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# SOUTH AFRICAN PSYCHIATRY

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ABOUT the discipline FOR the discipline

issue 35 • MAY 2023

**ADHD AND EATING  
DISORDERS**

**G E N D E R  
D Y S P H O R I A  
& A D H D**

**A D H D A N D  
C O A C H I N G**

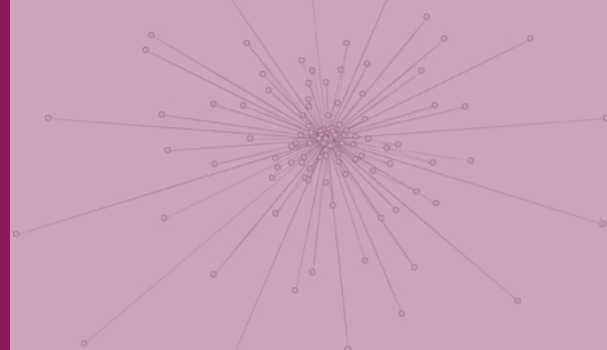
**THE HERE AND WOW!  
MINDFULNESS, TECHNOLOGY,  
AND THE ADHD BRAIN**

**CRIMINALITY &  
ATTENTION DEFICIT  
HYPERACTIVITY  
D I S O R D E R**



PUBLISHED IN ASSOCIATION WITH THE SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

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COVER IMAGE: Image of colorful leaves falling down from tree branches in autumn. Uludag National Park, Bursa, Turkey. By Hakan Elicaçık Design

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Dear Reader,

Welcome to the autumn issue...the leaves are turning, changing colour, and providing a wonderful variation - green, yellow, shades of brown... something to please the eye - if one notices the simple beauty, provided by nature, that surrounds us.

This issue is replete with *Feature* content from the last ADHD Congress, converting presentations into articles...each one providing a specific perspective on ADHD but taken overall demonstrating the range of clinical pathology, and complexity, when working with patients with ADHD, beyond the ADHD itself.



We also feature various *Report* content of significant events that provide non-attendees a sense of proceedings. There are also several *Perspective* articles providing unique clinician and patient insights based on experience as well medico-legal insights worth considering in relation to social media. And if you need a break from science...there is always art - with our movie review and a few recommendations.

Finally, as always - content from SASOP provides some awareness of what your professional body is up to... serving the membership.

Enjoy.

A handwritten signature in black ink, appearing to read 'C. Szabo'.

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# B E Y O N D M A D N E S S PODCAST RETURNS TO EXPLORE MENTAL HEALTH ISSUES

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The Beyond Madness podcast, hosted by Professor Christopher Paul Szabo returns with 15 new episodes starting Tuesday the 18th April 2023.

**A**fter 45 well received episodes, the *Beyond Madness* podcast, hosted by Professor Christopher Paul Szabo returns with 15 new episodes. This podcast series features psychiatrists, mental health professionals as well as relevant thought leaders in conversation. A wide range of topics related to issues in psychiatry that impact our society, as well as societal issues that affect mental health are covered, with the aim of providing a deeper understanding of both. In each episode, Prof Szabo discusses a different issue in each episode, taking it out of the realm of pure psychiatry and exploring its implications from a broader perspective. Mental health issues affect us all on a daily basis, echoing Prof Szabo's signature tagline "there is no health without mental health".

**BEYOND MADNESS AIMS TO PROVIDE A PLATFORM FOR INFORMED DISCUSSION AND DEBATE. EACH EPISODE PROVIDES VALUABLE INSIGHTS AND PERSPECTIVES ON HOW THESE ISSUES AFFECT US ON A PERSONAL AND SOCIETAL LEVEL. SOCIETAL ISSUES SUCH AS POVERTY, DISCRIMINATION, VIOLENCE, AND SOCIAL ISOLATION CAN HAVE A SIGNIFICANT IMPACT ON MENTAL HEALTH.**

Individuals who experience these issues are more likely to develop mental health problems such as anxiety, depression, and post-traumatic stress disorder. The stress and trauma associated with these experiences can also exacerbate pre-existing mental health conditions. Societal issues can create barriers to accessing mental health care and support, which can further contribute to negative mental health outcomes.

The first new episode, titled "Alcoholism, and the 12 steps", features Prof Szabo in conversation with Dr David Webb (a medical doctor and an Associate at Houghton House Addiction and Mental Health Treatment Centre) examining alcoholism and alcohol related diagnoses in depth. They discuss the impact of alcoholism on existing psychopathology, addiction versus substance abuse and the complicated recovery process.

A particularly hard-hitting episode will focus on "Journalists and trauma". With the alarming increase in global political events, this particularly topical episode examines how journalists are subjected to threats to life and the subsequent consequences, which can include psychiatric illness. Another episode, "Poverty and mental illness," features Prof Szabo in conversation with Prof. Crick Lund (Professor of Global Mental Health and Development at King's College, London) and

Dr John Parker (Psychiatrist – formerly at Lentegeur Hospital, Cape Town) around societal determinants of mental health and challenges surrounding effective interventions.

**OTHER EPISODES THIS SERIES INCLUDE TRAUMA AND RELATED DISORDERS OF STRESS, SEX AND PSYCHIATRY, PSYCHIATRY IN THE WORKPLACE, AGEING, GRIEF, LONELINESS, CHILDHOOD SEXUAL ABUSE AND BULLYING.**

“We are excited to share these new episodes in this podcast series, which we believe will provide a valuable contribution to the public discourse on mental health and societal issues,” said Prof Szabo. “We hope that our listeners will find the episodes informative, engaging, and thought-provoking.”

The *Beyond Madness* podcast series is sponsored by Adcock Ingram OTC, Sponsors of Brave and is produced by a team of experienced podcast producers at CliffCentral who are committed to bringing important issues to a wider audience.

**BEYOND MADNESS PODCAST – FORTHCOMING EPISODES (FINAL ORDER OF RELEASE SUBJECT TO CHANGE):**

1. Alcoholism, and the 12 Steps

2. Bullying
3. Journalists and mental wellness
4. Trauma, and disorders of stress
5. Childhood sexual abuse
6. The media, and suicide
7. Self-harm in adolescents
8. Sex and psychiatry
9. Poverty and mental illness
10. Psychiatry in the workplace
11. Ageing
12. Grief
13. Loneliness
14. PTSD and crime
15. Psychiatry – quo vadis?

New episodes will be available every Tuesday at 10am from Tuesday, 18 April 2023 on **cliffcentral.com** and are also available on Spotify as well as the Apple and Google podcast platforms.

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

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



# WHATSAPP AND EMAIL USE IN MEDICAL PRACTICE

*Volker Hitzeroth*

Good communication within the clinical setting, or as part of the administrative aspect of healthcare, is a cornerstone of modern medicine. To achieve this, practitioners must rely on electronic communication. This has numerous advantages but also poses occasional medicolegal risks to practitioners and their staff. This is the second of a series of articles exploring the use of social media and how to mitigate the associated risk.

**C**lear and coherent communication is vital to any healthcare service. Practitioners and their staff often rely on email and WhatsApp when communicating with patients, their families, or their colleagues. Email and WhatsApp are used to exchange information quickly and easily. They are familiar to many people in South Africa and accessible to most. Yet, their use is not without problems.

Practitioners should understand the associated risk and always act in a manner to prevent medicolegal consequences.

Email is mostly used to assist in the administration and running of a medical practice or department (e.g. reminders, memos, appointments, cancellations, notices, updates, billing) while WhatsApp has found significant traction in the medical setting (e.g. acute care in ER, routine outpatient visits and the provision of longer term chronic care).

**BOTH WHATSAPP AND EMAIL CAN BE USED TO CORRESPOND WITH INDIVIDUALS (E.G. PATIENTS OR COLLEAGUES) OR GROUPS (E.G. PRACTICE STAFF, PATIENT ADVOCACY GROUPS OR WHOLE DEPARTMENTS).**

At the outset it is worth emphasising that registered healthcare practitioners in South Africa are obliged

to abide by the ethical rules published by the Health Professions Council of South Africa (HPCSA) in their numerous information booklets. This applies to every practitioner and includes their interactions and communication with patients and colleagues alike. All communication and correspondence, whether a conversation, by pen on paper, email or WhatsApp, must comply with the HPCSA's ethical rules.



*Volker Hitzeroth*

**FURTHERMORE, THE PROTECTION OF PERSONAL INFORMATION ACT (POPIA) IMPACTS ON MANY ASPECTS OF PROFESSIONAL COMMUNICATION AND CORRESPONDENCE, ESPECIALLY WHEN PROVIDING A HEALTHCARE SERVICE. POPIA SETS OUT SEVERAL CONDITIONS THAT YOU MUST ABIDE BY, ALSO WHEN USING EMAIL OR WHATSAPP:**

- Accountability – you must ensure that the conditions for lawful processing are complied with.
- Processing limitations – you must ensure that a patient's information is processed in a fair and lawful manner e.g. information collection

must be appropriate, minimal, and specific to the purpose for which it is collected. It requires a patient's informed consent which must be acquired directly from the patient. The patient may object in a prescribed manner.

- Purpose specification – you must ensure that a patient's information is only processed for explicit, specific and legitimate reasons e.g. collecting a patient's information only for a specifically defined and lawful purpose in line with the function of your establishment. The patient must be aware of this purpose, you may not retain patient information longer than needed for the purpose for which it was initially collected for unless required to do so by law, contract or the patient consented to its retention. You also have to abide by certain obligations regarding the destruction, deletion or de-identification of information.
- Further processing limitation – you may not process a patient's information for a secondary purpose unless that processing is compatible with the original purpose e.g. you must consider the potential consequences, noting any contractual rights and obligations, with some allowances for historical, statistical or research purposes.
- Information quality – you must take reasonable steps to ensure that the personal information collected is complete, accurate, not misleading and updated as necessary.
- Openness – you must ensure that your patient is aware that you are collecting their personal information and for what purpose the information will be used e.g. the patient must be fully informed and your PAIA manual must be kept updated. The patient must be aware of your name and address.
- Security safeguards – you must keep your patients' information secure against the risk of loss, unlawful access, unauthorized destruction, and disclosure e.g. maintain appropriate and reasonable technical and organisational security measures and notify the Information Regulator in the event of a breach.

Data subject participation – patients' may request you to disclose where their personal information is held, and they may also request you to correct and/or delete any personal information held about them e.g. establish communication channels with patients, provide them with access to their information and facilitate correction of information as needed.

### WHILE THERE ARE MANY BENEFITS TO THE USE OF EMAIL AND WHATSAPP COMMUNICATION THERE REMAIN NUMEROUS MEDICOLEGAL RISKS.

Both WhatsApp and emails rely on written text to communicate with others. This means that complex

medical issues must be captured and conveyed in a relatively short narrative. An occasional accompanying photo of a patient's condition or a relevant radiology image may assist in clearer communication. Yet, it must be remembered that such brief written / text communication can never be a substitute for a longer and detailed conversation, be that between a healthcare practitioner and a patient or their family, or even between colleagues. WhatsApp and email will inevitably omit information as the usual verbal and non-verbal cues are absent.

### WHATSAPP USERS MAY MAKE USE OF NUMEROUS ABBREVIATIONS THAT MAY LEAD TO MISCOMMUNICATION AND MISTAKES. HENCE, THERE IS A RISK OF CLINICAL ERROR WHEN INFORMATION IS LOST "IN TRANSLATION" AND MISUNDERSTOOD BY THE RECEIVER.

At Medical Protection Society we have noticed that electronic communication is rarely added to the patient's clinical records. This is a serious omission and can cause significant problems for both the patient and the healthcare practitioner. Electronic correspondence is cumbersome to print out and is rarely filed in a patient's folder. The HPCSA has published ethical guidance in relation to record keeping (Booklet 9) and every healthcare practitioner is obliged to follow this guidance. Like the traditional handwritten or typed clinical notes, WhatsApp messages and emails sent to the patient, their family or a colleague are part of the clinical record and belong in the patient's folder.

### ANOTHER COMMON PROBLEM THAT WE ENCOUNTER AT MEDICAL PROTECTION SOCIETY IS WHEN WHATSAPP MESSAGES OR EMAILS ARE SENT TO THE WRONG RECIPIENT. THIS CAN OCCUR EITHER WHEN THEY ARE SENT TO A WRONG INDIVIDUAL OR THE WRONG GROUP. A SLIP OF THE FINGER, AN ERRONEOUS SELF-POPULATING CONTACT ADDRESS OR A MOMENT OF DISTRACTION CAN RESULT IN A MESSAGE BEING RECEIVED BY UNRELATED RECIPIENTS.

If any patient's identifiable information (e.g. name, email address, date of birth, ICD codes, diagnosis or treatment etc) is disclosed in the process, then a serious breach of a patient's confidentiality has occurred. The POPI Act speaks to such eventualities and directs what steps a practitioner is obliged to undertake in the event of such a breach of confidentiality. It is therefore imperative that all electronic communication is sent to, and received by, the correct individual(s). Healthcare practitioners must ensure that they have the correct, and up

to date, contact addresses of the individuals that they communicate with. Related to this problem is the fact that electronic devices are often left lying around, lost, misplaced, or forgotten. This means that messages sent to an individual may be visible, and accessed, by another person (e.g. partner, spouse, work colleague, or friend).

**THERE IS NO GUARANTEE THAT ELECTRONIC COMMUNICATION WILL REMAIN COMPLETELY CONFIDENTIAL. PRIVACY SETTINGS MAY VARY, AND WHATSAPP MESSAGES AND EMAILS CAN BE FORWARDED TO ANY NUMBER OF INDIVIDUALS. THEY MAY EVEN BE POSTED ON THE INTERNET. ELECTRONIC COMMUNICATIONS, UNLIKE PAPER-BASED RECORDS, CAN NEVER BE DESTROYED, REMOVED, OR DELETED.**

They are likely to remain in cyberspace in perpetuity – and may even be found and accessed far into the future by unrelated or malicious actors.

Healthcare practitioners should be very mindful when taking and sharing photographs or videos of patients. It is necessary to ensure that every patient whose photograph is taken and whose images are shared, has given their voluntary and fully informed consent to do so.

The consent should be in writing and documented in the contemporaneous clinical record. This may be complicated when treating incapacitated patients or those deemed mentally unwell. Specific precautions and care must be taken when taking photographs of intimate body areas (e.g. conditions relating to breast, genital or anal areas). This may be even more problematic when taking photographs of minors.

At Medical Protection Society we have had cases where a practitioner, after taking a photograph of a child's urological or gynaecological condition, was accused of possessing and disseminating child pornography – with very serious and unfortunate consequences.

**IT IS THEREFORE NECESSARY THAT PRACTITIONERS TAKE THE UTMOST PRECAUTIONS WHEN TAKING PHOTOGRAPHS OR VIDEOS OF THEIR PATIENTS, UPLOADING THESE TO THEIR ELECTRONIC DEVICE AND / OR SHARING SUCH IMAGES WITH ANY PATIENTS OR A COLLEAGUE.**

Another risk that practitioners may face is that the professional doctor-patient relationship changes into a more social one where the professional

boundaries become blurred, and practitioners assume that they are on friendly - or even social - terms with the patient or their family. This is likely to lead to numerous later problems, conflicts, and dilemmas. Whilst most therapeutic relationships remain professional, some may deteriorate into inappropriate friendliness, overfamiliarity, unusual requests, boundary crossing and subsequent medicolegal consequences. This may be even more of a risk when using social media like Facebook, Snapchat, Instagram and LinkedIn.

At Medical Protection Society we have seen many complaints at the HPCSA where a lengthy WhatsApp chat, a screenshot or an email trail is attached as evidence for the complaint – often demonstrating clear boundary crossings which can be detrimental (and very embarrassing) to the HCP when it is aired in the disciplinary process.

The process of sending a WhatsApp or email may require sending information across international borders to servers or cyber clouds located in various countries across the world. The implication of such a logistical arrangement is that a South African patient's communication and personal information is transferred to, and stored in, a foreign jurisdiction. This might conflict with South Africa's privacy legislation and may have legal implications.

**IT IS ADVISABLE THAT, TO MANAGE YOUR PROFESSIONAL WHATSAPP AND EMAIL COMMUNICATIONS SAFELY AND TO MITIGATE ANY POTENTIAL MEDICOLEGAL RISK, YOUR PRACTICE, DEPARTMENT, OR HOSPITAL PRODUCE A CLEAR AND COMPREHENSIVE ELECTRONIC / SOCIAL MEDIA COMMUNICATIONS POLICY THAT INCLUDES THE USE OF WHATSAPP AND EMAILS. THIS SHOULD BE ALIGNED WITH CURRENT LEGISLATION AND THE HPCSA'S ETHICAL RULES.**

It should be easily accessible to staff and patients alike. Your establishment's terms and conditions as per the initial "patient contract" should summarise the policy and refer the patient to its full text.

While much has been said about the use and risks of WhatsApp and email communication the underlying imperative remains your professional obligation to treat patients and colleagues with respect, to always place your patient's wellbeing above all else, and to be kind and courteous to all. If you are in any doubt about the risks you face either from your social media activity, or from interactions with patients on social media, contact your medical defence organisation for advice.

**Volker Hitzeroth** is Medicolegal Consultant at Medical Protection Society in London, United Kingdom.  
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# ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD) AND EATING DISORDERS

*Aleya Remtulla*

**A**ttention Deficit Hyperactivity Disorder (ADHD) is a condition characterized by inattention and hyperactivity, with or without impulsivity. According to the Diagnostic and Statistical Manual of Mental Disorders 5<sup>th</sup> Edition (DSM-5), ADHD can be categorized into: predominantly hyperactive, predominantly inattentive or a combined form. This depends on the presentation of the child. Behaviours/symptoms need to have persisted for at least 6 months and present in more than two different settings. They negatively impact the functioning of the child and present prior to the age of 12 years.<sup>1</sup> In this article, the focus is on impulsivity as the main culprit leading to eating disorders (EDs)

**EATING DISORDERS ARE BEHAVIOURAL CONDITIONS CHARACTERIZED BY SEVERE AND PERSISTENT EATING BEHAVIOURS THAT ARE ASSOCIATED WITH DISTRESSING THOUGHTS AND EMOTIONS.<sup>2</sup>**

These behaviours may impact social, physical and psychological functioning. According to DSM-5, eating disorders are classified into: anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED), avoidant restrictive food intake disorder, other specified feeding and eating disorder, pica and rumination disorder.<sup>3</sup> The most prevalent

eating disorder is BED and has an estimated lifetime prevalence of 3.5% in adults.<sup>4</sup> AN and BN are common in women, but can occur across any age or gender.



*Aleya Remtulla*

The most commonly discussed EDs include AN, BN and BED. Anorexia Nervosa entails restriction of energy intake leading to an extreme low body weight, an intense fear of weight gain as well as body image disturbance. Under AN there are have restrictive and binge-eating/purging subtypes.

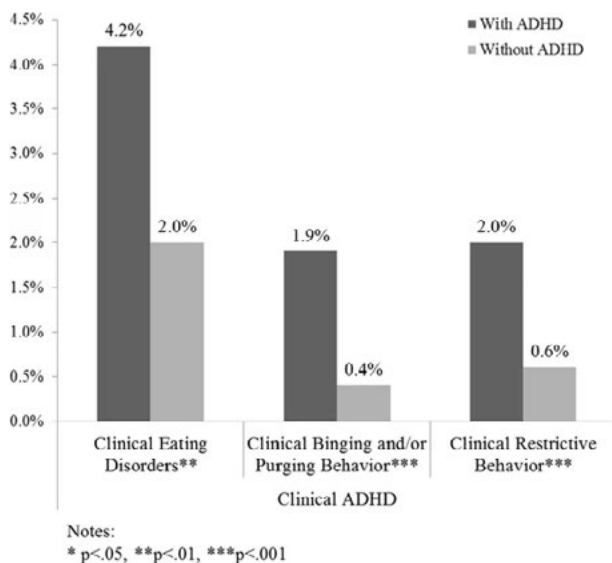
Bulimia Nervosa entails recurring binge eating episodes, followed by recurring inappropriate compensatory behaviour (laxatives, over exercising, diet pills) and a distorted self evaluation relating to body shape and weight. There is an overall sense of loss of control. Binge eating and compensatory behaviours occur at least once a week for 3 months on average.

Binge-eating disorder (BED) is a relatively new diagnosis added to the list of EDs. It is characterized by the presence of eating large amounts of food in a relatively short period of time, eating rapidly, with a feeling of lack of control. BED has no compensatory behaviours.

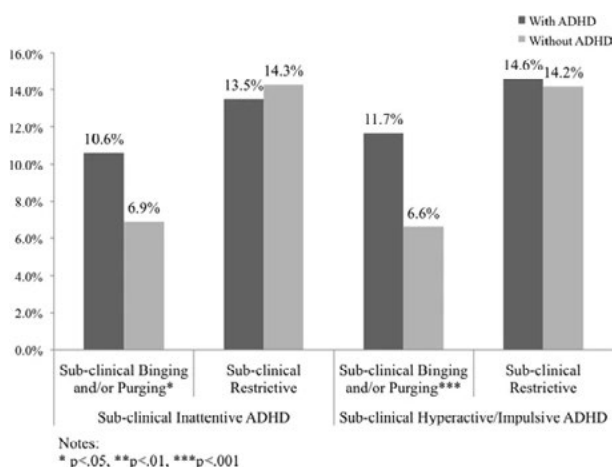
There seems to be a growing amount of evidence directed towards impulsivity leading to lack/loss of control and resulting in binge eating behaviours especially in individuals with ADHD. A study done by Mikami *et al.*, 2008, revealed that children with ADHD (combined type) had more BN at follow-up than those without ADHD. This was a 5 year prospective study. Impulsivity was the strongest predictor in this case.<sup>5</sup> Another prospective follow up study done by Mikami *et al.*, 2010, showed that children were at an increased risk of BN symptoms. Childhood impulsivity predicted the onset in adolescence 8 years later.<sup>6</sup> ADHD has also been linked to a lack of control when eating, resulting in BED.<sup>7</sup> Another study suggests that childhood ADHD symptoms had an increased risk of binge eating behaviours in adolescence<sup>8</sup> due to this lack of control.

Both ADHD and eating disorders begin earlier in life and may become chronic and persist into adulthood. A study done by Jennifer Bleck *et al.*, 2015, revealed that those with clinical ADHD were more likely to experience clinical eating disorder, bingeing or purging behaviours and restrictive eating behaviours.<sup>9</sup> While those with subclinical (not meeting all the criteria for diagnosis) ADHD were more likely to experience subclinical bingeing/purging behaviours but not restrictive behaviours (see Fig 1 and 2 below)

**Fig 1. Clinical ADHD and Clinical eating disorders**



**Fig 2. Subclinical ADHD and Subclinical eating disorders**



The relationship between BN and ADHD symptoms seems to be a double edged sword. The inattentive behaviours of ADHD have been associated with BN and patients with bulimia may present with impulsive behaviours that lead to binge eating possibly due to attention problems.

