# LINK BETWEEN PAIN AND DEPRESSION[1]




The two conditions often **co-occur, exacerbate one another,** and may display overlapping symptoms.

# DULTA

DULOXETINE 30 / 60 mg

**Duloxetine has been frequently utilised for managing both pain and depression.**

**DULTA 30, 60 mg.** Each tablet contains 30, 60 mg duloxetine respectively. S5 A46/1.2/0889, 890. NAM NS3 18/1.2/0126, 0127. For full prescribing information, refer to the professional information approved by SAHPRA, 27 August 2021. **1)** IsHak, W.W., *et al*, 2018. Pain and depression: a systematic review. *Harvard review of psychiatry*, 26(6), pp.352-363. **DAA983/07/2024**

pharma dynamics

EFFECTIVE AFFORDABLE HEALTHCARE

CUSTOMER CARE LINE **+27 21 707 7000**

**www.pharmadynamics.co.za**




# PROLONG THEIR POSITIVITY

Most cost-effective Bupropion in SA[1]

## PRODYNA 150 mg 300 mg XR

BUPROPION HYDROCHLORIDE

PARITY PRICED
**R150,00**
SEP Incl. VAT[1]

**PRODYNA 150, 300 mg XR.** Each tablet contains 150, 300 mg bupropion hydrochloride respectively. S5 A54/1.2/0181,0182. For full prescribing information, refer to the professional information approved by SAHPRA, 15 November 2024. **1)** Database of Medicine Prices (May 2026). Department of Health website. *http://www.health.gov.za/nhi-pee/.* **PDAC1132/08/2026**

pharma dynamics
EFFECTIVE AFFORDABLE HEALTHCARE

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

ISSN 2409-5699

# SOUTH AFRICAN PSYCHIATRY

ABOUT the discipline FOR the discipline

Issue 48 • AUGUST 2026



## TREATMENT RESISTANT DEPRESSION: A CONSENSUS REVIEW

## ASTRONOMY AND AWE

## GUIDELINES FOR NEW CONSULTANTS

## COLLEGE OF PSYCHIATRISTS ELECTION RESULTS

PUBLISHED IN ASSOCIATION WITH THE SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

www.southafricanpsychiatry.co.za

Unlocking potential

# CONTRAMYL XR

Methylphenidate HCl



# LOOK BEYOND ADHD.

## UNLOCK MORE OF EVERYDAY LIFE WITH CONTRAMYL XR[1]

- Once-daily dosing for 12-hour coverage[2]
- Enables consistent symptom control during school, home and social settings[1]
- Four dosage strengths support individualised titration from 6 years of age[2]




ADHD: attention-deficit/hyperactivity disorder

**References: 1.** Buitelaar J, Medori R. Treating attention-deficit/hyperactivity disorder beyond symptom control alone in children and adolescents: a review of the potential benefits of long-acting stimulants. *Eur Child Adolesc Psychiatry* 2010;19:325-340. DOI 10.1007/s00787-009-0056-1.**2.** Contramyl XR professional information, 25 March 2025.

S6 **CONTRAMYL XR 18 mg** (prolonged release tablets). Reg. No. 49/1.2/1137. Each prolonged release tablet contains 18 mg methylphenidate hydrochloride. Contains sugar (sucrose). S6 **CONTRAMYL XR 27 mg** (prolonged release tablets). Reg. No. 49/1.2/1138. Each prolonged release tablet contains 27 mg methylphenidate hydrochloride. Contains sugar (sucrose). S6 **CONTRAMYL XR 36 mg** (prolonged release tablets). Reg. No. 49/1.2/1139. Each prolonged release tablet contains 36 mg methylphenidate hydrochloride. Contains sugar (sucrose). S6 **CONTRAMYL XR 54 mg** (prolonged release tablets). Reg. No. 49/1.2/1140. Each prolonged release tablet contains 54 mg methylphenidate hydrochloride. Contains sugar (sucrose). For full prescribing information, refer to the Professional Information approved by the Regulatory Authority.

Viatris South Africa. Reg. No.: 1949/035112/07. 4 Brewery Street, Isando, Kempton Park, 1601. Tel: (011) 451 1300. Fax: (011) 451 1400. www.viatris.co.za. SA-MET-2026-00003. Exp: 07/2027.

VIATRIS

# CONTENTS



## AUGUST 2026


6 FROM **THE EDITOR**

8 **PODCAST** TALKING PSYCHIATRY

10 TOWARDS AN UNDERSTANDING OF **TREATMENT-RESISTANT DEPRESSION** - AN EXPERT CONSENSUS REVIEW

20 **ASTRONOMY AND AWE**: PERSONAL REFLECTIONS, AND AN OVERVIEW

28 **CMSA COLLEGE COUNCIL** ELECTION RESULTS

32 DEPARTMENTS OF PSYCHIATRY **NEWS**

45 **GUIDELINES FOR NEW CONSULTANTS:** A CONNECTING RELATIONAL MODEL FOR NAVIGATING WORK AND COLLABORATIVE KNOWLEDGE CREATION

50 EXPLORING THE ROLE OF **FRIENDSHIP IN MEDICINE**



**Advertising:** The Source Events and Marketing
**Design and Layout:** Rigel Andreoli and Kirsten Brooks
**Web:** www.southafricanpsychiatry.co.za
**Contact Person:** Vanessa Beyers - vanessa@thesourcesolutions.com
**COVER IMAGE:** Renoir, Pierre-Auguste. Self-Portrait. 1910. Oil on canvas, 42 x 33 cm. Private collection. This image is in the public domain.
**Design and layout:** The Source
South African Psychiatry is published quarterly by The Source Solutions. Its mission is to communicate the latest news and developments in the area of South African Psychiatry


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

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

Dear Colleagues



Welcome to the August 2026 issue, and as I write this- the coldest and wettest week of this year's winter gripped Johannesburg. But the blue skies have returned, and it now feels like a typical Highveld winter with just the right balance of sunshine and chill. There is something about nature behaving as expected that I find reassuring, that all is well with the world and yet there is so much that is not. Still, here we are and this is my final "from the editor" for 2026 as the next issue (November 2026) will be devoted to the Biological Congress featuring abstracts, invited speaker biographies and photos as well as messages from the Congress convenor and the President of the South African Society of Psychiatrists (SASOP). Between now and then there will also be the 2026 ADHD Virtual Congress as well as the Márce Society 2026 Congress – a busy schedule ahead. Both are promoted in the issue. And for good measure, so is the 6th Congress of the Global Psychiatric Association (online) as well as the African Association of Psychiatrists Congress (taking place in Ethiopia) with information for both also in the issue. And some of you might indeed be heading to Stockholm in September for the World Psychiatric Association Congress. Speaking of Congresses, I recently attended the PsychMG Congress (as an invited speaker) – the Congress of the Psychiatry Management Group, which falls within SASOP. Having been out of clinical practice for over 2 years now it was great to see familiar faces, and to encounter new ones as well as experiencing the discipline of Psychiatry in South Africa as one that is vibrant and evolving. Whilst PsychMG is focused on the private sector, with all its challenges, the state sector was represented too. I am hoping to publish several of the presentations from the PsychMG Congress in the February 2027 issue. Forward planning is essential.

The current issue sees the publication of several longer pieces, dealing with treatment resistant depression, the phenomenon of awe in relation to astronomy and some guidance for recently qualified consultants in navigating their new role. Alas, the *Department News* section notes the passing of, and pays tribute to, Helen Clark – a stalwart of the Department of Psychiatry at the University of the Witwatersrand and a dedicated Child and Adolescent psychiatrist. Another colleague whose time came too early, I feel, but no doubt her contributions will live on. May she rest in peace.

As I look out of my study window, writing this piece, I see some of the trees are already announcing the arrival of Spring. Until next time – take care.



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

**Disclaimer:** No responsibility will be accepted for any statement made or opinion expressed in the publication.

Consequently, nobody connected with the publication including directors, employees or editorial team will be held liable for any opinion, loss or damage sustained by a reader as a result of an action or reliance upon any statement or opinion expressed.

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

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

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

**Advisory Board:**

**Ugash Subramaney** - Head, Department of Psychiatry, University of the Witwatersrand

**Soraya Seedat** - Head, Department of Psychiatry, Uiversity of Stellenbosch

**Taiwo Akindipe** - Head, Department of Psychiatry, Sefako Makgatho Health Sciences University

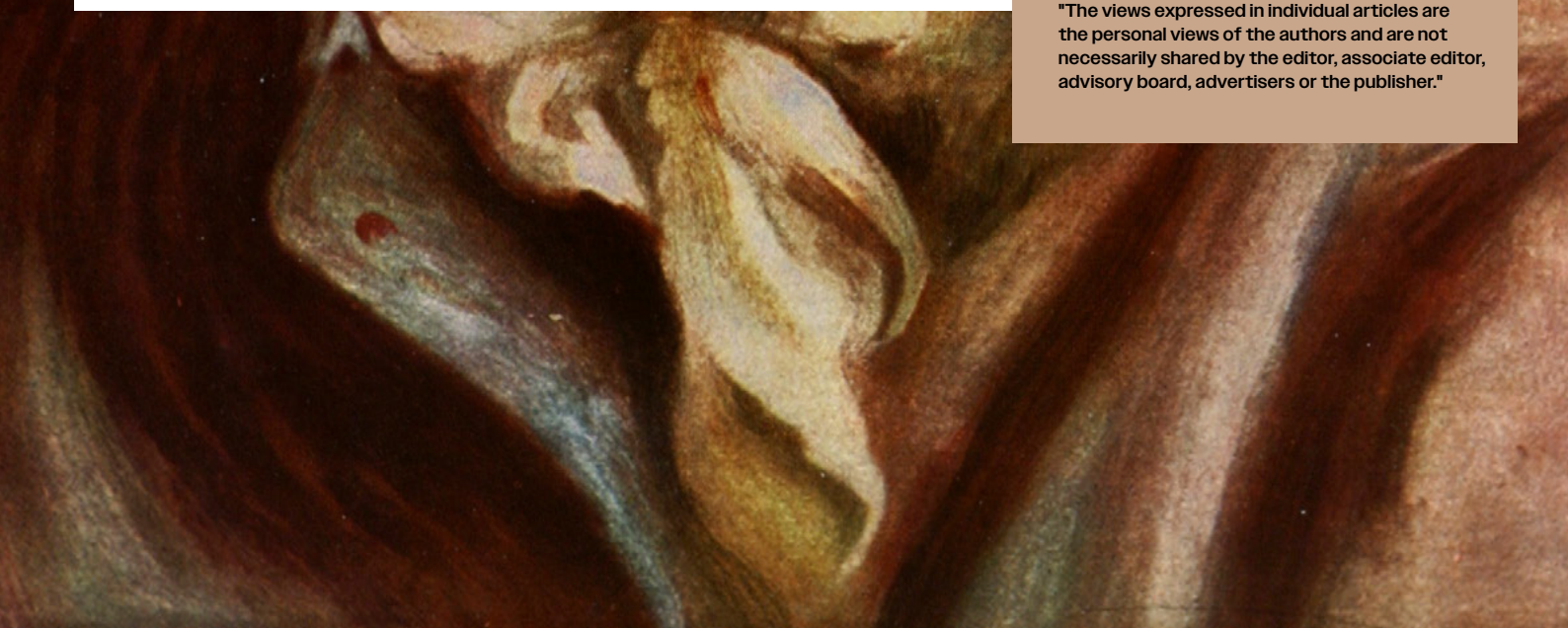
**Funeka Sokudela** - Head, Department of Psychiatry, University of Pretoria

**Janus Pretorius** - Head, Department of Psychiatry, University of The Free State

**Bonga Chiliza** - Head, Department of Psychiatry UKZN; President South African Society of Psychiatrists

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

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



NEW

# Relieve anxiety, preserve clarity




Stresigen

ETIFOXINE HYDROCHLORIDE 50 mg

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

pharma dynamics
EFFECTIVE AFFORDABLE HEALTHCARE

www.pharmadynamics.co.za

**STRESIGEN 50 mg.** Each capsule contains 50 mg etifoxine hydrochloride. S5 A59/2.6/0102. For full prescribing information, refer to the professional information approved by SAHPRA August 2025. **SNA1104/04/2026**



# TALKING PSYCHIATRY

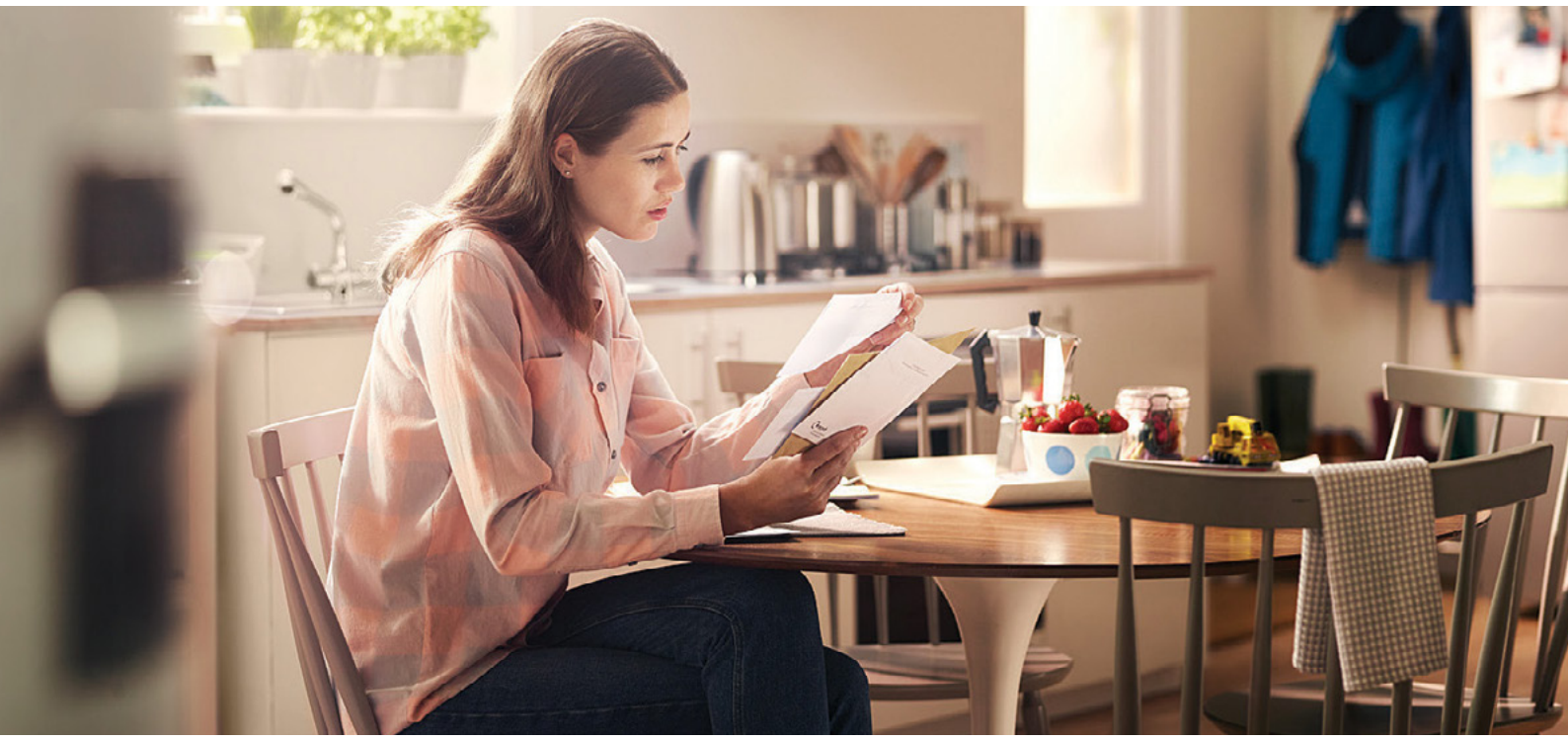
with

## CHRISTOPHER PAUL SZABO

**SUBSCRIBE ON YOUTUBE**

| | |
|---|---|
| **EPISODE 1** | Leadership in Psychiatry |
| **EPISODE 2** | Belief systems and Psychiatry |
| **EPISODE 3** | Stargazing and mental wellbeing |
| **EPISODE 4** | Burnout and resilience |
| **EPISODE 5** | Navigating uncertainty |
| **EPISODE 6** | Assisted dying – law and ethics |
| **EPISODE 7** | Maternal mental health |
| **EPISODE 8** | HIV and Psychiatry |
| **EPISODE 9** | Adolescence, ADHD and pornography |
| **EPISODE 10** | Adolescent suicide |



## Vortioxetine Lundbeck® can help with her mood, concentration and fatigue, so she is able to organise her day again[1-3]

Lundbeck

Brintellix® vortioxetine
Take care of *more than mood*

Vortioxetine Lundbeck®
Efficacy without compromise

**References: 1.** Baune BT et al. *Int J Neuropsychopharmacol* 2018; 21 (2):97-107. **2.** Fagiolini A *et al. Journal of Affective Disorders*. **3.** Brintellix® and Vortioxetine Lundbeck® 5 mg, 10 mg, 20 mg Approved Professional Information Leaflet.

S5 Vortioxetine 5 mg, 10 mg and 20 mg Lundbeck® Film-coated Tablets. Each film-coated tablet contains vortioxetine hydrobromide equivalent to 5 mg, 10 mg or 20 mg vortioxetine. Reg No.: 5 mg 55/1.2/0580; 10 mg 55/1.2/0581; 20 mg 55/1.2/0582. S5 Brintellix® (vortioxetine) film coated tablets. Each tablet contains vortioxetine hydrobromide - equivalent to vortioxetine. Reg No. 5 mg: 48/1.2/0429; 10 mg 48/1.2/0430; 20 mg 48/1.2/0432. For full prescribing information refer to the professional information approved by SAHPRA (January 2024).

**Applicant:** H. Lundbeck (Pty) Ltd., Office A1002 Knightsbridge, 33 Sloane Street, Bryanston, 2190. Tel: +27 11 699 1600. **Marketed by:** Adcock Ingram Limited. Co. Reg. No.: 1949/034385/06. Private Bag X69, Bryanston, 2021, South Africa. Customer Care: 0860 ADCOCK / 232625. www.adcock.com. ZA-BRIN-0206 March 2024. 28.02.20251000001412.

adcock ingram prescription

# TOWARDS AN UNDERSTANDING OF TREATMENT-RESISTANT DEPRESSION - AN EXPERT CONSENSUS REVIEW

***SASOP Interventional Special Interest Group Executive Committee: Marcelle Stastny*** *MBChB (Pret) FCPsych (UCT),* ***Michelle King*** *MBChB MMed(Psych) M(ECI) PG DIP (Pall Med) PG Dip (Interdis Pain Mx),* ***Joanna Taylor*** *BA MBBCh FCPsych (SA) MMed (Psych),* ***Kate Ord*** *MBChB(UCT) FC Psych(SA) MMed (Psych),* ***Laila Paruk*** *(FC Psych),* ***Alicia Swart*** *MBBCh FC Psych (SA) MMed(Psych),* ***Bavi Vythilingum*** *MBChB cum laude (Natal) FCPsych(SA) MMed(Psych) cum laude (Stell)*

**About the review panel**

*The authors of this review are members of the South African Society of Psychiatrists' (SASOPs') Interventional Special Interest Group's Executive Committee. This committee consists of eight practising psychiatrists with more than 100 years of experience between them. The Special Interest Group was convened in 2022 to explore novel treatment modalities in psychiatry.*

## ABSTRACT

In this expert consensus from the SASOP Interventional Psychiatry SIG, we define TRD (Treatment-Resistant Depression) pragmatically as failure of two adequate treatment trials, yet emphasise it as a dynamic state requiring iterative reassessment. We review under-utilised advances available in South Africa (measurement-based care, pharmacological optimisation, therapy, TMS, ECT, and ketamine) while cautioning against low-value practices (automatic hospitalisation, reflex polypharmacy, indefinite antipsychotic augmentation, premature psychedelic adoption). We offer a patient-centred pathway: confirm diagnosis and staging; screen for bipolarity, comorbidity, and iatrogenesis; prioritise rapid relief when suicidality is present; then pursue durable neuromodulation and psychosocial rehabilitation. We address implementation challenges, providing practical tools for South African services. Our goal is to sharpen clinical decisions and expand access to adequate, safe TRD care.

