



FULL THERAPEUTIC  
PRODUCT RANGE



# MAINTAINED PLASMA CONCENTRATION

WITH ONCE A DAY DOSING<sup>1</sup>



**QUERO XR 50, 150, 200, 300, 400 mg.** Each prolonged release tablet contains quetiapine fumarate equivalent to 50, 150, 200, 300, 400 mg quetiapine respectively. [S5]A49/2.6.5/0280, 0281, 0282, 0283, 0284. For full prescribing information, refer to the professional information approved by SAHPRA, May 2021. <sup>1</sup> Bui, K., et al (2013). Pharmacokinetic profile of the extended-release formulation of quetiapine fumarate (quetiapine XR): clinical implications. *Current medical research and opinion*, 29(7), pp.813-825. **00A770/06/2022**

pharma dynamics  
EFFECTIVE AFFORDABLE HEALTHCARE

CUSTOMER CARE LINE **+27 21 707 7000**  
[www.pharmadynamics.co.za](http://www.pharmadynamics.co.za)



# REGAIN A SENSE OF CONTROL

WITH PHARMA DYNAMICS ANTIPSYCHOTIC RANGE



**QUERO XR 50, 150, 200, 300, 400 mg.** Each prolonged release tablet contains quetiapine fumarate equivalent to 50, 150, 200, 300, 400 mg quetiapine respectively. [S]A49/2.6.5/0280, 0281, 0282, 0283, 0284. For full prescribing information, refer to the professional information approved by SAHPRA, May 2021. **ZOXADON 0,5 mg, 1 mg, 2 mg, 3 mg, 4 mg.** Each tablet contains 0,5 mg, 1 mg, 2 mg, 3 mg, 4 mg risperidone respectively. [S]A41/2.6.5/0468, 0445, 0446, 0469, 0470. NAM[NS]10/2.6.5/0021, 0022, 0023, 0024, 0025. For full prescribing information, refer to the professional information approved by SAHPRA, 6 January 2020. **ZOXADON ODT 0,5 mg, 1 mg, 2 mg.** Each orodispersible tablet contains 0,5 mg, 1 mg, 2 mg risperidone respectively. [S]A46/2.6.5/0362, 0363, 0364. For full prescribing information, refer to the professional information approved by SAHPRA, May 2019. NSCRA766/06/2022

pharma dynamics

EFFECTIVE AFFORDABLE HEALTHCARE

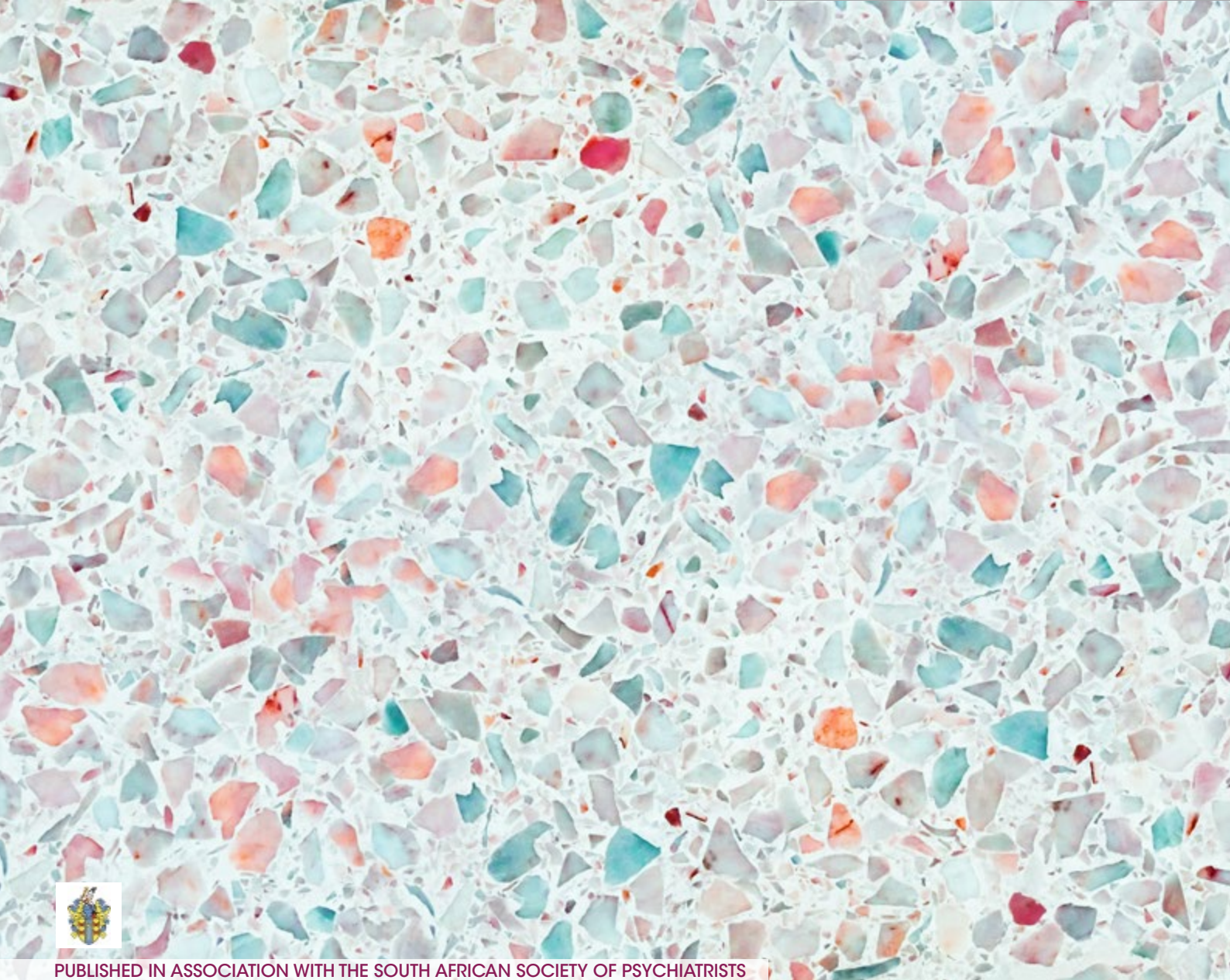
CUSTOMER CARE LINE +27 21 707 7000  
[www.pharmadynamics.co.za](http://www.pharmadynamics.co.za)

# SOUTH AFRICAN PSYCHIATRY

ISSN 2409-5699

ABOUT the discipline FOR the discipline

issue 34 • February 2023



PUBLISHED IN ASSOCIATION WITH THE SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

**REPORTS FROM THE 3<sup>RD</sup> SOUTH AFRICAN  
MULTIDISCIPLINARY  
ADHD CONGRESS**



[www.southafricanpsychiatry.co.za](http://www.southafricanpsychiatry.co.za)

# TURN THEIR WORLD RIGHT SIDE UP



“ADHD

should not be a barrier to  
realising my potential.”



Unlocking potential

**CONTRAMYL XR**  
Methylphenidate HCl

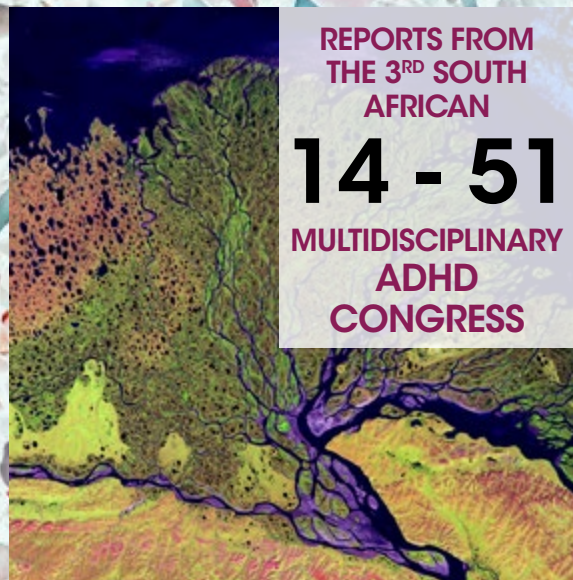
**[S6] CONTRAMYL XR 18 mg** (Extended Release Tablets). Reg. No. 49/1.2/1137. Each extended release tablet contains 18 mg methylphenidate hydrochloride. Contains sugar (sucrose). **[S6] CONTRAMYL XR 27 mg** (Extended Release Tablets). Reg. No. 49/1.2/1138. Each extended release tablet contains 27 mg methylphenidate hydrochloride. Contains sugar (sucrose). **[S6] CONTRAMYL XR 36 mg** (Extended Release Tablets). Reg. No. 49/1.2/1139. Each extended release tablet contains 36 mg methylphenidate hydrochloride. Contains sugar (sucrose).

**[S6] CONTRAMYL XR 54 mg** (Extended Release Tablets). Reg. No. 49/1.2/1140. Each extended release tablet contains 54 mg methylphenidate hydrochloride. Contains sugar (sucrose). For full prescribing information, refer to the Professional Information approved by the Regulatory Authority.

Mylan (Pty) Ltd. Reg. No.: 1949/035112/07. 4 Brewery Street, Isando, Kempton Park, 1600.  
Tel: (011) 451 1300. Fax: (011) 451 1400. www.mylansa.co.za. 19874L. M3667m Exp: 03/2023.



# Features



REPORTS FROM  
THE 3<sup>RD</sup> SOUTH  
AFRICAN

**14 - 51**

MULTIDISCIPLINARY  
ADHD  
CONGRESS

**NOTE:** "instructions to authors" are available at [www.southafricanpsychiatry.co.za](http://www.southafricanpsychiatry.co.za)

S  
T  
I  
N  
E  
T  
I  
O  
N

FEBRUARY 2023

5 FROM THE EDITOR

7 **PMHP**, END OF 2022 UPDATE

10 THE USE OF **SOcial MEDIA** IN THE SOUTH AFRICAN HEALTHCARE SECTOR

14 **IRON DEFICIENCY AND ADHD**

15 ADHD/AUTISM: **A DIMENSIONAL APPROACH**

16 **REASONABLE ACCOMMODATION: THE IMPERATIVE**

18 **CHILDRENS TV AND EXECUTIVE FUNCTIONING**

20 **INTIMATE PARTNER VIOLENCE** IN ADHD

22 **CLINICAL PAEDIATRIC DIETICIAN: AN OVERVIEW OF THE EVIDENCE AND A PRACTICAL APPROACH TO NUTRITION** FOR ADHD

23 **DIAGNOSTIC OVERLAP IN CHILD & ADOLESCENT PSYCHIATRY: A PRACTICAL APPROACH**

24 **SCREEN MEDIA USE AND ADHD RELATED BEHAVIOURS**

26 A SUMMARY OF SELECTED SESSIONS FROM THE CONFERENCE

32 **HISTORICAL OVERVIEW OF ADHD**

34 **THE BORDERLAND OF TOURETTE SYNDROME AND ATTENTION DEFICIT HYPERACTIVITY DISORDER**

36 ADHD AND THE **REPRODUCTIVE HORMONES** (FROM PRE-PUBERTY TO MENOPAUSE)

39 **WORKING FROM HOME: YES OR NO?**

41 THE IMPACT OF COVID ON ADHD IN **CHILDREN AND ADOLESCENTS**

42 **GOLDBLOCKS AND THE BEAR FOUNDATION**

43 **ADHD AND PTSD: A DIAGNOSTIC OVERLAP IN CHILD AND ADOLESCENT PSYCHIATRY: A PRACTICAL OVERVIEW**

44 **YOGA AND MINDFULNESS FOR ADHD**

45 SCREENTIME, **ADHD** AND COVID

46 **ADHD AS A DEFENSE**

48 **AUTISM AND ADHD - A PRESENTATION OF THE NEURODEVELOPMENTAL DISORDERS** IN ADULTHOOD

49 **GAMING: THE GOOD, THE BAD AND THE ESSENCE**

50 **CONCESSIONS: YES, OR NO?**

51 **AUTISM SPECTRUM DISORDERS (ASD) AND ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD), A CATEGORICAL APPROACH**

52 **DEPARTMENTS OF PSYCHIATRY NEWS**

57 OF SWEET PEAS, DANDELIONS, LADY BUGS AND MUSIC NOTES

59 **POEM: DISABILITY GRANTS...**

60 **BOOK REVIEW: THE MYTH OF NORMAL: TRAUMA, ILLNESS, AND HEALING** IN A TOXIC CULTURE

62 **WINE FORUM: WHEN SUSTANABILITY STARTS TO INCLUDE TRANSFORMATION**

64 **REVIEW: A BEAUTIFUL GAME: THE ART OF MAKING STRATEGIC CHOICES**

65 **MOVIES**

67 **SASOP**

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

**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.

COVER IMAGE: Terrazzo flooring or old marble by 'pramot48' on AdobeStock

Design and layout: The Source • Printers: Raptor Print

Dear Reader,

welcome to our first issue for 2023 with best wishes for the year ahead - which as you read this will be well underway. The February 2023 issue provides a showcase for the emerging generation of future psychiatrists who as current registrars attended the 2022 ADHD congress and subsequently wrote the *Report* content published in this issue. *South African Psychiatry* is proud to be able to provide a platform for the development of our discipline's specialists of the future. It is my hope that publication gives them a sense of their potential, and that we will see more of their published work in the years ahead - likewise their colleagues who did not contribute content but will likely read this content.



In the November 2022 issue we highlighted future content in the form of *Feature* articles, related to presentations at the 2022 ADHD Congress, that were already available as online pdfs in advance of hardcopy appearance in the May 2023 issue. I would like to add one more - the *Perspective* of Maria Dobрева regarding the use of ketamine for childhood/adolescent suicidality and depression. Finally, I want to briefly note the involvement of two KZN colleagues (Prof. Ramlall and Dr Mashaphu) with *The Brahma Kumaris (South Africa)* - an organization dedicated to encouraging coping strategies for the promotion and maintenance of emotional health. We hope to publish content in the May 2023 issue related to a specific event which took place in January 2023. So, as a publication we are indeed forward looking, and our August 2023 issue will feature content from another event highlighted in the November 2022 issue - the Dr Reddy's Academic weekend.

Finally, by the time this issue emerges the last episode of the current episodes of *Beyond Madness* will have been released. My good friend, colleague, and regular contributor of photographs related to all things ornithological - Dr Lennart Eriksson - has suggested that episodes be downloaded on to USB devices for easy listening in the traffic...or open road. Listener beware...

Until the next issue, take care.

**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, University of Stellenbosch*  
 Dan Stein - *Head, Department of Psychiatry and Mental Health, University of Cape Town*  
 Taiwo Akindipe - *Head, Department of Psychiatry, Sefako Makgatho Health Sciences University*  
 Funeka Sokudela - *Head, Department of Psychiatry, University of Pretoria*  
 Janus Pretorius - *Head, Department of Psychiatry, University of The Free State*  
 Zuki Zingela - *Head, Department of Psychiatry, Walter Sisulu University*  
 Bonga Chiliza - *Head, Department of Psychiatry UKZN; President South African Society of Psychiatrists*

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

**Advertising:** The Source Public Relations, Pharmapreneurs

**Design and Layout:** Rigel Andreoli

**Web:** [www.southafricanpsychiatry.co.za](http://www.southafricanpsychiatry.co.za)

**Contact Person:** Vanessa Beyers - [vanessa@thesourcepr.co.za](mailto:vanessa@thesourcepr.co.za)

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

*"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."*



FULL THERAPEUTIC  
PRODUCT RANGE



# OPEN UP TO NEW POSSIBILITIES

NOW AVAILABLE IN BOTH 225 mg AND UNIQUE 300 mg TABLETS



For further product information contact **PHARMA DYNAMICS**  
Email [info@pharmadynamics.co.za](mailto:info@pharmadynamics.co.za) **CUSTOMER CARE LINE** +27 21 707 7000

**pharma dynamics**  
EFFECTIVE AFFORDABLE HEALTHCARE

ILLOVEX XR 37,5, 75, 150, 225, 300 mg. Each extended release film coated tablet contains venlafaxine hydrochloride equivalent to 37,5, 75, 150, 225, 300 mg venlafaxine respectively.  
S5A48/1.2/0910, 0911, 0912, 0913, A53/1.2/0467. For full prescribing information, refer to the professional information approved by SAHPRA, 3 September 2021. IX624/04/2022

[www.pharmadynamics.co.za](http://www.pharmadynamics.co.za)



**Perinatal Mental Health Project**  
Caring for Mothers. Caring for the Future.

# END OF 2022 UPDATE

**T**hank you to all our loyal supporters, partners and donors. From all of us at the PMHP, we wish you and your families a safe and peaceful festive season. We are excited for 2023 and look forward to engaging with you in the New Year!



From left: Lele Sigwebela, Tyla Prinsloo, Liesl Hermanus, Thanya April, Simone Honikman, Justine Evans, Godfrey Abrahams and Emma McKinney

## MENTAL HEALTH ROUNDTABLE

In November, our director, Simone Honikman, was invited to present on the Impact of Perinatal Mental Health Issues on Child and Adolescent Development at a roundtable meeting "Improving Mental Health and Psycho-social Support Services (MHPSS) for Adolescents and Young People in South Africa: An Integrated, Intersectoral Approach".

**THE FORUM WAS HOSTED BY UNICEF, THE NATIONAL DEPARTMENT OF HEALTH AND THE FOUNDATION FOR PROFESSIONAL DEVELOPMENT.**

The hybrid event was attended by approximately 80 in-person and about 100 virtual delegates and vibrant discussion ensued.



## IT'S TOO COSTLY TO DO NOTHING

The research on the 'cost of inaction' for mental health problems in South Africa, which we conducted in collaboration with the London School of Economics and the Medical Research Council, was developed into a blog published on the prestigious Inspire the Mind website. Together with Percept consultants, we developed an infographic to help translate the technical aspects of this health economic work for the general public, health managers and decision-makers.

The impact on women over a ten-year period, and the long-term possible consequences for their children, over 40 years

South African society bears \$2.9 bn =

**R49.3 bn in economic cost**  
for every year of births.

That's just under \$3,000 per baby

## 16 DAYS OF ACTIVISM AGAINST GBV

From 25 November – 10 December, this important international campaign is used as a strategy by individuals and organisations to call for the prevention and elimination of violence against women and girls.

**16 Days of Activism against Gender-Based Violence**

Topic: International Day of No Violence Against Women



More than 1 in 3 women experience gender-based violence during their lifetime.

Less than 40% of women who experience violence seek help of any sort.

At the PMHP, we shared various activities on our social media that we have been involved in to contribute to the fight against gender-based violence. In addition, two of our team members wrote blogs.

[https://perinatalmentalhealth.wordpress.com/2022/12/05/disability-and-gender-based-violence/?ct=f\(PMHP-news-feb-2021\\_COPY\\_01\)&mc\\_cid=fcf8586672&mc\\_eid=acafa33d76](https://perinatalmentalhealth.wordpress.com/2022/12/05/disability-and-gender-based-violence/?ct=f(PMHP-news-feb-2021_COPY_01)&mc_cid=fcf8586672&mc_eid=acafa33d76)

### EQUIP TRAINING

In November, Clinical services coordinator, Liesl Hermanus, completed training in WHO-endorsed "Competency-based approaches with Ensuring Quality in Psychological Support (EQUIP)" organised by the George Washington University, School of Medicine and Health Sciences, in collaboration with our Department of Psychiatry and Mental Health. A diverse group of attendees including Ph.D. students, clinicians, and NGO workers came together over the two days of training at Valkenberg Hospital.

THE PMHP TEAM IS EXCITED TO USE THE METHOD IN OUR MATERNAL SUPPORT SERVICE AND IN OUR CAPACITY-BUILDING WORK WITH SERVICE PROVIDERS ELSEWHERE.



Participants attending the EQUIP training at Valkenberg Hospital.

### PUSH COMES TO SHOVE - STORIES OF OBSTETRIC VIOLENCE



On 8 December, Embrace premiered their Push Comes to Shove docuseries. The collection exposes different forms of obstetric violence told through the lens of four women who have experienced this

form of gender-based violence within the public and private healthcare sector in South Africa. Our clinical services coordinator, Liesl Hermanus, was invited to be part of a panel discussion where she highlighted the mental health impacts of obstetric violence and spoke about respectful maternity care. It was a great honour to be part of such a critical conversation and to engage with other health advocates.

### MARKETING AND COMMUNICATIONS WORKSHOP

A huge thank you to Lisa Pellatt and her team from Ten x Collective and Sarah Scarth from Operation Smile, who have offered to help us with our marketing and communications pro bono. Watch this space for some exciting new PMHP developments in 2023.



PMHP team attending marketing and communications workshop in December.

### FAREWELL LELE

We end the year with a goodbye to our amazing Research Officer, Siphumelele (Lele) Sigwebela. Lele has been with us since the beginning of 2020 and has contributed to many PMHP activities. We are fortunate that Lele will still be around next year, to assist us with various tasks on a consultancy basis. We will miss her positive energy and wish her all the best with her future endeavours! ■



Siphumelele (Lele) Sigwebela



# Redilev Indications<sup>1</sup>

**Redilev is indicated in adults and adolescents (from 16 years of age) as**

- **Monotherapy** for the treatment of newly diagnosed partial onset seizures with or without secondary generalisation
- **Adjunctive therapy to treat partial onset seizures**, with or without secondary generalisation

**Redilev is also indicated as adjunctive therapy in the treatment of:**

- Myoclonic seizures in adults and juvenile myoclonic epilepsy in adolescents (from 12 years of age),
- Primary generalised tonic-clonic seizures in adults, **and**
- Idiopathic generalised epilepsy in adolescents (from 16 years of age)

**Dr. Reddy's** 



HELPLINE : 0800 21 22 23  
[www.sadag.org](http://www.sadag.org)

References:1. Redilev [Professional Information]. Sandton, South Africa: Dr. Reddy's Laboratories (Pty) Ltd; November 2016. 2. Galderisi S, Heinz A, Kastrup M. Toward a new definition of mental health. *World Psychiatry*, 2015; 14(2), 231-233.

<sup>S3</sup> Redilev 250/500/750. Each tablet contains levetiracetam 250 mg/500 mg/750 mg. Reg. No's: 41/2.5/0460; 0461; 0462. Dr. Reddy's Laboratories (Pty) Ltd. Reg no. 2002/014163/07. Block B, 204 Rivonia Road, Morningside, Sandton, 2057. [www.drreddys.co.za](http://www.drreddys.co.za). ZA/05/2022-24/Redi/014

For full prescribing information refer to the professional information approved by the medicines regulatory authority.  
This content is for HCPs only and the intended recipient should not share or forward it.

**Dr. Reddy's**



NEUROPSYCHIATRY  
GOOD HEALTH CAN'T WAIT

# THE USE OF SOCIAL MEDIA IN THE SOUTH AFRICAN HEALTHCARE SECTOR

Volker Hitzeroth

The use of social media in healthcare practice has become ubiquitous. While this brings numerous benefits, it also adds several previously unknown risks to the modern healthcare arena. This is the first of a series of articles highlighting the use, and risks, associated with social media in healthcare.

**M**odern medical practice is characterised by many challenges. Not only is the field of medicine vast and everchanging but having to manage a busy medical practice and treating individual patients bring their own complexity. Furthermore, ongoing technological advances and complex pharmacological innovation also add to the numerous difficulties faced by healthcare practitioners. In South Africa there also remains practical concerns related to healthcare delivery, logistical difficulties, managerial issues, and various resource deficiencies.

THROUGHOUT THE LAST DECADE OR TWO ANOTHER CHALLENGE, PREVIOUSLY LARGELY UNKNOWN, HAS ARISEN. THE USE OF SOCIAL MEDIA HAS IMPACTED ON THE PROVISION OF HEALTHCARE ACROSS THE WORLD.

It is no exaggeration to state that social media has transformed the practice of medicine. Every healthcare service and every patient interaction has been affected by the rise of social media and electronic communication (e.g. emails, WhatsApp, public health forums, blogs, user content, sharing of information etc). While this has brought with it many benefits, especially in a country like South Africa, it has also raised numerous concerns and introduced previously unknown risks to everyday medical practice. Anyone working in the healthcare environment should become aware of such risks and be able to manage their use of social media

to maintain the high standards expected of the profession. An inability to do so may result in adverse consequences such as a bad review, a complaint before the HPCSA or even a claim in defamation.



Volker Hitzeroth

The benefits of social media in the healthcare sector are indisputable and include:

1. Improved communication and information sharing
2. Supporting patients and colleagues
3. Educating patients and colleagues
4. Provision of improved healthcare
5. Continued professional development, accessing specialist opinions, and receiving updates with regard to developments in your field of expertise or area of interest.

There are however real risks associated with inappropriate use of social media. In order to guide practitioners and protect the public, the HPCSA has published a booklet called *Ethical Guidelines on Social Media (Booklet 16)*. The booklet is very helpful, and in addition to *The General Ethical and Professional Rules of Conduct (Booklet 2)* as well as the numerous other HPCSA published Ethical Guidelines booklets, provides a helpful framework for healthcare practitioners. It would be prudent for every practitioner to familiarise themselves with the content.

The HPCSA's definition of social media includes various online tools and electronic platforms including social networks, content sharing platforms, personal and professional blogs, internet discussion forums as well as the comment sections of websites. In short, everything that a practitioner does electronically may be included in this definition, from simple emails, SMS and WhatsApp messages, to Facebook, LinkedIn and Twitter.

## **THE HPCSA'S GUIDANCE IN RELATION TO SOCIAL MEDIA EXAMINES THE FOLLOWING THEMES:**

### **1. Patient confidentiality and privacy:**

Patients are entitled to privacy and confidentiality – with very few exceptions. Appropriate and correct informed consent, in writing, must be obtained before any patient's personal information is published. Identifiable patient information should also be removed. Any disclosure should be kept to a minimum when it is published, and HCPs must be aware that such published information may be shared onwards and disseminated. The patient's right to confidentiality extends beyond their demise. The Protection of Personal Information Act (POPI Act) also has relevance to social media as it governs all information processing in the republic.

### **2. The practitioner – patient relationship:**

A common risk is that the doctor-patient relationship becomes blurred, and the usual firm professional boundaries become increasingly elastic resulting in further ethical dilemmas. When a practitioner is approached by a patient in a non-professional capacity, they should be cautious and consider the circumstances and implications before accepting such a request. Similarly, any inappropriate patient approach calls for the polite re-establishment of the professional boundaries with a brief explanation regarding the reasons for doing so. Furthermore, it is recommended that, except for emergencies, healthcare advice should not be given by social media but rather during a clinical consultation. Finally, any healthcare advice that is shared on social media should be evidence-based, scientifically sound and generic in nature while a recommendation to consult a healthcare practitioner is also made. In essence, it is imperative that healthcare practitioners separate their professional and personal online presence.

### **3. The health profession's image:**

It is worth emphasising that a practitioner's personal online activity may reflect on their own professionalism as well as the profession as a whole. It is therefore important that all social media activity, whether personal or professional, does not bring the profession into disrepute. Practitioners should avoid defamatory comments, hate speech and the infringement of copyright. Similarly, practitioners should not cast aspersions on the probity, skill, or reputation of a colleague. The traditional boundaries between trainees and teachers also apply online. Finally, practitioners are

advised to include disclaimers in their social media profile explaining that the views expressed are their own and not those of the profession or the relevant healthcare facility.

### **4. Conflicts of interest:**

Healthcare practitioners should never endorse any hospital, facility, product, or medicine in a manner that unfairly promotes certain practices, establishments, or products for financial or other gain. Practitioners must abide by the HPCSA's rules on advertising and may not engage in canvassing or touting.

### **5. Precautionary measures when using social media:**

It is expected that practitioners take all reasonable security measures. Complete anonymity and confidentiality are never assured. All privacy settings should be appropriately adjusted. Despite such measures, it should be remembered that any post on social media may be copied, reproduced, captured, or shared by the recipient. It is equally important to remember that anything shared on social media is likely to remain there in perpetuity and cannot be easily or completely removed. Finally, practitioners should not use social media while stressed, tired, upset or under the influence of alcohol.