**BULIMIA NERVOSA AND AN WERE THE MOST COMMON EDS FOUND IN ADULTS WITH ADHD SYMPTOMS. BINGE EATING AND PURGING SUBTYPES WERE THE MOST PREVALENT (35-37%).<sup>10</sup>**

Obesity is yet another comorbid condition associated with ADHD and linked to EDs. A study by Cortese *et al.*, 2013, showed that adult men with childhood ADHD had higher BMIs and obesity rates than men who didn't have ADHD.<sup>11</sup> Two similar studies conducted in Dutch and Korean children revealed that those with ADHD had four times the risk of being overweight.<sup>12,13</sup> Another study by Reinblatt *et al.*, 2015, revealed that 26% of children with ADHD had binge-eating behaviours that contributed to obesity.<sup>3</sup> Individuals with ADHD fluctuate between impulsive eating behaviours and skipping meals due to hyper-focusing and not wanting to interrupt that attention/focus. Skipping meals sets the body up for binge eating or overeating, especially foods that are high in calories, carbohydrates, fats and sugars.

**NEUROPSYCHOLOGICAL RELATIONSHIPS BETWEEN ADHD AND EDS ARE RELATED TO DEFICITS IN INHIBITORY CONTROL MECHANISMS. THIS IS FURTHER IMPACTED BY A REWARD SYSTEM THAT IS USED AS MOTIVATION TO DETERMINE BEHAVIOUR BASED ON LEARNING. STUDIES SUGGEST THAT FOODS HIGH IN CALORIES, FAT AND SUGARS TRIGGER THE DOPAMINERGIC MESOLIMBIC REWARD SYSTEM LEADING TO A DYSREGULATED FEEDING DRIVE. THESE FEEDING HABITS COMPEL INDIVIDUALS TO CONTINUE BINGE EATING DESPITE THE NEGATIVE CONSEQUENCES.<sup>14</sup>**

Genetic studies have revealed that individuals with BED may have a greater reward response due to polymorphism of the ANKK1 gene which is a genetic marker for dopamine.<sup>15</sup> Neuroimaging to show the causal relationship between ADHD and BED is yet to be clearly defined. Findings reveal the involvement of frontostriatal pathways to dopamine release and increased blood flow in relation to binge eating.

Regarding the management of ED, Cognitive Behavioural Therapy (CBT) is found to be effective in reducing the frequency of binge episodes. Antidepressants (SSRIs) are a group of drugs tested for treatment of BED. Antiepileptics and stimulants

were also tested. A couple of case reports showcase the effects of methylphenidate in BN for adults but no cases have been reported in children and adolescents. Until recently a case report by Arif Onder *et al.*, 2018., reported a 12-year old boy who received conventional CBT together with 20mg fluoxetine still struggled with binge eating. Upon adding Ritalin 20mg/day, these episodes reduced in frequency significantly.<sup>16</sup>

**DESPITE THIS RESULT, SEVERAL QUESTIONS ARISE. DOES IT DEPEND ON THE METHYLPHENIDATE PREPARATION (LONG ACTING VS SHORT ACTING), TIME OF DAY ADMINISTERED, SOLITARY OR WITH CONVENTIONAL APPROACHES? FURTHER STUDIES NEED TO BE CONDUCTED IN THE ADOLESCENT POPULATION.**

Based on the above studies, there is a strong correlation between ADHD and EDs. Whether they are risk factors for one another or comorbidities, is yet to be determined. As noted above, there is evidence linking ADHD to obesity (binge eating being a mediating factor) and BED. More studies are required in the pediatric population as well as other EDs to identify patterns and targeted management plan. Neuroimaging would greatly aid in developing appropriate and targeted treatments for these comorbid conditions.

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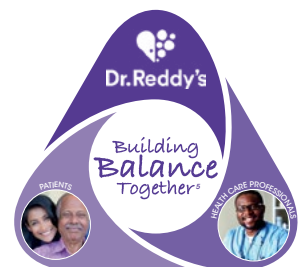
**Quetiapine** is recommended as a **first-line treatment** in the management of **acute mania** associated with bipolar disorder<sup>4</sup>

- 1. <https://toronto.cmha.ca/documents/balancing-your-life/> [Accessed February 2023]
- 2. Quetiapine. 7 things you should know. <https://www.drugs.com/tips/quetiapine-patient-tips#/> [Accessed February 2023]
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- 5. EFPIA Patient Think Tank. Working Together with Patient Organisations White Paper. June 2019.

<sup>[S5]</sup> Dopaquel 25 (tablet), Dopaquel 100 (tablet), Dopaquel 200 (tablet) and Dopaquel 300 (tablet). Registration numbers: Dopaquel 25: 43/2.6.5/0429. Dopaquel 100: 43/2.6.5/0430. Dopaquel 200: 43/2.6.5/0431. Dopaquel 300: 43/2.6.5/0432. Dopaquel 25: Each tablet contains quetiapine fumarate equivalent to quetiapine 25 mg. Dopaquel 100: Each tablet contains quetiapine fumarate equivalent to quetiapine 100 mg. Dopaquel 200: Each tablet contains quetiapine fumarate equivalent to quetiapine 200 mg. Dopaquel 300: Each tablet contains quetiapine fumarate equivalent to quetiapine 300 mg.

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# GENDER DYSPHORIA AND ADHD

Graham N de Bever

**A**s we become more aware of people claiming or being diagnosed with gender dysphoria (GD)/transgender people and their health needs, it necessitates reviewing what we know about GD and attention deficit hyperactivity disorder (ADHD). This discussion would not be complete, without also exploring the connection between GD and autism spectrum disorders (ASD).

## TERMINOLOGY [BASED ON WINTER ET AL. (2016)]

- **Sex (n):** a person's biological status (chromosomal, hormonal, gonadal and genital) as male, female or intersex
- **Gender (n):** the attitudes, feelings and behaviours linked to the experience and expression of one's biological sex
- **Gender Identity (n):** the personal experience of oneself as being male, female, a mix of the two, neither, or a gender beyond the two
- **Gender Expression (n):** the expression of one's gender identity, often through appearance, mode of dress, behaviour and interests
- **Sexual Orientation (n):** whom one is sexually attracted to (e.g. homosexual; heterosexual; bisexual; asexual; etc.); this is independent of gender identity but defined in alignment with it
- **Cisgender (adj):** a person who experiences their gender identity as matching the sex they were assigned at birth

- **Transgender (adj):** a person who experiences their gender identity as being incongruent with or not matching the sex they were assigned at birth

- **Trans man/boy:** a person assigned female at birth (AFAB) who identifies as male



- **Trans woman/girl:** a person assigned male at birth (AMAB) who identifies as female

- **Gender Dysphoria (n):** the discomfort or distress experienced by one's own gender incongruence
- **Gender Transition (n):** a person's adoption of characteristics that they feel match their gender identity; this may be social (e.g. changing names; pronouns; dress; identity documents; etc.) and/or physical (through gender-affirming health care e.g. cross-sex hormones; surgery; etc.)

## DSM AND ICD CLASSIFICATION

IT IS IMPORTANT TO EXAMINE HOW OUR UNDERSTANDING OF GD HAS EVOLVED OVER THE YEARS, AS SHOWN BY HOW THIS CONDITION HAS BEEN MEDICALLY CLASSIFIED.

IN THE DSM-IV, GD WAS TERMED "GENDER IDENTITY DISORDER" IN THE CHAPTER "SEXUAL AND GENDER IDENTITY DISORDERS"; NOW, IN DSM-5, "GENDER DYSPHORIA" IS IN ITS OWN CHAPTER, SEPARATE FROM "SEXUAL DYSFUNCTIONS".

In the ICD-10, "Gender identity disorders" fell under the category of "Disorders of adult personality & behaviour" in the chapter "Mental & behavioural disorders"; now, in ICD-11, GD is termed "Gender incongruence" and is in a separate chapter: "Conditions related to sexual health". One can see how this classification has moved away from pathologising an individual's identity and, rather, recognising GD as a naturally-occurring biological phenomenon.

**DSM-5 CRITERIA: GENDER DYSPHORIA IN CHILDREN**

- A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least six of the following (one of which must be Criterion A1):
  - 1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
  - 2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
  - 3. A strong preference for cross-gender roles in make-believe play or fantasy play.
  - 4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
  - 5. A strong preference for playmates of the other gender.
  - 6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
  - 7. A strong dislike of one's sexual anatomy.
  - 8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

- B. The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning.

**DSM-5 CRITERIA: GENDER DYSPHORIA IN ADOLESCENTS AND ADULTS**

- A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:
  - 1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
  - 2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
  - 3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
  - 4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
  - 5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
  - 6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
- B. The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.

**OVERLAPPING SYMPTOMS BETWEEN GD, ADHD AND ASD**

In transgender people, the preoccupation with gender must not be confused with an ASD special interest or ADHD hyperfocus.

DUE TO THIS PREOCCUPATION, IT IS ARGUED THAT GD COULD LEAD TO SYMPTOMS OF INATTENTION. AN INSISTENCE ON ONE'S GENDER DIFFERENCE AND REFUSAL TO WEAR STEREOTYPICAL CLOTHES FOR THE ASSIGNED SEX, MAY BE MISDIAGNOSED AS OPPOSITIONALITY.

Lack of social support for GD individuals may lead to shame, stigma and externalising behaviours, which may then lead to social problems with peers or even social withdrawal.

### PREVALENCE OF GD, ADHD AND ASD

In their systematic review, Thrower et al (2020), identified 30 studies that clearly looked at these connections. Of these 30, 22 studies examined the prevalence of ASD or ADHD in GD: they found a prevalence of 6–26% of ASD and 4.3–20.4% of ADHD in the GD population; the other 8 studies examined the prevalence of gender *variance* (GV) in ASD or ADHD, finding that the ASD population were 4–7 times more likely to report GV and, in a **single** study, the ADHD population were 6 times more likely to report GV.

THEIR CONCLUSION WAS THAT LOW LEVEL EVIDENCE SUGGESTS A LINK BETWEEN ASD AND GD BUT THAT THERE IS NOT SUFFICIENT DATA TO COMMENT ON ANY LINKS BETWEEN GD AND ADHD.

Their recommendation was that further population-based, controlled studies using the diagnostic criteria for ASD and ADHD, are required.

### GENDER-AFFIRMING CARE (GAC)

Firstly, NO person under 18 years will receive any form of gender-related surgery. In children (<13yr), GAC usually involves *only* social transition; it is important to note that NO children are receiving “hormones”.

ONCE A CHILD IS PREPUBESCENT/TANNER STAGE 2, PUBERTY BLOCKERS (GNRH ANALOGUES: LEUPROLIDE BEING THE MOST COMMONLY USED ONE IN SA) MAY BE PRESCRIBED. IN ADOLESCENTS, THIS **MAY** THEN PROGRESS TO CROSS-SEX HORMONES.

### MEDICATION ISSUES: HORMONES & THE BRAIN

In their systematic review, Karalexi et al (2020) reported that the current evidence does not show any adverse impact of gender-affirming hormone therapy on cognitive performance in either AMAB or AFAB individuals.

Furthermore, they found evidence for an enhanced effect on **visuospatial ability** following post-pubertal hormone therapy in **AFAB** (i.e. trans male) individuals and a higher performance in verbal working memory in treated **AMAB** (i.e. trans female) individuals.

They proposed that new longitudinal studies, with longer follow-up, should explore the long-term

effects of hormone therapy, especially the effects on younger individuals, where there is a greater scarcity of data.

### MEDICATION ISSUES: DRUG INTERACTIONS

There are no reported drug interactions between cross-sex hormones (i.e. testosterone or oestrogens) and ADHD treatment (specifically: methylphenidate, lisdexamphetamine and atomoxetine, i.e. those available in SA).

A caution was raised with the use of atomoxetine and leuprolide together, though, since both have the potential to increase the QTc interval.

### CONCLUSION

THERE IS GROWING EVIDENCE TO SUGGEST A LINK BETWEEN GD AND ASD, WHICH RAISES THE QUESTION OF WHETHER THIS IS TRUE FOR OTHER NEURODEVELOPMENTAL DISORDERS. AS YET, THERE IS NO STRONG EVIDENCE TO SUPPORT A LINK BETWEEN GD AND ADHD, ALTHOUGH THE TWO MOST CERTAINLY CAN AND DO CO-OCCUR.

There do not seem to be any major medication-related concerns regarding treating both conditions together. However, ultimately, more research is needed.

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# ADHD AND COACHING

*Philip Collier*

**A**ttention Deficit Hyperactivity Disorder (ADHD) is a chronic disorder, and when untreated is associated with significant personal and societal costs<sup>1</sup>. Estimates of the prevalence of ADHD in South Africa range from 1% to 5% of the general population.<sup>2,3</sup>

## THE ROAD TO COACHING

ADHD coaching offers a promising approach to the treatment of ADHD.<sup>4,5</sup> Coaching in a group context may be an affordable psychosocial intervention option in disadvantaged communities.

Where does ADHD coaching fit within the treatment of adult ADHD? The recommended framework for the treatment and management of ADHD combines psychosocial and psychopharmacological interventions.<sup>6,7</sup>

Psychoeducation is one aspect of psychosocial intervention. After an accurate diagnosis, psychoeducation is the first step in treatment.<sup>7</sup> This is important as it speaks to the need for those working with people with ADHD to have a thorough understanding of the disorder. We need to be able to educate clients, and their families, about what ADHD is, and how it impacts their lives.

When we think of psychosocial interventions we may automatically think about psychotherapy. While pharmacotherapy is the first line of intervention, sometimes it is not an option. Patients may not want to take the medication, may not be able to tolerate it, or do not have access to it.<sup>2,7</sup>

Medication is also not always sufficient.<sup>8</sup> "Pills don't teach skills". The combination of pharmacotherapy and psychotherapy – specifically, cognitive behavioural therapy (CBT) – leads to better outcomes than medication alone.<sup>5,9</sup>

CBT – tailored for ADHD – has emerged as the preferred psychosocial treatment for adult ADHD. Its success is attributed to its structured and goal-oriented approach.<sup>5,10</sup>

However, even with medication and therapy, adults with ADHD struggle with consistency, organisation, and task-follow. Coaching can help address these issues.<sup>11</sup>

## THE THREE HATS OF HELPING ADULTS WITH ADHD

WHEN WE THINK ABOUT THE PSYCHOSOCIAL TREATMENT OF ADULTS WITH ADHD, WE WEAR THREE HATS: THE TUTOR, THE THERAPIST, AND THE COACH – EACH HAT WORN WHEN NEEDED.

**The Tutor.** We need to be able to explain the basic neurobiology of ADHD and how it relates to the client's past experiences and current struggles. When seeing their functioning through the "lens" of ADHD clients better understand why they have difficulties with motivation, disorganization, procrastination, etc.<sup>12</sup> Most importantly when clients realise that their problems have a neurodevelopmental basis – "I'm



*Philip Collier*

not lazy, stupid, or irresponsible. I have ADHD” – it helps to lift self-esteem.<sup>13</sup>

**The therapist.** The experience of living with ADHD may lead to negative self-beliefs and thoughts that can undermine coping.<sup>10</sup> Low self-esteem and self-efficacy, lack of trust in self, fear of failure, and rejection sensitivity are common themes. The combination of negative experiences, negative beliefs and a pessimistic attitude are likely to contribute to anxiety and mood disorders among adults with ADHD.

WHEN WORKING WITH ADULTS WITH COMORBID ADHD AND ANXIETY AND/OR DEPRESSION, IT IS IMPORTANT TO ESTABLISH WHETHER ADHD IS TRIGGERING THE ANXIETY OR DEPRESSION.

For example, where ADHD is the cause of anxiety, often it is the thought of upcoming tasks, things that haven't been done, or feeling overwhelmed that drives anxiety. In these cases, the intervention focused on treating ADHD deficits is helpful, whether through therapy or coaching.

**The coach.** Managing ADHD is like training for the Comrades. You need a plan and keeping to the plan requires persistent effort. The more running becomes a habit, the easier it becomes. As with any exercise plan, slip-ups are the rule rather than the exception. It is how you handle them and how fast you can get back on track that matters.

IT MAKES SENSE THAT ADHD COACHING HAS ADOPTED ELEMENTS OF ATHLETIC COACHING, ALONG WITH ELEMENTS OF BUSINESS COACHING.

Having the picture of an athletics coach in mind is a good place to start when trying to understand ADHD coaching.

### WHAT DEFINES ADHD COACHING?

What is ADHD coaching? Coaching is not diagnosis, and it is not therapy. Therapy, in turn, is not coaching.

Therapy and coaching share similarities. Both aim to build self-awareness and self-regulation.<sup>7</sup> Both help clients better understand, accept, and manage their ADHD symptoms, improve quality of life and self-esteem, and are both supportive and encouraging.<sup>14</sup> Both CBT and coaching are structured and goal-oriented.<sup>12</sup>

Therapy and coaching are distinct from each other. What then makes ADHD coaching different from therapy? First and foremost, coaching uses a **salutogenic model** focused on improving health and wellness rather than treating pathology.<sup>14,15</sup> ADHD touches every aspect of the client's life: relationships, support structures, sleep, exercise, nutrition, etc., all impact daily functioning. ADHD

coaching, therefore, needs to be **holistic**.<sup>12,14</sup> ADHD coaching is **client-directed** where the client sets the agenda, decides what help they need, and what they want to achieve. ADHD coaching is always **goal-oriented**.<sup>12</sup>

### HOW DOES IT WORK?

ADHD coaching helps to enable self-directedness through five core mechanisms: partnership, structure, process, engagement, and relationship.

ADHD COACHING IS A **PARTNERSHIP MODEL** AND HAS A **PERSONAL-DEVELOPMENT ORIENTATION**.<sup>4</sup> IT IS AN ONGOING COLLABORATION, WHERE THE COACH PROVIDES STRUCTURE, SUPPORT, AND ENCOURAGEMENT.

Often it is the lack of structure undermines the client's ability to cope. Providing **structure** and leveraging the strengths of the client are important aspects of ADHD coaching. Helping build structures and routines that are aligned with their strengths and preferences is a core part of ADHD coaching.<sup>14</sup> Developing coping skills go together with creating structure. The skills set for acquisition are defined by the client and the client and coach work together to develop personalised implementation plans.<sup>4</sup> As clients acquire skills, develop structures and systems, and begin to see success in areas of their life their self-esteem improves.<sup>16</sup>

ADHD coaching helps clients develop self-awareness through a **process** of guided self-exploration. Like CBT coaching uses Socratic questioning to help clients gain insight into their strengths and challenges, and distance from the negative self-talk that holds them back.<sup>4,14</sup>

ADHD COACHING IS ESPECIALLY UNIQUE IN THE WAY THE ADHD COACH AND THE CLIENT ENGAGE. ADHD COACHING IS DIFFERENT IN THAT IT HAS A FLEXIBLE STRUCTURE, TAKING PLACE IN NON-CLINICAL OR NON-TRADITIONAL SETTINGS.

There is a greater degree of accessibility. Between session contact helps to ensure that clients don't become stuck between sessions, and access to the coach between sessions bolsters client accountability and **engagement**.<sup>4</sup>

Coaching is above all a collaborative partnership – a **relationship** – between the coach and client. ADHD clients often have not felt heard or understood. Therapy is also another area where they could “fail”. Establishing a solid therapeutic relationship is important when working with clients with ADHD.<sup>17</sup>

For therapeutic change to occur the therapist or coach must have an empathic understanding of the client's inter world, and the client needs

to perceive this empathic understanding, and through accurate empathy, the client believes the therapist or coach's unconditional regard for them.<sup>18</sup> Accurate empathy means that we need to understand the neurodivergent world of our ADHD clients – the culture, the language, the subtleties of their world.

ADHD clients are very aware that their world is different, that they are different, and often need a place where they don't feel different and feel understood. If we work to understand their world, we can provide that space for our clients.

### WHAT DOES ADHD COACHING LOOK LIKE PRACTICALLY?

ADHD coaching, like CBT, uses cognitive and behavioural interventions, and acceptance and mindfulness interventions. What stands out, when helping adults with ADHD is the focus on concrete and practical coping skills.

Task and time management is often the starting point for developing coping skills to help with executive function deficits.<sup>12</sup> Creating a to-do list, a daily planner, dealing with procrastination, motivation, and maladaptive thought patterns and self-esteem fall into this bucket.

Outsourcing coping skills helps to reduce the number of things that require direct management.<sup>12</sup> This might be hiring or bartering for help with difficult tasks, finding a "body double", and accountability partnerships are included here.

Another area of difficulty is managing all the information and data encountered in daily life. Reducing clutter, going digital, and setting up reminders for tasks, events, or assignment deadlines are helpful. Related to data management is materials management; that's staying organised and keeping track of "stuff". Think of the maxim "a place for everything and everything in its place".<sup>12</sup>

The environment can have a significant impact on coping and performance. Environmental engineering refers to personalising the client's environment to make it "ADHD friendly".<sup>12</sup> Workplace accommodations would fall in here.

Adults with ADHD often know what they need to do but can become overwhelmed or avoid dealing with certain problems often resulting in negative consequences. Clients benefit from talking through problems in a structured way so they can work through - and then internalise - the problem management process.<sup>15</sup>

A practical example of this might be sitting with a university student and saying, "You've got this big project coming up; it's ambiguous and you're anxious about it. Let's break it down into chunks". And then asking about other deadlines; perhaps reminding them of assignments coming up; checking progress on agreed-upon deadlines.

IT MIGHT INVOLVE TALKING ABOUT WAYS TO KEEP NOTES IN CLASS, MANAGING EXTERNAL COMMITMENTS, AND TALKING THROUGH PROBLEMS.

### THE NEED FOR A FUNDAMENTALLY HOLISTIC APPROACH

In summary, when working with adults with ADHD, consider that there are three hats we need to wear or three roles to be filled. The **tutor**: helping adults with ADHD understand the neurobiology of ADHD and how it relates to their symptoms and struggles. The **therapist**: helping clients unpack the connections between neurobiology and past struggles and building self-esteem. The **coach**: getting stuck in alongside them, being hands-on and practical, seeing the world through their eyes, cheering them on when they do succeed, and in doing so helping them build self-efficacy.

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# THE HERE AND WOW!