## INTRODUCTION

Treatment-resistant depression (TRD) is generally defined as the failure of two antidepressant treatments administered at an adequate dose and duration.[1] However, there is confusion surrounding: what constitutes an "adequate" dose and duration; what is defined as "failure"; and what a doctor can do to prevent TRD from becoming difficult-to-treat depression (DTD).[2]

TRD is not a fixed state, meaning it is still possible to transition the patient from being a non-responder to being a responder.[3] However, if depression persists and DTD is diagnosed, the therapeutic goal is no longer to cure depression. It then becomes palliative so that the patient can live a meaningful life despite ongoing illness. Taking the right action to prevent TRD from becoming DTD is therefore essential.

## HOW IS TRD DIAGNOSED?

When making a diagnosis of TRD, it is essential to distinguish between symptom reduction, response, and remission. Rigorous diagnostic clarification and staging of the illness, along with the use of structured rating scales, are crucial for ensuring that these and other nuances are fully considered to make an accurate diagnosis.

TRD is also often misdiagnosed- between 40% and 60% of TRD cases turn out to have a bipolar diagnosis after structured testing.[4] For this reason, the SASOP/PsychMg pathways require that a psychiatrist assess TRD as well as coordinate the care of the patient with TRD.

A thorough physical review is also needed to ensure that no other treatable aspects have been overlooked. Though they are rarely the sole cause of depression, medical problems such as chronic pain, obesity, and inflammatory illnesses frequently contribute to symptoms.

Evidence-based lifestyle interventions, such as exercise,[5] a whole-food diet,[6] prioritising sleep/ wake rhythms,[7] time in nature,[8] social connection,[9] mindfulness, or breathing meditation, need to be constantly revisited. These practices have been shown to improve neural plasticity

markers and mechanisms. As mood, attention, and executive control improve, adherence typically becomes easier, creating a collective gains cycle, rather than a one-off intervention.

### WHAT IS AN "ADEQUATE" DURATION FOR TREATMENT?

Depression must be treated actively and quickly to achieve remission. Traditional treatment pathways have recommended rigidly following linear approaches requiring longer intervals before adjusting or changing treatment.

This approach is not only unkind to a patient but worsen prognosis and runs the risk of fostering chronic disease.

The Maudsley Staging Method urges clinicians to adopt a dynamic approach that fosters early effective intervention.[10] Prolonged untreated depression predicts a worse prognosis – lower remission rates, slower response, and higher risk of chronic TRD.[1] A depressive episode, at twelve weeks, is already associated with lower response rates, and greater resistance to treatment.[11,12]

### WHY DOES DEPRESSION BECOME RESISTANT TO TREATMENT?

Without effective treatment, chronic depression over months or years – and certainly over decades – can alter the structure and functioning of the brain by causing the hippocampus to atrophy and triggering neurochemical dysregulation, among other neurobiological changes.[13] It can also entrench maladaptive behavioural and social patterns that disrupt sleep and affect social functioning, making recovery more difficult.[14]

### TREATMENT APPROACH

To identify TRD as early as possible, measurement-based care (MBC) is emerging as the gold standard. MBC involves measuring clinical outcomes and using the results to guide treatment decisions.[15] MBC in psychiatry assesses symptoms, response to medication, evaluates functioning, satisfaction with life, and identifies readiness to change.[16] A suitable standard for measuring the outcomes of depression treatments is the PHQ-9 (Patient Health Care Questionnaire-9).[17]

Follow up and assessment should take place every 2 weeks[18] after the initiation of an antidepressant.

### AT TWO-WEEKS:

- **Assess side effects.** Mood destabilisation or agitation (if it occurs in response to treatment) typically peaks at about this point.
- **Check adherence**
- **Assess the improvement trajectory**. Early improvement at two weeks predicts a good outcome.[19]

If no response is observed, switching or augmenting is justified – except with fluoxetine, which requires longer to become effective.[20]

At the **four-week** check-in:

- **Consider switching drug class.** If there is an improvement of less than 50%, consider switching drug class, for example, transition from a selective serotonin reuptake inhibitor (SSRI) to a serotonin-norepinephrine reuptake inhibitor (SNRI).
- **Explore treatment augmentation**
- **Alternatively, cautiously escalate the dose.** Increasing the dose beyond therapeutic levels generally adds side effects without meaningful benefits.[21] Potential benefits must always be weighed against risks.[1,22]

### DECISION POINT: AUGMENTATION STRATEGIES AVAILABLE IN SOUTH AFRICA

The landmark STAR*D trial showed that one-third of participants remitted on citalopram, with remission rates declining, and relapse rates increasing with every adjustment requiring a switch or augmentation strategy.[23] The original study reported a cumulative remission of 67%, but a 2023 reanalysis estimated it to be only 35%.[23]

In South Africa, the primary augmentation strategies available are hospitalisation, intensive psychotherapy, adding a second antidepressant, adding another kind of drug, ketamine therapy, transcranial magnetic stimulation (TMS) and electro-convulsive therapy (ECT).

### 1. HOSPITALISATION

Hospitalisation, in a multidisciplinary setting, for TRD can offer a meaningful short-term reduction in symptoms, and especially when combined with emerging interventions like repetitive TMS (rTMS) or ketamine therapy.[24-26] However, evidence shows that functional recovery and avoidance of readmission are often undermined by an abrupt discharge, the presence of residual symptoms, and inadequate support at home.[24]

Data from South Africa highlights that:

- Patients' high expectations during hospitalisation are often not met due to challenges experienced in maintaining gains at home[24]
- Post-discharge, many patients report isolation, role disruption, and poor functional recovery.[24]
- A private hospital review noted a 7.5% six-month readmission rate, mostly due to poor daily functioning and difficulties with reintegration.[24]

International findings echo these observations.[27-29]

**Conclusion:**

Hospitalisation can provide acute relief and a perception of reduced risk but rarely ensures sustained functional recovery without robust outpatient and community-based support.

### 2. INTENSIVE PSYCHOTHERAPY

Psychotherapy remains underused in TRD treatment despite robust evidence. A 2018 Cochrane review found that adding structured psychotherapy to antidepressant treatment improves short- and medium-term outcomes.[30] Comparative reviews indicate that psychotherapy often matches—or surpasses—pharmacologic augmentation, particularly in chronic or difficult-to-treat depression.[31] Evidence-supported modalities include cognitive behavioural therapy (CBT), interpersonal therapy (IPT), dialectical behaviour therapy (DBT), and mindfulness-

based cognitive therapy (MBCT). [31-33] The choice of modality should be guided by the primary presenting symptoms, with the aim being to restore function. DBT specifically targets emotional dysregulation, impulsivity and self-harm. CBT addresses negative thoughts and behavioural avoidance. IPT focuses on interpersonal strain and role transitions, while MBCT reduces relapse risk by strengthening metacognitive awareness.[31-33]

**Conclusion:**

The panel recommends matching the mechanism to a patient's dominant problems to shorten the time to response and reduce downstream costs by limiting ineffective medication trials, curbing polypharmacy, and improving functioning.

Delivery innovations, including online and group formats, are expanding access and scalability, making intensive psychotherapy available even in rural South Africa, where such modalities were not available in the past.

## 3. ANTIDEPRESSANT AUGMENTATION

Adding a second antidepressant remains a common strategy for treating TRD, although there is no strong evidence to support this. Further this method frequently increases the side effect profile.

Antidepressant augmentation typically focuses on combining an SSRI or SNRI with one of the following:

- **An α2-antagonist.** Large, rigorous trials show a small benefit (SMD ≈ 0.37) for combining an SSRI or SNRI with an α2-antagonist (such as mirtazapine or mianserin).[34]
- **Bupropion.** Bupropion combinations are not superior to antidepressant monotherapy (SMD ≈ 0.10.).[35]

The STAR*D and CO-MED (Combining Medications to Enhance Depression Outcomes) studies both recommend combining medications only when judiciously guided by the mechanism of action.[36-38] For example, augmenting with mirtazapine where insomnia and weight loss are a concern, or bupropion to target anergia and sexual dysfunction.

**Conclusion:**

Polypharmacy predictably increases adverse effects and drug–drug interactions without guaranteeing clinically meaningful gains.

The panel recommends taking a time-limited, symptom-targeted two-drug trial only when there's a clear mechanistic rationale for doing so, or when other evidence-strong options are inaccessible or contraindicated. Set hard-stop rules: if no material benefit is seen by six to eight weeks at the target dose, discontinue the second antidepressant treatment. Avoid triple combinations of drugs.

## 4. NON-ANTIDEPRESSANT AUGMENTATION

Non-antidepressant pharmacological augmentation typically focuses on adding an atypical antipsychotic, lithium, or thyroid hormone to the initially prescribed SSRI or SNRI.

### *4.1 Atypical antipsychotics*

Multiple randomized controlled trials and meta-analyses show modest yet significant short-term improvements when second-generation antipsychotics (SGAs) are added to antidepressants.[39]

Importantly, long-term, the initial gains tend to decline[40] with no consistent quality-of-life improvement. Additionally, long term SGA use can have substantial adverse effects, including increased morbidity rates, metabolic syndrome, prolactin elevation, extrapyramidal symptoms, tardive dyskinesia, sedation, and cognitive dulling.[40, 41]

Options approved by the United States Food and Drug Administration (FDA) include aripiprazole (best at <5 mg), quetiapine extended release (best at 150 mg), cariprazine*, and an olanzapine-fluoxetine combination. Higher doses worsen side effects without better outcomes.

**Although cariprazine was FDA-approved in 2022, a subsequent phase-3 randomized control trial of 750 participants found that cariprazine was not superior to a placebo at 1.5 or 3 mg/day on the primary outcome (using the Montgomery-Asberg Rating Scale scale) at six weeks.*[42]

**Conclusion:**
While atypical antipsychotic augmentation has a well-established role in short-term TRD treatment, the long-term evidence is weak and concerning. Deterioration in metabolic health, neurological damage, and lack of functional gains make prolonged use risky.

The panel's recommendation is to follow a pragmatic approach:

- Use atypical antipsychotics briefly, strategically and at low doses
- Transition to safer long-term options
- Monitor closely for adverse effects.
- Frequently re-evaluate the need for augmentation and stop if the benefits wane or negative outcomes appear.
- If higher doses of SGAs are beneficial, it would be worth reconsidering the diagnosis.

### *4.2 Lithium*

Lithium in addition to being the gold standard treatment for acute mania in bipolar disorder, is used to augment existing antidepressant therapy in TRD.[43] Beyond reducing symptoms, lithium is associated with a meaningful decrease in suicide risk in unipolar depression.[44, 45]

It is most effective when maintained within a narrow therapeutic window, with optimal plasma levels typically ranging between 0.6 and 1.0 mmol/L.[46]

**Conclusion:**
Lithium is a credible augmentation option for TRD, with a unique, strong anti-suicide signal. It is inexpensive as a drug but requires disciplined monitoring.

### *4.3 Thyroid hormone (T3/T4) augmentation*

The idea that thyroid hormone supplementation could be used in psychiatric settings is based on longstanding observations that link thyroid dysfunction—both hypo- and hyperthyroidism—to cognitive and mood disturbances, particularly depression.[47]

However, clinical evidence that supports thyroid hormone augmentation in TRD is limited.[48] A systematic review and meta-analysis published in 2020 evaluated the efficacy of thyroid hormones compared to placebo and lithium when used as adjunctive treatments for TRD. The study found no significant advantage of thyroid hormone therapy.

**Conclusion:**
The panel regards T3/T4 augmentation as unproven for TRD. Consider a trial of treatment only if there are borderline hypothyroid signals; this should be time-limited and accompanied by rigorous lab follow-ups.

### 5. KETAMINE

Ketamine was first synthesised in the 1960s as an anaesthetic. Interest in its potential as an antidepressant arose from "emergence" observations – some patients reported a brief lift in mood on waking from anaesthesia.[49] Since 2006, randomised trials have shown that intravenous (IV) racemic ketamine can produce antidepressant effects within hours, typically waning over three to seven days.[50]

Most major guidelines – including the Canadian Network for Mood and Anxiety Treatments (CANMAT), the American Psychiatric Association (APA), the National Institute for Health and Care Excellence (NICE) in the United Kingdom – list ketamine or intranasal esketamine as options for short-term relief of TRD under specialist supervision, especially when a rapid reduction of severe suicidal ideation is needed.[49-52] Ketamine is an effective, rapid-acting agent for such emergency situations and could provide relief where other modalities have failed, or while longer-term treatment options for TRD are being considered. However, such interventions should be limited to six to eight treatments over two to four weeks. There is limited data on the use and efficacy of intramuscular ketamine.

In South Africa:

- **IV Ketamine** is available in parts of the private sector. Some medical schemes may authorise a short induction course on a case-by-case basis.
- **Intranasal esketamine** (Spravato) is not easily accessible, with access limited by cost and procurement logistics.

All current major guidelines advise against maintenance use of ketamine due to safety, dependence, and cognitive concerns.[49-52] There is evidence that ketamine exposure – especially in frequent, high-dose or long-term use – could cause painful ulcerative/interstitial cystitis in a condition known as ketamine-induced cystitis.[53] Even so, some patients only respond to ketamine and experience a return of severe illness without ketamine treatment.

There is growing evidence of the benefits of judicious ketamine maintenance.[54] A psychiatrist needs to manage such cases, and careful, informed consent and combined decision-making -which involves evaluating the risks and benefits and acknowledging the limited current data- need to be carefully documented.

**Conclusion:**
There is strong evidence that IV ketamine provides rapid, short-term relief in TRD. However, its use is best reserved for acute episodes under the supervision of a specialist psychiatrist, with support by a suitably qualified anaesthesiology specialist, while longer-term treatment options are being explored. SASOP and SASA have issued a joint position statement outlining its safe use.

**A word of caution on ketamine**

Ketamine is an anaesthetic agent and has been associated with addiction. The use of ketamine in TRD is still off-label. As such, several caveats exist regarding its use:

- Patients should be screened for psychosis, substance use disorders, and cardiovascular risk. Ketamine is contraindicated in patients who are experiencing an active psychosis or are currently abusing substances.
- Ketamine must be prescribed by a psychiatrist and administered in a clinic with cardiopulmonary monitoring equipment, which should be supervised by trained personnel (such as an anaesthesiologist or a general practitioner with a diploma in anaesthetics).
- The clinic should have resuscitation equipment available for emergencies.
- Use is generally limited to between six and eight acute treatments over two to four weeks.

These guidelines are in line with the position statements of SASOP (the South African Society of Psychiatrists) and guidelines on the administration of ketamine from the South African Society of Anaesthesiologists (SASA).

### 6. TRANSCRANIAL MAGNETIC STIMULATION

Transcranial magnetic stimulation (TMS) is a non-invasive technique that delivers focused magnetic pulses to stimulate the cortical circuits implicated in depression. It is an approved treatment in South Africa and reimbursed by some medical aid schemes for patients with TRD, typically with motivation from a psychiatrist.

Two large meta-analyses have found that TMS is a more effective augmentation strategy than antipsychotics (like aripiprazole) or mood stabilizers (like lithium) in TRD. Ketamine achieves more rapid symptom reduction at two weeks, but by eight weeks, TMS surpasses ketamine in efficacy and durability of response.[55, 56] Unlike pharmacological augmentation, TMS avoids the polypharmacy burden, the long-term metabolic risk, and the cognitive side effects that accompany antipsychotics and mood stabilizers.

TMS is endorsed by the APA, CANMAT, and NICE as an effective, first-line augmentation option for TRD after at least one or two failed antidepressant trials. The evidence suggests that TMS is:

- Effective. Randomised controlled trials and meta-analyses consistently show clinically meaningful remission and response rates in TRD, with durable benefits beyond acute treatment. [55, 56]
- Safe and tolerable. TMS is very well tolerated, with transient scalp discomfort and a mild headache being the most common side effects. No cognitive impairment, metabolic burden, or dependency risk has been observed.[57]
- Scalable and accessible. With clinic infrastructure in South Africa expanding, and more and more medical aids recognising this as a treatment option, TMS is becoming more accessible and cost-effective.

# DOLIN

Escitalopram oxalate (10 mg & 20 mg tablet)

**BRING BACK CONFIDENCE**






## Dosage and Directions for Use:

**Administer as a single daily dose, with or without meals.**

| | |
|---|---|
| **Major depressive episodes** | • Administer as a single dose of 10 mg daily.<br>• Dose may be increased to 20 mg depending on patient response (2 – 4 weeks are usually necessary for an antidepressant response). |
| **Elderly patients (> 65 years)** | • Due to longer half-life and decreased clearance, maximum dose for elderly patients is 10 mg daily. |
| **Reduced renal or hepatic function** | • No dose adjustment for mild or moderate renal impairment - no information available for severe renal impairment (creatinine clearance < 30mL/min).<br>• Dosages should be halved to the lower end of dose range in patients with hepatic insufficiency.<br>• Maximum dose for patients with hepatic insufficiency is 10 mg daily. |

AUROGEN CNS

SAHPRA approved **DOLIN** professional information. Date of publication: 15 November 2022. S5 **DOLIN 10 mg** (tablet). Reg. No: 44/1.2/0952. S5 **DOLIN 20 mg** (tablet). Reg. No: 44/1.2/0953.
Each film-coated tablet contains escitalopram oxalate equivalent to 10 mg or 20 mg escitalopram respectively. Sugar free.
For full prescribing information refer to the professional information approved by the medicines regulatory authority.

**HCR:** AUROGEN SOUTH AFRICA (PTY) LTD. Woodhill Office Park, Building No. 1, First Floor, 53 Phillip Engelbrecht Avenue, Meyersdal, Ext. 12, 1448, Johannesburg, South Africa.
Tel: (011) 867 9100, Fax: (011) 867 9111. https://auro-space.com

ASA.26.03.1427

TMS offers flexible clinical treatment protocols that range from standard daily sessions over four to six weeks, to accelerated protocols that achieve remission in as little as one to two weeks – without the systemic adverse effects associated with long-term pharmacological augmentation strategies.

**Conclusion:**
TMS is an effective, safe, evidence-based and increasingly accessible option for TRD that avoids the pitfalls of pharmacological polytherapy. Given its superior long-term outcomes compared to other augmentation strategies and its favourable side-effect profile, TMS should be considered early in the treatment algorithm for TRD.

## 7. ELECTROCONVULSIVE THERAPY

Electroconvulsive therapy (ECT) remains the touchstone treatment for severe mental illnesses such as psychotic depression and catatonic depression. Based on a meta-analysis of the literature and the panel's own clinical experience, ECT is also among the most effective and rapid treatments for TRD.[58]

Patients and caregivers often hold negative perceptions of ECT, with social media and widespread misinformation fuelling their fears. Many hold the false belief that ECT causes serious, permanent cognitive damage, memory loss, or neurological harm, despite modern evidence to the contrary.[59] Despite these preconceptions, ECT should not be sidelined as a last-resort treatment. Rather, it should be a planned, evidence-based treatment with clear indications, patient consent, and close monitoring.[58] Clinically, the main challenge with ECT is relapse, emphasising the need for clear continuation strategies.

**Conclusion**
It is the panel's opinion that ECT remains one of the most effective and rapid interventions for severe TRD, but its use needs to be balanced against the risk of relapse and the patient's preference. ECT should be offered transparently as one option within a stepped care pathway. It should never be imposed, and it should always be accompanied by a clear discussion of the benefits, risks, and alternatives.

## 8. NEW AND NOVEL TREATMENTS

Psychiatry, like any speciality, is a constantly evolving field. Several emerging TRD treatment options are being tested for efficacy and safety, including anti-inflammatory drugs, psilocybin and pramipexole. These are discussed in greater detail below.

