: <30% of months during the previous five calendar years spent with symptoms,
- Intermediate: 30 to <80% of months during the previous five calendar years spent with symptoms,
- Long: >80% of months during the previous five calendar years spent with symptoms.

Score: Short = 1; intermediate = 2; long = 3

First-line pharmacological treatment trials

Selective serotonin reuptake inhibitors (SSRIs), serotonin-noradrenaline reuptake inhibitors (SNRIs).

Score: 0 = 0; 1-2 = 1; 3-4 = 2; 5-6 = 3; 7-10 = 4; >10 = 5

Second-line pharmacological treatment trials

Tricyclic antidepressants (TCAs), monoamine oxidase inhibitors (MAO-I), tetracyclic antidepressants, high potency benzodiazepines, pregabalin, and buspirone.

Score: 0 = 0; 1-2 = 1; 3-4 = 2; 5-6 = 3

Adequate psychological treatments

At least 10 consultations with a psychologist, psychotherapist, or psychiatrist, or at least 16 consultations at a mental health centre.

Score (number of psychotherapy trials): 0 = 0; 1 = 1; ≥2 = 2

Total score (2-23):

PSEUDO-RESISTANCE VS. TRUE RESISTANCE

Pseudo-resistance can be due to clinician errors in selecting and delivering an appropriate treatment effectively, or to patient non-adherence to a course of treatment. In contrast, true treatment resistance can be due to unrecognised exogenous anxiogenic factors (e.g., caffeine overuse, sleep deprivation, use of alcohol or marijuana) or an incorrect diagnosis (e.g., atypical bipolar illness, occult substance abuse, attention deficit-hyperactivity disorder and other medical conditions).

THE BASIC DEFINITION OF TR-AD REQUIRES THAT STANDARD ANXIETY DISORDER TREATMENTS HAVE BEEN SUCCESSFULLY DELIVERED AND FOUND TO BE EITHER TOTALLY INEFFECTIVE (NO RESPONSE) OR ONLY MODESTLY EFFECTIVE (RESPONSE BUT NO REMISSION).

MANAGEMENT OF TR-AD

The standard treatment for anxiety is medication. First line treatments include selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs). They are broadly effective across multiple aspects of anxiety disorders, including for cognitive, phobic/avoidant, and physiologic/autonomic symptoms. They also effectively treat the comorbid depression.

High-potency benzodiazepines (e.g., clonazepam, lorazepam, alprazolam) are effective agents for panic disorder (PD), generalised anxiety disorder (GAD), and social anxiety disorders (SAD), but have no proven efficacy in either OCD or PTSD. Advantages are offset by their narrow spectrum of action and the risk of abuse, cognitive side effects, and withdrawal effects with attempted discontinuation. Withdrawal symptoms often mimic the original anxiety syndrome (worse in PD versus GAD). Although they have been used to reduce anxiety early in the course of SSRI treatment, studies suggest that they are no more effective than counselling the patient regarding possible worsening of anxiety, and they are no longer recommended for this indication.

THE FIRST-LINE PSYCHOTHERAPEUTIC TREATMENT FOR ALL FIVE ANXIETY DISORDERS IS COGNITIVE-BEHAVIOURAL (CBT) OR BEHAVIOURAL (PROLONGED EXPOSURE FOR PTSD, EXPOSURE WITH RESPONSE PREVENTION FOR OCD) TREATMENT.

APPROACH TO THE EVALUATION OF TREATMENT-REFRACTORY ANXIETY

The basic approach follows a similar logic to that utilised in the approach for treatment refractory depression. The initial step is to exclude pseudo-resistance and consider factors that are known to contribute to TR-AD. The primary diagnosis should be re-evaluated to exclude other confounding conditions, such as MDD, BD (and antidepressant-induced switch to a bipolar illness "mixed state" in an undiagnosed patient), ADHD or substance abuse, and complicating medical conditions (Table 3).

THE MOST COMMON MISDIAGNOSIS IS MDD.

Factors that may facilitate anxiety and worsen the course of illness (e.g., overuse of caffeine, sleep deprivation, interpersonal or familial conflicts) must also be identified (Table 4).

Table 3. Medical conditions that may be associated with anxiety

More common	Less common
Hyper- and hypothyroidism	Hypo- and hyperparathyroidism
Cardiac arrhythmias	Phaeochromocytoma
Vestibular dysfunction	Pulmonary embolus
Seizure disorders (e.g., complex partial seizure)	Electrolyte disturbance
	Cushing syndrome
Hypoglycaemia	Menopause/oestrogen deficiency

Table 4. Exogenous causes of TR-AD

1. Excess caffeine intake is rarely a "cause" of anxiety but is a frequent aggravator/amplifier;
2. Over-the-counter cold preparations containing phenylpropylamine and pseudoephedrine, obvious stimulants;
3. The use of energy drinks with combinations of both caffeine and stimulants;
4. One night's total sleep deprivation has been shown to exacerbate panic, and relative sleep deprivation almost certainly plays an important role in aggravating anxiety;
5. Life events, poor social support, and financial adversity are associated with inadequate or incomplete treatment response;
6. "Social" drinking is known to aggravate panic and likely other anxiety syndromes, as the short-acting effects of alcohol wear off rapidly there is a rapid rebound to a state of hyper-excitability;
7. Marijuana is known to be associated with anxiety in some patients, though the exact causal relationship is unclear.

Treatments must also be re-evaluated. There are a range of medications that are ineffective and might be associated with pseudo-resistance when they are used inappropriately. They include bupropion (no efficacy for any anxiety disorder), beta-blockers (no efficacy except in performance anxiety), buspirone and trazodone (only effective

for GAD), and tricyclic antidepressants (not effective in SAD). However, pharmacotherapy is not always inappropriate and failure to prescribe a sufficient dose and, even more often, to wait an adequate duration before giving up, is much more commonly a cause of pharmacotherapy delivery failure. For some patients, response may not occur until 8 to 12 weeks and response may continue to increase during the second 6 months of treatment.

IN CONTRAST TO PATIENTS WITH DEPRESSION, THOSE WITH ANXIETY WANT TO FEEL BETTER QUICKLY, SO HAVING TO WAIT FOR AN ADEQUATE TIME FOR A RESPONSE CAN BE UNCOMFORTABLE FOR THEM AND ALSO FOR THE TREATING CLINICIAN, LEADING TO PREMATURE DISCONTINUATION AND SWITCHING TO ANOTHER MEDICATION.

The biggest contributor to pseudo-resistance in pharmacotherapy is poor patient adherence. Lack of adherence is often explained as being due to medication intolerance, but medication intolerance in anxious patients may be a nocebo effect rather than excess sensitivity to physiologic effects of the drugs. Specific attitudes, experiences, conflicts, beliefs about anxiety, and preferences for treatment may contribute to non-adherence. "Normalising" attitudes, which interpret symptoms as a normal and expected consequence of stress (panic and GAD), personality (SAD), and trauma (PTSD) may also lead to poor adherence.

THE BIGGEST CONTRIBUTOR TO PSEUDO-RESISTANCE FOR CBT INVOLVES THE THERAPIST RATHER THAN PATIENT FAILURES. IMPORTANTLY, THERAPY MUST ADDRESS BOTH COGNITIVE AND BEHAVIOURAL CHANGE, AND MANY STUDIES HAVE DOCUMENTED THAT THE FAILURE TO PROGRESS TO THE EXPOSURE PART OF THE CBT TREATMENT PROTOCOL MAY SIGNIFICANTLY LIMIT SYMPTOM IMPROVEMENT.

After all the above considerations have been addressed, the clinician needs to provide additional treatment.

COMBINATION MEDICATION AND CBT

Randomised trials comparing combined antidepressant and CBT treatment, with either modality alone and also with an active placebo, have most often been done in non-refractory patients seeking initial treatment. These studies have suggested slight superiority for combined treatment with panic disorder, more definitive advantage for social anxiety disorder, but no advantage of combined treatment compared with CBT alone for OCD. Added SSRI medication may help CBT-refractory panic disorder.

Combination of benzodiazepines with CBT is more controversial. In one study of refractory panic given higher dose and longer duration SSRI treatment without benefit, there was an equivalent benefit of added CBT in comparison to added clonazepam.

A novel combination treatment has been the addition of d-cycloserine, a partial agonist at the N-methyl-D-aspartate (NMDA) receptor, to CBT. It enhances the extinction process either by increasing NMDA-mediated neuroplasticity or by interfering with reconsolidation or reinstatement of fear via a reduction of NMDA activity. An augmenting effect has been shown for panic, SAD, OCD, specific phobia, and PTSD.

NOVEL TREATMENTS FOR TR-AD

Studies document superiority, compared with placebo, for both gabapentin (for social anxiety and high-severity panic) and pregabalin (for generalized and social anxiety). These agents have a unique mechanism of blocking the alpha delta calcium channel. A number of studies have showed comparability in onset and amount of effect with comparison benzodiazepines, such as alprazolam and lorazepam, and with earlier onset and comparable effect as standard SNRIs such as venlafaxine.

Prazosin may provide significant benefit for PTSD patients struggling with nightmares and other symptoms of hyperarousal.

THERE HAVE BEEN A NUMBER OF POSITIVE OPEN TRIALS OF MORE TYPICAL ANTICONVULSANT AGENTS SUCH AS VALPROATE, TOPIRAMATE, AND TIAGABINE, BUT THERE IS NO CONSISTENT EVIDENCE SHOWING EFFICACY OF THESE AGENTS IN RANDOMISED CONTROLLED TRIALS.

Individuals with emotional distress are more likely than those without distress to seek out and use herbal medicine. However, studies on plant-based substances with possible efficacy for anxiety are small and methodologically poor. One of the most well supported agents used in the past for anxiety has been kava kava, but recently this has been found to have unacceptable hepatotoxicity and is no longer widely used. Omega-3 fatty acids and St John's wort have not been shown to be effective for anxiety, and valerian root has limited evidence of efficacy. In contrast to several positive reports, a systematic review and meta-analysis failed to find a sustained anxiolytic effect of cannabinoids.

Psilocybin has been demonstrated to be helpful for anxiety and depression in patients with cancer-related psychiatric distress, with reduced depression

and anxiety after 2 weeks which was sustained at 3 month and 6 month follow-ups. At higher doses approximately 80% of participants at the 6-month follow-up continued to show clinically significant decreases in depressed mood and anxiety, and approximately 60% showed remission.

Meta-analyses of data from randomised controlled trials of ketamine in the treatment of refractory anxiety spectrum disorders demonstrated a statistically significant increased likelihood of acute treatment response for SAD compared with controls and a statistically significantly greater percentage of responders among patients with GAD and comorbid SAD. A dose-response profile was observed for ketamine and changes in SAD symptoms, with doses of 0.5 mg/kg or higher being associated with greater reduction in anxiety rating scores than lower doses. In various studies, maintenance therapy with ketamine was associated with sustained anxiolytic effects and improved social and/or work functioning. However, analysis of pooled data from 3 PTSD studies did not find any difference in response between ketamine and controls.

NEVERTHELESS, THESE PRELIMINARY ANALYSES SUGGEST THAT ACUTE KETAMINE MAY BE BROADLY EFFECTIVE ACROSS TREATMENT-RESISTANT ANXIETY SPECTRUM DISORDERS, AND THESE EFFECTS CAN BE PROLONGED WITH MAINTENANCE TREATMENT.

Treatment options that have been shown to be of benefit in specific disorders associated with TR-AD are listed in Table 5.