## MINDFULNESS, TECHNOLOGY, AND THE ADHD BRAIN

Hugo Theron

### THE LINK BETWEEN TECHNOLOGY AND ADHD

A growing body of research has been looking at the neurodevelopmental effects of digital technology in children and adolescents.

According to Crone and Konijn (2018), adolescents are eminently vulnerable to emotion-arousing media due to their elevated emotional sensitivity and the prolonged maturation of cognitive control and reflective processing. They are therefore highly sensitive to both acceptance and rejection through social media.

However, one must be careful not to dismiss digital technology as "all bad" when it comes to brain development. Social media use can for instance hamper offline interaction but may, on the other hand, provide a simplified way of engaging with others, which may be useful for children and adolescents who have difficulty decoding complex social cues (Gwynette *et al.*, 2017; van Schalkwyk *et al.*, 2017).

**BRAIN REGIONS INVOLVED IN REACTING TO EXCITING OR REWARDING STIMULI AND THOSE THAT GOVERN PLANNING AND IMPULSE CONTROL WORK TOGETHER TO PROMOTE LEARNING. DURING CHILDHOOD AND ADOLESCENCE, THE BRAIN DEVELOPS AND THE BALANCE BETWEEN REWARD AND CONTROL REGIONS CHANGES.**

These brain developments accompany the behavioural processes of exploration, risk taking and learning from peers. During these brain changes, children and adolescents struggle to regulate their behaviours, especially among their peers. Digital technology can play an important role in enhancing the learning process by tapping into the balance between reward and control. There are, however, many types of digital technology that can cause an imbalance in this process, promoting unhealthy social interactions and decreasing impulse control (Magis-Weinberg & Berger, 2020). Dopamine reward pathways in the brain (which

are linked to an increased sensory pleasure that can cause addictive behaviour) have, for instance, been shown to be actively involved in the use of the majority of digital technologies.



Hugo Theron

The nucleus accumbens (NA), which is involved in reward-based learning (Berridge & Kringelbach, 2013) and in the motivation of goal-oriented behaviour (Ikemoto & Panksepp, 1999) has been implicated in social media behaviours like information sharing (Tamir & Mitchell, 2012) and receiving positive feedback (Davey *et al.*, 2010; Sherman *et al.*, 2016). One study showed the NA to have a robust response to positive reactions on participants' own posts (i.e., seeing own photos that received many likes), as well as on viewing popular peer posts (Sherman *et al.*, 2016). This may begin to explain why adolescents spend so much time on curating social media portfolios.

Cataldo and colleagues (2021) reviewed social media use and the development of autism spectrum disorder and ADHD in late childhood and adolescence. According to their review, the cognitive characteristics associated with ADHD, namely persistent inattention, hyperactivity and/or impulsivity have been linked to greater digital technology overuse (Gul *et al.*, 2018). Similarly, Settanni and colleagues (2018) found a correlation between ADHD traits and a greater tendency for addictive or compulsive digital technology use. According to Choi (2019), adolescents with ADHD also find it more difficult to change or stop these problematic digital technology behaviours than their peers without ADHD.

### THE LINK BETWEEN MINDFULNESS AND DIGITAL TECHNOLOGY

Mindfulness practices have been shown to promote executive control in adults (Cásedas *et al.*, 2019). Although some researchers remain sceptical about the impact of mindfulness in children and adolescents (e.g., Saunders & Kober), there have recently been various studies indicating that dispositional mindfulness and mindfulness

practices can reduce negative emotional reactions that result from and/or contribute to psychiatric problems among children and adolescents (Clear *et al.*, 2020; Marusak *et al.*, 2018; Perry-Parrish *et al.*, 2016) and that mindfulness can promote resilience in this population segment (Arpaci & Gundogan, 2020).

Geronimi and colleagues (2020) found that mindfulness practices in children were significantly associated with improvements in response inhibition, task shifting and working memory. Similarly, studies involving adolescents have shown that mindfulness can enhance self-regulation among this age group (Felver *et al.*, 2014; Lyons & De Lange, 2016). According to Marusak and colleagues (2018), mindfulness improves interactions between neurocognitive networks over time in younger populations.

### GIVEN THIS EVIDENCE, IT IS NOT UNREALISTIC TO PROPOSE THAT MINDFULNESS CAN BE A SHIELDING FACTOR AGAINST PROBLEMATIC DIGITAL TECHNOLOGY USE.

A study by Poon and Jiang (2020) showed, for instance, that participants with greater dispositional mindfulness experienced less psychological distress, negative emotions, hostility and antisocial inclinations when receiving a lack of attention on social media. Likewise, a study by Arpaci (2019) demonstrated that schemas related to smartphone addiction decreases as mindfulness increases. Yang and colleagues (2019) found similar results, namely that the correlation between mobile phone addiction and both anxiety and depression was diminished by mindfulness. An interesting study by Emirtekin and colleagues (2019) found that mindfulness-based intervention programmes may reduce the engagement in cyberbullying of adolescents who were emotionally abused in childhood.

On the other hand, digital technology overuse may unfortunately cause a decrease in trait mindfulness, leading to a greater likelihood of an individual resorting to problematic emotion-focused coping mechanisms (Sriwilai & Charoensukmongkol, 2015). Roberts (2018) makes various important points in this regard: Children need to be educated about the permanence of their digital footprint, they must be taught to be more discriminatory of information they consume (much of which can be false or misleading), and adults should model healthy patterns of digital technology use. Not only can mindfulness protect against problematic digital technology use, but the possibility also exists that digital technology can be employed to promote mindfulness.

### HOW IT ALL COMES TOGETHER

Social connectedness, along with healthy and effective intrapersonal coping mechanisms, are

essential for the development of resilience (Arslan & Coşkun, 2021; Poon & Jiang, 2020; Sriwilai & Charoensukmongkol, 2015). Mindfulness practices can be helpful in this regard by reducing feelings of isolation (Poon & Jiang, 2020), while also reducing rumination (a problematic mental process that leads to poor stress management) (Hong *et al.*, 2021). Mindfulness interventions delivered through online platforms can enhance resilience (Joyce *et al.*, 2018), which can in turn help to combat Internet addiction (Arslan & Coşkun, 2021).

When thinking about how to use digital technology to enhance mindfulness, mobile apps immediately come to mind. Donovan and colleagues (2016) suggest that such apps may be a practical way of widely distributing mindfulness programmes among younger populations. Hilt and Swords (2021) demonstrated how just such an app intervention can reduce rumination, worry and anxiety in adolescents. Nunes and colleagues (2020) reviewed mindfulness apps for children, finding that they are becoming increasingly popular but that their quality is not yet satisfactory.

According to Balconi and colleagues (2019), wearable neurofeedback devices could be another way of improving mindfulness practices. Participants who used such wearable technology to receive neurofeedback showed a decrease in stress, anxiety and mental fatigue, and an increase in vitality.

Virtual reality (VR) is becoming increasingly popular among adolescents (Perry & Singh, 2016) and it is therefore important to consider VR as a possible means of mindfulness delivery. There is already evidence that this mode of mindfulness interventions may be as effective as cell phone-based or other digital technology interventions (Seabrook *et al.*, 2020; Wren *et al.*, 2021).

### AT PRESENT LITTLE IS STILL KNOWN ABOUT THE LONG-TERM MENTAL HEALTH AND SOCIAL EFFECTS OF VR ON CHILDREN AND ADOLESCENTS.

References available from author.

**Hugo Theron** has been a registered clinical psychologist since the late 90s. He studied clinical psychology at Stellenbosch University, and medical and health psychology at Leiden University. He obtained his PhD in Child Psychology from the University of the Free State. He has worked with children, adolescents, and adults in South Africa, the Netherlands, and the United Kingdom.

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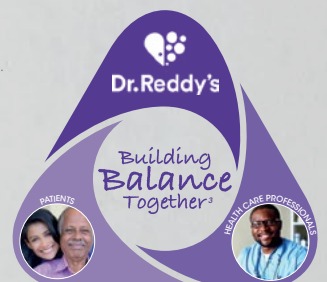
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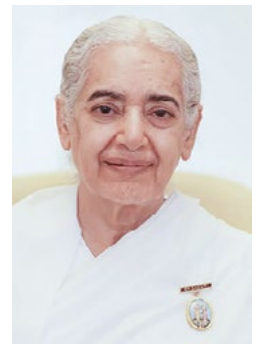
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# CRIMINALITY & ATTENTION DEFICIT HYPERACTIVITY DISORDER

*Elsie Amaley Abakisi*

**C**riminal behaviour can be hypothesized to be caused, partly by low levels of self-control and high levels of impulsivity, which are also hallmark features of ADHD. Criminality can be classified into violent and nonviolent crimes. Violent crimes which include sexual offenses, and murder carry a large burden due to their impact on socioeconomic status. These types of crimes are known to lead to an increasing burden of disease and mortality with the low and middle income countries bearing the brunt of it.

According to the statistics released by the South African police, (SAPs) in the first quarter of 2022, there was a 6.9% increase in reported crime, murder, and rape mostly affecting women and children. Sexual offenses are the leading crimes in South Africa.

## SEX RELATED CRIMES ACCOUNT FOR A SUBSTANTIAL AMOUNT OF ALL CRIMES COMMITTED.

There is a bidirectional relationship between serious mental illness (SMI) and criminality in that persons with SMI are more violent than the general

population and also people who live with SMI are also more likely to be victims of violent crimes. In South Africa (SA), according to the criminal procedure Act 1977, people are allowed to use insanity and profound or severe intellectual disability as a defense and if found to be unwell, are not held criminally liable for the crime by reason of insanity. The most prevalent mental illnesses associated with crime include antisocial personality disorder and substance use disorder.



*Elsie Amaley Abakisi*

Among prison populations, about 25% meet the criteria for psychopathy and 75% meet the criteria for antisocial personality disorder. A meta-analysis of 42 studies published in 2020 revealed that ADHD occurred in about 25.5% of those in detention.

Attention deficit hyperactivity disorder (ADHD) is a neurodevelopmental disorder that is normally diagnosed in childhood with symptoms that often persist into adulthood. The Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM 5) divided ADHD into three subcategories:

impulsive/hyperactive, inattentive, and combined types. Impulsivity impairs the brain's function to self-regulate, control behaviour, thinking, and planning. ADHD and impulsivity is sometimes apparent even before a child is 5. Prevalence is about 2%-10% of school going children.

APART FROM SUFFERING FROM DEFICITS SUCH AS DIFFICULTIES WITH RELATIONSHIPS AND EDUCATIONAL DEFICITS AMONG OTHERS, PEOPLE WITH ADHD TEND TO ENGAGE IN CRIMINAL BEHAVIOUR. SIMILARLY, FAMILIES OF CHILDREN WITH ADHD TEND TO HAVE HIGHER RATES OF CONFLICT AND NEGATIVE PARENT CHILD RELATIONSHIPS.

Children and adolescents with ADHD and Conduct disorder have higher rates of risky behaviour and this may continue into adulthood. Research revealed that men with ADHD were more likely to experience externalizing disorders such as Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD), as well as more aggressive and rule-breaking behaviours. Females with ADHD tend to exhibit internalizing, inattention symptoms, greater intellectual impairment, and lower levels of hyperactivity which lead to less disruptive behaviours and lower referral, diagnosis, and treatment rates. These features in females are better predictors of future poor academic performance, poor interpersonal relationships and future alcohol or drug abuse than in their male counterparts.

A Swedish study revealed daring to take risks, sensation seeking, restlessness, and poor concentration were the strongest predictors of future violence in children with ADHD. Sex offenders have a high prevalence of ADHD. Despite people with ADHD being overrepresented in the forensic population, ADHD is under recognised, under diagnosed and sometimes misdiagnosed.

MOST OF THE STUDIES UNDERTAKEN ARE RETROSPECTIVE. CHILDREN THAT ARE DIAGNOSED WITH ADHD ARE AN AT RISK GROUP AS FUTURE OFFENDERS.

A recent meta-analysis revealed that men with childhood ADHD are 2 to 3 times more likely to be arrested, convicted or incarcerated than the general population. There is no unidirectional link between ADHD and becoming a criminal. However, ADHD puts one at risk of mental illness like ODD or CD which may lead to substance use disorders with the increased probability of developing criminal behaviour. Factors that may alter this cycle include home circumstances and environmental factors, among others.

Some studies reveal that patients with the hyperactive subtype tend to commit impulsive behaviour crimes like robbery and stealing because they have poor planning. They are likely to be caught and arrested compared to the inattentive subtype where there is some form of planning. The inattentive type is more likely to illegally possess drugs, burglary, and theft. However, there is an overlap between these. In a study by Young et al., 96% of ADHD offenders have comorbid psychiatric disorders like mood, anxiety, conduct, substance, and personality disorders, especially cluster B.

A STUDY CONDUCTED REVEALED THAT PERSONS WITH ADHD WITH CD AND PERSONS WITH CD AND EARLY SUBSTANCE USE WERE VERSATILE OFFENDERS WITH A MORE COMPREHENSIVE HISTORY OF AGGRESSIVE BEHAVIOUR IN GENERAL WITH MORE PSYCHIATRIC COMORBIDITIES, MORE VARIED SUBSTANCE ABUSE, AND DESTRUCTIVE SUBSTANCE ABUSE IN ADULT AGE.

ADHD and psychopathy share common symptoms such as impulsivity, poor social adaptation, and antisocial behaviour, however, ADHD has no relation to the affective features of psychopathy and also there are many people who are psychopaths but do not engage in criminal activities or antisocial behaviours.

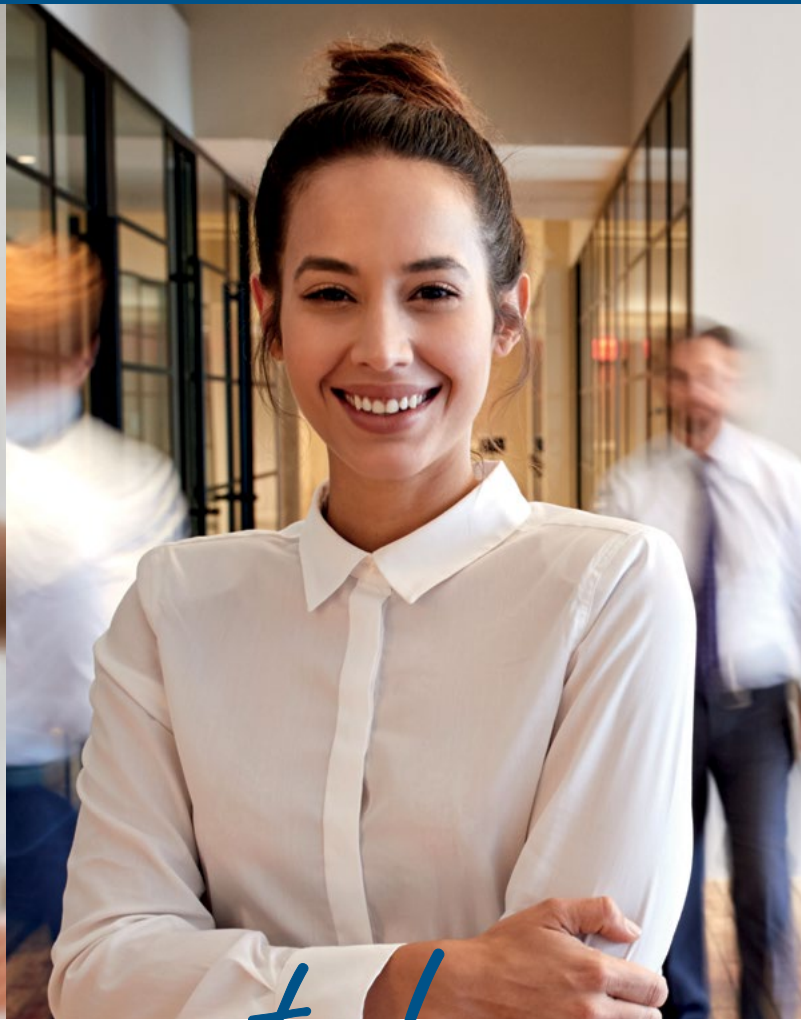
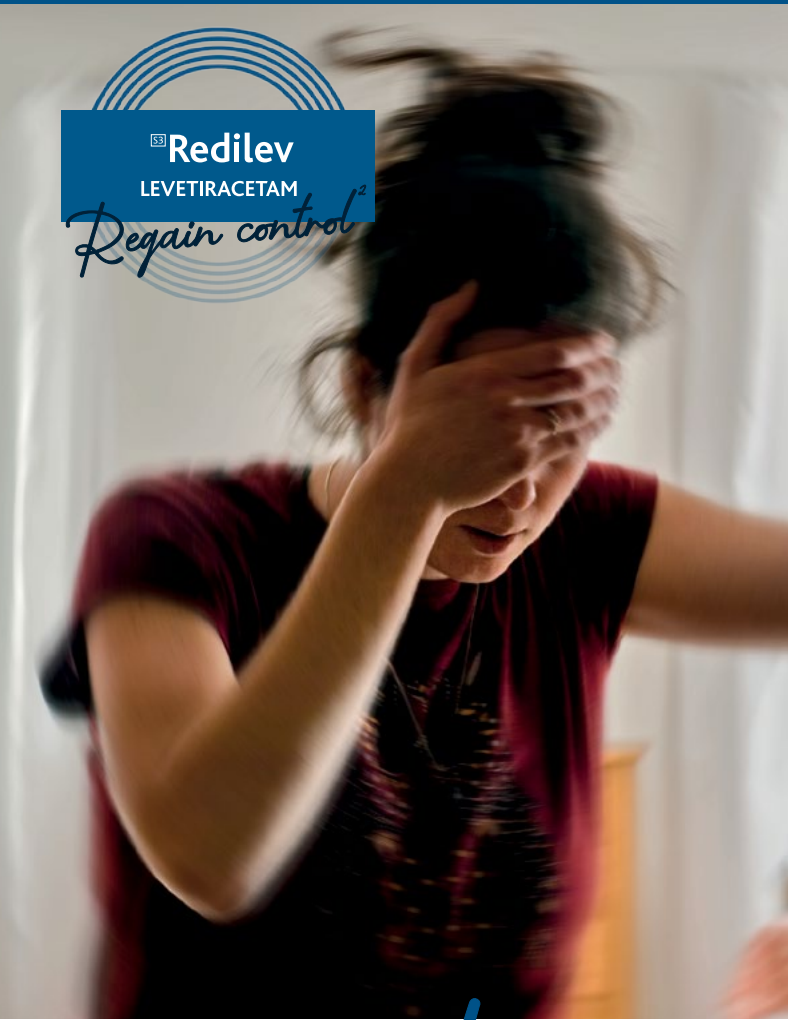
Children and adults diagnosed with ADHD have earlier contact with the justice system than those without ADHD. They also have a high recidivism rate, are more likely to make false confessions during trials, and when incarcerated and in detention centres are more likely more likely to exhibit problematic behaviours, hence contributing to high rates of institutional violence.

ADHD should be treated in prison and studies have shown that pharmacotherapy and Cognitive Behavioural Therapy (CBT) display high effectiveness.

One of the the roles of the psychiatrist in the forensic system and working with the prison population is to assess risk and manage risk to prevent recidivism. The aim is to ensure that the patient is fully rehabilitated. When ADHD is detected early and managed adequately, it may result in diversion from crime to accessing community based mental health resources

References available from the author

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References: 1. Redilev [Professional Information], Sandton, South Africa: Dr. Reddy's Laboratories (Pty) Ltd; November 2016. 2. <https://www.mayoclinic.org/drugs-supplements/levetiracetam-oral-route/side-effects/drg-20068010?pg=1> 3. EFPIA Patient Think Tank. Working Together with Patient Organisations White Paper. June 2019.

[S3] 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).

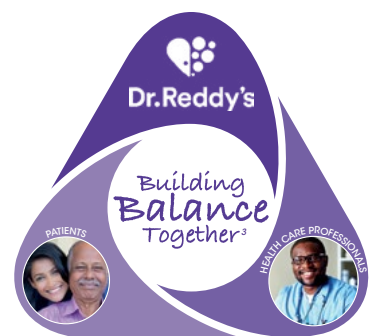
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# MANAGING LONG COVID-19 BRAIN FOG

Michelle King

**C** COVID-19 caused a worldwide pandemic which resulted in 120 million cases with 2.6 million deaths to date<sup>1</sup>. When symptoms exist beyond 12 weeks Post-COVID-19 syndrome (long COVID) is diagnosed<sup>2</sup>. Its development is unrelated to the severity of the acute illness<sup>2</sup>.

## HOW COVID-19 AFFECTS THE BRAIN

PEOPLE STRUGGLING WITH COGNITIVE DEFICITS AFTER COVID-19 INFECTION DESCRIBE IT AS "BRAIN FOG"<sup>3</sup>.

The brain can be directly or indirectly affected during infection with SARS-COV-2<sup>4</sup>. It is hypothesised that the cognitive dysfunction we are seeing could be due to hypometabolic lesions in the brain, probably associated with neuroinflammation<sup>5</sup>. The virus causes cytokine and microglial activation leading to neuro toxicity<sup>1</sup>; inflammation with blunted monoamine transmission<sup>1</sup>; an interplay of inflammation and coagulation<sup>1</sup>; and hypoxic injury.

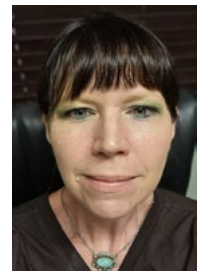
Contributing factors are multifactorial<sup>6</sup>, and include: persistent viraemia<sup>7</sup>; relapse or reinfection<sup>8</sup>; inflammatory and immune reactions<sup>9,10</sup>; deconditioning<sup>11</sup> and psychological factors<sup>12</sup>. Sleep deprivation and psychiatric disorders have a secondary negative impact on cognition<sup>13</sup>.

## PREVALENCE

In a UK study, 1/10 people self-reported symptoms 12 weeks after acute infection with COVID-19<sup>14</sup>. Over

half of this number experienced a reduced ability to function and many were unable to return to work<sup>15</sup>.

In a study of 236,379 patients with COVID, the incidence of neurological and psychiatric disorders was 33%<sup>16</sup>. The most common neurological symptom in patients who had COVID but were not hospitalised were brain fog 81%<sup>17</sup>. Brain MRIs were abnormal in 18% with mainly white matter changes<sup>17</sup>.



Michelle King

MARKED ATTENTIONAL AND EXECUTIVE IMPAIRMENT WAS ASSOCIATED WITH HYPOMETABOLIC AREAS OF THE CINGULATE CORTEX ON PET SCANS<sup>5</sup>.