**WHILE THERE ARE NUMEROUS RISKS ASSOCIATED WITH THE USE OF SOCIAL MEDIA THIS SHOULD NOT PREVENT HEALTHCARE PRACTITIONERS FROM MAKING USE OF THE OPPORTUNITIES THAT SOCIAL MEDIA OFFERS.**

Given the current situation it is not possible for a practitioner to ignore or sidestep social media anymore. It has become part and parcel of our modern society and of modern medical practice. The challenge facing healthcare practitioners is to be able to use social media responsibly and professionally, to be aware and alert to the associated risks and to manage their social media use in such a manner as to benefit from its advantages and minimise the medicolegal risk associated with inappropriate use.

If HCPs are in any doubt about the risks you face either from your social media or interactions with patients on social media, they should contact their medical defence organisation for advice.

### **REFERENCES:**

- HPCSA: *Ethical Guidelines on Social Media (Booklet 16)*.
- HPCSA: *The General Ethical and Professional Rules of Conduct (Booklet 2)*

**Volker Hitzeroth** is Medicolegal Consultant at Medical Protection Society in London, United Kingdom.  
**Correspondence: [Volker.Hitzeroth@medicalprotection.org](mailto:Volker.Hitzeroth@medicalprotection.org)** ■

**Dopaquel**  
QUETIAPINE FUMARATE

# TRUST is EARNED

Treatment with  
**PROVEN EFFICACY**  
For the treatment of schizophrenia  
and manic episodes associated  
with bipolar disorder<sup>1</sup>

## HARMONY in MENTAL HEALTH<sup>2</sup>

Dr. Reddy's 



HELPLINE : 0800 21 22 23  
[www.sadag.org](http://www.sadag.org)

Dr. Reddy's



NEUROPSYCHIATRY  
GOOD HEALTH CAN'T WAIT

References: 1. Dopaquel Package Insert. Dr. Reddy's Laboratories (Pty) Ltd. June 2017. 2. Galderisi S, Heinz A, Kastrup M et al. Toward a new definition of mental health. *World Psychiatry*, 2015;14(2): 231-233.

[S5] Dopaquel 25/100/200/300. Each tablet contains quetiapine fumarate equivalent to quetiapine 25 mg/100 mg/200 mg/300 mg. Reg No's 43/2.6.5/0429/0430;0431;0432. Dr. Reddy's Laboratories (Pty) Ltd. Reg no. 2002/014163/07. Block B, 204 Rivonia Road, Morningside, Sandton, 2057. [www.drreddys.co.za](http://www.drreddys.co.za). ZA/03/2021-23/Dop/005

For full prescribing information refer to the professional information approved by the medicines regulatory authority. This content is for HCPs only and the intended recipient should not share or forward it.



# SAVE THE DATE

## 4th Southern African Multidisciplinary ADHD Congress

30 August - 2 September 2023

presented by



Goldilocks and  
the Bear Foundation

in partnership with



**Stellenbosch  
Business School**

Virtual format

Earn CPD Points (clinical and ethical)

Early bird reduced registration fees

World-class local- and international speakers

Competition prizes and live entertainment

For further information, please contact:

Congress Secretariat: Sonja du Plessis

Cell: 082 455 7853 | E-mail: [sonja@londocor.co.za](mailto:sonja@londocor.co.za)

Or:

Marida Kroukamp

[marida@londocor.co.za](mailto:marida@londocor.co.za)

Congress Convenor: Prof Renata Schoeman:

[renata@renataschoeman.co.za](mailto:renata@renataschoeman.co.za)

# IRON DEFICIENCY AND ADHD

– PRESENTED BY DR KOBUS ROUX

*Illana Juliette Links*

Iron is an essential nutrient and plays an important role in living organisms. Its main functions include oxygen transport, electrolyte transport and cellular respiration. In addition to these functions iron also plays a vital role in energy production, cell growth and glucose metabolism. Key functions identified specifically in the central nervous system includes synthesis of neurotransmitters, DNA synthesis and myelin synthesis.

Humans use about 20mg of iron each day for production of new red blood cells. Iron excretion during menstruation or other bleeding is a closed system and new red blood cells are recycled from old red cells. Iron stores, also called ferritin, and free iron is maintained in a vital homeostatic process and iron absorption is triggered when ferritin levels and iron saturation is low. The most specific marker of iron deficiency is serum ferritin; thus, a low ferritin level is likely to indicate an iron deficiency. Ferritin is an acute phase protein and can be falsely high in certain situations. A recent meta-analysis and systematic review have found contradictory findings for the relationship between ferritin levels and ADHD, and thus the extent to which ferritin levels in blood correlate with brain iron levels remains unclear.

**IRON DEFICIENCY IS ONE OF THE MOST COMMON MICRONUTRIENT DEFICIENCIES. IT IS VERY COMMON IN PREGNANT FEMALES AND SUPPLEMENTS ARE USUALLY PROPHYLACTICALLY PRESCRIBED TOGETHER WITH FOLATE TO ALL PREGNANT WOMEN.**

The developing infant is reliant on iron for neurodevelopment. Low serum iron in pregnant women during the perinatal period may lead to

permanent neurodevelopmental deficits in the newborn and postnatal depression in the mother.

The most severe consequences of iron deficiency are present in early childhood which marks a period of high growth and thus increases need for iron intake.

Neurodevelopmental disorders have been identified in babies born to mothers with iron deficiency and include attention deficit hyperactivity disorder (ADHD), impulsivity and impaired executive functioning. These neurodevelopmental problems cause the infant to have delayed development for the rest of his life. Studies suggest that the severity of symptoms in ADHD patients with low serum levels may improve with iron supplementation: poor executive functioning, impulsivity and restless legs have been implicated. However, some symptoms are irreversible, thus iron balance in pregnancy should be closely monitored and iron replacement is essential.

The relationship between iron deficiency and ADHD is supported by the following evidence: Firstly, iron is a co factor of enzymes needed for the production and breakdown of monoaminergic neurotransmitters including dopamine. Dopamine have been linked to ADHD. Secondly iron deficiency is associated with dopamine transporter expression and the corresponding gene is linked to a genetic vulnerability associated with ADHD. Lastly iron deficiency can cause dysfunction in basal ganglia which plays a significant role in ADHD pathophysiology.



*Illana Juliette Links*

**Illana Juliette Links** is a psychiatry registrar at Walter Sisulu University, Umtata. **Correspondence:** [illalinks@gmail.com](mailto:illalinks@gmail.com)

# ADHD/AUTISM: A DIMENSIONAL APPROACH

## – PRESENTED BY DR LINDA KELLY

*Jeanneré Jordaan*

**A**ttention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Disorder (ASD) are commonly diagnosed Neurodevelopmental Disorders with onset in early childhood. Recently the ADHD/ASD overlap has been a controversial and debated area. These disorders are perhaps not distinct entities but represent phenotypic variabilities of the same disorders or have significant overlap of features that mimic each other or resemble each other.

According to the DSM-5 ADHD is defined as a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development prior to the age of 12 years with symptoms interfering in two or more settings. ASD is defined by persistent deficits in social communication and interactions that occur across multiple settings, along with the presence of restricted, repetitive behaviours, interests or activities, or sensory symptoms. These symptoms should be present in early development and is specified based on the severity and amount of support required.

The developmental hypothesis could help us understand the underlying pathology. Environmental and genetic risks pre-conception with additional neuro-inflammation during the prenatal period could disrupt normal brain development and other neurological processes. However, these disorders are still currently being defined behaviourally.

In youth living with ASD, ADHD is the most common co-occurring disorder (40-70%). Other research also suggests that children with ASD have symptoms of ADHD and vice versa. Development of ASD increases the risk of developing ADHD, these disorders might have common environmental and genotypical risk factors, but they remain separate entities. Some associated clinical features include sensory processing, theory of mind, executive functions, effortful control, motor functioning, sleep disturbances and anxiety.

Even though there is an overlap in the symptomatology of the disorders, the quality of impairments are different. In ADHD and ASD both have difficulties with executive functioning, skills involving mental control, self-regulation and effortful control. However, in ADHD inhibition and problem solving is impaired. Cognitive flexibility, set shifting and switching between multiple perspectives are the most challenging deficits in ASD.

The motor function difficulties in ASD are described by fine and gross motor problems, balance difficulties, hypotonia and discoordination. Similarly, ADHD individuals have fine and gross motor problems as well as balance difficulties. Sleep disturbances

and anxiety are common in both disorders and have a positive correlation with one another. Oxidative stress, decreased antioxidant proteins and other neurodevelopmental toxins have been considered in both disorders. Impaired methylation might be a contributor. HPA-axis dysfunction occurs in both, such as impaired dehydroepiandrosterone (DHEA) in ADHD, low cortisol and high ACTH in ASD and elevated androgen levels in ASD.



*Jeanneré Jordaan*

A Meta-analyses by Dougherty CC et al (2016) and Rommelse N et al (2017) suggested that these disorders are disorders affecting global neural connectivity rather than specific regions, except for similar disconnectivity noted in the the Default Mode Network, the precuneus. These disorders affect synaptic efficiency, cell adhesion, neurite overgrowth and signaling pathways. The social functioning in ADHD and ASD have similar difficulties in social perception, however in individuals with ADHD, social knowledge is intact but with impaired social interactions often related to poor inhibition. In ASD knowledge deficits drive social communication difficulties.

### THE CO-OCCURRENCE OF ADHD AND ASD THEREFORE INCREASES THE IMPAIRMENT AND SEVERITY OF ASD AND THE RISK TO DEVELOP OTHER MOOD OR ANXIETY RELATED DISORDERS.

In terms of diagnostic tools, the ADOS-2 and ADIR remain useful tools to diagnose ASD and other various standardised rating scales are used to aid in the diagnostic process of ADHD. However, no tool exists to diagnose ADHD in youth with ASD. There is also not enough evidence for treatment options in ASD + ADHD. However, there are well established data and tx options for ADHD and ASD, but it should be taken into consideration there there are higher rates of side effects in youth with ASD.

ASD and ADHD are therefore considered related disorders but sufficiently distinct to be considered separate based on qualitative and quantitative differences. Which diagnosis causes the most impairment for the individual and which diagnosis is most appropriate for the individual? How does diagnosing the comorbid state help us to predict, plan and individualise treatment options? More research needs to explore the transdiagnostic aspects and treatment options of the ASD and ADHD comorbidity.

*Jeanneré Jordaan* is a psychiatry registrar, University of Cape Town. **Correspondence:** [jeannerej@gmail.com](mailto:jeannerej@gmail.com) ■

# REASONABLE ACCOMMODATION: THE IMPERATIVE

– PRESENTED BY LINDA HIEMSTRA

*James Burger*

Linda Hiemstra is an occupational therapist working in work assessment and pain management, with extensive experience in both public and private health services. Her presentation on *Reasonable Accommodation: The Imperative* walked congress attendees through an approach to reasonable accommodation for persons with functional impairment due to Attention-Deficit Hyperactivity Disorder (ADHD).

ADHD IS ASSOCIATED WITH CHALLENGES IN ATTAINING, RETAINING, AND PROGRESSING IN EMPLOYMENT. AS WORKPLACES ARE GENERALLY DESIGNED FOR NEUROTYPICAL WORKERS, THEY POSSESS POTENTIAL BARRIERS TO THE FUNCTIONING AND MENTAL STATE OF NEURODIVERSE WORKERS. HOWEVER, DISABILITY IS CONTEXTUAL – IMPAIRMENTS CAN BE DISABLING IN ONE ENVIRONMENT BUT NOT IN OTHERS.

Providing the necessary and appropriate adjustments and modifications to the work environment enables a person to participate

and advance in employment. Reasonable accommodation is a legal right for persons with disabilities in both international and local legislature, with the National Strategic Framework on Reasonable Accommodations in Persons With Disabilities being released in South Africa in 2020.



*James Burger*

Our constitution and legal frameworks promote equity and justice; employers would need to provide different supports for their employees in order to allow those with disabilities to function equally well.

Beyond the legal imperative of providing reasonable accommodation for those who qualify, there are also ethical and human right imperatives that healthcare workers have to help our patients access these accommodations.

In order to qualify for reasonable accommodation, there are three criteria which must be met:

- 1) There must be an impairment (physical, psychosocial, intellectual, neurological and/or sensory impairment)

- 2) The impairment must be long-term (at least 12 months in duration).
- 3) The impairment must be substantially limiting in nature, affecting their ability to perform the essential functions of the job or their daily activities independently, without been assisted.

**THE EMPLOYEE'S DECISION TO DISCLOSE THEIR DISABILITY IS VOLUNTARY. HOWEVER, IF THE EMPLOYER IS UNAWARE OF THE DISABILITY AND LIMITATIONS, THEY WOULD NOT BE REQUIRED TO PROVIDE REASONABLE ACCOMMODATION.**

Accessing these rights requires the employee being defined as a person with a disability, which may be a challenging and uncomfortable situation for them. Healthcare workers need to engage with the patient about the benefits of disclosure, working how best to frame their disability and limitations, as this may allow them access to tools to reach their full potential.

Work assessments by professionals can help to determine what is required in terms of accommodations. The patient needs to be involved in the process so that inappropriate recommendations are not made on their behalf.

**REASONABLE ACCOMMODATIONS CANNOT RESULT IN 'UNJUSTIFIABLE HARDSHIP' FOR THE EMPLOYER. IT IS IMPORTANT TO MAKE APPROPRIATE RECOMMENDATIONS THAT ARE REALISTIC IN THE CONTEXT OF THE EMPLOYER, SO AS TO AVOID RISK OF UNFAIR DISMISSALS AND PATIENTS NEEDING TO GO THROUGH THE CCMA AND LABOUR COURT.**

Effective and defensible accommodations, which have minimal impact on operations, are more likely to be successful, especially if these will be beneficial for all in the organisation. Larger organisations with high gross incomes may have more scope to provide more extensive accommodations within the entirety of their organisation. The majority of accommodations for ADHD would fall into the 'no tech' and 'low tech' categories, which would likely mean lower costs to the employer, while still being effective. What is justifiable would depend on what is practical, and not just on the cost to employer.

For patients with ADHD, individual recommendations would depend on the clinical presentation, the job tasks, as well as the capacity of the employer. Linda Hiemstra suggested a number of potential avenues to explore for these patients, such as recommendations related to time and planning, with additional preparation time and organisational systems with colour coding and checklists. Changing the format of instructions from verbal to written may help with task completion. They may benefit from flexi-time, as well as working from different and alternating environments and work positions, such as times where they work from home or coffee shops. It may be better for those with ADHD to work away from high-traffic areas and distracting windows. In some cases office dividers may be helpful. Other ways of avoiding distractions, such as through noise-cancelling headphones, may also help with productivity and focus. Keeping the employee appropriately stimulated, with fidget toys, resistance bands for proprioceptive input, and other individualised recommendations may be helpful.

**THE OFFICE COULD HAVE DECOMPRESSION AREAS WITH TIME ALLOWED TO REST AND DECOMPRESS, EVEN FOR SHORT PERIODS E.G. FIVE MINUTES. THEY MAY ALSO CONSIDER ALLOWING SNACKING. HEALTHCARE WORKERS MAY HELP WITH PROVIDING TRAINING AND EDUCATION TO THE REST OF THE WORKFORCE. THIS MAY BE MOST EFFECTIVE IF IT COMES FROM THE PATIENT THEMSELVES, SO EMPOWERING THE INDIVIDUAL TO PROVIDE THE TRAINING MAY BE OF USE.**

These types of specific reasonable accommodations for an individual patient with ADHD can be low cost and effective, allowing our patients to have equal access to their right to employment. As healthcare professionals, we have the imperative to conduct or facilitate a proper assessment, discuss appropriate framing and disclosure of disability, and help with the design and implementation of reasonable accommodations that are acceptable and appropriate for both the patient and their organisation.

**James Burger** is a psychiatry registrar, University of Cape Town Dept of Psychiatry and Mental Health **Correspondence:** [burger.james.w@gmail.com](mailto:burger.james.w@gmail.com) ■

# CHILDRENS TV AND EXECUTIVE FUNCTIONING

– PRESENTED BY DR WIUM ERASMUS

Iviwe Gqirana

Television has become more and more accessible with advancing technology and childrens TV programs can be viewed through various mediums including TV, smart devices, cellphones, tapes or streaming services. Children can be exposed to these programs from infancy right up to adulthood. They are spending more and more time consuming digital media (actively and passively) and clear evidence exists of developmental influences as a result (Deborah L., 2015).

CHILDREN'S TV PROGRAMS ARE DESIGNED FOR CHILDREN, WITH THE PURPOSE OF ENTERTAINING AND/OR EDUCATING. THIS CAN EITHER HAPPEN INTENTIONALLY OR INCIDENTALLY (EG. SESAME STREET). TELEVISION MEDIA HOLDS THE ATTENTION AND INTEREST OF THE AUDIENCE OR GIVES PLEASURE AND DELIGHT (EG. SPONGEBOB SQUARE PANTS, POWER RANGERS ETC.).

These are some of the many reasons why parents and care givers find it useful to expose children to TV but with the increase in programs and exposure through various forms of access whether at home or outside, the question of how this affects a child's executive functioning is raised. How much is too much?

Children's TV programs can roughly be divided into 4 categories according to age:

1. Those aimed at infants and toddlers
2. Those aimed at children aged 6-11 years old.
3. Those for adolescents
4. Those aimed for all children



Iviwe Gqirana

There has been an increasing concern over the impact of TV on the development of attention networks, this was first raised in the 1970s following the appearance of fast paced television programming (Blumberg FC et al., 2017). Numerous studies have indicated that children who watch more TV show increased obesity, aggression (especially if watching violent content), stereotyped cognitions and other misconceptions, and, even worse, academic performance compared to children who watch less television (Lillard AS et al., 2015).

This should not take away from the numerous benefits of some TV programs. Shows with educational content like Sesame Street were seen to have a positive impact on children in low income settings and improved their school readiness compared to children who didn't watch the show (Anderson DR). Other positive benefits include:

- Improving social skills
- Enhancing creativity

- Better engagement in learning
- Education
- Relaxation

While there are studies indicating both the advantages and disadvantages of television, another key factor seems to be around regulating the time spent watching TV shows. Too much of anything, even the most positive and educational content, can negatively affect children at any stage of development.

These concerns have led to numerous recommendations on exposure of children to television and even legislative control of children's TV eg. Children's Television Act 1990 (USA).

Children's TV shows and their effects on Executive Function (EF), predict other key development outcomes.

EF encompasses cognitive processes that underlie goal directed activity/behaviour and are orchestrated by activity within the Prefrontal cortex (PFC). Functions include: Attention, Inhibitory control, Planning, Emotion regulation, Initiation, Self-Monitoring, Flexibility, Organisation and Working memory. These functions develop from birth up to adulthood, reaching the peak in the 20s. Developmental mechanisms include both biological and environmental factors. There are several contributing factors namely: practice, intense motor activity, language (including bilingualism), maternal education and parenting, theory of mind and cultural differences. Much of the development and changes occur during the toddler/preschool years (especially 2-5 years), thereafter followed by more gradual fine-grained improvements later.

Executive function has been shown to be beneficial both immediately and prospectively. It is strongly associated with success in school and later life. E.g.: It has been shown that childhood self-control predicts physical and mental health, wealth, and criminal behaviours by early adulthood.

Impairments in EF may present as trouble with impulse control, tantrums, and difficulty in self-regulating emotions, challenges with school organization, time management, and remembering instructions.

### IN ADOLESCENTS IT OFTEN LEADS TO DIFFICULTIES IN REACHING INDEPENDENCE AND MAKING FUTURE PLANS.

Most published studies report that television viewing is associated with lower attention skills concurrently and/or over the long term. (Lillard AS et al., 2015). Total television and video game exposure in middle

school has been found to be related to attention problems 13 months later, controlling for earlier attention. (Swing et al., 2010). Numerous studies have found that EF skills are worsened directly after exposure to television media (10-30 minutes). This effect is however highly correlated to the type/ characteristics of the program being viewed. For example, pacing, which is the rate of on screen audio-visual changes. Includes: colour, luminance, motion, flickering, and changes in music and speech. Programs with fast-pacing result in greater EF impairments than slow-pace programs. Very generalized educational TV tends to have slower paced programs and is less fantastical whereas entertaining TV tends to have faster pacing with greater fantastical content.

### FANTASTICAL EVENTS AND FAST-PACED PROGRAMS ARE SURPRISING, ATTENTION GRABBING AND TRIGGER INVOLUNTARY ATTENTION (BOTTOM-UP) THUS LIMITING THE OPPORTUNITY FOR PRACTICING TOP-DOWN ATTENTIONAL CONTROL REQUIRED FOR EXECUTIVE FUNCTION TASKS.

Literature consistently identifies an association between children's TV in both long and short-term executive function impairments.

These are highly correlated with features that increase the cognitive processing demand, such as pacing and fantastical content. (Educational VS Entertaining), correlated to the amount of time exposed. Greatest effects are seen in exposure to infants, toddlers and preschoolers.

Multiple theories have been postulated to account for these impacts, but further research is required to better define and explore possible causal relationships. However, this impact is critical. If early television exposure is truly impacting executive function in a long-term manner, unregulated media exposure may have detrimental effects on academic achievement, socioemotional learning, and more. Population level implementations may be required to protect children.

Parents and care givers need to be conscious of what content children are watching, how long/ often it is being consumed and it is crucial to avoid early exposure to television in children as the negatives tend to outweigh the positive benefits.

Screen Time recommendation by age

- 0-18 months: Avoid screens
- 18-24 months: Co-view, minimal viewing
- 2-5 years: 1 hour screen time max
- 6+ Consistent limits are key

**Iviwe Gqirana** is a psychiatry registrar, at Walter Sisulu University. **Correspondence: iviwegqirana@gmail.com** ■

# INTIMATE PARTNER VIOLENCE IN ADHD

– PRESENTED BY DR LERATO DIKOBÉ-KALANE

Gillian Atkinson

**D**r Lerato Dikobe-Kalane, a psychiatrist in the Western Cape delivered this topic in a presentation entitled '**ADHD Highway to Violence**'.

Her presentation began with a definition of ADHD being a neurodevelopmental disorder that affects both children and adults. A meta-analysis of more than 100 studies, estimated worldwide prevalence of ADHD in children and adolescents to be 5.3%, decreasing from childhood (6.5%) to adolescence (2.7%).

The prevalence of symptomatic ADHD still requiring treatment in adults was found to be between 2.5% and 3.4%. This prevalence in adults was found to decrease with age (from estimated 9% in young adults to 4.5% above age 60 years).

Despite this high prevalence, fewer than 20% of adults with ADHD are possibly due to adults who received a diagnosis in childhood, but were lost to follow up as they aged, or the ADHD symptoms were unrecognized or misdiagnosed.

There is a lack of awareness that ADHD symptoms affects adults. Onset of symptoms and the impairment of ADHD can be separated by many years particularly among individuals living in supportive well-structured childhood environments or among individuals with strong intellectual abilities.

Symptoms of poorly controlled ADHD in adults may include impulsivity, poor time management skills, poor planning, problems focusing on tasks, disorganization, and difficulties prioritising, as well as low frustration tolerance, frequent mood swings and trouble coping with stress. Men tend to be more hyperactive and impulsive, whereas women are more likely to be more inattentive.



Gillian Atkinson

**IN UNTREATED ADULTS, THESE SYMPTOMS WILL INCREASE THE RISK OF POOR ACADEMIC OR WORK PERFORMANCE, JOB INSTABILITY, FINANCIAL PROBLEMS, TROUBLE WITH THE LAW, ALCOHOL OR OTHER SUBSTANCE MISUSE, FREQUENT CAR OR OTHER ACCIDENTS, POOR PHYSICAL AND MENTAL HEALTH, LOW SELF-ESTEEM, NEGATIVE PARENT-CHILD INTERACTIONS, AND UNSTABLE RELATIONSHIPS.**

Those with ADHD are more likely to experience emotional dysregulation which could lead to anger outbursts. These violent or aggressive behaviours may be more likely to occur in those

with more hyperactive/impulsive symptoms than those with predominantly inattentive symptoms. However, inattention can be associated with low educational achievement, compromised cognition related to working memory, and executive difficulties impairing the regulation of interpersonal interactions. This could lead to violent altercations.

Longitudinal studies show that childhood ADHD is a risk factor for a wide range of adverse psychiatric outcomes in adulthood, including violence, addiction, mood disorders, anxiety disorders and antisocial personality disorder (ASPD).

Intimate partner violence (IPV) is described as “any behaviour within an intimate relationship that causes physical, sexual or psychological harm” (World Health Organisation, 2013). This violence occurs against a current or former intimate partner in the context of a romantic relationship. IPV can range from one episode of violence, to repetitive and severe episodes over multiple years, leaving a long lasting impact.

**THE WORLDWIDE PREVALENCE WAS SLIGHTLY HIGHER FOR FEMALE-PERPETRATED COMPARED TO MALE-PERPETRATED PHYSICAL IPV: MORE THAN 1 IN 4 WOMEN (28.3%) AND 1 IN 5 MEN (21.6%) REPORTED PERPETRATING PHYSICAL VIOLENCE IN AN INTIMATE RELATIONSHIP.**

The South African prevalence of IPV against women is 30 – 50%. In August 2022, the South African Minister of Police, General Bheki Cele, announced that from April to June 2022, 855 women were killed and over 11 000 female victims opened cases of assault GBV. During this same time period, 9516 rape cases were opened (3780 took place in the victims’ homes).

Emotional intensity is common in ADHD and could be a positive attribute but often it could also make people more likely to overreact in ways that could damage relationships with friends, colleagues as well as romantic partners.

Adults diagnosed with ADHD as children, particularly those with persistently high ADHD symptoms, reported higher rates of IPV perpetration and victimization than adults with ADHD histories but low current symptoms and adults who were never diagnosed with ADHD.

In a cross-sectional study of 433 college students, correlational analyses indicated that those with greater ADHD symptom severity reported higher rates of psychological and physical IPV perpetration, and higher rates of psychological IPV victimization. Students who reported no alcohol abuse or drug use, but did report greater ADHD symptom severity (particularly inattention) indicated higher rates of psychological IPV perpetration and victimization

than those reporting no alcohol abuse or drug use and low ADHD symptoms. Another study showed that men with ADHD who reported higher heavy episodic drinking or alcohol use problems from age 19 to 24 were more likely to perpetrate IPV than problem drinkers without ADHD.

**A RETROSPECTIVE STUDY LOOKING AT THE CONNECTION BETWEEN CHILDHOOD ADHD AND IPV PERPETRATION SHOWED THAT CONDUCT DISORDER (CD) IS CONSISTENTLY ASSOCIATED WITH VIOLENCE IN INTIMATE RELATIONSHIPS. EVEN AFTER CONTROLLING FOR CD, THERE WAS STILL AN ASSOCIATION BETWEEN ADHD AND IPV.**

Other risk factors of IPV include environmental adversities such as childhood maltreatment, exposure to domestic violence, coercive parenting, deviant peer affiliation and neighbourhood criminality. Case control studies comparing IPV offenders to controls revealed that offenders more were likely to have witnessed parental domestic violence and were more likely to have been abused as children.

Violence associated with severe ADHD is also often explained by co-existing psychopathology and this should be identified. There is evidence that the identification of symptomatic ADHD in adults who are perpetrators of IPV, and appropriate treatment of these adults could decrease the risk of IPV. This treatment would include the use of either stimulants or non-stimulants specifically for the symptoms of ADHD as well as the treatment of any identified comorbidities such as depression and anxiety.