Table 5. Treatments that have been shown to be of benefit in TR-AD

Generalised anxiety disorder	Obsessive compulsive disorder	Panic disorder
• Gabapentinoids (gabapentin and pregabalin) • Atypical antipsychotics (quetiapine, risperidone, aripiprazole and ziprasidone)	• SSRIs, with switch to an alternative SSRI, SNRIs or clomipramine in TR-AD • Augment with second-generation antipsychotic (e.g., risperidone, aripiprazole) • Augment SSRI with CBT • Repetitive transcranial magnetic stimulation (rTMS) • Deep TMS (dTMS) • Deep brain stimulation for severe TR-AD	• SSRIs (e.g., citalopram, escitalopram, fluoxetine, sertraline, fluvoxamine, paroxetine) • Tricyclic antidepressants (TCA) • SNRIs (e.g., venlafaxine, duloxetine) • Mirtazapine • CBT Second line: • Benzodiazepines (alprazolam, clonazepam, lorazepam and diazepam) • Phenelzine

NOVEL NON-MEDICATION TREATMENTS

There is emerging evidence from randomised controlled trials documenting efficacy of psychodynamic psychotherapy for panic, generalised, and social anxiety, and for interpersonal therapy (IPT) for both social anxiety and PTSD. Mindfulness-based stress reduction appears to be effective in pilot work for mixed groups with multiple anxiety disorders, with a particular benefit versus CBT against rumination, but less efficacy against arousal symptoms.

STUDIES OF EXERCISE AND YOGA IN PATIENTS WITH TR-AD HAVE NOT SHOWN ANY BENEFIT.

CONCLUSION

The initial focus of the clinician facing a patient seeking care for treatment-refractory anxiety should be on the factors related to pseudo-resistance. The most common factors relate to an unrecognised mood disorder, often a bipolar spectrum variant, occult substance abuse, often with alcohol, and beliefs and attitudes that have prevented adequate treatment uptake. After the above factors have been addressed, the clinician should proceed by exploring combination treatment with multiple modalities (this has usually been tried already) and then either multiple novel medications, more aggressive, longer-duration CBT, or a switch to another psychotherapeutic modality such as IPT or psychodynamic psychotherapy.

The problem with anxiety is that it tends to be pervasive and it is unlikely that any management strategy will render the patient completely anxiety-free. Therefore perhaps the most important aspect of treatment is to manage patient expectations and guide them to live a meaningful life despite residual symptoms of anxiety.

References available on request.

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NEUROPSYCHIATRIC CONSIDERATIONS IN THE MANAGEMENT OF **OBESITY**

Sundeep Ruder

THIS ARTICLE IS A REVIEW OF A PRESENTATION AT THE DR. REDDY'S PSYCHIATRY ACADEMIC WEEKEND MEETING HELD 9TH TO 11TH JUNE 2023. THE MEETING, SPEAKERS AND WRITING ASSISTANCE WERE SPONSORED BY DR. REDDY'S LABORATORIES PTY. LTD. THE SPEAKER ACKNOWLEDGES DR DAVID WEBB FOR WRITING ASSISTANCE. ***dawebb@mweb.co.za***

Despite advances in science and knowledge, the Western world appears more unhealthy than ever before. In particular, rates of obesity and all of its attendant health complications have increased substantially over the last 50 years. It is estimated that worldwide 1.9 billion people live with overweight or obesity, and 650 million of them are obese. In South Africa, a country with one of the highest rates of obesity, 69% of women and 31% of men are obese.

Since the 1970s, food, and especially energy dense palatable foods, has become plentiful.

Sundeep Ruder

Individual energy intakes have increased and energy expenditure has decreased. People are eating more and exercising less. However, the causes of the obesity epidemic are not that simple, and the aetiology of obesity is multifactorial and complex. It includes an interplay between food production, food consumption, societal influences, individual psychology, biology, individual activity and the activity environment (Table 1).

Table 1. Examples of overlapping factors influencing the obesity epidemic

Contributing factor	Examples	Contributing factor	Examples
Food production	· Societal pressure to consume · Efforts to increase efficiency of consumption · Desire to minimise cost · Desire to maximise volume · Pressure to cater for acquired tastes · Pressure to improve access to foods · Market price of foods · Purchasing power · Food marketing	Food consumption	· Food exposure · Food abundance · Demand for convenience · Convenience of food offerings · Food variety · Alcohol consumption · Palatability of foods · Energy density of foods · Nutritional quality of food and drink · Tendency to graze, snacking · Force of dietary habits · Peer pressure
Social psychology	· Education · Media availability and consumption · Social media · Social acceptability of fatness · Importance of ideal body size image	Individual psychology	· Food literacy · Self-esteem · Face to face social interaction · Individualism · Stress · Psychological ambivalence

Social psychology	· Peer pressure · Conceptualisation of obesity as a disease · Social rejection of smoking · Smoking cessation · Exposure to food advertising · TV watching · Parental control · Policies	Individual psychology	· Demand for indulgence/ compensation · Perceived inconsistency of science-based messages
Physical activity environment	· Opportunity for team-based activity · Access to opportunities for physical activity · Cost of physical exercise · Reliance on labour saving devices and services · Safety of unmotorised transport · Dominance of sedentary employment · Dominance of motorised transport · Walkability of living environment · Ambient temperature	Individual physical activity	· Parental modelling of activity · Degree of innate activity in childhood · Learned activity patterns in childhood · Degree of physical education · Level of recreational activity · Level of domestic activity · Level of occupational activity · Physical challenges · Emotional barriers
Physiology	· Degree of primary appetite control · Level of adipocyte metabolism · Insulin resistance · Level of fat free mass · Resting metabolic rate · Level of thermogenesis · Genetic and epigenetic predisposition to obesity · Quality and quantity of breastfeeding (and weaning) · Appropriateness of child growth · Central dopamine reward system	Energy balance	· Neurocircuits of appetite an satiety regulation · Importance of physical need · Effort to acquire energy · Tendency to preserve energy · Level of available energy · Aging · Neuroendocrine factors · Brown fat · Sarcopenia · Microbiota · Medications

DEFINITION AND CLASSIFICATION OF OBESITY

Obesity is defined as an excessive accumulation of adiposity that may impair health. Body mass index (BMI) provides the most convenient population-level measure of overweight and obesity, not as a measure of excess fat, but as a measure of risk (Table 2). It is not accurate in some populations (e.g., very muscular individuals, extremes of age), and other anthropomorphic measurements may be a more accurate measure of adiposity in some populations and ethnicities (e.g., waist circumference and waist to hip ratio).

In general, the higher the BMI, the greater the risk of complications.

Table 2. Body mass index

Classification	BMI (kg/m²)		
	International classification	**Asian population**	**Japanese guidelines**
Underweight	<18.5		<18.5
Normal range	≥18.5 - <25	≥18 - <23	≥18.5 - <25
Overweight	≥25 - <30	≥23 - <25	
Obesity	≥30	>25	
Obesity class I	≥30 - <35		≥25 - <30
Obesity class II	≥35 - <40		≥30 - <35
Obesity class III	≥40		≥35 - <40
Obesity class IV			≥40

COMPLICATIONS

Obesity is associated with multiple co-morbidities and complications (Table 3).

The risk of complications can be reduced substantially by even modest weight loss.

Even 5% to 10% weight loss may be associated with reduced risk of type 2 diabetes, reduction in cardiovascular (CV) mortality, improvements in blood lipid profile and blood pressure, improvement in severity of sleep apnoea, and improvements in health-related quality of life.

Table 3. Potential complications associated with obesity

· Depression · Anxiety · Asthma · Nonalcoholic fatty liver disease (NAFLD) · Gallstones · Incontinence · Knee osteoarthritis · Chronic back pain · Sleep apnoea	Cardiovascular disease and risk factors: · Stroke · Dyslipidaemia · Hypertension · Coronary artery disease · Heart failure · Pulmonary embolism	· Type 2 diabetes · Prediabetes · Thrombosis · Gout Reproductive system : • Infertility · Subfertility · Hypogonadism · Polycystic ovary syndrome · Pregnancy complications

OBESITY IN PATIENTS WITH PSYCHIATRIC DISORDERS

Patients with psychiatric disorders are 2 to 3 times more likely to have obesity and higher rates of obesity-related morbidity and premature mortality. Antipsychotics play an important role in the increased rates of obesity, and it is preferable to prevent the excess weight gain due to psychotropic medications than to treat it, although this is not always possible.

Dopamine-2 (D2) receptor blockade is associated with significant weight gain, especially among treatment naive patients presenting with a first episode of psychosis. All antipsychotic medications in current use are D2 blockers, and it is essentially impossible to avoid D2 blockade when prescribing pharmacotherapy to patients with schizophrenia and other psychotic disorders. They are also associated with lipid abnormalities and insulin resistance through independent effects on fat and muscle tissues.

Mood stabilizers such as lithium and valproate, are weight inducing through unknown mechanisms, but are associated with less weight gain than antipsychotic agents.

Newer antidepressants are weight neutral, or may even be associated with weight loss (e.g., bupropion).

Any medication that is an antagonist at histamine 1 (H1) receptors can increase appetite and produce weight gain. Examples include antipsychotics (e.g., olanzapine and quetiapine), antidepressants (e.g., mirtazapine and several older tricyclic antidepressants), and central antihistamines used to treat anxiety (e.g., hydroxyzine). These drugs should be avoided as initial treatments, or switched to alternatives with lower weight gain liability whenever possible. Many of these medications also block serotonin 2c (5HT2c) receptors, which also induces appetite (though to a lesser extent than H1 blockade).

This may explain why some second-generation antipsychotics which are not antihistaminic may cause significant weight gain in some patients.

SWITCHING MEDICATION

Switching to an alternative pharmacological agent may be considered in obese patients, those who have gained a clinically significant amount of weight (>5% of body weight), or where there is evidence of severe metabolic dysfunction (e.g., poor diabetes disease control). Under these circumstances, switching medications can lead to weight loss of 2-3 kg after 24 weeks, and clinically significant changes in non-HDL cholesterol, triglyceride and glucose levels. When the patient is carefully monitored, switching can be tolerated without increased risk of psychiatric hospitalisation or significant exacerbations of psychiatric symptoms.

CV RISK ASSESSMENT AND LIFESTYLE ADVICE

CV risk assessment should be done at the initial consultation and at regular intervals thereafter (initially every 3 months and thereafter annually), including lipids, blood pressure and fasting glucose, and a glucose tolerance test when indicated.

All individuals, regardless of body size or composition, would benefit from adopting a healthy, well-balanced eating pattern and

engaging in regular physical activity. Several minutes of every consult should be reserved for weighing the patient and patients should be counselled on healthy nutrition and exercise.

BECAUSE THE PATIENT'S EATING AND EXERCISE HABITS WILL BE STRONGLY INFLUENCED BY WHAT FOOD IS PREPARED AT HOME AND THE HOME ENVIRONMENT, IT IS IMPORTANT TO EDUCATE THE FAMILY ALSO IN HEALTHY LIFESTYLE HABITS.

Healthy nutrition includes whole foods – fruits and vegetables, nuts, legumes and a source of protein (chicken, fish and meat). In general, patients and their families can be advised to avoid processed foods.

A USEFUL TOOL IS TO ADVISE PATIENTS TO AVOID MOST THINGS THAT 'COME FROM A FACTORY OR HAVE AN ADVERTISEMENT'. WARN PATIENTS OF THE DANGERS OF SOFT DRINKS. REFERRAL TO A NUTRITIONIST MAY BE HELPFUL.

Aerobic physical activity (30-60 minutes of moderate to vigorous intensity most days of the week) can help to achieve modest weight loss, reduce visceral fat even in the absence of weight loss, improve cardiorespiratory fitness and mobility, and is associated with improvement in mood disorders and quality of life.

Suggestions should be offered at every visit, and might include:

- Identifying one high calorie dietary component such as a sugared beverage or fried chicken, and suggesting healthier alternatives (diet soda or baked chicken);
- Incorporating increased physical activity into daily routine, such as taking stairs instead of elevators, or walking to work;
- Alerting patients against non-hunger related calorie intake, such as snacking or emotional eating or eating in response to stress;
- Stimulus reduction, such as not storing high calorie food.

MANAGEMENT OF OVERWEIGHT AND OBESITY

Management options for overweight and obesity include stepwise implementation of lifestyle modification, pharmacotherapy and surgery, depending on BMI and clinical response (Table 4).