## WHAT IS BRAIN FOG?

Brain fog<sup>18</sup> affects four different areas of cognition. These being: executive function disorders; impairments in complex long term memory impairments; language deficits; and impairments in complex attention.

Becker *et al.*, 2021<sup>3</sup> studied cognitive impairment in 740 patients who had been infected with COVID-19. This was a young cohort with ages between 38-59 and a mean age of 49. They found the most prominent deficits to be: 18% processing speed; 16% executive functioning; 15% phonemic frequency; 20% category fluency; 24% memory encoding; and memory recall.

## LONG TERM COURSE

Symptoms can be unpredictable, debilitating<sup>18</sup> and they can fluctuate diurnally<sup>18</sup>. A gradual improvement is expected to occur over weeks to months. Patients describe profound psychological, occupational, and social impacts due to the symptoms of Long COVID. They are often not able to return to work at all or require reduced work hours or adaptations. Many patients who have jobs which have little place for error e.g. doctors, accountants may experience anxiety when they return to work<sup>18</sup>. This impairment can lead to feelings of guilt and shame<sup>18</sup>.

THE LONG-TERM COURSE IS DIFFICULT TO PREDICT AT PRESENT. SOME RESEARCHERS BELIEVE THAT THERE MIGHT BE AN EVOLUTION TOWARDS NEURODEGENERATIVE DISEASES<sup>4</sup>, AS STUDIES HAVE SHOWN THAT SARS-COV-2 CAN INDUCE HYPERPHOSPHORYLATION OF THE TAU PROTEIN OR ACTIVATION OF PKR KINASE, THE TWO PROTEINS THAT ARE ASSOCIATED WITH ALZHEIMER'S DISEASE<sup>5,19</sup>.

## ASSESSMENT

Recommendations are made based on expert opinion as there is not sufficient robust data<sup>2</sup>. Shah et al.,<sup>2</sup> recommend the following approach:

- Ask how your patient's life and activities are affected. You need to explore areas such as work or education as well as mobility and independence.
- Take time to listen to your patient with empathy and acknowledge the impact that long COVID has had on their lives. You need to have a good understanding of their experience of their illness as well as their fears and concerns.
- Neuropsychological evaluation can be helpful in quantifying the brain fog related cognitive complaints and for ruling out cognitive deficits due to an anoxic injury or undiagnosed seizures<sup>13</sup>.
- Always screen for sleep disorders and assess sleep quality<sup>13</sup>. If indicated, refer for a polysomnogram to diagnose an underlying sleep disorder.
- Careful assessment of psychological factors is needed. Studies show that 45% of patients post-COVID have depression, 47% anxiety<sup>20</sup> and 6.5% PTSD<sup>21</sup>. For 8.63% of patients this is the first onset of a psychological disorder.<sup>16</sup>

## TREATMENT

Once a thorough assessment has been made, a

care plan needs to be created together with your patient using shared decision making.

## THIS PLAN MUST INCLUDE WHAT SUPPORT AND REHABILITATION IS NEEDED AND HOW IT WILL BE PROVIDED<sup>2</sup>.

- **SELF-MANAGEMENT**
  - Patients can be given advice on self-management e.g., learning how to plan, prioritise and pace themselves so that they don't end up trying to do everything at once and exhausting themselves.
  - The idea of a "fatigue piggy bank" can be taught. This is where patients must identify the things in their life that tire them out and identify the things that give them energy. When they are tired and their piggy bank is empty, they need to focus on doing things that re-energise them and avoid the things that deplete their energy levels.
  - Symptom diaries or symptom tracking apps might be helpful for your patient to monitor their symptoms and track their progress.
  - Have discussions around returning to work or studies. For some patients, a phased in approach can be helpful with reduced hours or reduced work-load.
- **MULTIDISCIPLINARY TREATMENT**
  - Cognitive rehabilitation<sup>13</sup>.
  - This includes psychoeducation for your patient ie, defining what is meant by brain fog and explaining the possible aetiology and factors that could potentially impact the recovery process.
  - Patients need to learn compensatory strategies to manage the areas of cognitive impairment identified by neurocognitive testing. These strategies might include teaching prioritising, learning how to reduce distraction and working with patients with attentional training<sup>22</sup>.
  - Physical exercise<sup>23</sup>.
  - All patients should be encouraged to exercise. However, it must be something that they enjoy doing and it must be something that they can do without overexerting themselves. Exercise must be slowly increased in duration and intensity.
  - Nutrition<sup>13</sup>
  - Neuroinflammation can be reduced with nutrition with the help of a dietician. There are several theories regarding this for example, following a Mediterranean diet or a keto-genic diet.

### Treating neuroinflammation

Due to the lack of studies available, you should get informed consent from your patient when prescribing treatment so that they can decide what treatments they might want to try. If one looks at treatments that inhibit mast cell associated neuro-inflammation<sup>24</sup>, flavonoids e.g., luteolin and quercetin might be an option. They inhibit neuroinflammation and reduce cognitive decline as well as acting as mast cell inhibitors.

### LUTEOLIN PENETRATES INTO THE BLOOD BRAIN BARRIER FASTER THAN QUERCETIN AS WELL AS INHIBITING MICROGLIA AND MAST CELLS WHICH MIGHT MAKE IT THE BETTER OPTION OF THE TWO.

Melatonin activates NRF2 and as a result reduces oxidative stress. It is also neuroprotective and improves mitochondrial function<sup>25</sup>. Dosages from 2mg to 6mg nocte PO have been used. Other options include atorvastatin or apixaban. A multicentre trial called, 'HEAL COVID' is currently underway which compares atorvastatin to apixaban to care as usual. Atorvastatin improves endothelial function by decreasing oxidative stress and vascular inflammation. The dosages used in the trial are 40mg daily for 12 months. Apixaban is a prophylactic anticoagulant used to manage undiagnosed thromboembolism following long COVID.

### OTHER MEDICATION OPTIONS

Manu<sup>26</sup> proposes that more research is needed to investigate the use of methylphenidate. It is currently used for patients with cancer and traumatic brain injury. Further, methylphenidate improves fatigue in many life limiting illnesses such as HIV and Parkinson's disease. He also proposes Brexpiprazole, an atypical antipsychotic, which has shown to be useful in treating PTSD as well as improving daytime alertness, sleep efficacy, sleep dependent depressive symptoms, energy levels, cognitive ability and general functioning<sup>27,28</sup>. The pro-cognitive effect is due to its alpha 2 and 5HT7 affinity.

### TREATING PSYCHOLOGICAL FACTORS<sup>13</sup>

With the hypothesis that medications with an anti-inflammatory effect might be helpful in treating long COVID, choosing antidepressants with this effect might give better outcomes e.g. duloxetine<sup>26</sup>, agomelatine<sup>25</sup> or paroxetine<sup>29</sup> when treating depression. Patients with comorbid generalised anxiety disorder might benefit from duloxetine<sup>26</sup> while patients with comorbid PTSD might benefit from brexpiprazole<sup>26</sup>. For patients who have mild symptoms of anxiety or depression with primary cognitive complaints, CBT can be helpful in adjusting to their impairment. Cognitive restructuring can help patients shift their focus from what they can't do to where their strengths lie. For patients who are unable to return to work or who

are challenged by significant impairment, therapy can be helpful in developing self-acceptance, adjusting to their new role, and developing coping strategies.

### BE AWARE THAT MANY PATIENTS ARE EXPERIENCING GRIEF, AS WELL AS BURN OUT IN HEALTH CARE PROFESSIONALS WHICH CAN IMPACT THEIR COGNITIVE FUNCTIONING AND WILL NEED TO BE REFERRED FOR GRIEF COUNSELLING.

Further, referral to a support group is always beneficial.

### TREATING INSOMNIA

Insomnia has a big impact on daytime fatigue and cognition. Patients should be given good sleep hygiene advice before any sedative-hypnotic medication is prescribed. Avoid medications which will further worsen cognitive impairment. If present, treat the underlying sleep disorder.

Treating long COVID requires a team approach so refer to other members of the multidisciplinary team where needed and other specialists when indicated.

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# THE 1<sup>st</sup> AFRICAN NEUROSCIENCE & PSYCHIATRY SUMMIT 2023

*Sthembile Jili*

**O**n 24 – 26 February 2023, Janssen South Africa Neuroscience hosted the 1st African Neuroscience & Psychiatry Hybrid Summit in Johannesburg in collaboration with the African Global Mental Health Institute (AGMHI).

THE AIM OF THIS AFRICAN NEUROSCIENCE & PSYCHIATRY SUMMIT WAS TO SHARE MEDICAL AND SCIENTIFIC KNOWLEDGE, ENCOURAGE IMPACTFUL DISCUSSIONS AND DRIVE PROGRESSIVE CHANGE IN THE SUB-SAHARAN AFRICAN MENTAL HEALTH SPACE. THIS INCLUDED HIGHLIGHTING PERTINENT NEUROSCIENTIFIC ASPECTS RELATED TO VARIOUS PSYCHIATRIC CONDITIONS FOCUSED ON MOOD DISORDERS AND SCHIZOPHRENIA.

## THE SUMMIT COVERED VARYING TOPICS RELATED TO MENTAL HEALTH IN AFRICA:

Highlights from the opening day included a welcome from the President of South African Society of Psychiatrists (SASOP), Dr Sebolelo Seape, AGMHI (delivered by Prof. Bonga Chiliza) and a Janssen South Africa presentation delivered by the Country General Manager, Ahmed El Hofy. Dr David Henderson, guest speaker from the USA, presented a plenary session on "Understanding the role of metabolic syndrome in schizophrenia".

The second day's main highlight was the launch of the #breakingstigma campaign; Janssen South Africa's Neuroscience-led campaign in collaboration with the South African Depression and Anxiety Group (SADAG) and the South African Society of Psychiatrists (SASOP), aimed at highlighting and creating awareness on the stigmas associated with mental health in South Africa. During this launch, two patients and a caregiver shared their stories about living with depression and the importance of seeking help, speaking up, and spreading the word in an effort to help end the stigma.

Day two also included plenary sessions covering novel therapies in treating and managing mood disorders specifically depression and a session with a focus on HIV and depression. A child psychiatry session highlighted the importance of child mental health with an Afrocentric approach, while ending the day on a high note about the Ethics and bioethics around novel Neuromodulatory treatments in managing treatment resistant depression (TRD).

The last day's plenary sessions covered various topics: Breaking the stigma associated with schizophrenia, Patient X-Files - A deep dive into treating and managing Schizophrenia in the South African landscape and Queering mental health: The ethics and biopolitics of an inclusive LGBT+ agenda.

This Summit welcomed mental health professionals from across the Sub-Saharan African region; such as Botswana, Malawi, Zimbabwe, Rwanda, Tanzania, Uganda, Kenya, Nigeria, and Lesotho.

## APPRECIATION OF THE SCIENTIFIC COMMITTEE MEMBERS:

- Prof Bonga Chiliza
- Prof Saeeda Paruk
- Dr Mvuyiso Talatala
- Dr Lihle Mgweba
- Dr Philip Opondo (Botswana)
- Dr Michele Durham (USA)

## REFLECTIONS FROM SUMMIT ATTENDEES:

**Dr Wisani Makhomisane (Psychiatrist, Limpopo)** – *"Firstly I would like to thank you and Janssen/AGMHI for a well organised summit. I attended physically and everything about the hotel and support staff was great."*

*All the topics were well thought through and well presented by industry leaders in their field. For me, what made this summit exceptional was that it was Africans discussing mental health in Africa. It said to*

me that there is a space and room for us to support each other in all small corners of Africa.

*The session that stood out to me was the child psychiatry session which highlighted some of the fundamentals around Autism spectrum disorders. I also particularly enjoyed the session on neuroethics, Dr Olivia and Dr Lihle had highlighted such important aspects around neuromodulatory treatment in psychiatry which I felt is something very important to highlight especially in a progressive treatment landscape in Africa.*

*Lastly, Sadiyah (Janssen MSL – Psychiatry), excuse the pun but you are the man. You took this summit as your new-born through all milestones, you were even running around with the microphone during the Q&A, and I can safely say your baby has fully achieved all her milestones.*

*Well done. Keep on excelling and through you, Janssen/AGMHI is becoming a household name. We look forward to the next Summit."*

**Dr Marcia Ntimani (Psychiatrist, Johannesburg South)** – *"Thank you so much to Janssen/AGMHI for the summit. It was well organised and very insightful. The pre-summit workshop was very helpful because as health professionals we use motivational interviewing a lot in substance use disorders. But the workshop has further highlighted for me that one can use these techniques with other disorders and for medication compliance.*

*Furthermore, the patient interviews done at the Summit was the highlight of the show, especially the lady who came with her son. Reality kicked in for me when he spoke about his experience of living with a depressed mom. Sometimes we don't realise the impact of mental illness on family members, and it was so insightful to get to hear their experiences and truly understand the caregiver's burden. This perspective will always remain with me as I treat and manage patients.*

*All the topics were nicely presented and I like the fact that it was short presentations that were straight to the point. The sessions were all informative and I definitely look forward to another Summit next year. Thank you for the hosting us and we appreciate that refreshments were always available."*

#### QUOTE HIGHLIGHTS FROM THE SUMMIT:

"Janssen South Africa is committed to providing unbiased medical education and content excellence in the field of neuroscience and psychiatry to healthcare professionals in South Africa. Through our valued collaboration with AGMHI, we aim to highlight our commitment to

providing medical excellence and transforming the landscape of mental health in Africa with the goal of improving patient outcomes." **Sadiyah Cassim, Medical Scientific Liaison (Psychiatry) at Janssen South Africa**

"Mental health remains one of the most important areas in public health. The stigma and discrimination attached to mental health diseases prevent many people from seeking treatment, leading to significant social and economic consequences. The #breakingstigma campaign is an opportunity for us to collaborate with key stakeholders to break down the stigma surrounding mental health and encourage individuals to prioritize their mental wellbeing. Unchecked, mental health can grow to become a major health risk amongst South Africans." **Moustafa Kamel, Medical Affairs Director at Janssen South Africa**

"One of the few positives about the COVID-19 pandemic is that it really unearthed how important mental health is. The problem with stigma is ignorance, attitude and discrimination, or behaviour against people with mental health. And that's what we should be targeting - the knowledge. The #breakingstigma campaign is a wonderful initiative to educate people about these mental health issues." **Prof. Bonga Chiliza Associate Professor/Chief Specialist and Head of the Department of Psychiatry at the University of KwaZulu-Natal & Co-Director of AGMHI**

"There has been a marked increase in mental health challenges amongst South Africans due to the significant amount of stress citizens live and work under. Economic, social, and family pressures are immense right now. It's important that people take the first step toward mental health." **Dr Sebolelo Seape, President at SASOP**

"Living with treatment resistant depression (TRD) is not easy and I think depression overall is misunderstood. The worst thing about living with it is the very deep dark hole that you go into; where you contemplate the worst things in life, for example, suicide or self-harm, and consequently hurting your family." **John Clay, a patient living with TRD**

"There is no shame in mental health. It can be overwhelming, however with support and treatment it is manageable." **Pearl Ndlovu, a patient living with depression**

"There cannot be enough emphasis on the risks of ignoring mental health, and it starts with dispelling stigmas that are associated with various conditions that many people suffer from. It is, in many ways, impacting more people than we realise, but the door should be open to allow people to come forward, without judgement." **Cassey Chambers, Operations Director at SADAG**

**Sthembile Jili** is Administrator of the AGMHI, Department of Psychiatry, University of KwaZulu-Natal **Correspondence:** [JiliS@ukzn.ac.za](mailto:JiliS@ukzn.ac.za) ■

# A MENTAL HEALTH COLLOQUIUM: PSYCHOTHERAPY IN LMICS

*Morgan Watson, \*Keleabetswe Orthelia Gare, \*Yolisa Jakavula, \*Juliet Stromin, \*Jess Henn, \*Melisa Zulu, Lena Andersen, Stephan Rabie, John Joska*

*\*These authors contributed equally.*

**A** third of South Africans experience a common mental disorder in their lifetime (Petersen et al., 2016). Yet, it is estimated that fewer than 10% of people living with a mental health condition receive the necessary care (Docrat et al., 2019). This mental health treatment gap is a key priority in the mental health care domain to improve the delivery of effective psychological interventions in resource-limited settings. This was the topic of the second annual Psychotherapy Symposium held in Cape Town on 9 March 2023.

THE MAIN THEME FOR THIS MEETING WAS AN UPDATE ON PSYCHOTHERAPY TRIALS THAT HAVE BEEN IN PROGRESS SINCE THE LAST MEETING IN 2019, AS WELL AS EXPLORING THE MOVE TO IMPLEMENTATION AND UPTAKE.

The event included keynote addresses, rapid fire presentations, workshops, as well as a concluding panel discussion. Topics ranged from the importance of regular, organic and interactive engagement between stakeholders and policymakers to the findings of a variety of recently published randomised controlled trials in the context of mental health. The long-awaited event was attended by a myriad of mental health and wellness specialists, provincial and City of Cape Town stakeholders, prospective psychological professionals, and interventionists.

The opening plenary was delivered by Dr Yogan Pillay, a trained clinical psychologist and former Deputy Director-General of Health in the South African Department of Health and Wellness. Essentially, his address spoke to whether psychotherapy has any relevance in a resource-restrained context such as ours. Having considered the opinions of expert colleagues, the response of artificial intelligence chatbot ChatGPT, and key findings within current psychological literature, the response appeared to be yes, psychotherapy is

relevant and needed in South Africa. However, he emphasised a few caveats. Firstly, he noted the importance of cultivating a transparent dialogue between the mental health care provider and client in order to ensure that the therapy being offered is effective. Encouraging feedback is fundamental in ensuring treatment success, despite – according to Dr Pillay – not being taught this during his own professional training. Secondly, in resource-constrained contexts, task-sharing is crucial. This global approach focuses on training non-specialist health professionals, like lay workers or peer counsellors, to screen for and treat specific mental health conditions (Kemp et al., 2019).

TASK-SHIFTING HAS BEEN FOUND TO BE INSTRUMENTAL IN INCREASING THE POTENTIAL REACH OF PSYCHOTHERAPY IN SETTINGS THAT FACE A LACK OF HUMAN, FINANCIAL AND INFRASTRUCTURAL RESOURCES.

Given the promise shown by this approach, the theme of task-sharing continued throughout the duration of the symposium.



*Photograph of Dr Yogan Pillay during his opening plenary. Photo credit: Zaheer Seedat: Zeus Media Productions*



Photograph of Professor Kathleen Sikkema during her presentation on the Someleze Project. Photo credit: Zaheer Seedat: Zeus Media Productions

Following the plenary address was the first of two rapid-fire sessions where both local and global experts within various health and academic environments presented research which ultimately spoke to the importance of taking a holistic approach in considering the individual, community and psychosocial context within which mental disorders may manifest.

**PEOPLE WITH HIV (PWH) ARE AT HIGHER RISK OF POOR MENTAL HEALTH OUTCOMES SUCH AS DEPRESSION, ALCOHOL USE DISORDERS AND ANXIETY. AS SUCH, THIS POPULATION REPRESENTED A MAIN POINT OF DISCUSSION THROUGHOUT THE DAYS PRESENTATIONS.**

Kathleen Sikkema and Stephan Rabie from Project Someleze spoke to the synergistic connection between high levels of sexual trauma and HIV infection in South Africa, and how this relationship increases a woman's risk of developing either post-traumatic stress disorder (PTSD) or a mood disorder. Sikkema and Rabie noted the importance of this research given that PTSD and mood disorders have been found to increase the likelihood of treatment non-adherence as well as avoidance of care-engagement among PWH.

This study succinctly highlights PWH's vulnerable position at the intersection of chronic healthcare and mental healthcare. Finally, the researchers concluded by discussing a coping-based psychotherapy intervention titled Improving AIDS Care after Trauma (ImpACT+), which aims to improve both clinical and mental health outcomes among women living with HIV by decreasing avoidant coping.

Thereafter, speaking to the treatment gap, Alexandra Rose and Jessica Magidson presented their results on a pilot randomised controlled trial (*Project Khanya*). The pilot used an evidence-based, task-shared behavioural intervention to address substance misuse and antiretroviral therapy (ART) non-adherence in HIV care.

**THE FINDING WAS THAT THE INTERVENTION IS FEASIBLE, AND THAT PEERS ARE APPROPRIATE MENTAL HEALTH CARE PROVIDERS AS THEY ARE ABLE TO DRAW FROM LIVED EXPERIENCE, THUS REDUCING POTENTIAL STIGMA.**

Similarly, Dr Lena S Andersen and Professor John Joska contributed to the discourse of task-shared psychotherapy amongst an HIV population. Their presentation detailed the effectiveness of nurse-delivered cognitive behavioural therapy (CBT) for HIV treatment adherence and depression for virally unsuppressed people living with HIV. The presentation further highlighted the intersection between mental health and physiological health in the context of chronic disease.

**CONTINUING WITH THE THEME OF TASK-SHARING WITHIN HIV CARE, CONCILIA TARISAI BERE PRESENTED THE NZIRA ITSVA STUDY CONDUCTED IN ZIMBABWE. TRANSLATING TO 'NEW DIRECTION', NZIRA ITSVA ALSO USED A TASK-SHARED CBT APPROACH TO INCREASE HIV ADHERENCE THAT HAD BEEN CULTURALLY-ADAPTED TO THE SETTING.**

This model included a Shona translation, the addition of local metaphors and phrases, as well as culturally-relevant probes to elicit what the possible barriers to ART adherence may be. Bere reported that the model proved to be effective in increasing adherence among a cohort of clients and was



Photograph of Gill Douglas responding to a presentation. Photo credit: Zaheer Seedat: Zeus Media Productions

found to be considered acceptable by both clients and counsellors. The success of this project reiterates the importance of cultural adaption in research exploring the transferability of task-shared interventions across a variety of settings.

Going further into the topic of task-sharing, Professor Bronwyn Meyers and her colleagues discussed the implications of integrating a dedicated versus designated approach to task-shared psychological interventions in chronic disease care. Dedicated healthcare workers (HCWs) are assigned to mental health work exclusively, whereas designated HCWs are trained to deliver the work in addition to their existing job description. The design of this study acknowledges that HCWs are already heavily burdened and confirmed that, although task-sharing amongst this cadre of mental health workers is effective in some settings, employing dedicated counsellors in this environment is needed to elicit the most change.

Selohilwe and colleagues went on to consider what duration may be needed for a successful task-shared psychotherapeutic intervention. The researchers addressed the question of how much exposure an individual may need before they can expect to see psychosocial improvements, to which the findings suggested five to eight sessions. Thereafter, individuals can expect optimised functional ability, reduced stigma and reduced mood symptoms. However, Selohilwe and colleagues acknowledged the fact that the study's findings were limited by a poor retention rate of participants. The recommendation of focusing on counsellor selection – particularly on whether character traits are similar to person-centred care qualities – was made.