Psychotherapies suggested to be of assistance would include:

- Cognitive Behavioural Therapy (CBT) – Teaching specific skills with challenging negative thinking patterns and managing behaviour
- Dialectical Behavioural Therapy (DBT) – Focusing on emotion regulation, interpersonal effectiveness, and distress tolerance
- Family Therapy – Improve relationships with the family
- Couple Therapy – Helps the partner cope with challenge of living with someone who has ADHD. Can improve communication and conflict resolution
- ADHD Coach – Improve time management, goal setting and organisational skills

**Gillian Atkinson** is a psychiatry registrar at Walter Sisulu University, based at Cecilia Makiwane Hospital in Mdantsane in the Eastern Cape. **Correspondence:** [drгатkinson@gmail.com](mailto:drгатkinson@gmail.com) ■

# CLINICAL PAEDIATRIC DIETICIAN: AN OVERVIEW OF THE EVIDENCE AND A PRACTICAL APPROACH TO NUTRITION FOR ADHD – PRESENTED BY KATH MEGAW RD(SA)

*Dennilee Naicker*

The talk delved into the history of the ketogenic diet by taking us back to 400 BC where Hippocrates noted that a person with epilepsy improved when they were starved of food and water, however this was not sustainable. In the 1920s with an increase in research around diabetes it was discovered that the body couldn't access glucose and as a result used fat in the form of ketones to produce energy. After connecting the dots, a trial showed that people with epilepsy that were put on a purely fat diet had an 80-90% reduction in seizures. However, phenobarbital then came on to the market and the ketogenic diet was shelved. In the 1980s a boy in Hollywood had refractory epilepsy. His parents came across the available research which showed success with the ketogenic diet. Under medical supervision their son was put on this diet and became seizure free 3 days later.

Pharmacology still plays a huge role but we should not forget about our fundamentals in the form of our diet. The microbiome is an area of accelerated study in the past 5 years and the human microbiome is a very complex one with 10 to 100 trillion microbial cells. The gut-brain connection is really imperative and can not be looked at in isolation hence the new science called neurogastroenterology. This bidirectional axis involves many systems such as the endocrine, immune, autonomic and nervous system.

Monoamines such as serotonin and dopamine are active in both the brain and the gut and influence an array of functions. It is important to be able to absorb and digest nutrients provided in our diet, avoid a leaky gut, have a balance of good and bad bacteria in the gut, reduce inflammation in the gut and in turn this is connected to our nervous systems.

Some strategies to maintain a healthy gut include feeding the good bacteria with soluble plant fibres, fruit and vegetables, as well as consuming probiotics in the correct manner, avoid over sanitising our environments, avoid unnecessary antibiotics, play in the garden, snuggle your pets, spend time outdoors, get dirty, avoid processed food and eat enough protein.

There are a few micronutrients in the spotlight currently however not much research is available but they certainly deserve more study. Tryptophan is an amino acid which is part of the serotonin pathway. It is uncertain if taking high doses of isolated tryptophan is of any benefit at this stage. Vitamin B6 has a huge role in biological processes in the body, as well as in the production of dopamine, and should be taken

with magnesium. More research is required to say if all children with ADHD should be supplemented with these nutrients in the context of their diets if deficient. Other nutrients such as vitamin C is beneficial for the immune system and some studies have shown that a carnitine deficiency might play a role in ADHD.



*Dennilee Naicker*

**OVERALL, MOST RESEARCH SUGGESTS THAT ONLY OMEGA-3 SUPPLEMENTATION IS BENEFICIAL IN ADHD. OUR DIETS ARE ALREADY HIGH IN OMEGA-6 AND DON'T NEED SUPPLEMENTATION AS PREVIOUSLY THOUGHT.**

The relevance of the keto diet today is extraordinary as it may have started with the treatment of epilepsy but has now broadened. Parents reported that children concentrated and focused better which improved overall outcomes, before seizure improvement was reported. Studies are currently showing the relevance of the keto diet to brain health by examining the brain's metabolism. It has the ability to use 20% of our bodies calories and needs constant source. It can use ketones as an alternate source of energy. The brain can function on 75% ketones. Ketones also enhance the mitochondria of the cells of the brain. Neuromodulation is another component whereby ketones increase GABA and decrease glutamate. Different variations in diet exist, with the classic strict keto diet which is great for refractory epilepsy; modified keto based diet used for children with autism with or without epilepsy and a low refined carb diet for children with epilepsy, ADHD and autism across the board.

Key aspects of an ADHD diet include:-

- Correcting the microbiome,
- Eliminating food additives,
- Limit added sugars and simple carb foods,
- Remove all food allergens,
- Stimulate ketone production,
- Correct nutritional deficiencies,
- Use science based supplements.

As a registrar in the midst of final examinations it was an honour to attend the 3rd Southern African Multidisciplinary ADHD Virtual Congress. It was an eye-opening experience and my knowledge has increased substantially. I would definitely encourage the reader to attend next year.

**Dennilee Naicker** is a psychiatry registrar, at the University of Pretoria. **Correspondence: dennileenaicker@gmail.com**

# DIAGNOSTIC OVERLAP IN CHILD & ADOLESCENT PSYCHIATRY: A PRACTICAL APPROACH

## OPPOSITIONAL DEFIANT DISORDER AND ADHD

– PRESENTED BY DR TERRI HENDERSON

Carine Gagiano

In her presentation, Dr Henderson described the dual diagnosis of Attention Deficit/Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder (ODD) as an “oh dear” diagnosis. This combination of diagnoses is complex, treatment is costly and often unsuccessful and families are often desperate and hopeless. She stated that the combined diagnosis of ADHD and ODD comprise up to 70% of referrals to tertiary child and adolescent units in South Africa.

**THIS COMBINED DIAGNOSIS IS ASSOCIATED WITH A POOR PROGNOSIS, EARLIER ONSET, MORE DELINQUENCY AND HIGHER RISK FOR COMORBID MOOD AND ANXIETY DISORDERS THAN EACH DIAGNOSIS INDIVIDUALLY.**

Dr Henderson highlighted overlapping symptoms between ADHD and ODD as well as symptoms that are distinct to ODD. She explained that ODD symptoms are seen across developmental stages- symptom onset is usually seen in pre-school years and persists throughout the patient’s life into adulthood.

#### Overlapping symptoms included:

- Losing temper
- Angry and resentful
- Easily annoyed
- Argumentative

#### ODD distinct symptoms included:

- Refusing to comply with rules
- Deliberately annoying others
- Blaming others for their own mistakes

Dr Henderson discussed risk factors for the development of ODD as well as for the dual diagnosis of ADHD and ODD.

#### Overlapping risk factors

- Antenatal maternal smoking
- Family history of ODD or ADHD
- High levels of family conflict
- More adverse life events experienced by child
- Higher birth weight
- Low socioeconomic status

#### Risk factors specific to ODD

- Deviant peer affiliation
- Harsh inconsistent parenting
- Low levels of parental affection
- Exposure to family violence

Treatment options for the combined diagnosis of ADHD and ODD was discussed and included psychological interventions, behavioural programs and pharmacotherapy.

#### Psychological interventions and behavioural programs.

Dr Henderson explained that it is ideal to implement interventions in children from the age of 3 years old and before the age of 8. Programs promote pro-social behaviour and interaction through modeling and praise and reward systems.



Carine Gagiano

#### *Psychosocial interventions include:*

- Parenting training. This is an important aspect of addressing behaviour in ODD and ADHD. When parents are stressed and desperate, they tend to be critical and use harsh and often severe physical disciplinary methods. This, however has a negative effect on the child’s emotional state and the child might harbour feelings of anger, defeat and self-blame. This could lead to further deterioration in the child’s behaviour.
- Child CBT
- Social skills training
- Specialized foster homes

#### *Preventative targeted programs:*

- Chicago parent program is a 12-week program and should ideally be implemented before the age of 7 years.
- Incredible years program (basic/with literacy/enhanced)
- Nurse family partnership is a program that focuses on single mothers and is a 26 week program.
- ROAR program targets 13–18-year-old
- Sporting Chance and Wave of change

#### Pharmacotherapy

Dr Henderson advised optimization of ADHD treatment and to add one of the following effective agents for aggression, disruptive behaviour and emotional dysregulation: Clonidine, Valproate, Risperidone, Olanzapine or Quetiapine. She advised to treat co-morbid mood and anxiety with an SSRI and/or aripiprazole. Dr Henderson promotes early intervention while there is “a window of opportunity”. She advises a step-wise approach with adequate dosing and sufficient time on a specific medication. It is crucial to effectively manage side effects to improve compliance. Perseverance is key in the treatment of ADHD and ODD.

This presentation was informative, useful, and very interesting.

**Carine Gagiano** is a psychiatry registrar at Stellenbosch University. **Correspondence:** [carinegagiano@gmail.com](mailto:carinegagiano@gmail.com) ■

# SCREEN MEDIA USE AND ADHD RELATED BEHAVIOURS

– PRESENTED BY DR LESLEY CAREW

Mahlitse Thosago

This topic was interesting to me because there was a rise in screen media usage because of the two-year lockdown due the Covid-19 pandemic. Dr Carew restructured the topic to a question where she asked “What is the relationship between screen media use and attention problems related to hyperactivity and impulsivity in adolescents?” since, I presume, children and adolescents were the biggest consumers of screen media and because ADHD is most prevalent amongst these groups.

Dr Carew went through a plethora of literature, reviewed articles and empirical studies which dated as far back as the 1970s where different theoretical and analytical perspectives were observed. Studies were integrated into 2 meta-analyses in which they had applied in which the Differential Susceptibility to Media effects Model was applied.

Two meta-analyses from 2014 and 2015 looked at the correlation between ADHD-behaviours, aggression, mental health, prosocial behaviour and academic performance and media use amongst children and adolescents.

The study by *Nikkelen et al, 2014* concluded that boys were more susceptible to ADHD-behaviours as a result of video games and television viewing compared to girls even though this study was criticized for the family environment not being included as another moderator.

**FERGUSON, 2015 CONDUCTED 9 EMPIRICAL STUDIES WITH AGE AND GENDER AS BACKGROUND VARIABLES. THIS STUDY WAS CRITICIZED BECAUSE IT REDUCED BECAUSE IT REDUCED THE POOLED CORRELATION WHICH UNJUSTLY WASHED AWAY THE TRUE EFFECTS OF THE MEDIA IN CERTAIN SUBGROUPS.**

The key points from the presentation were categorized into three, namely: Indirect media effects, conditional media effects and transactional media effects. The indirect media effects aimed to elaborate on the mechanisms that explain the Media-ADHD relationship.



Mahlitse Thosago

Three response states under the Indirect Media effects were identified as intervening or mediating variables between screen media use and ADHD behaviours: Cognitive: attention to and processing of media content. Emotional: affective reactions e.g. fear or joy while watching/playing. Excitative: physiological arousal while or after watching/playing.

Cognitive and Excitative responses were the main variables in the *Fast-pace arousal-habituation hypotheses* from various studies in the 1990s and late 2000s. The Cognitive response was identified as the variable in the *Violence induced script hypotheses* from the 2000 and 2010 cross-sectional studies which had ethical limitations. The Excitative response was noted as a variable in the *Violence induced arousal habituation hypotheses* from the 2001 and 2006 studies

The indirect effects of program pacing on ADHD-behaviours in children were difficult to draw conclusions from designs of the studies, but the exposure to violent media use is positively correlated to ADHD-like behaviours although the direction of the relationship could not be determined since cross-sectional studies were mostly used.

The Conditional Media Effects aim to determine who is affected in the Media-ADHD relationship by looking at the susceptibilities. Lineberger, 2005 theorized that younger children are more vulnerable but there was no empirical evidence to support this and the article concluded that

there is no relationship between video game playing, attention problems and hyperactivity in preschoolers when adjusting for parenting styles. Many empirical studies fail to investigate age differences.

Dispositional susceptibilities were investigated in 2005 and 2006 where it was hypothesized that physically aggressive adolescents were more susceptible to the effects of violent media on attention, but more robust information is needed. The social aspect of susceptibility looked at parenting style, media specific parenting, demographic risk, parental well-being (depression) and peer pressure, with the latter being a neglected area of research

The Transactional effects aim to determine the direction of the relationship. Three articles were identified which looked at the transactional effects between media use and children who display ADHD-like behaviours. One concluded that children with ADHD behaviours are more likely to choose high arousal media which in turn increases ADHD behaviours. One of the other studies concluded that children with ADHD have low baseline arousal states and they seek out and engage in high arousal behaviours such as violent or fast-paced media. The final article from *Vandewater et al, 2005*, theorized that screen media was a way to escape conflict with parents or peers

In conclusion, there is statistically small but significant relationship between screen media use and ADHD-like behaviours but there is next to nothing about the direction of the relationship or the pathway through which the relationship occurs.

**THE LIMITATIONS WHICH WERE NOTED INCLUDED THE FACT THAT THE EXISTING RESEARCH LARGELY IGNORES MEDIATING VARIABLES; VARIABLES ARE MODELLED AS CONTROLS AND CORRELATIONAL RESEARCH DOES NOT ALLOW ONE TO ASSESS THE DIRECTION OF THE RELATIONSHIP BETWEEN SCREEN MEDIA AND ADHD-RELATED BEHAVIOURS**

*Recommendations:* Longitudinal studies are required to determine the transactional effects. There is hope for more research to come since technology has become advanced in the last 10 and it has become a lot more accessible in the last 5 years.

I'd like to send my gratitude to the organizers of the ADHD symposium for sponsoring me and affording me the opportunity to expand my knowledge about ADHD.

**Mahlatshe Thosago** is a psychiatry registrar, Stellenbosch University. **Correspondence:** [thosago@sun.ac.za](mailto:thosago@sun.ac.za)



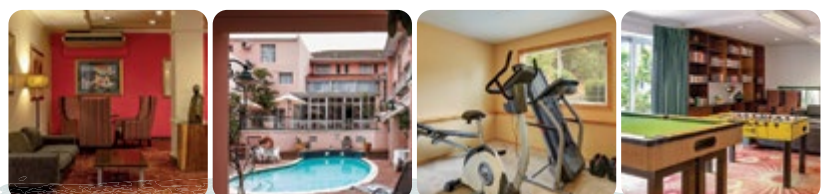
## Over a decade of excellence and success in mental health



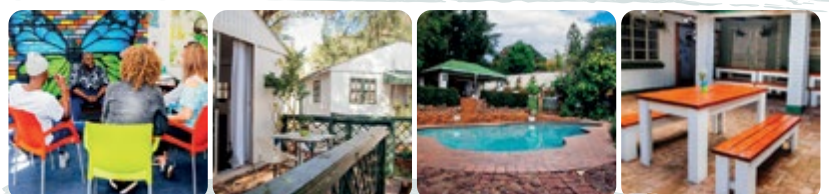
### Papillon Recovery Centres

Welcome to South Africa's only private psychiatric step-down centres. Papillon has a full multi-disciplinary team ready to assist clients in developing meaningful futures. The programme is based on the McLean Hospital five phase rehabilitation programme.

The focus is on each individual's uniqueness: This is paramount to the treating team who collaborate with clients treating psychiatrists. For affordable healthcare look no further than the Papillon 12 week programme.



**Cape Town** - 10 Union Street, Gardens



**Johannesburg** - 271 Pine Avenue, Ferndale, Randburg

# A SUMMARY OF SELECTED SESSIONS FROM THE CONFERENCE

Lisa Selwood

## 1. NEW PERSPECTIVES ON RESEARCH AND CLINICAL CARE FOR ADHD

Prof Stephen Faraone’s catch phrase for this presentation was the powerful phrase ‘*Stigma – the most painful word in mental illness*’. The presentation covered various aspects relating to stigma in mental illness, and ADHD in particular and also addressed various paradoxes occurring in the clinical care setting.

**THE EFFECTS OF STIGMA ARE FAR REACHING AND HAVE REAL CONSEQUENCES, INCLUDING A DECREASE IN SELF-ESTEEM, SOCIAL ISOLATION, AND LESS ACCEPTANCE BY PEERS.**

A study which used hypothetical situations regarding adults with ADHD, showed they were increasingly likely not to be accepted when marrying into a family, when being introduced to a friend, when renting premises or when being recommended for a job.

Communication strategies to decrease stigma:

- Humanize struggles and experiences
- Highlight policy barriers to the treatment of mental illness
- Emphasize that treatment for mental illness is effective
- Don’t place blame on the individuals or their families
- People with mental illness should not be described as violent, particularly by the media
- Do not describe the disorder as an adjective e.g. ‘An ADHD patient’ when it is preferable to say ‘A patient with ADHD’

Paradox 1: Medications for ADHD are highly

effective, yet are demonized by the media

One of the most effective groups of medication are those used to treat ADHD and yet the stigma associated with taking these medications may lead to increased rates of non-adherence, leading patients to:



Lisa Selwood,

- Stopping their medication to see if they can manage without it – this may also be at prompting from a parent or the physician
- Think they are doing well and don’t need to take their medication
- Think it is not helping them
- Forgetting to take the medication, due to the ADHD itself
- Tired of taking it
- Stop taking medication due to adverse events

Perhaps it is prudent to consider if stigma creates a placebo effect when a treatment is associated with side effects or worsening of symptoms due to negative expectations of the psychological condition of the patient.

Paradox 2: Parents and patients crave nondrug treatments, with homeopathic remedies four times more likely to be recommended. Parents in particular, expressed a desire to avoid stimulant medication, partially due to their beliefs regarding the causes of the illness, their knowledge of available treatments, treatment goals and previous experiences with treatment

Paradox 3: An ADHD diagnosis is criticized as subjective, but ADHD is a valid disorder. A well balanced view considers that the youngest children in the grade are more likely to be diagnosed with ADHD as they struggle with the academic and social

demands placed on them, which could contribute to ADHD related functional impairment. By this token, the inverse interpretation is then also possible and older children may be underdiagnosed. This has also led to the development of neuropsychological tests to try and confirm objectivity; however, it has been clinically proven that these tests cannot confirm or rule out a diagnosis, and high stake decisions cannot be made based on the results of these tests. A good diagnosis is reproducible and gives meaningful predictions regardless of whether it is objective or subjective, and clinicians need to stop apologizing for the so-called 'subjectivity' of the ADHD diagnosis.

Paradox 4: ADHD is both a disorder and a trait which occurs on a continuum in the population.

**IN PSYCHIATRY, THE CONTINUUM IN A POPULATION IS NOT TREATED – A DISORDER IS TREATED. BASED ON DNA ASSAYS, POLYGENIC RISK SCORE INDEXES ONE'S RISK FOR ADHD AND INDICATES IT FALLS ON THE EXTREME AND IMPAIRING TAIL AT ONE END OF THE CONTINUUM. THRESHOLDS, SUCH AS THOSE WHICH ARE COMMON IN OTHER BRANCHES OF MEDICATION (HYPERTENSION, BMI, CHOLESTEROL) NEED TO BE DEFINED.**

It is also important to be cognizant that some patients may show subthreshold symptoms, which do not warrant a full-blown ADHD diagnosis, however there is still psychopathology, scholastic failure, substance use and psychosocial impairment. These patients may have a high cognitive reserve, cope well and hence the diagnosis is missed in childhood and may only present later only when demands are increased.

Scaffolding, or routine and structure may protect against the emergence of ADHD symptoms.

## 2. MANAGEMENT GUIDELINES AND UPDATES

- An overview of international guidelines**

Dr Frans Korb began the session with a comprehensive overview of factors pertaining to the diagnosis, treatment, and long-term outcomes of ADHD, before referring to the international guidelines and their recommendations regarding the initiation, continuation and maintenance phase of treatment. Guidelines should be evidence based or consensus driven and cover children, adolescents, and adults.

A diagnosis of ADHD should be made when looking at specific behaviours in multiple settings. Owing to the many areas of the brain involved, and the high heritability results in a complex aetiology. However, this alone is not diagnostically specific. Interventions include both medication and behavioural elements.

Medication is the foundation of treatment and has been proven as efficacious in a plethora of rigorous studies. Both interventions target specific symptoms which indicates that ADHD is a chronic illness. Successful treatment requires ongoing adherence. Prescribing medication should be in done in a step wise approach.

**FIRSTLY, THE TREATMENT OBJECTIVES NEED TO BE ESTABLISHED, THE MEDICATION IS SELECTED FOLLOWED BY TITRATION AND MONITORING AND THERE SHOULD BE ONGOING FOLLOW UP.**

The selection of medication is complex and needs to take several factors into account:

Patient factors	Medication factors	Other considerations
<ul style="list-style-type: none"> <li>• Age</li> <li>• Individual variation in symptoms</li> <li>• Duration of effect by examining the timing of symptoms</li> <li>• Concurrent psychiatric or medical conditions</li> <li>• Attitudes of the patient, the family, and the treating physician</li> </ul>	<ul style="list-style-type: none"> <li>• Active ingredient</li> <li>• Doses</li> <li>• Indications</li> <li>• Mechanism of action</li> <li>• Drug interactions</li> <li>• Delivery, onset, duration</li> <li>• Affordability</li> <li>• Accessibility and reimbursement</li> </ul>	<ul style="list-style-type: none"> <li>• Combining medications for adjunctive effects</li> <li>• The potential for misuse, abuse, and diversion</li> <li>• Generic formulations</li> </ul>

There are several international guidelines which can be consulted with reference to ADHD and medication selection. Two such guidelines include the Canadian Guidelines (<https://www.caddra.ca/download-guidelines/>), which suggest long acting psychostimulants should be the first line therapy for ADHD as they have the best evidence base, maintain privacy, and increase compliance due to once daily dosing. If one class of stimulants fail, the second class should be tried, before moving onto second line therapy which includes atomoxetine and guanfacine XR. Finally, third line treatment includes several offlabel options, which may be useful when treating comorbidities as well as ADHD. The British Guidelines (NICE - <https://www.guidelines.co.uk/mental-health/nice-adhd-guideline/454106.article>) recommend methylphenidate as first line therapy in children and adolescents, followed by lisdexamphetamine as second line. In adults, both groups of stimulants are recommended as first line, and a switch between agents if the first stimulant trialled was not successful.

• **South African guidelines**

The Special Interest Group (SIG) for ADHD was launched in 2015, with one of the aims to develop South African guidelines for the diagnosis and treatment of adult ADHD specifically, and to update the guidelines for the treatment of child, adolescent and adult ADHD. As the co-convenor of this group, Prof Renata Schoeman was in the best position to give an update on these guidelines.

**SOUTH AFRICA REMAINS ONE OF THE ONLY COUNTRIES WORLDWIDE WITH A GUIDELINE SPECIFIC TO ADULTS, AND WHICH DO NOT FOLLOW AN ALGORITHMIC APPROACH AS THEIR INTERNATIONAL COUNTERPARTS DO.**

ADHD is a neurodevelopmental disorder, occurring across the lifespan, with a complex aetiology and is associated with multiple genetic and environmental factors. The prevalence in children is 5% and 60 – 70% of children with ADHD will become adults with ADHD. ADHD occurs across several domains, with significant occupational, social, and emotional impairment.

**Assessment and diagnosis:** A comprehensive assessment should be undertaken, with collateral information obtained if possible. Comorbidities should be screened for, and any complexities considered. Although rating scales may be useful, there are no rating scales which are diagnostic in nature. Similarly, psychometric assessments may be useful with specific disorders, but are not, in and of themselves, diagnostic.

**Management:** Management should be holistic and include both pharmacological and non-pharmacological interventions. Any potential stressors should be addressed, and therapy should be recommended, as well as educational or occupational support.

Behavioural programs are useful where the symptoms are mild or moderate, causing only minimal impairment; if the diagnosis is uncertain; if medication is rejected as an option or if an urgent response is not required.

**IN TERMS OF MEDICATION, THE TREATMENT CHOICE WILL DEPEND ON THE PATIENT, THEIR PREFERENCES, REQUIREMENTS AND ANY COMORBIDITIES, AS WELL AS THE MEDICATION PROFILE, WITH A BALANCE BETWEEN EFFICACY AND TOLERABILITY.**

In terms of the latest guidelines, short-, long- or ultra-long acting methylphenidate (MPH) or the amphetamines should be used first, followed by the non-stimulant atomoxetine or various other medications which can be used off label.

Initiating medication could occur in the face of a previous diagnosis, or in the first presentation and diagnosis. Drug treatment is the chosen and adapted but should not be initiated if the diagnosis is uncertain, or the benefit is not clear.

To maintain the response, an individualised treatment plan is of utmost importance. A regular review of efficacy and tolerability should be done. Comorbidities should be addressed and treated appropriately, and compliance should be addressed if problematic.

Some patients may only have a partial response, or a complete nonresponse, in which case comorbidities and stressors need to be reviewed; compliances, stressors and lifestyle factors need to be addressed and the dosage and schedule of the medication should be reviewed.

Finally, untreated ADHD has a significant negative impact on quality of life. As ADHD is a lifespan disorder, an individualised approach for each patient is required, as they may require assistance when transitioning through different phases of their lives.

**3. A CHILD PSYCHIATRIST'S PERSPECTIVE ON CURRENT TREATMENT OPTIONS**

Dr Brendan Belsham, a child and adolescent psychiatrist from Johannesburg, delved into treatment options focusing on children specifically. The three main themes of his presentation addressed:

- What nonpharmacological treatments are evidence based?
- Where do amphetamines fit in?
- What is the role of precision medicines and pharmacogenetics?

Nonpharmacological treatments include the following:

**Psychoeducation**

- Educate and empower the patients and their families by providing information on ADHD
- Look at lifestyle factors such as sleep, diet, and exercise
- Examine modifications that can be made in both the school and home setting

**Parent management training**

This mostly occurs in a group setting and has shown to be effective in reducing symptoms of ADHD and disruptive behaviour disorders. All training of this nature shares similar behavioural principles, which consists mostly of reinforcing positive behaviours, ignoring low level provocative behaviours, and providing clear, consistent, and safe responses to unacceptable behaviour. Parents should be engaged as partners. This is the first line treatment for pre-schoolers under five years of age

## OTHER INTERVENTIONS

These include social skills training, CBT, mindfulness training and digital therapeutics. The recent trend towards ‘gamification’ tries to train working memory via a computerised intervention, considering that those with ADHD are likely to choose ‘smaller, sooner’ than ‘larger, later’ rewards. However, digital interventions cannot currently be recommended for ADHD due to inconsistent findings.

Pharmacological treatments:

- Psychostimulants, including methylphenidate (MPH) and the amphetamines
- Non stimulants, such as atomoxetine
- Other medications, which are used offlabel

It is important to remember that although medications have similar efficacy and tolerability at population level, individual response to certain agents will vary. A combination of a stimulant and a non-stimulant can be combined as augmentation for suboptimal responders.

How to decide on which medication to use?

Age	For pre-schoolers (less than five years of age): <ul style="list-style-type: none"> <li>• Check which medications are indicated</li> <li>• Look at the potential for titration</li> <li>• Assess the ability to swallow the medication</li> </ul>
Previous medication history	<ul style="list-style-type: none"> <li>• Different MPH preparations may give vary different results</li> <li>• Patients may respond differently to the same medication years later</li> <li>• Interesting, 70% will respond to MPH and 70% will respond to amphetamines, but if the classes are switched then 90% will response</li> </ul>
Pattern of impairment	At what time of the day are the symptoms most problematic?
Are there family members who have received treatment for ADHD either currently or in the past?	<ul style="list-style-type: none"> <li>• Response between family members may be similar</li> <li>• The family may trust a medication more if it has helped someone else in the family</li> </ul>
Comorbidities and side effects	<ul style="list-style-type: none"> <li>• Consider anxiety, tics, insomnia.</li> <li>• The comorbid disorder may need to be treated first</li> <li>• Start one medication at a time</li> <li>• Document pre-existing symptoms</li> </ul>

## PHARMACOGENETICS

There is genetic variability in medication response and in drug metabolism, although only small effect sizes were shown in trials. Adverse effects are also related to various genetic variants, and this is important as it may affect adherence. However, in 2018, CADDRA said there was insufficient evidence to recommend the routine use of pharmacogenetics.