Table 4. Treatment options for overweight and obesity

	BMI (kg/m²)				
	25-26.9	27-29.9	30-34.9	35-39.9	≥40
Healthy nutrition and physical activity	Everyone, regardless of body size or composition, benefits from a healthy, well-balanced eating pattern and regular physical activity				
Behavioural modification	✓	✓	✓	✓	✓
Pharmacotherapy		With adiposity-related complications	✓	✓	✓
Surgery			When optimal medical and behavioural therapy has been insufficient	With adiposity-related complications	✓

Multicomponent psychological interventions combining behaviour modification (goal-setting, self-monitoring, problem-solving), cognitive therapy (reframing) and values-based strategies to alter diet and activity should be incorporated into care plans for weight loss. They can improve health status and quality of life, and promote adherence, confidence, self-efficacy and intrinsic motivation (personal, meaningful reasons to change).

Pharmacotherapy is recommended for all patients with BMI greater than 30 kg/m2 and for those with BMI 27 to 29.9 kg/m2 with adiposity-related complications. Weight loss medications that are available in South Africa are listed in Table 5.

Table 5. Pharmacotherapy for weight loss

Drug	Mechanism of action	Adverse effects	Contraindications
Orlistat	Gastric and pancreatic lipase inhibitor	Oily rectal leakage, abdominal distress, abdominal pain, flatulence with discharge, faecal urgency, steatorrhea, faecal incontinence, increased defecation	Patients with chronic malabsorption syndrome or cholestasis, pregnancy
Phentermine / topiramate[1]	Norepinephrine agonist/GABA agonist, glutamate antagonist	Elevation in heart rate, mood and sleep disorders, cognitive impairment, metabolic acidosis, paraesthesia, dry mouth	Glaucoma, hyperthyroidism, during or within 14 days following the administration of monoamine oxidase inhibitors, hypersensitivity to sympathomimetic amines, pregnancy
Naltrexone / bupropion	Opioid receptor antagonist/dopamine and norepinephrine reuptake inhibitor	Nausea, constipation, headache, vomiting, dizziness, insomnia, dry mouth, diarrhoea, sleep disorder	Glaucoma, hyperthyroidism, during or within 14 days following the administration of monoamine oxidase inhibitors, hypersensitivity to sympathomimetic amines, pregnancy
Liraglutide	GLP-1 analogue	Increased heart rate, hypoglycaemia, constipation, diarrhoea, nausea, vomiting, headache	Personal or family history of medullary thyroid carcinoma or multiple endocrine neoplasia syndrome type 2, pregnancy
Semaglutide[2]	GLP-1 analogue	Nausea, vomiting, diarrhoea, abdominal pain, constipation, headache	Personal or family history of medullary thyroid carcinoma or in patients with multiple endocrine neoplasia syndrome type 2, pregnancy

1. Combination not available, drugs may be prescribed separately.
2. 1.34 mg/ml available in SA for prevention of complications in patients with diabetes; 2.4 mg dose has been approved for weight loss and is not available in SA.

In patients with psychiatric conditions, orlistat is not effective for weight loss. The sympathomimetics (e.g., phentermine) are associated with risk of psychosis exacerbation and they are relatively contraindicated.

Topiramate may be helpful for weight loss in patients with schizophrenia, but it can be limited by neurocognitive side effects and metabolic acidosis. Naltrexone/bupropion has not been well studied in psychiatric patients and the efficacy and safety in this group is unknown.

Metformin has a low potential for drug-drug interactions and can be safely used in patients with psychiatric conditions. It will not significantly increase the risk of hypoglycaemia when used alone. When combined with healthy nutrition and physical activity, it may be associated with weight loss of up to 3 kg at 16 weeks.

ALTHOUGH IT IS NOT APPROVED FOR WEIGHT LOSS, IT MAY BE APPROPRIATE FOR OFF-LABEL USE IN THIS POPULATION OF PATIENTS.

Numerous studies have evaluated the efficacy and safety of liraglutide (1.8 mg or 3 mg daily) in patients with schizophrenia, schizoaffective disorder or first

episode psychosis and treated with antipsychotic drugs, either as monotherapy or in combination. Treatment was associated with placebo-subtracted body weight loss of up to 6 kg, a decrease in BMI and waist circumference, and improvement of glycaemia and lipid profile. Studies on semaglutide in patients with schizophrenia are ongoing.

GLP1-RECEPTOR AGONISTS ARE THE DRUGS OF CHOICE FOR WEIGHT LOSS IN PATIENTS OVER THE AGE OF 65 YEARS, AND WHERE THEY ARE NOT CONTRAINDICATED, PHENTERMINE/TOPIRAMATE MAY ALSO BE CONSIDERED FOR THIS AGE GROUP.

In patients with comorbidities, drug choices are guided by the potential for adverse effects and contraindications (Table 6).

Table 6. Drug choices for weight loss based on presence of comorbidity

Comorbidity	Consider
CV disease or diabetes	Liraglutide, orlistat, semaglutide
Depression	Liraglutide, naltrexone/bupropion, orlistat, phentermine/topiramate
History of medullary thyroid cancer or pancreatitis	Naltrexone/bupropion, orlistat, phentermine/topiramate
Nonalcoholic fatty liver disease	Liraglutide, orlistat, semaglutide
Obstructive sleep apnoea	Liraglutide, orlistat, phentermine/topiramate, semaglutide
Opioid use or history of seizure	Liraglutide, orlistat, phentermine/topiramate, semaglutide
Uncontrolled tachycardia or hypertension	Liraglutide, orlistat, semaglutide

FINAL THOUGHTS

Encouraging lifestyle change and pharmacotherapy are approaches to manage a condition that has already become problematic and detrimental to quality of life and flourishing. Taxation, regulating marketing, food labels, restrictions on the junk food industry and so on, while aiming to protect health, removes autonomy and the responsibility of the individual to maintain their own health.

AUTONOMY, HOWEVER, REQUIRES SOME PREREQUISITES. IT REQUIRES A PERSON TO HAVE THE ABILITY TO CRITICALLY THINK ABOUT A DECISION, OBJECTIVELY AND NOT IMPULSIVELY, AND LINK SUCH DECISIONS TO HIGHER VALUES. IT REQUIRES THE ABILITY TO DELAY INSTANT GRATIFICATION.

It is the speaker's opinion that this fundamental ability in human decision making is lacking in modern society and the education required to develop such critical thinking is not available. Utilitarian education is pervasive, but that knowledge which improves self-sufficiency is lacking in schools and universities. The solution perhaps lies in drawing from scriptural philosophy of life and presenting it in a logical and scientific manner that can be practically applied. This education should be presented from youth to develop independent critical thinking and fundamental values, such that each individual's health is important to them and they take responsibility for it themself from a young age. Without that, it seems unlikely that efforts to curtail the global pandemic of overweight and obesity will be successful.

A FUNDAMENTAL CHANGE IN PERCEPTION OF LIFE AND REALITY IS THE ORDER OF THE DAY AND WE MAY HAVE TO DRAW ON UNTAPPED RESOURCES BEYOND CONVENTIONAL EVIDENCE-BASED MEDICINE TO HELP HUMANITY IN ITS CURRENT NEED.

Psychiatric patients are a special population. Unfortunately the medications that control the symptoms of mental illness themselves have adverse weight and metabolic effects. For these patients a multidisciplinary approach with involvement of the family and regular monitoring can help to improve outcomes in terms of both physical and mental health.

References available on request.

Sundeep Ruder Endocrinologist in private practice; Life Healthcare, Gauteng, South Africa **Correspondence: drsruder@hotmail.com**

DEPARTMENTS OF PSYCHIATRY
UNIVERSITY OF THE WITWATERSRAND

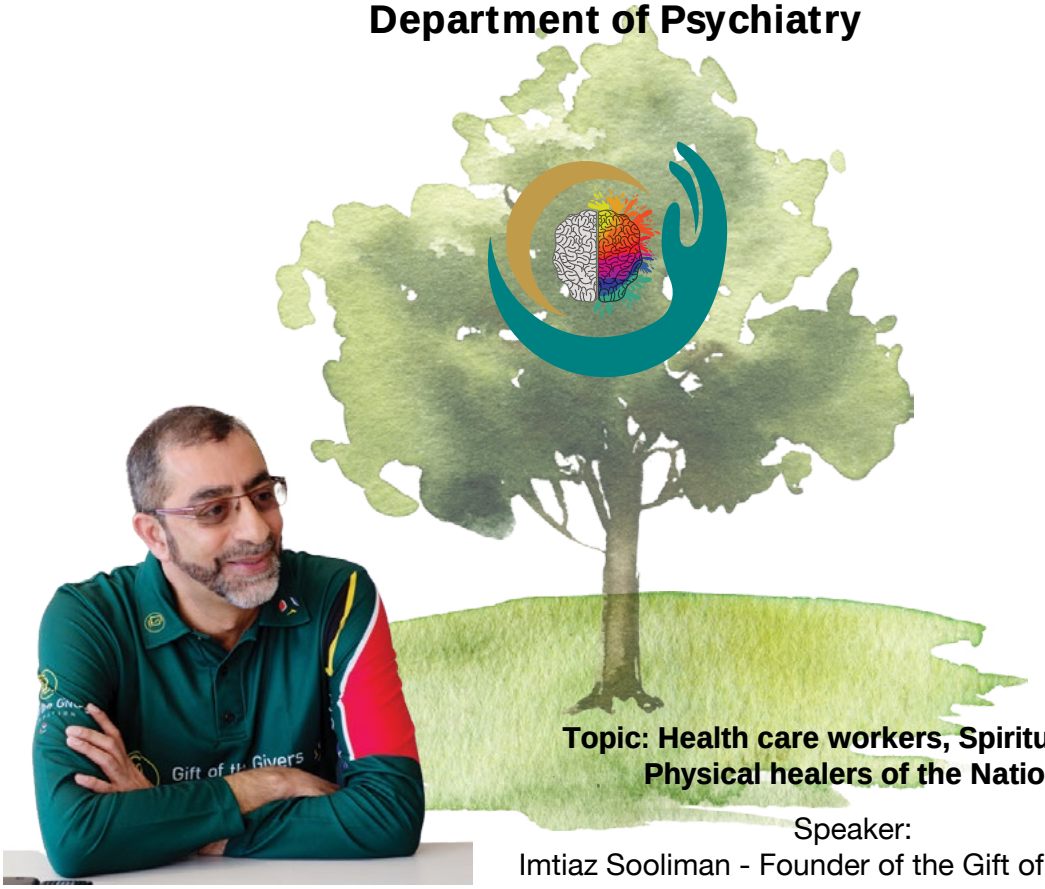
THE ANNUAL BJVR MEMORIAL LECTURE

16 APRIL 2024

Venue: Marie Curie Lecture Theatre

Time: 16:30

Wits Faculty of Health Sciences - School of Clinical Medicine
Department of Psychiatry



Topic: Health care workers, Spiritual and Physical healers of the Nation

Speaker:
Imtiaz Sooliman - Founder of the Gift of the Givers

Dr. Imtiaz Sooliman commenced private practice in Pietermaritzburg in 1986 but chose to close his flourishing practice in mid-1994, choosing instead to focus his attention on Gift of the Givers Foundation, which he founded in early August 1992. His establishment of Gift of the Givers Foundation was the consequence of a message he received from his spiritual leader in Istanbul, Turkey, who called on him to serve all people of all races, of all religions, of all colours, of all classes, of all political affiliations and of any geographical location... a calling he honoured then and continues to honour today.