**THE SECOND TARGET POPULATION OF THE SYMPOSIUM WAS CHILDREN AND ADOLESCENTS. RESEARCH IN THIS FIELD IS HIGHLY VALUABLE AS CHILDREN ARE AT HIGH RISK OF VIOLENCE, ABUSE AND MALTREATMENT BY PEERS AND ADULTS. THIS DRIVES INCREASED RISK FOR DEVELOPING MENTAL DISORDERS AMONGST THIS POPULATION.**

In response to this, two studies focused on parenting strategies. First, John-Joe Dawson-Squibb presented a pre-pilot on a novel intervention using Parent-Child Interaction Therapy (PCIT) to address children living with Oppositional Defiant Disorder (ODD). Caregiver dyads, received the intervention after which they reported high rates of satisfaction. Whilst small in sample size, the evidence is the first of its kind to be documented in South Africa and suggests that PCIT may be acceptable and feasible in the country.

Second Genevieve Haupt Ronnie and colleagues presented a study which aimed to address abusive parenting practices by proposing an

alternative and supportive method of interaction between parents and children. The study's sample consisted of individuals living in low-and middle income settings and was based on social and developmental psychological theorems. Furthermore, the intervention made use of task-sharing with psychologists used purely for the purpose of supervision. The findings were positive in that violence perpetrated towards children and adolescents was reduced. Finally, Jaco Rossouw presented on the long-term follow-up of a randomised controlled trial which contrasted the impact of prolonged exposure therapy (PE-T) with supportive counselling (SC) for PTSD in adolescents.

The findings suggest that PE-T is more effective than SC in treating PTSD symptoms while also ensuring a better quality of life for these young individuals.



*A photograph of attendees contributing to parallel breakout group workshops. Photo credit: Zaheer Seedat: Zeus Media Productions.*

**IN THE SECOND KEYNOTE ADDRESS OF THE DAY, DAISY SINGLA SPOKE ABOUT SCALING UP PSYCHOTHERAPIES FOR COMMON MENTAL DISORDERS. DESPITE PSYCHOTHERAPY BEING CONSIDERED THE FIRST LINE TREATMENT FOR MENTAL DISORDERS WORLDWIDE, ACCESS TO TREATMENT STILL REMAINS INACCESSIBLE TO THE WIDE MAJORITY OF THE POPULATION. TAKING INSPIRATION FROM THE SUCCESS OF TASK-SHARING INTERVENTIONS IN OTHER LMICS TO DECREASE THE TREATMENT GAP, DAISY SPOKE ABOUT ITS IMPLEMENTATION IN A HIC SETTING.**

Highlighting the value of sharing knowledge learnt from other settings.

To follow, the symposium included workshop breakout groups across four sub-themes, namely: 1) Training and supervision in task sharing psychotherapy, 2) Implementation science methods in scaling up psychotherapy, 3) Building partnerships between communities, researchers, clinicians and people with lived experience and 4) Introduction to Prospective Economic Evaluations. These stimulated critical discussions and collaboration amongst the diverse group of attendees. Considerations regarding the

limitations of psychotherapy and its delivery in a low resource setting were discussed. Firstly, the Health Professionals' Council of South Africa's (HPCSA) guidelines only recognise registered health professionals as able to administer psychotherapy.

**QUESTIONS WERE RAISED REGARDING THIS OCCUPATIONAL BOTTLENECK AND THE SUBSEQUENT DISCREPANCY THAT NOW EXISTS IN THE NUMBER OF PATIENTS COMPARED TO MENTAL HEALTHCARE PROVIDERS. THIS IS IMPORTANT TO ADDRESS CONSIDERING THAT THE LIMITED NUMBER OF PROFESSIONALS ABLE TO DELIVER PSYCHOTHERAPY COULD BE EXACERBATING THE MENTAL HEALTH BURDEN WE ARE CURRENTLY EXPERIENCING.**

Secondly, it was mentioned that the current specialist-training puts a limit on the capacity for task-sharing to lay counsellors who are an available resource in South Africa. In this regard, training programmes do not generally train psychologists to capacitate, supervise, or task-share interventions in community settings. The need for additional training at tertiary level to address this training gap was one of the key messages of the symposium.

**OVERALL, THE CONSENSUS WAS THAT MENTAL HEALTHCARE IS CHRONICALLY UNDER-RESOURCED AND UNDER-FUNDED IN SOUTH AFRICA. CURRENTLY, THE NATIONAL GOVERNMENT ALLOCATES 5% OF ITS NATIONAL HEALTHCARE BUDGET TO MENTAL HEALTH SERVICES; THIS FIGURE IS SIGNIFICANTLY LOWER THAN INTERNATIONAL BENCHMARKS.**

Additionally, 86% of this budget is represented by inpatient psychiatric care, thus leaving very little available at a primary healthcare level. In addition to a severe shortage of "dedicated" and even "designated" mental healthcare workers in the public sector, there are severe infrastructure constraints. Private counselling spaces are limited in the primary healthcare setting; this kind of space remains exclusive to those who can afford private mental health care. The cost of mental health being side-lined is that it remains stigmatised; this was raised as an additional barrier to care. The need to tailor psychological interventions to individuals, settings, and sub-populations is a challenge to scale-up. Therefore, the theme of "no one size fits all" in psychotherapy delivery and intervention was raised. In South Africa, a myriad of cultures, languages, and ideas of what it means to receive mental healthcare services exists.

As such, psychotherapy and how it is delivered, should be informed by the client's unique

presentation. Evidently, there is a need to adapt psychotherapy to the individual client and work towards making this form of intervention more accessible to the everyday South African. Ultimately, there is a need to revisit who may take part in psychotherapy delivery to ensure that those in need receive the most effective form of therapy available.

In closing there was a final panel discussion chaired by Professor John Joska. The panel focused on future planning for mental healthcare in LMICs in the face of a substantial mental health treatment gap. The importance of task sharing was consolidated and its role to play in low resourced settings irrefutably agreed upon.

**OPTIMISED UTILISATION OF MENTAL HEALTH WORKERS ALONG THE SPECTRUM OF SPECIALISATION IS ALSO NEEDED – FROM LAY AND SEMI-PROFESSIONAL HEALTHCARE WORKERS TO PROFESSIONAL MENTAL HEALTH CARE SPECIALISTS. FURTHER OPTIMIZATION WITHIN HEALTHCARE SYSTEMS IS REQUIRED, WITH INCREASING IMPLEMENTATION OF 'STEPPED CARE' OR SMART DESIGNS WITHIN THE DOMAIN OF MENTAL HEALTH.**

The panel discussion acknowledged the barrier that mental health stigma provides to patient care, highlighting further the need for psychoeducation opportunities.



*A photograph of Daisy Singla during the final panel discussion. Photo credit: Zaheer Seedat: Zeus Media Productions*

The day's proceedings resonated back to Dr Yogan Pillay's initial question of whether psychotherapy has relevance in South Africa. Despite its limitations, which were openly acknowledged by those gathered, the dearth of work being done in this field shows that this is clearly not an arid therapeutic discourse. Ultimately, we need direct engagement on all levels, stake-holders, policy makers and law makers in order to generate change in the current mental health milieu.

The organising committee comprised of John Joska, Lena Anderson, Crick Lund, Lenny Naidoo, Umesh Bawa, Catherine Ward, Soraya Seedat and Ashraf Kagee ■



# SAVE THE DATE

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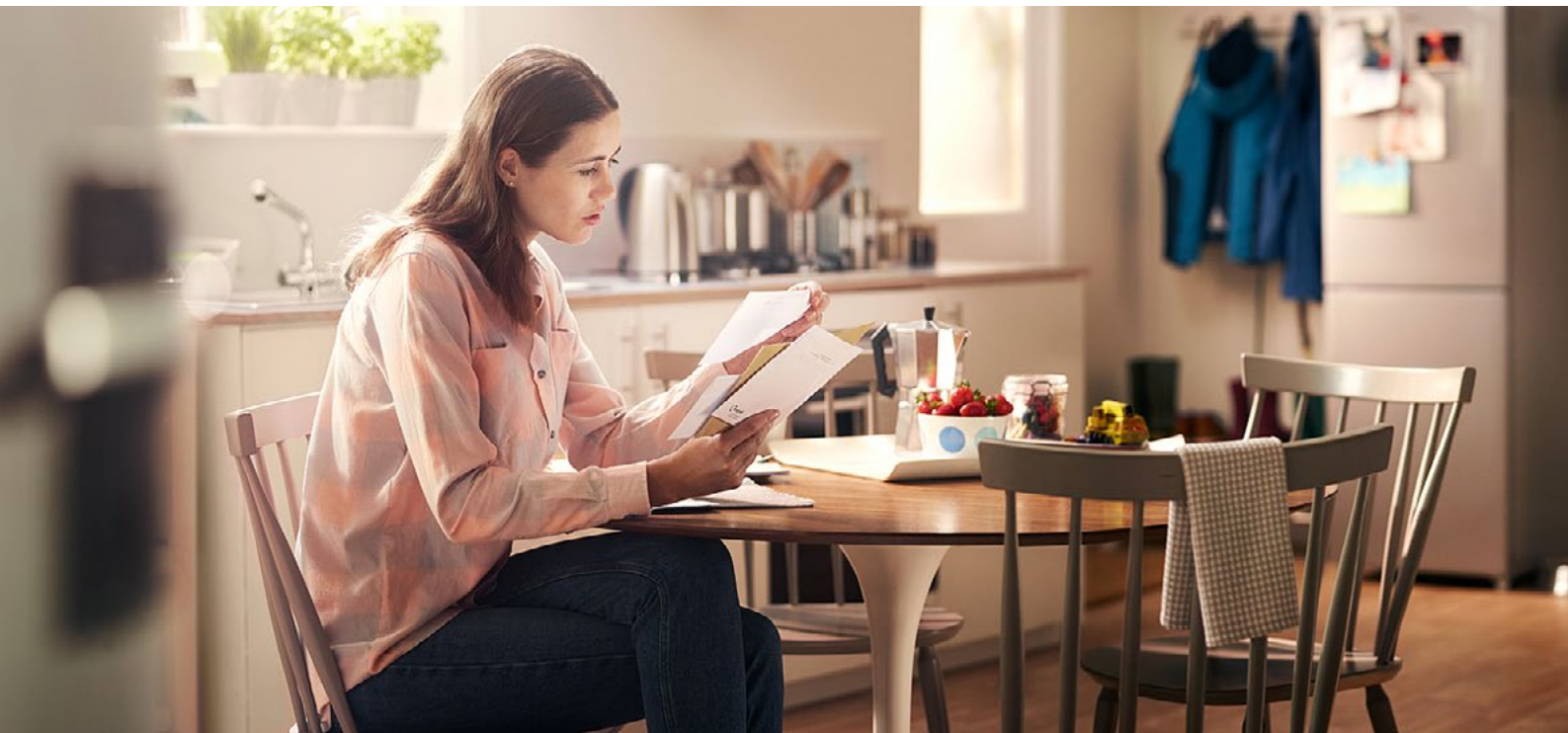
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# DEPARTMENTS OF PSYCHIATRY

## UNIVERSITY OF THE WITWATERSRAND



### INTRODUCING THE DIVISIONAL HEAD - NEUROPSYCHIATRY

Dr Sandra Fernandes (Neuropsychiatrist) was appointed as the Divisional Head of Neuropsychiatry, in early 2022, in the Department of Psychiatry at the University of the Witwatersrand. As a Division there are 4 neuropsychiatrists across the academic platform (1 at Chris Hani Baragwanath Academic Hospital, 1 at Charlotte Maxeke Johannesburg Academic Hospital and 2 at TARA), with 1 fellow in training. The Division is making its mark collaborating across other disciplines to ensure that Neuropsychiatry develops at Wits, but also across South Africa. The Division has been approached by not only other provinces to provide a second opinion on complex patients but also other African countries with an interest in training. The future offers many opportunities in Neuropsychiatry research and development and Dr Fernandes feels "...privileged to be in the position to coordinate and develop this exciting field in Gauteng."



Dr Sandra Fernandes

### AMERICAN PSYCHIATRIC ASSOCIATION (APA) VISIT

The President and CEO of the APA visited the Department of Psychiatry at the end of March 2023 for 2 days. Following a light lunch with members of the Department's Executive, they joined our grand ward round in the School of Public Health auditorium as guests. The next day was spent at CHBAH, hosted by the clinical HOD, Dr Mvuyiso Talatala. After a brief tour of the Psychiatry department, the President, Prof Rachel Brendel, delivered an excellent talk on ethics in the CHBAH lecture room. Lundbeck SA kindly sponsored the event.



From left to right. Back row - Department Executive members: Drs Ariefdien, Brummerhof, Talatala, Fernandes, Chetty, Price-Hughes; Seated - Dr Saul Levin (APA-CEO), Prof. Subramaney (Department of Psychiatry - Academic HoD), Prof. Rachel Brendel (APA - current President)

# LOUIS FRANKLIN FREED PRIZE FOR PSYCHIATRY

In 2022, the prize was awarded to Dr Ashleigh Prior.

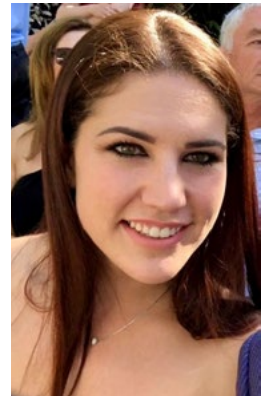
The title of her MMED research report is: **"Construct Validity of the Brief Psychiatric Rating Scale - Expanded Version in a South African community psychiatry setting using Rasch Model Analysis"**. Dr Prior was supervised by Professor Lesley Robertson

The prize is awarded on the basis of registrar performance throughout the 4 years, performance in the Part 1 and 2 examinations, time to completion of the degree and importantly, the MMED research report mark. The latter was based on comments from the examiners as well the mark obtained.

**BACKGROUND:** LFF was a psychiatrist, sociologist, philosopher, lecturer and author whose versatility, breadth of interests and long list of academic qualifications set him apart. He was a rare intellectual, a creative thinker and a man who was deeply involved in his society and its problems. He had a long and varied

career and was associated with all the major South African universities as well as the University of St Andrews where he graduated in medicine; Oxford, Cambridge and the Hebrew University in Jerusalem (criminology and mental health). He was a member of the New York Academy of Sciences and the South African Association for the Advancement of Science, and had several fellowships: FRSSAF, FSS, FRAI, FRGS and FRCPsych.

He was a representative on the executive committees of numerous learned societies and institutions. Dr Freed, who died in December 1981, established a prize in 1959 to be awarded to the most distinguished postgraduate student for the Master of Medicine degree in Psychiatry ■



Dr Ashleigh Prior

## UNIVERSITY OF CAPE TOWN



### 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 University of the Western Cape (UWC) and 4th year medical students from University of Cape Town (UCT) return as part of their practical training. Our Clinical Services Coordinator, Liesl Hermanus, orientates students to our service and to maternal mental health, introducing them to empathic engagement skills, particularly during labour, with vulnerable clients.

Read more in our June newsletter here: <https://tinyurl.com/h3n4h7my>

In the second half of the year, the Perinatal Mental Health Project (PMHP) worked on a short film titled "No Maternal Health without Mental Health". Together with a doctoral occupational therapy student from Boston University, Leah Smith, we produced

a 22- minute film to support training of maternity health workers. Using a narrative approach, the film demonstrates how to implement mental health promotion, screening, basic psychosocial support and referral for perinatal women with psychosocial needs. It also highlights empathic engagement skills and how health workers may take action for their own self-care. The film content was workshopped with a wide range of experts who greatly helped to inform the final product. The aim of this film is to support the implementation of the new National Maternal, Perinatal and Neonatal Care Guidelines. For these, we have been tasked by the National Department of Health to lead the mental health and respectful maternity care components – due for finalisation in 2023.

For more information on the PMHP in our December newsletter visit: <https://tinyurl.com/45d59n8v> ■



# COMMENTARY ON THE INTEGRATION OF MENTAL HEALTH CARE FOR HCWS 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 support 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. Patients' 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. For the full article visit <https://sajs.co.za/article/view/13904> ■

# RESEARCH PRESENTATIONS AT PSYSSA 2022

BY TONI ABRAHAMS

Members of the division of Intellectual Disability (ID) had the opportunity to attend PSYSSA's 26<sup>th</sup> Annual congress at Emperor's Palace in Johannesburg on 12-14th October 2022. It was the first face-to-face conference hosted by the Psychological Society of South Africa in a few years and presented a wonderful opportunity to connect with colleagues in the field of psychology across the country. This year's theme was "Tending to the seeds of Crisis: Looking to a new horizon of African-centred psychology". The first day was comprised of plenary discussions on challenges to preserving democracy, on what it means to be an African and how to build solidarities with psychology's next generation, with a thought-provoking president's lecture by writer, activist and political analyst Sisonke Msimang.

Prof Sharon Kleintjes chaired a symposium, "Power through participation: Enabling people with intellectual disability to self-advocate", in which three of her current students presented their research work. Babalwa Tyabashe-Pume shared the findings of a study in which she has developed a conceptual framework to inform self-advocacy for policy priorities of adults with intellectual disability, beautifully interwoven with the uniquely African framework of Ubuntu. Cole Goldberg then shared the results of her study which looks at self-advocacy strategies for people with intellectual disabilities in South Africa to empower participation in practical ways. Siphesihle Zihlazi then shared her work on social and health-related policy priorities from the perspectives of adults with intellectual disability. The session ended with a powerful video in which young people with intellectual disability offer the audience insight into their experiences, desires, hopes and dreams. In a session focused on public health,

prevention and policy advocacy, Toni Abrahams shared her findings from a survey of respite care providers for those with intellectual disability to offer some insight into what South African respite care looks like. We were pleased that former divisional member, Siyabulela Mkabile, co-supervisor to Siphesihle's study, also shared his research work on barriers to access to health services for parents of children with intellectual disability and traditional healer's explanatory models of intellectual disability in Cape Town. All in all, the division managed to throw light on the importance of and developments it is making in research in the ID sector in an African way ■



Left to right: Siphesihle Zihlazi, Dr Siyabulela Mkabile, Toni Abrahams, Prof Sharon Kleintjes, Babalwa Tyabashe-Pume and Cole Goldberg.

# FINDING MEANING AND PURPOSE: HOW TO STEP INTO THE YEAR AS A LEADER IN YOUR LIFE

*Peter Laburn*

inevitably, the start of a new year brings with it a renewed sense of promise. Even if you're averse to setting resolutions or intentions, it's difficult to resist the opportunity to reflect on where you're at in your life and what changes might be necessary — and to feel inspired (even temporarily) to make these changes.

As 2023 settles into a groove, and we find ourselves returning to the rat race and our day-to-day routines, that initial flurry of enthusiasm might subside.

WHAT REMAINS, ESPECIALLY AS WE CONTINUE TO REBUILD AFTER THE COVID YEARS, IS PERHAPS A DEEPER SENSE OF REFLECTION AND A MORE EARNEST QUEST: WHO AM I? HOW DO I CONNECT MORE DEEPLY TO MY PURPOSE AND REASON FOR BEING? HOW DO I BECOME A LEADER IN MY LIFE?

These questions can come to us at any point in time, of course, but if they resonate with you now, there are ways to uncover the answers.

## WHAT DOES IT MEAN TO KNOW ONESELF?

To know oneself involves fully appreciating and understanding who we are. Not what we are, but who we are, and who we are not. This entails fully comprehending our values and beliefs, our natural potential, our innate skills and gifts, and what we stand for. It is an intrinsically vulnerable path, and one deeply tied to our authentic lived experience.

Knowing these things about ourselves isn't easy. It takes work and commitment — not just over the new year period, but consistently.

The consequences of not knowing these things about ourselves is that we can spend our lives being defined by something else entirely: another person or our relationship to them, a particular event, or our job title. If we conflate what we do for a living with our identity, our sense of self and possibly even of purpose will always be defined by other people.



*Peter Laburn*

BY PLAYING TO SOMEONE ELSE'S AGENDA, WE'RE LIKELY TO SEE OURSELVES THROUGH THEIR EYES RATHER THAN OUR OWN.

This experience detaches us from our sense of authenticity, and can lead to a protracted experience of not knowing who we are and what we want or need.

## HOW DO WE GO ABOUT FINDING MEANING AND PURPOSE IN OUR LIVES?

There is no easy answer to this. Ultimately, it's a journey.

In practical terms, it involves conducting an honest assessment of different areas of our lives on an ongoing basis. We need to look at what's in balance and why, and seek to introduce these patterns of behaviour to the areas of our lives that are not in harmony. Once again, acting from a point of truth is critical. If we're not honest and authentic with ourselves during this process, we're unlikely to find the insight we need and achieve the change we're striving for.

It can be useful to start this process by looking at all the things that don't serve us, and don't feel true to us. Just as Michelangelo allegedly "chipped away at everything that wasn't David" when he sculpted his masterpiece, we can begin by working on aspects of our life that don't resonate with who we are and the life we envision for ourselves.

IT CAN BE USEFUL TO HAVE SOMEONE SUPPORT YOU DURING THIS PROCESS, AND BOTH LIFE COACHES AND BUSINESS COACHES HAVE AN IMPORTANT ROLE TO PLAY.

### WHAT DOES IT MEAN TO BE A LEADER IN ONE'S LIFE?

Everyone has a natural propensity to be a leader — if not to multiple people, then certainly in their own life. Coming into our own in this position involves distancing ourselves from environments, interactions and people that make us behave in a way that isn't authentic to who we are.

THIS MAY MEAN RECONSIDERING CERTAIN FRIENDSHIPS OR PARTNERSHIPS, OR LEAVING WORK POSITIONS THAT FEEL STIFLING AND UNFULFILLING.

This is not to suggest that such transitions are easy. They may require effort and may take time to achieve. But if we're consistently putting in the work, we're likely to get there over time.

"THERE" ISN'T A DESTINATION OF COURSE; RATHER, IT'S THE POINT WHERE WE FEEL LIKE WE'RE IN THE DRIVING SEAT OF OUR LIVES. AND WHILE TAPPING INTO OUR PURPOSE MAY SEEM SELFISH, THE FACT THAT IT HELPS US TO ENGAGE WITH OTHERS AND CONTRIBUTE TO THE WORLD AROUND US MORE EFFECTIVELY SHOWS THAT IT ISN'T SELFISH AT ALL.

Knowing oneself and finding purposes is a deliberate and intentional journey. It's driven by motivation, and is likely to be both personal and solitary, and supported and fuelled by others.

