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issue 32 • November 2022

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Features

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

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NOVEMBER 2022

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

COVER IMAGE: 3d geometry vertically complex pattern white interior wall space by Digital technology on AdobeStock

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Dear Reader,

remarkably we are facing the end of the year which seems to have flashed by…so, welcome to the November issue – the final one for 2022. Thankfully the past year has, for all its challenges, seen a return to something approximating normality in terms of direct, person - person contact. Humans are social beings, and the extent to which such interaction was curtailed has certainly impacted. For some, an online, remote life has indeed settled into their "new normal", and yet the use of the word "normal" might be contested. The idea that office environments would be irrevocably changed with empty office spaces now the norm looks like it is being challenged, as more than one corporation is requiring workers to return, in-person. There has been resistance. It seems that a convenience driven, blended, version will likely emerge. Beyond socio-political issues that drive agendas, my personal view is that human contact is core to human wellness. Enough said.

In the current issue we have the usual range of content from regular contributors - Original research, Reports and South African Society of Psychiatrists (SASOP) updates. The Reports document several important events, both on-line and in-person. The ADHD virtual Congress has established itself as an annual event that showcases local and international speakers as did the Dr Reddy's Academic Weekend, with the latter providing a bridge between international Congress attendance and a local audience through requiring local psychiatrists funded to attend the Congress to provide specific feedback through presentations at the local meeting. Having been present at the local meeting I was impressed with the quality of the presentations, and it provided an illustration of how the pharmaceutical industry supports local academia – noting that none of the presentations were product related.

As we approach what will hopefully be a quieter period, allowing for time to relax and reflect – I wish you all peace and joy and look forward to welcoming you back in 2023.

Acknowledgement: *Thanks to Lisa Selwood for assistance with proof reading*
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THIRD SEASON OF BEYOND MADNESS PODCAST LAUNCHES DURING MENTAL HEALTH AWARENESS MONTH

It is fitting that during October, which in South Africa is Mental Health Awareness Month, the **Beyond Madness** podcast releases the third season of 15 podcast episodes which explore topics rarely spoken about in such detail in open forums. Hosted by Prof Christopher Paul Szabo, another 15 new weekly episodes will be released on the day following WHO's Mental Health Awareness Day, commencing on Tuesday, 11 October 2022.

The impact of this important mental health podcast series was re-enforced when, along with partners Adcock Ingram OTC Sponsors of Brave, **Beyond Madness** was recently announced as a finalist in the New Gen Awards 2022. An impressive accolade for a podcast series which aired the first of 15 weekly podcast episodes on CliffCentral in October 2021, followed by an even more well-received second series which began airing in May 2022. In addition, CliffCentral included **Beyond Madness** in their series of interpreted content during International Deaf Awareness Month, when a sign language interpreted video was adapted from the episode examining the psychology of serial killers.

Until as recently as a decade ago, mental health issues and psychiatry were taboo subjects that were rarely discussed openly on public platforms. The introduction of forums such as the **Beyond Madness** podcasts on CliffCentral have underpinned the urgent need for meaningful understanding surrounding mental health issues. It is not a stretch of the imagination to say that removing the shameful stigma on these subjects can and does save lives, or at very least bring about a level of awareness which did not exist before despite Mental Health Awareness Month being established in 1949 to increase awareness of the importance of mental health and wellness in Americans' lives, and to celebrate recovery from mental illness.

IT IS VITAL TO REDUCE THE STIGMA AND DISCRIMINATION THAT PEOPLE SUFFERING FROM MENTAL ILLNESSES FREQUENTLY FACE. HOWEVER, IT IS IMPORTANT TO ESTABLISH A BETTER UNDERSTANDING OF WHERE 'MADNESS' AND 'MENTAL ILLNESS' INTERSECT.

The word 'madness' in and of itself conjures up images of mental institutions where people who are beyond help are sent to see out their days. This is not an accurate depiction. Beyond Madness will take you behind the scenes through the voices of selected individuals, and while their work may appear to have specific relevance to psychiatry, each issue raised will eventually be understood to have broader societal implications.

Professor Szabo shares insights on his motivation: "The previous episodes of Beyond Madness - 30 in total thus far – have proven successful, inspiring us to forge ahead in our quest to raise awareness and understanding about the discipline of psychiatry."

Beyond Madness Podcast – forthcoming episodes:

1. Abortion and psychological consequences
2. Religion and psychiatry
3. What's the fuss about serotonin?
4. Body image and aesthetic surgery
5. Victims and perpetrators – the emotional toll of parole
6. Mindfulness and mental health
7. Traditional healers and psychiatry
8. Animals, healing and comfort
9. Does the gut control the mind?
10. Corporate mental health
11. Compassion and care fatigue – when healers struggle
12. Palliative care and dying
13. Self - help and psychiatry
14. Gender dysphoria
15. Therapy – when is enough?

NEW EPISODES ARE AVAILABLE EVERY TUESDAY AT 10AM FROM TUESDAY, 11 OCTOBER 2022 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/

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

About Adcock Ingram OTC Sponsors of Brave

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

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SCREENING FOR DEPRESSION IN WOMEN ATTENDING ANTENATAL CLINICS IN THE JOHANNESBURG HEALTH DISTRICT

Moosa MYH, Jeenah FY, Khan R, Naidu K, Talenyane N.