His endeavor in this regard has seen Gift of the Givers Foundation emerge as one of the most respected humanitarian organisations in the world and is today the largest disaster response agency of African origin anywhere on the continent. Since 1992, Dr. Sooliman has steered the organisation to many Notable Achievements and World Firsts, including: Coming to the assistance of millions of people in no fewer than 46 countries across the globe, inclusive of South Africa; Designed and developed, in 1993, the world's first and only containerised mobile hospital of its kind, which has been compared by CNN to any of the best hospitals in Europe; Designing the world's first containerised primary health-care unit in 1994; Heading the first organisation in the history of South Africa to have received R60 million in 2003 from Government for the design and successful roll-out of 20 4000 food parcels in KZN and E.C during hunger crises; assisting 210 hospitals during Covid-19, including the delivery of 3500 oxygen machines. He has received 10 Honorary Doctorates ■

WITS UNIVERSITY 100 | FACULTY OF HEALTH SCIENCES

UNIVERSITY OF CAPE TOWN

STELLAR PSYCH GEN IN 2023!

BY SHAREEFA DALVIE AND NASTASSJA KOEN

Last year the Psychiatric Genetics Group of the Brain-Behaviour Unit, UCT Neuroscience Institute, continued to go from strength to strength. In addition to welcoming three new Msc Med Neurosci candidates (Anje Grobler, Mia Lombard and Pheziwe Mshunqwane), a number of our group members excelled in 2023:

Tsaone Charlotte Chalumbila (PhD candidate) participated in the Equinox Conference (September 2023), at which she presented her doctoral work, "Investigating transgenerational effects of maternal psychological distress through infant gene expression profiles in a South African birth cohort study".

Dr Shareefa Dalvie and A/Prof Nastassja Koen (Co-Heads, Psychiatric Genetics Group) organised and chaired the symposium, "The Contribution of African Genomics Research to Innovation in Psychiatry" at the International Congress of Human Genetics (ICHG) in Cape Town (February 2023). To complement the congress theme of "coming home", this session provided an update on findings from psychiatric genomic initiatives focussed on African populations.

In addition, Shareefa presented a poster at ICHG entitled "Does childhood adversity influence immune-related gene expression?". She also presented her work on "PRS Associations with Subcortical Volumes, Cortical Thickness and Surface Area in ENIGMA-OCD" at the Society of Biological Psychiatry (SOBP) Annual Meeting in San Diego, USA (April 2023).

Anje Grobler (MSc candidate) has been elected as the incoming Chairperson of the UCT Cortex Club for 2024. The Cortex Club is a student-run Neuroscience Society that deals with cutting-edge topics and challenging issues in neuroscience.

A/Prof Nastassja Koen (Co-Head, Psychiatric Genetics Group) was awarded a NRF Research Excellence Award for Early Career/Emerging Researchers (Life Sciences), as well as a UCT College of Fellows Young Researcher Award 2023. Nastassja's research interests include the genomic, epigenomic and transcriptomic neurobiology, and transgenerational effects of trauma-related disorders, particularly in South Africa and Africa.

A/Prof Nastassja Koen receives a NRF Research Excellence Award (left) and a UCT College of Fellows Young Researcher Award (right)

Dr Lerato Majara at the ASHG meeting (November 2023)

Dr Lerato Majara (Prior Co-Head, Psychiatric Genetics Group) attended the 75th celebration of the American Society of Human Genetics (ASHG) in Washington DC, USA (November 2023). At the awards ceremony, her paper, "Low and differential polygenic score generalizability among African populations due largely to genetic diversity" (DOI: 10.1016/j.xhgg.2023.100184), was selected as one of two Outstanding Early Career Publications in the journal, Genetics and Human Genomics Advances (award made to senior author, Dr Alicia Martin).

Lerato – together with Dr Olivia Wootton (PhD candidate) and Prof Dan Stein – also presented, "Towards integration of clinical neuroscience and global mental health research in the South African context" at the NIMH's Research Domain Criteria (RDoC) Framework in Global Mental Health Research Webinar (September 2023).

Lihle Moyakhe (PhD candidate) presented a poster of her doctoral work, "Using polygenic risk scores to find potential links with developmental and mental health outcomes in children: A systematic review" at the ICHG 2023; and was awarded an International Scholar and Cultural Exchange Program scholarship to attend the International Statistical Genetics workshop, in Boulder, Colorado (March 2023).

Dr Mary Mufford (Postdoctoral Fellow) published her work, "The genetic architecture of amygdala nuclei" in Biological Psychiatry (DOI: 10.1016/j.biopsych.2023.06.022). She also presented this work, and her work on "Amygdala nuclei volumes associated with PTSD and related measures in ENIGMA-PTSD" at the SOBP Annual Meeting in San Diego, USA (April 2023), for which she was one of the international early career travel awardees.

Dr Olivia Wootton (PhD candidate) was awarded a travel bursary to attend the Wellcome Connecting Science Genomics of Brain Disorders Conference (May 2023) for her work entitled, "Characterising the shared genetic influences between schizophrenia and reaction time variability" ■

THE VANGUARD CHC'S PROJECT

BY NONDUMISO GQOMFA, NASERA CADER-MOKOA AND WASEEM HAWA

The need for mental health services at primary health care level and the value of making such services available to pregnant mothers is indisputable. Equally valid is the reality of limited resources available to meet the ever-growing need of counselling services where they are needed most. In bridging the gap between those two realities, the department of psychiatry and mental health has implemented a solution to this problem, the involvement of 6th year medical students in the collaborative counselling project at Vanguard Community Health Centre's (CHC) Maternal Obstetrics Unit.

A joint initiative of the Western Cape Department of Health and the University of Cape Town, the project is targeted at pregnant women who are booked for their antenatal care visits at the clinic. A key aim of the project, which was initiated by UCT Faculty of Health Sciences Deanery in 2020, and strongly supported by the Director of Specialty Hospitals, is to provide students of medicine and allied health professions an opportunity to learn about mental health screening and mental health interventions in the primary care context.

The Intervention: A manualised brief solution-focused therapy intervention designed to treat maternal depression and anxiety (developed by Professor Katherine Sorsdahl) is administered by 6th year MBChB students during their rotation in the psychiatry block. Two students from Valkenberg Psychiatric Hospital's Acute Ward receive 1-hour training in the intervention and are placed at Vanguard CHC on Tuesdays for the 3-week duration of their rotation. The use of medical students during their final year of training is meant, in part, to prepare them for varying internship demands and to enhance their 'soft' skills.

Implementation of the Intervention: The project enjoys the support of Professor Mosedi Namane's family medicine team as well as the Maternity and Obstetrics Unit at the Vanguard CHC clinic. Students screen all new bookings of the day for mental health issues and engage with all patients about these issues (psychoeducation) early on in their pregnancy journey.

Student Wellness: The students are supervised by the psychotherapy lecturer, a clinical psychologist who oversees the implementation of the project at the clinic. While at the clinic, the students are supported by the intern psychologist and have debriefing sessions at the end of each day.

Medical Students Attitudes: A project of this nature poses challenges to students who have not had adequate training in psychological modalities and who often feel unprepared for what they see as a mammoth task. The patients come from under-resourced communities where there are high rates of exposure to traumatic stressors and students may be exposed to material they have not previously experienced. Feedback from students has been mostly positive ■

STUDENT PSYCHIATRY SOCIETY UPDATE

BY NIAMH AHERN

2023 was an exciting year for UCT's Psychiatry Society (PsychSoc). We did not host as many events or spearhead as many initiatives as we would have liked to but made the most out of what we did achieve.

The main event in which the PsychSoc was involved this year was an Autism Buza, a panel discussion organised and run in collaboration with the Students with Disabilities' Forum (SWDF) and Office for Inclusivity and Change (OIC). The purpose of the Buza was to celebrate Autism Awareness Month by blending lived experience, clinical expertise, and education in order to further people's knowledge of autism. Our incoming Chairperson, Niamh Ahern, was one of two students who spoke on their lived experiences of being autistic. Following their discussions, Prof Petrus de Vries, autism expert and head of UCT's Centre for Autism Research in Africa (CARA), spoke to the importance of addressing autism in an African context, the value of taking various perspectives and disciplines into account, and the necessity of listening to autistic voices. The Buza was a great success, and the society hopes to be a part of similar events in the future.

Salmaan Moosa, outgoing Chairperson, and Niamh Ahern were invited to the Western Cape Subgroup Psychiatry Registrars Dinner at the Mount Nelson. They had many fruitful conversations with psychiatrists-in-training and Stellenbosch PsychSoc members ■

Niamh Ahern (2023 Vice Chair and Treasurer, 2024 Chairperson) and Salmaan Moosa (2023 Chairperson) at the Western Cape Subgroup Psychiatry Registrars Dinner.

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MANAGING DIFFICULT SITUATIONS IN THE ONLINE WORLD

Volker Hitzeroth

The exponential use of social media is affecting the doctor-patient relationship in ways that were unknown a mere few years ago. When using electronic devices practitioners must navigate the digital world cautiously and always remain vigilant of possible medicolegal risks. This is the fifth of a series of articles. It specifically highlights common social media challenges encountered by healthcare practitioners across South Africa.

The use of social media in medicine has often led to better healthcare delivery, smarter working, and speedier communications. Yet, sadly, it has also brought with it several new challenges fraught with medicolegal risk. Such situations can cause much distress and self-doubt among practitioners. It is therefore useful for practitioners to familiarise themselves with the Health Profession Council of South Africa's (HPCSA) various guidelines published in its many booklets. While all the different guidelines have relevance, booklet 16 is of particular importance when dealing with ethical dilemmas related to social media use. At Medical Protection we are often asked to advise on some of these scenarios.

ONLINE HARASSMENT

Sadly, healthcare practitioners often experience abuse in the clinical setting (e.g. threatening behaviour, verbal confrontation, or even physical assault) A 2023 Medical Protection survey found that over half of doctors (58%) say they have recently experienced or witnessed verbal abuse, physical violence or damage to their work premises from patients or their relatives. Such behaviour is never acceptable and should not be tolerated in any healthcare environment. Social media platforms have unfortunately further enabled such abuse and facilitated an escalation in quality and quantity.

Examples include trolling, stalking, doxing, defaming, and impersonating. Such harassment can be initiated by patients, their families, or even other colleagues. Unlike a brief and once-off verbal or physical confrontation in a consultation room, online interactions can continue for much longer, occur any time of the day or night, be conducted by anonymous agents, and may trigger a social media 'pile-on' by others.

To minimise the risk of becoming involved in such matters you should manage any disagreements with your patients or colleagues amicably and professionally. You should not engage with any form of online harassment and always remain calm, courteous, and respectful. It would be sensible to also keep a record of the relevant texts, posts and/or messages. Inform a colleague, senior partner, or practice manager. If possible, identify the individual concerned. Initial steps available to a practitioner, in less serious scenarios, would include simply ignoring such posts if they are merely annoying, find no traction and do no harm.

Volker Hitzeroth

OCCASIONALLY YOU MAY WANT TO RESPOND IN A BRIEF, FACTUAL, AND DISPASSIONATE MANNER CORRECTING ANY MISINFORMATION. THE PURPOSE OF ANY REPLY IS TO PREVENT ESCALATION AND NOT NECESSARILY TO EXPLAIN YOURSELF OR EVEN TO PUT THE RECORD STRAIGHT.

You may also choose to block the individual. Alternative options include reporting the harassment to the relevant online platform or even alerting the authorities. It may be prudent to alert your indemnifier and seek their advice too.

YOUR OWN ONLINE PRIVACY

Healthcare practitioners should be aware of the limitations of online privacy. Everyone should manage their privacy settings on electronic devices appropriately and review these regularly. Despite this, your own privacy can never be guaranteed. Furthermore, your electronic communication and posts (privately or professionally) are likely to be accessed or viewed by individuals you may prefer

did not view them. Similarly, other people, at some time in the future (e.g. future employers, hospitals, pharmaceutical companies, charities you align yourself with) are also likely to view your previous and current online posts and profile. Geo-location is relatively easy to access and your whereabouts can usually be easily traced. Be cautious when posting photographs of yourself or your family members on social media platforms.

DO NOT SHARE YOUR PERSONAL CONTACT DETAILS WITH PATIENTS OR THEIR FAMILIES. THE RISK OF OVERSHARING IS REAL WHEN USING SOCIAL MEDIA - EVEN IN A PRIVATE CHAT GROUP.