## GUIDELINES IN SOUTH AFRICA

**THE GUIDELINES IN SOUTH AFRICA DO NOT UNFORTUNATELY COVER ALL PATIENTS WITH ADHD, AS ECONOMIC DISPARITY IS NOT TAKEN INTO ACCOUNT. THERE ARE TWO DISTINCT HEALTHCARE SYSTEMS, AND PATIENTS UTILIZING THE PUBLIC SECTOR MAY NOT HAVE ACCESS TO THE TREATMENT OPTIONS REFERRED TO IN THE GUIDELINES.**

The local guidelines avoid algorithms, and physician discretion and clinical judgement determines the final choice of treatment intervention.

### 4. THE ETHICS AND LEGALITIES OF MEDICAL SCHEME REIMBURSEMENT FOR ADHD

Dr Indhrin Chetty is a forensic psychiatrist and holds a degree in law, which enabled him to provide the audience with a thought provoking, and balanced presentation on what has been, and will for the foreseeable future remain a contentious topic.

ADHD remains a long-term diagnosis for the majority of patients. The symptoms often have immediate effects and long-lasting consequences.

When considering ethical and legal concerns, there are several questions which need to be asked:

- How is a chronic condition conceptualized?
- What is treatment of the condition aiming to achieve?
- How is the decision regarding which disorder requires treatment made?
- How much impairment in functioning is needed to affect the decision to treat?

There are many hurdles which may be encountered on the path to treatment:

- Lack of awareness there is a condition which requires treatment
- Lack of resources, particularly evidenced in a resource constrained environment
- Resource distribution at an individual level
- The stigma surrounding certain diagnoses
- Lack of funding

There are also ethical issues which are important to be consider:

- Is there conformation in the approaches to good practice?
- Can practitioners defend the decisions they make?
- Can areas of difficulty or uncertainty be identified?
- Can appropriate courses of action be identified?

The ethical approach is consistent with principlism, which is an applied ethics approach to the examination of moral dilemmas based upon the application of the four principles of autonomy, beneficence, non-maleficence and justice.

**WHERE THERE ARE ETHICAL CONCERNS, LEGAL CONCERNS MAY ENSUE. LEGAL PROCESSES ARE TO ENCOURAGE ETHICAL PRACTICES, AND TO ENSURE THAT MANAGEMENT PRIORITISES THE INTERESTS OF THE PATIENT.**

**AUTONOMY:**

The physician needs to ensure there is consent, and the information presented is understood and should ideally be in the written form. There needs to be adequate competency to make decisions. The disclosure of sensitive information to a third party, such as to a school or to funders is another area of which the clinician needs to be mindful. The level of autonomy may change as the child ages.

**BENEFICENCE:**

Symptoms should be accurately documented to provide an appropriate and accurate diagnosis, and the physician’s opinion should be based on clinical presentation. Clinicians should be careful or have an increased index of suspicion when there is coercion to diagnose a condition, or, conversely, a reluctance to accept a diagnosis.

**NON MALEFICENCE:**

Diagnoses should be accurate, and evidence based to avoid mis-labelling. Any coercion into a diagnosis may ultimately be harmful to the patient, and mis- or over-diagnosis may increase the resistance to the provision of care.

**JUSTICE:**

A major hurdle in South Africa is unequal resource distribution, including the lack of professional expertise in many geographical areas. There are many competing health needs in a resource limited setting and there is competition for resources at an individual level.

**LEGAL CONSIDERATIONS:**

Any diagnosis should be rational and reasonable to guard against professional and legal sanction;

however, if a diagnosis is missed, the door to legal sanctions may also be opened.

**THERE ARE LONG TERM CONSEQUENCES FOR A PATIENT AS A RESULT OF A LACK OF CARE. WITH ADHD IN PARTICULAR, THERE MAY BE INCREASED IMPULSIVITY LEADING TO INCREASED RISK TAKING, AN INCREASED RISK OF OFFENDING BEHAVIOUR AND AN INCREASED RISK OF SUBSTANCE RELATED CRIMES.**

Medical schemes and funding

- Justification for care
- Expertise in making the diagnosis
- Clear diagnostic criteria
- Outcomes trajectories should examine the impact of treating versus not treating.

All improvements associated with treatment should be documented,

- Comorbidities and worsening outcomes cause an increased cost to the scheme
- There are also economic considerations, as well as contractual terms between the scheme and the member

Funders operate in a legal environment and are regulated by various acts, regulations, and amendments, which are intended to protect the interests of members.

**SECTION 29 OF THE MEDICAL SCHEMES ACT EXAMINES THE SCOPE AND LEVEL OF THE MINIMUM BENEFITS AVAILABLE TO BENEFICIARIES. THE TREATMENT OF CHRONIC CONDITIONS REQUIRES A THERAPEUTIC ALGORITHM PER CONDITION.**

Ethical and legal considerations affect different aspects of care, and in order to formulate effective care for patients, it is important to follow and adhere to the four ethical principles.

Various considerations need to be considered and there should be ongoing engagement and expert input to keep communication channels open. Diagnoses need to be accurate, and HCPs properly trained in order to avoid abuse.

Positive outcomes associated with effective treatment need to be utilised to motivate for more favourable funding.

**Lisa Selwood** is the Medical Affairs Manager at Lundbeck, South Africa and a medical writer. **Correspondence: LIEW@lundbeck.com**

Depression can  
make keeping  
on top of daily  
tasks a struggle



Vortioxetine Lundbeck® can help with her mood,  
concentration and fatigue, so she is  
able to organise her day again<sup>1,2</sup>

Lundbeck



Brintellix®  
vortioxetine

Take care of *more than mood*

NEW  
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*. Nov 2020. 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 55/1.2/0583 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 H. Lundbeck (Pty) Ltd. Office A1002 Knightsbridge, 33 Sloane Street, Bryanston, 2190 Tel: +27 11 699 1600. For full prescribing information refer to the professional information approved by the medicines regulatory authority. ZA-VOR-0017 June 2022

# HISTORICAL OVERVIEW OF ADHD

Lerato Masenya

**ADHD: A Historical Review (Past to Present)** was presented by Francois Levrat MD, PhD on behalf of Eric Konofel MD, PhD. Dr Eric Konofel serves as a senior medical consultant for the Paediatric Sleep Disorders Center at Robert Debre University of Paris in France. He published a book in 2019 titled "ADHD & its medications, an illustrated history over time" in which he acknowledges Dr. Francois Levrat's work on the manuscript, the illustrations, and references. The book is available for purchase on Amazon. The illustrative nature of the text is compelling, and perhaps it is intended to pay homage to historic Epinal prints where children who had the characteristics of ADHD can be seen portrayed.

Attention Deficit Hyperactivity Disorder (ADHD) can be traced as far back as the 1700s where children showing the characteristic symptoms of the disorder can be seen portrayed in mainstream literature.

ONE DEPICTION FROM THAT TIME WAS "FIDGETY PHILIP" - A POEM BY THE GERMAN PSYCHIATRIST HEINRICH HOFFMAN IN 1845. AS THE NAME OF THE POEM SUGGESTS, PHILIP IS "FIDGETY" AND THE AUTHOR WANTS TO "SEE IF PHILIP CAN BE A LITTLE GENTLEMAN", IF HE IS "ABLE TO SIT STILL FOR ONCE AT A TABLE".

He "swings backwards and forwards" at the dinner table, exasperating his parents when he falls over

with his chair, clutching at the tablecloth, pulling down with him "glasses, plates, knives, forks, and all" which lie over him while the dinner table is left bare. How shall they have their dinner now?



Lerato Masenya

What we now know as ADHD in clinical practice has changed names and diagnostic criteria over time. It began as Hyperkinetic Reaction of Childhood/Adolescents in the second edition of the Diagnostic and Statistical Manual of Mental Disorders published in 1968. The term ADHD was introduced in the third edition of the DSM, first as Attention Deficit Disorder with or without hyperactivity in 1980 and subsequently ADHD in the revised edition published in 1987. Since then, up until now the label remains in use in the current DSM-5. Prior to the DSM there had been various

descriptions including Brain Damage Syndrome, Post-Encephalitic Behaviour Disorder in Children, Minimal Brain Dysfunction, Mild Retardation, Hyperkinesis, amongst other terms.

It can be understood looking at the evolution of the diagnostic criteria how the view of ADHD as exclusively a disease of childhood and adolescence took shape - a key factor in making the diagnosis using the DSM-II was that the behaviours diminished by adolescence. It was the DSM- III-R that noted that the symptoms can persist into adulthood. The current understanding in the DSM-5 is that ADHD is a neurodevelopmental condition with onset of symptoms in childhood before the age of 12 as opposed to the age of 7 set by its preceding edition.

**THE DIAGNOSIS CAN BE MADE IN ADULTHOOD WITH OLDER ADOLESCENTS AND ADULTS REQUIRING LESS SYMPTOMS TO MEET THE DIAGNOSTIC CRITERIA. IN AN ARTICLE PUBLISHED IN THE WORLD JOURNAL OF BIOLOGICAL PSYCHIATRY IN 2010 THE AUTHORS, ONE OF THEM DR. KONOFEL, HIGHLIGHTED THE DIFFICULTIES OF MAKING THE DIAGNOSIS OF ADHD IN ADULTHOOD DUE TO THE DSM-IV CRITERIA DESCRIBING BEHAVIOUR OBSERVABLE IN CHILDHOOD.**

Furthermore, functional impairment in adults may be seen in various other settings such as parenting, intimate relationships, social and leisure.

In addition to portrayal of ADHD characteristics and the history of labels that ADHD has had over the years, Dr. Levrat's presentation also gave an overview of the history of medication used to treat ADHD. Psychostimulant medications existed in the United States since the 1800s but their use in ADHD began in the mid 1980s with recognition of ADHD as a clinical diagnosis. The discovery that stimulants can be effective for behaviour control and enhancing concentration was recognized in 1938, albeit serendipitously, by Dr. Charles Bradley, a psychiatrist treating children with behavioural disorders who realized that when Benzedrine, a racemic amphetamine, was given to children to alleviate headaches their behaviour and school performance as well as their social and emotional reactions improved.

**THE APPROVED USE OF METHYLPHENIDATE IN PSYCHIATRY BEGAN WITH ITS USE IN THE TREATMENT OF CHRONIC FATIGUE, NARCOLEPSY AND DEPRESSION IN ADULTS AND GERIATRIC PATIENTS IN 1955, AT WHICH POINT THE INTERESTS IN EXPLORING THE EFFECTIVENESS OF METHYLPHENIDATE FOR THE TREATMENT OF CHILDREN WAS BEING RESEARCHED.**

Since the 1960s Ritalin was the gold standard of treatment for children with ADHD until challenged by other stimulants. In recent history the options for treating ADHD have broadened to include non-stimulants, prescription medical foods as well as non-pharmacological measures. It was interesting to learn through the presentation by Dr. Levrat that the first conference on Inattention was held in 1911 in Mexico.

**MUCH HAS CHANGED BETWEEN THAT FIRST CONFERENCE AND THIS YEAR'S MULTIDISCIPLINARY ADHD CONGRESS IN SOUTH AFRICA.**

There have been contributions from various fields of science from different parts of the globe over time leading to current knowledge and practice. What remains certain is that the condition can have a significant impact on one's ability to function at home, at school or work, and in social settings- thus requiring intervention.

A look at the history of ADHD enables a broader insight when assessing a patient presenting with the symptoms of ADHD, including understanding the myths and stigmas the condition has attracted over the years. Similarly, understanding the history of its treatments empowers the clinician with an awareness of influences or perceptions when presenting patients with treatment options to relieve the negative impact of impulsivity, hyperactivity and inattention.

Now Fidgety Philip, whether in his childhood or adulthood, can be a little gentleman at the dinner table and perform at his best in his various areas of functioning.

## REFERENCES

1. Leahy L. Attention-Deficit/Hyperactivity Disorder: A Historical Review (1775 to Present). *Journal of Psychosocial Nursing and Mental Health Services*. 2017;55(9):10-16.
2. Rafalovich A. Framing ADHD children. 1<sup>st</sup> ed. Lanham, Md.: Lexington Books; 2008.
3. Rosler M, Casaa M, Konofel E, Buitelaar J. Attention deficit hyperactivity disorder in adults. *The World Journal of Psychiatry*, 2010; 11: 684-698.
4. Diagnostic and statistical manual of mental disorders. 5<sup>th</sup> ed. Arlington, VA: The American Psychiatric Association; 2013.
5. Fidgety Philip - Storynory [Internet]. Storynory. 2022 [cited 10 September 2022]. Available from: <https://www.storynory.com/fidgety-philip/>

**Lerato Masenya** is a psychiatry registrar at the University of the Witwatersrand. **Correspondence:** [dr.leratomasenya@gmail.com](mailto:dr.leratomasenya@gmail.com) ■

---

# THE BORDERLAND OF TOURETTE SYNDROME AND ATTENTION DEFICIT HYPERACTIVITY DISORDER

---

*Linda Tindimwebwa*

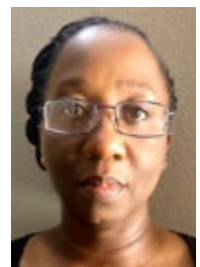
An online lecture on the borderland of Tourette Syndrome and ADHD delivered by Prof Renata Schoeman.

Several studies have described the association between Tourette Syndrome (TS) and Attention Deficit Hyperactivity Disorder (ADHD). (Oluwabusi, Parke and Ambrosini, 2016). The co-occurrence of ADHD and TS is often associated with a higher burden of illness and impairment.

ADHD SYMPTOMS USUALLY HAVE THEIR ONSET BETWEEN FOUR AND FIVE YEARS, AND USUALLY PRECEDE THE ONSET OF MOTOR AND VOCAL TICS BY AN AVERAGE OF 2.4 YEARS (UEDA AND BLACK, 2021).

The two conditions co-occur more often than realised; often the presence of tics is not enquired

about when diagnosing ADHD and vice versa, with the result that one goes undiagnosed and untreated and/or there is a misperception that tics emerge as a side effect of ADHD medication.



*Linda Tindimwebwa*

Regarding the co-existence, in clinical settings, between 60-80% of individuals with TD have ADHD when compared with 15% in community settings. In those with ADHD, in clinical settings, 20% have tic disorders whereas in the community this number is 2.3%. Practically this means that a significant proportion of individuals in the community who have both disorders are undiagnosed and untreated, which would have a significant negative impact on social and occupational functioning.

Epigenetic risk factors for ADHD and TS can be broken up into gestational and perinatal, psychosocial and immunological.

*Gestational and perinatal risk factors:*

- Severe nausea
- Alcohol and tobacco use during pregnancy
- Low birthweight and Apgar scores
- Being born preterm is a specific risk factor for ADHD
- Older paternal age is a specific risk factor for TS

*Psychosocial risk factors* include parenting style, adoption, psychological trauma and recurrent daily stress.

*Immunological factors:* Paediatric Infection Triggered Autoimmune Neuropsychiatric disorders (PITANDS) which is an area of ongoing research.

Approach for assessment is the 5 Cs, which are clinical diagnosis, comprehensive assessment, collateral information, comorbidity and treatment complexity. Neuropsychological deficits in combined TS and ADHD specifically include: lower IQ, impulsivity, difficulty sustaining attention, written language dysfunction and slower motor output. Deficits in executive function are those of poorer verbal fluency, lack of inhibition, poor planning and cognitive inflexibility.

**TREATMENT METHODS ARE HOLISTIC AND APPLICABLE TO BOTH ADHD AND TS AND CONSIST OF: THERAPY, EDUCATIONAL OR OCCUPATIONAL SUPPORT, ADDRESSING POTENTIAL STRESSORS AND LIFESTYLE CHANGES.**

A behavioural program is used in the event of symptoms being mild or moderate with minimal impairment, if there is diagnostic uncertainty, if the patient or parents refuse medication or if an urgent response is not required.

**IN THE CASE OF ADHD THIS WOULD BE COGNITIVE BEHAVIOUR THERAPY AND SOCIAL SKILLS TRAINING. IN TERMS OF TS ONE WOULD USE HABIT REVERSAL TRAINING, COMPREHENSIVE BEHAVIOURAL INTERVENTION AND EXPOSURE AND RESPONSE PREVENTION.**

If the tics cause subjective discomfort, functional interference and social and emotional problems, the next step is to add pharmacotherapy. Options are antipsychotics (Aripiprazole, Pimozide, Sulpride, Risperidone and Haloperidol), Noradrenergic agents like Clonidine (registered for use in South Africa) which have the advantage of less side effects, and other treatments including Deep Brain Stimulation.

**IF ADHD SYMPTOMS ARE SEVERE, COMMENCE MEDICATION.**

Treatment options are stimulant and non-stimulant medications. Stimulant medications available are Methylphenidate of varying durations of action, and the Amphetamines Dexamphetamine and Lisdexamphetamine.

**IN THE TREATMENT OF ADHD AND TS, ADHD SHOULD BE PRIORITISED.**

In 1983 the Food and Drug Administration stated that stimulants were contraindicated in individuals with tic disorders, however, a meta-analysis by Cohen in 2015 found no increase in new onset or worsening of tics with stimulant use. With this in mind, treatment options are: Alpha-2 agonists or psychostimulants, followed by Atomoxetine or Aripiprazole and nutraceuticals.

**THE BEST EVIDENCE IS FOR A COMBINATION OF AN ALPHA-2 AGONIST AND A PSYCHOSTIMULANT.**

TS and ADHD have a significant negative impact on the quality of life of both patients and their families. It is important to look for symptoms of both in sufferers, and institute early intervention so as to ameliorate the impact of the illness and improve wellbeing.

## REFERENCES

Oluwabusi, O.O., Parke, S. and Ambrosini, P.J., 2016. Tourette syndrome associated with attention deficit hyperactivity disorder: The impact of tics and psychopharmacological treatment options. *World journal of clinical pediatrics*, 5(1), p.128.

Ueda, K. and Black, K.J., 2021. A comprehensive review of Tic disorders in children. *Journal of Clinical Medicine*, 10(11), p.2479.

**Linda Tindimwebwa** is a psychiatry registrar, at Walter Sisulu University and Cecilia Makiwane Hospital Mental Health Unit. **Correspondence: lintin@hotmail.com** ■

# ADHD AND THE REPRODUCTIVE HORMONES (FROM PRE-PUBERTY TO MENOPAUSE)

– PRESENTED BY DR JANE INDERGAARD

*Mmaphuti Kaaka*

**D**r Jane Indergaard is an associate professor of nursing at Concordia college in Moorhead, Minnesota, USA. She is a registered nurse and a mother whose youngest son was diagnosed with combined type attention deficit hyperactivity disorder (ADHD) at the age of seven 20 years ago. She invested in research on ADHD and became a member of a renowned organisation called CHADD (Children and adults with attention deficit hyperactivity disorder). She obtained a doctorate on ADHD and has psycho-educated and trained parents, teachers and health providers who work with children with ADHD. Her interests moved to ADHD in women.

## WOMEN AND ADHD:

At the 2022 Southern African multidisciplinary ADHD virtual congress, she presented evidence from the literature to show how reproductive hormone fluctuations affect ADHD symptoms in women across the lifespan and provided evidence-based recommendations. She opened with the statement that the diagnosis of ADHD in women is commonly missed or diagnosed late.

In contrast to males, females with ADHD tend to present predominantly with inattention, can compensate for their symptoms and usually show symptoms of other comorbidities such as anxiety and depression.<sup>1,2</sup>

Worldwide, women are renowned for their abilities to plan, make wise decisions and multi-task. Women with ADHD face societal pressure to function with similar attentional and executive functional resources as those without ADHD. These women often internalise their struggles, hiding symptoms in shame and stringing together depleted resources to cope.



*Mmaphuti Kaaka*

Women's reproductive hormones fluctuate at puberty, during the menstrual cycle, during pregnancy, the post-partum period, and during peri-menopause. A woman experiences these changes once a week each month after menarche, for weeks to months after giving birth and for a few years prior to the climacteric.

THE PREMENSTRUAL PERIOD IS A TIME OF DECREASED OESTROGEN, AS IS THE POST-PARTUM PERIOD AND THE PERIOD PRIOR TO MENOPAUSE. OESTROGEN NEVER FUNCTIONS ON ITS OWN WITHOUT OTHER HORMONES, BUT FOR CLARITY, WILL BE MENTIONED ON ITS OWN.

Gonadal hormones influence the development of the female versus male brain and in addition, affect neurotransmitters, synaptic plasticity, neuronal activity and intracellular signalling pathways. Oestrogen acts as an agonist to dopamine, promoting its release in the prefrontal cortex and thus affecting executive function, working memory, attention, reward processes, mood and cognition.

The pre-frontal cortex of people with ADHD has lower levels of dopamine and due to this alteration, might possibly be vulnerable to hormonal fluctuations. During hypo-oestrogenic periods, there might be an exacerbation of symptoms of ADHD in women and there might be decreased efficacy of ADHD medication.

### **EARLY PUBERTY:**

Precocious puberty and early menarche might result in severe ADHD symptoms, including inattention, emotion dysregulation and increased risk-taking.<sup>3</sup>

### **MENSTRUAL CYCLE:**

Dorani<sup>4</sup> and colleagues documented that women with ADHD were more likely than controls to suffer severe mood symptoms associated with premenstrual dysphoric disorder. Antidepressants seemingly worsened these symptoms. The combined oral contraceptive pill, when used continuously without withdrawal bleeding, improved ADHD symptoms across the menstrual cycle.<sup>4</sup>

### **PREGNANCY:**

During pregnancy, which is a hyper-oestrogenic period, ADHD symptoms might improve.<sup>5</sup> Doctors might stop ADHD medication during pregnancy because of concerns about the safety of stimulant medication on the foetus or unborn baby but the impact of this has not been studied.

**PATIENTS WHO DISCONTINUED THEIR ADHD MEDICATION, AS OPPOSED TO CONTINUING OR ADJUSTING THE MEDICATION DURING PREGNANCY AND THE POSTPARTUM PERIOD, WERE SHOWN TO EXPERIENCE SIGNIFICANT INCREASES IN DEPRESSIVE SYMPTOMS (NOT ADHD SYMPTOMS) AND OVERALL FAMILY FUNCTIONAL IMPAIRMENT.<sup>6</sup>**

There are studies disputing the overall increased teratogenicity of methylphenidate use prenatally and during pregnancy.<sup>7</sup> Methylphenidate exposure in early pregnancy was associated with a small but significantly increased risk of cardiac malformations.<sup>7,8</sup>

The American Psychiatric Association recommends that women be assessed individually regarding the risks versus benefits for continuing ADHD medication

during pregnancy. A woman could opt to continue her ADHD medication if the risk for functional impairment is high, provided the foetus is assessed for the development of cardiac abnormalities by foetal echocardiogram.<sup>7,8</sup>

If the risk to the foetus is unacceptably high, medication could be stopped with support or accommodations/ adjustments during activities which require additional attentional resources, such as driving or work.

A trial of withholding medication prior to pregnancy might succeed, with support structures and monitoring in place. Alternatively, stimulants could be withheld in pregnancy only during periods of highest risk to the foetus (early first trimester and last trimester) and recommenced when the risk to the foetus is lower.

### **THE POST-PARTUM PERIOD AND BREASTFEEDING:**

The post-partum period is a transition period with increased functional demands on women, especially those with altered neural circuits due to ADHD. Good attention and executive function are necessary for child rearing and maintenance of households. Women with ADHD are more prone to post-partum depression and anxiety due to lower oestrogen levels, and these symptoms may signal a worsening of their ADHD.<sup>4</sup>

### **THE CLIMACTERIC:**

**THE PERIOD PRIOR TO MENOPAUSE IS NOTABLE FOR INDUCING SYMPTOMS SIMILAR TO THOSE OF ADHD IN WOMEN WITHOUT ADHD.<sup>9</sup>**

Women with ADHD experience worsening of their symptoms due to lower oestrogen and progesterone levels. In addition to increased inattention, they may be more vulnerable to developing mood disorders. Hormone replacement therapy, stimulants such as methylphenidate and lisdexamfetamine, and non-stimulants such as atomoxetine could improve symptoms of hyperactivity, impulsivity and emotional dysregulation.<sup>9</sup>

### **CONCLUSION:**

Dr Indegaard concluded that dedicated research was necessary to understand the role of oestrogen in ADHD, to explore the interactions oestrogen had with the larger system of reproductive hormones and the importance of oestrogen receptors, among others. Research could improve the way ADHD is treated in women across the lifespan.<sup>10</sup>

### **REFERENCES**

1. Quinn PO, Madhoo M. A review of attention-deficit/hyperactivity disorder in women and girls: uncovering this hidden diagnosis. *Prim Care Companion CNS Disord.* 2014;16(3).

2. Fraticelli S, Caratelli G, De Berardis D, Ducci G, Pettorruso M, Martinotti G. Gender differences in attention deficit hyperactivity disorder: an update of the current evidence. *Rivista di psichiatria*. 2022;57:159-164.
3. Ostojic D, Miller CJ. Association between pubertal onset and symptoms of ADHD in female university students. *Journal of Attention Disorders*. 2016; 20(9):782-791.
4. Dorani F, Bijlenga D, Beekman ATF, van Someren EJW, Kooij JJS. Prevalence of hormone-related mood disorder symptoms in women with ADHD. *J Psychiatr Res*. 2021 Jan;133:10-15.
5. Quinn PO, Nadeau KG. Gender issues and AD/HD: research, diagnosis and treatment. 2002. Advantage Books, Silver Spring, MD.
6. Baker AS, Wales R, Noe O, Gaccione P, Freeman MP, Cohen LS. The course of ADHD during pregnancy. *J Atten Disord*. 2022 Jan;26(2):143-148.
7. Kolding L, Ehrenstein V, Pedersen L, Sandager P, Petersen OB, Uldbjerg N, et al. Associations between ADHD medication use in pregnancy and severe malformations based on prenatal and postnatal diagnoses: a Danish registry-based study. *J Clin Psychiatry*. 2021 Jan 5;82(1).
8. Koren G, Barer Y, Ornoy A. Fetal safety of methylphenidate – a scoping review and meta analysis. *Reproductive Toxicology*. 2020 April; 93:230 – 234.
9. Epperson CI, Shanmugan S, Kim DR, Mathews S, Czarkowski KA, Bradley J, et al. New onset executive function difficulties at menopause: a possible role for lisdexamfetamine. *Psychopharmacology (Berl)*. 2015 Aug; 232(16): 3091-3100.
10. Kok FM, Groen Y, Fuermaier ABM, Tucha O. The female side of pharmacotherapy for ADHD—A systematic literature review. *PLoS ONE*. 2020.15(9): e0239257. <https://doi.org/10.1371/journal.pone.0239257>

**Mmaphuti Kaaka** is a psychiatry registrar, in the Department of Psychiatry, University of the Witwatersrand, Johannesburg. **Correspondence: [drmdkaaka@gmail.com](mailto:drmdkaaka@gmail.com)**



GREAT WHITE PELICANS ( *Pelecanus onocrotalus* ) , photographed at Cape Agulhas (wetlands), January 2023. Photo courtesy of Lennart Eriksson, Psychiatrist – Pennington, KZN. [lennarte@africa.com](mailto:lennarte@africa.com)

# WORKING FROM HOME: YES OR NO?

*Robyn Leigh Safers*

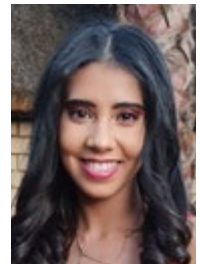
Goldilocks and the Bear Foundation, in partnership with the University of Stellenbosch Business School, recently hosted an Attention-Deficit Hyperactivity Disorder (ADHD) congress. Dr Charlene Gerber, an associate professor at the Business School, discussed reasonable accommodations, specifically with regard to working from home. As someone whose entire household has been clinically diagnosed with ADHD, Dr Gerber is no stranger to concessions. It is imperative to consider accommodations so that each individual may perform at their best. The current report is based on her discussion on the 3rd of September 2022.