Corresponding Author: Yusuf Moosa; Clinical Head of Unit: District Specialist Mental Health Team (DSMHT) Johannesburg Health District & Adjunct Professor (Department of Psychiatry, University of Witwatersrand) yusuf.moosa@wits.ac.za

ABSTRACT

AIM *This study aimed to determine, among women attending the antenatal clinics in the Johannesburg Health District and who were screened for depression using the EPDS, the prevalence of and some factors associated with a positive screening.* ***METHOD*** *Screenings were conducted in the following CHCs: Zola, Discoverers, Mofolo, Itereleng, Orlando, Embalenhle, Crosby, Lenasia, Westbury, Alexandra, Hillbrow, and Halfway House clinics. Attendees, aged 18 years and over, were invited by the mental health staff to voluntarily participate in the screening. The staff recorded these screenings for clinical services monitoring and kept them in the respective clinic. This study was a retrospective review of all patients who were screened at the above-named CHCs between June 2021 and November 2021. From the records of the screenings conducted at the above clinic, the authors obtained the following data namely name of the clinics, participants' age in years, gender, gestational age in weeks, history of depression, total EPDS scores, and the intervention post-screening.* ***RESULTS*** *The total number of EPDS screenings conducted during the study period was 2865, of which 531 were women in the postnatal period and 2334 in the antenatal period. Of the 531 women in the postnatal period who were screened, 114 scored above the cut-off point of 10, which is used to identify pregnant women with depressive symptoms, representing a yield of 21.5%. There was no significant association between those that screened positive and age groups ($p=0.82$) or a previous history of postnatal depression ($p=0.62$). There was, however, a significant association with a history of major depression ($p<0.05$). Of the 2334 women in the antenatal period who were screened, 542 scored above the cut-off point of 10, representing a yield of 23.2%. There was no significant association between those that screened positive and age groups ($p=0.71$), history of postnatal depression ($p=0.22$), or gestational trimester ($p=0.15$). There was, however, a significant association with a history of major depression ($p<0.05$).* ***CONCLUSION*** *This study's prevalence of antenatal depression is as high as most published studies in similar settings. Given the profound consequences on both mother and infant, there is a need for contextually and culturally appropriate and pragmatic mental health interventions by primary health care workers. This includes the creation of awareness of depression during pregnancy and promoting patient autonomy through early supportive psychosocial therapy when screened positive.*

INTRODUCTION

In addition to the challenges of a new infant facing expectant mothers, there is an array of psychological and physiological changes that occur during and soon after pregnancy (Ayano G, *et al.* 2019), which increases the mother's risk of developing mental health-related problems (Bennett HA, *et al.* 2004; Kuhner C. 2016).

DEPRESSION IS ONE OF THE MOST COMMON MENTAL DISORDERS THAT CAN OCCUR.

The prevalence of depression varies significantly across different studies, estimated between 7% and 20% in developed countries (Lee AM, *et al.* 2007; Melville JL, *et al.* 2010) and around 25.3% in low and middle-income countries (Gelaye B, et al. 2016). Some published studies in lower to middle-income countries have reported prevalence rates of 20.2% in Brazil (Faisal-Cury A, *et al.* 2009), 25% in Pakistan (Rahman A, *et al.* 2003), 29% in Bangladesh (Nasreen HE, *et a*l. 2011), and 39% in South Africa (Hartley M, *et al.* 2011; Manikkam L & Burns JK. 2012). The type of instrument used to screen for depression, the study setting, the trimester of pregnancy, and the socioeconomic and cultural differences are but a few of the reasons reported for these variations (Osborne LM & Monk C. 2013; DiPietro JA. 2012).

DEPRESSION DURING AND SOON AFTER PREGNANCY HAS ADVERSE EFFECTS ON BOTH THE MOTHER AND THE INFANT'S HEALTH (ALDERDICE F, ET AL. 2013).

It can impair fetal development, result in preterm birth or low birth weight, or have long-term effects on neurological, behavioural, and emotional development (Van Ngo T, *et al.* 2018; Grote NK, *et al.* 2010). Women with antenatal depression are at a higher risk for preeclampsia, premature rupture of membranes, and hemorrhage (Bitew T, *et al.* 2017; Plant DT, et al. 2016). It is a major contributor to perinatal morbidity and mortality in women (Mathers CD & Loncar D. 2006). Several other factors including younger age, unplanned pregnancy, lack of family/spouse support, violence during pregnancy, low socioeconomic status, poor antenatal care, and pregnancy-related complications have been reported to be associated with an increased risk of depression (Barton K, et al. 2017; Howard LM, 2014). However, the reported associations are inconsistent and there are only a few reviews to support the veracity of these associations (Jeong HG, *et al.* 2013; Nasreen HE, *et al.* 2018).