At its heart, it's about authenticity. Find that truth, and the rest will follow.

**Peter Laburn** is the founder of the transformational leadership movement, Lead with Humanity, and the author of the pioneering book, Leading with Humanity. **Correspondence: email Lauren Hills at [lauren@foxstreetcomms.co.za](mailto:lauren@foxstreetcomms.co.za)** ■



Bronze Winged Mannikins...the happy couple in spring fever. Photo courtesy of Lennart Eriksson, Psychiatrist - Pennington, KZN. [lennarte@iafrica.com](mailto:lennarte@iafrica.com)

# RISK FACTORS FOR DISABILITY DUE TO MENTAL ILLNESS

## – A PSYCHIATRIST'S PERSPECTIVE

*Christoffel Grobler*

**M**ental health disorders are a significant concern for individuals, families, and society as a whole. They impact daily functioning, well-being, and quality of life, often leading to disability and increased healthcare costs. A recent question by a medical advisor as to what the risk factors are for claiming for disability due to a mental health disorder prompted the writing of this article.

THE INSURANCE INDUSTRY PLAYS A CRUCIAL ROLE IN PROVIDING FINANCIAL SUPPORT AND STABILITY TO THOSE AFFECTED BY MENTAL ILLNESS. UNDERSTANDING THE RISK FACTORS ASSOCIATED WITH MENTAL HEALTH DISORDERS CAN HELP INSURERS DEVELOP EFFECTIVE STRATEGIES FOR PREVENTION, EARLY INTERVENTION, AND TREATMENT.

This is essential to alleviate the burden on individuals, their families, and the healthcare system. In this article, we discuss the various biological, psychological, environmental, and social factors contributing to mental health disorders and their implications for the insurance industry. It serves to keep in mind that there are also modifiable risk factors that can be addressed, such as a toxic work environment, to improve mental health outcomes and reduce insurance claims related to mental health disabilities.

### RISK FACTORS FOR DEVELOPING MENTAL HEALTH DISORDERS



*Christoffel Grobler*

It is important to understand that the development of mental health disorders is often influenced by a combination of biological, psychological, and social factors. These factors are complex and multifaceted, but some of the most prominent ones include genetics, brain structure and function, neurotransmitters, and prenatal exposure to stress or substances.

- **Genetics:** Research has shown that mental health disorders can have a genetic component. Family studies, twin studies, and adoption studies have demonstrated that there is often a hereditary component to disorders such as schizophrenia, bipolar disorder, and major depressive disorder. Specific genes may be associated with the development of these disorders, although the exact mechanisms are not yet fully understood.
- **Brain structure and function:** Abnormalities in brain structure and function can contribute to the development of mental health disorders. For example, individuals with schizophrenia may have differences in the size and connectivity of certain brain regions, while those with major depressive disorder may have reduced hippocampal volume. These structural differences may lead to altered neural processing, which can contribute to the symptoms of the disorders.

- **Neurotransmitters:** Imbalances in neurotransmitter levels can also play a role in mental health disorders. Neurotransmitters are chemical messengers that facilitate communication between neurons. Examples include serotonin, dopamine, and norepinephrine. Imbalances in these neurotransmitters can lead to disruptions in mood regulation, motivation, and other cognitive functions.
- **Prenatal exposure to stress:** Exposure to stress or substances during critical periods of fetal development can have long-lasting effects on an individual's mental health.

FOR EXAMPLE PRENATAL EXPOSURE TO ALCOHOL OR DRUGS, CAN INCREASE THE RISK OF DEVELOPMENTAL AND PSYCHIATRIC DISORDERS.

**Psychological risk factors** are rooted in an individual's emotions, thoughts, and behaviours, and can interact with biological and environmental factors. Some of the key psychological risk factors include:

- **Early life experiences:** Adverse childhood experiences, such as physical, emotional, or sexual abuse, neglect, separation or witnessing violence, can significantly impact an individual's mental health. These experiences can lead to the development of maladaptive coping mechanisms, which in turn may increase the risk of mental health disorders later in life. Moreover, these experiences can affect brain development, further contributing to the vulnerability to psychiatric disorders.
- **Personality traits:** Specific personality traits may predispose individuals to mental health disorders. For example, high levels of neuroticism, characterized by emotional instability and a tendency to experience negative emotions, have been linked to an increased risk of depression and anxiety disorders. Similarly, traits like impulsivity, introversion, and perfectionism can also contribute to the development of various mental health disorders.
- **Coping styles:** Ineffective coping strategies can exacerbate mental health issues. For instance, emotion-focused coping, such as avoidance, denial, or wishful thinking, may be less effective in managing stress and can contribute to the development of mental health disorders.

ON THE OTHER HAND, PROBLEM-FOCUSED COPING, WHICH INVOLVES ADDRESSING THE ROOT CAUSE OF THE STRESSOR, MAY BE MORE ADAPTIVE AND PROTECTIVE AGAINST MENTAL HEALTH ISSUES.

- **Thinking patterns:** Certain repetitive patterns of thinking can predispose an individual to

developing mental health disorders. These include negative self-schema, cognitive distortions, and rumination. Negative self-schema refers to a set of beliefs about oneself that are negative and pervasive. Cognitive distortions are irrational thought patterns that can lead to maladaptive emotions and behaviours. Rumination is a repetitive, negative pattern of thinking that can contribute to the maintenance and exacerbation of depressive and anxious symptoms.

UNDERSTANDING PSYCHOLOGICAL RISK FACTORS CAN HELP BETTER IDENTIFY AT-RISK INDIVIDUALS, DEVELOP TARGETED INTERVENTIONS, AND PROVIDE APPROPRIATE SUPPORT AND TREATMENT.

Additionally, fostering resilience and promoting adaptive coping strategies can help mitigate the impact of these psychological risk factors and improve mental health outcomes for patients.

There are also **environmental and social risk factors** that contribute to the development of mental health disorders. These factors are critical components of the biopsychosocial model of mental health, which posits that biological, psychological, and social factors interact to influence an individual's mental well-being.

- **Socioeconomic factors:** Socioeconomic status (SES) is a significant determinant of mental health. Low SES is associated with increased risk of developing mental health disorders, as it often involves limited access to resources, increased exposure to stressors, and reduced social support. Poverty, unemployment, and low levels of education can all contribute to increased vulnerability to mental health issues.
- **Social support:** Social support plays a crucial role in mental well-being. Supportive relationships with family, friends, and the community can act as a buffer against the negative effects of stress and adversity.

CONVERSELY, SOCIAL ISOLATION AND A LACK OF SOCIAL SUPPORT ARE ASSOCIATED WITH AN INCREASED RISK OF DEVELOPING MENTAL HEALTH DISORDERS, SUCH AS DEPRESSION AND ANXIETY.

- **Life events:** Significant life events, both positive and negative, can impact an individual's mental health. Events such as the loss of a loved one, divorce, or serious illness can lead to increased stress, vulnerability, and the development of mental health disorders. Even positive events, like getting married or starting a new job, can generate stress and contribute to mental health issues.

- **Traumatic events:** Experiencing traumatic events, such as natural disasters, accidents, or interpersonal violence, can have a profound impact on an individual's mental health. These experiences can lead to the development of post-traumatic stress disorder (PTSD), depression, anxiety, and other psychiatric conditions. The risk of developing mental health disorders following trauma is influenced by factors such as the severity of the event, pre-existing vulnerabilities, and the availability of social support.
- **Repeated multiple traumas:** Individuals who experience multiple traumas, such as childhood abuse, domestic violence, or combat exposure, are at increased risk of developing mental health disorders.

REPEATED TRAUMAS CAN RESULT IN A CUMULATIVE EFFECT, LEADING TO HEIGHTENED VULNERABILITY, INCREASED SYMPTOM SEVERITY, AND A GREATER LIKELIHOOD OF DEVELOPING CONDITIONS LIKE PTSD, DEPRESSION, OR ANXIETY.

- **Ongoing stress:** Chronic stress from various sources, such as financial difficulties, interpersonal conflicts, or caregiving responsibilities, can have detrimental effects on mental health. Over time, ongoing stress can lead to dysregulation of the body's stress response system, which can contribute to the development of mental health disorders like depression, anxiety, and other psychiatric conditions.
- **Substance abuse:** The use of drugs or alcohol can contribute to the development of mental health disorders, either directly by affecting brain function and neurotransmitter systems, or indirectly by exacerbating existing vulnerabilities and impairing coping mechanisms.

SUBSTANCE ABUSE CAN ALSO RESULT FROM AN INDIVIDUAL'S ATTEMPT TO SELF-MEDICATE OR COPE WITH EXISTING MENTAL HEALTH ISSUES, CREATING A VICIOUS CYCLE THAT FURTHER EXACERBATES BOTH CONDITIONS.

- **Work-related factors:** Job-related stressors, such as high demands, low control, and lack of social support, can contribute to mental health problems. Burnout, characterized by emotional exhaustion, cynicism, and reduced personal accomplishment, is a common consequence of chronic work stress and can lead to increased risk of depression and anxiety.
- **Disrupted sleep patterns:** Sleep is essential for maintaining mental health, and disrupted sleep patterns can significantly impact mental well-being. Insomnia, sleep apnea, and other sleep

disorders can contribute to the development or exacerbation of mental health disorders such as depression, anxiety, and bipolar disorder. Furthermore, irregular sleep schedules, common in shift workers, can negatively affect mental health by disrupting the body's natural circadian rhythms.

- **Stigma:** Cultural norms, values, and expectations can shape the way individuals express and cope with psychological distress. Stigma around mental health issues, for example, can prevent individuals from seeking help, exacerbating their symptoms and increasing the risk of developing mental health disorders.

In the context of disability claims, it is of utmost importance to acknowledge the influence of a toxic work environment on mental health.

A TOXIC WORK ENVIRONMENT IS CHARACTERIZED BY POOR LEADERSHIP, FREQUENT CONFLICTS, EXCESSIVE COMPETITION, LACK OF APPRECIATION, AND HIGH LEVELS OF EMPLOYEE TURNOVER.

Employees in such an environment may experience increased stress, anxiety, and burnout, leading to a higher risk of developing mental health disorders. Factors contributing to a toxic work environment can include micromanagement, harassment, discrimination, unrealistic expectations, and excessive workloads.

Addressing factors contributing to a toxic work environment and promoting a healthy work culture can help reduce the risk of mental health problems among employees and create a more supportive and inclusive environment for all workers.

RECOGNIZING AND ADDRESSING WORKPLACE FACTORS CONTRIBUTING TO MENTAL ILL HEALTH IS CRITICAL FOR THE INSURANCE INDUSTRY TO DEVELOP STRATEGIES THAT EFFECTIVELY SUPPORT INDIVIDUALS WITH MENTAL ILLNESS AND MINIMIZE THE COSTS ASSOCIATED WITH DISABILITY CLAIMS.

## IMPLICATIONS FOR THE INSURANCE INDUSTRY

### Customized Coverage:

By understanding the risk factors associated with various mental disorders, insurers can create tailored coverage options that address specific vulnerabilities. For example, policies could include coverage for targeted interventions that address modifiable risk factors such as tobacco and cannabis use, physical inactivity, or social isolation.

### Wellness Programs and Incentives:

Insurers can develop wellness programs that

promote healthy behaviours linked to a reduced risk of mental disorders. By offering incentives to policyholders who participate in these programs, insurers can encourage preventative measures that contribute to better mental health outcomes and reduced claims.

**Early Intervention Strategies:**

By identifying and addressing risk factors early, insurers can help clients manage their mental health more effectively and minimize potential claim costs.

INSURERS CAN COLLABORATE WITH HEALTHCARE PROVIDERS TO DEVELOP EARLY INTERVENTION PROGRAMS THAT TARGET MODIFIABLE RISK FACTORS AND LEVERAGE DIGITAL TECHNOLOGIES TO MONITOR PROGRESS AND ENGAGEMENT.

**Mental Health Education:**

Insurers can play a role in raising awareness about the risk and protective factors for mental disorders. By offering educational resources and hosting webinars, insurers can help clients understand the importance of addressing modifiable risk factors and making informed choices about their mental health.

**Collaboration with Healthcare Providers:**

Insurers can work closely with healthcare providers to implement evidence-based workplace mental health programs and strategies for mental health promotion and prevention.

**Early return to work with the assistance of reasonable accommodation and occupational therapy input:**

Insurers can facilitate clients' early return to work by providing coverage for necessary accommodations and occupational therapy services. This approach can help individuals regain a sense of purpose and normalcy while reducing claim costs.

**Vocational rehabilitation after illness absence from work:**

Insurers can support clients in transitioning back to work after a mental health-related absence by providing coverage for vocational rehabilitation services. This assistance can help individuals develop new skills and adapt to the workplace, leading to better long-term mental health outcomes.

**Abolishment of waiting periods for claim payout:**

Reducing or eliminating waiting periods for claim payouts can decrease financial stress and increase access to much-needed psychiatric help for vulnerable and distressed individuals whose salaries have been stopped.

**Preventative strategies:**

Insurers can invest in preventative strategies that address modifiable risk factors for mental health

disorders. For example, coverage could include access to stress management courses, counseling services, and support for healthy lifestyle changes.

**CONCLUSION**

Understanding the risk factors for mental health disorders is essential for the insurance industry in order to develop effective strategies that support individuals with mental illness.

BY ADDRESSING MODIFIABLE RISK FACTORS AND PROMOTING EARLY INTERVENTION AND PREVENTATIVE MEASURES, INSURERS CAN CONTRIBUTE TO IMPROVED MENTAL HEALTH OUTCOMES, REDUCED CLAIMS, AND A HEALTHIER SOCIETY. COLLABORATING WITH HEALTHCARE PROVIDERS, OFFERING EDUCATIONAL RESOURCES, AND SUPPORTING CLIENTS THROUGH VOCATIONAL REHABILITATION AND EARLY RETURN TO WORK INITIATIVES ARE JUST A FEW WAYS THE INSURANCE INDUSTRY CAN MAKE A POSITIVE IMPACT ON MENTAL HEALTH.

It is crucial not to underestimate the impact of a toxic work environment as a risk factor contributing to disability due to mental illness. This potentially modifiable risk factor can be addressed through targeted interventions, such as workplace mental health programs that focus on promoting a supportive and inclusive work culture.

By implementing strategies like employee training on mental health awareness, fostering open communication, offering flexible work arrangements, and providing access to counseling services, employers can mitigate the negative effects of a toxic work environment.

IN TURN, THE INSURANCE INDUSTRY CAN BENEFIT FROM REDUCED CLAIMS RELATED TO WORK-RELATED MENTAL HEALTH DISORDERS, WHILE CONTRIBUTING TO HEALTHIER, MORE PRODUCTIVE WORKPLACES FOR THEIR CLIENTS.

Prioritizing early intervention and a proactive approach to mental health, insurers can foster a more resilient and healthier population, leading to a reduction in long-term healthcare costs and improved quality of life for their clients.

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# OF BREAKING SILENCE AND BUILDING BRIDGES

*Claudia Campbell*

**T**RAPPED!!!! I have felt the effects of the trapped-ness that the trauma of violent sexual trauma slams me with for much of my life, but over the last while I have begun to understand, on a different level, how the silenced, hidden, unspoken, shadowy experience of violation punches into my being.

The concept of squashing human experience, illness and even recovery into various medical silos is not something new to me. The tug of war between my body and mind has been clear for years. 'It's as if the trauma lives in your cells Claudia' could not have been a truer comment made by my therapist a few years ago. 'Trauma', that psychiatric and psychological monster is something that is acknowledged, but it's not something that is often willingly spoken about outside the ambits of mental health care.

AS THE PATIENT, IT'S FLIPPING HARD TO SPEAK ABOUT THE HORRORS OF WHAT HAPPENED TO ME. PERHAPS IT'S AN UNDERSTATEMENT TO SAY IT'S HARD, IT HAS OFTEN BEEN IMPOSSIBLE. SPEAKING OPENLY TO A NEW DOCTOR HAS, UP UNTIL NOW, REMAINED AN ALMOST INSURMOUNTABLE OBSTACLE.

'The time for silence is now over' has become my mantra. It sounds like such a courageous and resolute statement - but it does not in any way feel that way. It feels terrifying. The terror includes a feeling of being washed with shame. I guess it's easy to think the shame is solely linked

to what happened to me. But it's not, it is also attached to the silence that I feel I have allowed to stalk me. 'Oh no, Claudia! It's not at all like that'. I know this is true. Again though, feeling it is a tough ask at the moment. I have not managed to build the bridge between cognitive understanding and visceral experience yet. The bridge that says silence is not shame.



*Claudia Campbell*

Additionally, to tear the gag off my mouth to break through the silence is excruciating. I don't feel it in my brain, I feel it in the heavy and humiliating pain in my heart... but do I? Migraines being a symptom of the assault is a concept I have been able to, for the first time, explore with a doctor outside the realm of traditional mental health care.

TREATING THE TRAUMATIC SYMPTOMS OF THE RE-EXPERIENCE OF ASSAULT WITHOUT MEDICATION IS TOUGH, AND IT IS A VERY DESOLATE, REMOTE, LONELY PLACE. IT'S NOT GOOD SOLITUDE, IT'S DEAFENING SILENCE.

I often wish I could swallow a pill to help the feelings of terror subside enough to take a breath, regroup, and face the challenge ahead of me with a little more strength. I don't have that though. So, talking becomes my 'medication', it's the thing that helps me take a breath, realize that there are hands willing to hold mine, if I let them.

Historically, hoping to rely on others has proved disappointing and damaging. However, I am now beginning to see that the hands outstretched do not belong to the same people. Throughout my medical journey I have balked at the idea that I am anyone's 'job', simply a means for them to make a living. It's an unfair idea. Sure, being a 'job' is part of what this process is, but it's not all of it. Traditionally, a neurologist is not expected to explore my world of terror but that is what is happening – I think it's a hand and I'm trying my best to trust it enough to believe it's safe. The thing is, I don't trust it yet. Despite this I've ploughed ahead and ripped open the story enough for another person to see, a person I don't know yet. This is an entirely new thing for me. As much as it feels like a process headed in the right direction, it also feels soaked with trepidation.

**BUILDING TRUST, BUILDING HEART-MIND BRIDGES, OPENING THE GAP IN THE CURTAINS OF MY MIND, AND THE WINDOW TO MY HEART – IT'S HARD AND SOMETIMES UNFORGIVING WORK. BUT, IF I'M GOING TO STAY TRUE TO 'THE TIME FOR SILENCE IS NOW OVER' I HAVE TO TRY AND TRY MY DARNDDEST.**

I'm not sure if it's fair to say that this morning I needed a brave doctor to plunge into my 'trauma' experience and breach my mental blockades. I found it quite difficult to wrap my head around the conversation that we had – what I said and how it was received. Ordinarily it's a situation where my barricades are so firmly planted that entry remains closed, because opening the door to my mind and walking into it feels sacred, albeit muddy. I've never allowed a total stranger into this space before. I remain cautious to trust and believe I have done the right thing.

**FOR TODAY I AM TRYING TO BELIEVE THAT THE DIFFICULTIES OF THIS ROOM, THE WIRES, THE LACK OF MOVEMENT, THE DEPRIVATION OF NATURE WILL BE WORTH IT IN THE LONG RUN.**

**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) ■



We are focused and sharp! Crowned Hornbill. Photo courtesy of Lennart Eriksson, Psychiatrist – Pennington, KZN, [lennarte@iafrica.com](mailto:lennarte@iafrica.com)

# DEPRESSION AND SUICIDALITY IN ADOLESCENTS AND CHILDREN – SHOULD OUTPATIENT KETAMINE INFUSION BE CONSIDERED?

*Maria Dobreva*

**D**epression is a common mental health disorder in children and adolescents. The prevalence is around 3% in younger children and about 8% in adolescents. The prevalence of depression in this age group is increasing and is often underreported and underdiagnosed in younger children.

Clinical severity can vary, and childhood depression can present in a number of ways. Major depressive disorder (MDD) is associated with functional impairment in the crucial phase of childhood development.

Risk factors for childhood depression are multiple. They include a positive family history of depression, previous history of depression or suicide, concomitant mental health disorders, chronic medical illnesses, obesity, body image disorders, female gender, child abuse or neglect, adverse childhood experiences, poor school performance, loss of a family member or loved one, low socioeconomic status, uncertainty about sexual orientation, break up of a romantic relationship, family problems and other adverse childhood experiences (ACEs) at a younger age, with multiple ACEs leading to more severe depression.

Children with depression can have concomitant mental disorders such as anxiety, conduct disorder, oppositional defiant disorder, ADHD, or substance use disorder. Early diagnosis and effective treatment of depression in children is paramount.

Globally, suicide rates among children and adolescents are increasing. They have surpassed deaths due to MVAs. 7 in 100 000,00 children die of suicide. More than 80% of children who attempt suicide are not identified as 'at risk' by paediatricians in routine visits months before the suicide attempt. Hence, depression and suicide in children constitute a major global public health problem.

According to one study, suicidal thoughts in children are linked to a more problematic course of the depression, including earlier onset, longer duration, and shorter intervals of remission.

Not all depressed children will have suicidal thoughts or show suicidal behaviour. Also, not all children with suicidal thoughts or behaviour are depressed.



*Maria Dobreva*

Some important warning signs of potential suicidal ideation in children are:

- Aggressive or hostile behaviour
- Anxiety or restlessness
- Change in personality
- Hopelessness
- Shame, guilt, self-hatred
- Frequent statements on social media about self-harm
- Neglect of personal appearance
- Preoccupation with death (writing/drawing)
- Reckless or risk-taking behaviour

Management of depression in children includes counselling, traditional antidepressant medications, psychotherapy, and possibly other therapeutic modalities.

## THE TREATMENT SHOULD INVOLVE SHARED DECISION MAKING WITH THE PATIENT AND THE FAMILY.

Ketamine is the most widely used procedural sedative worldwide (particularly in children), in both first and third world countries, and has a safety record spanning half a century. Low dose, outpatient ketamine infusions are recognised as an effective way to reverse suicidal ideation (in around 75% of patients after a single infusion) and has recently been endorsed by the South African Society of Psychiatrists (SASOP) as an effective treatment option for 'Treatment Resistant Depression' (TRD). Given ketamine's proven safety record in children (at much higher used dosages) and the increasing incidence of depression and suicidal ideation in children, does ketamine infusion therapy (KIT) in children not deserve much closer scrutiny?

## THERE IS A PAUCITY OF PUBLISHED RESEARCH EXAMINING THE EFFICACY OF KIT IN DEPRESSED, SUICIDAL CHILDREN, WHILE THERE IS AN ABUNDANCE STUDYING THIS IN ADULTS.