Regarding current literature on working from home (previously known as “flexi work hours”), a lot of research has been done, even before the COVID-19 pandemic. Previous research investigations have been deconstructed to mainly focusing on how working from home affects productivity, work-life balance, and well-being. While companies exploring these effects may state that they are concerned about employee well-being, they may be more interested in how productive the employees are when working from home.

Conversely, it has been found that although people are more productive at home, as they are not commuting and, thus, have more time on their hands, there has been a deterioration in people’s work-life balance and psychological well-being. Most researchers are, however, in agreement that people are quite productive at home, despite the decline in other functions, as this is the current state of affairs. While a large amount of research has been dedicated to working from home, few researchers have focused on ADHD in that regard. Working from home is truly not a one-size-fits-all approach, even if it may seem like a great idea. There remains much to be explored in terms of how people with ADHD can juggle working from home, or on approaching this relatively new hybrid system that is being implemented at most institutions. With regard to the hybrid work model, typically one would expect atypical people, specifically people with ADHD, to experience difficulty when it comes to distractions, and, in turn, distractibility. As

people differ, so do their levels of distractibility, as well as the objects they are distracted by.

In a study mentioned in Dr Gerber’s talk, productivity seemed to be improved among all participants during the COVID-19 pandemic, contrasting the views and expectations of the researchers.



*Robyn Leigh Safers*

**BE THAT AS IT MAY, ADULTS PRESENTING WITH ADHD SYMPTOMS CONSISTENTLY SCORED LOWER WITH REGARD TO PRODUCTIVITY, AND ALSO PRESENTED WITH MORE DEPRESSIVE SYMPTOMS THAN THOSE WITHOUT ADHD SYMPTOMS. THESE INDIVIDUALS WERE ALSO SHOWN TO HAVE POORER QUALITY OF LIFE.**

Dr Gerber had been in discussion with ADHD-diagnosed individuals from some of her support groups. One individual shared their experience of working from home with ADHD, and highlighted being distracted by the brightness and motion of the computer screen when communicating with someone via video meeting, and thus not being able to engage as effectively as he/she would have liked to. Others share similar sentiments, but with regard to other impairments ADHD may bring about, disorganisation, impulsiveness, time management issues, forgetfulness, as well as fixations.

## DISORGANISATION

Reportedly the most common concern of ADHD-diagnosed individuals working from home, one such individual had stated that she had been unable to organise the chaos that came with her new work environment. Her house was filled with children, and as a result, disorder, now had to become her office, which was seemingly more structured and less chaotic than her home environment. Now that her two worlds had been combined, she has had to juggle the stress of managing the chaos, as well as doing her actual job.

## IMPULSIVENESS

Another individual reported that she had become more aware of her impulsive behaviour whilst working from home, and more able to filter her responses to situations, managing inappropriate behaviour as a result thereof. She stated that she had been able to hide her frustrations behind a switched-off camera.

## FIXATION

While working from home may be positive for some individuals, working from the office may be more effective for others. With regard to fixation as a symptom of ADHD, a working professional reported that working with and around people helps him to take breaks. On one particular day, he had checked his watch at 08:30 in the morning. Once he had gotten busy with his work and finishing up with the data report, he had lost track of time and it was already 13:30.

ONE SOLUTION TO HIS ISSUE WOULD HAVE BEEN TO LOWER THE DOSAGE OF HIS MEDICATION WHICH WAS CAUSING HIM TO HYPER-FIXATE, AS THERE ARE FEWER DISTRACTIONS AT HIS HOME THAN AT HIS OFFICE.

## TIME MANAGEMENT

One particular individual, a working mother, had reported that she was “not working from home, but rather sleeping at the office”. She had stated that she’d been struggling to gauge when and when not to be working, and would be able to work for 5 hours per day at the office, but find herself working for 10 hours per day at home. Some individuals may require more defined boundaries with regard to time management, more specifically, dependent on the perception of how people are managing their symptoms of ADHD. Due to the break in time structure and rules surrounding work, symptoms of ADHD may become more difficult to manage. Another individual stated that because she had been able to separate herself from the world, i.e., shut her door, put on noise-cancelling headphones and lock her pets up for a set amount of time, she had been more productive. Whereas if she’d been at the office, she would not have been able to lock her door and people would insistently bother her, distracting her from the work.

## FORGETFULNESS

For individuals who are typically forgetful on a day-to-day basis, working from home could potentially be a disaster, especially if there is a lot of demand from home life. These individuals are unable to sustain attention as there is a lot of distractibility due to not being able to prioritise tasks, and they cannot decide where to focus their attention.

Large companies and corporations are seemingly working towards a more flexi work environment, granting employees the choice to either work from home, or at the office. The hybrid working model (alternating between home and the office), seems to be a more ideal option, however one would need to ascertain their distraction triggers, and truly understand how the atypical behaviour manifests in their lives. Resultantly, the distractibility will need to be managed. In essence, times, days and instances would need to be monitored regarding recognition of triggers in order to identify which days would be more suitable to be office-based, rather than home-based.

A large proportion of research dedicated to working from home, in general, highlights the need for social interaction, and is in favour of a hybrid model, as humans are social beings, and crave connectedness. However, people who present with ADHD symptoms would have to truly understand their disorder, and manage the triggers thereof.

## INDIVIDUALISED APPROACH

The best example of distractibility in the office, before COVID-19, is possibly the open-floor plan offices that many companies have implemented. It is hard for atypical people with symptoms indicative of ADHD to work in those types of environments due to the levels of distractibility. They should be offered the choice of working from home on some days, and working in the office on others, all dependent on when they are not to be distracted.

The key take-away of the discussion is that an individualised approach is necessary with regard to working from home, as different systems work for different people. Open communication with employers could assist in employee productivity, well-being, and work-life balance. Some employees may require two days at home, and some three, all dependent on the individual. Importantly, it is not a one-size-fits-all model, and as life stages differ and change, so could triggers and distractions. An approach that could have worked today, might not work in a year's time,, so it is essential to re-assess. Openness to a flexible system also demonstrates flexibility within employers.

**Robyn Leigh Safers** holds a Bachelor of Social Science Honours degree in Psychology. She is responsible for screening children for mental health challenges at Goldilocks and the Bear Foundation in the capacity of the mental health screening assistant. **Correspondence:** [robynleigh.rls@gmail.com](mailto:robynleigh.rls@gmail.com)

# THE IMPACT OF COVID ON ADHD IN CHILDREN AND ADOLESCENTS

– PRESENTED BY DR DAVID COGHILL (UNIVERSITY OF  
MELBOURNE, AUSTRALIA)

*Marine Beltran*

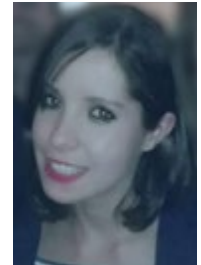
**W**hile COVID's fatality rate is declining and social isolation and quarantine is slowly becoming a thing of the past in some countries, the effects of the COVID-19 pandemic on people with ADHD suggests some differences to people without the diagnosis of ADHD.

Early during the pandemic, public health measures put in place such as social distancing, wearing masks and quarantine were incredibly necessary to minimise spread and risk and sometimes difficult to enforce. Interestingly, people with untreated ADHD were found to be at increased risk of contracting Covid-19 with rates and prevalence being higher in those with untreated ADHD than without. Symptoms of ADHD such as impulsivity and hyperactivity interfered with adherence of public health guidelines and likely contributed to the increased prevalence and risk of contracting COVID-19. Additionally, the relationship between ADHD and COVID-19 severity had conflicting evidence with some studies suggesting the severity of Covid-19 was higher amongst those with ADHD and other studies suggesting the opposite and higher recovery rates, revealing a variable relationship between severity of Covid-19 and ADHD.

It was also revealed that people with ADHD experienced greater perceived stress during the pandemic than those without ADHD and that children with ADHD are hypothesised to be more sensitive to stress than those without and the experience of stress during the developmental period can have a prolonged influence on future ADHD symptom severity. This takes into account the experience of the worldwide pandemic likely contributed to increased severity of ADHD.

Externalising behaviours significantly increased in children with ADHD with increased symptoms of hyperactivity, impulsivity, disruptive behaviour, inattention and oppositionality noted as well as increased media use and decreased exercise and outdoor time. There were also associated

home learning difficulties, and unavoidable schooling adjustments during the pandemic, with many schools moving to home-based learning for extended periods of time. This suggests the inattentive symptoms of ADHD and severity of anxiety symptoms surrounding the pandemic may be an important indicator of home learning difficulties.



*Marine Beltran*

Adolescents with ADHD were also found to be at greater risk of experiencing increases in mental health symptoms and substance use during the pandemic than those without ADHD and the use of positive coping strategies and routines buffered against increases in mental health problems and substance use.

**THIS IMPLIES THAT CLINICIANS WORKING WITH CHILDREN WITH ADHD SHOULD SCREEN FOR STRESSORS RELATING TO THE PANDEMIC THEY SHOULD CONTINUE TO BE SUPPORTED IN ACCESSING MEDICATION, AND EMPHASISING THE IMPORTANCE OF POSITIVE COPING STRATEGIES DURING THE PANDEMIC.**

Additionally, patient's access to ADHD assessments and treatment should be available because of the constraints of the pandemic and clinicians should be aware of the risk factors for non-compliance due to pandemic regulations. In conclusion, the pandemic has had multiple impacts on everyone's lives, with those with ADHD having exaggerated impacts. However, assessment and clinical care for those with ADHD can and should be successfully delivered and lessons learned have the potential to benefit practice as we emerge through the pandemic.

**Marine Beltran** is a psychiatry registrar, at Walter Sisulu University.  
Correspondence: [beltranmarine@gmail.com](mailto:beltranmarine@gmail.com) ■

# GOLDILOCKS AND THE BEAR FOUNDATION

Claire Tobin

**W**hile COVID's fatality rate is declining and social isolation and quarantine is slowly becoming a thing of the past in some countries, the effects of the COVID-19 pandemic on people with ADHD suggests some differences to people without the diagnosis of ADHD.

South Africa continues to face a high level of inequality and poverty which leads to an increased risk for mental health conditions and limited access to healthcare services. Approximately one in six children will live with a mental health condition at any given time in South Africa. Of these, only 25% will receive the necessary treatment. The South African Human Rights Commission (2017) reported that only 1% of government expenditure is allocated to mental health in South Africa. Although mental health clinics exist in the public sector, children with ADHD often never reach this point of diagnosis and treatment due to a lack of awareness and knowledge in their communities. They may be labelled as naughty, or "stupid", or just silently fall out of the educational system.

Goldilocks and The Bear Foundation is a non-profit organisation founded in 2017 by Professor Renata Schoeman (psychiatrist in private practice) and entrepreneur Nic de Beer.

**THE FOUNDATION OFFERS FREE ADHD AND MENTAL HEALTH SCREENING AND EARLY INTERVENTION SERVICES FOR CHILDREN FROM UNDERPRIVILEGED COMMUNITIES.**

The Foundation came into existence to identify and help these vulnerable children get the necessary support and in doing so improve the quality of life of children and families and provide the opportunity for them to reach their full potential.

Any child with emotional, behavioural or academic difficulties can be referred to the Foundation.

The Foundation visits underprivileged schools, or children can attend our screening centre in Parow, where we provide non-profit (free) screening for ADHD, anxiety, depression, visual- and hearing problems, and developmental delays for children. This ensures early referral, diagnosis, and treatment, and improves the quality of life of these children. Further to these services, the Foundation also focuses on training, research, raising awareness, and educating parents, teachers, as well as communities about ADHD and other mental health conditions.



Claire Tobin

**THE TEAM WORKS WITH PASSION AND COMMITMENT TO ENSURE THAT THESE CHILDREN AND PARENTS GET THE SUPPORT THEY NEED.**

Although the Foundation utilises the services of the Department of Health to assist with medication for ADHD, depression, anxiety, or other medical concerns, it still relies greatly on volunteers to assist in identifying other challenges. Some of their volunteers include psychiatrists, psychologists, psychometrists, optometrists, audiologists, occupational therapists, and registered counsellors. The Foundation is completely dependent on volunteers, fundraising initiatives, and donors to ensure that they can change children's lives. If you would like to assist in any way, by donating your time or expertise please email [info@gb4adhd.co.za](mailto:info@gb4adhd.co.za) for more information.

**Claire Tobin** is a psychometrist at Goldilocks and The Bear Foundation. **Correspondence:** [claire@gb4adhd.co.za](mailto:claire@gb4adhd.co.za) ■



## SOUTH AFRICA'S FIRST CHILDREN'S BOOK ON ADHD

"All of these things are important to me" tells the story of a day in the life of Zee, a South African girl living with ADHD. This book aims to increase awareness and educate communities about ADHD (and related mental health disorders) and to destigmatise the disorder and its treatment.

Written in five languages: English, Afrikaans, isiXhosa, isiZulu and seSotho, all in one book



To order your book, please go to our website:  
[www.gb4adhd.co.za/shop](http://www.gb4adhd.co.za/shop)



**Goldilocks and The Bear Foundation**  
191-227NPO, PBO 930057313

# ADHD AND PTSD: A DIAGNOSTIC OVERLAP IN CHILD AND ADOLESCENT PSYCHIATRY: A PRACTICAL OVERVIEW

– PRESENTED BY DR RONELLE PRICE – HUGHES

*Bongiwe Tyhala*

**R**onelle Price Hughes, a child and adolescent psychiatrist, started her talk citing difficulties in diagnosing what might seem like straight forward ADHD, when one is faced with a real-life patient. This, she attributed to other comorbid diagnoses complicating clear diagnostic criteria. She went on to explain how ADHD is not always a simple disorder to diagnose, as it is clinically a heterogenous disorder that changes throughout an individual's lifespan. It is also complicated by comorbidities that can worsen an individual's symptom severity, cause functional impairment and has the ability to mask symptoms of other disorders and vice versa.

She defined PTSD as being an exposure to trauma associated with intrusive symptoms, persistent avoidance of stimuli and negative alteration of cognition and mood. She noted that symptoms vary more widely than captured depending on the child's age with widespread psychological and biological consequences. This has an impact on the child's ability to regulate affect and behaviour, a symptom shared by ADHD, ODD and Conduct disorder. These children display reduced coping abilities and difficulties in self soothing. They become easily overwhelmed, overreact to minor stressors, have difficulty in regulating mood and react excessively in response to mutual stimuli. The difficulties in modulating anger results in deficits in social problem solving which can be distressing for these children and adolescents, who present with motor restlessness, difficulty concentrating, explosive and aggressive outbursts with emotional restriction. They also lack attention, have decreased impulse control and are hyperactive. These symptoms are typical of ADHD.

## PTSD INCREASES VULNERABILITY TO ADHD DEVELOPMENT.

Both PTSD and ADHD have common specific genetic risk factors. Neuro imaging studies have shown irregularities in dopaminergic neuro transmission and polymorphism in dopamine transporter genes and cannabinoid receptor genes. In utero mice exposure to nicotine lead to both ADHD and fear circuit abnormalities. Despite the shared characteristics and symptom overlap, ADHD and PTSD are distinct disorders of subcortical disinhibition and dysregulation of cortical inhibition. ADHD is a generalized failure of attentional focusing or executive functioning. It involves corticostriatal systems where attention, goal directed thought and behaviour is controlled. On the other hand, PTSD is a dysregulation of the central nervous system, and peripheral stress response systems

override and reduce functionality of brain systems necessary for learning and memory. It presents with cognitive processing deficits that appear to be influenced by attentional biases towards or away from the threat and deficits in emotional regulation. ADHD is present from birth and PTSD is caused by traumatic events. ADHD is an important risk factor, and can be a precursor for PTSD.



*Bongiwe Tyhala*

Diagnostic challenges: Avoidance symptoms of PTSD may resemble the inattentive cluster of ADHD, Hyperarousal symptoms of PTSD may resemble hyperactivity symptoms of ADHD. Intrusive recollections and reexperiencing of trauma in PTSD may resemble difficulty in organizing and incapacity to listen in ADHD, and reexperiencing leading to disorganized and agitated behaviour may resemble the impulsivity cluster in ADHD. The symptom overlap may mask or mimic one another. This may present a challenge as either a diagnosis may be missed, or incorrect diagnoses may be made. Many children presenting to psychiatry may have presented with or experienced symptoms of PTSD. ADHD and comorbid disorders are antecedent risk factors for PTSD. Science of fear links ADHD and PTSD. Individuals with ADHD are at an increased risk for PTSD and vice versa. Risk of PTSD in ADHD is 4 times greater, and risk of ADHD in PTSD is 2 times as great. Half the population experience trauma but the majority do not develop PTSD which suggests genetic predisposition.

Take home messages:

1. Screen for trauma, PTSD and ADHD as symptoms overlap and misdiagnosis or missed diagnoses may be a challenge.
2. Accurate assessment of trauma and PTSD to get a clear understanding of when symptoms started and impact on their functioning.
3. Prevention of PTSD by treating ADHD as ADHD is a risk factor for trauma and PTSD
4. Identify and treat all comorbid conditions to improve functioning
5. Monitor for substance use as ADHD is a risk factor for substance abuse
6. Relatives are at high risk for both ADHD and PTSD and if not identified and treated, they might not be able to support the patient or the child.

**Bongiwe Tyhala** is a psychiatry registrar, University of Cape Town, Department of Psychiatry and Mental Health. **Correspondence:** [bbtyhala@gmail.com](mailto:bbtyhala@gmail.com) ■

# YOGA AND MINDFULNESS FOR ADHD

– PRESENTED BY DR MELANÉ VAN ZYL

*Siki Gwanya-Mdletye*

**M**y first observation on the virtual lecture on yoga and mindfulness, was the fact that the presenter blurred the background on her camera, which was helpful for me in that it minimized distractions, so we were off to a good start. The talk was highly informative, shedding light on the basics of yoga, its origins and contemporary practice. Dr van Zyl went on to debunk some of the myths or impressions that are often held regarding yoga and the people who practice it. I enjoyed the candid way in which she delivered her message. For instance, regarding cognition she remarked “Just like our hearts want to beat, our brains want to think”.

She offered mindfulness, not so much as a remedy, but rather as a tool to recognize the roaming tendency of the mind; to notice and accept where it is found, and then to redirect or play with where the attention then goes. During the talk I learnt about mindfulness exercises like the body scan and choiceless awareness which in my ignorance I was previously not aware of. When the speaker transitioned to exploring how mindfulness and yoga complement each other, this helped me to put into perspective the content of the talk which preceded this one on the program.

AS SHE DESCRIBED HOW YOGA AND MINDFULNESS CAN HELP IN ADHD, I REALIZED THAT DE-LINKING PERSONAL IDENTITY FROM COGNITIVE CAPABILITY CAN BE VALIDATING FOR PATIENTS WHO STRUGGLE WITH SELF-ACCEPTANCE AS A RESULT OF ADHD.

As I write this review, I am reminded of the example that Dr Van Zyl made about talking to nurses during the COVID-pandemic, encouraging them to incorporate mindfulness even in simple daily

tasks like writing. At that thought I become aware of the clickety-clack of the keyboard keys as I type. The variations in speed which represent both the pace of my ideas and the level of comfort which I now have with using the computer... I wasn't always this fast, I become grateful as I realize how far I have come... aah the wondering of a restless mind.



*Siki Gwanya-Mdletye*

Indeed, as the speaker pointed out, the practice of mindfulness ought to become habitual. And so, as I catch my mind wandering, I draw my attention back to the task at hand, that of writing this review.

The physiology behind the positive effect of yoga on ADHD was presented clearly and concisely. The presentation indicated that among its postulated mechanisms of action, yoga may help balance sympathetic/ parasympathetic stimulation, profoundly affects vagal tone, and favours GABAergic (inhibitory) neurotransmission.

The speaker shared insights from the yoga therapy institute, which she recommended as being 'a contemporary, science-backed resource for those keen on learning about yoga therapy'. Her frequent mention of the terms 'pure yoga' and 'secular' toward the end of the presentation prompted me to wonder about the extent to which the adaptation of a spiritual practice for clinical therapeutic purposes could potentially dishonor or pay homage to the roots of that practice.

I thought it was generous of the speaker to share her contact details for those who would like to access her pdf presentation. Overall, I found this talk interesting, informative and thought provoking.

**Siki Gwanya-Mdletye** is a psychiatry registrar at Walter Sisulu University. Correspondence: [sisikelelwe.m2@gmail.com](mailto:sisikelelwe.m2@gmail.com)

# SCREEN TIME ADHD AND COVID

– PRESENTED BY DR JOHAN ERASMUS

Sarah Boshoff

**W**ith the Covid-19 pandemic and the effects thereof most children were, at some time or another, forced to spend an extended period in lockdown. With the lockdown a noticeable increase in screen time has been found. This increase in screen time was due to a number of reasons including the introduction of remote learning, the increased time at home with limited sources of entertainment resulting in increased gaming, internet use and the need for social connection with technology. The presentation broached the topic of screen time and Problematic Use of the Internet (PUI), screen time and ADHD and then looked at the three factors combined, screen time, ADHD and Covid.

It is known that children with ADHD seem particularly prone to excessive screen time and therefore perhaps PUI. Dr Erasmus explained this by presenting the possible pathophysiology underlying internet gaming disorder. Affected pathways include the dopamine-mediated reward mechanisms, reduced brain activation in areas associated with impulse control and decision-making, and reduced connectivity in executive function networks. Notably, similar networks to those impaired in ADHD.

Three studies were reviewed which look specifically at screen use, mental illness and Covid. The first study, a cohort study conducted by Xuedi Li et al. in Canada, was to determine whether specific forms of screen use were associated with symptoms of depression, anxiety, conduct problems, irritability, hyperactivity and inattention in children and the youth during the Covid-19 pandemic. This study confirmed increased screen time during the Covid-19 pandemic and demonstrated the association between increased screen time and higher levels of mental health symptoms. A study conducted in Switzerland by Werling et al. looked specifically at the impact of the Covid-19 lockdown on screen media use in patients referred for ADHD to child and adolescent psychiatry. This study found that

there was a significant increase in the negative effects of media use during lockdown regulations, including deterioration of ADHD symptoms. However, there were a small number of participants who were reported to have improvement in ADHD symptoms during lockdown, this can possibly be explained by the reduction in school related stress. The final study Dr Erasmus reviewed, also conducted in Switzerland by Werling et al. looked at media use and emotional distress under Covid-19 lockdown in a clinical sample referred for internalising disorders.



Sarah Boshoff

**THIS STUDY FOUND THAT LOCKDOWN HAD INCREASED ADVERSE EFFECTS ON PATIENTS WITH INTERNALISING DISORDERS, SUCH AS ANXIETY AND DEPRESSION, COMPARED TO THOSE WITH NON-INTERNALISING DISORDERS SUCH AS ADHD AND ASD ETC, HOWEVER IT WAS NOTED THAT HIGH MEDIA USE DID NOT ALWAYS CORRESPOND WITH NEGATIVE EFFECTS AND THEREFORE EACH CASE SHOULD BE VIEWED INDIVIDUALLY.**

In conclusion Dr Erasmus noted that internet use should be viewed as lying on a spectrum from adaptive to maladaptive and therefore a distinction should be made between dysfunctional versus functional use. ADHD appears to be a risk factor for PUI and therefore screening for PUI should form part of the assessment of ADHD. This was heightened during Covid and children with ADHD were at a high risk for adverse effects on mental wellbeing.

**Sarah Boshoff** is a psychiatry registrar at Walter Sisulu University and is based in Gqeberha.  
**Correspondence:** sarahboshoff123@gmail.com ■

# ADHD AS A DEFENSE

– PRESENTED BY DR YOLISHA SINGH

*Rasheel Singh*

**A**DHD is one of the most common neurodevelopmental disorders with a global prevalence averaging 5% in children and 2.5% in adults. Studies have shown however, that the prevalence of ADHD in prison populations, is over-represented, averaging around 25%.

The hallmarks of the disorder include impulsivity, inattentiveness, inability to retain information and poor executive functioning. Often there is comorbidity with other disorders including conduct disorder, learning disability or intellectual disability, oppositional defiant disorder, depression, anxiety disorders, autistic spectrum disorders, as well as antisocial disorder.

**THERE IS ALSO A PROPENSITY FOR SUBSTANCE USE, AND TOGETHER WITH AGGRESSION AND POOR FRUSTRATION TOLERANCE, LEAD TO DELINQUENT BEHAVIOUR. ADHD IS ALSO LINKED TO GREATER RATES OF RECIDIVISM.**

Criminal behaviour is often linked to symptoms and personality factors associated with ADHD, including recklessness, sensation-seeking behaviour, poor control, labile temperament and a confrontational interpersonal style. These symptoms when present in affected individuals make them vulnerable to committing crimes, but can also disadvantage them when they come into contact with the law. One theory is that offenders with ADHD are more easily caught due to poor planning, impulsivity or lack of attention to details.

People with ADHD may often make false confessions, or give vague or factually incorrect information, which may be perceived as them being evasive or deliberately misleading. There is also an increased suggestibility, which may lead to them to be manipulated as they tend to agree with police officers. The stress of the arrest itself, as well as police interviews and cross examination, can exacerbate impulsivity and inattention. They could also have increased levels of agitation and aggression, which may be detrimental to them in this setting.



*Rasheel Singh*

**IN SOUTH AFRICA, THE CRIMINAL PROCEDURE ACT 51 OF 1977 OUTLINES PROCEDURES TO BE FOLLOWED WHEN THERE IS A QUESTION OF MENTAL ILLNESS AFFECTING FITNESS AND RESPONSIBILITY. SECTION 77 DEALS WITH FITNESS AND SECTION 78 DEALS WITH RESPONSIBILITY, WHILE SECTION 79 DEALS WITH THE ASSESSMENT PROCEDURE ITSELF.**

'Fitness' refers to ability of the defendant to stand trial. The accused must have sufficient intellect to understand the nature of the charge, as well as the nature of court proceedings. There must be an ability to understand the evidence, and decide what defense to offer. Also there should be the ability to challenge jurors, and be able to present their version of events.

According to common law, a defendant is found responsible only if they were shown to have engaged in a guilty act (Actus Reus), while possessing a 'guilty mind' (Mens Rea); that is knowing that the act was wrong. There is also a lack of affirmative defenses (self-defense, or insanity defense). It is usually presumed that all defendants are responsible until proven otherwise.

**CRIMINAL RESPONSIBILITY IS ASSESSED ON TWO COMPONENTS; THAT IS THE ABILITY TO UNDERSTAND THAT AN OFFENCE WAS WRONG, AND THE ABILITY TO ACT IN APPRECIATION OF THE WRONGFULNESS OF THE OFFENCE. NEUROSCIENCE HOWEVER, CANNOT DETERMINE IF A DEFENDANT IS MORALLY OR LEGALLY RESPONSIBLE FOR THEIR ACTIONS, AS THERE IS NO BIOLOGICAL OR BRAIN CORRELATE OF RESPONSIBILITY. SCIENCE DOES HOWEVER SUGGEST THAT SOME PEOPLE, IN SOME SITUATIONS, FIND IT ALMOST IMPOSSIBLE TO CONTROL THEIR BEHAVIOUR EVEN IF THEY KNOW IT IS WRONG.**

The insanity defense is based on the assumption that at the time of the crime, the defendant was not of sound mind, and therefore, was incapable of appreciating the nature of the crime and differentiating right from wrong behaviour.

One type of insanity may be defined as "cognitive insanity", where a defendant was suffering from a mental disease or defect at the time of the crime, which impaired his psychological ability to appreciate the wrongfulness of the act. These principles, which were first described in 1843, are referred to as The McNaughton's rules.