Depression associated with pregnancy often goes unrecognized and untreated in lower-middle-income countries (Klainin P & Arthur DG. 2009). As part of the mental health services rendered by the Johannesburg health district, mental health staff screen attendees at the antenatal and postnatal clinics in community health centres (CHCs) using the Edinburgh Postnatal Depression Scale (EPDS). The screenings have assisted the staff with identifying depressive symptoms amongst at-risk mothers and expectant mothers and offering immediate intervention strategies, such as health education and referral for group or individual supportive therapy. The screenings have been conducted since the beginning of 2021, however, there has been no review of these screenings to establish the positivity rate and whether the objectives of early detection are being achieved. Hence the need for this study.

AIM

This study aimed to determine, among women attending the antenatal clinics in CHCs in the Johannesburg Health District and who were screened using the EPDS, the prevalence of and some of the factors associated with a positive screening.

OBJECTIVES

The specific objectives were to:

1) Describe the demographic and clinical characteristics of the study population
2) Determine the prevalence of women who screened positive both in the antenatal and the postnatal period using the EPDS tool
3) Describe, if any, factors associated with the presence of a positive screen
4) Describe the interventions offered to those that screened positive

METHOD

Screenings were conducted in the following CHCs: Zola, Discoverers, Mofolo, Itereleng, Orlando, Embalenhle, Crosby, Lenasia, Westbury, Alexandra, Hillbrow, and Halfway House clinics. Attendees, aged 18 years and over, were invited by the mental health staff to voluntarily participate in the screening. The staff recorded these screenings for clinical services monitoring and kept in the respective clinic.

This study was a retrospective review of all patients who were screened at the above-named CHCs between June 2021 and November 2021. From the records of the screenings conducted at the above clinic, the authors obtained the following data namely name of the clinics, participants' age in years, gender, gestational age in weeks, history of depression, total EPDS scores, and the intervention post-screening. The data was captured on a separate excel spreadsheet for further analysis. The cut-off point of 10 on the EPDS scores was used to identify pregnant women with depressive symptoms (Matthey S, et al. 2016).

DATA ANALYSIS

Data was coded and populated into a Microsoft Excel Spreadsheet and then transported into a compatible statistical software package.

Demographic and clinical data were described using median, range, frequency, and percentages. Correlations between continuous variables were done using Pearson's correlation test. Significance between categorical groups was assessed with chi-squared tests.

ETHICAL CONSIDERATIONS

As this is a retrospective study, it was not required to obtain written informed consent from each patient (or family member) for the use of his/her medical information. The University of the Witwatersrand Research Ethics Committee approved the protocol (Protocol No: M211011). Permission to conduct the study was obtained from the research committee of the Johannesburg Health District and registered with the NHRD (GP_202111_020). All records made on the data collection sheet were kept confidential. The name and patient numbers were anonymized on the populated databases in Microsoft Excel and only raw data was reviewed by the investigators and statistician.

RESULTS

The total number of EPDS screenings conducted during the study period was 2865, of which 531 were women in the postnatal period and 2334 in the antenatal period.

a) Postnatal Group

The mean EPDS score in the postnatal group (n=531) was 6.18 (SD=5.53), and the median score was 5 (range: 0 to 26). The mean age was 29.53 (SD=6.80) years and the median age was 29 (range: 18 to 50) years. The EPDS scores showed a trend towards a mild increase with advancing age, however, there was no significant correlation (r=0.09) (Fig 1).

Of the 531 women in the postnatal period who were screened, 114 scored above the cut-off point of 10, representing a yield of 21.5%. There was no significant association between those that screened positive and age groups (p=0.82) or a history of postnatal depression (p=0.62) (Table 1). There was, however, a significant association with a previous history of major depression (p<0.05).

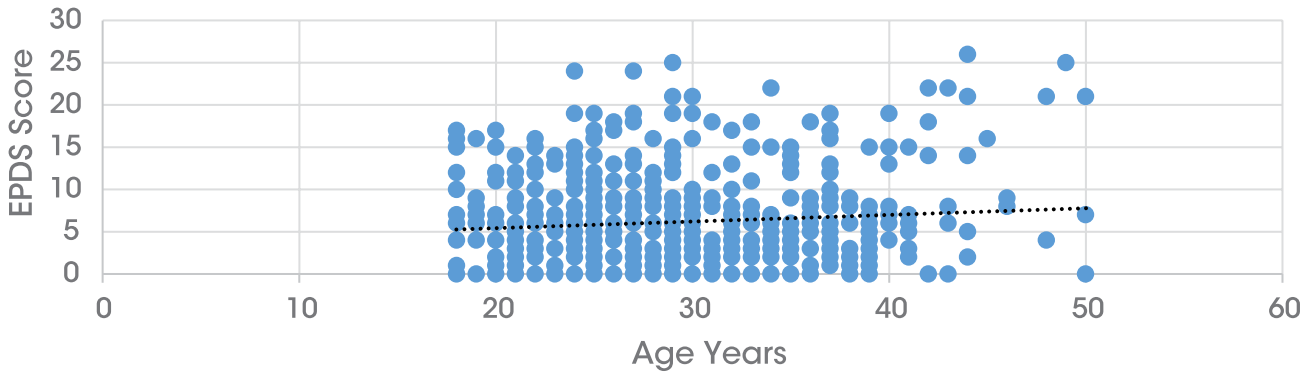

FIG 1: Correlation between postnatal EPDS scores and age (years)