I present three brief case studies involving children whom I referred to a KetaMIND outpatient clinic, and a testimonial from the mother of a suicidal teenage girl who completed a series of ketamine infusions. In my opinion, the efficacy of this treatment in children should not be overlooked. These cases demonstrate that KIT can offer a safe and rapid solution, particularly when suicidal ideation is at the forefront.

### CASE STUDY 1

Piet – 11 Years old

Piet was brought to me in May 2022 for assessment and treatment (referred by his psychologist).

His parents are both high achievers. The mother, (who brought Piet) was very distressed and tearful.

It transpired that Piet had been severely depressed for a long time and had been verbalizing strong suicidal ideation (“I don’t want to live”) Piet was a premature baby. Mom worked throughout her pregnancy and never rested, as her job is rather demanding. She admitted that she never bonded with either of her sons (age 11 and 9). Piet went to creche at 18 months and began displaying “behavioural problems”. In primary school he was disruptive and restless. The pediatrician diagnosed ADHD and initiated Ritalin LA. The response was minimal.

He was bullied at school for years. When I first saw him, the mother was falling apart, trying to cope with the demands of a busy job and controlling 2 boys with behavioural problems. Piet’s suicidal ideation was rather alarming.

I commenced him on Serdep 25mg and carried on with Ritalin LA 30mg. Piet had his first infusion on the 03.06.2022. His PHQ 9 before the first infusion was 18/27. The response was remarkable. Compared to his mental state prior to the infusion, when he hardly spoke and drew pictures of scary black creatures, he began smiling and drawing colorful pictures of birds. He became calm and friendly, expressing love for his parents and brother.

He had a top up infusion on 17.06.2022 during which he kept on repeating to his dad “I Love You Dad”.

When I saw him on 31.08.2022 he was friendly, cooperative, and engaging.

His account of the Ketamine experience was “*I saw colourful beautiful fish as well as turtles. They were swimming in the ocean and wanted to be my friends. I felt happy and my heart was warm. I never saw the spooky dark faces I used to see before.*”

Piet looked and behaved like a totally different child. His family was relieved and extremely grateful.

### CASE STUDY 2

Kayleen – 8 years old.

Kayleen was referred to me by her therapist in October 2021. It was reported that she began looking unwell a month prior to that – appeared fatigued, pale, despondent, and not her usual bubbly self. She shared with her therapist that she did not want to live anymore and was thinking of ways to end her life either by stabbing herself, shooting herself or throwing herself under a moving car.

When I assessed her, she was cooperative and spoke to me at ease.

Kayleen confessed how “sore” her heart was. “*If magic was possible, I would love my mom and dad to be together like when I was younger*” she shared tearfully.

The trigger for her depression was an acrimonious divorce and ongoing disagreements between her parents. There was a family history of depression and suicide attempts.

With the help of her mom the PHQ-9 was completed and the initial score was 22/27. I initiated escitalopram 5mg mane and referred her for a ketamine infusion. She responded remarkably well. The suicidal ideation/ intent subsided almost immediately, and she was her old self again. Her depression escalated again in December 2021. She confided in her therapist that she would be better off dead, as she “*wouldn’t feel the guilt*” “*Being in heaven would be better*”.

Both her therapist and I were now seriously concerned, as her suicidal plans became even more elaborate. A second Ketamine infusion was administered at the end of December 2021. Her PHQ -9 scores dropped to 0/27. Her mother was so relieved and excited she took her daughter to the beach, and they spent a lovely day together.

Kayleen’s smile was back on her face, and she returned to normal activities, showing interest in her hobbies and pets, acting like a normal happy child. I assessed her progress recently.

She remains euthymic and despite the ongoing parental discord, Kayleen is surprisingly resilient and grounded. She proudly told me that she is raising funds towards a pair of love birds, once her coin jar is full. She has remained depression free to date.

### CASE STUDY 3

Angela – 13 years old.

I first saw Angela at the end of July 2022. She is a scholar at a popular private school in town. She is one of three children raised by her mother.

Her parents divorced when she was eight. Her father suffered severe mental illness for many years (? Schizophrenia). The trigger factors for her depression were the breakup of mom's relationship with her partner, the death of a beloved pet and academic pressure at school.

She presented with emotional numbness, anhedonia, academic underachievement, anxiety, panic attacks, insomnia, and low appetite. She was already on Serdep 50mg at the time I saw her but remained anhedonic and depressed.

I had suspected an underlying ADHD, which was only diagnosed at her last appointment with me a month previously. The clinical presentation and possible ADHD symptoms led me to initiate Wellbutrin, starting at a low dose.

Due to the severity of her depression, I referred her for a Ketamine infusion. Her PHQ- 9 prior to her first infusion was 23/27 (29.07.2022). She subsequently had 2 more infusions.

16.09.2022 PHQ-9 19/27 (before infusion)

30.09.2022 PHQ-9 16/27 before the 3<sup>rd</sup> infusion.

When I saw her on 10.10.2022, her mood was significantly better, and her PHQ-9 had dropped to 3/27. However, she reported trouble concentrating and complained that her mind felt like a "washing machine". Once she completed the ADHD self-report scale it became evident that she had severe ADHD (15 of the 18 symptoms) and fell in the range moderate to severe. I subsequently initiated a long-acting Methylphenidate (Contramyl XR 36mg) and stopped her Wellbutrin. She has responded exceptionally well.

I asked Angela to write about her experience with Ketamine and this is what she wrote:

*"Before Ketamine, I felt hopeless and constantly down, like there was no point to continue. During the Ketamine treatment I felt so happy and free, I felt like I didn't have any worries and that nothing should have the power to get me down. The weight was removed off my shoulders and it didn't seem impossible to do basic things. I felt better and thought it was a little unfair that some people get to feel like this every day! I found that it wasn't as difficult to find motivation to continue".*

Despite ongoing family stressors and pressure at school, Angela is coping well, and her academic performance has improved greatly.

**The following is a brief account of a mother's harrowing experience with her 14-year-old suicidal daughter who tried to hang herself in a bathroom. She subsequently presented for a series of 40-minute ketamine infusions at a KetaMIND (KCSA) clinic. Identities have been protected.**

Dear KetaMIND,

Below is a short account of my experience with the ketamine treatment that Belinda underwent,

My daughter was a free spirited, fun loving gregarious child up until the end of her grade 7 year, when she started showing signs of severe depression. For a year her depression became progressively worse. She started cutting herself. She retreated into a dark, sad world of her own.

We tried psychologists and psychiatrists and so many different types of medication to help her, but nothing seemed to help. At the end of her grade 8 year at school, when she turned 14, she tried to commit suicide and we had to place her in a psychiatric hospital for adolescents in Stellenbosch. Three days after her release from the hospital she cut herself so badly that she needed to go to casualty at our local hospital. Both the attending psychiatrist and emergency room doctor recommended ketamine infusion therapy.

We were surprised to hear that there was a KCSA Ketamine clinic nearby, and after intense research and speaking to the National Director of Ketamine

Clinics of South Africa (Dr Howard) decided that we would try the treatment. My daughter underwent 6 treatments with 3-4-day intervals. The day after her first treatment the family noticed a remarkable improvement in her disposition. My daughter wanted to have friends over for a play date. This was a major breakthrough. We were sceptical that it was a result of the treatment, as the effect was so immediate but were absolutely taken aback by the improvement after each of the 6 treatments. She started listening to music, socialising with her friends, laughing (something we haven't heard for a year). She is enjoying going to school and is doing art in her spare time. She is the carefree child that we used to know.

Ketamine treatment has been such an amazing breakthrough and together with her psychologist and psychiatrist I truly believe that this has saved her life.

KCSA you have no idea how appreciative we are of this incredible gift which you have given us. You have given us our daughter back.

Kindest regards,

*Belinda's Mother*

*Informed consent for publication was obtained from both parents and children. References can be obtained from the author.*

**Maria Dobрева** is a psychiatrist in private practice and has practiced in the Natal Midlands for over 20-years. **Correspondence:** [mariadobрева43@gmail.com](mailto:mariadobрева43@gmail.com) ■



Society of Ketamine Practitioners of South Africa

SELECTION | SAFETY | SETTING

# CHOOSING A **KETAMINE** **INFUSION** PROVIDER CAN BE A **MINEFIELD...**

As has happened in the USA, since the endorsement of ketamine infusion therapy (KIT) as an effective treatment for Resistant Depression (TRD) by the likes of the American Psychiatric Association (APA), it is anticipated that there will be an explosion of ketamine providers in South Africa in the near term. There are already early signs of this.

Nasal esketamine was approved by the FDA back in 2019 and recently (under stringent conditions) by SAHPRA here in South Africa. An 'Implementation Checklist' was published in the American Journal of Psychiatry, and similar guidance on outpatient ketamine administration has been released by the South African Society of Psychiatrists (SASOP).

There is little that can be done to regulate the off-label use of racemic ketamine for TRD. Inadequately experienced and unqualified providers will be (and have already begun) jumping on the outpatient ketamine bandwagon. Administration of intramuscular ketamine in an unmonitored environment, administration of ketamine by nurses, combining ketamine with other compounds and administering high-dose intravenous boluses are some of the practices that can place patients at risk.

REPRESENTATIVES FROM SOKEPSA, THE KETAMIND GROUP AND SASOP ARE IN ADVANCED DISCUSSIONS WITH MAJOR FUNDERS (SUCH AS DISCOVERY HEALTH) TO DEVELOP GUIDANCE AND OVERSIGHT THAT WILL LEAD TO BENEFITS FOR APPROPRIATELY SELECTED PATIENTS AT ACCREDITED OUTPATIENT CLINICS.

- Is the clinic accredited by The Society Of Sedation Practitioners of South Africa (SOSPOSA)?
- Is the route of administration endorsed by SASOP?
- Does the provider make unsupported claims about efficacy?
- Does the clinic monitor patient progress and provide feedback?
- Will the clinic motivate for and assist with claims from funders?

View the url below for helpful guidance for patients when it comes to selecting a safe ketamine provider:

<https://tinyurl.com/uxxukbxz>.



# NIHILISTIC DELUSIONS IN A PATIENT WITH PELVIC ORGAN PROLAPSE

*Sarah Brown, Christoffel Grobler*

**S**tudies have shown that most psychiatric patients do not receive thorough physical examinations (Baillon S, 2020; Murray J, 2015). This may be due to a lack of gold standards for such examinations, time constraints, fear of exacerbating a patient's agitation, and a lack of equipment in psychiatric wards for conducting physical examinations.

While psychiatrists believe they are competent in physical examination skills, they admit that their skills have declined since working in psychiatry (Baillon S, 2020). Murray and Baillon (2013) found that psychiatric patients generally receive less detailed physical examinations than other patients. This may be because physicians assume that changes in mental status are caused solely by mental illness.

When psychiatric patients present with somatic complaints, the treating physician may focus on the psychiatric condition rather than making a proper somatic diagnosis, hindering efforts to elicit a history of possible alternative physical diseases (Sokal J, 2004). Hodgson (2004) found delays in performing physical examinations of psychiatric inpatients. It was reported that if a patient's mental state on admission prevents physical examination, there is a higher risk that the patient will not be examined during their inpatient stay (Hodgson R, 2004).

However, it must also be noted that there are sometimes legitimate reasons for postponing a physical examination upon admission to a psychiatric inpatient unit, such as a lack of cooperation or refusal to be examined (Vanezis A, 2010).

## PSYCHIATRIC PATIENTS ARE NO LESS AT RISK OF DEVELOPING GYNAECOLOGICAL CONDITIONS.

One study in South Africa found a psychiatric morbidity rate of 21% in a general hospital, including gynaecology wards, which is consistent with other international studies (Al-Atram, 2018; Nair MG, 1997; Scott et al., 2021).

## PELVIC ORGAN PROLAPSE AND GYNAECOLOGICAL EXAMINATION

The diagnosis of pelvic organ prolapse is based on a thorough history and physical examination. A patient may complain of vaginal symptoms such as pelvic pressure or heaviness, urinary or bowel dysfunction, or a sensation of something protruding from the vagina (Raju R, 2021). A history of recurrent bladder infections, chronic constipation, urinary incontinence, incomplete bladder emptying, or an overactive bladder may raise suspicion of pelvic organ prolapse.

During the gynaecological history taking, it is important to address topics that may make the patient feel uncomfortable or hesitant to discuss, such as sexual dysfunction, vaginal dryness, obstructed intercourse, and dyspareunia (Raju R, 2021). Physical examination is important for making a diagnosis of pelvic organ prolapse. This includes an abdominal examination and a pelvic examination.

If suspicion is high, a speculum examination must be performed to assess the extent of the prolapse (Raju R, 2021). A Valsalva manoeuvre can also be performed once the speculum has been removed to assess apical descent (Iglesia CB, 2017). The literature is unclear on when to perform a vaginal examination in asymptomatic women (Bloomfield HE, 2014; McNicholas C, 2017; Stewart RA, 2006; Stormo AR, 2012).

**HOWEVER, IT IS IMPORTANT TO REMEMBER THAT PELVIC ORGAN PROLAPSE MAY ALSO PRESENT ASYMPTOMATICALLY AND HAS OFTEN BEEN FOUND INCIDENTALLY ON EXAMINATION. IT HAS BEEN REPORTED THAT WOMEN ARE USUALLY NOT SYMPTOMATIC UNTIL THE LEVEL OF THE HYMENAL REMNANT IS REACHED (RAJU R, 2021).**

#### CASE STUDY

A 57-year-old female patient presented to a designated psychiatric facility in South Africa, with an admission diagnosis of bipolar mood disorder with psychosis (based on her previous admission). Her husband gave a collateral history that since 2017 she has complained that "she is dying inside" or that she feels as if "she is dying". She had been seen by multiple doctors, psychiatrists, and psychologists privately and had also had a previous admission to a private psychiatric hospital.

On admission, the patient admitted that she had been defaulting on her medication since January 2022. She also reported a somatic complaint of feeling ill, with a painful stomach and difficulty swallowing. The patient also reported a low mood for the previous 6 months. Her medical history included a query of peptic ulcer disease and/or hiatal hernia. Examinations of the central nervous system, cardiovascular system, respiratory system, and abdominal system were performed. The abdominal examination results indicated that her abdomen was soft and non-tender, with no organomegaly felt. She was then admitted to the female acute psychiatric ward.

During her admission, the patient was assessed once or twice a week and received an assessment for any issues raised on the ward. On her assessments, she spoke about ongoing hallucinations and consistently displayed poor insight and judgement. However, a somatic complaint of stomach pain was consistently reported. This complaint took the

form of stomach pains, feeling "dead inside," or right flank pain.

This somatic complaint of stomach pain was assessed in each evaluation of the patient, with more than 5 abdominal exams performed over a period of 8 weeks before a per vaginal examination was done. Only then was it discovered that the patient had a Grade 3 pelvic organ prolapse. Her last complaint was of constipation, with again, an insignificant physical examination. The doctor then performed a rectal examination and a vaginal examination.

The vaginal examination revealed the presence of a pelvic organ prolapse, which was confirmed by a positive Valsalva manoeuvre. The patient was then discussed and transferred to the Gynaecology Emergency Unit at another tertiary hospital. Her diagnosis before leaving the psychiatric inpatient hospital included Bipolar Mood Disorder, with her most recent episode having psychotic features, as well as peptic ulcer disease and a hiatal hernia.

#### DISCUSSION

Psychiatric treatment choices, therapeutic responses, and risk of polypharmacy (especially for pain management) can be influenced by unexplained somatic symptoms. This highlights the importance of identifying underlying physical disease in psychiatric patients in order to optimize all aspects of their care.

Studies have found significant rates of physical disease after a thorough medical examination in psychiatric patients (Koran LM, 2002; Murray J, 2015). It has been shown that people with severe mental illness have a high risk of comorbid physical health problems, many of which go undetected (Baillon S, 2020; Hodgson R, 2004; Koran LM, 2002; Phelan M, 2001; Sokal J, 2004).

Furthermore, psychiatric patients are less likely to seek out help for their somatic complaints or illness. When psychiatric patients do seek medical care, lack of social skills and stigma surrounding the patient have been shown to make it unlikely for a physical illness to be detected (Pettipher A, 2015). A meta-analysis found that persons with Bipolar Spectrum Disorder experience somatic symptoms at nearly double the rate of the unipolar Depression control group and that they are highly prevalent (Edgcomb JB, 2016). The psychotic features the patient was noted to have, were described as known, persistent, and fixed delusions about herself "dying." In the notes, there was no further elaboration on the cause of this.

While the patient was clear and consistent with her somatic complaint of abdominal pains, perhaps she was unable to express her symptoms in a way that would warrant clinical suspicion of a pelvic prolapse. An issue found in psychiatric patients is that they have difficulty explaining their symptomatology, which may be due to cognitive deficits, poor social skills, or symptomology of their illness (Baillon S, 2020). After multiple weeks

of somatic complaints with uneventful physical findings, it may have been useful to consult with family medicine or internal medicine for further diagnostic investigation.

A study by Murray included a questionnaire given to all psychiatrists, and one of the questions was whether the physician performed a vaginal examination during their physical examinations. 2% of the respondents replied with the answer "always" while 78% of the respondents chose the option "if the patient complains of symptoms" (Murray J, 2015). While there is no clear recommendation on when to do a vaginal examination on an asymptomatic patient, this makes it even more difficult in a psychiatric context.

### NOT ONLY IS IT DIFFICULT TO RECEIVE AN ADEQUATE HISTORY THAT WOULD RAISE CLINICAL SUSPICION OF A VAGINAL ISSUE, BUT IT IS ALSO DIFFICULT TO PERFORM AND GAIN CONSENT FROM THE PATIENT.

This brings up the dilemma of consent in an actively psychotic patient, that is, if the psychotic patient has poor judgement, how can one weigh the benefits of an examination that is not indicated?

While Bailon found that psychiatrists do believe they are competent in their examination skills from the study he conducted with psychiatrists regarding their physical examinations, it was mentioned that a structured form to document the examination findings would be beneficial. Guidance for conducting physical examinations, especially more invasive in nature, needs to be documented and suggested in a stepwise manner.

The physician who did the vaginal examination on the patient did so after the patient complained about constipation. Since complaining about constipation, with no reveal on abdominal examination, a rectal examination was performed. After this, the physician decided to perform a vaginal examination, which incidentally revealed the pelvic organ prolapse.

From this, it is clear that psychiatric inpatients should undergo a thorough physical examination to attempt to screen for any undetected or possibly missed medical issues. The monitoring of physical health of psychiatric inpatients should be as important as their mental health. It is important to pay attention to physical complaints in psychiatric patients and take them seriously. If no improvement is seen with medication and no diagnosis is made through physical examination, it may be helpful to seek additional consultation for these symptoms.

### CONCLUSION

Underperforming physical examinations in psychiatric patients is common. Clear guidelines and structured forms for these examinations can be useful in improving outcomes. It is important not to

overlook somatic complaints of psychiatric patients and to give them careful attention. It is advisable to encourage more communication between Psychiatry and other Medical Departments.

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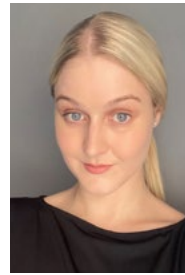
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**Informed consent to publish patient information was obtained from the patient.**



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**Christoffel Grobler** qualified as a medical doctor in 1989 at the University of Pretoria. His post-graduate qualifications include a Diploma in Occupational Health, an MMed in Psychiatry, cum laude, a Fellowship of the Colleges of Psychiatrists and a Doctorate in Medicine on the topic of bipolar mood disorder. Presently he is Extraordinary Professor at the University of Pretoria, School of Public Health and Associate Professor at the Walter Sisulu University. He has published extensively, most notably in the field of workplace stress and disability and presented both nationally and internationally. His special interest lies in the field of corporate mental health education, prevention of disability due to common mental health disorders and psychiatric impairment assessment. He is also a qualified Psychodynamic-systemic Group Leadership Coach ■



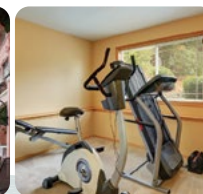
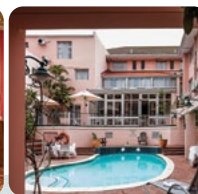
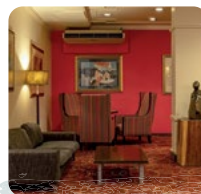
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# JOKER

## EXPLORING THE SMILE OF AN ANTISOCIAL PERSONALITY DISORDER

Kim Laxton

In 1940 the collective genius of Bill Finger, Bob Kane and Jerry Robinson created what is considered to be the greatest comic-book villain of all time, *Joker*. With his warped sense of humour, dramatically painted smile and devil-like lack of empathy, this character makes for a delicious, sadistic portrayal of what one can only conclude is the very definition of someone with antisocial personality disorder.

Enter the movie! Arthur Fleck is played by actor Joaquin Phoenix. This waif-like man, whose clothes wrap around him like oversized blankets and with a clown's expression smeared on his face, is transformed into *Joker*. In the film, director Todd Phillips, together with set designer Mark Friedberg, art director Laura Ballinger, costume-designer extraordinaire Mark Bridges, plus a team of theatre specialists, transform Phoenix into *Joker*, who is so alive and metaphorically colossal that one can feel *Joker's* breath in every scene.

The story slowly weaves the viewer into the life and barbaric personality of *Joker*. His signature characteristic, a pathological laugh, blends into the horrors perpetrated by Fleck in Gotham City, a fictional city typically appearing in American comic books.

The weight of the story cannot be described in a single page, and it would be unfair to the film to attempt to relay it in a simple review. Instead, the movie poses the question that has, for decades, tantalized the minds of psychologists and psychiatrists and anyone interested in the human condition and its personality types: how, exactly, do you define a psychopath? And how come, deeply embedded within us, is the strange conundrum of why we feel an unlikely, remote sense of pity for these dangerous, dark, and disgusting people?

According to basic definitions, *psychopathy* is the deficiency of emotional response, lack of empathy, poor behavioural control, and persistent antisocial deviance. A *psychopath* is a narcissistic

**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) ■



person with superficial charm, lacking all impulse control, whose callous and unemotional traits lend themselves to the absence of guilt and empathy.

The beauty and brilliance of this film is the story – the life of the psychopathic *Joker*, who yearns to make a normal life in the world. He uses fractured attempts at public humour, but his inability to form meaningful relationships causes many people to fall prey to him. Phoenix draws the viewer into a world of guns, clowns, violence, and sadistic laughter. He portrays a character the viewer despises and yet, toward the end of the film, one begins to pity him.