### *8.1 Anti-inflammatory drugs*
Anti-cytokine drugs have not overall shown a positive response in major depressive disorder, but a positive signal in high-C-reactive protein subgroups has been replicated.[60]

### *8.2 Psilocybin*
The COMP 005 clinical study on psychedelic-assisted therapy recently completed Phase 3 trials in the United States. The company conducting the trial reported that patients that were given 25 mg psilocybin, accompanied by psychotherapeutic support, scored 3.6 points higher on the Montgomery-Åsberg Depression Rating Scale than a control group that was given niacin plus psychotherapy at the six-week mark. However, the panel notes that these results have not yet been peer-reviewed. Similar findings have emerged in earlier, smaller trials, although durability, optimal psychotherapy containment, and comparative effectiveness remain unresolved.[61]

### *8.3 Pramipexole*
Pramipexole, a dopamine agonist with a high affinity for D3 receptors, was initially approved for use in Parkinson's Disease. It has been demonstrated to show significant benefit as an augmentation strategy for patients with TRD.[62]

Patients frequently discontinue pramipexole due to intolerable side effects, including poor impulse control, insomnia, nausea and dizziness. Based on the panel's clinical experience, it is important to start treatment at a low dose, titrate patiently, and actively monitor for nausea, orthostasis, sleep attacks/somnolence, emergent impulsivity, and mood elevation.

Pramipexole can be considered as a targeted, third-line augmentation for TRD when (a) standard augmenters are ineffective or not desired, and/or (b) anhedonia/motivational deficits are prominent.

**Conclusion**

Anti-inflammatory drugs do not yet play an established, guideline-level role in TRD treatment.

Psychedelic drugs are illegal in South Africa, and psychedelic-assisted therapy is currently not approved for major depressive disorder or TRD in South Africa. SASOP's position statement on psychedelics states that the clinical use of psychedelic substances should only occur under research trial conditions, which include oversight by an institutional research ethics committee, careful monitoring, and clear reporting of the efficacy and safety outcomes.

The off-label use of pramipexole and its complex side effect profile make it best suited to specialist supervision.

None of these treatments are approved for major depressive disorder or TRD. They require in-depth consent and monitoring by a specialist. Established safe and efficacious evidence-based interventions - namely TMS, ECT, ketamine and structured psychotherapy- should always be considered first.

## 9. COMMONLY USED, LIMITED EVIDENCE

Clinicians sometimes treat prominent symptom clusters before diagnostic certainty is complete. Examples include adding stimulants (e.g., methylphenidate or amphetamine formulations) or lamotrigine in treatment-resistant depression (TRD). Although these approaches are used in clinical practice, the evidentiary footing is comparatively weak.

### *9.1 Stimulants (methylphenidate/amphetamines)*
Cognitive slowing and subjective "brain fog" can be disabling, and patients often report short-term relief with ADHD medications or with wake-promoting agents. However, randomized trials of classical stimulants[63] do not show reliable improvements in core depressive symptoms, and major guidelines do not recommend stimulants as standard TRD augmentation.[64] By contrast, modafinil/armodafinil have a modest evidence base

for fatigue/hypersomnia, but should still be viewed as later-line, symptom-targeted options rather than primary augmenters.

***9.2 Lamotrigine***

A comprehensive meta-analysis suggested overall improvement versus placebo for augmentation. The authors' cautious conclusion—possible benefit, particularly in certain populations—comes with uncertain external validity.[65] Clinically, any potential gain must be weighed against slow titration and the need for patience before assessing effect.

**Conclusion:**

If low-evidence interventions are considered, they should be initiated by a psychiatrist, with:

- Explicit targets (e.g., energy, psychomotor speed, hypersomnia) and a time-limited trial.
- A monitoring and stop plan (vitals, sleep, anxiety, misuse/diversion for stimulants; rash protocol and drug interactions for lamotrigine).
- A fresh diagnostic review: screen for bipolar-spectrum illness, ADHD, sleep disorders (OSA), medical contributors (thyroid, anaemia, inflammation), substance use, and medication adverse effects.

These strategies remain adjunctive and provisional—appropriate when first-line augmenters are contraindicated or poorly tolerated, not as default TRD care.

## SUMMARY

TRD is a profoundly disabling illness that touches as many as one in three people living with depression. Yet it is not without hope: we now have multiple effective strategies to ease suffering and restore function. The clinician's role is to identify TRD early on, and to guide patients through evidence-based options that use augmentation and neuromodulation thoughtfully and proactively.

While the benefits of various treatments may be time-limited without maintenance, this reflects the chronic nature of depression, not a failure of treatment. With appropriate relapse prevention and support, many patients can achieve sustained relief.

The authors of this paper call on medical aids to recognise the heavy burden of TRD and to stand alongside patients and their clinicians in meeting it. By investing in comprehensive, ongoing care, we can transform outcomes and offer renewed hope to individuals and families living with this condition.

## TREATMENT-RESISTANT DEPRESSION: PATIENTS' STORIES

Too often, the experience of living with treatment-resistant depression (TRD) is described only in clinical terms: symptoms, scales and treatment outcomes. But behind every diagnosis is a person, and behind every treatment decision is a human story of struggle, hope and resilience.

Here we centre the voices of those who live with TRD every day. Their words remind us of the profound emotional and social impacts of this illness – and of the importance of partnership in care. Listening to their perspectives can help guide clinicians towards more respectful and effective approaches to treatment, ensuring that the care we offer truly aligns with what matters most to our patients.

To capture the voice of their patients, the psychiatrists on this review panel invited a selection of patients with TRD to answer a short survey in their own words. Their answers have been anonymised.

**What is it like to live with TRD?**

Patients often describe TRD as isolating and exhausting. "It's like living in a deep, dark prison cell not seeing the sun for weeks, months, years."

"Each time it resurfaces, there's a deeper level of exhaustion… it makes it so tempting to just give up."

Patients report trying multiple treatments – up to five antidepressants, plus augmentation strategies – yet still face persistent symptoms. Barriers to treatment include medical aids refusing to pay, the high cost of treatment, a lack of awareness about more treatment options, and a scarcity of providers. Nevertheless, many find hope in the most effective treatments described here: TMS, ECT and psychotherapy. Access to comprehensive care is crucial.

**How could society help you more?**

Patients believe that medical aids have a role to play in making appropriate treatments more available. They request:

- Broader medical aid coverage for TRD treatments, including TMS and ketamine
- The elimination of session limits for psychotherapy and support groups
- Simpler administration processes to obtain treatment authorisations
- Recognition of depression as a disabling condition that deserves sustained support.

"Being in the brain fog of depression is bad enough, but having to advocate for yourself is just too exhausting."

## REFERENCES


1. McIntyre RS, Alsuwaidan M, Baune BT, *et al*. Treatment-resistant depression: definition, prevalence, detection, management, and investigational interventions. World Psychiatry. 2023;22(3):394–412.

2. Paganin W, Signorini S, Sciarretta A. Difficult-to-treat depression. Scoping review. *Clinical Neuropsychiatry.* 2023;20(3):173.

3. Fekadu A, Rane LJ, Wooderson SC, Markopoulou K, Poon L, Cleare AJ. Prediction of longer-term outcome of treatment-resistant depression in tertiary care. *Br J Psychiatry.* 2012;201(5):369–375.

4. Francesca MM, Efisia LM, Alessandra GM, Marianna A, Giovanni CM. Misdiagnosed hypomanic symptoms in patients with treatment-resistant major depressive disorder in Italy: results from the improve study. *Clin Pract Epidemiol Ment Health.* 2014;10:42–47.

5. Noetel M, Sanders T, Gallardo-Gómez D, *et al*. Effect of exercise for depression: systematic review and network meta-analysis of RCTs. *BMJ*. 2024;384:e075847

6. Abukmail E, *et al.* Moderate- to long-term effect of dietary interventions for depression and anxiety: Systematic review/meta-analysis. *Ann Intern Med*. 2025;178

7. Irwin MR, Carrillo C, Sadeghi N, Bjurstrom MF, Breen EC, Olmstead R. Prevention of Incident and Recurrent Major Depression in Older Adults With Insomnia: A Randomized Clinical Trial. *JAMA Psychiatry*. 2022;79(1):33–41.

8. Nguyen PY, Astell-Burt T, Rahimi-Ardabili H, Feng X. Effect of nature prescriptions on cardiometabolic and mental health, and physical activity: a systematic review. *Lancet Planet Health.* 2023;7(4):e313–e328.

9. Siette J, Cassidy M, Priebe S. Effectiveness of befriending interventions: a systematic review and meta-analysis. *BMJ Open.* 2017;7(4):e014304.

10. Fekadu A, Wooderson SC, Markopoulou K, Cleare AJ. The Maudsley Staging Method for treatment-resistant depression: prediction of longer-term outcome and persistence of symptoms. *Journal of Clinical Psychiatry.* 2009;70(7):952

11. Souery D, Papakostas GI, Trivedi MH. Treatment-resistant depression. *Journal of Clinical Psychiatry.* 2006;67:16.

12. Souery D, Oswald P, Massat I, Bailer U, Bollen J, Demyttenaere K, et al. Clinical factors associated with treatment resistance in major depressive disorder: results from a European multicenter study. *Journal of Clinical Psychiatry.* 2007;68(7):1062–1070.

13. Rădulescu I, Drăgoi AM, Trifu SC, Cristea MB. Neuroplasticity and depression: Rewiring the brain's networks through pharmacological therapy. *Experimental and therapeutic medicine.* 2021;22(4):1131.

14. Kupferberg A, Hasler G. The social cost of depression: Investigating the impact of impaired social emotion regulation, social cognition, and interpersonal behavior on social functioning. *Journal of Affective Disorders Reports.* 2023;14:100631.

15. Scott K, Lewis CC. Using measurement-based care to enhance any treatment. *Cogn Behav Pract.* 2015;22(1):49-59. doi:10.1016/j.cbpract.2014.01.010

16. Hong RH, Murphy JK, Michalak EE, *et al.* Implementing Measurement-Based Care for Depression: Practical Solutions for Psychiatrists and Primary Care Physicians. *Neuropsychiatr Dis Treat.* 2021 Jan 14; 17:79-90. doi: 10.2147/NDT.S283731

17. Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. *Journal of general internal medicine.* 2001;16(9):606–613.

18. Gorwood P, Bayle F, Vaiva G, Courtet P, Corruble E, Llorca PM. Is it worth assessing progress as early as week 2 to adapt antidepressive treatment strategy? Results from a study on agomelatine and a global meta-analysis. *Eur Psychiatry.* 2013;28(6):362–371.

19. Szegedi A, Jansen WT, van Willigenburg AP, van der Meulen E, Stassen HH, Thase ME. Early improvement in the first 2 weeks as a predictor of treatment outcome in patients with major depressive disorder: a meta-analysis including 6562 patients. *Journal of Clinical Psychiatry.* 2009;70(3):344.

20. Nierenberg AA, Farabaugh AH, Alpert JE, Gordon J, Worthington JJ, Rosenbaum JF, *et al.* Timing of onset of antidepressant response with fluoxetine treatment. *American Journal of Psychiatry.* 2000;157(9):1423–1428.

21. Jakubovski E, Varigonda AL, Freemantle N, Taylor MJ, Bloch MH. Systematic review and meta-analysis: dose-response relationship of selective serotonin reuptake inhibitors in major depressive disorder. *American Journal of Psychiatry.* 2016;173(2):174–183

22. Lam RW, Kennedy SH, Adams C, Bahji A, Beaulieu S, Bhat V, *et al.* Canadian Network for Mood and Anxiety Treatments (CANMAT) 2023 Update on Clinical Guidelines for Management of Major Depressive Disorder in Adults: Réseau canadien pour les traitements de l'humeur et de l'anxiété (CANMAT) 2023: Mise à jour des lignes directrices cliniques pour la prise en charge du trouble dépressif majeur chez les adultes. *The Canadian Journal of Psychiatry.* 2024;69(9):641–687.

23. Xu C, Kim TT, Kirsch I, Plöderl M, Amsterdam JD, Pigott HE. Restoring STAR* D: A reanalysis of drug-switch therapy after failed SSRI treatment using patient-level data with fidelity to the original STAR* D research protocol. medRxiv. 2025. Doi https://pmc.ncbi.nlm.nih.gov/articles/PMC11844611

24. Franzsen D *et al.* Challenges impacting functional recovery experienced by Mental Health Care Users with Major Depressive Disorder post-hospitalisation in South Africa. *South African Journal of Occupational Therapy.* 2021;51(2):55-64

25. Bröcker E, van den Heuvel L, Seedat S. Accelerated theta-burst repetitive transcranial magnetic stimulation for depression in South Africa. *South African Journal of Psychiatry.* 2019;25(1): 1-4. doi: https://doi.org/10.4102/sajpsychiatry.v25i0.1346

26. Juby VM, Paruk S, Tomita M, Chiliza B. Ketamine for depressive symptoms: A retrospective chart review of a private ketamine clinic. *South African Journal of Psychiatry.*2024;30: 2176. doi: https://doi.org/10.4102/sajpsychiatry.v30i0.2176

27. Lin J, Szukis H, Sheehan JJ, *et al.* Economic Burden of Treatment-Resistant Depression Among Patients Hospitalized for Major Depressive Disorder in the United States. *Psychiatr Res Clin Pract.* 2019;1(2):68-76.

28. Lundberg J, Cars T, Lööv S, *et al.* Association of Treatment-Resistant Depression With Patient Outcomes and Health Care Resource Utilization in a Population-Wide Study. *JAMA Psychiatry.* 2023;80(2):167–175. doi: https://pubmed.ncbi.nlm.nih.gov/36515938

29. Chopra A, Luccarelli J, Cohen JN, *et al.* Evaluation, treatment, and referral of treatment-resistant depression in primary care. *Primary Care Companion CNS Disorders.* 2023;25(4):48083

30. Ijaz S, Davies P, Kessler D, Lewis G, Wiles N. Psychological therapies for treatment-resistant depression in adults. *Cochrane database of systematic reviews.* 2018(5).

31. Trivedi RB, Nieuwsma JA, Williams Jr JW. Examination of the utility of psychotherapy for patients with treatment resistant depression: a systematic review. *Journal of general internal medicine.* 2011;26(6):643–650.

32. Harley R, Sprich S, Safren S, Jacobo M, Fava M. Adaptation of dialectical behavior therapy skills training group for treatment-resistant depression. *The Journal of nervous and mental disease.* 2008;196(2):136–143.

33. Moukaddam N, Hashmi AM, Nguyen P. Use of psychotherapy in treatment-resistant depression. *Psychiatric Annals*. 2016;46(4):230–235.

34. Kessler DS, MacNeill SJ, Tallon D, Lewis G, Peters TJ, Hollingworth W, *et al.* Mirtazapine added to SSRIs or SNRIs for treatment resistant depression in primary care: phase III randomised placebo controlled trial (MIR). *BMJ*. 2018;363

35. Henssler J, Alexander D, Schwarzer G, Bschor T, Baethge C. Combining antidepressants vs antidepressant monotherapy for treatment of patients with acute depression: a systematic review and meta-analysis. *Jama Psychiatry*. 2022;79(4):300–312.

36. Rush AJ, Trivedi MH, Stewart JW, Nierenberg AA, Fava M, Kurian BT, *et al*. Combining medications to enhance depression outcomes (CO-MED): acute and long-term outcomes of a single-blind randomized study. *American Journal of Psychiatry*. 2011;168(7):689–701.

37. Lam RW, Kennedy SH, Adams C, Bahji A, Beaulieu S, Bhat V, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) 2023 Update on Clinical Guidelines for Management of Major Depressive Disorder in Adults: Réseau canadien pour les traitements de l'humeur et de l'anxiété (CANMAT) 2023: Mise à jour des lignes directrices cliniques pour la prise en charge du trouble dépressif majeur chez les adultes. *The Canadian Journal of Psychiatry.* 2024;69(9):641–687.

38. Huynh NN, McIntyre RS. What are the implications of the STAR* D trial for primary care? A review and synthesis. Primary care companion to the *Journal of clinical psychiatry.* 2008;10(2):91.

39. Zhou X, Ravindran AV, Qin B, Del Giovane C, Li Q, Bauer M, *et al.* Comparative efficacy, acceptability, and tolerability of augmentation agents in treatment-resistant depression: systematic review and network meta-analysis. *The Journal of clinical psychiatry.* 2015;76(4):3423.

40. Spielmans GI, Berman MI, Linardatos E, Rosenlicht NZ, Perry A, Tsai AC. Adjunctive atypical antipsychotic treatment for major depressive disorder: a meta-analysis of depression, quality of life, and safety outcomes. *Focus.* 2016;14(2):244–265.

41. Gerhard T, Stroup TS, Correll CU, Setoguchi S, Strom BL, Huang C, *et al.* Mortality risk of antipsychotic augmentation for adult depression. *PLoS One.* 2020;15(9):e0239206.

42. Riesenberg R, Yeung PP, Rekeda L, Sachs GS, Kerolous M, Fava M. Cariprazine for the Adjunctive Treatment of Major Depressive Disorder in Patients With Inadequate Response to Antidepressant Therapy: Results of a Randomized, Double-Blind, Placebo-Controlled Study. *J Clin Psychiatry.* 2023;84(5).

43. Taylor DM, Barnes TR, Young AH. The Maudsley prescribing guidelines in psychiatry: John Wiley & Sons; 2025.

44. Cipriani A, Hawton K, Stockton S, Geddes JR. Lithium in the prevention of suicide in mood disorders: updated systematic review and meta-analysis. *BMJ.* 2013;346.

45. Cleare AJ, Kerr-Gaffney J, Goldsmith K, *et al.* Clinical and cost-effectiveness of lithium versus quetiapine augmentation for treatment-resistant depression: a pragmatic, open-label, parallel-group, randomised controlled superiority trial in the UK. *The Lancet Psychiatry.* 2025;12(4):276-288. doi:10.1016/S2215-0366(25)00028-8

46. Chokhawala K LS, Saadabadi A. Lithium. 2025 [cited 2025 Aug 11]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing. Updated 2024 Jan 14. [cited 2025 Aug 11]. Available from: https://www.ncbi.nlm.nih.gov/books/NBK519062/.

47. Bauer M, Whybrow P. Role of thyroid hormone therapy in depressive disorders. *Journal of endocrinological investigation.* 2021;44(11):2341–2347.

48. Lorentzen R, Kjaer JN, Østergaard SD, Madsen MM. Thyroid hormone treatment in the management of treatment-resistant unipolar depression: a systematic review and meta-analysis. *Acta Psychiatrica Scandinavica*. 2020;141(4):316–326.

49. Milev RV, Giacobbe P, Kennedy SH, Blier P, Blumberger DM, Daskalakis ZJ, *et al.* Canadian Network for Mood and Anxiety Treatments (CANMAT) 2023 Clinical Guidelines for the Management of Adults with Major Depressive Disorder. *Can J Psychiatry*. 2023;68(5):328-341. doi:10.1177/07067437231161526.

50. Sanacora G, Heimer H, Hartman D, Mathew SJ, Frye MA, Nemeroff CB, *et al.* Consensus Statement on the Use of Ketamine in the Treatment of Mood Disorders. *JAMA Psychiatry.* 2017;74(4):399-405. doi:10.1001/jamapsychiatry.2017.0080.

51. National Institute for Health and Care Excellence (NICE). Esketamine for treatment-resistant depression [TA854]. London (UK): NICE; 2022. Available from: https://www.nice.org.uk/guidance/ta854

52. Papakostas GI, Dome P, Dold M, Kasper S, Montgomery SA, Moeller HJ, *et al.* European Psychiatric Association Guidance on the Use of Ketamine in the Treatment of Mood Disorders. *Eur Arch Psychiatry Clin Neurosci.* 2021;271(8):1667-1677. doi:10.1007/s00406-021-01313-5.