A second type of insanity is based on the concept of "irresistible impulse", where a defendant is psychologically able to appreciate and distinguish between right and wrong behaviour, but has suffered from a mental illness leading to an inability to control one's actions.

It is noted, according to Verdins Principals, that mental illness could:

- 1) Reduce the accused moral culpability (but not legal responsibility)

- 2) Influence the type of sentence imposed and the conditions in which the sentence is served
- 3) Reduce the weight given to deterrence as a purpose of sentencing
- 4) Increase the hardship of the offender in prison if they suffered from a mental illness
- 5) Justify a less severe sentence where there is a risk that imprisonment could have an adverse effect on the offender's mental health

ADHD symptoms would need to be taken into account with respect to these principles.

But, a diagnosis of ADHD does not provide a defense, or a significant mitigation of culpability. However, ADHD can have relevance to the partial defense of diminished responsibility, and can be a mitigating factor in the sentencing phase by explaining some of the context in which the accused displayed problematic judgement or anti-social behaviour.

**GIVEN THE THEORIES REGARDING RESPONSIBILITY, THE ETHICAL DILEMMA THAT SURFACES QUESTIONS WHETHER PUNISHMENT OF SUCH INDIVIDUALS IS JUST OR EFFICIENT. THOSE WITH ADHD MAY FIND PRISON PARTICULARLY DIFFICULT IN TERMS OF SELF-REGULATION, IMPULSIVITY, AND CHALLENGING BEHAVIOUR, ESPECIALLY IF THEY REMAIN UNTREATED.**

While the association between ADHD and offending is now better recognized, suspects with ADHD, learning disabilities and mental health problems are often not identified as vulnerable and therefore not provided with the protection they need.

Research has pointed out that patients' behaviour and cognitive functioning does improve once medication is initiated. There is therefore a need to increase awareness and advocate for appropriate pharmacological and psychological interventions, so as to improve patients' symptoms, which would in turn encourage pro-social behaviour.

**Rasheel Singh** is a psychiatry registrar at Walter Sisulu University/ Fort England Hospital. **Correspondence:** rash0158@yahoo.com ■

# AUTISM AND ADHD - A PRESENTATION OF THE NEURODEVELOPMENTAL DISORDERS IN ADULTHOOD

- BASED ON A PRESENTATION RELATED TO AUTISM SPECTRUM DISORDER/ ADHD BY RACHEL MAKONI (SA)

Matuka Banyane

**A**s the incidence of neurodevelopmental disorders being diagnosed has remarkably increased, there has been increased recognition of these disorders having a lifelong impact. ADHD is defined by the DSM 5 as the impairing symptoms of inattention and / or hyperactivity with onset before age 12, presenting across two settings and cannot be better explained by another condition. While Autism Spectrum Disorder is defined by enduring and impairing social communication and interaction deficits that occur across multiple settings, along with the presence of restricted, repetitive behaviour, interests or activities or sensory symptoms. The core symptoms of both ASD and ADHD do not overlap but research suggests that 30%- 83% of children with ASD have symptoms of ADHD and 20-60% of children with ADHD have ASD-like social difficulties.

**THE HAS BEEN AN INCREASE IN THE DIAGNOSIS OF THESE COMORBID CONDITIONS AS A RESULT OF CRITERION CHANGES, THE INCLUSION OF MILD CASES, AND EARLIER AGE OF DIAGNOSIS.**

ASD is 4 times more likely to be diagnosed in males than in females, with ADHD 2-3 times more likely to develop in males than females, with a lifetime prevalence of 4.4% and 50-65% persisting into adulthood, with the full syndrome persisting in 15%,

Presentation in adulthood is rare, but practitioners need the skills to identify the core symptoms to effectively manage patients. The core features of ASD are a deficit in reciprocal social interaction, restricted and repetitive behaviours and interest and communication impairment. In adulthood communication skills often improve but social deficits can be more problematic, maybe reflecting the complex interactions required in forming and maintaining relationships. Research shows that patients who present in adulthood may present with anxiety and mood disorders. Making a diagnosis requires collateral history and/or supporting information i.e. school reports evidencing the presence of symptoms since early childhood. ADHD's core features in adulthood are social problems that result from inattentiveness and impulsivity, such as difficulty maintaining relationships and employment. Criminal behaviours amongst youth with ADHD are common in prisons and young offender units, with substance misuse and addiction, especially with stimulants

reflecting social neglect and self-medication.

Understanding the dynamics of the two conditions can assist in optimum management, this can be understood by the differences in presentation but the overlap of the deficiencies, and an understanding that both conditions are neurodevelopmental disorders with childhood onset that can persist into adulthood. They both have social deficits. ASD sufferers lack social knowledge and are more likely to respond to social training for deficits causing difficulties (in the absence of positive behaviour) i.e. social approach and eye contact. There is a struggle with cognitive flexibility which requires holding and switching between multiple perspectives rapidly. In contrast, with ADHD the social knowledge is intact but there is a performance deficit causing social difficulties through negative behaviour such as interrupting or intruding behaviour and they struggle with inhibition, planning/problem-solving.

Management requires the practitioner to consider the comorbidities, encouraging supportive adjustment of the environment to suit the patient. This includes noise reduction with earphones, routine to accommodate ASD, and psychoeducation. Treating the comorbid condition with appropriate psychotropic agents considering lifestyle is a necessary consideration.

## REFERENCES

1. "Health - Neurodevelopmental Disorders | US EPA." 11 May. 2022, <https://www.epa.gov/americaschildrenenvironment/health-neurodevelopmental-disorders>.
2. American Psychiatric Association. 2013. Diagnostic and Statistical Manual of Mental Diseases (DSM-V), 5<sup>th</sup> ed. Washington, DC, American Psychiatric Publishing.
3. Antshel, Kevin M.; Russo, Natalie (2019). Autism Spectrum Disorders and ADHD: Overlapping Phenomenology, Diagnostic Issues, and Treatment Considerations. *Current Psychiatry Reports*, 21(5), 34-. doi:10.1007/s11920-019-1020-5



Matuka Banyane

**Matuka Banyane** is a psychiatry registrar, Department of Psychiatry at the University of the Witwatersrand. Correspondence: [matuka.banyane@wits.ac.za](mailto:matuka.banyane@wits.ac.za)

# GAMING

## THE GOOD, THE BAD AND THE ESSENCE

– PRESENTED BY MICHELE VAN NIEKERK

Phumla Gasa

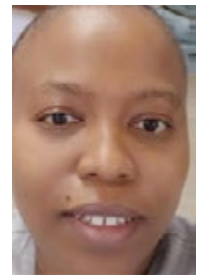
**G**aming has been around for many years and through the years there has become greater variety in the available content and improvement in animation. This had made it appealing for all ages and genders but is there a good and / bad side to this ever-growing market. How can this impact certain neurodevelopmental disorders?

Just like a coin, there are two sides to this topic of gaming and one can argue in favour of it or against it. But is there really a good to gaming? Yes. People of varying ages game, from the very young (3 years of age or younger), the adolescent, young adult, and older individuals. The male gender are more frequent gamers when compared to females. The reason why people game could be for social or entertainment purposes, to attain certain skills or it can be for medical purposes e.g., pain management. There are also cognitive benefits to gaming with not all the gaming themes having the same impact on one's cognitive function. Some benefits are said to be improvement in attention/ concentration and vision (Daphnie Buvelier). Gaming can also in the future be seen as a medium to motivate learning in a more desirable interactive way than current teaching mediums and in turn create more engagement in schoolwork (Jane McGonigal).

**WITH THE COGNITIVE EFFECTS, COULD GAMING BE SEEN AS SOMETHING THAT POSITIVELY ASSISTS RATHER THAN ADVERSELY AFFECTS CERTAIN NEURODEVELOPMENTAL DISORDERS?**

This all sounds appealing; if gaming can create such an positive impact but there needs to be a balance between passionate engagement in gaming and pathological use of gaming. This brings me to the bad side of gaming. The DSM 5 has criteria for pathological gaming- gaming disorders. Gaming can have the ability to create a magical world and hence make the user assume unrealistic consequences to certain actions e.g., in games with violent content. This can create an increase in aggressive emotions or behaviours in an individual. Individuals with ADHD could have

an increased risk to develop addiction (to the game and pathological gaming) and result in an increase in impulsivity due to the instant gratification provided by the game and content of the game. In these individuals, social skills/socialisation may deteriorate as more time is spent gaming. There may also be impaired reality testing, poor sleeping patterns and impaired judgement.



Phumla Gasa

**BESIDES INDIVIDUALS WITH ADHD, INDIVIDUALS WITH THE OTHER EARLY SYMPTOMATIC SYNDROMES SOLICITING NEURODEVELOPMENTAL CLINICAL EXAMINATION (ESSENCE) ARE ALSO AT RISK OF NEGATIVE INFLUENCE OF GAMING.**

These neurodevelopmental disorders include ASD, learning disorders/ intellectual disability, reactive attachment disorder, Tourette's and the already mentioned ADHD. Difficulties with affect regulation, problem solving, self-esteem and identity problems amongst other things can be as the result of the gaming (content and preoccupation) and the social isolation (pathological use of the gaming) from this. This can also be argued to assist in those with neurodevelopmental disorders as it might be a way to self sooth any conflicts that they might be experiencing, and decrease perceived anxiety as they have a sense of control and satisfy a need for social interaction.

Is it another toss at "everything in moderation" or is it a question of why one chooses to game? I think an informed decision on both the good and bad aspects would assist in making one's decision on this topic and also to keep an open, unbiased mind when choosing to game or not to game.

**Phumla Gasa** is a psychiatry registrar at the University of KwaZulu Natal. **Correspondence: phumlag87@gmail.com** ■

# CONCESSIONS: YES, OR NO?

– PRESENTED BY JESSICA CHEESMAN

*Nokukhanya Biyana*

**C**oncessions, also known as accommodations, are a brilliant resource for students with learning barriers to make the playing ground level at schools for learning purposes. Learners who are eligible for concessions are those who have special educational needs arising from disabilities including learning disabilities associated with mental disorders like ADHD.

ADHD is a neuro-developmental disorder, which affects a person's ability to use age-appropriate self-control. It is characterized by patterns of impulsivity, inattentiveness, and hyperactivity. Because people with ADHD have learning disabilities, this means that they are likely to perform below average compared to their counterparts. It therefore becomes imperative that such individuals are referred for appropriate interventions to receive similar and fair chances in learning as others.

According to the WHO, there are 139,84 million adults, 388,000 children between the ages of 2 - 5 years, 2,4 million adolescents aged 12 - 17 who are diagnosed with ADHD globally. ADHD is often underrecognized and people with ADHD are often under supported in institutions and areas of higher learning. Due to lack of awareness about the disorder, people with the disorder are often ignored and unnecessarily marginalized. ADHD individuals are at a high risk of dropping out of schools and resort to the use of illicit drugs and get involved in other antisocial behaviours with hazardous consequences if no interventions are put in place.

**TEACHERS PLAY A CRUCIAL ROLE AND ARE OFTEN SEEN AS THE CORNERSTONE IN OBSERVING, IDENTIFYING, SUPPORTING, ACCOMMODATING, AND ASSISTING LEARNERS WITH LEARNING DIFFICULTIES SUCH AS ADHD IN SCHOOLS.**

Once these individuals are identified, relevant referrals are required so that appropriate assessments are implemented timeously.

Accommodations or concessions refers to a process of change or modification made to assessments or assessment venue or regulations for learners with learning difficulties or disabilities to ensure that these do not unfairly affect a learner's

academic performance. It's a process that allows support and allows students with disabilities achieve the same instrumental goals as the students without disabilities. Accommodation removes barriers in the classroom and provides every individual with equal access to learning.



*Nokukhanya Biyana*

Barriers to learning are significant long-term disabilities which compromise learners exam performances. Some of the accommodations may be granted and this includes change to measures such as additional time, Braille, a computer, enlarged print, handwriting, reader, prompter, rest breaks etc. In certain circumstances, accommodations may not be granted, when the learner has been found to have low cognitive functioning, which falls below the average range of intellectual ability or if the learner has difficulty with the language assessment as it is in an alternative language to their home language.

After the process of identifying said individuals has taken place, the school-based support team puts forward an application for the learner for an assessment. This process involves teachers who have identified learners who need accommodation or concession to complete a Support Needs Assessments (SNA). The process of the SNA is outlined in the Screening, Identification and Assessment and Support document also called the SIAS document. The SIAS document is a policy document that was adopted by the DBE in 2014 in SA. Its main aims include standardizing procedures that all schools need to follow to support all learners with learning difficulties to have equal opportunities for learning.

Having worked and lived with ADHD sufferers in close proximity and witnessed some of their day-to-day struggles, concessions and accommodations are 'the way to go'. I would strongly recommend the government should prioritise making education and employment ADHD friendly, and substantial investments should be made to improve and facilitate educational and employment outcomes associated with the disorder.

**Nokukhanya Biyana** is a psychiatry registrar at Walter Sisulu University. [nokukhanyabiyana@gmail.com](mailto:nokukhanyabiyana@gmail.com)

# AUTISM SPECTRUM DISORDERS (ASD) AND ATTENTION DEFICIT/HYPERACTIVITY DISORDER ADHD A CATEGORICAL APPROACH

## – PRESENTED BY DR NERICA RAMSUNDHAR

Tigist Zerihun

### SUMMARY OF CRITICAL POINTS

- ADHD and ASD are neurodevelopmental disorders with onset in childhood and persist throughout adulthood.
- There is a high prevalence of comorbidity in these two conditions i.e. 50-70% of children with ASD have ADHD and at least one in 8 children with ADHD has ASD.
- ASD and ADHD comorbidity are associated with increased severity of symptoms and worse treatment outcomes.
- Comorbidity additionally increases the risk of a third psychiatric condition comorbidity than each disorder alone.
- ASD and ADHD comorbidity have poorer cognitive abilities than ASD alone (Rosello, 2021)
- ASD and ADHD have overlapping phenomenology, symptomatology, and treatment considerations.

### LIMITATIONS OF THE CATEGORICAL APPROACH:

- Do not address the developmental trajectories
- Problem with setting a specific threshold or addressing subthreshold symptoms
- Do not address co-occurring conditions

ASD and ADHD categorical approach helps to

- Make a comprehensive diagnosis, including the specifiers
- Understand associated phenotypes
- Allow multidisciplinary intervention based on the need
- Provide an individualised management plan, e.g. level of support, language therapy

- Encompass challenges faced by the patient
- Aid in research and documentation of phenotypic presentations
- Unlock the available resources such as individual educational plans, different therapies



Tigist Zerihun

### DIAGNOSTIC SCALES

- Diagnostic tools have advantages; for example, the Autism Diagnostic Observation Scale differentiates ASD and ADHD adequately. However, the scale may have limitations in differentiating between similar symptoms in ADHD and ASD, e.g. Social impairment, which can be rated twice, and the discrepancies between parent and teacher reports. It remains to be a future research area.

### MANAGEMENT

- The treatment of the co-occurrence of ADHD and ASD follows individual disorder management protocols. However, the response is limited to a single diagnosis. Studies reported that polypharmacy is a common scenario.
- In conclusion, using a categorical approach helps to individualise and address the person's difficulty with dimensional management.

N.B All the citations taken from the presentation.

**Tigist Zerihun** is a psychiatry registrar at Division of Child and Adolescent Psychiatry (DCAP) University of Cape Town. **Correspondence:** [zerukaye@gmail.com](mailto:zerukaye@gmail.com) ■

Clinical features	ASD	ADHD
Social impairment	Absence of positive social behaviour eg. Eye contact	Negative behaviour, Impulsivity, intrusiveness, poor team or group functioning
Social Knowledge	Limited or lacking	Intact social knowledge but a problem in performance
Social Perpetual Abilities	Greatest deficit	Moderate deficits
Executive functioning	Lack of cognitive flexibility	Struggle with inhibition and cognitive flexibility
Repetitive behaviour	Repetitive rapid movement, scripted speech	Fidgets and taps hands
Movement	Can be sensory-seeking behaviour	Hyperactivity

# DEPARTMENTS OF PSYCHIATRY

## UNIVERSITY OF THE WITWATERSRAND



### GRADUATIONS DECEMBER 2022:

#### MMED



Prof. Subramaney and Dr Valabdass



Prof. Subramaney and Dr Mwenda



Dr Subrayadoo and Dr Mhlane with Prof. Subramaney



Drs Mwenda Jones, Juanita Subrayadoo, Sonali Valabdass, Thato Kalane

#### PhD

##### Dr Samantha Naidoo

The PhD was titled "The mental health needs of female inmates in Durban, South Africa". It was a mixed methods study, and the first of its kind in South Africa. The supervisors were Prof. Ugash Subramaney, Prof Saeeda Paruk and Liezel Ferreira ■



Prof. Ugash Subramaney and Dr Samantha Naidoo

# STELLENBOSCH UNIVERSITY



## GRADUATES

At the Stellenbosch University December 2022 graduation ceremony, the Department of Psychiatry, Faculty of Medicine and Health Sciences had 3 PhD graduates:



Dr Jaiyeola A. Kajero

Dr Anusha Lachman

Dr Eileen Young

**Dr Jaiyeola A. Kajero** investigated the potential attenuating effects of cannabidiol (CBD) on antipsychotic-induced vacuous chewing movements, behavioural and biochemical aberrations, and cognitive and negative symptoms of schizophrenia in rodent models of tardive dyskinesia and psychosis.

**Supervisor:** Prof S Seedat Co-supervisors: Dr O Aina (external), Dr A Akindele (external), Prof J Ohaeri (external).

**Dr Anusha Lachman** investigated the shared pleasure paradigm in mothers with and without mental illness and their young infants in a clinical and community setting in the Western Cape. The study included a range of neurodevelopmental, infant withdrawal and maternal mental health variables.

**Supervisor:** Prof DJH Niehaus Co-supervisor: Prof K Puura (external)

**Dr Eileen Young** investigated the potential role of adiponectin in predicting the onset of posttraumatic stress disorder and cardiometabolic disease in female rape survivors early after rape.

**Supervisor:** Prof S Seedat Co-supervisors: Profs N Abrahams (external), SMJ Hemmings (internal), N Peer (external) ■

## STELLENBOSCH UNIVERSITY MSc (NEUROSCIENCE)

Stellenbosch University's new **MSc (Neuroscience) programme** is a research-based programme with no study modules.

This programme **will train researchers who can contribute towards the biopsychosocial understanding of neuropsychiatric disorders** and develop much-needed research capacity in neuroscience in South Africa.

This programme is a **distinct offering** from many other programs in that it represents an interdisciplinary, cross-faculty research programme, which will draw on expertise in various fields to create a comprehensive research programme, yielding globally competitive Masters students.

### PROGRAMME DETAILS

The programme will be administered by the Department of Psychiatry.

**Duration:** Two calendar years on a full-time basis

**Programme Structure:** This is a research-based degree programme with no study modules. The programme consists of a research project, thesis and project presentation.

### Assessment and examination:

- Progress is monitored continuously by the supervisor.

- You must complete a research project, present the results in a thesis and deliver a project presentation.
- The thesis is assessed according to University guidelines by an internal and external examiner.
- The final mark is calculated from the marks obtained for the research project (supervisor's mark), thesis (internal and external examiners) and project presentation.
- You must obtain 50% to pass and 75% to pass with distinction.

### PROGRAMME OUTCOMES

#### Admission and Selection requirements

The specific admission requirements for an MSc include an average final mark of more than 60% in one of the following qualifications from a recognized tertiary training institution:

- 4-year Bachelor's degree (NQF level 8) or an Honour's degree (NQF level 8) in a field relevant to neuroscience e.g. Medicine, BSc Honours in Genetics, Physiology, Biochemistry, Psychology or Engineering

Application deadline (for registration in 2023): 30 September 2022 ■



## COMMENTARY ON THE INTEGRATION OF MENTAL HEALTH CARE FOR HCW DURING COVID-19

BY TONI ABRAHAMS

Prof Jackie Hoare recently penned a moving commentary for the South African Journal of Science sharing her lived experience as a liaison psychiatrist at Groote Schuur Hospital during the COVID-19 pandemic. She offers insightful reflections on key lessons to supporting the mental health of patients and staff. COVID-19 has to an extent, equalised our experience of anxiety and fear and brought on a global mental health crisis. Prof Hoare shares that her role was to provide psychological support to patients hospitalised with COVID-19 requiring high or intensive care, to mitigate against worsening physical symptoms and prevent the longer-term deleterious effects of prolonged anxiety on mental

health. Patient's decisions about their clinical treatment were significantly affected by this fear and anxiety and they needed to be non-judgementally supported to make sound decisions. Traditional norms of how clinicians should be with their patients were tested by the unprecedented situation. Supporting colleagues was of equal importance and only possible through becoming part of the COVID-19 team and providing a normalising and affirming group space where all belonged through their collective experience of loss, grief and trauma. A key lesson from the experience was that mental health and health cannot be separated, nor can our common vulnerability and humanity be disowned ■

## UPDATE ON THE PERINATAL MENTAL HEALTH PROJECT

BY SIMONE HONIKMAN

The Perinatal Mental Health Project (PMHP) has had a busy and productive start to 2022, at the Hanover Park MOU, offsite in various locations and virtually through seminars, talks and webinars.

The PMHP mental health service at the Midwife Obstetric Unit (MOU) in Hanover Park is starting to resemble a working environment similar to that of pre-pandemic times: 3rd year nursing students from the University of the Western Cape (UWC) and 4th year medical students from the University of Cape Town (UCT) returned as part of their practical training. Our Clinical Services Coordinator, Liesl Hermanus, orientates students to our services and to maternal mental health, introducing them to empathic engagement skills, particularly during labour, and especially with vulnerable clients.

Groote Schuur Hospital's Maternity Unit hosted a Pregnancy Awareness Programme at Phoenix High School in Manenberg. The aim was to highlight important topics that promote a healthy pregnancy, including maternal mental health. Liesl facilitated a lively discussion with the pupils who spoke freely about mental health matters.

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

There have been two key outputs arising from the USAID/WHO Maternal Mental Health Technical

Consultation that took place late 2021, and for which our director was an invited speaker and advisory committee member. A report "The Silent Burden: a Landscape Analysis of Common Perinatal Mental Disorders in Low- and Middle-Income Countries" was published on the USAID MOMENTUM website. As our director was a key informant for the document, we were able to inform the content directly drawing on our two decades of experience and research. The second output has been an open access commentary piece published in the peer-reviewed journal, BMC Pregnancy and Childbirth, entitled "Silent burden no more: a global call to action to prioritize perinatal mental health". We were able to include PMHP's lessons in systems strengthening.

Our Director and our Clinical Services Co-ordinator, presented on the maternal mental health (MMH) webinar series hosted by the African Alliance for Maternal Mental Health and Global Alliance for Maternal Mental Health. This was directed at MMH advocates, researchers, practitioners, educators and policy makers, globally. Attendance was high with participants from African countries as well as North and South America, India, UK and Europe.

National COVID-19 Clinical and Operational Guideline for Mothers, Newborns and Children: The National Department of Health invited us to lead the development of a chapter on 'Psychosocial care' for a new iteration of COVID-19 guidelines. The earlier edition had little mention of psychosocial health considerations. We thus included a range of issues including health worker mental distress and wellness, empathic engagement, communication and messaging, respectful maternity care, mental health conditions, gender-based violence, bereavement, adolescent pregnancy, poverty etc ■

# TRANSGENDER HEALTHCARE: A GENDER-AFFIRMING MULTI-DISCIPLINARY APPROACH

BY CLAUDIA DE CLERCQ, LISA DANNATT AND ADELE MARAIS

The Social Responsiveness Committee hosted a virtual CPD Symposium on 'Transgender Healthcare: A Gender-Affirming Multi-Disciplinary Approach'. The event took place on 24 May 2022. The symposium was offered by the multi-disciplinary Grootte Schuur Hospital (GSH) Transgender Clinic Team.

Transgender and Gender Diverse (TGD) persons are a minority group who face significant prejudice, stigma, and discrimination in society. The human rights and dignity of TGD persons are often undermined in interactions with institutions, including the healthcare system (for example, having their identities repeatedly scrutinised, questioned and pathologized, and being treated with paternalism by their healthcare providers).

The GSH Transgender team are committed to providing clinically sound and competent gender affirming healthcare services to the TGD community with the overarching goal of ensuring that a client's dignity and right to identity and expression is respected. Access to gender-affirming healthcare can have a powerful impact on the well-being and quality of life of those seeking it, beyond the immediate psychological and physical benefits.



The GSH Transgender clinic is recognised as a Centre of Excellence in gender affirming healthcare in Africa. The team follows best practice standards of care and has contributed to the development of the new national 'Gender-Affirming Healthcare

Guidelines' recently published by the Southern African HIV Clinician's Society (SAHCS).

The GSH Transgender team has input from a range of disciplines: Clinical Psychology, Psychiatry (Adult and Adolescent), Endocrine (Adult and Adolescent), Plastic Surgery, Gynaecology, Speech Therapy, Family Medicine, Sexology, Clinical Social Work, and includes representatives from both private and public sectors, as well as NGOs and advocacy groups. The team has seen over 350 clients since the clinic's inception in 2009.

This symposium served as an introduction to Gender-affirming healthcare from a multi-disciplinary perspective, and provided a solid foundation for a future symposium offering more specialist input across the range of disciplines.

The symposium speakers represented the full range of a multi-disciplinary approach to gender-affirming healthcare, and underscored the value of consultation and collaboration across disciplines in this field of work.

In the first session, Clinical Psychologist and ordained Reverend, and Chair of the Professional Association for Transgender Health in South Africa (PATHSA), Chris McLachlan, spoke eloquently (both from a professional and lived experience perspective) on "Que(e)ring Gender: Am I trans, cis, or gender-diverse?"

Associate Prof Elma de Vries, a Family Physician passionate about the right to access to healthcare for marginalized populations, gave an "Introduction to Gender Affirming Health Care (GAHC), and the role of the GP in the new GAHC guidelines".

Associate Prof Adele Marais, a Senior Clinical Psychologist in our department, and the Chair of the GSH Transgender Clinic, gave a comprehensive presentation on "Gender Incongruence in Adults and the Role of the Mental Health Care Practitioner". This included highlighting the changes in classification in the DSM 5, and ICD-11, and the implications of these changes. Prof Marais was a member of the WHO ICD-11 Working Group that made the revisions to the diagnosis of 'Gender Incongruence'. Prof Marais is also the chair of the GSH multi-disciplinary transgender team. Prof Marais summarised both international and local guidelines for mental health practitioners, and shared her clinical expertise with regards to client-centered interviews, and areas to focus on in psychotherapy with trans and gender-diverse clients.

Clinical Social worker, Sexologist and academic at UCT, Ron Addinall elaborated on the "Psychosocial Care" of gender diverse individuals, their families

and their environments. He emphasized supportive psychotherapy for young people in their process of gender “discovery and affirmation”.

In the second session of the symposium Dr Simon Pickstone Taylor, a Child and Adolescent Psychiatrist, shared his expertise with regards to “Gender Incongruence in Children and Adolescents and the role of the Mental Health Care Practitioner”. The audience appreciated the comprehensive outline on how to approach working with adolescents and their parents, and what should be included in the provision of psychoeducation.

The rest of the second session addressed gender-affirming medical and surgical interventions for trans and gender-diverse clients. Paediatric Endocrinologist at GSH, Dr Ariane Spitaels, carefully explained an “Approach to Hormone Therapy in Adolescents”, followed by Physician and Endocrinologist at GSH, Associate Prof Ian Ross, who discussed an “Approach to Hormone Therapy for Adults and the role of the Endocrinologist”. Thereafter, Plastic, Reconstructive and Maxillofacial Surgeon at GSH, Dr Kevin Adams, gave an informative and illustrative talk on the different types of “Gender-affirming Surgeries”.