TABLE 1: Frequency distribution of the demographic and clinical characteristics of the postnatal group

VARIABLES	STUDY POPULATION (N = 531)		EPDS SCORES: 0-9 (N = 417)		EPDS SCORES: 10-30 (N= 114)		P values
	n	%	n	%	n	%	
Age group (years)							
18-25	179	33.71%	137	32.85%	42	36.84%	0.82
26-34	215	40.49%	173	41.49%	42	36.84%	
>35	137	25.80%	107	25.66%	30	26.32%	
History of Postnatal Depression							
Yes	439	82.67%	343	82.25%	96	84.21%	0.62
No	92	17.33%	74	17.75%	18	15.79%	
Unknown	0	0.00%	0	0.00%	0	0.00%	
Past History of Major Depression							
Yes	32	6.03%	12	2.88%	20	17.54%	< 0.05
No	367	69.11%	314	75.30%	53	46.49%	
Unknown	132	24.86%	91	21.82%	41	35.96%	

b) Antenatal Group

The mean EPDS score of the antenatal group (n=2334) was 6.53 (SD=5.41), and the median was 6 (range: 0 to 30). The mean age was 28.56 (SD=6.12) years and the median age was 28 (range: 18 to 52) years. There was no significant correlation between EPDS scores and advancing age (r=0.008) (Fig 2).

Of the 2334 women in the antenatal period who were screened, 542 scored above the cut-off point of 10, representing a yield of depression of 23.2%. There was no significant association between those that screened and screened positive and age groups (p=0.71), history of postnatal depression (p=0.22), or the gestational trimester (p=0.15) (Table 2). There was, however, a significant association with a previous history of major depression (p<0.05) (Table 2).

All participants who screened positive in both antenatal and postnatal groups were given health education and referred for group or individual supportive therapy based on the patient's preference.

DISCUSSION

The prevalence rate of positive screening for depression in this study was found to be high in both the antenatal (23.2%) and the postnatal period (21.5%).

FOR FURTHER COMPARATIVE DISCUSSION, NO DISTINCTION WAS MADE CONCERNING THE ANTENATAL AND POSTNATAL PERIODS.

The overall prevalence rates are similar to those reported in studies in both developed (Gavin NI, *et al.* 2005; Lee AM, *et al.* 2007; Melville JL, *et al.* 2010) and in low and middle-income countries (Gelaye B, *et al.* 2016; Manikkam L & Burns JK. 2012; Hartley M, *et al.* 2011). There are, however, some studies that reported much higher rates such as 50.3% reported in the Witzenberg subdistrict of Western Cape (Stellenberg E. & Abrahams J. 2015), 49.3% in a primary health

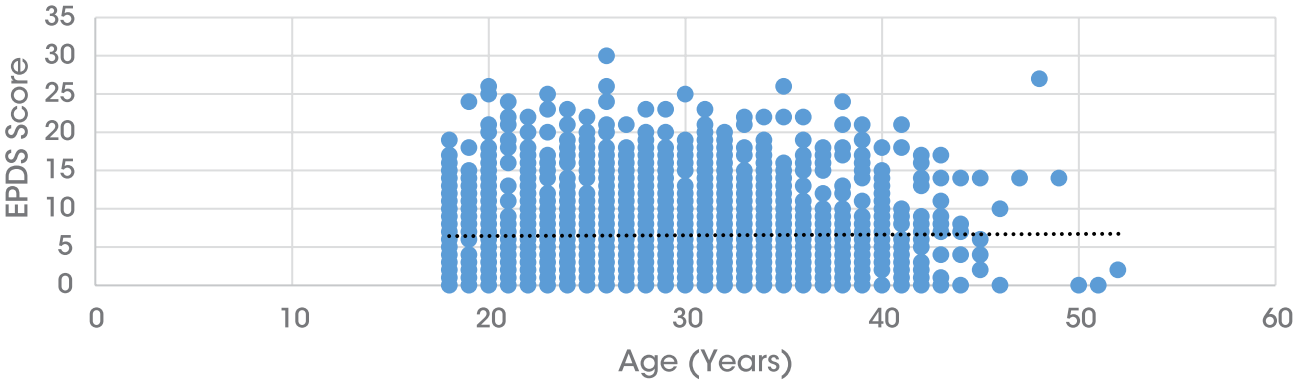

FIG 2: Correlation between antenatal EPDS scores and age (years)

TABLE 2: Frequency distribution of the demographic and clinical characteristics of the group in the antenatal period