If you notice that unprofessional content is shared and/or visible in a group setting, then you should approach the matter cautiously and professionally. It would be advisable to seek advice, discuss the issue with a senior colleague, supervisor or even Medical Protection. You may have to contact the specific individual offline to highlight your concerns. Furthermore, you may also have an obligation, upon becoming aware of disturbing content on a private chat group, to raise your concerns with the group administrator so that the scenario can be managed appropriately. If you have done so and the problem remains unresolved you should seek more formal advice, consider reporting your concerns externally and leaving the group. Lastly, never become embroiled in negative or unconstructive discussions.

RESPECT FOR COLLEAGUES

The HPCSA is clear in that a practitioner shall not cast reflections on the probity, professional reputation, or skill of another registered person. This means that you should not make unsubstantiated comments about a colleague and always treat them courteously, fairly, and respectfully. While this seems obvious and clear, there is a risk that when using social media, text messages or emails the temptation to comment and criticise a colleague, their interpersonal relationships or their patient management cannot be resisted.

You should also not harass or bully, intimidate or exploit other healthcare practitioners. If you are stressed, frustrated or angry you should be especially cautious and take time to reflect on the situation and your own position prior to posting or responding. Beware of power imbalances (eg patient/doctor and trainee/teacher relationships). When commenting on, or quoting from, another's publication you should be aware of the relevant copyrights and ensure that you do not infringe these. You should also ensure that you have verified any source material as being factually correct and scientifically sound. Finally, it is worth emphasising that all the same rules, regulations and laws of defamation apply to the online world as they do in the verbal or written world.

CONFLICTS OF INTEREST

Conflicts of interests arise when an individual's self-serving interests could compromise their professional judgement, decisions, or actions. While such conflicts usually arise in relation to monetary rewards this is not always the case. They could also relate to incentives, shares, commercial relationships, professional status, reputation, pharmaceutical interests, ownership, and other benefits. Usually, such scenarios encroach on the individual by stealth and are, at least at the outset, far from clear. Practitioners must always be honest and open about any potential conflict of interest - remembering that it is often just the perception of a conflict of interest that can cause damage.

ANONYMITY

It is unlikely that, when posting content on any social media, you will be able to remain anonymous. In almost all instances anything posted anonymously can be traced back to the individual who posted it. You should therefore be open and honest about who you are, your education, training, and experience as well as your qualifications. Be aware of your professional limitations as well as your scope of practice and abide by them.

While you may believe that you are posting content merely as a concerned member of the public it is likely that the public will see you as the healthcare practitioner that you are. They may also believe that you are representing the views of the healthcare profession. It is therefore important that you do not bring the profession into disrepute when posting material – either in your private or professional capacity.

MAINTAINING BOUNDARIES

Beware of the disinhibition effect with its associated risk of oversharing, posting inappropriate comments and possible boundary blurring. Many posts and comments may seem innocuous or comical to you, but they can also easily lead to misunderstandings, misinterpretation and subsequent problems and ethical dilemmas.

Your online relationships with patients should be as professional, and no different, to your clinical relationship in the consultation room. Be especially cautious when a patient asks you to accept a 'friend' request. You should be clear about your role and indicate that you cannot move into a social relationship. Explain what the professional boundary is and include this in your practice terms and conditions. You may also direct such patients to your professional or practice profile.

It is therefore prudent to keep your personal and professional roles separate, be that in the consulting room or online.

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

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1. Trezot Package insert (June 2021) 2. Stahl S. (2009). Mechanism of Action of Trazodone: A Multifunctional Drug. CNS Spectrums, 14(10), 536-546. 3. Cuomo A, Ballerini A, Bruni AC, et al. Clinical guidance for the use of trazodone in major depressive disorder and concomitant conditions: pharmacology and clinical practice. Rivista di Psichiatria. 2019 Jul-Aug;54(4):137-149. 4. Fagiolini, Andrea et al. "Rediscovering trazodone for the treatment of major depressive disorder." CNS drugs vol. 26,12 (2012): 1033-49. S5 TREZOT 50 mg Capsules. Each capsule contains 50 mg Trazodone hydrochloride. Reg No.: A47/1.2/1035. S5 TREZOT 100 mg Capsules. Each capsule contains 100 mg Trazodone hydrochloride. Reg No.: A47/1.2/1036. 01/TRE/04/24/ADV

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Dedicated To Life

AN ODYSSEY WITH DEMENTIA

Sandra Maytham-Bailey

THE FOLLOWING CONTENT IS BASED ON A PRESENTATION FOR THE ART FOR MENTAL HEALTH EXHIBITION OPENING 10TH OCTOBER 2023 HOSTED BY THE DEPARTMENT OF PSYCHIATRY AT THE ADLER MUSEUM, FACULTY OF HEALTH SCIENCES, UNIVERSITY OF THE WITWATERSRAND

In my quest for understanding dementia, triggered by the passing of my father in October 2015 and the revelation of my mother Margaret's gradual decline, I initially approached it like many would. I joined social groups such as Art for Dementia on Twitter, subscribed to newsletters, and immersed myself in online information, all while earnestly seeking a cure. Unknowingly, I clung to a sense of denial, coupled with a certain naivety.

Yet, amidst this search, a common thread emerged. Families navigating dementia often grapple with resistance, battling to preserve cherished memories. As someone outside the direct experience, I came to realize that the fear is amplified for the person grappling with the disease. A poignant moment with Margaret remains etched in my memory. It was a shared recognition that she was undergoing a transformation, an awareness without a clear understanding of how or why. This moment encapsulated sheer fear, creating a bubble of uncertainty. Unfortunately, the skills required to navigate this uncharted territory seemed to have dissipated with my father's passing.

When I was asked to share my journey with dementia at WITS University's Mental Health exhibition opening, I recounted a moment with my mum long before my father's passing. During an outing to Simonstown, she took her slice of lemon meringue pie and stirred it into her tea, spilling it over onto the saucer, and then proceeded to drink the sludge. My initial reaction was one of horror, leading me to pledge never to take her out in public again. Little did I realize then that she was regressing to her inner child. Recently, I sat with her as she playfully mushed her shortbread into a paste on her tea saucer and then licked the plate clean. Only this time, I found myself laughing. At that moment, she looked up with a glimmer of lucidity, perhaps recognizing something familiar in my laughter. She reciprocated with a laugh of her own. It was a precious and rare connection.

Sandra Maytham-Bailey

REFLECTING ON THIS, I'VE COME TO UNDERSTAND THAT DEMENTIA IS LIKE A CAUSEWAY – IF YOU EMBRACE IT THERE IS A BEAUTIFUL JOURNEY AHEAD OR YOU CAN AVOID IT AND CAUSE UNDUE STRESS TO EVERYONE.

One of the things that helped me was the "pineapple flan" strategy. Instead of announcing my arrival with loud greetings and inquiries about how she was doing, I'd casually put my bag down, catch her eye, and mention that I was just there to check on her pineapple flan. This made our visits more personal and comfortable. It became a shared moment that linked us to something familiar, sparing her the stress of having to navigate typical conversation. Still to this day, the first thing I do is check on the pineapple flan.

In my quest to preserve the essence of my mother, I initially turned to photography[1] (Images 1 – 4), using the lens as a filter for capturing seemingly ordinary moments that held the beauty of her fleeting lucidity. Music, art, and dance became our conduits to discovering those elusive moments. However, I grappled with a disquieting realization about the inherent act of censorship through framing.

[1]*Black and white film photography using a Nikon FM2 and a medium format Bronica*

1. Sketching at Boulders Beach

2. What is in your head, dear mum?

3. Jelly and orange juice slush

4. Beach dance

To quote the impassioned Susan Sontag, "Photographs are a way of imprisoning reality. One can't possess reality, one can possess images - one can't possess the present but one can possess the past" (Sontag, 2008). The urgency to cling to the past was palpable for me. Eventually, I made peace with this realization, and as I revisit those images now, I see an archive of my visual melancholy.

MARGARET, A ROYAL ACADEMY BALLET TEACHER, RETAINED HER APPRECIATION AND UNDERSTANDING OF MUSIC DESPITE LOSING HER ABILITY TO MOVE COMFORTABLY.

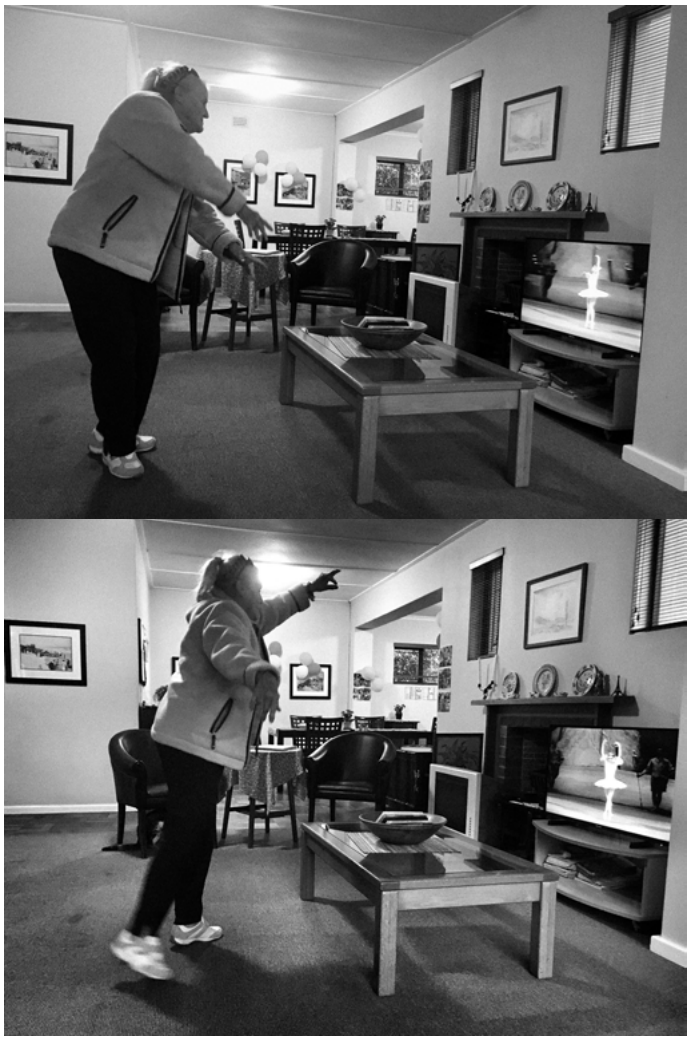
Instead, she replaced it with subtle gestures, often accompanied by humming, fixated on ballets like Swan Lake or the Nutcracker. I recommend watching the 2014 documentary, Alive Inside: A Story of Music and Memory ("Alive Inside - a story of Music and Memory," n.d.).

Inspired by her own stylized sculptures made from paper maché and wire, around 1990, I decided to explore sculpture. Next to her bed, three of her sculptures served as inspiration, alongside the numerous spontaneous photographs capturing her dancing on the beach or in front of the TV to a Swan Lake DVD. I embarked on creating a series of three bronze dancers, aiming to convey the awkward beauty of her ageing body while capturing the subtleties of movement. Subsequently, I crafted a series of five plaster Paris sculptures inspired by her beloved Swan Lake by Sir Matthew Bourne[2] (Images 5 – 8).

It was when I encountered the compelling self-portraits of British artist William Utermohlen, born in 1933 and diagnosed with Alzheimer's disease in 1995, that my perspective on dementia underwent a profound shift. Utermohlen's self-portraits poignantly illustrate the artist's battle to preserve his artistic consciousness in the face of the relentless progression of dementia.

In an insightful article by Tulika Bahadur in Art and Aesthetics ("Colourful Conversation Pieces to Dramatic Self-Portraits under Alzheimer's," 2018), the author notes that Utermohlen's final self-portraits serve as unique artistic, medical, and psychological documents, stating that "The artist, with courage and perseverance, adapts his style and technique at each juncture, navigating the growing limitations of his perception and motor skills. The resulting images communicate his predicament with extraordinary clarity and economy, offering a profound glimpse into the complex interplay between art and the impact of neurodegenerative disease".