The third and last session for the day included a range of interesting topics. Dr Tracey Adams, a subspecialist in Gynaecological Oncology at GSH discussed “The role of the Gynaecologist in screening and prevention”, and highlighted the importance of screening in primary healthcare settings.

Lindi Bester, a Speech-Language and Hearing Therapist at GSH, discussed gender-affirming voice and communication services for transgender and gender-diverse people. She shared some

illuminating video-clips and spoke to the role of our voice in our identity.

Ron Addinall and Dr Deirdre Pieterse (a Consultant-Liaison Psychiatrist at Valkenberg Hospital-VBH) presented an Ethics talk on “Institutional policies and the Ethics of gender affirming care”. Dr Pieterse reflected on her team’s experiences of providing care to trans-clients at VBH, and the development of the VBH gender-affirming hospital policy.

Savuka Matyila, a gender non-conforming human rights activist represented the NGO ‘Gender Dynamix’, and discussed “Community Based Resources” available to transgender and gender-diverse populations. He highlighted the challenges that are faced by this population, and what some of the recommendations are for future research and practice.

Lastly, Landa Mabenga – a transgender educationalist, advocate, researcher and author, and PhD student at UCT – shared his inspirational lived experience as a transgender man in South Africa who received gender-affirming care and surgery from the Transgender Clinic at GSH.

The symposium was truly excellent, informative, engaging and very well-received. Almost 200 delegates attended the symposium online – with the majority being Clinical Psychologists and Psychiatrists (Adult and Child & Adolescent) from across the country. Attendees displayed a willingness to enhance their knowledge and skills in the field of gender-affirming care, and a commitment to being gender-affirming practitioners. The presenting team and organisers have received very positive and appreciative feedback for the input offered. Congratulations to all involved! ■

# SEFAKO MAKGATHO HEALTH SCIENCES UNIVERSITY



## CONGRATULATIONS

Dr P Mazibuko has been appointed as the new Head of Department of Psychiatry at Dr George Mukhari Hospital and SMU. He will commence duties on the 01/12/22. We congratulate him for accepting the appointment and wish him well in his new role! ■

# OF SWEET PEAS, DANDELIONS, LADY BUGS AND MUSIC NOTES

Claudia Campbell

## Dated: Sometime in 2012

*The fly kept hitting the window again and again. He could see the outside world and could feel its presence, but one invisible glass panel made it impossible to reach.*

*So, I helped the fly out the window and was thankful for my frontal lobe and opposable thumbs.*

*However, when I laid my cheek on the pillow my tears ran hot. For some time, I grappled to understand their source. And then I realised, I was reflected perfectly in that little fly's desperate and solitary frenzy. It's an odd thing to empathise with a fly. But the isolation of being trapped behind an indiscernible barricade is chilling and remote.*

*I realised the only medication I can rely on, the one thing which unfailingly soothes and encourages me to carry on forward, is being understood. Looking in the eyes of another person who comprehends the complexity and doesn't judge is a most powerful medication to quiet the panic. Being able to share my fears and frustrations about my unreliable body with such a person offers a few moments of not being in solitary confinement.*

*I thought about the two invaluable places I rely on for this understanding and I fear that the moment is coming when I'll be asked to leave because nothing more can be done. I ache with distress that my springs of encouragement and understanding may dissolve in a moment, and I'll be left trapped behind this indiscernible barricade without someone to open the window for me, even if it is only for a fleeting breath.*

*And it ached to know that when my husband wraps his arms around me, he doesn't understand. He genuinely cares and loves and does all he can to protect, but he doesn't understand. And talking to my friends about things undoubtedly turns my situation into a joke - because what else do you do when there is no understanding. And with each hug, each touch of the hand or squeeze of the elbow and each joke I feel further and further removed, more and more isolated.*



Claudia Campbell

I found this piece of writing from 2012. At the time I was in hospital, desperately ill and miserable, trapped in an unreliable body.

**THE 'TWO INVALUABLE PLACES' I REFER TO ARE MY PSYCHIATRIST AND PSYCHOLOGIST'S OFFICES. THINGS WERE SUCH A MESS AND I FELT SO HOPELESS.**

The isolation steadily increased as I projected my fear onto the 'two invaluable places'. I was convinced I would be rightfully deserted because it seemed there was never any progress, just regression.

It's pretty sad when one relates to a trapped fly. Just like the little fly beating itself against the pane of glass trying to get to the other side, each time I tried a new treatment, each time my body failed to improve I felt that I was beating myself against a closed pane of glass with little hope of a window

being successfully opened. I knew those treating me had tried their best, but it seemed my window would not open. Of what value is a trapped fly anyway?

I think my projected fear perhaps speaks to how treatment can overwhelmingly focus on illness and not wellness. By that I mean in-the-moment wellness. There was so much talk, so many tests, so many medication trials, which all focused on what was wrong - overwhelmingly wrong. Every day I felt that we spoke about unexpected reactions and failed responses to treatment. I realise this was entirely my subjective reflection and does not represent the experience of those treating me. However, with so much focus on what was broken, I felt I was all broken and I seemed 'unfixable'. What do you do with broken, unfixable things? You get rid of them. I truly felt and feared I was going to be disposed of.

**IN RETROSPECT I HAVE TO WONDER IF I WOULD HAVE FELT DIFFERENTLY SHOULD A FEW CONSULTATIONS EXPLICITLY AND SINGULARLY FOCUSED ON WHAT WAS WELL ABOUT ME - NOT ABOUT MY SUPPORT SYSTEM, NOT ABOUT THOSE WHO LOVE ME, OR ANYTHING 'EXTERNAL', ONLY ME.**

I'm also not talking here about conversations regarding the importance of focusing on 'the positive'. These conversations can imply one needs to find the energy to counterbalance a load of negative (read illness) with 'positive'. It can make one feel you're never doing enough, because there is more effort needed to find positivity in your body or mind which constantly feels rubbish.

The whole positivity thing can feel contrived when your world is genuinely not great. However, talking about the small things that were 'well' about me would have simply been discussing facts, without added pressure to do anything else, even 'focus on the positive'. I think this would have gone some way in helping me feel my 'window' had been opened.

Granted, even in hindsight, there wasn't much that was well. However, I see now that I have always (or almost always) been able to find beauty in music and tiny things: a lady bug crossing a petal, the curious look of the sparrow dancing at his reflection in the window, the warmth of sunshine swooping across my hospital bed, the smooth sounds of an Alexis French piano solo.

"Claudia, for an hour we are not going to talk about medication, we are not going to talk about symptoms, we are not going to talk about tests. I want to sit outside with you so you can show me something beautiful I probably would have missed without you pointing it out". I don't think an entirely broken person would be able to do this. I see now, that without knowing it then, the ability of noticing the beauty of tiny things helped save my life, not

just official treatment. My being able to specifically help someone step into the world of tiny beauty would have shifted focus to what was well, working, and wonderful in my mind.

I know now that my psychiatrist and therapist always saw those things in me, and even acknowledged them in relation to resilience. The thing is, resilience is a big concept which, involves being strong and elastic enough to bounce back from difficulty. In the face of such illness, the concept of resilience seems so immense, that one's ability to see oneself as resilient can be absent. Resilience felt more like a concept than a characteristic. When facing deteriorating symptoms, being told you're resilient risks feeling the person telling you this is speaking an untruth, which is wholly unfair towards a truthful practitioner. However, it would be entirely believable if we had spoken my ability to find beauty in tiny things and recognise this 'small wellness' represented something very unbroken. Maybe seeing a shimmer of wellness would have made resilience plausible.

**I REALLY TRUSTED BOTH MY PSYCHOLOGIST AND MY PSYCHIATRIST, THE PROBLEM IN THIS CONTEXT IS I DID NOT, IN ANY WAY, TRUST MYSELF. HOW COULD I WHEN I KNEW, ALBEIT INCORRECTLY, THAT I WAS BROKEN. HOW COULD I TRUST A BROKEN, UNRELIABLE MIND? HOW COULD I EVER BELIEVE THAT IN THIS SAME MIND EXISTED THAT BIG THING, 'RESILIENCE'?**

I was wrong, very wrong. I was resilient. When I reflect back on how ill I was physically and mentally I realise I had to be resilient to come out the other side. I believe I would have seen, and more importantly, believed in my resilience if we had intentionally, even for an hour, brought life back to the tiny, beautiful things I noticed.

Last year I saw how powerful intentional focus on tiny, beautiful things can be. I saw it in the incredible woman who taught it to me. Over two weeks in March I spent every day with my grandmother. She was 97, and after a magnificent existence, her life was ebbing away. She knew it, I knew it. It's horrible to witness a body fail. However, up until her last day she appreciated flowers and the dancing of birds in the trees. I witnessed how peaceful her face was as she heard her great-granddaughters sing to her as she took her last breath. Until her final moment in a dying body, she was resilient in the wellness of a mind intent to never let a tiny moment of beauty pass her by.

So, let me show you sweet peas, dandelions, lady bugs, and music notes.

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

# DISABILITY GRANTS ...

*Oupa Habib*

Oh yes  
Most sad and heartsore  
It is!  
Attempts to obtain  
Disability grants  
On psychiatric grounds,  
Where there are none!  
Totally  
Understandable  
It is,  
For when there is:  
So much  
Unemployment, poverty,  
Financial desperation,  
It makes  
Complete sense,  
That persons,  
Will attempt  
To obtain  
Any  
Financial relief!  
A sane response  
To an insane world!

Only:  
A state sector psychiatrist  
Knows,  
The pain, torture  
And dilemmas in this area!  
Malingering, desperate  
Heart rendering pleas,  
And  
Sometimes  
Even threats  
Are the common order  
Of the day!

Oh  
How,  
I have struggled in this area!  
Much pain and stress  
It has caused me!  
Strong, tough, resolute  
One  
Has to be!  
Establish proper criteria,  
Get the  
Assistance of the occupational therapist

To perform  
Functional assessments,  
And  
Stick to your guns,  
Or  
The floodgates  
Will  
Just open!

For example:  
"True madam  
Your son  
Most psychotic  
Did he become!  
Drug induced  
It was!  
Barely  
Twenty two  
Is he!  
Most fine  
Is he now!  
If  
His indulgence  
Is stopped!  
Most  
Certainly  
Does  
Not  
Quality for a grant!  
For that ,  
Would  
Just reward,  
Bad behaviour!"

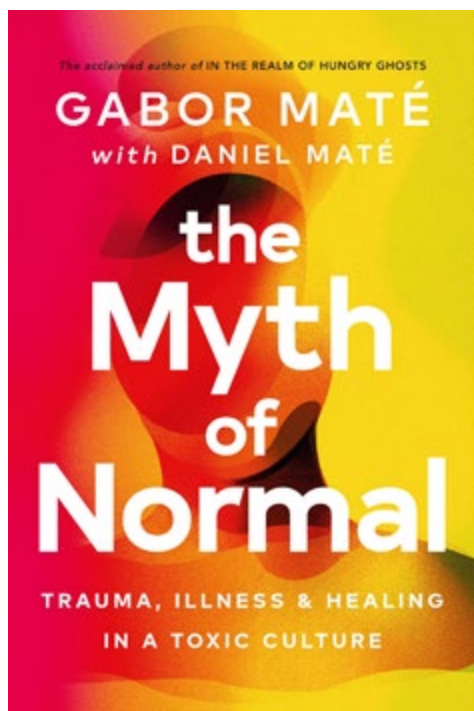
Her response:  
"Most cruel  
And insensitive  
Be you!  
What kind  
Of psychiatrist are you?"

I  
Rest,  
My case!  
And  
Hide,  
Under my bed!

**Dr Habib** (nickname "Oupa") is the Principal Psychiatrist at Port Shepstone Regional Hospital in Southern KwaZulu Natal. He has a professional interest in the issues of psychotherapy. **Correspondence: [habib@telkomsa.net](mailto:habib@telkomsa.net)** ■

# THE MYTH OF NORMAL: TRAUMA, ILLNESS, AND HEALING IN A TOXIC CULTURE

Koffi Kouakou



**Title:** The Myth of Normal: Trauma, Illness, and Healing in a Toxic Culture  
**Publisher:** Hay House  
**Author:** Gabor Maté, (MD) with Daniel Maté  
**ISBN:** ISBN 978-178504 2720

Five pages of praise by a swarm of renowned clinical psychologists, psychiatrists and bestselling authors for Gabor Maté and his son Daniel Maté’s most recent and intimidating book, *The Myth of Normal*, is more than impressive. First, it’s a lot. Second, it’s intellectually overwhelming, besides the size of the book. Third, where do I start ?

Among the many, there are two powerful testimonials, worth sharing that captivate me. *“In the Myth of Normal, Gabor Maté takes us on an epic journey of discovery about how our emotional well-being and our social connectivity (in short, how we live) are intimately intertwined with health, disease, and addictions. Chronic mental health and physical illnesses may not be separated and distinct diseases but intricate, multilayered processes that reflect (mal)adaptation to the culture that we live in and the values we live by. This riveting and beautifully written tale have profound implications for all our lives, including the practice of medicine and mental health,”* beautifully says Bessel A. van der Kolk, medical doctor and president of the

Trauma Research Foundation and professor of psychiatry at Boston University School of Medicine in the USA.



Koffi Kouakou

Esther Perel, a psychotherapist and author, says it is *“a book in which readers can seek refuge and solace during moments of profound personal and social crisis.”*

They couldn’t have said it any better. The book is already a bestseller, together with a recently -and anonymously- published workbook that complements it.

I find the extensive praise both suspicious and intriguing. But my suspicion always leads to curiosity and deep inquiry. Most importantly, I wanted to find out and do justice to a Christmas gift I thought was a warning signal from the giver, reminding me to pay more attention to my own mental health and deal with the potential hidden trauma I fail to acknowledge.

**IT WAS INDEED A GENUINE GIFT TO PRY OPEN MY SCEPTICISM ABOUT THE MENTAL LETHARGY OF MY SURROUNDINGS SUBDUED BY THE EFFECTS OF THE PAST THREE YEARS OF THE COVID-19 PANDEMIC. IT WAS ALSO A PRESENT TO SATISFY MY INTELLECTUAL CURIOSITY ON THE STATE OF OUR HEALTH SOVEREIGNTY AS A SPECIES.**

This book is packed with so much information, insights and wisdom that it transcends the boundaries of health and healing. At times, the medical jargon is very technical and daunting. Yet, it reads well with an ocean of real-life cases and footnotes that soothe the fear of reading about trauma, illness and healing in a toxic culture. Interestingly, there are no diagrams, fancy medical charts, mathematical formula nor daunting statistics to coerce the reader into submission about the validity of the Matés’ personal stories and the numerous case experiences in a medicalised culture the authors chronicle.

Maté senior, a Hungarian-Canadian, trained physician and author, famous for his research on trauma, anxiety and mental health, is a humble

and almost introverted man with sharp intellect and a straightforward mind. His has an extensive background in “family practice and a special interest in childhood development, trauma and potential lifelong impacts on physical and mental health including autoimmune disease, cancer, attention deficit hyperactivity disorder, addictions and a wide range of other conditions.”

Much of his work and family life are informed by his childhood trauma in Eastern Europe fleeing the Nazis with his parents to Canada during World War II and the legacy trauma that imprinted his memories for life.

Maté junior, not to be confused with Daniel Francisco Maté Badenes, the Spanish billionaire, and the owner of about 3% of Glencore, a Swiss multinational commodity trading and mining company, is a reputable outgoing artist. The Maté’s father-and-child relationship experiences deeply inform the making of this book that took ten years of solid, collaborative and evidence-based research to complete.

**IN A SERIES OF POWERFUL STORIES, THE AUTHORS LAY OUT A SUPERB AND FRIGHTENING DIAGNOSIS OF THE ILLNESSES THAT AFFECT UNHEALTHY SOCIETIES OF THE WESTERN WORLD. AND IT IS NOT PRETTY. IT’S PAINFUL.**

Western nations boast about their superb healthcare systems, yet “*chronic illness and general ill-health are on the rise. Nearly 70 percent of Americans are on at least one prescription drug; more than half take two. In Canada, every fifth person has high blood pressure. In Europe, hypertension is diagnosed in more than 30 percent of the population. And everywhere, adolescent mental illness is on the rise.*”

Moreover, the Covid-19 pandemic, over the past three years, has exposed the giant failure of Western nations’ healthcare systems to provide rapid-response medical help and post-traumatic relief to vast numbers of their citizens. This is shocking evidence of dysfunctional and unhealthy societies.

So, the authors proceed to ask uncomfortable questions about the afflictions that govern the state of health in those nations and analyse the deep and unattended traumas that engender them while attempting to propose ways to heal them. As the co-developer of a psychotherapeutic method known as *Compassionate Inquiry*, he (Gabor) has helped thousands of people to heal.

Of significance asks Maté father, “what is really “normal” when it comes to health in traumatised societies?” Is an unhealthy society normal? Or have unhealthy conditions been normalised?

Through these questions, the Matés attempt to address the troubles of traumatised societies and

their communities from childhood trauma to many other depressive conditions. They also define and explain the myth of normal, why it matters, and demystify the veneer of unhealthy normalcy that govern our medicalised societies today.

Gabor Maté’s long decades of clinical experience, helps him to debunk the acceptable societal norms that dismiss the dangerous, unhealthy and long-term effects of trauma, “stress and the pressures of modern living exert on our bodies and our minds at the expense of good health.” He questions the notion of “normal” and why it is falsely accepted and used in the West.

He goes further to shame the failures of so-called technological sophisticated Western medicine to treat the wholesome person rather than their symptomatic aspects for emotional balance. Finally, he demystifies the common myths about what really makes humans sick, unhealthy and “normal.”

The book is the product of a traumatic healing journey between father and son with a wider validated trauma experience with the rest of the world they live in. It is both a cry and an alarm for dealing with and managing trauma in a modern society with a wider range of psychological tools. More important, it is a remarkable story of the obsession with mental health, childhood, healing and health sovereignty seeming controlled by large medical corporations.

**HOLD YOUR HORSES THOUGH. THERE IS ALMOST NOTHING ABOUT AFRICA IN THIS BOOK. STRANGE.**

However, what the book illustrates well is the nature of personal and collective trauma in modern societies, with emphasis on childhood, that are constantly battling with great social changes and strife. And here by extension, South Africa, as a society in transition, could qualify as a giant case and experimental study for the Maté’s book.

From the lingering trauma of the dreadful psychological brutalities of the Apartheid era to the continuing anxieties of a hopeful transitional nation, much of the experiences in this book can be applied to South African’s experiences. Moreover, they relate closely to the painful generational trauma, tragic and traumatic legacies of racism, slavery and colonialism in the United States, and especially in South Africa where the psychological human dysfunctions deepened by the current energy crisis, blackouts and power outages contribute to accentuate the unwelcome fears of living in darkness and its ensuing rampant crimes. Therefore, the relevance of this book to South African readers is paramount.

It is a great present in a challenging new year for those who want to understand the trauma conundrums of our modern societies today and their associated healing journeys.

**Koffi M. Kouakou** is Managing Director of Stratnum Futures, a foresight consulting and advisory company in Pretoria, South Africa. **Correspondence:** [koffizulu@gmail.com](mailto:koffizulu@gmail.com) ■

# WHEN SUSTANABILITY STARTS TO INCLUDE TRANSFORMATION

David Swingler

**C**APEWINE is the largest wine trade show in Africa, an international shopfront of the South African wine industry. At its most recent iteration late last year, 2000 guests from over 60 countries visited the three-day jamboree in Cape Town to meet, greet and do business with some 417 exhibiting producers. Its theme was 'Sustainability 360', similar to the last event in 2018 before Covid-19 disrupted its continuity.

I reviewed that event in somewhat scathing terms in this journal at the time as, in the context of sustainability, I was concerned there was a myriad of small plastic water bottles everywhere and nobody seemed to care about water and carbon-based energy usage, or the discharge of phosphates into riverine estuaries, with washing of single use glasses for each wine tasted, which seemed to be the norm.

THE ORGANISER'S MEDIA AT LEAST, DISMISSED MY ENVIRONMENTAL QUERIES WITH APPARENT DISDAIN.



CapeWine 2022

But somebody, somewhere, listened. As CapeWine dropped the curtain in 2022, the press release was prepared: "Glasses were rotated roughly four times," wrote Maryna Calow on behalf of Wines of SA. "Which means roughly 32,000 units were used and approximately 26,400 bottles of wine, to the value of R6 million, were shipped into the show for tasting over the three days. According to partners Waste(Planet),

roughly 7 tons of wine bottles were poured and recycled, 2 tons of water bottles joined 6,5 tons of general waste, over 4,500 meals were served and almost 4,000 cups of coffee kept exhibitors going. An additional 160 support staff assisted within the hall, which included trainee chefs from School of Skills in Rocklands, waiters, glass washers, baristas and runners." Promising.



David Swingler

BUT TRANSFORMATION NEEDS TO CREEP INTO THE SUSTAINABILITY SPACE FOR BOTH TO SURVIVE.

Transformation needed space at CapeWine, and got it. Calow again: "In her address at the Opening Seminar on the first morning of CapeWine, keynote speaker Minister of Agriculture, Land Reform and Rural Development, Thoko Didiza, noted: "The wine industry is one of the exciting industries of our agricultural sector, with clear and growing results of transformation, both on gender and race."



All-day free pour regional tastings

Approaching thirty years of democracy, what's the report card of transformation in the wine industry which shares many parallels with rugby in the perception of Afrikaner dominance of an apartheid instrument?



Visitors' deliberations

An overview at <https://www.wosa.co.za/Sustainability/Socially-Sustainable/BEE/Empowerment-Projects/> is pretty darn impressive. Many of the original worker/landowner initiatives like Fair Valley (Paarl), Thandi (Elgin) and Thokozani (Wellington) have grown and thrived while more recently Visio Vintners (Klein Zalze) and Adama Appollo Workers Trust (Bosman Family) have started to command column centimetres. One or two – Solms Delta sadly – have failed spectacularly.

### IT WAS HEARTENING TO SEE AN AMORIM SPEAKERS CORNER EVENT AT CAPEWINE 2022 DEDICATED TO "A NEW LOOK AT TRANSFORMATION AND SUSTAINABILITY IN THE SOUTH AFRICAN WINE INDUSTRY" FEATURING PAUL SIGUQUA, OWNER OF KLEIN GOEDERUST.

On the way in I met Wendy Petersen, Operations Manager of SA Wine Industry Transformation Unit who seemed charged with lithium batteries during load-shedding – indefatigable!

WITU is a Non – Profit Company incorporated under the first schedule of the companies act of the Republic of South Africa. Incorporated on 17 October 2016 by its founding members, the National Agricultural Marketing Council (NAMC), Vinpro and SA Liquor Brand Owners Association (SALBA), it brands itself 'The Home of Change' and has the



Trizanne Barnard is behind Dawn Patrol Wines

**David Swingler** is a writer and taster for Platter's South African Wine Guide for over 21 years to date. Dave Swingler has over the years consulted to restaurants, game lodges and convention centres, taught wine courses and contributed to radio, print and other media. A psychiatrist by day, he's intrigued by language in general, and its application to wine in particular.

**Correspondence:** [swingler@telkomsa.net](mailto:swingler@telkomsa.net) ■

primary purpose of generating and promoting equitable access and participation within the wine value chain in and for the wine industry, and all that goes with it. A powerful resource, indeed.

The Speakers Corner gave a stage to activities at Merwida, Lubanzi, Journeys End, De Grendel, Bosman Family, and Headstart, amongst others. But it's the stories that captivate, that differentiate. Like that of Mohseen Moosa and Daphne Neethling who have toiled and invested in Paardenkloof in Bot River for over 20 years, to establish it, the wine brand and eatery 'Ecology' on the R43 and, more recently, their acquisition and makeover of the Bot River Hotel.

Stories like that of Berene Sauls who recalls, as a child, accompanying her mother over the hills of the Kleinrivier Mountains south of Caledon, with the more difficult task of later getting an inebriated mother home after a family gathering. She seemed destined for the cycle of early motherhood and poverty when Hamilton Russell Vineyards owner Anthony employed her for domestic childcare. Recognising her ability, he offered her a clerical position in the farm office and Berene quickly took control of HRV's extensive exports. But that's not all. Fascinated with wine and seeing the resources around her she trademarked her home town Tesselaarsdal as a wine brand and, in association with Emul Ross and the HRV team makes a Chardonnay and Pinot Noir that command foreign demand and commensurate prices.

And stories like that of Franschoek Boutique Estate Klein Goederust's developer Paul Siguqa. Paul's mother was a farm labourer at Paarl's Backsberg who told young Paul, repeatedly, that he would not be one – she was the last. She advocated education and sacrificed for it. Armed with a degree, Mr Siguqa work in Johannesburg until he had just more that chutzpah, and returned to establish a wine farm. Seizing opportunity and embracing a sense of community in sharing his dream, he now proudly receives guests at Klein Goederust. The original moniker, in Afrikaans, *nogal?* "We did not name the place, we found it here. We need to embrace the history of this place but also bring in our own identity."

Kit Heathcote's review in The Daily Maverick does better than I could ever: <https://www.dailymaverick.co.za/article/2022-10-14-old-farm-new-vines-and-a-man-who-dared-to-dream/>

Stories tell. Stories sell.



# A BEAUTIFUL GAME

## THE ART OF MAKING STRATEGIC CHOICES

Kim Laxton



by Anya Taylor-Joy), navigating a post-Cold War era. On the surface Beth might be viewed as a "typical" orphan girl with no identity, faceless in a crowd of fellow orphans. However, Beth is set apart from the other children by her exceptional talent for the game of chess. One day Beth finds a dusty board and its pieces in the basement of the orphanage, and together with her friend Mr Shaibel, secretly learns the art and technique of the game. The story weaves through the life of Beth, as she evolves into a woman of great chess stature, entering and dominating local and eventual international chess tournaments.

BUT WHAT MAKES THIS SERIES PARTICULARLY SPECIAL IS THE DEVELOPMENT OF BETH'S DEEP AND DYNAMIC CHARACTER, BEAUTIFUL YET INEXTRICABLY FLAWED, IMPOSSIBLE TO DISENTANGLE FROM HER CHESS BRILLIANCE.

As a psychiatrist The Queen's Gambit raises important questions about the *humanness* of a developing young prodigy; *can the desire to win be classified as an addiction? Is chess a strategic game of pieces on a board and can it be extended into this world?*

These questions envelop the story that is crafted to perfection with a remarkable dialogue and beautiful and bold cinematography. Set in exquisite locations, colours, props, and score compliment the evolving story of a fractured young woman navigating her path of chess brilliance. The characters are deep and complex, and the viewer has no option but to dissolve into the plot, its mystery, and its excitement.

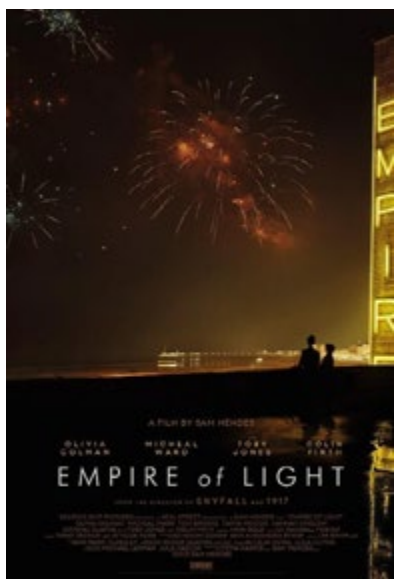
I loved The Queen's Gambit. It taught me something about me, what I consider to be of great significance: Chess, like life, is unpredictable, yet we own the pieces to the story and may often preempt the future move; it's what we do with the *now* that is so important.

When I think about 2019, it feels like a decade ago. I find it difficult to imagine what happened that year. The highlights, such as South Africa winning the Rugby World Cup, are overshadowed by the hovering thundercloud of 2020 and the beginning of a new era, that being Covid-19.