53. Anderson DJ, Zhou J, Cao D, McDonald M, Guenther

M, Hasoon J, et al. Ketamine-Induced Cystitis: A Comprehensive Review of the Urologic Effects of This Psychoactive Drug. *Health Psychol Res*. 2022;10(3):38247

54. Haikazian S, McIntyre RS, Meshkat S, Kratiuk K, Llach C-D, Orsini DK, *et al.* Real World Effectiveness of Maintenance Ketamine Infusions for Treatment-Resistant Depression in Major Depressive Disorder and Bipolar Disorder. *Psychiatry Research.* 2025:116691.

55. Papadimitropoulou K, Vossen C, Karabis A, Donatti C, Kubitz N. Comparative efficacy and tolerability of pharmacological and somatic interventions in adult patients with treatment-resistant depression: a Bayesian network meta-analysis. *BMC Psychiatry.* 2017;17(1):1–14. doi:10.1186/s12888-017-1314-9

56. Liu B, Zhang Y, Zhang L, Li L. Repetitive transcranial magnetic stimulation as an augmentative strategy for treatment-resistant depression: a meta-analysis of randomized, double-blind and sham-controlled studies. *BMC Psychiatry.* 2014;14:342.

57. Cole EJ, Stimpson KH, Bentzley BS, Gulser M, Cherian K, Tischler C, *et al.* Stanford Accelerated Intelligent Neuromodulation Therapy for Treatment-Resistant Depression. *Am J Psychiatry.* 2020;177(8):716–726.

58. Park MJ, Kim H, Kim EJ, Yook V, Chung IW, Lee SM, *et al.* Recent Updates on Electro-Convulsive Therapy in Patients with Depression. *Psychiatry Investig.* 2021;18(1):1–10.

59. Mutz J, Vipulananthan V, Carter B, Hurlemann R, Fu CHY, Young AH. Comparative efficacy and acceptability of non-surgical brain stimulation for depression: a systematic review and network meta-analysis. *BMJ.* 2019;364:l1079.

60. Köhler-Forsberg O, Lydholm CN, Hjorthøj C, et al. Efficacy of anti-inflammatory treatment on major depressive disorder or depressive symptoms: meta-analysis of clinical trials. *Acta Psychiatr Scand.* 2019;139(5):404-419.

61. Goodwin GM, Aaronson ST, Alvarez O, *et al.* Single-Dose Psilocybin for a Treatment-Resistant Episode of Major Depression. *N Engl J Med*. 2022;387(18):1637-1648.

62. Browning M, Cowen PJ, Galal U, *et al.* Pramipexole augmentation for the acute phase of treatment-resistant unipolar depression: a placebo-controlled, double-blind, randomized trial in the UK. *Lancet Psychiatry.* 2025;8(5):579-589. doi:10.1016/S2215-0366(25)00194-4.

63. Patkar AA, *et al.* Extended-release methylphenidate augmentation in TRD: randomized, double-blind, placebo-controlled trial. *J Clin Psychopharmacol.* 2006;26(6):653-656.

64) Lam RW, Kennedy SH, Adams C, Bahji A, Beaulieu S, Bhat V, *et al.* Canadian Network for Mood and Anxiety Treatments (CANMAT) 2023 Update on Clinical Guidelines for Management of Major Depressive Disorder in Adults: Réseau canadien pour les traitements de l'humeur et de l'anxiété (CANMAT) 2023 : Mise à jour des lignes directrices cliniques pour la prise en charge du trouble dépressif majeur chez les adultes. *Can J Psychiatry.* 2024;69(9):641–687.

65. Goh KK, Chen C-H, Chiu Y-H, Lu M-L. Lamotrigine augmentation in treatment-resistant unipolar depression: a comprehensive meta-analysis of efficacy and safety. *J Psychopharmacol.* 2019;33(6):700-713



# ASTRONOMY AND AWE: PERSONAL REFLECTIONS, AND AN OVERVIEW

**Marc Roffey**

*A presentation at the 'Event Horizon' star-party, Leeuwenboschfontein, Western Cape, South Africa, 17 January 2026.*



*Marc Roffey*

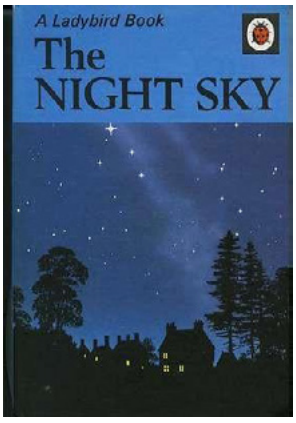
## INTRODUCTION

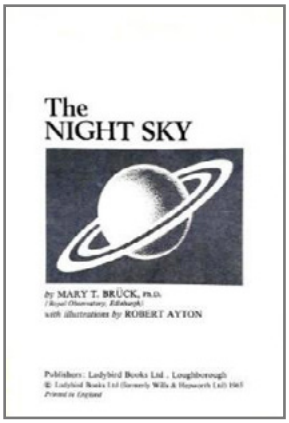
The study of astronomy, and the activity of stargazing, provide direct access to experiencing awe, a topic which is rapidly gaining momentum in the worlds of psychology, psychiatry, and neuroscience.

Before we get into this, a little bit about my background, and my interest in this topic.

Although I am a psychiatrist by profession, I have had a deep and life-long interest in astronomy. When I was five years old my parents gave me a wonderful little book, the 'Ladybird Book of The Night Sky', which was published in 1965 (and which I still have). I can clearly recollect the feelings which the illustations elicited, and still do to this day. They include enchantment, and an evocation of beauty, mystery, and vastness – and at the same time an uncanny and comforting sense of familiarity, a recognition that the stars above us are no less a part of the world than is the ground beneath our feet. Although the illustrations are hand-drawn and quaint, and are from a bygone era, they remain powerfully evocative. It has taken numerous decades for me to finally label these feelings, as described above, as being quite simply ones of *awe*.

Here is the cover and title page of the book, with a sample of illustrations from it which moved me in mysterious ways in early childhood (the Orion Nebula, Jupiter, and Saturn).










For much of my early life I was set on becoming a professional astronomer, but the stars had something different in store for me, and so I duly embarked on a career in medicine, specialising in psychiatry, and then sub-specialising in forensic psychiatry. Still, my intention is to revisit astronomy in a different kind of professional capacity, through studying its potential to provide mental health benefits.

I spent many years employed as a 'joint appointee' psychiatrist by the Western Cape Deparment of Health and UCT (University of Cape Town), and worked in this capacity at Valkenberg Hospital, which is the specialist teaching psychiatric hospital affiliated to the University's Faculty of Health Sciences.

In 2012 I gave a lecture on astronomy at Valkenberg Hospital, which is immediately adjacent to the SAAO (South African Astronomical Observatory). Both are situated on a tract of land in a southern district of Cape Town (aptly named 'Observatory') which affords spectacular views of the Devil's Peak mountain. The Observatory and Hospital were each established in the 1800s, and both are South African National Heritage Sites.

This excerpt from the SAAO website demonstrates the historic and scientific significance of the Observatory:

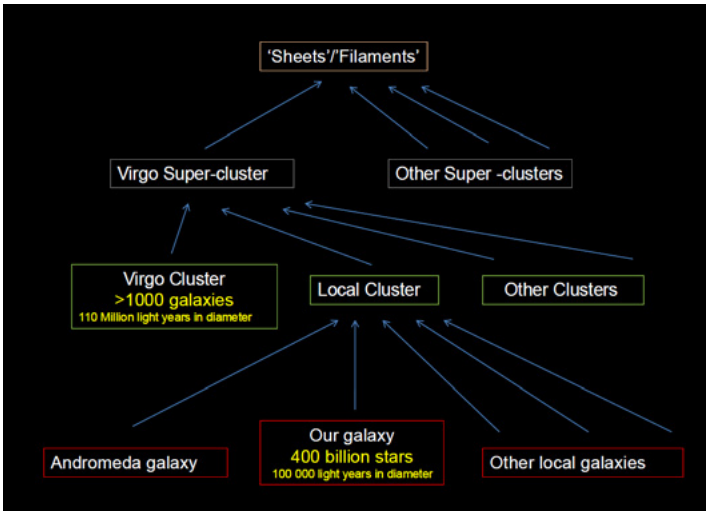
*"The South African Astronomical Observatory in Cape Town has played a highly significant scientific role over time as the oldest permanent observatory in the Southern Hemisphere. The site offers an overview of the history of astronomy both locally and internationally. It is a "living site" with almost 200 years of history while still retaining its prominence in the international astronomical community.*

*Contributions to astronomy from the site range from some of the first accurate measurements of the distance to a star (Alpha Centauri), first catalogues of the principal southern*

*stars, the first photographic survey of the sky, accurate measurements of the distance to the Sun (a value that became the benchmark to measure all other cosmic distance and represented a paradigm shift in astronomy), development of spectroscopy, remeasurement of Lacaille's Arc of Meridian, establishment of the true shape of the Earth in the Southern hemisphere and the first accurate geodetic surveys of southern Africa."*

The idea for the talk developed from the realisation that it was ironic that these two historic and neighbouring institutions had no professional or other affiliation with each other in any way, and yet one was concerned with exploring 'outer space' and the other (metaphorically at least) with exploring the 'inner space' of the mind and psyche. The talk was duly titled 'Exploring Inner and Outer Space: Two Disciplines Converge'. 2012 was also the year in which competition between South Africa and Australia was intensifying as to which of the two countries would be the prime site of the proposed SKA (Square Kilometer Array) telescope, one of the most ambitious scientific and engineering projects ever undertaken. I was surprised that many of my colleagues at the hospital were unaware of this project, and one of the main aims of the lecture was to raise awareness of this.

In addition to providing information about this, which included showing a promotional video of the SKA project, the lecture provided information about basic astronomy concepts, the concept of multi-wavelength astronomy, and the structure and scale of the universe. Aspects of the latter are illustrated in the following slide from the talk (which in retrospect was my first astronomy outreach endeavour).




Other subjects which linked astronomy with the life sciences were introduced, including astrobiology, and theories and ideas relating to perception and consciousness. The talk was well received and variations of it were given over the next two years, including to project engineers at the SKA head office (which at the time was situated very nearby to the hospital) and at several mental health forums.

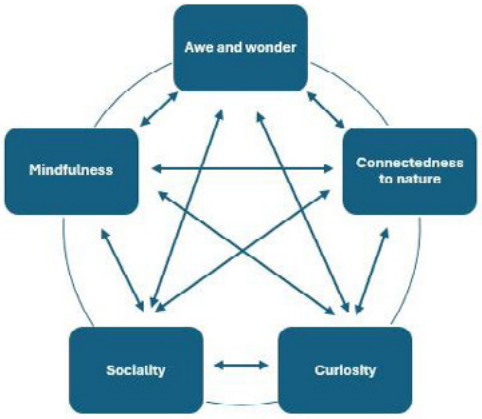
Fast forward to early 2025, when I gave a talk at an Event Horizon star-party[1] gathering of amateur astronomers called 'Merging Inner and Outer Space – an Event Horizon'. My focus was now moving from *exploring* the relationship between the stars and the mind, towards *merging* these themes. I had by this time attended several star-parties, and was struck by the commitment shown by amateur astronomers and astrophotographers – who often stay up all night, sometimes in bitterly cold winter conditions - to observe and image the stars. Professionally, I had by this time also furthered a longstanding interest in mindfulness, and had recently completed a two-year certificate training in mindfulness-based interventions through IMISA (Institute for Mindfulness South Africa) and the University of Stellenbosch.

I started to think about the motivating factors behind this committed engagement, and the benefits which stargazers clearly derive from their hobby. I became increasingly curious about this, realising that the early outreach ideas were starting to reveal subject matter which could be academically studied. Two articles arose from this talk: 'Stargazing and the Mind: Amateur Astronomy and Mental Wellness', published in South African Psychiatry (Issue 43, 2025)[2], and 'Proposed Psychosocial Benefits of Amateur Astronomy, and Implications for Astronomy Teaching and Outreach – a South African Perspective' (currently under review for publication in the Astronomy Education Journal).

There will be numerous exciting opportunities to further my interest in this field in the coming year. These include delivering scheduled podcasts, talks, and articles which focus on the phenomenology and neuroscience of awe, and on mindfulness-informed stargazing, and a proposed pilot study which explores aspects of mental health in amateur astronomers.

## THE PSYCHOSOCIAL BENEFITS OF STARGAZING

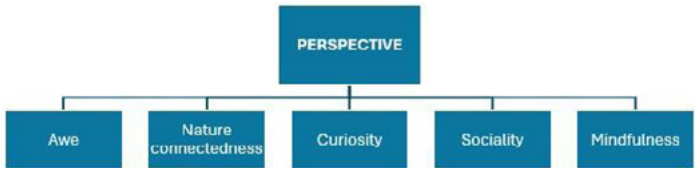
In my talks and writings on this subject I have formulated five psychosocial benefits of stargazing. This is based on a literature review of this subject, and from thinking about what motivates experienced stargazers to pursue amateur astronomy with enthusiasm and commitment.




They include the following, shown schematically in the graphic above: experiencing awe and mindfulness, fostering social connectedness, stimulating curiosity and exercising cognition (and the sense of fulfilment and mastery which arises from this) and deepening a connection to nature. For good reasons 'awe and wonder', which will be the subject of this talk, appear at the apex of this 'benefits star'. All of these benefits interact with and reinforce each other, as shown by the connecting arrows, and this will be revisited later in the presentation.

[1] *'Star-parties' are immersive stargazing experiences, arranged by serious amateur astronomers, which usually last for at least several days.*
[2] *(PDF) Stargazing and the Mind: Amateur Astronomy and Mental Wellness - South African Psychiatry (Issue 43, 2025).*

These benefits may all contribute towards a changed personal worldview, or perspective, and this in itself may be considered another benefit which stargazing provides.

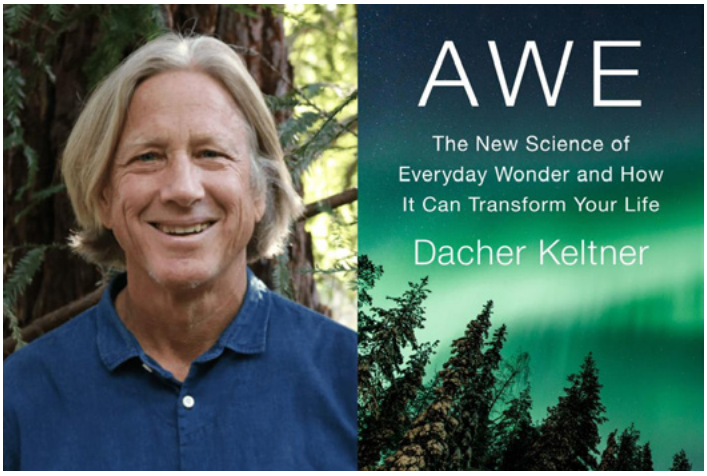



## AWE AND WONDER

### AWE

- There is rapidly growing interest in this topic in the world of psychology
- Emerging literature strongly suggests that experiencing awe is good for us!
- Dacher Keltner, a psychologist in the USA, has been pioneering research in this field over the last few decades.

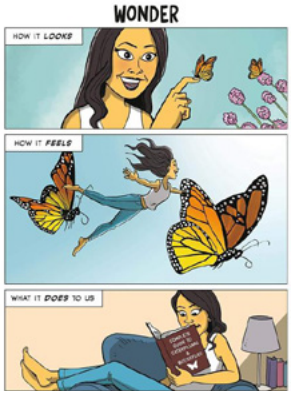
Dacher Keltner (PhD, University of California, Berkeley) has written a book on awe, which is highly recommended reading for anyone interested in this topic; much of the following discussion derives from it, and from academic articles he has published on awe.




What is awe exactly? Here is a definition, provided by the Merriam Webster online dictionary:

*'An emotion variously combining dread, veneration, and wonder that is inspired by overwhelming greatness (as in beauty, power, or size).'*




Wonder is a closely related emotion to awe, but conveys an additional sense of curiosity, and a desire to learn. The difference between them is beautifully illustrated in these graphics which appear in Brené Brown's book 'Atlas of the Heart'. Both have an expansive and 'in the moment' quality.

Retuning to awe, Jennifer Stellar (PhD, University of Toronto) describes awe as "an emotion that we feel in response to something or someone that is extraordinary and challenges the way you think about the world."

This brings us a little closer to the essential and defining features of awe:

### AWE - Psychological Aspects

- Awe is the feeling of being in the presence of something vast that transcends your current understanding of the world.
- Characterised by *vastness, mystery,* and the *dissolving of boundaries between the self and others.*
- Vastness may be *physical, perceptual, semantic or psychological.*
- The accommodation and integration of a diminished sense of self into a wider picture of the outside world.

Keltner and his colleagues, after conducting research which involved many thousands of people from different countries and cultures across the globe, identified eight categories of awe. Reflecting on them readily reveals examples of each.

## AWE - TYPES

- Moral awe/beauty (other people's courage, kindness, strength, or overcoming)
- 'Collective effervescence' (weddings, christenings, graduations, sports celebrations, funerals, political rallies etc.)
- Nature
- Musical awe
- Visual design (visual and fine arts, architecture, geometry etc.)
- Spiritual and religious awe
- Life and death
- Epiphanies (philosophical insights, scientific discoveries, metaphysical ideas, personal realistations).

## ASTRONOMY AND AWE

The experience of awe in astronomy can be accommodated into six of the above categories, and will be discussed below.

Experiencing awe in astronomy:

- Collective effervescence
- Nature
- Visual design

- Spiritual and religious awe
- Life and death
- Epiphanies

There is an inherent reward in finding and viewing celestial objects, and perhaps imaging them too - doing so with fellow enthusiasts is very often accompanied by feelings of accomplishment, excitement, amazement, and immediately wanting to share the discovery with them. In short, every amateur astronomer has experienced the joy and delight which accompanies sightings, discoveries and learnings made during stargazing events, and the need for this to be shared with others! This then is the 'collective effervescence' of stargazing.

Regarding the 'nature' dimension of awe, stargazing activities often take place in nature-rich settings; in addition it is very relevant that the cosmos itself, which is the primary object of study and observation by stargazers, can be viewed as an extension of our own natural world.

Taking 'design' out of 'visual design' (so as not to suggest or imply that the universe has in any way been 'designed' – although some stargazers may of course believe this) does not in any way detract from the purely visual awe which stargazing provides. The visual impact of seeing the night sky in a relatively light unpolluted setting, and with fully dark-adapted eyes, is a stunning sight which simply cannot be experienced in cities. In South Africa we are fortunate to have large swathes of relatively unpolluted night skies, and as Southern Hemisphere inhabitants we are privileged to be able to see the bright centre of our own Milky Way galaxy (something our northern neighbours cannot do from their own territories).

For city-dwellers who are not able to get out into the countryside there is however a compromise, which is to view sky objects through a large telescope. In Cape Town the SAAO offers regular viewings which are open to the public – such events are awe-inspiring not only because of the celestial riches which can be observed in the southern sky, but also as the McClean telescope (with an eighteen inch diameter lens) and its surrounding dome are magnificent in their own right. They were constructed in the late 1800s, and the hydraulically-operated floor of the dome rises so that viewers can be elevated to the level of the telescope's eyepiece.

Over and above the purely visual awe that is afforded by seeing the stars spanned across the dome of the night sky, is the remarkable realisation that they cannot otherwise be perceived (with the exception of feeling the heat of the sun). Contrast this with a walk in nature, where objects can be seen, touched, heard, smelled, and even tasted. This makes our extraordinarily detailed knowledge of sky objects all the more astounding, and brings a numinous quality to astronomy as a science, and to stargazing as an activity.