VARIABLES	STUDY POPULATION (N=2334)		EPDS SCORES: 0-9 (N=1792)		EPDS SCORES: 10-30 (N=542)		P values
	n	%	n	%	n	%	
Age group (years)							
18-25	813	34.83%	634	35.38%	179	33.03%	0.71
26-34	1091	46.74%	835	46.6%	256	47.23%	
>35	430	18.42%	323	18.02%	107	19.74%	
History of Postnatal Depression							
Yes	194	8.31%	155	8.65%	39	7.2%	0.22
No	2120	90.83%	1617	90.23%	503	92.8%	
Unknown	0	0.00%	0	0%	0	0%	
Past History of Major Depression							
Yes	40	1.71%	12	0.67%	28	5.17%	<0.05
No	1564	67.01%	1328	74.11%	236	43.54%	
Unknown	730	31.28%	452	25.22%	278	51.29%	
Gestational Trimester							
First trimester (<14 weeks)	361	15.47%	273	15.23%	88	16.24%	0.15
Second trimester (14–27 weeks)	748	32.05%	559	31.19%	189	34.87%	
Third trimester (>27 weeks)	1225	52.49%	960	53.57%	265	48.89%	

clinic in Pretoria (Shiba KMD. 2014) and the 38.8% in Levai Mbatha clinic in Evaton (Olufemi B, *et al*. 2020). Although Sankapithulu *et al* (2010) reported up to 60% prevalence rates in their study among Indian women, their sample size was small and the participants included post caesarian section delivery, which might account for the very high rate. On the contrary, Govender *et al* (2020) reported a low rate of only 8.8% in their study amongst 326 adolescent females in KwaZulu-Natal.

The wide variation in reported prevalence rates is likely to be related to different EPDS cut-off scores for depression, different screening tools, the study setting, the sample size, the trimester of pregnancy, and the socioeconomic and cultural differences of the participants (Osborne LM & Monk C. 2013; DiPietro JA. 2012; Shiba KMD, 2014). Although the EPDS was used in this study, the PHQ-9 is an alternate research screening tool that is a reliable and valid measure of depression (Kroenke K, *et al*. 2001). Despite the limitations, the prevalence rate found in the present study is consistent with global estimates within low to middle-income countries.

THE STUDY ALSO FOUND A STATISTICALLY SIGNIFICANT ASSOCIATION BETWEEN A PREVIOUS HISTORY OF MAJOR DEPRESSION AND SCREENING POSITIVE AMONGST BOTH ANTENATAL AND POSTNATAL WOMEN.

Other studies have also reported this as a major risk factor to develop depression during or soon after pregnancy (Suri R, *et al*, 2017; Milapkumar P, *et al*. 2012; Hirst PK & Moutier YC. 2010). It is proposed that the elevated levels of negative thinking, characteristic of a past depressive episode, make these women more likely to be negatively affected by the stress of the current pregnancy and birth of the infant (Moulds ML, *et al*; 2018). Further, women with a previous history of depression may also be more vulnerable to the hormonal changes and social stressors that are consequent to this pregnancy (Bisetegn TA, *et al*. 2016; Biratu A & Haile D. 2015). Following birth, the depressive symptoms may hinder the ability of the mother to form healthy attachments and her ability to adequately mother the new infant, consequently worsening her existing negative feelings and leading to either exacerbation or maintenance of these depressive symptoms (Moulds ML, *et al*; 2018; Schmidt D, *et al*. 2017). Untreated depression has consequences on the fetus (low birth weight, intrauterine growth restriction) and the newborn infant due to poor quality parenting and unhealthy maternal behaviours such as substance abuse (Gelaye B, *et al*. 2016; Dunkel Schetter C & Tanner L. 2012).

Studies have shown no increased risk of depression in older mothers, however, older women do have higher rates of pregnancy complications, such as blood pressure and diabetes, which is associated with a higher risk of antenatal depression (Koleva H, *et al*. 2011). This study also found that a greater percentage of women who screened positive were in the older age group (> 25 years).

Symptoms of depression may occur at any time during the course of the three trimesters of pregnancy (Li M & Feng Q. 2005). However, studies report that the incidence is particularly higher during the second and third trimesters (Zhou X, *et al*. 2019; Li M & Feng Q. 2005). Although this study did not show any statistically significant association concerning the gestational trimester, the prevalence was highest in the third trimester. The differing sample sizes for each trimester may have confounded our analysis of depression versus trimester.

Numerous other factors are strong predictors of the onset of depression in pregnancy (Dadi AF, *et al*. 2020). These include, but are not limited to, obstetric complications (Bitew T, *et al* 2017; Martha AS, *et al*. 2017), lack of satisfaction with the marital relationship, current or previous intimate partner violence (Hutchens BF, Kearney J. 2020; Martha AS, *et al*.2017), lack of emotional support by the partner and family (Biaggi A, *et al*. 2016; Dudas RB, . 2012) and low socioeconomic circumstances (Rahman A, *et al*, 2003; Biaggi A, *et al*. 2016). Although these factors did not form part of this study, they should be considered in future studies.

The study was restricted to certain clinics and a select population of antenatal women in the Johannesburg district. These results cannot be generalized to all primary care clinics in the District and other communities in Gauteng since the demographic and contextual nature of those accessing the clinic is different. The stigma associated with reporting mental illness during motherhood may also have resulted in participants' under-reporting their psychological symptoms (Govender D, *et al*. 2020). While the EPDS allows us to assess the likelihood of current depression, it is merely a rating scale and not a diagnostic tool. Despite these limitations and the simple design of the study, we feel that the findings are clinically significant as it highlights a problem that is under-researched in our part of the world.