[2]Matthew Bourne is said to have challenged the landscape of dance when the traditionally female parts of the swans was danced by men. Bourne received an OBE for his services to dance



5. Dancing to Swan Lake in front of the TV

6. Dancers, Paper Mache and Wire, Margaret Maytham, circa 1990

7. Memory Dance, bronze, Sandra Maytham-Bailey, 2019

8. Swans, plaster of Paris, Sandra Maytham-Bailey, 2020

I began to recognize striking parallels between William Utermohlen and Margaret. Born in the same year as Utermohlen, 1933, Margaret was also diagnosed with dementia soon after moving to Fish Hoek in 1995. Despite being a dance teacher rather than a full-time artist, she had produced numerous artworks and sculptures over the years. Intrigued by these parallels, I sought to trace Margaret's artistic journey and reframe her creations with newfound insight, drawing inspiration from Utermohlen's work.

UTERMOHLEN'S ARTISTIC EVOLUTION UNFOLDS IN DISTINCT CYCLES, WITH THE LATTER TWO SPEAKING POIGNANTLY TO HIS EXPERIENCE WITH DEMENTIA: THE CONVERSATION PIECES, JUST BEFORE HIS DIAGNOSIS, AND HIS FINAL SELF-PORTRAITS BEFORE HIS PASSING IN 2007.

The Conversation Pieces are considered a celebration of Utermohlen and his wife, Patricia's, life together, exuding warmth and happiness, capturing the joy of their home and friendships (Images 9 & 10). Yet, subtle indications of the encroaching disease manifest in shifting perceptions of space, objects, and people. They serve as perhaps forewarnings of a new reality, a world of silence and sensory deprivation closing in on the artist.

In his painting "Blue Skies" from 1995 (Image 11), Utermohlen captures his emotional response to the Alzheimer's diagnosis. Neuropsychologist Sebastian Crutch(Crutch et al., 2001) interprets the artwork as the artist's attempt to resist being "swept out" of the open window above. Crutch highlights the observable change in artistic ability, indicative of a process beyond normal ageing, especially considering Utermohlen's relatively young age at onset. While at the National Hospital for Neurology and Neurosurgery, Utermohlen was encouraged to continue drawing and portraying himself. These drawings were later published in the British medical journal, The Lancet in 2001, offering a poignant glimpse into the intersection of art and neurodegenerative disease.

In the self-portrait cycle spanning from 1995 to 2000, a profound transformation unfolds in William Utermohlen's style, reflecting a stark deterioration in the quality of his artwork and laying bare the psychological and traumatic dimensions of his battle with dementia. The evolution of his self-portraits mirrors the artist's escalating fear and anguish, bordering on desperation. Notably, in portraits like 'In the Studio' and 'Self Portrait with Easel' (Images 12 & 13), Utermohlen's frustrations manifest in twisted facial expressions, vividly conveying the emotional toll of his cognitive decline. The painting 'Portrait with Saw' (1997) (Image 14) introduces a haunting element – a vertically positioned wood saw, likened to a guillotine blade. This imagery is thought to symbolize an autopsy, a definitive diagnostic step that carries an undertone of death approaching.

As I delved into Margaret's artworks, recognizing the absence of a need for her to document her decline, I observed a parallel deterioration in

her artistic ability. 'Poinsettias' (circa 1980), a still life oil on board, reveals intricate brush strokes demonstrating remarkable skill and technique, reminiscent of Irma Stern. Interestingly, I stumbled upon this painting being repurposed as a shelf in Margaret's cramped studio in Fish Hoek when we cleared the space for her move into a care home after my father's passing. In an earlier self-portrait (circa 1970), also discovered among discarded works, Margaret portrays herself in a contemplative mood. I ponder whether this reflected stillness mirrors a mind searching for calm amidst the tumult of cognitive changes (Images 15 & 16).

As I sifted through boxes and old drawing books, I discovered a treasure trove of eclectic items, ranging from elaborate pewter lampshades and mirrors to oxtail bone sculptures (a nod to my father's culinary preferences). The craftsmanship varied, with some pieces exquisitely detailed and others bearing a more childlike and crude aesthetic. Grappling with the challenge of dating many of these items, I focused on those I could recall and place on a timeline.

IN THIS PROCESS, WHILE SPENDING TIME WITH MY MOTHER IN AN ATTEMPT TO COAX OUT THE LAST REMNANTS OF HER MEMORY, I BEGAN TO NOTICE THE ONSET OF PRIMARY PROGRESSIVE APHASIA (PPA). THIS MANIFESTED IN HER STRUGGLE TO RETRIEVE LINGUISTIC TAGS AND A NOTICEABLE DECLINE IN SEMANTIC PROCESSING. A BOOK OF PRESSED FLOWERS (CIRCA 1998) REVEALED A PLECTRANTHUS MISLABELLED AS A SPECTANTHEM (IMAGE 17), PROVIDING AN EARLY GLIMPSE INTO THE LINGUISTIC CHALLENGES SHE WAS FACING.

However, it was the adult colouring books that showed the most striking deterioration. Initially, Margaret had skilfully stayed within the lines, or employed one-colour shading to impart a three-dimensional and textured appearance to her drawings (Image 18). Over time, this precision gave way to crude scribbling, accompanied by frustration-induced tearing of the pages. A particularly dramatic gorilla colour-by-numbers piece (Image 19) revealed intentionality tinged with evident frustration, painting a poignant picture of the evolving challenges she faced in expressing herself through art.

In William Utermohlen's final portrait in 2000 (Image 20), created seven years before his death, he rendered a pencil-drawn head with darkened areas around the nose. This poignant detail is interpreted as a manifestation of his fear regarding the disintegration of his sense of self and the gradual loss of his senses. In this instance, the emphasis is on his last sense to fade away - his sense of smell.

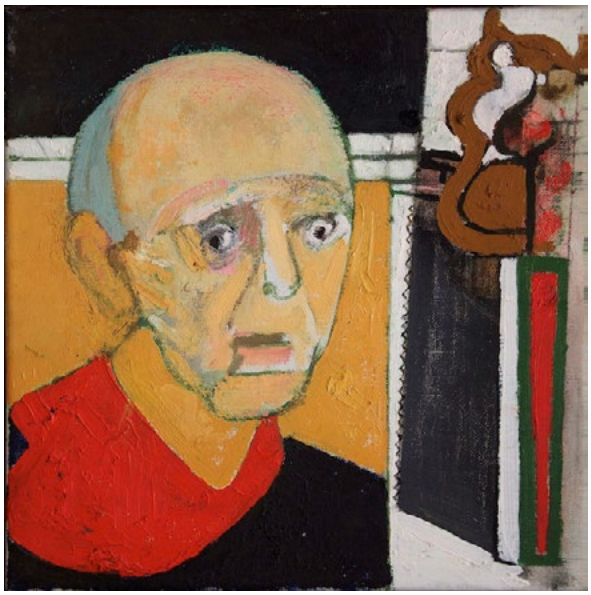
9. William Utermohlen, Conversation Pieces: Snow, 1991, oil on canvas

10. William Utermohlen, Conversation Pieces: Conversation, 1991, oil on canvas

11. William Utermohlen, Blue Skies, 1995, oil on canvas

12. William Utermohlen, In the Studio, 1996

13. Self Portrait with Easel, 1996



14. William Utermohlen, Saw, 1997

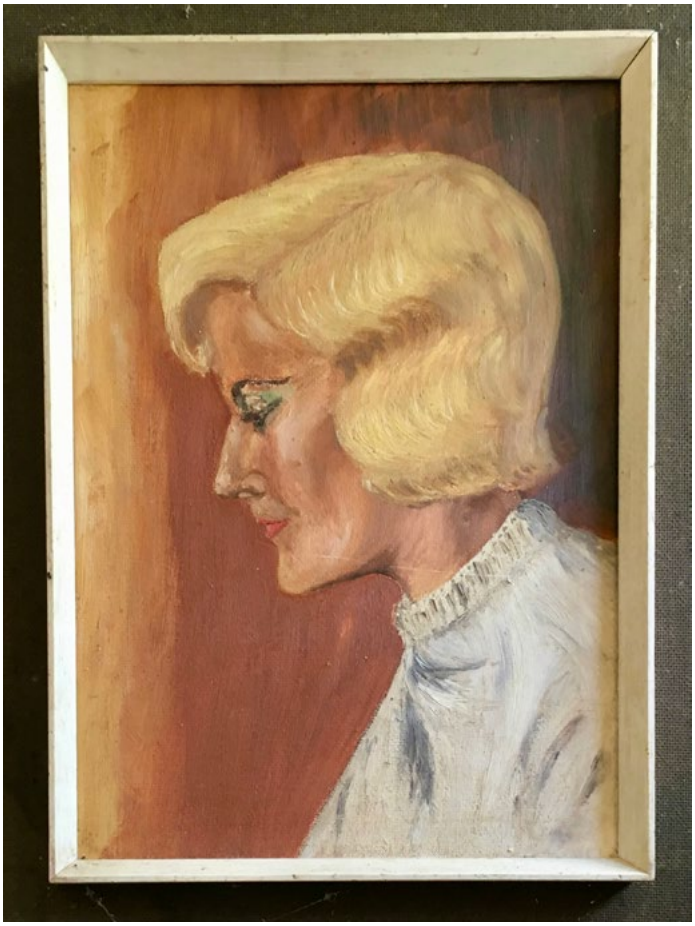
In Margaret's case, her interest in colouring had long waned, requiring encouragement and the physical act of placing a paintbrush into her hand to elicit even a vague response (Image 21).

WHAT RESONATES ACROSS BOTH UTERMOHLEN'S AND MARGARET'S ARTISTIC EXPRESSIONS IS AN ENDURING SENSE OF ARTISTIC INTENT. DESPITE THE INCREASING ABSTRACTION IN THEIR CREATIONS, THERE IS A RECOGNITION THAT NOTHING IS SACRIFICED IN TERMS OF THE POWER AND EMOTIONAL DEPTH CONVEYED THROUGH THEIR ART.

Even as the medium and style evolved, the core essence of their artistic voices remained intact, transcending the challenges posed by cognitive decline and sensory loss.

William Utermohlen images used with courtesy of Chris Boïcos Fine Arts, Paris

15. Margaret Maytham, Poinsettia, circa 1980, oil on board



16. Self Portrait, circa 1970, oil on board

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Sandra Maytham-Bailey is an accomplished photographer and sculptor, with academic roots in Journalism from Rhodes University and a master's in Documentary Art from the University of Cape Town. Formerly directing the Cape Town School of Photography, she expanded her horizons with a postgraduate course in Medical Anthropology at WITS University after relocating to Johannesburg in 2016.

Her diverse portfolio encompasses projects like "Mundane Moments," a photographic exploration of her sons' transition to adulthood, and "One Lens Three Views," a book delving into the Zulu Maiden Reed Dance from three journalistic perspectives that questioned controversies, neutrality, and biases. She also produced the captivating short film "Running with a Vision," chronicling the journey of a blind extreme athlete who conquered the Iron Man competition.Beyond photography and film, Sandra's artistic expression includes acclaimed exhibitions of plaster of Paris dancing forms and captivating large wood sculptures. She collaborates with WITS University on projects building visual archives for rural research programmes.