The technologies and instruments developed to investigate the cosmos are no less deserving of our awe than the objects which they study (everyone will have their favourite, whether it is the Vera Rubin Observatory in Chile, or the James Webb Space Telescope, poised in a point in space which is stable relative to the Earth, 1.5 million kilometres away from it). When I visited the SKA site in 2025, I was equally in awe of the sixty-four hi-tech dishes which appeared across the skyline as we approached them (and which through binoculars looked like a rebel base in a Star Wars movie) as I was by the fact that the antennas of the HERA (Hydrogen Epoch of Reionisation Array) telescope, which is part of the SKA complex, are made of wooden poles, PVC pipes, and chicken wire!

Spiritual/religious aspects of contemplating the universe, reflecting on life and death in a wider, cosmic context, and experiencing epiphanies can be collectively considered an *existential* awe which is frequently experienced by stargazers. Simply contemplating the 'big bang' birth of the universe - and therefore the birth itself of space and time - and the immense temporal and spatial scales required to measure and comprehend the universe, leads to this.

Some examples of this which have struck me over the years include the following. Amongst the very first *homo sapiens* who inhabited this planet were those who lived in the Karoo region of Southern Africa, including right here at Leeuwenboschfontein, and further north where the SKA telescope is situated. The realisation that the SKA will assist in constructing a scientific perspective of the dawning of our universe, whilst situated on land on which Indigenous inhabitants of Africa (and quite possibly the planet) lived and gazed up at the stars, is a profoundly poetic one.

They looked up at stars which, as science has revealed to us, born and die and have life cycles. It fills one with awe to view the Orion Nebula during the summer months through a telescope, and to realise that it is a 'stellar nursery' where millions of young stars are being born. This would not have surprised our ancestors, and local Indigenous cosmologies described an intimate and animistic relationship between the people and the environment in which sky objects were personified.

According to the |Xam people, who were likely the first inhabitants of the Karoo, the moon, sun, stars and Milky Way arose from events which occurred on Earth; these involved people, animals and things from the earth itself, including scented roots and their ashes. In this way the sky, far from being a remote and incomprehensible space, was an integral part of the landscape. From this perspective, the universe is a constant process of co-creation, in which all the Earth's inhabitants, human and non-human, share a common humanity. These Indigenous inhabitants intuited a startling fact which has been revealed to us by modern science – that we and star-matter are indivisible, due to elements essential to organic life on Earth being forged in the hearts of stars and then flung out across the cosmos by exploding supernovae.

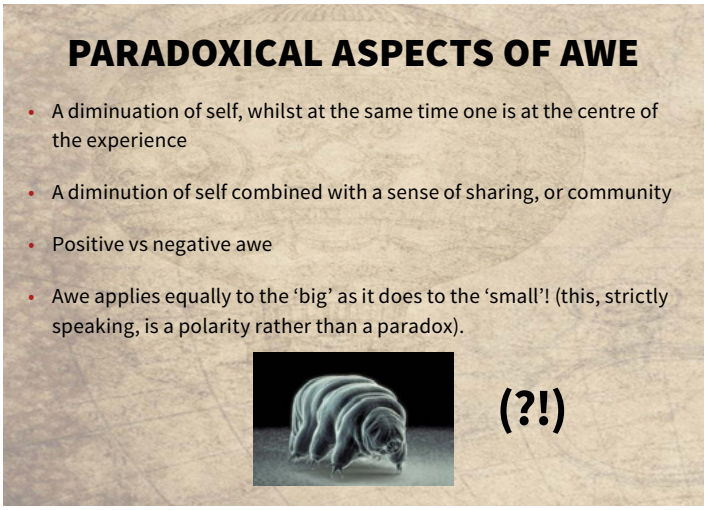
Even further north, the ancient Greeks and Romans mythologised the night sky in their own way - an enduring image for me at Leeuwenboschfontein (at the right time of the year) has been to view the magnificent constellations of Orion (the hunter) and Scorpius (the scorpion) rising and setting on opposite horizons (respectively the west and east). After Orion boasted that he could vanquish every beast on Earth, the Earth goddess Gaia created a scorpion to kill him (which it did with its powerful venom). Zeus immortalised the scorpion by placing it among the stars, but on the opposite side of the sky to Orion, in this way symbolising him fleeing his pursuer.

Every stargazer has their own favourite type of object that they enjoy 'hunting' in the night sky, including the moon and planets, star clusters, nebulae, double stars, and

even asteroids (and during the day, sunspots!). My own favourites are galaxies, even though they appear in amateur telescopes as just faint smudges of light. Whilst viewing them there is something spellbinding in the realisation that they very likely have billions of planets within them, and that they are probably teeming with life-forms that are unimaginable to us.

At the centre of each is a 'supermassive black hole', and black holes – supermassive and otherwise - are other celestial entities which inspire existential reflection (our own galaxy's supermassive black hole, at the centre of the Milky Way, lies very close to our now familiar scorpion, in the neighbouring constellation of Sagittarius). The fate of the light and information that they consume at their 'event horizons' remains a cosmological conundrum, leading to ideas that they may be space-time portals within the universe. A recent study detailing the rotational spin of observable galaxies has led to the even more extraordinary suggestion that the universe itself may exist inside a black hole.

In the near vicinity of black holes, events occur at relativistic speeds, and relativity itself is a theory which provides awe of the 'epiphany' kind – not only the theory itself, but its derivation by a towering genius in the world of science. For me, learning about basic relativity has provided the revelation that all my instinctive and intuitive ideas about time are completely wrong. Time does not 'flow', and cannot be understood outside of a four-dimensional space-time continuum – it is quite sobering for a mindfulness practitioner to realise that asking what is happening at the present moment, or 'now', on Alpha Centauri or the Andromeda galaxy is utterly meaningless! (but that is a conversation for 'another time').

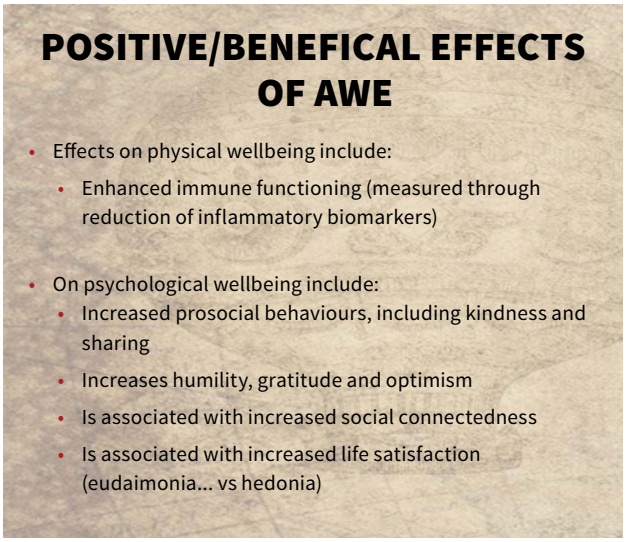



Some paradoxical aspects of awe can be noted, as shown in the slide above. 'Negative awe' deserves some comment, as this discussion has focused on positive and affirming aspects of awe. Outright terror can accompany awe - think of the fear inculcated by dictators, and military campaigns designed to induce 'shock and awe', or the fear experienced during natural disasters or when confronted by a dangerous animal in the wild (all are terrifying, but are nonetheless awe-inspiring).

Although astronomy is by its nature concerned with the very large, feelings of awe can just as easily accompany viewing or contemplating the small, tiny or microscopic. This may occur by simply looking at the tiny details contained in a plant or insect, or by viewing a drop of pond water through a microscope, or the structure of a cell with an electron microscope. The image in the above slide is of a tardigrade, viewed through an electron microscope. Tardigrades, commonly known as 'water-bears', are tiny aquatic invertebrates which are widespread across the planet and are extremely resilient to severely adverse conditions.[3]

### THE BENEFITS OF EXPERIENCING AWE

As discussed above, there are compelling reasons to suggest that in various ways stargazing provides an immediate gateway into the experience of awe. Whilst this in itself is valuable (as experiencing positive awe is enjoyable), awe can have physical and psychological effects that go beyond being in a 'good' but momentary emotional feeling state. As such, it is beneficial to recognise the emotion of positive awe, and to cultivate the experience of it.




There is no clarity amongst researchers about what emotions are, with regard to conceptualising and understanding them, and numerous scientific models attempt to elucidate this. Not least of all, untangling and quantifying subjective experiences is difficult - and emotions, which have complex evolutionary origins, have physiological, brain-related, expressive, and behavioural elements.

Nevertheless, we have come a long way since psychologist Paul Ekman's pioneering studies done in the 1960s on the six emotions of fear, anger, sadness, happiness, disgust, and surprise. His work established that the facial expressions of these emotions are universally recognised across cultures, suggesting that they are innate rather than learned. Ingenious studies involving large population samples have since then established that there are likely at least twenty human emotions. Awe is amongst a set of about eight positive emotions which includes surprise, amusement, contentment, elation, love, relief, and triumph.

*[3] They have allegedly survived exposure to outer space - Trekkies will not need to be reminded that, somewhat absurdly, a giant tardigrade with space-navigating properties played an important role in the 'Star Trek: Discovery' series.*

In the wake of this more refined and advanced understanding of emotions, much work has suggested health-promoting effects which are specifically associated with awe. Five pathways have been proposed by Dacher Keltner and Maria Monroy (PhD, University of California, Berkeley), as facilitating these effects.

The first of these are physiological and neurophysiological effects of experiencing awe; these may include a reduction in sympathetic nervous system arousal (although there are mixed findings around this), an increase in secretion of oxytocin (a neurohormone implicated in social bonding), and enhanced immune functioning (measured in one study through reductions of inflammatory biomarkers). Because negative emotional states such as depression, anxiety, and social rejection have been associated with proinflammatory immune responses and cardiovascular disease, it is reasoned that awe may promote physical health.

The other proposed pathways are more compelling, and are derived from psychological benefits which have been studied in laboratory and field settings, and from narrative and diary accounts (they varyingly include people assessed as having dispositional awe, and those in whom awe has been induced). These pathways arise from awe facilitating i) a transformed sense of self, ii) enhanced prosocial behaviours (social behaviours which benefit others), iii) integration into strong social networks, and iv) an elevated sense of meaning-making, or sense of purpose, in life. The latter can include life satisfaction, as assessed in at least one awe study, and these ideas can be conveyed by the word *eudaimonia*, which suggests fulfilment and self-realisation (vs hedonia, which is a more pleasure and gratification-orientated approach to satisfaction in life).

The sense of self in awe is a good pathway to look at in a little more detail; the core feature of awe is integrating a diminished sense of self into a wider picture of the outside world, and this is clearly relevant in an astronomy context. This aspect of awe also relates to other psychological benefits associated with it (in a way that seems paradoxical, as noted before); for example, whilst associated with decreased self-salience (the importance of the self over others in social contexts), studies suggest that awe contributes to an increased sense of connectedness with others and the environment.

This in interesting, as conversely an increased or amplified focus on the self is often clinically evident across a wide range of dysfunctional mental states, including personality disorders, anxiety disorders, and depression (a 2025 study found that an awe intervention in people living with long COVID reduced depressive symptoms and increased wellbeing). Preoccupation with the self, or at least the somatic self, can also accompany physical illness.

Intriguingly, and corroborating the diminished-self hypothesis in awe, neuroimaging studies have demonstrated a reduction in activity in the DMN (default mode network) when awe is induced in subjects. The DMN is a distributed network of regions within the brain's 'connectome' of neurons and their synaptic connections which is activated during self-referential thinking. Studies suggest that selective DMN network activity is high in some mental illnesses, including those in which there is excessive rumination and obsessional thinking.

It is unclear how *much* awe is needed to experience, in an enduring way, the psychological benefits of it which have been outlined above. If experiencing awe in an immersive and prolonged manner (such as one might do at a star-party of a few nights duration) is viewed as an intervention, then it would be reasonable to postulate that doing so regularly might lead to some of these benefits being more pronounced. The well-established ability of the brain to change in response to new and repeated experiences, or neuroplasticity, might plausibly provide a mechanism for this.

A strategy to amplify the effects of awe in a stargazing context might be to consciously explore the other aspects of the 'benefits star', as they all interact with and reinforce awe (this will be discussed below). Another would be to seek and cultivate other experiences of awe. The numerous categories of awe outlined earlier could serve as a guide, and readily provide many opportunities for such exploration.

## CULTIVATING AWE

- 'Hunting' for awe is not helpful and is at risk of being contrived
- Recognising awe (through stargazing, for example!) and then being open/receptive to further experiences of it is a better approach
- Experiencing vastness, mystery, a temporary cessation of the 'chatter' of the mind, and an accompanying sense of expansiveness or 'spaciousness' (which may be felt somatically, cognitively, or emotionally) suggest that one has encountered awe.
- Can be experienced in day-to-day life, and during apparently mundane activites

'Awe-walks' have been studied by Virginia Sturm (PhD, University of California, San Francisco). Participants at star-parties can be encouraged to attend these during the day in the usually nature-rich settings in which they occur, or in other environments. These have been so extensively written about in numerous online popular psychology blogs and posts that they are at risk of being trivialised; this should not however detract from the fact that studies on them have yielded promising results. Guidelines for awe walks are shown below.

## AWE - WALKS

- Regular walks of short duration with no cell-phone distractions, preferably in novel settings where there may be a sense of vastness.
- This may be in either natural or urban settings.
- If finding novel settings is difficult, attention can be paid to finding new details in familiar settings. Vastness can be at a grand scale, and if this is not accessible, then looking close-up at the details and patterns of small objects (e.g. a leaf or flower) is an acceptable substitute.
- It is important that a child-like sense of wonder, as though experiencing the environment for the first time, is brought to the awe walk activity.

It is time to return to the 'benefits star' shown earlier

It is apparent, as we approach the end of this discussion, that awe and wonder relate directly to the other

psychosocial benefits. Moving clockwise around the circle, we experience awe in the presence of nature; wonder, and by extension awe, link with curiosity; awe is often experienced collectively, and promotes prosocial behaviours; awe has an immediate and 'in the moment' quality which it shares with mindfulness.

Each of the bidirectional arrows between these benefits, shown on the perimeter of the circle, and within it, indicate reinforcing relationships which are supported by findings from the scientific literature. As suggested earlier, a strategy to augment awe in amateur astronomy might be to consciously cultivate and harness the other benefits. There are good reasons to think that mindfulness is an especially good candidate in this respect, and this warrants further investigation and study.

## THE OVERVIEW EFFECT

- A sense of awe, and a transformed view of the planet and our place upon it.
- Suggests that awe is a **strong driver of changed perspective.**

May influence one's perspective on:

- Environmental awareness
- Climate change
- Geopolitical conflicts
- Personal problems



A clue that awe might play a very important role in how astronomy influences one's personal perspective, or worldview (which is an additional benefit of stargazing) is provided by the 'Overview Effect'. This is the profound and well-documented reaction experienced by astronauts who view the Earth from space. It is characterised by feelings of awe and transcendence, powerful and often overwhelming emotion, and a newfound sense of connection to the Earth and its inhabitants. Similar but less intense effects may arise from contemplating and viewing iconic views of the Earth from outer space.

To end again on a personal note, this year I am planning to conduct a pilot qualitative study which touches on some of the factors discussed in this presentation; it will explore their potential influence on the general wellbeing of local amateur astronomers. This, to the best of my knowledge, will be the first research of its kind in South Africa, and will contribute towards knowledge in the fields of mental health and astronomy in this country. There are many other areas of interest, and many questions, which warrant further study in the wider subject of astronomy and mental health, and over time I look forward to discussing and exploring these with yourselves and the wider Southern African astronomy community.

### TO CONCLUDE

- Astronomy, and the activity of stargazing, facilitate access to an emotional state which enhances physical and psychological wellbeing.
- Awe is a valuable asset in a world and time where there is much distress and turmoil.
- Cultivate it, and savour it whenever it appears in your lives!
- Thank you to the Leeuwenboschfontein astronomers for enabling us to regularly experience awe, through your commitment to amateur astronomy, and through the Observatory which you have established here.




*References and image credits available on request.*

*Last year the Leeuwenboschfontein (LBF) Observatory[4] received the ASSA (Astronomical Society of Southern Africa) Director's Award for promoting astronomy in the Western Cape. The Award was given, in August of 2025, "for conceptualising, constructing and diligently operating the Leeuwenboschfontein Observatory as a significant stimulus of Astronomy in the Western Cape".*

***Marc Roffey*** is a psychiatrist and certified mindfulness facilitator. He has had a deep, lifelong interest in astronomy, and is a member of the Cape Centre of ASSA (the Astronomical Society of South Africa). Article references are available on request. **Correspondence: marc.roffey@uct.ac.za**

[4] *https://www.leeuwenboschfontein.co.za/pages/lbf-astronomical-observatory/*

# Don't panic, life goes on






**Short-term symptomatic relief of anxiety**

**Treatment of anxiety disorders**

S5 Xipanz XR

*0,5 mg extended- release tablet*

ALPRAZOLAM

SAHPRA approved **XIPANZ XR** professional information. Date of publication: 14 September 2021.
S5 **XIPANZ XR 0,5 mg** (tablet). Reg. No.: 50/2.6/0094. Each tablet contains 0,5 mg alprazolam respectively.
Contains sugar: 255,68 mg lactose respectively.

**For full prescribing information refer to the professional information approved by the medicines regulatory authority.**

**HCR:** AUROGEN SOUTH AFRICA (PTY) LTD. Woodhill Office Park, Building No. 1, First Floor, 53 Phillip Engelbrecht Avenue, Meyersdal, Ext. 12, 1448, Johannesburg, South Africa. Tel: (011) 867 9100, Fax: (011) 867 9111. https://auro-space.com

ASA.26.06.1516

AUROGEN CNS

# CMSA COLLEGE COUNCIL ELECTION RESULTS

**Outcome of the Constituent College Council Elections for the 2026 – 2029 Triennium in the College of Psychiatrists**

Below, please find the list members who have been successfully elected to serve on the Constituent College of Psychiatrists Council for the 2026 – 2029 Triennium. The names are place in alphabetical order according to surnames.

Below, please find the list members who have been successfully elected to serve on the Constituent College of Psychiatrists Council for the 2026 – 2029 Triennium. The names are place in alphabetical order according to surnames.

- **Prof Nadira Khamker**
- **Prof Carla Kotzé**
- **Dr Paslius Sizwe Mazibuko**
- **Prof Lebogang Simon Phahladira**
- **Dr Gabariel Sephodi Sefala**
- **Dr Shwetha Suresh**
- **Dr Mvuyiso Talatala**
- **Dr Lindokuhle Thela**
- **Dr Rita Gillian Marie Thom**
- **Assoc. Prof Leigh Luella van den Heuvel**

*NB: The Elections Council resolved to increase the composition to 10 members due to a tie in votes for 9th position*

**OUTCOME OF ELECTION FOR THE POSITION OF PRESIDENT OF THE COLLEGE OF PSYCHIATRISTS**

Following the conclusion of the first phase of the College Council Election Process, **Prof Lebogang Simon Phahladira** has been elected as your College President for the 2026 - 2029 Triennium.

# VEDANTA WELLNESS RETREAT

**23 - 25 October 2026 - Farmhouse 58, Muldersdrift**

Step away from the noise of the modern world. Return to the ancient, pristine, primeval source within the Self.

**FACILITATORS**

Craig Warren and Dr Sundeep Ruder, dedicated disciples of Swami A Parthasarathy, will guide you through this immersive experience.