CONCLUSION

The prevalence of antenatal depression in this study is comparatively higher than in most published studies. Given the serious consequences for both mother and the infant, there is a need for mental health interventions by primary care workers targeting pregnant women. Integrating mental health services into a routine, primary level antenatal services and screening women for depressive symptoms may help to identify those who are vulnerable before the onset of depression (Patel V, *et al*, 2007; Petersen I, *et al*. 2012) and enable access to appropriate mental health interventions, that are contextually and culturally appropriate and feasible, and which address some of the risks factors (Buist AE, *et al*. 2002; Milgrom J, *et al*. 2008). These interventions may include amongst others, mental wellbeing programs, coping skills enhancement, brief group psychotherapy, providing social or

financial assistance in the form of food vouchers for women who are food insecure, etc. (Patel V, *et al.* 2009; Rahman A, 2004; Simon GE. 2009).

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Acanthrocercus atricollis.The common name is Black-necked Agama. A truly silly name as the Agama has no black on the neck! Photo curtesy of Lennart Eriksson, Psychiatrist – Pennington, KZN, lennarte@iafrica.com

THE 3RD SOUTHERN AFRICA MULTIDISCIPLINARY (VIRTUAL) ADHD CONGRESS

31ST AUGUST – 3RD SEPTEMBER 2022

Renata Schoeman

The 3RD Southern African Multidisciplinary (Virtual) ADHD Congress aimed to bring together psychiatrists, paediatricians, general practitioners, psychologists, and occupational therapists – the whole team involved with the optimal management of ADHD across the lifespan.

THIS INITIATIVE IS A PARTNERSHIP BETWEEN THE GOLDILOCKS AND THE BEAR FOUNDATION AND THE STELLENBOSCH BUSINESS SCHOOL, SUPPORTED BY THE SASOP ADHD SPECIAL INTEREST GROUP AND LONDOCOR, AND SPONSORED DR REDDY'S (TITLE SPONSOR), ADCOCK INGRAM, PHARMA DYNAMICS, SANDOZ, VIATRIS, ACINO, SANOFI AND CIPLA.

Attendance grew this year to 331 delegates from 12 countries (South Africa, Australia, Canada, France, Ghana, Hong Kong, The Netherlands, Norway, Spain, UAE, UK and USA). It was truly a multidisciplinary congress with psychiatrists, psychologists, paediatricians, paediatric neurologists, general practitioners, social workers, occupational therapists, educators, coaches, and others, attending and contributing. We (in collaboration with PsychMg) were able to sponsor 30 registrars to attend this year's congress. A wide range of topics were covered (which we are sharing in the form of brief reports) by excellent international and local speakers – to whom we are very grateful.

Renata Schoeman

The congress was concluded by Russell Fox Magician Insane, who shared his story of living with ADHD and specific learning disorders. His neurodivergency became his inspiration to succeed in a predominantly neurotypical world.

Please save the date for the next congress planned for 30 August – 2 September 2023

Prof Renata Schoeman[1,2,3,4] [1] Psychiatrist, Bellville, [2] Head: MBA in Healthcare Leadership, Stellenbosch Business School,[3] Convenor: SASOP ADHD Special Interest Group,[4] Co-founder: The Goldilocks and The Bear Foundation. **Correspondence: renata@renataschoeman.co.za**

3RD SOUTHERN AFRICAN MULTIDISCIPLINARY ADHD VIRTUAL CONGRESS

WEDNESDAY 31 AUGUST 2022

08:00 - 09:00	**PHARMA DYNAMICS SYMPOSIUM**	
	Welcome and introduction of speaker	Chair: Eva Minkov
	Tracto app for ADHD: Empowered parents. Thriving children	Pieter Fourie (SA)
12:30 - 13:30	**SANDOZ SYMPOSIUM**	
	Welcome and introduction of speaker	Chair: Kagiso Sekati
	The International Consensus Statement on Attention Deficit Hyperactivity Disorder: Implications for Diagnosis and Treatment	Stephen Faraone (USA)
14:00 - 16:10	**SCIENTIFIC SESSION 1 - FORENSICS**	
14:00 - 14:10	Official Welcome & Opening	Mark Smith (Stellenbosch Business School)
14:10 - 14:15	Introduction of speakers	Chair: Renata Schoeman
14:15 - 14:50	ADHD and criminality	Nyameka Dyakalashe (SA)
14:50 - 14:55	Q & A	
14:55 - 15:30	ADHD as a defence	Yolisha Singh (Australia)
15:30 - 15:35	Q & A	
15:35 - 16:05	Intimate partner violence in ADHD	Lerato Dikobe-Kalane (SA)
16:05 - 16:10	Q & A	
16:10 - 16:35	*Break / News from the sponsors*	
16:35 - 18:00	**SCIENTIFIC SESSION 2 - CONTROVERSIES IN ADHD**	
16:35 - 16:40	Introduction of speakers	Chair: Andre Venter
16:40 - 17:15	ADHD/Autism: a dimensional approach	Linda Kelly (SA)
17:15 - 17:20	Q & A	
17:20 - 17:55	ADHD/Autism: a categorical approach	Nerica Ramsundhar (SA)
17:55 - 18:00	Q & A	
19:00 - 20:00	**DR REDDY'S SYMPOSIUM**	
	Welcome and introduction of speaker	Chair: Wanda Mileham
	Stimulants vs non stimulants in ADHD	Wendy Duncan (SA)