Throughout the film silent questions are raised: what trauma did *Joker* experience in his youth? Can we blame him for his behaviour if he is ultimately unwell?

**AS THE FILM EVOLVES, ONE BEGINS TO REALISE THAT EVERYONE HAS FAULTS AND WEAKNESSES, INCLUDING OURSELVES. CAN WE DISMISS THESE PEOPLE, WHO ULTIMATELY END UP TRANSFORMED INTO GUN-WIELDING PSYCHOPATHS? CAN WE FORGIVE THEM?**

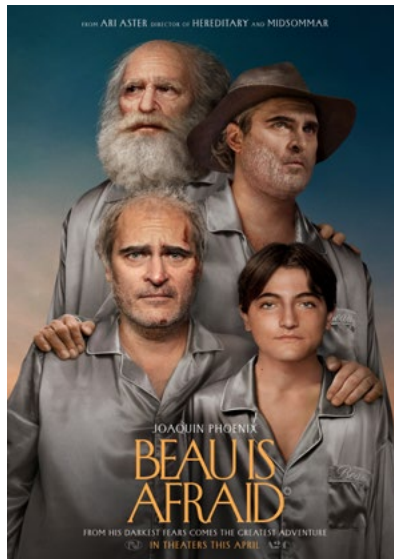
*Joker* is horrifyingly beautiful. It's a film for the viewer who's mind wants a challenge. By the end one is left startled, with thoughts and emotions circling for days. It is a frightening, moving, emotional journey that doesn't disappear as the credits fade.

# M O V I E S



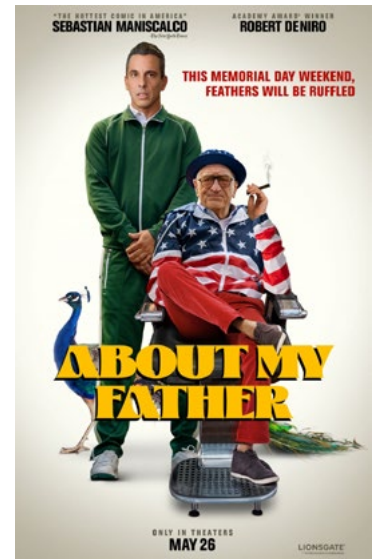
**Title:** The Unlikely Pilgrimage of Harold Fry  
**Release Date:** 05 May 2023  
**Director:** Hettie Macdonald

Harold is an ordinary man who has passed through life, living on the side lines, until he goes to post a letter one day...and just keeps walking.



**Title:** Beau is Afraid  
**Release Date:** 05 May 2023  
**Director:** Ari Aster

Following the sudden death of his mother, a mild-mannered but anxiety-ridden man confronts his darkest fears as he embarks on an epic, Kafkaesque odyssey back home.



**Title:** About My Father  
**Release Date:** 26 May 2023  
**Director:** Laura Terruso

When Sebastian tells his old-school Italian immigrant father Salvo that he is going to propose to his all-American girlfriend, Salvo insists on crashing a weekend with her tony parents.



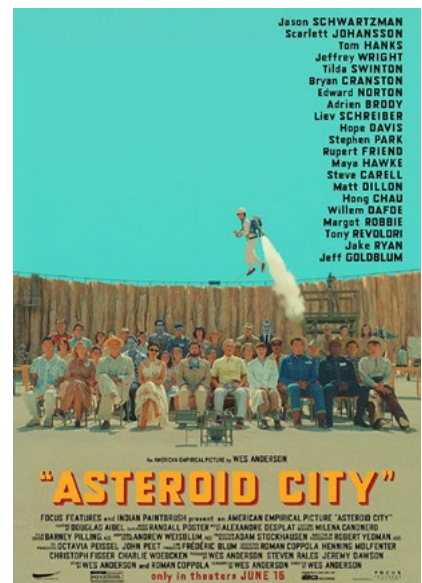
**Title:** Kandahar  
**Release Date:** 26 May 2023  
**Director:** Ric Roman Waugh

A CIA operative and his translator flee from special forces in Afghanistan after exposing a covert mission



**Title:** Greatest Days  
**Release Date:** 16 June 2023  
**Director:** Coky Giedroyc

A feature adaptation of the 'The Band' musical, featuring the songs of Take That.



**Title:** Asteroid City  
**Release Date:** 16 June 2023  
**Director:** Wes Anderson

The itinerary of a Junior Stargazer convention is spectacularly disrupted by world-changing events

S5

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## SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

# TRAIN THE TRAINEE WORKSHOP

The **SASOP Special Interest Group for ADHD** hosted a Train-the-trainee workshop for registrars at Evertsdal Guesthouse, Durbanville on the 6<sup>th</sup> May 2023

This workshop was presented by Prof Renata Schoeman and Dr Jannie van der Westhuizen and really pinpointed the nitty gritty information for registrars in the diagnosis and management of ADHD: everything from the neurobiology, diagnosis, management, and the ethics of the treatment thereof.

*"The ADHD workshop was a very enriching experience and really cemented my knowledge in treating and managing ADHD. I think what stood out for me was how personal the entire workshop was, from the friendly organizers to the well-equipped, warm conference room, to the presenters making the effort to learn our names and presenting from their experience and real life scenarios when treating children with ADHD. As a registrar it was heartwarming to see that passion for psychiatry continues to thrive, and that it's about positively changing the course of these children's lives so that they can become the best versions of themselves. This is something very close to my heart and I hope I will be able to use all the information and expertise that was shared in an effective way in my everyday clinical practice."*

(Shwetha Suresh, 4<sup>th</sup> year Registrar, University of Stellenbosch)

*"The ADHD Train the Trainee workshop was timely for me in that it found me at the tail end of my registrar journey, and on the eve of my career as a psychiatrist. I appreciated the balance between the academic rigor, reflected in the rich range of references which were supplied with the material, and a pragmatic approach, which was evident in both the structure of the program and some case-based discussions."*

*This meant that since I broadened my knowledge on ADHD throughout the workshop, on Monday when I returned to work, I was able to apply that knowledge practically in my patient consultations. For instance, one of the reasons why I applied to attend was my interest in child and adolescent psychiatry."*

*The inclusion and discussion of the SASOP guidelines on adult ADHD reminded me that ADHD is a lifespan condition, and since then I found that I am enquiring more deliberately into childhood symptoms in adults who present with inattentive and impulsive symptoms. Another benefit of the workshop was exposure to the career paths and day-to-day experiences of the two psychiatrists who were our presenters. I am grateful to all who made the training possible."*

(Sisikelelwe Gwanya-Mdletye, WSU Psychiatry registrar, Fort England Hospital)

*"Attending the "Train the Trainee" workshop presented by Prof Renata Schoeman and Jannie van der Westhuizen on ADHD was undoubtedly a valuable experience for psychiatric registrars. Prof Schoeman is a well-known expert in the field of psychiatry and has a wealth of knowledge and experience to share."*

*The workshop provided a comprehensive overview of ADHD, its diagnosis, and management. It covered the latest research findings and evidence-based treatment options, including pharmacotherapy and psychotherapy. The interactive nature of the workshop ensured that attendees were engaged and able to apply the knowledge gained in practical situations."*



## SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

*The presenters' teaching style was engaging and informative, and they were adept at explaining complex concepts in a way that was easy to understand. They encouraged active participation and provides ample opportunities for attendees to ask questions and share their experiences.*

*Overall, attending this workshop was a valuable investment of time and effort for psychiatric registrars. It equips them with the knowledge and skills necessary to diagnose and manage ADHD effectively, and to assist others in doing so. I highly*

*recommend this workshop to anyone interested in advancing their knowledge and skills in the field of ADHD."*

**(Frederic Raw, 2<sup>nd</sup> year registrar at UCT)**

This workshop was made possible through an educational grant by Acino Takeda ■



**Back (from left to right):** Hennie du Plessis, Mine Swart, Dewald Richter, Nico Nel, Jaco Marais, Andre Raats, Grant Fourie, Nico Vermeulen, Magdel Smit  
**Front (from left to right):** Pieter Fourie, Bernard Linde, Camilla Moolman, Eira Agenbach, Louise Serfontein, Rykie Liebenberg, Renata Schoeman, Tawni Voges, Claire Tobin, Trix Gassner, Hester vd Walt, Jonda Kerner



**Back from left to right:** Drs Sibongile Dondolo, Patience Makatsa, Lenora Samuel (Acino Takeda), Drs Dimpho Mdlalose, Frederic Raw, Musa Ngwenya, Jannie van der Westhuizen

**Middle from left to right:** Prof Renata Schoeman, Drs Siki Gwanya-Mdletye, Anne Raju, Mahlatshe Thosago, Nolitha Mcanyangwa  
**Front from left to right:** Drs Palesa Nondabula, Meryl Roman, Kirsten Rowe, Shwetha Suresh, Ashvena Gajathar (Acino Takeda)



# SASOP ROADSHOW 2023

Dear Colleagues,

We are in the fortunate position that PharmaDynamics has made sponsorship possible again this year for a Roadshow, taking the leaders of SASOP and PsychMg to the major centres. We have found in the past that these are valuable opportunities to meet with psychiatrists at a local level and learning about the unique challenges encountered in each area, whilst also updating our colleagues on developments in the private and public sectors.

It is an opportunity to be updated on how the leadership is responding to challenges that psychiatrists face in their places of service - and these seem to be increasing rapidly. You will have the opportunity to raise your specific problem areas and have your questions answered, as well as having discussions about issues unique to your area of work, and challenges that the subgroup that you belong to face.

This year we would want to specifically address areas of concern that have emerged in the relationship between psychiatrists and hospitals where you work and the contractual responsibilities of both parties as we have noted that in the private sector this is inadequately addressed.

We want to provide an opportunity for all SASOP members to attend, both public sector and private colleagues.

Each Subgroup will have an opportunity to draw up "20 Questions" beforehand that will be used to form the basis of the discussion. It is hoped that this will ensure that any aspects pertaining to private practice, public sector service, managed healthcare, billing, hospital "politics" etc. will be covered in a way that will be relevant to each area.

## THE PROPOSED AGENDA FOR THE ROADSHOW:

- 15h00-16h00: Arrival and registration.
- 16h00-18h30: Workshop: "Your 20 Questions Answered" (session facilitated by Drs Ian Westmore, Eugene Allers, Kobus Roux and Sebo Seape)
- 18h30-19h00: Pre-dinner drinks.
- 19h00-21h00: Dinner with presentation from SASOP/PsychMg/Pubsec.

It will be expected that each Subgroup chairperson will collate these questions and submit them to me at least 7 days prior to your specific event.

## WE LOOK FORWARD TO MEETING YOU IN YOUR REGION ON THE FOLLOWING DATES:

- 28.06.2023: Southern Gauteng
- 29.06.2023: Northern Gauteng
- 30.06.2023: Nelspruit
- 19.07.2023: Free State
- 17.08.2023: Western Cape
- 06.09.2023: KZN
- 11-12.10.2023: Eastern Cape (Gqeberha and East London)
- 01.11.2023: Limpopo

For catering and logistical purposes it is essential that you register for your region as soon as possible. Separate Registration links will be sent out to all regions.

Regards,

**Dr Ian Westmore  
Convenor**



SOUTH AFRICAN SOCIETY OF  
PSYCHIATRISTS

# TRAIN THE TRAINER WORKSHOP

**SASOP Special Interest Group for ADHD.** On 22<sup>nd</sup> and 23<sup>rd</sup> April 2023, a Train-the-Trainer workshop was hosted at the Homestead Villas, Bellville.

**T**he purpose of the Train-the-Trainer workshop was to provide training to members and affiliate members, of the SASOP ADHD SIG, to ensure alignment in diagnostic and management aspects of ADHD. Attendance and participation in this workshop provided endorsement to individual SIG members to act as trainers. This enables the SIG to decentralise training of other health care providers (psychiatrists, registrars, general practitioners, and other health care professionals).

## PRESENTATIONS INCLUDED:

**Prof Renata Schoeman** (convenor of the SIG): the neurobiology of ADHD, the diagnosis of ADHD, comorbidity, and co-occurring conditions (Tourette's, epilepsy, autism and pregnancy/lactation), pharmacological and non-pharmacological interventions for ADHD, workplace

interventions for ADHD, and ethical dilemmas in the prescription of stimulants.

**Dr Jannie van der Westhuizen:** neuropsychology of ADHD, comorbidities (mood disorders, anxiety disorders, sleep and eating disorders, and substance use disorders), psychotherapeutic interventions for ADHD, and lifestyle intervention for ADHD.

This workshop was made possible through an educational grant from Adcock Ingram.



Congratulations to the newly endorsed ADHD trainers! ■



**Back from left to right:** Mr Zaahir Omar (Adcock), Me Anneke Vlok (Adcock), Drs Jannie van der Westhuizen, Sarah-Jane Smith, Prof Renata Schoeman, Drs Bernice Naborn, Caroline Serebro, Kediemetse Motingoe, Mwanja Chundu, Sauyrie Rasen, EJ Smith, Renschka van den Berg, Thembani Ngwenya, Graham de Bever, Marcia Ntimani, Mr Heinrich Koekemoer, Dr Dainty Meyer  
**Front from left to right:** JoLynne du Randt, Drs Louise Serfontein, Joanna Taylor, Wendy Vogel, Nerica Ramsundhar, Angeline Thomas



# JOIN OUR DISCUSSION GROUP FOR SPORT AND EXERCISE PSYCHIATRY

## Dear Colleagues

Sport and Exercise Psychiatry is a growing field internationally involving the care of athlete mental health as well as the use of exercise in managing mental health symptoms and disorders. We have formed a discussion group for South African psychiatrists and mental health practitioners interested in the field and would like to invite members to join.

The group uses WhatsApp to share core literature and recent developments, to share resources for upskilling in the field, as well as carve the way forward to formalise the group. We have been liaising with international sports psychiatry groups to

learn from their processes and create international connections. The group has also been engaging with local sports bodies, including the South African Sports Confederation and Olympic Committee, who have been reporting the need for a network of providers in athlete mental health services due to the additional complexities in assessment and management.

Members interested in joining the **Sport and Exercise Psychiatry Discussion Group** can get in touch with James Burger (drjameswburger@gmail.com) or Bonginkosi Mafuze (bmafuze@gmail.com).

Students and allied health professionals are also welcome to the discussion group ■

SASOP EARLY CAREER PSYCHIATRISTS  
WOULD LIKE TO REMIND YOU OF...

*Our virtual monthly  
academic meeting*

The last Monday of every month  
29th of May 2023

18:30 - 19:30  
Zoom ID: 892 7995 1787  
Passcode: 234630

Speaker: Jonelle du Plessis  
Topic: Dialectical behavioural therapy

# 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



# TRAIN THE TRAINER WORKSHOP

On 4<sup>th</sup> and 5<sup>th</sup> March 2023 a Train-the-Trainer workshop was hosted at the Indaba hotel, Fourways.

The purpose of the Train-the-Trainer workshop was to provide training to members and affiliate members, of the SASOP ADHD SIG, to ensure alignment in diagnostic and management aspects of ADHD. Attendance and participation in this workshop provided endorsement to individual SIG members to act as trainers. This enables the SIG to decentralise training of other health care providers (psychiatrists, registrars, general practitioners, and other health care professionals).

## PRESENTATIONS INCLUDED:

**Prof Renata Schoeman** (convenor of the SIG): the neurobiology of ADHD, the diagnosis of ADHD, comorbidity and co-occurring conditions (Tourette's, epilepsy, autism and pregnancy/lactation), pharmacological and non-pharmacological interventions for ADHD, workplace

interventions for ADHD, and ethical dilemmas in the prescription of stimulants.

**Dr Rykie Liebenberg:** neuropsychology of ADHD, comorbidities (mood disorders, anxiety disorder, sleep and eating disorders, and substance use disorders), psychotherapeutic interventions for ADHD, and lifestyle interventions for ADHD.

This workshop was made possible through an educational grant from Adcock Ingram.



Congratulations to the newly endorsed ADHD trainers! ■



**Back from left to right:** Drs Bongzi Nkhahle, Nadine Lindinger, Rykie Liebenberg, Luzuko Magula, Jannie van der Westhuizen, Henriette Smith, Jacqui Bezuidenhout  
**Middle from left to right:** Drs Antoinette Miric, Androula Ladikos, Rassie Erasmus, Kelebogile Sebogodi, Wisani Makhomisané  
**Front from left to right:** Prof Renata Schoeman, Drs Michelle van Niekerk, Karen Vukovic, Christelle Nel, Heather Thomson, Francois Esterhuizen



# NOMINATION AND ELECTION OF SASOP BOARD OF DIRECTORS 2023 - 2025

Dear SASOP Member,

The term of the current SASOP Board of Directors (2021 - 2023) will be coming to an end in November 2023. The Board consists of the following members: President; Past President; President Elect (Vice President); Honorary Secretary; Honorary Treasurer; the Convenor of the SASOP Public Sector Group; and the Convenor of the SASOP Private Sector Group. According to the MOI, all Directors shall be elected, after being nominated in writing and accepting the nomination in writing, during the next Biennial General Meeting. The next Annual General Meeting of SASOP, will be held during the SASOP Congress from 19 - 23 November 2023 in Cape Town.

While, according to the MOI, nominations for the other Board members must be received, by the Honorary Secretary, 4 weeks prior to this meeting, the election of the President is governed by the MOI, which determines that nominations should be called 6 months before the Annual General Meeting by the SASOP Secretariate.

## NOMINATIONS AND ELECTIONS OF CANDIDATES FOR PRESIDENT

In order to comply with the specifications of the MOI, nominations for President must be signed by 5 SASOP members with voting powers and who are in good standing, and should be received by the Honorary Secretary of the SASOP within 5 weeks of the mailing/posting on the website of this notice of the call for nominations, i.e., by 24h00 on 23 May 2023, as this period constitutes a deadline.

Completed nomination forms may be submitted to the Honorary Secretary or HealthMan:

- Electronically by email as a legible scanned document to:
  - [porter.sasop@gmail.com](mailto:porter.sasop@gmail.com)
  - [voting@sasop.co.za](mailto:voting@sasop.co.za)
- By regular mail to:
  - HealthMan  
PO Box 2127,  
Cresta,  
2118



- Deliver to:
  - HealthMan  
Unit 16 Northcliff Office Park,  
203 Beyers Naude Drive,  
Northcliff,  
2115

203 Beyers Naude Drive,  
Northcliff,  
2115

Nominated candidates shall then be asked to submit a biographical note and a vision for the Presidency not exceeding 400 words. The SASOP Secretariate will be responsible for circulating ballot papers and the supporting biographical notes to all members. An allowance for secret ballot via email will be permissible. A return date for the ballot papers shall be 4 weeks after mailing and posting of these documents on the SASOP website. Counting of votes shall be performed by an independent auditor appointed by the SASOP Board.

The nomination forms will also be available on the SASOP website ([www.sasop.co.za](http://www.sasop.co.za)) in the 'Members' Section under "SASOP Board of Directors Election", and under the "My Community" tab.

### VOTING AND PROXIES

Voting at the Annual General Meeting in November 2023 shall be done by a show of hands unless the majority of members present at voting requests a secret ballot.

As specified by the MOI, a proxy may be appointed by a member with voting power (i.e., a fully paid-up Full Member, Life Member, Pensioner Member or Honorary Member).

### NOMINATIONS OF CANDIDATES FOR HONORARY SECRETARY, HONORARY TREASURER AND CONVENORS OF SASOP PUBLIC SECTOR AND SASOP PRIVATE SECTOR GROUPS

The appointed proxy may be present at the meeting, debate and vote on behalf of the proxy grantor but must himself, or herself, be a member with voting power as described above. Such appointment is for a specific meeting and must be so specified. The appointment of the proxy must be received in writing by the grantor (not someone who acts as his/her agent) and must reach the Honorary Secretary or HealthMan before 24h00 on 12 November 2023.

All nominations for the other members of the Board of Directors, the Honorary Secretary, Honorary Treasurer and Convenors of SASOP Public Sector and SASOP Private Sector Groups, should only be received 4 weeks before the Annual General Meeting of SASOP during the SASOP Congress from 19 – 23 November 2023 in Cape Town, i.e., 24h00 on 22 October 2023.

*A reminder, a specific date and time will be circulated to members as some information regarding the Annual General Meeting still needs to be confirmed.*

Nominations should carry the signature of the candidate and two voting members (a proposer and seconder) and accompanied by a manifesto and CV of the proposed candidate. It must be made by submitting the completed applicable forms to the Honorary Secretary of HealthMan:

- Electronically by email as a legible scanned document to:
  - [porter.sasop@gmail.com](mailto:porter.sasop@gmail.com)
  - [voting@sasop.co.za](mailto:voting@sasop.co.za)
- By regular mail to:
  - HealthMan  
PO Box 2127,  
Cresta,  
2118
- Deliver to:
  - HealthMan  
Unit 16 Northcliff Office Park,  
203 Beyers Naude Drive,  
Northcliff,  
2115

- Electronically by email as a legible scanned document to:
  - [porter.sasop@gmail.com](mailto:porter.sasop@gmail.com)
  - [voting@sasop.co.za](mailto:voting@sasop.co.za)
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Unit 16 Northcliff Office Park,  
203 Beyers Naude Drive,  
Northcliff,  
2115

*A reminder, a specific date and time will be circulated to members as some information regarding the Annual General Meeting still needs to be confirmed.*

We encourage you to participate in this process to again ensure democratically duly elected SASOP Board of Directors for the term 2023 – 2025.

**Issued by Dr Alicia Porter  
SASOP Honorary Secretary**

On behalf of the SASOP Board of Directors ■

# 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.

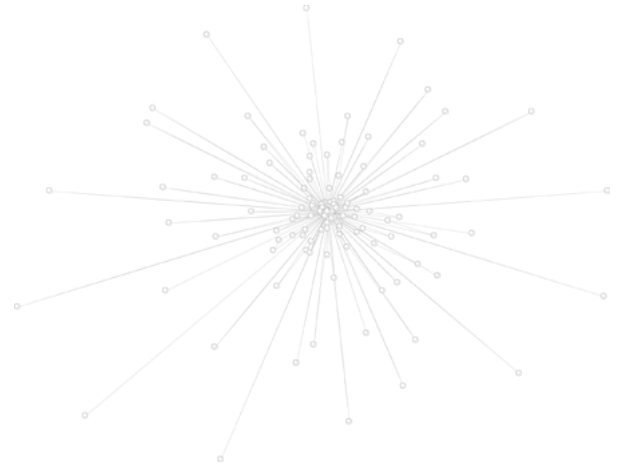
## REVIEW / ORIGINAL ARTICLES

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**  
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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.