**THE DAILY RHYTHM**

- Early Morning Rising & Chanting
- Yoga, Poetry & Music
- Lectures, Self-Study & Discussion
- Sattvik Vegetarian Meals

**BOOKING INFORMATION**

Places are limited — secure yours early. Various room types available across Stable & Dairy wings. All rates are fully all-inclusive. Book directly through Farmhouse 58

Website
stay@farmhouse58.co
Reservations: +27 87 147 3558 (Mon–Fri 8am–5pm, Sat 8am–12pm)
Front Desk: +27 87 092 9097

S6

# RuTrex Methadone hydrochloride 10 mg/ml

| Dose Required | RuTrex Strength | Comparator Strength |
|---|---|---|
| | **10 mg / ml** | 2 mg / ml |
| 20 mg | **2 ml** | 10 ml |
| 30 mg | **3 ml** | 15 ml |
| 40 mg | **4 ml** | 20 ml |
| 50mg | **5 ml** | 25 ml |
| 60 mg | **6 ml** | 30 ml |
| 70 mg | **7 ml** | 35 ml |
| 80 mg | **8 ml** | 40 ml |




## HIGH DOSE METHADONE

## CONVENIENT & CONSISTENT

Pleasant Cherry Flavour

**Arya Pharma (PTY) Ltd.** Reg. No.: 2015/413329/07. Corner Barbara and North Reef Road, Elandsfontein, Germiston, 1601. Tel.: 010 060 0741. Email: admin@aryapharma.co.za
Website: www.aryapharma.co.za

Arya

## EXPANDING ACCESS. GIVING HOPE.




## DISCOUNTED REGISTRATION FOR 65+ OR RETIRED DELEGATES

**Retired delegates and delegates aged 65 years and older can now take advantage of specially discounted registration fees.**

Join us in Cape Town, South Africa, as the International Marcé Society for Perinatal Mental Health meets on the African continent for the first time. Explore an exciting scientific programme featuring keynote lectures, plenary sessions, symposia, and opportunities to connect with colleagues from around the world.

**REGISTER ONLINE**

**VIEW REGISTRATION FEES**

**VIEW THE PRELIMENARY PROGRAMME**




**Join us at MARCE Conference 2026 for a special screening of this award-winning documentary, sparking important conversations on women's health, justice, and the societal forces that shape maternal experiences.**

30 years ago, Gail Ritchey, a young woman from a conservative Christian community in rural Ohio, gave birth alone and left her newborn in the woods. Now a mother of three, her quiet suburban life is shattered when DNA evidence links her to "Geauga's Child," and she is arrested for murder – despite saying the baby was stillborn. Facing a life sentence, Gail leans on her family for support as she confronts the weight of societal and religious pressures. Directed by Jessica Earnshaw (Jacinta), BABY DOE cuts through the headlines to uncover the human complexity of Gail's case – examining the intersection of women's health, justice, and the outside forces that continue to shape stories like hers.

**LEARN MORE AND BOOK ONLINE**




**Tygerberg Hospital is a major tertiary academic hospital in Cape Town and the second largest hospital in South Africa, serving over 3.6 million people across the Western Cape.**

The Women's Mental Health Clinic, established in 2017, provides specialised perinatal and women's mental health care. The clinic runs weekly and is supported by a transdisciplinary team offering consultation-liaison psychiatry, psychology, nursing, and allied health input.

Services include care during pregnancy and the post-partum period, as well as mental health support related to reproductive and hormonal health.

A weekly mother-baby group is also facilitated to support bonding and early mental wellbeing.

**LEARN MORE AND BOOK ONLINE**

20 26

Thursday 26 November - Sunday 29 November 2026

# Biological Psychiatry Congress

Century City Conference Centre, Cape Town

*Bridging Brain, Behaviour & Beyond*

www.biopsychsa.co.za

In collaboration with

INTERNATIONAL NEUROPSYCHIATRIC ASSOCIATION

Supported by

SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

**Congress Organisers: Londocor Event Management**

***Sonja du Plessis***
+27 82 455 7853 | sonja@londocor.co.za

***Elize Kloosterzie***l
+27 (0)76 979 9379 | elize@lo

***Natalie Kreusch***
+27 84 500 0784| natalie@londocor.co.za

***Kim Raats***
**Registration Manager**
+27 (0)84 551 1411 | kim@londocor.co.za



# DEPARTMENTS OF PSYCHIATRY

University of The Witwatersrand

## Tara Run and World Move for Health Day

**Compiled by Dr Belinda Marais – Consultant Psychiatrist, Tara Hospital. Correspondence: Belinda.Marais@wits.ac.za**




On Friday the 8th of May 2026, Tara Hospital patients and staff celebrated the World Move for Health Day to promote the importance of physical as well as mental well-being. The event was organised by a small committee including Mrs Maureen Motaung, the hospital's Employee Health & Wellness Coordinator, and led by Dr Belinda Marais, one of Tara's psychiatrists, who is also an executive member of the Sports and Exercise Psychiatry Subgroup (SEPSIG) South African Society of Psychiatrists (SASOP). The day started with a 2km fun run/walk for patients and staff around the hospital grounds.

Ultrarunner Donovan Shirley, who was preparing to run an ultra-marathon in June as part of his "Get Back Up" mental health awareness campaign, also joined for the Tara Run to motivate staff and patients. Prizes were awarded to the top 3 winning female and male patients. The run was followed by more fun outdoor physical activities for the hospital staff members. An aerobics session was conducted by a representative from Virgin Active. Health screening by the Government Employees Medical Scheme (GEMS) was on offer for staff, who were also pampered with head, neck and shoulder massages.

Various other stakeholders joined for the day, including the South African Depression and Anxiety Group (SADAG) and Lace Up for Mental Health. Refreshments were generously sponsored by Randburg Fruit and Veggies, as well as the Occupational Therapy Department that provided additional snacks that had been prepared by some of the patients. Over 100 people participated in this event, all "moving" towards better health!



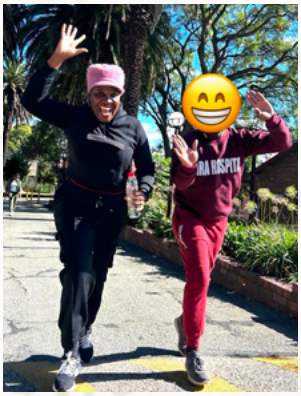

*Misha Marais (Lace Up for Mental Health), Amos Choeu (Tara Stores Dept.), Maureen Motaung (Tara employee health and wellness coordinator)*



*Lungelwa Mogase, Shanna Miller, Wesley Pereira (Psychology interns), Dr Craig Bracken (Psychiatrist)*




*Donavan Shirley (Pirates running club – Ultra-marathon runner), Shreya Pillay (SADAG), Dr Belinda Marais (Psychiatrist)*



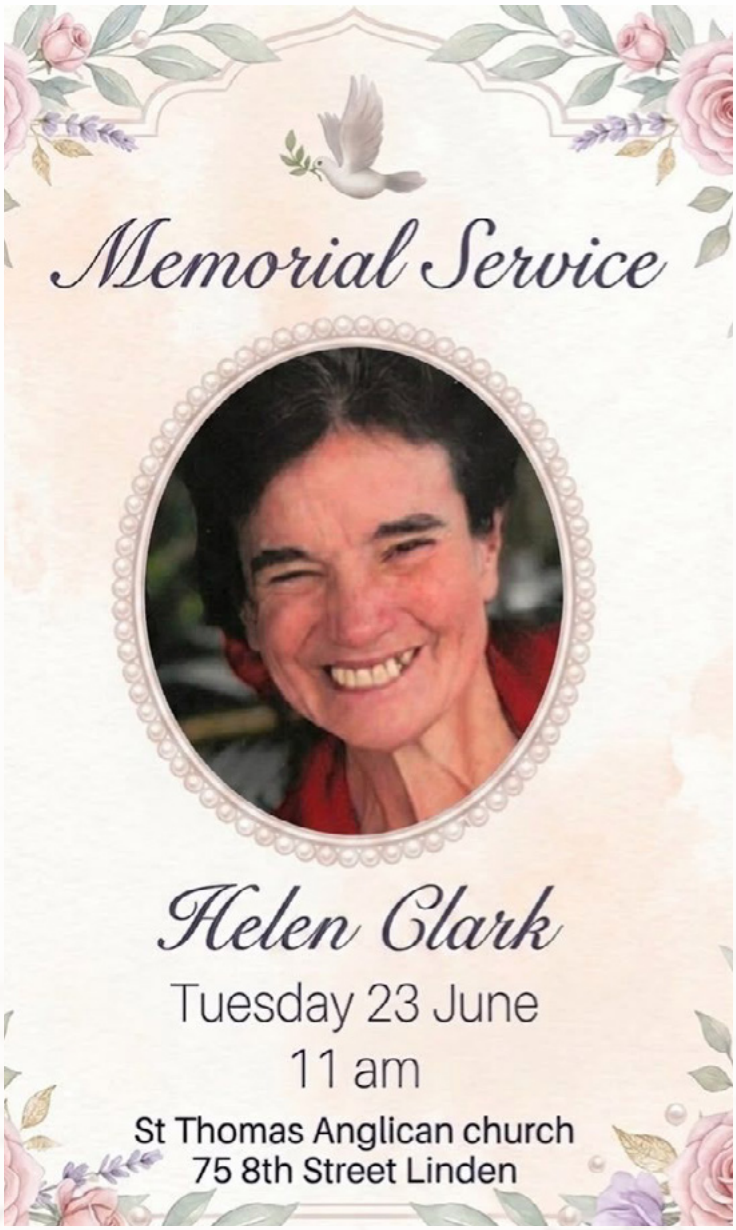
*Susan Rachoene (Stores Dept.); patient (incognito)*

# HELEN CLARK

## 28 June 1963 – 10 June 2026

**Dr Wendy Friedlander, Consultant Psychiatrist – Department of Psychiatry, Chris Hani Baragwanath Academic Hospital. Correspondence: Wendy.Friedlander@wits.ac.za**

Helen Clark, a devoted child psychiatrist whose passion and commitment inspired countless individuals, passed away on 10 June leaving behind a legacy of empathy and dedication.




After graduating from Wits university medical school in 1986, she embarked on registrar training in the department of psychiatry at Wits and obtained her fellowship from the College of Psychiatrists in 1996. She qualified as a child psychiatrist in 2000. She devoted her entire working life to the child and adolescent unit at Chris Hani Baragwanath Academic Hospital, spending 28 years at the helm. During her tenure, the services offered by the child and adolescent unit expanded significantly. From being an entirely outpatient service, the first dedicated adolescent beds were established followed by a bespoke ward for children under 14 years old funded by the Kirsty Watts Foundation. The unit also provided an active consultation-liaison service to all paediatric departments in the hospital.

Helen targeted her service to those overlooked by the system. She established the first specialist psychiatry clinic devoted to children under six years old at Chris Hani Baragwanath and actively ran an outreach project targeting children with special needs at Eureka school. In addition to providing specialist level care to marginalised children, these programs were valuable learning opportunities for fellowship candidates and sources of academic research material. Her willingness to assist all children in need resulted in telephonic and in-person assessments and help for children from further afield and included those in children's homes or places of safety. There was never a time when Dr Clark could not be counted on to give advice and help even when she was not on duty.

She is known by so many health care workers as an active, engaging and tireless educator. Teaching was her passion and her enthusiasm for imparting knowledge and her obvious love of the material resulted in students developing interest and understanding. In the medical sphere, being a role model is an important component of developing professionalism, the joy she took from her subject matter and her unparalleled devotion to child psychiatry made a lasting impression on medical students, psychiatry registrars and child psychiatry fellows as well as intern psychologists, neurodevelopmental occupational therapists and nurses.

Helen was a caring and kind colleague who really enjoyed being part of the team. No permanent staff member left child psych without a farewell party with an appropriately chosen piece of music playing, a giant teddy bear to hug and a plate of cheese scones. At Easter and Christmas, she made sure that not only the patients attending clinic left with an easter egg or a big bag of treats, but her colleagues received chocolate too. She was interested in the lives of those around her and their families, she shared her love of music and celebrated the achievements of others.

Helen Clark's commitment to helping children navigate their pathology and her academic engagement touched the lives of so many individuals in a multitude of different ways. She has left the discipline of child psychiatry enriched by not only her academic input and commitment to training but also as a role model. As mental health care practitioners, following her example will enrich the discipline immeasurably.

# WITS FORENSIC PSYCHIATRY SEMINAR 2026

**CPD Accredited : 3 Ethics Points**

# MERCY OR MURDER?

## Clinical concerns, ethical issues, and legal aspects of euthanasia

Wits Faculty of Health Sciences
Department of Psychiatry

## PROGRAMME

| | |
|---|---|
| 9h00 - 9h30 | **Registration and Welcome** |
| 9h30 - 10h30 | **Right to Life vs. Right to Die: A Historical Tug-of-War**<br>*Dr MA Tau* |
| 10h30 - 11h30 | **International Perspectives on Assisted Dying**<br>*Dr TP Tlolane* |
| 11h30 - 12h30 | **The Right to Die: A South African Perspective**<br>*Dr M Mahlakametsa* |
| 12h30 - 13h30 | **Closure and Lunch** |

**Friday, 12 June 2026**
**9h30 - 12h30**
*Microsoft Teams link will be made available on the day.*

**Netcare Akeso Randburg**
Cnr. President Fouche Drive and Hawken Ave, Boskruin, Randburg
*Extra parking is available at Boskruin Village Shopping Centre across the road.*

**FREE to Wits joint appointees**

**R 250** for SASOP members / **R 350** for non-members

Please indicate in-person vs virtual attendance.
Kindly include proof of payment, if applicable, with registration.

RSVP by 3 June 2026

**In proud partnership with**

NETCARE akeso
SUN PHARMA

**CLICK HERE TO REGISTER**

**Banking details: SASOP Southern Gauteng, First National Bank 54480048635**
Reference: Initial Surname FP26

# Speakers



## Dr Machipi Alice Tau

Dr Machipi Tau is a specialist psychiatrist at Sterkfontein Hospital, and currently a fellow in forensic psychiatry. She obtained a Bachelor of Medicine and Bachelor of Surgery (MBBCh) from the University of the Witwatersrand, where she also completed her Master of Medicine in Psychiatry (MMed Psychiatry). She further holds an FC Psych (SA), which is fellowship with the College of Psychiatrists of South Africa.

Focusing on the interface of between mental health and the legal system, her clinical interests include forensic mental health, medico-legal assessments, and the ethical dimensions of psychiatric practice. She values family time, and enjoys staying fit, reading, and travelling.



## Dr Thabo Patrick Tlolane

Dr Thabo Tlolane is a specialist psychiatrist at Sterkfontein Hospital, currently a fellow in forensic psychiatry. He obtained a Bachelor of Medicine and Bachelor of Surgery (MBChB) from the University of Cape Town. He completed his Master of Medicine in Psychiatry (MMed Psychiatry) with the University of the Witwatersrand. He additionally holds a fellowship, an FC Psych (SA), with the College of Psychiatrists of South Africa. His clinical interests include malingering and victim assessments.



## Dr Mpho Mahlakametsa

Dr Mpho Mahlakametsa is a specialist psychiatrist at Sterkfontein Psychiatric Hospital. He completed his medical and psychiatry training at the University of Cape Town. He is a fellow in forensic psychiatry at the University of the Witwatersrand and has a special interest in juvenile offenders.

# University of the Witwatersrand Department of Psychiatry's 37TH ANNUAL RESEARCH DAY

**Compiled by Dr Asakundwi Nevhutalu, Registrar, Department of Psychiatry. Correspondence: asakundwi.nevhutalu@wits.ac.za**

This year, the University of the Witwatersrand held its 37th Annual Research Day at the Killarney Country Club. The event, on 17th June 2026, was organised by a committee of registrars, supervised by Dr Belinda Marais and Dr Lisa Galvin. The event aimed to showcase the research being conducted by the Department and inspire further research. Prof Maswime, the Head of the School of Clinical Medicine, was also present. The keynote speech was given by Professor Lawrence Chauke, a clinician-scientist, medical educator, and academic in Obstetrics and Gynaecology with extensive expertise in maternal and perinatal health. Professor Chauke holds multiple degrees, including dual doctorates: a PhD in Obstetrics and Gynaecology from the University of the Free State and a PhD in Education Research from Lancaster University, an MPhil in Health Professions Education from Stellenbosch University, and an MSc in Clinical Research from the University of Liverpool. He is a Fellow of the Colleges of Medicine of South Africa in Obstetrics and Gynaecology (FCOG) and holds multiple specialist certifications. His research focuses on reducing maternal and perinatal morbidity and mortality in resource-limited settings, with emphasis on high-risk pregnancies, health systems strengthening, and implementation science. His work has advanced evidence in hypertensive disorders of pregnancy, HIV in pregnancy, maternal mental health, and quality of obstetric care. His presentation was inspiring and highlighted mental health as one of the contributors to maternal and perinatal outcomes.








In addition, eight registrars presented their MMed research, ranging in topics from forensic psychiatry and neuropsychiatry to maternal mental health and addiction psychiatry. Dr Tejil Morar presented her PHD titled "Barriers and facilitators to accessing mental healthcare in medical doctors."

Dr Muhammed Sheik won the best presentation for his research titled, "The prevalence of cannabis associated mania-like presentations in hospitalised psychiatric patients". His research was supervised by Dr N Nhiwatiwa and Dr M Talatala. The South African Society of Psychiatrists awarded him a sponsorship to attend the 2026 SASOP congress in Cape Town.

**The Research Day was sponsored by SASOP, Johnson & Johnson, Adcock Ingram, Aspen Pharmacare, Dr. Reddy's and Cherrymed.**




*Head of School of Clinical Medicine: Prof. Salome Maswime and Prof. Ugash Subramaney*



*Best presentation winner Dr Muhammed Sheik receiving the prize from Dr Mvuyiso Talatala and Prof. Ugash Subramaney*




*PhD speaker: Dr Tejil Morar*



*Prof. Ugash Subramaney, Dr Tejil Morar and the registrars who presented their MMed research.*



*Prof. Ugash Subramaney, Dr Tejil Morar and the registrars who presented their MMed research.*



*Prof. Ugash Subramaney, Dr Belinda Marais and Dr Lisa Galvin*

WITS DIVISION OF
PSYCHOLOGY

# ETHICS CONFERENCE 2026

## The Digital Third:

*Supervising the Ethical Management of AI Use in Clinical Contexts*

Exploring the ethical implications of AI in supervision, training, and clinical decision-making.

| DATE | VENUE | REGISTRATION | CPD POINTS | FEES |
|---|---|---|---|---|
| 7 OCTOBER 2026 | Tara the H Moross Centre – Rec Hall | 08:30 – 09:00<br>CONFERENCE<br>09:00 – 14:00 | 4 POINTS APPLIED FOR | R350 – General<br>R100 – Students |

### WHO SHOULD ATTEND

- Psychologists
- Psychiatrists
- Social Workers
- Registrars
- Interns
- Students
- Mental Health Professionals

*Professionals passionate about ethics, supervision and the evolving role of AI in clinical practice.*

### CONFERENCE TOPICS

**AI AS MENTOR, MIRROR OR MASK?**
Navigating the challenges of supervising in the age of AI
MILDRED GODJI

**THE THERAPIST WITHOUT AN UNCONSCIOUS:**
The Therapeutic Relationship in the Age of Artificial Intelligence
ITUMELENG KHUTLANG

**OUTSOURCING THE MIND:**
How AI Is Reshaping the Brain, Cognition and Human Thinking
COEN JACOBS

**THE SLOW WORK OF BECOMING:**
Clinical training in the age of AI
BARRY VILJOEN

### KEYNOTE SPEAKER



## DINEO LIOMA

*Join colleagues from across the mental health professions as we reflect, question, and engage with the future of ethical clinical practice.*

PLEASE RSVP AND PAY USING THE GOOGLE FORM ATTACHED.

SEATS ARE LIMITED.
BOOKING IS ESSENTIAL.

# University of Cape Town

Compiled by Toni Abrahams Toni.Abrahams@westerncape.gov.za and Jade Bouwer Jade.Bouwer@westerncape.gov.za

## Introducing a New Study in The Division of Neuropsychiatry: Project iNpower

**By Lucy Wagner**

Depression is one of the most common mental health conditions experienced by people living with HIV, yet access to effective mental health care remains limited in many healthcare settings. Depression can affect quality of life, engagement in care, and adherence to antiretroviral therapy (ART), making it an important component of holistic HIV treatment.

Project iNpower aims to address this challenge by exploring how effective, scalable, and sustainable mental health care can be integrated into routine HIV services in South Africa. The project is a collaboration between the Division of Neuropsychiatry, the City of Cape Town, the University of Miami, and Massachusetts General Hospital.