THURSDAY 1 SEPTEMBER 2022

08:00 - 09:00	**ACINO SWISS SYMPOSIUM**	
	Welcome and introduction of speaker	Chair: Kavendren Odayar
	ADHD and Comorbid Substance Use: Epidemiology, Neurobiology, and Treatment	Wim van den Brink (The Netherlands)
12:30 - 13:30	**VIATRIS SYMPOSIUM**	
	Welcome and introduction of speaker	Chair: Susan Appelgryn
	Creative Coupling: Chess and Cognition	Hemant Nowbath (SA)
14:00 - 16:05	**SCIENTIFIC SESSION 3 - COVID**	
14:00 - 14:05	Introduction of speakers	Chair: Kobus Roux
14:05 - 14:40	The impact of Covid on ADHD in children and adolescents	David Coghill (Australia)
14:40 - 14:45	Q & A	
14:45 - 15:20	Screentime, ADHD and Covid	Rassie Erasmus (SA)
15:20 - 15:25	Q & A	
15:25 - 16:00	The role of stimulants in the treatment of long Covid	Michelle King (SA)
16:00 - 16:05	Q & A	
16:05 - 16:30	*Comfort Break / News from the sponsors*	

3RD SOUTHERN AFRICAN MULTIDISCIPLINARY ADHD VIRTUAL CONGRESS

THURSDAY 1 SEPTEMBER 2022 (continued)

16:30 - 17:55	**SCIENTIFIC SESSION 4 - ADHD**	
16:30 - 16:35	Introduction of speakers	Chair: Frans Korb
16:35 - 17:10	The borderland of Tourette's and ADHD	Renata Schoeman (SA)
17:10 - 17:15	Q & A	
17:15 - 17:50	Substance misuse and ADHD	Jason Kilmer (USA)
17:50 - 17:55	Q & A	

FRIDAY 2 SEPTEMBER 2022

08:00 - 09:00	**SANOFI SYMPOSIUM**	
	Welcome and introduction of speaker	Chair: Dr Lerato Dikobe-Kalane
	Drug switching and treatment holidays	Sebolelo Seape (SA)
14:00 - 16:00	**SCIENTIFIC SESSION 5 - SCREENTIME**	
14:00 - 14:05	Introduction of speakers	Chair: David Griessel
14:05 - 14:40	Gaming: The good, the bad, and the ESSENCE	Michele van Niekerk (SA)
14:40 - 14:45	Q & A	
14:45 - 15:20	Screen media use and ADHD related behaviours	Lesley Carew (SA)
15:20 - 15:25	Q & A	
15:25 - 16:00	Children's TV and executive functioning	Wium Erasmus (SA)
16:00 - 16:05	Q & A	
16:05 - 16:30	*Comfort Break / News from the sponsors*	
16:30 - 18:00	**SCIENTIFIC SESSION 6 - TIME TRAVELS**	
16:30 - 16:35	Introduction of speakers	Chair: Renata Schoeman
16:35 - 17:10	A historical overview of ADHD	Eric Konofal (France)
17:10 - 17:15	Q & A	
17:15 - 17:50	New Perspectives on Research and Clinical Care for ADHD	Stephen Faraone (USA)
17:50 - 17:55	Q & A	

SATURDAY 3 SEPTEMBER 2022

08:30 - 09:30	**ADCOCK-INGRAM SYMPOSIUM**	
	Welcome and introduction of speaker	Chair: Anneke Vlok
	New ADHD Treatment Options: Medikinet MR and Amfexa	Frans Korb (SA)
10: 00 - 11:25	**SCIENTIFIC SESSION 7 - WOMEN AND ADHD**	
10:00 - 10:05	Introduction of speakers	Chair: Lesley Carew
10:05 - 10:40	ADHD and the reproductive hormones (from pre-puberty to menopause)	Jane Indergaard (USA)
10:40 - 10:45	Q & A	
10:45 - 11:20	The impact of motherhood on women with ADHD	Lavinia Lumu (SA)
11:20 - 11:25	Q & A	
11:25 - 12:00	*Comfort Break / News from the sponsors*	
12:00 - 13:25	**SCIENTIFIC SESSION 8 - DIET**	
12:00 - 12:05	Introduction of speakers	Chair: Michelle King
12:05 - 12:40	Iron deficiency and ADHD	Kobus Roux (SA)

3RD SOUTHERN AFRICAN MULTIDISCIPLINARY ADHD VIRTUAL CONGRESS

SATURDAY 3 SEPTEMBER 2022 (continued)