However, for me, 2019 saw something quite special rising from the series archives of Netflix. The Queen's Gambit brought about the resurgence of an interest, even a passion, for chess. The Queen's Gambit, based on the book by the same name, written by Walter Tevis, was adapted for the small screen to tell the story of a young woman, Beth Harmon (played

**Kim Laxton** qualified as a psychiatrist in 2016 and is currently in private practice at Akeso Crescent Clinic, Johannesburg. She works within the life insurance industry in addition to teaching, academia and clinical practice. At SASOP 2021, she assisted in coordinating a parallel session: "The Art of Psychiatry and the Therapy of Play". This included the movie evening at the conference. She is an avid movie-goer, Funko-Pop collector and wildlife fanatic! **Correspondence: [drkimlaxton@gmail.com](mailto:drkimlaxton@gmail.com)**

# M O V I E S



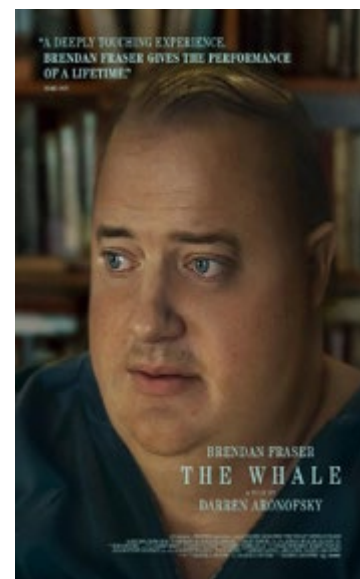
**Title:** Empire of Light  
**Release Date:** 03 Feb 2023  
**Director:** Sam Mendes

A drama about the power of human connection during turbulent times, set in an English coastal town in the early 1980s.



**Title:** Knock at The Cabin  
**Release Date:** 03 Feb 2023  
**Director:** M. Night Shyamalan

While vacationing, a girl and her parents are taken hostage by armed strangers who demand that the family make a choice to avert the apocalypse.



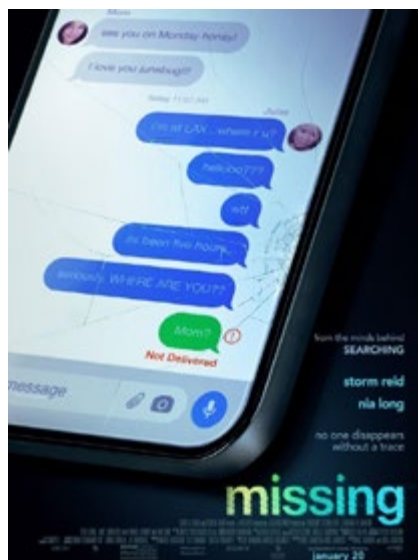
**Title:** The Whale  
**Release Date:** 10 Feb 2023  
**Director:** Darren Aronofsky

A reclusive, morbidly obese English teacher attempts to reconnect with his estranged teenage daughter.



**Title:** A Man Called Otto  
**Release Date:** 17 Feb 2023  
**Director:** Marc Forster

Otto is a grump who's given up on life following the loss of his wife and wants to end it all. When a young family moves in nearby, he meets his match in quick-witted Marisol, leading to a friendship that will turn his world around.



**Title:** Missing  
**Release Date:** 24 Feb 2023  
**Directors:** Nicholas D. Johnson and Will Merrick

An 18-year-old girl goes in search of her her missing mother who disappeared in Columbia while vacationing with her boyfriend.



**Title:** Cocaine Bear  
**Release Date:** 24 Feb 2023  
**Director:** Elizabeth Banks

An oddball group of cops, criminals, tourists, and teens converge in a Georgia forest where a 500-pound black bear goes on a murderous rampage after unintentionally ingesting cocaine. ■

  
S5 Yelate  
DULOXETINE HCl

# PITCH for PERFECT HARMONY

**TOGETHER** we are  
**STRONGER**

Dual serotonin and noradrenaline  
reuptake inhibitor<sup>1</sup>

**HARMONY** in **MENTAL HEALTH**<sup>2</sup>

Dr. Reddy's 



HELPLINE : 0800 21 22 23  
[www.sadag.org](http://www.sadag.org)

Dr. Reddy's



NEUROPSYCHIATRY  
GOOD HEALTH CAN'T WAIT

References: 1. Yelate 30/60 package insert. Dr. Reddy's Laboratories (Pty) Ltd. January 2020. 2. Galderisi S, Heinz A, Kastrup M et al. Toward a new definition of mental health. *World Psychiatry*, 2015;14(2): 231-233.

S5 Yelate 30/60. Each capsule contains duloxetine hydrochloride equivalent to duloxetine 30/60 mg. Reg No's 44/1.2/0114:0115. Dr. Reddy's Laboratories (Pty) Ltd. Reg no. 2002/014163/07. Block B, 204 Rivonia Road, Morningside, Sandton. 2057. [www.drreddys.co.za](http://www.drreddys.co.za). ZA/03/2021-23/Yel/003

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



## SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

# UPDATE & NOTICE FOR SPECIAL INTEREST GROUPS

**T**o The SASOP Membership, SIG Chairs and Members of SIGs

The National SASOP Board of Directors (BoD) has noted with support the need for consensus guidelines and position statements on pressing, current and controversial issues, practices and treatment options in psychiatry.

However it is important that the BoD clarifies the purposes and requirements of the different statements that are sent out, and for this we wish to circulate the attached preferred though not exhaustive definitions that we would like SIGs to abide by.

Please also take note of the following definition as per our MOA for SASOP and constitution:

- A Special Interest Group by definition is: *a duly constituted group of **SASOP members** committed to the Company's objectives and activities in terms of specific areas of interest in Psychiatry.*
- Such SIGs may have additional Rules, which are not in conflict with the MOA and governance processes and financial mechanisms must be aligned with the overall processes and

mechanisms implemented by the SASOP Board Rules of the Company, but as interest area subsidiaries of the SASOP NPC, all.

The BoD also notes that there are several WHATSAPP groups with a variety of allied and health professionals contributing to Special Interest Groups - however these are not strictly SIG members, who per definition above are required to be paid up SASOP members.

While the BoD is in support of wider discussions, multi-disciplinary input and engagements in the special groups, when Statements (Consensus, Guidelines or Position) are sent to the BoD for approval and distribution, SIGS are required to adhere to the guidance set out, and ensure that the statements have **received consensus support from the SASOP members in that SIG**. In the event that the SIG is not a representative enough group (<5 members) there will be a requirement that the statement is first circulated amongst a wider membership for commentary before the BOD approves it.

We trust this clarifies the BoD position on this matter.

Thank you

**SASOP EXCO** ■

# SAVE THE DATE

SUNDAY 19 NOVEMBER – THURSDAY 23 NOVEMBER 2023  
CENTURY CITY CONFERENCE CENTRE, CAPE TOWN



# SASOP

**21<sup>st</sup> National Congress  
of the  
South African Society of Psychiatrists**

*Shifting the paradigm towards community care  
and the unheard voices in mental health*

FURTHER DETAILS TO FOLLOW SHORTLY  
PLEASE CONTACT [SONJA@LONDOCOR.CO.ZA](mailto:SONJA@LONDOCOR.CO.ZA) FOR ANY FURTHER DETAILS  
+27 82 455 7853



## CONSENSUS STATEMENTS, GUIDELINES, POSITION STATEMENTS

### INTRODUCTION

Consensus statements, clinical guidelines and Position paper/statements are sometimes employed as if they were interchangeable, but the purpose of such documents and the robustness of advice vary as the evidence base does not have the same depth in each.

### MEDICAL OR CLINICAL 'CONSENSUS STATEMENT' DEFINITION:

#### DEFINITION:

A public statement on a particular aspect of medical knowledge that is generally agreed upon as an evidence-based, state-of-the-art knowledge by a representative group of experts in that area. It reflects opinions from an organized group of individuals.

#### PURPOSE:

Its main objective is to counsel clinicians on the best possible and acceptable way to address a particular decision-making area (diagnosis, management or treatment). It constituted the expression/collection of the general opinion of the experts and does not necessarily imply unanimity.

#### METHOD/EVIDENCE:

It can be considered a "snapshot" in time, so will need periodic re-evaluation as new information emerges.

A "Delphi process" can be used for a consensus statement – which involves sending out questionnaires, aggregating and analysing feedback and sharing with a group of identified experts, with unidentified comments facilitating better consensus and reducing bias.

#### LEGAL STAND:

Consensus statements are not formal evidence review or clinical practice guidelines. It is not a legal document and level of evidence varies according to the quality and consistency of the literature used.

### CLINICAL PRACTICE GUIDELINES

#### DEFINITION:

Advisory statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options.

#### PURPOSE:

Guidelines are one way of increasing

implementation of evidence into practice. They can serve as a guide to best practices, a framework for clinical decision making, and a benchmark for evaluating performance. Aims to streamline particular processes according to sound practice.

#### METHOD/EVIDENCE:

Highest level of evidence available based on systematic review of the literature. Ideally includes randomized trials, when available. Risk of bias is minimized through explicit and transparent methodology.

#### CRITERIA:

- must include transparency in all aspects of the guideline development;
- multidisciplinary panel composition with participation of patients or patient advocates;
- reliable grading of evidence for the recommendations.

#### LEGAL STAND:

It is never mandatory or enforced. Guidelines are not prescriptive or directive, but doctors who fail to follow widely recognized guidelines risk criticism and may even, in the event of poor outcomes be at risk of legal action.

### POSITION PAPER/STATEMENT

#### DEFINITION:

Presents an opinion about an issue, typically that of the author or another specified organization or entity. A position statement is a concise explanation of an organization's position on a certain issue that should include background information and clarify rationale behind the position. Can range from the simple format of a letter to the editor through to the most complex in the form of a multi-author academic position paper.

#### PURPOSE:

To publicize the position or support for a particular standpoint, or for use in advocacy efforts, to clarify the organization's position on certain practices within the specialty.

#### METHOD/EVIDENCE:

Based on an informal process of expert or committee consensus (usually BOD) that draws upon best available evidence.

#### LEGAL STAND:

Position papers are published in academia, in politics, in law and in other domains. Position papers can be used by organizations to communicate their official policy or declaration of purpose ■



# CHILD AND ADOLESCENT PSYCHIATRY SPECIAL INTEREST GROUP SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

## POSITION STATEMENT

### IACAPAP 2022, THE EXCLUSION OF COLLEAGUES FROM COUNTRIES ON THE AFRICAN CONTINENT

It is with distress that we learn of the denial of visas for colleagues of the AACAMH who were registered to attend, participate, and present their work in Dubai in December 2022. The IACAPAP Congress invites participants to “join along with your peers, discover new areas of learning and network with your peers” and yet we have the exclusion of colleagues from 20 African countries including Nigeria, Ghana, Uganda, Liberia, Senegal, and the DRC.

The IACAPAP Congress 2014 was hosted in Durban, South Africa by SAACAPAP with Professor Brian Robertson as Convenor. Professor Robertson championed CAMH on the African continent throughout his career. Professor Olayinka

Omigbodun, the President of IACAPAP, was in attendance and an active participant in Durban. As a Nigerian, Professor Omigbodun would be denied access to this Congress in Dubai.

We call upon IACAPAP to speak out on the exclusion and discrimination against the African continent and to offer a hybrid option to facilitate the attendance and contribution of colleagues from Africa who were motivated to attend the Congress.

On behalf of CAPSIG COMMITTEE

**Convenor:** Dr Merryn Young  
**Secretary:** Dr Lesley Carew

# POSITION AVAILABLE

## HEAD OF CLINICAL UNIT: CHILD PSYCHIATRY

**DIRECTORATE:** Child Psychiatry

**CENTRE:** Charlotte Maxeke Johannesburg Academic Hospital

**SALARY** R 1 807 380.00 (All-Inclusive remuneration package)

### REQUIREMENTS :

An Appropriate qualification that allows for registration with the HPCSA as Medical Specialist in Psychiatry or a recognised sub-speciality Registration with the Health Professional Council of South Africa (HPCSA) as Specialist in Psychiatry or in a recognised sub-speciality is mandatory. A minimum of three (3) years’ appropriate experience as Medical Specialist after registration with the HPCSA as Medical Specialist in Psychiatry or in a recognised sub-speciality.

### DUTIES

Provide and manage a subspecialist service in the assessment and management of children and

adolescents. Supervise other specialists and multi-disciplinary mental health team members. Provide strategic and operational leadership for Child and Adolescent Psychiatry service within the institution. Contribute to clinical management within the hospital and assists the Clinical Manager with matters related to clinical management within the institution. Conduct, support and promote teaching and research. Serve as a joint appointee of the Department of Psychiatry, University of the Witwatersrand and to participate in the teaching and training of various categories of undergraduate and postgraduate students and health professionals. Engage with cluster facilities in standardized treatment guidelines and provision of training where necessary. The incumbent will be required to work longer hours.

### ENQUIRIES:

Dr N Arafdien / Tel: 010 214 0612

Ms P Rapetswa / 011 488 3711/3762

Masikwane.Rapetswa@gauteng.gov.za



# POSITION STATEMENT

## SASOP POSITION STATEMENT ON THE USE OF PSYCHEDELIC & EMPATHOGENIC AGENTS FOR MENTAL HEALTH CONDITIONS

### A. PURPOSE

SASOP developed this Position Statement to provide information for psychiatrists about the potential utility of psychedelic substances for mental health conditions.

### B. KEY MESSAGES

1. There is limited but emerging evidence that psychedelic substances combined with psychotherapeutic interventions may have therapeutic benefits in the treatment of a range of mental illnesses.
2. MDMA and psilocybin are the most well studied, and may show promise in highly selected populations when administered in closely supervised settings and with intensive support. Additional and larger randomised-control trials are needed to confirm initial promising results.
3. Current research confirms the presence of psychological support as an essential component of the psychedelic treatment model.
4. Further research is required to assess the efficacy, safety and effectiveness of psychedelic therapies to inform future potential use in psychiatric practice.
5. Clinical use of psychedelic substances should only occur under research trial conditions that include oversight by an institutional research ethics committee and careful monitoring and reporting of efficacy and safety outcomes.
6. SASOP concurs with the South African National Drug Master Plan (2019 - 2024) that calls for SAHPRA to periodically re-evaluate or re-assess the scheduling of substances based on the risk-access profile of the substance and that

impediments to the availability and accessibility of controlled substances for medical and scientific purposes must be removed.

7. Psychiatrists have an ethical duty to follow a harm reduction approach that is evidence-based and complies with legal and professional practice guidelines when patients indicate that they are likely to seek access to unregulated psychedelic substance use in a non-research setting.

### C. DEFINITION & SCOPE

The scope of this position statement about the use of psychedelic substances and therapies for mental health conditions includes clinical practice and research settings and excludes settings where psychedelic substances are used recreationally or for religious or cultural purposes. Most recent research into psychedelic therapy has focused on methylenedioxymethamphetamine (MDMA), a chemical sometimes found in the drug ecstasy, and psilocybin, a compound in its natural form found in a number of species of psychedelic mushrooms (Reiff et al, 2020). These substances are the primary focus for this SASOP position statement, although it does cover use of other psychedelic substances in therapeutic use. This SASOP position statement excludes the use of ketamine, as SASOP developed a separate position statement on the use of ketamine.

- Psychedelic substances (also called psychedelic drugs or hallucinogens) are any of the so-called mind-expanding drugs that are able to induce states of altered perception and thoughts, frequently with heightened awareness of sensory input but with diminished control over what is being experienced.



- Psychedelic therapy refers to therapeutic practices involving psychedelic substances.
- Harm reduction in clinical practice refers to the clinical interventions that reduce the potential negative effects of substance use. Harm reduction occurs within a legal and regulatory context and is based on the ethical requirement that clinicians have a duty to reduce the risk of harm while respecting the patient's dignity and autonomy.

#### D. BACKGROUND

Novel and effective therapeutic interventions are urgently needed to address the rising incidence and prevalence of psychiatric conditions globally (GBD 2019 Mental Disorders Collaborators, 2022). The increasing burden of mental illnesses, the barriers to accessing treatment, and the proportion of patients who fail to respond adequately to evidence-based interventions are some of the factors that emphasize the need to support innovation in mental healthcare (Wainberg et al, 2017). An increasing number of clinical trials evaluating psychedelic therapy have found promising results in a variety of psychiatric conditions, including treatment-resistant depression, end-of-life anxiety in terminal illnesses, substance use disorders, post-traumatic stress disorders, and anxiety disorders (Luoma et al, 2020). Internationally policy changes that support decriminalization and legalization have been made based on the emerging scientific evidence of the relative safety and effectiveness of psychedelic therapy (Belouin et al, 2022; Dos Santos et al, 2021).

Increasing public awareness and enthusiasm for psychedelic therapy and the lack of a clear legal and medical pathway to accessing psychedelic therapy, contributes to unregulated use of psychedelic substances (Pilecki et al, 2021). Individuals intending to use psychedelic substances for their mental health or self-exploration may approach clinicians to ask for advice or recommendations for referral to practitioners that offer unregulated psychedelic therapy. Any action that increases the chance a patient claims their use of a prohibited substance was because of the involvement of a licensed practitioner might result in a licensing board determining that the clinician was an integral part of the illegal experience under the guise of providing professional services (thereby violating duty of care and acting in an unprofessional or unethical manner). Due to the commitment to ethical and professional principles guiding patient care, clinicians may find themselves facing the dilemma of addressing the individual's unique needs (e.g. reducing potential harm) while respecting the professional and legal requirements of the profession and larger society (Gorman et al, 2021).

Medicine scheduling allows for different levels of regulatory control of substances. Psychedelic

substances such as psilocybin, lysergic acid diethylamide (LSD), and MDMA are in the Schedule 1 of the United Nations Convention on Psychotropic Substances from 1971 which means that they are illegal under South African law. In the South African setting The Medicines and Related Substances Act (Act No 101 of 1965 as amended) as well as the Hazardous Substances Act (Act No 15 of 1973) provide the mandate to the South African Health Products Regulatory Authority (SAHPRA) to regulate all health products.

Psychedelic substances such as psilocybin and MDMA are currently scheduled by SAHPRA as Schedule 7 indicating that they are "not recognized for medical use and have an extremely high potential for abuse or producing dependence with limited scientific purposes." This restrictive scheduling status means that access to these substances may only be obtained under special conditions and a Section 21 application may be submitted to SAHPRA to allow import.

South Africa's National Drug Master Plan (4<sup>th</sup> edition) for the period 2019 to 2024 states as one of its goals the increase in the availability of and access to controlled substances exclusively for medical and scientific purposes while preventing their diversion. The Plan calls on SAHPRA to periodically re-evaluate or re-assess the scheduling of substances based on the risk-access profile of the substance and that impediments to the availability and accessibility of controlled substances for medical and scientific purposes must be removed. The National Drug Master Plan also emphasizes that harm reduction interventions are evidence-based public health principles to support people who use drugs. Harm reduction interventions aim to reduce the current and future risks and potential harms related to drug use. Rather than ignoring or condemning harmful behavior, it seeks to work with the individual or community to minimize the harmful effects of specific behaviors.

#### E. SASOP POSITION

1. SASOP welcomes the emergence of safe, evidence-based treatment options to address the shortcomings of currently available treatment options for individuals with mental health disorders. SASOP has a duty to support the development of emerging evidence-based treatments and clinical trial research into promising therapeutic options, provided they are conducted with patient well-being and safety being paramount.
2. Until there is sufficient compelling clinical evidence, and systematic research to overcome the current limitations, SASOP would not, at this stage, endorse the widespread use of psychedelic-assisted therapy. The clinical use of psychedelic substances should only



occur under research trial conditions that include oversight by an institutional research ethics committee and careful monitoring and reporting of efficacy and safety outcomes. Active research is encouraged to build on the current evidence-base.

3. Regulatory approval of psychedelic therapy should not pre-empt the adequate evidence-base of the treatment. In addition, prior to any regulatory approval or movement into use outside of research trials, there is need for appropriate treatment methodologies, adequate training by those delivering the treatment, and an ethical and legal framework that provides appropriate safeguards.
4. SASOP supports psychiatrists continuing to expand their knowledge base through continuous medical education and to contribute within the framework of current research practice to help inform the future use of psychedelic therapy.
5. SASOP concurs with the South African National Drug Master Plan (2019 – 2024) that calls for SAHPRA to periodically re-evaluate or re-assess the scheduling of substances based on the risk-access profile of the substance and that impediments to the availability and accessibility of controlled substances for medical and scientific purposes must be removed. Given the inhomogeneity of different psychedelics' effects and safety and efficacy profiles, it is not appropriate to treat them the same. Specific research is required to determine each substance's therapeutic potential.
6. Psychiatrists are ethically bound by the principles of respecting patient autonomy, non-maleficence, and beneficence. SASOP concurs with the South African National Drug Master Plan (2019 – 2024) that emphasises a harm reduction approach that is evidence-based and complies with legal, professional practice, and ethical requirements. Clinicians should follow a harm reduction approach when patients indicate that they are likely to seek access to unregulated psychedelic substance use in a non-research setting.

## F. REFERENCES:

- Belouin, S. J., Averill, L. A., Henningfield, J. E., Xenakis, S. N., Donato, I., Grob, C. S., Berger, A., Magar, V., Danforth, A. L., & Anderson, B. T. (2022). Policy considerations that support equitable access to responsible, accountable, safe, and ethical uses of psychedelic medicines. *Neuropharmacology*, 219, 109214. <https://doi.org/10.1016/j.neuropharm.2022.109214>
- Breeksema, J. J., Niemeijer, A. R., Krediet, E., Vermetten, E., & Schoevers, R. A. (2020). Psychedelic treatments for psychiatric disorders: a systematic review and thematic synthesis of patient experiences in qualitative studies. *CNS drugs*, 34(9), 925-946. <https://doi.org/10.1007/s40263-020-00748-y>
- Department of Social Development, Republic of South Africa (2019). National Drug Master Plan (4<sup>th</sup> edition) 2019 to 2024. [https://www.gov.za/sites/default/files/gcis\\_document/202006/drug-master-plan.pdf](https://www.gov.za/sites/default/files/gcis_document/202006/drug-master-plan.pdf)
- Dos Santos, R. G., Bouso, J. C., Rocha, J. M., Rossi, G. N., & Hallak, J. E. (2021). The Use of Classic Hallucinogens/Psychedelics in a Therapeutic Context: Healthcare Policy Opportunities and Challenges. *Risk management and healthcare policy*, 14, 901-910. <https://doi.org/10.2147/RMHP.S300656>
- GBD 2019 Mental Disorders Collaborators (2022). Global, regional, and national burden of 12 mental disorders in 204 countries and territories, 1990-2019: a systematic analysis for the Global Burden of Disease Study 2019. *The Lancet Psychiatry*, 9(2), 137-150. [https://doi.org/10.1016/S2215-0366\(21\)00395-3](https://doi.org/10.1016/S2215-0366(21)00395-3)
- Gorman, I., Nielson, E. M., Molinar, A., Cassidy, K., & Sabbagh, J. (2021). Psychedelic Harm Reduction and Integration: A Transtheoretical Model for Clinical Practice. *Frontiers in psychology*, 12, 645246. <https://doi.org/10.3389/fpsyg.2021.645246>
- Luoma, J.B., Chwyl, C., Bathje, G.J., Davis, A.K., & Lancelotta, R. (2020). A Meta-Analysis of Placebo-Controlled Trials of Psychedelic-Assisted Therapy. *J Psychoactive Drugs*. 2020 ; 52(4): 289-299. <https://doi.org/10.1080/02791072.2020.1769878>
- Pilecki, B., Luoma, J. B., Bathje, G. J., Rhea, J., & Narloch, V. F. (2021). Ethical and legal issues in psychedelic harm reduction and integration therapy. *Harm reduction journal*, 18(1), 40. <https://doi.org/10.1186/s12954-021-00489-1>
- Reiff, C.M., Richman, E.E., Nemeroff, C.B., Carpenter, L.L., Widge, A.S., Rodriguez, C.I., Kalin, N.H., McDonald, W.M.; the Work Group on Biomarkers and Novel Treatments, a Division of the American Psychiatric Association Council of Research. Psychedelics and Psychedelic-Assisted Psychotherapy. *Am J Psychiatry*. 2020 May 1;177(5):391-410. <https://doi.org/10.1176/appi.ajp.2019.19010035>
- Wainberg, M. L., Scorza, P., Shultz, J. M., Helpman, L., Mootz, J. J., Johnson, K. A., Neria, Y., Bradford, J. E., Oquendo, M. A., & Arbuckle, M. R. (2017). Challenges and Opportunities in Global Mental Health: a Research-to-Practice Perspective. *Current psychiatry reports*, 19(5), 28. <https://doi.org/10.1007/s11920-017-0780-z> ■

# THE MAKING OF *a Strong Heart* AND HAPPY MIND

Supporting you on the healing journey

Struggling to successfully handle life's stresses, feeling anxious, overwhelmed, and low in energy and mood? This is the new global pandemic - you are not alone. Let us begin 2023 with an evening of exploring solutions with Sister Jayanti, a renowned international motivational speaker, and panel of experts in the field - Prof S Ramlall (Professor in Psychiatry at UKZN & President of the College of Psychiatrists), Dr S Mashaphu (specialist psychiatrist, lecturer, researcher, PhD) and Despina Forbes (counselling psychologist, yoga and mindfulness practitioner), as they help us navigate our way through these difficult times on:

**Wed, 25<sup>th</sup> Jan 2023 - 5:30 pm for 6pm**  
**Durban Jewish Centre, 44 KE Masinga Rd, North Beach**  
**Entry is free**

We all wish for a more joyful, peaceful, and meaningful future. The question that many are facing is how do we build ourselves mentally, emotionally and spiritually so that we can rise above our continuous challenges and live with greater wisdom and contentment. What are the practices we need to strengthen our inner being? What is the wisdom we need to shift our mind-sets and develop the outlook of greater hope?

**Special Launch:** The Brahma Kumaris aim to offer their service, free of charge, as an organisation which encourages coping strategies for the promotion and maintenance of emotional health. Compassion in Action, a program supporting the healing and recovery journey of individuals affected by stress, anxiety, and depression, utilises meditation, relaxation, mindfulness and purposeful reflection which are proven to have mental health benefits. This 3-part programme will be offered monthly at all our meditation centres on the 1st Saturday of each month from 9:30am to 2:30pm



Sister Jayanti




Prof S Ramlall





Dr S Mashaphu



Despina Forbes

 081 534 4446

 31 563 3502

 [ban@za.brahmakumaris.org](mailto:ban@za.brahmakumaris.org)

# INSTRUCTIONSTO AUTHORS

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

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

## LETTERS TO THE EDITOR

- \* Novel experiences
- \* Response to published content
- \* Issues

## FEATURES

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

## REPORTS

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

## PERSPECTIVES

- \* Personal opinions written by non-medical contributors

## NEWS

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

## ANNOUNCEMENTS

- \* Congresses, symposia, workshops
- \* Publications, especially books

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

## REVIEW / ORIGINAL ARTICLES

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

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

Acceptance of submitted material will be subject to editorial discretion

**All submitted content will be subject to review by the editor-in-chief, and where necessary the advisory board. All content should be forwarded to the editor-in-chief, Christopher P. Szabo - [Christopher.szabo@wiits.ac.za](mailto:Christopher.szabo@wiits.ac.za)**



# A helping hand



*When your MDD patients need it most<sup>†</sup>*

## New Deslafore XR 50 and XR 100<sup>1</sup>

- First-line for the treatment of depressive symptoms, adults  $\geq$  18 years of age<sup>1,2</sup>
- Convenient once daily dosing<sup>1</sup>
- Limited clinically significant drug interactions<sup>3</sup>
- 25 % Monthly saving vs. originator<sup>4</sup>




**NEW**  
**Deslafore**   
 Desvenlafaxine succinate monohydrate

MDD - major depressive disorder

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

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

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

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