Working across ten HIV clinics in Cape Town, Project iNpower focuses on improving access to evidence-based depression treatment for people living with HIV. The project seeks to understand how best to implement mental health screening, referral pathways, and treatment within existing healthcare systems, ensuring that patients can access the support they need as part of routine HIV care. A key component of the project is Cognitive Behavioural Therapy for Adherence and Depression (CBT-AD), an evidence-based intervention that addresses both depression and HIV treatment adherence.



*Nurse-Interventionists being trained to deliver CBT-AD (Cognitive Behavioural Therapy for Adherence and Depression).*

The project is currently in the process of implementation. Over the past few months, the team has been working closely with participating clinics to prepare for the integration of mental health services into routine care. As the project progresses, we look forward to sharing updates on implementation activities, lessons learned, and the impact of integrating mental health care into HIV services.

## Strengthening Adolescent Mental Health Through Evidence-Based Intervention: WHO EASE Stakeholder Training

**By Mirriam Mkhize**

The Alan J. Flisher Centre for Public Health offered a series of stakeholder training workshops in June 2025, led by Mirriam Mkhize, aimed at equipping professionals to deliver an evidence-based mental health intervention for adolescents. The World Health Organization's Early Adolescent Skills for Emotions (EASE) intervention was designed to improve symptoms of depression and anxiety among adolescents aged 10 to 14 years and provide parenting support to their caregivers. Katherine Sorsdahl led the prior work to adapt EASE to the South African setting, in collaboration with young people and has engaged stakeholders in government and civil society. The first workshop was facilitated by Mirriam Mkhize, Claire van der Westhuizen and Chesney Ward-Smith at Karl Bremer Hospital.

The workshop generated much enthusiasm amongst the thirteen managers and supervisors from key government departments, including the Department of Health and Wellness, Western Cape Education Department, Social Development and Department of Cultural Affairs and Sport, as well as representatives from non-governmental organizations

including Hope Cape Town, the Trauma Centre, and Centre for the Study of Violence and Reconciliation. These stakeholders were trained in the core evidence-based components of EASE.

The second workshop was held at Alexandra Hospital, led by Mirriam Mkhize and co-facilitated by Joanie Mitchell, Cebokazi Ngcakani-Mtati, Corlette Heyns, and Azola Sibonda. The four-day intensive workshop trained 23 dedicated facilitators who work directly with adolescents and their caregivers in school and community settings.

Participants described the programme and training as highly relevant and applicable to their work, particularly valuing the experiential learning through group role-plays. Overall, the June 2025 EASE training exemplified the value of collaborative, evidence-based approaches for adolescent mental health. We would like to thank our funder, the Sue Struengmann Initiative, for supporting the training.



*EASE-SA workshop for government and NGO partners*

# UCT Department of Psychiatry Collaborates with Good Hope FM on Mental Health Awareness

**By Imthiaz Hoosen**

Goodhope FM's popular lunchtime program, the "Lunch Club" co-hosted by presenters Carissa Cupido and Chad Saaiman, recently launched a weekly mental health radio feature entitled "Good Living". In this segment various mental health professionals and representatives from NGOs participated in live interviews facilitated by clinical psychologist, Bradley Knight.

The Social Responsive Committee was invited to collaborate with Good Hope FM to provide expert speakers and content for these sessions—particularly during October, in recognition of Mental Health Awareness Month. Several members of the Department of Psychiatry participated including Dr Goodman Sibeko who discussed substance misuse, Dr Idorenyin Akpabio addressed the important topic of suicide, A/Prof John-Joe Dawson-Squibb talked about autism, and Dr Imthiaz Hoosen did two interviews covering depression and anxiety disorders.

The engagement with Good Hope FM was an opportunity for the Department to reach a wider audience and bring the topic of mental health into public spaces, with the aim of raising awareness about mental wellbeing and educating the general public about various mental health conditions.

We, the UCT Department of Psychiatry, extend our heartfelt thanks to Good Hope FM for inviting us to collaborate on this vital platform to empower and educate the public, improve mental health literacy, and equip the community with tools for the early identification of mental health challenges. We look forward to further collaborations with Good Hope FM as we continue to promote mental wellbeing and foster a more informed and supportive community.

Click here for more information on the above project, training and collaboration, as well as more news from the department.




*Left to right, Carissa Cupido, Bradley Knight, Dr Imthiaz Hoosen and Chad Saaiman.*

# Dr.Reddy's

## Good Health Can't Wait.

## NEUROPSYCHIATRY
RESTORING IDENTITY

**Dopaquel** QUETIAPINE — *Restoring balance & calm*

**Yelate** DULOXETINE — *Free to thrive*

**Redilev** LEVETIRACETAM — *Ready, Set, Live!*

**INIR** ATOMOXETINE — *Focused, Active, & Balanced*

**VOXBRINT** VORTIOXETINE — *Perform better everyday*

**METHYLPHENIDATE DRL** METHYLPHENIDATE — *Focus redefined*

**REDIRUNO XR** DESVENLAFAXINE — *Stability brings freedom*

## Help your patient's journey come full circle with Dr.Reddy's CNS portfolio.



CNS: Central Nervous System.

S5 DOPAQUEL 25. Reg.No.: 43/2.6.5/0429. Each tablet contains quetiapine fumarate equivalent to quetiapine 25 mg. Contains sugar (lactose). S5 DOPAQUEL 100. Reg.No.: 43/2.6.5/0430. Each tablet contains quetiapine fumarate equivalent to quetiapine 100 mg. Contains sugar (lactose). S5 DOPAQUEL 200. Reg.No.: 43/2.6.5/0431. Each tablet contains quetiapine fumarate equivalent to quetiapine 200 mg. Contains sugar (lactose). S5 DOPAQUEL 300. Reg.No.: 43/2.6.5/0432. Each tablet contains quetiapine fumarate equivalent to quetiapine 300 mg. Contains sugar (lactose). S5 YELATE 30. Reg.No.: 44/1.2/0114. Each capsule contains duloxetine hydrochloride equivalent to duloxetine 30 mg. Contains sugar (sucrose). S5 YELATE 60. Reg.No.: 44/1.2/0115. Each capsule contains duloxetine hydrochloride equivalent to duloxetine 60 mg. Contains sugar (sucrose). S3 REDILEV 250. Reg.No.: 41/2.5/0460. Each film-coated tablet contains levetiracetam 250 mg. S3 REDILEV 500. Reg.No.: 41/2.5/0461. Each film-coated tablet contains levetiracetam 500 mg. S3 REDILEV 750. Reg.No.: 41/2.5/0462. Each film-coated tablet contains levetiracetam 750 mg. S3 REDILEV ORAL SOLUTION. Reg.No.: 51/2.5/0095.094. Each 1 ml contains 100 mg of levetiracetam. Holder of the certificate of registration (HCR): Hetero Drugs South Africa (Pty) Ltd., Waterfall Corporate Campus, Building No. 2, First floor, 74 Waterfall Drive, Midrand, 2066. Reg. No.: 2016/260234/07. S5 INIR 10. Reg. No.: 43/1.2/0809. Each capsule contains atomoxetine hydrochloride equivalent to atomoxetine 10 mg. S5 INIR 18. Reg. No.: 43/1.2/0810. Each capsule contains atomoxetine hydrochloride equivalent to atomoxetine 18 mg. S5 INIR 25. Reg. No.: 43/1.2/0811. Each capsule contains atomoxetine hydrochloride equivalent to atomoxetine 25 mg. S5 INIR 40. Reg. No.: 43/1.2/0812. Each capsule contains atomoxetine hydrochloride equivalent to atomoxetine 40 mg. S5 INIR 60. Reg. No.: 43/1.2/0813. Each capsule contains atomoxetine hydrochloride equivalent to atomoxetine 60 mg. S5 INIR 80. Reg. No.: 57/1.2/0370. Each capsule contains atomoxetine hydrochloride equivalent to atomoxetine 80 mg. S5 VOXBRINT 5. Reg.No.: 55/1.2/0600. Each film-coated tablet contains 5 mg vortioxetine (as vortioxetine hydrobromide). Contains sugar alcohol (mannitol). S5 VOXBRINT 10. Reg.No.: 55/1.2/0601. Each film-coated tablet contains 10 mg vortioxetine (as vortioxetine hydrobromide). Contains sugar alcohol (mannitol). S5 VOXBRINT 20. Reg.No.: 55/1.2/0602. Each film-coated tablet contains 20 mg vortioxetine (as vortioxetine hydrobromide). Contains sugar alcohol (mannitol). S6 METHYLPHENIDATE 18 DRL. Reg.No.: 57/1.2/0036. Each prolonged-release tablet contains 18 mg methylphenidate hydrochloride. Contains sugar (lactose monohydrate). S6 METHYLPHENIDATE 27 DRL. Reg.No.: 57/1.2/0037. Each prolonged-release tablet contains 27 mg methylphenidate hydrochloride. Contains sugar (lactose monohydrate). S6 METHYLPHENIDATE 36 DRL. Reg.No.: 57/1.2/0038. Each prolonged-release tablet contains 36 mg methylphenidate hydrochloride. Contains sugar (lactose monohydrate). S6 METHYLPHENIDATE 54 DRL. Reg.No.: 57/1.2/0039. Each prolonged-release tablet contains 54 mg methylphenidate hydrochloride. Contains sugar (lactose monohydrate). S5 REDIRUNO 50 XR Reg.No.: 57/1.2/0569. Each extended-release tablet contains desvenlafaxine benzoate equivalent to 50 mg desvenlafaxine. S5 REDIRUNO 100 XR Reg.No.: 57/1.2/0570. Each extended-release tablet contains desvenlafaxine benzoate equivalent to 100 mg desvenlafaxine.

For full prescribing information please refer to the professional information approved by the Medicines Regulatory Authority.

Dr. Reddy's Laboratories (Pty) Ltd., Block C, Woodmead North Office Park, 54 Maxwell Drive, Woodmead, Sandton, Gauteng. 2191. Reg.No.: 2002/014163/07. Tel.: +27 11 324 2100. www.drreddys.co.za. M1006898-ZAR-CO-11052026-7773. THIS INFORMATION IS INTENDED FOR HEALTHCARE PROFESSIONALS ONLY.

# 6th CONGRESS OF THE GLOBAL PSYCHIATRIC ASSOCIATION

## ONLINE CONFERENCE • 11–13 SEPTEMBER 2026

Challenges and Opportunities in Global Psychiatry

**Organised by REINHARD HEUN & SUJIT KUMAR KAR**

**ONLINE VIRTUAL PLATFORM**
London 1:00–5:30 PM | India 5:30–10:00 PM

**EACH TALK**
30 min + 15 min discussion

## DAY 1 • 11 SEPTEMBER 2026

### Mental Health, Cancer, Dementia & Rehabilitation

**1:00–1:45 PM**
**Michelle Riba (USA)**
Severe Mental Illness and Cancer

**1:45–2:30 PM**
**Monika Thakur (India)**
Psychooncology

**2:30–3:15 PM**
**Aliki Eleni Pouli (UK)**
Immunopsychiatry: Current Research Findings and Challenges for the New Framework for Mental Health Disorders

**3:15–4:00 PM**
**Deblina Roy (India)**
Psychological Intervention in Burns and After Disability

**4:00–4:45 PM**
**Florian Riese (Switzerland)**
Person-Centred Dementia Care

**4:45–5:30 PM**
**Adivya Srivastava (India)**
The Next Frontier in Psycho-oncology: Precision Psychiatry Across the Cancer Continuum

## DAY 2 • 12 SEPTEMBER 2026

### Innovations, Global Mental Health & Alzheimer's Disease

**1:00–1:45 PM**
**Vikas Menon (India)**
Brain-Based Diagnostic Paradigms in Psychiatry: Models, Applications, and Challenges

**1:45–2:30 PM**
**Roy Kallivayalil (India)**
Cultural Contexts and Social Determinants: Enhancing Access and Sustainability in Mental Healthcare

**2:30–3:15 PM**
**Norman Sartorius (Switzerland)**
Unrecognized Priorities of Psychiatry

**3:15–4:00 PM**
**David M Ndetei (Kenya)**
School Mental Health in Kenya: Bridging Gaps and Scaling Opportunities for Adolescent Wellbeing

**4:00–4:45 PM**
**Christopher Szabo (South Africa)**
Lifestyle Medicine – Implications for Psychiatry and Psychiatrists

**4:45–5:30 PM**
**Rishab Gupta (USA)**
New Options and Opportunities in Alzheimer's Disease Care

## DAY 3 • 13 SEPTEMBER 2026

### Suicide Prevention, Psychosis, Personality & Academic Life

**1:00–1:45 PM**
**Sujit Kumar Kar (India)**
Suicide Among Students in South Asia: Prevention Scopes and Policy Initiatives

**1:45–2:30 PM**
**Dragana Ignjatovic Ristic (Serbia)**
Where Are We Standing with Clozapine in the 21st Century?

**2:30–3:15 PM**
**Dusica Lexic Tosevski (Serbia)**
Many Faces of Personality Disorders

**3:15–4:00 PM**
**Christian Schuetz (Canada)**
Umbrella Guidelines for Concurrent Schizophrenia Spectrum Disorder and Substance Use Disorder / Substance-Induced Psychosis

**4:00–4:45 PM**
**Deblina Roy (India)**
Navigating Academic Responsibilities, Family, Support & Challenges

**4:45–5:30 PM**
**Salman Shafiq (UK)**
Hatred in Medicine and Society: Lessons Learnt from Two Systematic Reviews

## REGISTER NOW

Scan the QR code or use the registration link:

**https://forms.gle/CQLMWCPn5SdoEScJ9**

**Bridging Minds • Transforming Lives**

Advancing Mental Health Across Borders




Join us online from **2–5 September 2026** for the **7th Southern African Multidisciplinary ADHD Congress.**

With insights from leading local and international experts, the congress offers practical tools and collaborative learning for professionals across psychiatry, psychology, education, and more.

REGISTER HERE

REGISTRATION FEES

SPEAKERS

VIEW THE LATEST PROGRAMME

**Congress Organisers**
**Londocor Event Management**

Marida Kroukamp
*Congress Organiser*
+27 (0)84 903 5102 | marida@londocor.co.za

Presented by

Goldilocks and The Bear Foundation

In partnership with

Stellenbosch Business School
STELLENBOSCH UNIVERSITY

NETCARE akeso

# An empty chair to fill

## Psychiatrist opportunities within Netcare Akeso

**Increasing demand** for quality mental health services presents the opportunity for **YOU** to establish your private practice at Netcare Akeso.



For more information, contact

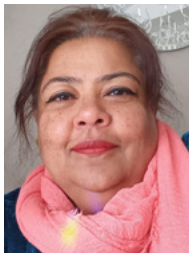
Dr Lerato Motshudi, Netcare Akeso Medical Director
lerato.mo@akeso.co.za
www.akeso.co.za | Crisis Line 0861 435 787

Providing YOU with the best and safest care.

NETCARE

# GUIDELINES FOR NEW CONSULTANTS: A CONNECTING RELATIONAL MODEL FOR NAVIGATING WORK AND COLLABORATIVE KNOWLEDGE CREATION

**Mariam Karjiker**



*Mariam Karjiker*

This *Perspective* emanates from a request made to me first by a young consultant, who then organized other young consultants in the department, to give them some relational guidelines on how best to perform at their jobs. I have led a process since 2006 to structure the undergraduate curriculum on a Relational framework. The role of the quality of human relationships, especially of our closest relationships, on our overall physical and mental wellbeing is not really taught in Medicine. There is a wealth of research to back up this evidence. My personal philosophy is that Psychiatry needs to take the conversation into Medicine and this is my attempt to do so and hopefully encourage other experienced clinicians to share their wisdom and knowledge with the younger generation.

I have divided my guidance into various facets of leadership, and aspects of it may be unique to Psychiatry, but many will apply in general to young consultants. It will be very valuable for others to share from other specialties, then we will hopefully create a diverse experiential knowledge base which young consultants can draw on for guidance in the future.

## CROSSING THE COLLEGIAL THRESHOLD AND NAVIGATING LIMINALITY

When we become a specialist, we enter the anxiety provoking space from having been a registrar, where we were constantly being observed, to a space where we must observe ourselves. We were surrounded by other registrars, and it is not unusual to find that passing your Part II exam is an anticlimax. You may also find yourself physically exhausted for a long time, the kind of exhaustion that is not relieved by sleep. Effectively you were in survival mode in the four years as a registrar, you are battle weary. Be good and kind to yourself. Your sleep and eating patterns were often totally disrupted, so give attention now to your selfcare. It is not abnormal to feel inadequate and insecure in your new position. Acknowledge those feelings because denial of them will result in your overcompensation and a dysfunctional pseudo-confidence. Every senior colleague you admire felt the same way and it takes years to grow authentic self-confidence. Be patient with the process of building knowledge and experience day by day.

There are both joys and pains to experience. Firstly, the privileges of your own office. You may now find you dress differently just because you have a safe office to leave a good bag or jacket. This is all part of the process of inhabiting space beyond the threshold.

Another privilege is becoming the colleague of someone you really admire and who may be a role model. That could be a very joyful experience. On the other hand, there is pain. You may become the colleague of someone whom you disrespect, actively dislike or who you feel was very unjust to you when you were a registrar. In your new role as colleagues, you may need to revisit a painful past and feel angry about past interactions. You will need to find ways to process these feelings.

There is one absolute rule. You will most likely have friends who are still registrars. Absoutely no information that may have occurred in discussion with consultants should get back to them. This is an absolute boundary; there are no exceptions to this rule. It will not be good for them in their training, and you will lose the respect of the other consultants.

## INTERNALIZING THE FOUNDATIONAL TRIAD – HOW TO CREATE DYNAMIC MODELS WHICH ARE SUSTAINABLE

I have a triad which I have developed which in my experience leads to genuine satisfaction in the workplace. It is **PRESENCE, RESPONSIVENESS and ENGAGEMENT.**

I call it the 'Holding Framework' because this is the emotional and psychological containment it creates. It says, 'I am here for you', 'If you need my knowledge or experience, never hesitate to approach me' and 'I am willing to go beyond the literal description of my job."

Create what I call 'Intimacy with the day'. Keep a journal of problems, how you approached them, what did you get right and what did you get wrong? Reflect deeply. Record seemingly simple daily interactions because becoming intimate with the day makes every circumstance a potential gift for connection.

Over time you will create sustainable models for working out of your deeply reflective trials and errors.

## GENERAL GUIDELINES FOR ENGAGING WITH STAFF IN THE WORKPLACE

The person, or persons, holding the most power in any system from the individual family to multinational organizations, sets the emotional tone of the space. There are no exceptions to this rule. As a psychiatrist, when someone tells me their child has behavioural problems, I ask only one question, 'what is happening in your marriage'? I am using this example to illustrate that leaders in any capacity must pour a lot of energy into themselves and their leadership relationships. When that system is stable, those over whom they have power are contained by that functionality. That is not to say that, for example, a child cannot have autonomous problems independent of the relationship between the parents. However, that conclusion can only be reached once we have analyzed the relationship between the parents. The

same goes for leadership, and consultants are leading clinical teams. Stabilize systems from the top downwards.

Everyone matters, everyone adds unique value, let others define themselves, be open to the meaning they make about their jobs, make it your culture to greet everybody, grow genuine interest in the dynamics of the workplace, and learn the skill of enquiring about appropriate important personal details and enquiring later as needed on follow-up.

Be conscious of other hierarchies like the nursing hierarchy etc. Become fluent in its emotional and psychological nuances and workplace dynamics.

Do not be afraid to practice **Connection.** It can feel awkward and odd in a disconnected space, but practice grows skills and eventually you master the skills. Greeting a hospital cleaner would feel odd if nobody modelled it, so don't be afraid to traverse kind avenues of potential connection. Given the history of this country, we all need relational skills to help bridge socio-economic and racial divides.