Across photography, sculpture, and film, Sandra Maytham-Bailey continues to intrigue audiences, offering profound insights into the human condition and the transformative potential of art. **Correspondence: maythambailey@gmail.com**

Image 17

Image 18

Image 19

20. William Utermohlen, Head 1, 2000

21. Margaret Maytham, watercolour palette

OF ENDURANCE AND PRIVILEGE, ADVENTURE AND MUNDANE WONDERS

Claudia Campbell

You know those memories that make you glow warm colours? The ones that are borne from moments when whirlwinds of stress or paralysing fear simmer down and morph into comfortable ones - safe ones? As I wrote this I realise some of my readers may have just presumed I'm referring to an excellent result to a new prescription. But, no: I'm referring you to memories, which for me, often began on Friday afternoons. I would regularly spend Friday afternoons sitting in the sun outside, seeing how far I could spit cherry pips (or the like) with two of my best friends, my almost-centenarian grandparents. They were remarkable people - you have to be able to show someone how to create adventure and world of wonder from just one's brain and the observation of a few square metres within city limits.

THE LAST FEW MONTHS HAVE BEEN PRETTY DOCTOR/MENTAL HEALTH CARE INTENSE. REALLY GOOD THINGS HAVE HAPPENED, BUT MY MIND HAS DISHED OUT SOME FAIRLY HORRIFIC MEMORIES TOO.

They've been chilling and disturbing, but I've kept going. More importantly I've kept going because I wanted to, not because I had to. I started writing about navigating through all the ups and downs within my own body and mind, as well as the professional and personal collaboration needed to shift medical treatment to another province before a move - rather than after it. What I've kept coming back to though, in terms of managing, is not 'medical', it's simply a way of thinking - Friday Afternoon Thinking. It's taking a moment to tell myself to 'Look up, avoid being so overtaken you forget life is happening around you, and you're actually part of it'.

Claudia Campbell

There have been a fair number of instances that I've needed to 'rearrange' the emotional order of my heart because circumstances became more tempestuous than desired. My 'internal rudder' has not always felt so stable. But, when I think about our earth, the planet itself and all it's creatures, in whichever form they may take, as well as the elements and forces that enable this beautiful orb to sustain life, I realise I want to always be curious - it's become a hardwired sense of adventure. I want to know the what, where, when, who and how about everything, and in that way life is never boring. It's easy to think I was born this way, rather though, I learnt it - from exceptional grandparents.

Waking up everyday to a sense of wonder and curiosity, anticipation that each day is going to bring about something new to add to my knowledge or memory bank is a truly beautiful thing. Curiosity turns dull existence into something that sparkles with anticipation. Curiosity and adventure (even in tiny forms) most definitely contributed to preventing this vessel called 'Claudia' drifting away, or ashore, or even sinking completely.

Beauty is often not in the obvious or extravagant, but many times it's in the small and even mundane. Watching a lizard warm itself in the sun, seeing the newly dressed weaver birds in their yellow and black spring time suits desperately try to construct acceptable homes for their missus, or listening to

the gurgling summertime croak of domestic frogs can be just as enchanting as seeing the Big Five or being awestruck by the power of a whale surfacing off the coast, or the mammoth power of an electric storm. I have learnt to literally take a moment to smell the roses, and in that breath remember we are not surrounded by only bad but also beauty. Everyday things, the 'pedestrian' things in life can all be viewed as an adventure - these lenses can make life amazing despite warring with symptoms and an unreliable body.

GIVE OUT SMILES AND LAUGHS GENEROUSLY TO ALL THOSE AROUND, BECAUSE PLEASURE CAN BE TAKEN FROM THE SMALLEST MOMENTS IN LIFE ESPECIALLY WHEN WE AGREE TO SHARE THEM, TO BE PRESENT WITH EACH OTHER.

"Embrace life. Enjoy it. Respect it. Endure it"; a one line email sent to me by my 95 year old grandfather. This will always be my motto, because it helps me never forget that even though things may be tough, by enduring them we continue to embrace life. This is a beautiful thing. It gives me the courage to do and say things I otherwise wouldn't, it makes me feel brave enough to tackle the mountains of life without a sense of preconceived defeat.

WHAT IS PRIVILEGE?

Privilege is sharing. It's being excited about a rosy tomato. It's watching a sparrow talk to himself in your side mirror. It's the first few beats of your favourite song. It's being able to call yourself a spouse. It's a hug from a friend. It's the smell of the hot berries from your herbal tea. It's knowing and feeling what it means to have friends. It's knowing and feeling what it means to be a friend.

It's sharing your story with the world. It's the shivers that skip down your spine when you bite the chocolate off your favourite ice cream. It's the magical smell of the flawless rose that greets you at your front door. It's the writing of messages and letters as you empty out your heart into a story written in black and white – and emojis. It's the unexpected message just to say someone was thinking of you. It's the cloud of whipped cream on any dessert. It's the whispered "I love you" from your husband. It's the feeling that embraces you when someone lets you know they believe in you. It's the gentle gust of air as you breathe in a beautiful view. It's listening to astonishing experiences of others. It's the kiss hello from the person you love most. It's the ability to think. It's the ability to love. It's the ability to feel passion. It's the ability to dream, to imagine, to hope, to wish and to just be….

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

MPS RESEARCH INITIATIVE

GLOBAL RESEARCH INITIATIVE INVITES GRANT APPLICATIONS FOR PATIENT SAFETY AND WELLBEING PROJECTS

The MPS Foundation - a global not-for-profit research initiative that aims to shape the future of patient safety – has opened for applications for its 2024 grant programme.

Medical Protection Society (MPS) launched the Foundation in 2022. Now in its third year, it has already supported over 30 research projects from across the world.

South Africa projects awarded funding in 2023 includes research into non-specialist physicians providing anaesthesia care in rural low- and middle-income countries. Additionally in the dental field, the Foundation is supporting a study investigating patient complaints and strategies to preventing these in dentistry, and another study investigating informed consent and individual autonomy with African traditional values and beliefs.

The Foundation is now inviting new research grant applications from both MPS members and non-members. It will invest in research and analysis with a key focus on patient safety and the wellbeing of healthcare professionals and teams, both medical and dental. Applications will be considered from the jurisdictions where MPS has members. This includes South Africa, Hong Kong, the UK, Singapore, New Zealand, Ireland, Australia, Malaysia, the Caribbean and Bermuda.

Research projects supported by The MPS Foundation need to be academically robust and evidence based. Available funding will range from ZAR 120,675 to ZAR 4,827,000 - the equivalent to £5,000 to £200,000 (subject to currency fluctuations), depending on the scale, focus and duration of the proposal.

The funding focusses on five main areas:

- the impact of human factors on patient safety, outcomes, and risk
- the impact of processes and delivery modes on patient safety, outcomes, and risk
- the personal and professional wellbeing of healthcare professionals and teams
- the impact of digital integration and technology on patient safety, outcomes, and risk
- the impact of the effectiveness of teaching and learning innovations upon patient safety, outcomes and risk.

Dr Graham Stokes, dentist and MPS Foundation Chair, said: "We are delighted to launch our third grant programme to support research projects on patient safety and the wellbeing of healthcare professionals. Funding for research in this area has been limited but our grant programmes have been changing that. Projects that we have supported in previous years have shown great success in promoting best practise and wellbeing across several countries.

"OUR AIM IS SIMPLE: TO FUND RESEARCH THAT IMPROVES SAFETY FOR PATIENTS AND THE WELLBEING OF HEALTHCARE TEAMS.

"If you have a research project that you think is suitable, register your interest and join our growing community of grant recipients. I strongly encourage healthcare professionals to consider applying for support whatever the scale of the proposal and to make the most of the additional resources available to support applicants this year."

Applicants can register their interest and apply by visiting www.thempsfoundation.org and entering their details via the online grant portal. Calls for expressions of interest close on 3 May 2024 at 17:00 BST.

The MPS Foundation team held two online question and answer clinics on 8 March and in April to introduce the 2024 grant programme, explain the application process and what makes a successful application. The team can also respond to any questions applicants have about the process.

The Foundation is part of MPS – the world's leading protection organisation – which currently supports more than 300,000 doctors, dentists and healthcare professionals, and has almost 130 years of global healthcare experience and expertise.

For media queries contact:
pressoffice@medicalprotection.org

FAQs can be found at:
https://www.thempsfoundation.org/our-grants/faqs

THE MPS FOUNDATION

Our areas of focus

The personal and professional wellbeing of healthcare professionals and teams

The impact of human factors

The impact of processes and delivery models

The impact of digital integration and technology

Evaluation of the effectiveness of teaching and learning innovations

A safer tomorrow starts with research today

Our goals

- Improve patient care, safety, and outcomes through research
- Reduce the risks facing healthcare and dental professionals through research
- Improve the wellbeing of healthcare and dental professionals
- Support, commission, and conduct applied research that establishes 'what works'

Our research

- Over 30 research projects, across 9 different countries, funded since 2022
- Involving healthcare and dental professionals
- We've funded projects worth between £2,500 to £199,000
- We've funded ground-breaking published research
- Working with partners to address healthcare challenges through research

Annual grant programme

- Calls for Expressions of Interest open in March every year
- Open to all with an interest in research that supports healthcare and dental professionals
- Projects can be funded for up to 3 years

Research competitions

- Supporting new researchers
- Supporting new professionals
- Local and national cash prizes
- Recognising the impact that young researchers can make

Priorities

- Applied research
- Exploring all healthcare environments including private medical and dental healthcare
- Outcomes and solutions shared with members and healthcare professionals to help improve patient safety and outcomes

Find out more at thempsfoundation.org

MOVIES

Title: Callengers
Release Date: 03 May 2024
Director: Luca Guadagnino

A former tennis prodigy, turned coach married to a champion on a losing streak, What will it cost to help him win when he faces his former best friend?

Title: Just Now Jeffrey
Release Date: 3 May 2024
Directors: Brett Morris and Hylton Tannenbaum

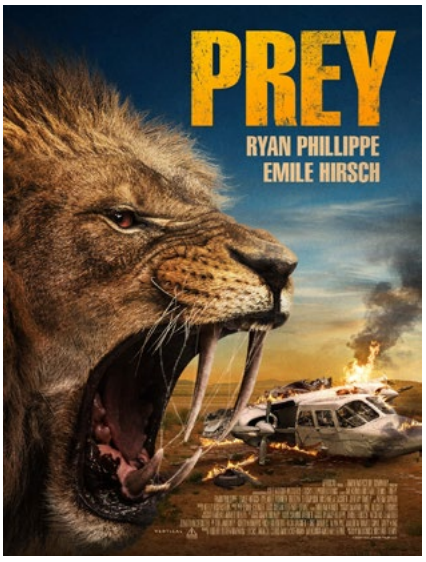
A coming of age comedy set in Johannesburg, South Africa, 1989. While the world was changing around him, teenager Jeffrey Greenbaum just wanted to get laid.

Title: Kingdom of The Planet of The Apes
Release Date: 10 May 2024
Director: Wes Ball

A young ape goes on a journey that will lead him to question everything he's been taught about the past.

Title: The Garfield Movie
Release Date: 24 May 2024
Director: Mark Dindal

Garfield is about to go on a wild outdoor adventure. After an unexpected reunion with his long-lost father - the cat Vic - Garfield and Odie are forced to abandon their pampered life to join Vic in a hilarious, high-stakes heist.



Title: Prey
Release Date: 31 May 2024
Director: Mukunda Michael Dewil

A couple is compelled to leave their Christian missionary station in the Kalahari Desert after being threatened with death by a militant gang. After crashing their aircraft, they must battle man and beast for their lives.

Title: Face Deep
Release Date: 31 May 2024
Director: Mathabo Bila

Luna is a young woman living with her pensioner lover Noah. She will do anything to keep her secretes in the past and won't let anyone get in her way. How deep her deception goess is unknown ■

THE HARP: THE STORY OF A STORYTELLER

David Swingler

My friend Tiffany, who peddles high end Champagne to, *hmm,* the wealthy, had mentioned it a while back but I was completely unprepared for the telephone call that came my way. 'Morning David. This is Keize and I'd like to show you my wine.' Now selling wine in the current economic climes is hard work and this approach was not out of the ordinary. 'Oh well,' I thought, 'Tiffany introduced him so let's give it a shot. There's nothing to lose.' And everything to gain, as it turned out!