## GENERAL GUIDELINES FOR PATIENTS AND THEIR FAMILIES AND NAVIGATING GRATITUDE AND GIFTS

We must hold confidentiality for both the patient and the family. Our fiduciary and clinical duty is towards the patient first and thus we reassure them that we will never pass anything they told us to their families. We listen to families supportively and with empathy and reassure them that we have heard their collateral information. When there is an adolescent patient, it requires sensitive negotiations because parents, who are paying the hospital bills, may feel entitled to any information given by the patient.

In a psychiatric setting I have found that children visiting may present a potential problem. They may hear inappropriate language or even witness inappropriate behaviours which can traumatize them. Make a judgement call on whether children should enter the ward. At hospitals like Valkenberg, there are beautiful natural surroundings to sit and walk in, so perhaps encourage those types of visits for patients with children, if the patient is assessed by the clinical team to be able to do so. Otherwise, if the patient is too unstable, then encourage only adult visitors.

We must never discourage gratitude; it is a wonderful deeply spiritual attribute in individuals. We must learn to channel it for the good of the overall system. It is a good idea to discourage personal gifts. There is a reason why we don't accept gifts from our enemies. A gift always implies an obligation to the recipient of the gift. Accepting a personal and possibly expensive gift from a patient tilts the therapeutic relationship. We may find it hard in the future to refuse a sick certificate which is not really needed. Patients also tend to put doctors on a pedestal; they do not see that it is the entire clinical team that cares for the patient. I have developed a strategy where if patients express a desire to give me a gift, I give them guidance towards giving a gift to the entire clinical team. I encourage them to bring a plant or flowers we can all enjoy in the nursing station or a cake we can all enjoy at teatime. I encourage young consultants to organize the team into creating a wish list for ward supplies like card games, dominoes, table tennis bats and balls etc. Display this prominently on a colourful creative chart and encourage families to choose items to buy for the ward if they feel moved to do so through gratitude.

Commend individual staff members from the multidisciplinary team to family members when appropriate and always commend when appropriate to their line managers. Take time to write an email praising good attitudes and good work.

## GENERAL GUIDELINES FOR ENGAGING WITH UNDERGRADUATE AND POSTGRADUATE STUDENTS

We all long to be 'seen' by our teachers and this mirrors the parent-child relationship.

1) The students are our junior colleagues.
2) In the clinical environment in Psychiatry, the bulk of their training is the responsibility of the registrars and medical officers etc. In other words, it is the doctors on the ground who ensure their clinical competence. The consultant only sees them on the ward rounds and teaches them in that context.
3) The consultant is primarily responsible for training the registrars.
4) Conflict is inherent in human relationships and learning the communication skills to repair ruptures is the key to a mutually satisfactory quality of human relationships.
5) I have a heuristic for dealing with difficult conversations and feedback with students. It is **CLARITY, KINDNESS and HOPE.**
6) Always have difficult conversations in private.
7) Be very careful about the tone of your voice, don't show impatience, agitation or irritability. Use non-threatening language which is not emotionally distancing.
8) Be very clear from the start that you have heard good things about the student, and this conversation is about a specific thing, not the totality of their clinical/academic performance. Then address the issue in a caring tone of voice. Give the student an opportunity to reflect. Ask them how they think they can improve.
9) Then end off on hopeful positive points. The model is thus start with the positive, clearly boundary the negative feedback, and end off on a hopeful positive.
10) The reason this is so important is because students live in a zero-sum game world. In their minds they are either only passing or failing, and they easily catastrophize negative feedback.
11) Do not be afraid to use appropriate gentle humour to relieve tension. Humour is very connecting when used appropriately.
12) Ideally feedback should be given a quarter of the way into a block. If there are things the student needs to work on, then they can prove themselves by midway through the block. Then give feedback midway and then at the end.
13) Many a registrar, including myself when I was one, felt ambushed in the six-monthly feedback. It is unjust to bring up issues there which were not discussed within the block. Frankly, I felt resentful and at times thought the consultant was cowardly and underhanded by not being more transparent during the block. Be transparent in the block if you feel there are problems. Be willing to hold pain…. that is part of the job.

## THE CRUCIAL UNDERSTANDING OF BOUNDARIES, REPUTATION AND SEXUAL POLITICS IN THE WORKPLACE

This section is a difficult but necessary topic to cover because after decades in the system, I have seen some painful experiences which could best have been prevented by an understanding of boundaries. I am speaking here from a heterosexual perspective, but I think the general guidelines can be used by everyone.

1) The students are adults and have the right to pursue relationships with whomever they choose to do so. By the very nature of male /female relationships, it is more often the female who is younger, and research shows that in the workplace and in academia, should the relationship end badly, the person holding less power in the relationship may find themselves in a position where their future career prospects are compromised in the workspace. Statistically this means more women will be compromised professionally. My advice to young people is as follows. It is always flattering to our sense of self and our egos, when someone of a perceived higher professional status gives us attention or shows romantic interest. The question to ask yourself is if this is a pattern of behaviour towards young people or a genuine interest in pursuing a sustainable relationship into the future. Universities after all have a constant intake of young people who are all attractive physically because to be young is to be beautiful. If it is a genuine mutual relationship, then take that information as soon as possible to the head of the department. That allows them to organize rotations etc. in a way where you do not interact often at work. The couple must be prepared to make some sacrifices for themselves and the system.

2) It is a truism that as men age and gain power, the holding of power itself can be very appealing for women. In a professional setting men need to be mindful of this fact and be careful with their words. Flirtatious banter with students and junior colleagues may seem harmless, but amongst the students and the colleagues that is a form of power to be chosen for flirting. In my experience they share that information with other students and their peers as a power play and some staff members. This does real reputational damage and detracts from the individual's professional achievements. Nothing sticks to our reputation like sexual rumours, years after the facts have been forgotten. My advice to men is what I always teach my young male students. Authentic honourable masculinity is defined by restraint, using your words with care around women, because a man holds out the promise and hope of connection to women through his words, always treat women with the utmost respect and only get emotionally close to them when you are clear that you intend to pursue sustainable connection with them. I have the utmost confidence in this process, as it protects both men and women.

3) It is also a truism that as women age, they lose sexual power. This is only a problem if women define themselves through the male gaze and their physical appearance is the sole source of their self-esteem. Women who have a more holistic understanding of femininity find that they too gain power as they age, the multifaceted power that proceeds through the feminine strengths of nurturance and creation.

4) All research points to the fact that the greatest risk factor for having extra-marital affairs is opportunity. This is a sobering fact that should encourage healthy boundaries around speech and socializing amongst colleagues.

## RELATIONAL GROWTH WITH THE HEAD OF DEPARTMENT AND JUNIOR AND SENIOR COLLEAGUES

In functional family systems there is respect for the generational lines. Individuals must contend with generational history and holding memories and history for each other. Generations have unique circumstances and people feel empathy and compassion by the shared experience of difficulties and mutually shared vulnerability. This creates deep connections and bonds within the generations.

Be mindful that new consultants do not need to know aspects of the history that took place years ago between older colleagues. Be judicious about sharing unnecessary information and allow people to develop relationships with each other even if you fail to do so. I am advocating a generosity of spirit and a general sense of camaraderie within departments. Be welcoming to new staff and help them to find their feet. Give people the benefit of the doubt and check yourself if you find you easily draw negative conclusions about individuals with no proof in sight. Nobody is liked by everybody, but civility and good manners go a long way towards creating a cohesive pleasant workplace. Ultimately work towards a collaborative functional community of colleagues.

Try to develop good generational understanding, younger people live in different times and grapple with unique contextual challenges. Grow empathy and compassion for them and try not to idealize a mythical past, the past too had its unique pains.

The Head of Department (HOD) is one person…. with enormous responsibility resting on their shoulders. Whatever your problems are, it is possible that their problems could be ten times more stressful. Be mindful of what power you may be projecting onto them to change the system. There is a space for robust discussion and even confrontation with leadership, but it must be done with a clear intent and correct tone. Like with the students, you need to be clear that what you are raising is not personal but to make the system better.

Something that I have learnt through conflict with the Head of Department, is to be very clear to yourself what you are concerned or angry about. Be very careful that others do not use your anger to inflate your issues by passing onto you their difficult issues. It is ultimately being very clear about your own boundaries that allows you and your HOD to resolve the issues and even to grow connection through effective communication around the conflict. Mutual respect can grow from such a process, and both people can find common ground to pour in intellectual energy for the good of the overall department. As somebody once said, anger can be an engine to drive good changes or a 'destructive fire which destroys everything in sight'. Harness your anger for positive outcomes and even for eventual connection.

After the conflict has settled, make time to discuss both of your growth journeys. Share your plans and vision in your area of work with your HOD.

Ultimately call out for and pour emotional and intellectual energy into growing the system towards greater wholeness.

## ACHIEVING GROWTH AND CONNECTION THROUGH APPROPRIATE LEVELS OF OPENNESS AND SHARED VULNERABILITY

If we do not share anything about ourselves, then nobody can grow relationships or connections with us, and we remain isolated from others.

There is however such a thing as unprofessional over-sharing and new consultants need to navigate this pathway between appropriate sharing and sharing which will compromise their capacity to lead the team and even grow disrespect from colleagues and students.

We are all wounded people and there is a skill as we heal our wounds, to know what is teachable through our healing for the growth of others. The wounded healers and their healing powers are a real strength as we attempt to heal others. All human beings after all are the instruments through which God's will is actualized in the world. Embrace your victories and failures…. growing through them hopefully turns you into the best version of yourself and in that way your life becomes a gift to the world.

Discourage perfectionism….it is an escape from connection, allow for genuine mistakes, we are all fallible human beings and try to avoid scapegoating others for seemingly insurmountable problems.

## ROOTING OURSELVES IN MEANING AND COMPASSION AND SHARING POWER

Ask yourself what the meaning of your work is. Why did you choose it? Do you feel some aspect of your work is a calling? Have you listened to the signs in your own life and even to significant dreams you may have had in the past. Have self-compassion for the tasks you feel you need to accomplish and do not forget your self-care while you go about your daily work.

It was Martin Luther King Jr who gave one of the best descriptions of power. He said 'Power is the ability to achieve purpose and effect change'.

A good way of thinking about power dynamics is to understand that there are four ways of dealing with power relationships.

1) Power Over Relationships are the traditional hierarchical systems where those close to the source of the ultimate power benefit preferentially because they have more access to speaking to the person and are privy to high level meetings etc. This model is very easily open to being used in an abusive pattern sadly if the tables are reversed, and the previously powerless are given the reins of power. They often behave in the same way as the people they complained about when they were powerless. We see this when medical interns abuse the medical students.
2) Power With Relationships is based on mutual support, collaboration and respect for differences. This style tries to pool potential and resources to make a collaborative bigger impact.
3) Power To Relationships is where we respect the fact that everyone has unique skills and strengths and we give them agency to grow often by growing their skills and knowledge.
4) Power Within Relationships is where individuals have grown their self-confidence, sense of self-worth and self-knowledge to the point where they are comfortable with questioning the status quo and want to reflect and create dialogue on potential different ways of doing things. At the same time, they recognize differences and respect others.

Systems should strive to create and model many opportunities for Power With, Power To and Power Within frameworks within departments. There is a place for Power Over dynamics, but it must be used judiciously with as many people benefitting as possible through the exercise of it.

In the deepest spiritual understanding, power is our ultimate test and reveals us to the world and to ourselves. It unmasks our hearts and souls and for good or bad leaves us totally exposed.

## MENTORSHIP – SAFE TRUSTING SUPPORT THAT GROWS REFLECTION THROUGH EXPERIENCE AND EMPATHY

Older experienced people hold institutional and life memories. We must learn to develop a culture where they pass on the institutional history or else it does not get transmitted to the next generation. The past is thus lost to future generations. We must develop a strong culture of guiding and 'parenting' our junior colleagues. Guide them with experience, wisdom, empathy and care. Be open to listening to the changing contexts they experience. Support them in a frighteningly tumultuous and uncertain world. Acknowledge the harshness of the clinical challenges which they face. A senior colleague remarked to me that the current clinical environment is 'no country for old men'. The daily struggles of clinicians holding teams together are often heartbreaking to hear. Try to frame the positives and acknowledge the negatives and the gross difficulties.

Between the senior colleagues and the junior ones there should ideally be trust and respect. Senior experienced mentors should ideally hold out connection as the yardstick for engagement.

I want to end off by quoting what Lao Tzu said in the Tao, 'The Sage does not experience a crisis, because he goes out on the road to meet it'.

Older colleagues have lived longer and should thus use their lived experience to help the new consultants meet their challenges and struggles by empowering them with knowledge, guidance and helping them grow in confidence to face the future. The future is totally unknown and in the deepest spiritual sense is with God only until it is revealed to us in its due time. What we can all try to commit to is a willingness to engage with it when its time comes through sincere authentic work in the present and through growing in the present sustainable connection and relationships with others.

***Mariam Karjiker*** is a psychiatrist and the clinical courses convener for the undergraduate MBCHB program in the Department of Psychiatry and Mental Health at the University of Cape Town. She has been in the role of convener since 2006. She qualified with an MBBCh from the University of the Witwatersrand in 1989, followed by a year of internship at Tygerberg Hospital in 1990. In 1991 she started working as a medical officer in Psychiatry at Lentegeur Hospital in Mitchells Plain where she worked for 11 years whilst also doing regular GP locums at the same practice in Mitchells Plain. She thus has extensive general practitioner experience as well as psychiatry experience. Her specialist training commenced in 2002 and was completed it in 2006 having obtained the FCPsych qualification.

www.biopsychsa.co.za

Thursday 26 November - Sunday 29 November 2026

# Biological Psychiatry Congress

Century City Conference Centre, Cape Town

*Bridging Brain, Behaviour & Beyond*

## EARLY BIRD REGISTRATION EXTENDED

The discounted Early Bird registration rates have been extended until **31 August 2026**, giving you another opportunity to register at the reduced rates.

Join leading psychiatrists, psychologists, researchers, registrars, students, and other healthcare professionals in Cape Town for the 2026 South African Biological Psychiatry Congress.

**Register Here**

**View Accommodation**

**Leigh van den Heuvel**
Stellenbosch University
Congress Convenor

**Valsamma Eapen**
University of New South Wales
INA President 2025

In collaboration with

INTERNATIONAL NEUROPSYCHIATRIC ASSOCIATION

Supported by

SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

**Congress Organisers: Londocor Event Management**

***Sonja du Plessis***
+27 82 455 7853 | sonja@londocor.co.za

***Elize Kloosterzie***l
+27 (0)76 979 9379 | elize@lo

***Natalie Kreusch***
+27 84 500 0784| natalie@londocor.co.za

***Kim Raats***
**Registration Manager**
+27 (0)84 551 1411 | kim@londocor.co.za



THE MPS

# EXPLORING THE ROLE OF FRIENDSHIP IN MEDICINE

**Raj Rattan**

I've spent more than 30 years working with the Medical Protection Society, the last ten as Dental Director at Dental Protection. As I move into the new Global Advisor role, I've been looking back at my career and all the people I've worked with who have helped shape it, from the colleagues who have taught me to the friends I have come to trust completely. A recent conversation with a friend has got me thinking about the importance of friendship in getting through the episodes of life, especially in our profession. In this article, I'll explore what friendship is, what it isn't and its importance in our lives. First, let me take you through the event that precipitated all this.



*Raj Rattan*

It is late evening in early April. Artemis 2 has cleared the launch tower when my phone rings. It is a school friend who, knowing my long-standing interest in space travel, has waited until the launch abort window closed before calling. I answer, expecting another discussion about the ethics of space exploration – a long-running debate. I am mistaken. He sounds distressed and wants to discuss a difficult situation with a patient he feels he did not manage well. He tells me he is calling not for dentolegal advice but as a friend. He had delayed calling, he says, knowing I would be glued to the television.

I am struck by the contrast: after decades of waiting, humanity reaches once more for the Moon, while one dentist has waited several hours, out of courtesy, before reaching out to a friend for help.

## THE DIFFERENT WAYS TO BE A FRIEND

In Nicomachean Ethics, Aristotle describes three types of friendship.[1] The first is based on utility – relationships formed because they are mutually beneficial. The second is based on pleasure, rooted in enjoyment. The third, and highest form, is friendship of virtue – relationships founded on mutual respect and shared values.

In our professional lives, we build friendships of utility – colleagues we consult, refer to, collaborate with, and learn from. We also foster friendships for pleasure through conferences, peer-review groups, and social gatherings. Both types are valuable. Yet, when difficulties arise, it is friendships of virtue that we rely on.

They take time to develop and are sustained by mutual trust and reciprocal regard for one another's good. Aristotle describes such relationships as *teleia philia*, meaning complete or fully realised friendship.

## WHAT ISN'T A FRIEND

Today, social media can blur what we mean by friendship. Followers, likes, and friends are not the same.

Followers constitute an audience. They observe what you share and might feel they know you, but the relationship remains primarily one-sided.

Likes are signals, not relationships. They reflect fleeting attention – effortless and easily forgotten.

Friends are different. They get to know your character over time and stay by your side when times are tough.

## THE SCIENCE AND PHILOSOPHY OF FRIENDSHIP

Evidence shows that relationship quality matters more than quantity. Strong, supportive connections reduce stress and boost resilience. Conversely, excessive social media use links to increased anxiety, depression, and lower wellbeing.

Friendship benefits mental health in many ways. It provides emotional support through listening, understanding, and validation. Systematic reviews confirm that meaningful, supportive relationships are linked to better mental health, lower morbidity, and even longer life expectancy.[2]

These findings align with a broader philosophical tradition. For Aristotle, friendship is not merely a social convenience, but a vital aspect of what he called eudaimonia – a state of

human flourishing rooted in virtue, purpose, and meaningful activity. Genuine friendship, in this context, is not just about companionship but about mutual moral growth. Friends recognise the good in each other, reinforce it, and support one another in reaching their potential.

## CLOSING THOUGHTS

When I hung up the phone after speaking with my friend, he said he felt better, even though I did not say anything he did not already know. Why? Perhaps because friendship does not always have to provide new answers but helps us return to the ones we already know. Virtue friendships are not a luxury but a professional resource.

For generations, such friendships have provided emotional support, perspective, and resilience. No digital platform, however sophisticated, can fully replace that.

As I finish this article, I am reminded of John Glenn, the first American to orbit the Earth, inside a tiny spacecraft called Friendship 7. Its name honoured not only the Mercury astronauts, but also the camaraderie and shared purpose that united them.

Aristotle might have recognised a deeper truth in that name – that achievement rests not only on skill, endeavour, and virtue, but also on the strength of meaningful friendship.

## REFERENCES

1 Aristotle. Nicomachean Ethics. Book VIII–IX.

2 Keles B, McCrae N, Grealish A. A systematic review: the influence of social media on depression, anxiety and psychological distress. *Int J Adolesc Youth.* 2020;25(1):79–93.

***Raj Ratan*** MBE BDS FCGDent. Dip. MDE FICD FFLM FDTFEd. MA is Global Advisor to the **Medical Protection Society**, having spent ten years as Dental Director at Dental Protection. His portfolio career includes over 30 years' clinical experience in general dental practice. He owned and operated a small practice group and was involved in postgraduate dental education for over 20 years, first as a programme director and then Strategic Association Dean at the London Deanery. He has been an examiner for the FGDP and for the Faculty of Forensic and Legal Medicine. He is the author/co-author of several textbooks, has contributed articles to dental publications for more than 25 years and has lectured extensively. His new book on how ancient philosophy can be applied to modern healthcare is due for publication later this year.
**Correspondence: pressoffice@medicalprotection.org**

---

The history of the peoples of Africa date back many hundreds of years. People of Africa held strong animistic beliefs. Animistic beliefs venerate the natural world. The Ground Hornbill was a symbol of various beliefs - death and misfortune, protection against evil spirits and lightening and was also seen as the timekeeper announcing the beginning and end of the working day.



***Dr Lennart Eriksson*** is a psychiatrist living and practising in Pennington KZN **Correspondence: lennarte@iafrica.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**