Our respective diaries and the contingencies of traffic flow meant we could only meet early one weekday morning, when tannins seem tougher, and extended oak maturation and cleansing acidity are more foe than friend. But this was a story worth discovering: the story of a storyteller.

Keize Mumba

Keize (pronounced *'keys'* as in 'car …') Mumba was born and bred in Zambia where, in the absence of a climate for wine growing, beer is *de rigueur.* He is a storyteller and wrote screenplays for the film industry. It was both the search for new stories as well as the vibrant film industry that drew him to Cape Town a decade ago. Before long, fascinated by the story behind each label, he was seduced by wine.

David Swingler

KEIZE APPRECIATED THAT ONE COULDN'T TRULY UNDERSTAND WINE WITHOUT THE REQUISITE KNOWLEDGE, SO HE EMBARKED ON FORMAL WINE COURSES GAINING THE INTERNATIONAL *WINE & SPIRIT EDUCATION TRUST WSET* LEVEL 3 (WITH LEVEL 4 DUE IN OCTOBER).

This led to a career as Sommelier at *Grub & Vine Restaurant* and its associated *Culture Wine Bar* on Bree Street, Cape Town, epicentre of Chef Patron Matt Manning's burgeoning hospitality offering. [Manning recently opened a Grub & Vine at the Norval Museum of African Art in Constantia that is still, but not for long, a hidden gem.]

Here, not only could Keize apply his expertise in a restaurant environment highly sympathetic to a wine culture, but he also got to taste the Cape's best, as well as great wines of the world. [*Grub & Vine / Culture's* cellar is, in my view, the best on-consumption wine list in the country.] This allowed him to hone personal style preferences and inevitably led to a dream to craft his own wine, to tell his own story.

Seeking to create a wine with power, a firm structure encasing juicy black plum and blackberry wreathed in spice and braced by crisp acidity, certain for longevity, his palate led him to Stellenbosch, where he could mould the complementary attributes of grapes grown on the Helderberg and Simonsberg slopes. And the destination was Jeremy Walker at Grangehurst.

Grangehurst

Jeremy is a man with a story of his own. Taking a break after having trained as a winemaker, he wrote a thesis for his UCT MBA that proved one could not sustain an economically viable, independent boutique winery. With more than a hint of irony, he set out to 'defend the thesis' by starting to make wine in the squash court on his parents Helderberg farm, where they owned no vineyard. Over thirty years later, he's still putting food on the table, when not surfing. I kid you not.

Jeremy consistently conjures wine in the style Keize sought: firmly tannic, with a powerful muscularity encapsulating the juicy black cherry/berry fruits tempered by sustaining acidity to chaperone long oaking and maturation to venerable longevity. He gave Keize access to parcels of wine fermented with 50% whole berries (for fruit retention) that enjoyed manual punch downs (for extraction), traditional basket press and full malo-lactic acid fermentation during a lengthy 28 months in oak casks. Keize spent seven months isolating just seven barrels that would give life to his vision: The Harp 2017.

THE HARP? A COMPLEX INSTRUMENT BEST SUITED TO AN ORCHESTRA WHERE'S ITS BEAUTY SHINES AS A CONFLUENCE OF INSTRUMENTS COAXED BY DIFFERENT MUSICIANS TO GIVE EXPRESSION TO A COMPOSER'S MUSICAL SCORE.

Like the intensity, complexity, length, and balance of The Harp 2017 from 49% Cabernet Sauvignon, 31% Merlot and 20% Petit Verdot. Only 2014 bottles were made, bone-dry with 14.23 % alcohol.

Keize Mumba is also an Associate Taster for *Platter's South African Wine Guide* and, in a UK *Decanter* article [25 March 2014], listed his three favourite local Cabernets: Keermont 2020, Erica Obermeyer 2019 … and Grangehurst 2009.

keizemumba@gmail.com

Call 0783167697

The Harp pack

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

2024 BIOLOGICAL PSYCHIATRY CONGRESS

Thu 28 Nov - Sun 1 Dec

Century City Conference Centre

Brain & Mind: Broadening Horizons

You're invited to the 2024 Biological Psychiatry Congress, where we'll explore the theme 'Brain and Mind: Broadening Horizons'. Our program dives deep into the connections between brain and mind, and the latest in understanding and treating psychiatric disorders. Join us for engaging discussions, networking, and forging new friendships in a vibrant setting. Your expertise is vital to making this event intellectually stimulating and rewarding, especially for registrars, early career psychiatrists, researchers, and students. Enjoy Cape Town's Century City precinct with its great accommodation and amenities. We're committed to ensuring a memorable mix of scientific insights and leisurely exploration throughout the program. Looking forward to your presence!

www.biopsychsa.co.za

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SOUTH AFRICAN SOCIETY OF PSYCHIATISTS

SASOP FIRST QUARTER UPDATE

Anusha Lachman

Dear Colleagues

It has been a pleasure to step into the role of SASOP President at the National Conference in November 2023 in Cape Town.

I would like to take this opportunity to thank our new Board of Directors for availing themselves to serve in their respective leadership roles. As a reminder of the executive SASOP BOD members at your service:

- President Elect: Dr Anersha Pillay, neuropsychiatrist, private practice
- Past President: Dr Sebo Seape, adult psychiatrist, private practice
- Secretary: Dr Alicia Porter, child & adolescent psychiatrist, state sector
- Treasurer: Dr Thupana Seshoka, adult psychiatrist, state and private
- Public Sector Convenor: Dr Thuli Mdaka, adult psychiatrist, state and private
- PsychMG private practice convenor: Dr Melane van Zyl, adult psychiatrist, private
- COO of SASOP: Dr Mvuyiso Talatala, adult psychiatrist, state and private

MY KEY PRIORITIES FOR THIS TERM OF OFFICE ARE AS FOLLOWS:

Anusha Lachman

1. CHILD & ADOLESCENT MENTAL HEALTH

- As a child psychiatrist I am committed to prioritizing the agenda for CAMH services, support and development in the country and with an extension to the continent. There is an opportunity for us as SASOP to focus not only on service provision but to focus on early screening, awareness, partnerships with advocacy groups and driving for better medical insurance coverage.

Action:

- To this end, we have already commenced with active engagement from the CAP SIG members first statement on Transgender Care for C&A (released March 2024), and they will be contributing to the discussions on care pathways for CAP alongside the adult pathways.

2. ACADEMICS AND RESEARCH:

- SASOP has not traditionally been associated

SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

with research or significant academic input apart from our mentorship and support for the Diploma in Mental Health preparation and the Registrar Finishing School.

- Data drives decision making and we are obliged to contribute to this if we are to meaningfully influence policy and protocols in SA.
- My second focus will be to enable support and collaboration within this area – both in private and public sectors.
- Targeted goals include:

  a) A Research Hub – support that will enable registrars to seek out assistance from SASOP to help complete their MMED Dissertations to facilitate their full registration at psychiatrists. This hub will also be available to any SASOP member who requires support to engage in any research projects within their practices.

  b) Publications – with the support of a science writer, and editorial assistance, we will be in a position to assist with building up a publication base for clinical and scientific work of SASOP to contribute to the local literature.

  c) Support for supervisors of MMed and MPhil Students, including workshops and upskilling in the task at hand.

  d) The creation of Training Institutes to facilitate SASOP led partnerships to advance training and upskilling of the psychiatric workforce, including accreditation of courses for allied health professionals, GPs and other specialists who wish to further their mental health training.

Action:

- On the 15 March 2024, we hosted a dinner for the Funding and Pharmaceutical Industry to engage with our goals from the current BOD and we look forward to meaningful partnerships specifically related to our academic and research focus.
- I have met with the Editor of the SAJP Professor Jonathan Burns, and we have made progress on welcoming a new Editor of the SAJP – Prof Bonginkosi Chiliza (UKZN)
- We will also notify the membership of the new editorial board of the SAJP, which we hope will reflect the diversity and representation of our membership.

3. SOCIAL RESPONSIBILITY FOR SCIENCE COMMUNICATION

- SASOP in the words of our late past President Prof Bernard Janse van Rensburg "needs to be a flagship for what a social contract is all about".
- As an organization we are leaders in highlighting our social justice voice
- My final focus will be on steering this social responsibility into the direction of more effective science communication.

This will take the form of more thoughtful, clear messaging of mental health issues, tackling misinformation in the media and taking the lead in the public forum for effective science communication for psychiatry.

Action:

- We are engaging with our PR and media company Jigsaw to facilitate a more targeted and clearer social and broadcast media focus in the next 2 years with novel topics

I look forward to engaging with the membership of SASOP as we embark on an exciting two years ahead. I would like to also remind our membership that amongst all the pressure and inevitable strain of the profession, we need to remember to serve as a mirror to our colleagues, patients and service providers – as an example of what courteous, kind, respectful and empathic professionalism can look like.

I welcome any feedback and ideas, thoughts or reflections throughout my term – email me directly at *anusha.sasop@gmail.com*

Warm Regards

Anusha Lachman
SASOP President 2023-2025

Directors:

Dr A Lachman (President)
Dr T Mdaka (Public Sector Convenor)
Dr A Pillay (President-Elect)
Dr A Porter (Honorary Secretary)
Dr S Seape (Past-President),
Dr T Seshoka (Honorary Treasurer)
Dr M van Zyl (Private Sector Convenor)

SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

SAVE THE DATE
ROADSHOW 2024

PHARMADYNAMICS HAS AGREED TO SPONSOR ANOTHER ROUND OF SASOP/PSYCHMG ROADSHOWS IN 2024.

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

There will be a workshop for the subgroup committee with identified younger leaders in the first part of the meeting, which will be followed by a workshop for all members where any emergent issues will be discussed over brunch/dinner.

There will also be feedback from the boards of SASOP and PsychMg.

Please diarise the dates the dates below.

Opportunities to register with details of venues and starting times will follow shortly.

DATES FOR ROADSHOW 2024:

Wednesday	08.05.2024	FS/Bloemfontein (afternoon/evening meeting)
Friday	31.05.2024	Nelspruit (afternoon/ evening meeting)
Wednesday	12.06.2024	KZN/Durban (afternoon/ evening meeting)
Saturday	27.07.2024	Cape Town (morning meeting)
Wednesday	14.08.2024	PE/Gqeberha (afternoon/evening meeting)
Thursday	15.08.2024	East London (afternoon/ evening meeting)
Saturday	14.09.2024	Gauteng (combined Northern and Southern with Northwest) (morning meeting)
Wednesday	09.10.2024	Southern Cape (George) (afternoon/evening meeting)
Saturday	02.11.2024	Limpopo (morning meeting)

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SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

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CLOSING THE GAP: INNOVATIONS IN MENTAL HEALTH

7TH ANNUAL
AFRICAN DIASPORA GLOBAL MENTAL HEALTH CONFERENCE

4-6 NOVEMBER 2024
SAROVA PANAFRIC HOTEL, NAIROBI, KENYA

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Black Psychiatrists of America, Inc.

2024 TRANSCULTURAL CONFERENCE

THE POWER OF US: COLLECTIVE ACTION FOR BLACK MENTAL HEALTH ACROSS THE DIASPORA

SAVE THE DATE

Conference | November 7-11, 2024
Nairobi Serena Hotel

Safari | November 11-13, 2024
Amboseli Safari

SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

24TH WORLD CONGRESS OF PSYCHIATRY

The 24th World Congress of Psychiatry (WCP 2024) will be held on 14-17 November in Mexico City. The four-day event offers a dynamic platform for collaboration and dialogue with mental healthcare peers.

You'll leave reinvigorated and ready to elevate your career. Be among the first to hear cutting-edge insights from experts, gain access to emerging data, and grow your professional network by connecting with those facing similar challenges. The World Psychiatric Association (WPA) unites 140 psychiatric societies across 120 countries, supporting over 250,000 psychiatrists and fostering specialized collaborations in the field of psychiatry.

Take an active role and shape the program by submitting an abstract.

For more information, visit: https://wcp-congress.com/

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

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

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

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