12:40 - 12:45	Q & A	
12:45 - 13:20	An overview of the evidence and a practical approach to nutrition for ADHD	Kath Megaw (SA)
13:20 - 13:25	Q & A	
14:00 - 16:00	**SCIENTIFIC SESSION 9: PARALLEL SESSIONS**	
	SESSION 9.1 - MANAGEMENT GUIDELINES AND UPDATE	
14:00 - 14:05	Introduction of speakers	Chair: Karen Vukovic
14:05 - 14:35	An overview of international guidelines	Frans Korb (SA)
14:35 - 15:05	An overview and update of the South African guidelines	Renata Schoeman (SA)
15:05 - 15:35	Child psychiatrist perspective on current treatment options	Brendan Belsham (SA)
15:35 - 16:00	Pharmacotherapy - interactive discussion	
	SESSION 9.2 - REASONABLE ACCOMMODATIONS: AN INTERACTIVE DISCUSSION	
14:00 - 14:05	Introduction of speakers	Chair: Marele Venter
14:05 - 14:35	Reasonable accommodation: the imperative	Linda Hiemstra (SA)
14:35 - 15:05	Concessions: yes or no	Jessica Cheesman (SA)
15:05 - 15:35	Working from home: yes or no	Charlene Gerber (SA)
15:35 - 16:00	Discussion	
	SESSION 9.3 - NON-PHARMACOLOGICAL INTERVENTIONS	
14:00 - 14:05	Introduction of speakers	Chair: Michelle King
14:05 - 14:35	ADHD and coaching	Philip Collier (SA)
14:35 - 15:05	The Here and Wow! Mindfulness, Technology and the ADHD Brain	Hugo Theron (SA)
15:05 - 15:35	Yoga and mindfulness	Melane van Zyl (SA)
15:35 - 16:00	Discussion	
	SESSION 9.4 - DIAGNOSTIC OVERLAP IN CHILD & ADOLESCENT PSYCHIATRY: A PRACTICAL APPROACH	
14:00 - 14:05	Introduction of speakers	Chair: Lesley Carew
14:05 - 14:25	Austism Spectrum Disorder/ADHD	Rachel Makoni (SA)
14:25 - 14:45	PTSD/ADHD	Ronelle Price-Hughes (SA)
14:45 - 15:05	Oppositional Defiant Disorder/ADHD	Terri Henderson (SA)
15:05 - 15:25	Eating Disorders/ADHD	Christopher Szabo (SA)
15:25 - 15:45	Gender Dysphoria/ADHD	Graham de Bever (SA)
15:45 - 16:00	Discussion	
16:15 - 17:00	**SESSION 10 - ETHICS**	
16:15 - 16:20	Introduction of speaker	Chair: Renata Schoeman
16:20 - 17:00	The ethics and legalities of medical scheme remuneration for ADHD	Dr Indhrin Chetty (SA)
17:00 - 18:00	**PRIZES, ENTERTAINMENT AND CLOSING**	
17:00 - 17:10	Goldilocks & The Bear Foundation	Claire Tobin (SA)
17:10 - 17:15	Prizes	Renata Schoeman (SA)
17:15 - 17:55	**ENTERTAINMENT "MAGICIAN INSANE"**	
	Performance by Africa's most inspirational, influential, and insane Mentalist, Perceptionist and Illusionist	Russell Fox (SA)
17:55 - 18:00	**Closing of congress**	**Renata Schoeman (SA)**

3RD SOUTHERN AFRICAN MULTIDISCIPLINARY ADHD VIRTUAL CONGRESS

"THE IMPACT OF MOTHERHOOD ON WOMEN WITH ADHD"

Siobhan Booysen

THE PERFECT STORM

It is widely accepted that the journey of motherhood proves to be a rollercoaster time in one's life - bringing with it the indescribable joys and the harshest of lows. Dr Lavinia Lumu provided a thought-provoking overview of the 'Impact of motherhood on women with ADHD' at the 3rd Southern Africa Multidisciplinary ADHD Congress.

As with most psychiatric diagnoses, ADHD is met with much controversy, and even more so within special population groups. Dr Lumu provided an outline showing that ADHD, though more prevalent in male vs female children, is equally prevalent amongst adult males and females.

DESPITE THIS, ADHD IS UNDERDIAGNOSED AMONGST FEMALES OWING TO OFTEN MISSED INATTENTIVE SYMPTOM PROFILES OR ELSE ARE OTHERWISE MISINTERPRETED AS EMOTIONAL DIFFICULTIES OR DISCIPLINARY PROBLEMS. THE CONCEPT OF 'PREGNANCY BRAIN' IS ALLUDED TO IN JEST - BUT TRUTH BE TOLD THAT HORMONAL FLUCTUATIONS MAY VERY WELL BE THE GUILTY CULPRIT.

Coupled with the inherent challenges of the peripartum period - both biological and circumstantial, unrecognised, or untreated ADHD symptoms would certainly make this period significantly more difficult to navigate. Controversies and reluctance to use stimulant medication during this time furthermore cloud the scene.

PREGNANCY AND ADHD

Siobhan Booysen

ADHD symptoms have been associated with unplanned and unwanted pregnancies. The state of pregnancy is a vulnerable one, where symptoms of anxiety, depression and stress are elevated. Of course, the concern here is the quality of life for not only the mom, but also for the baby who may suffer an increased risk of a poor foetal outcome. Dr Luma shared with us evidence from Jones et al that ADHD symptoms are associated with poorer health behaviours during pregnancy, including compromised abilities to follow recommended nutritional and physical activity guidelines.

ADHD and substance use disorders share some common biological underpinnings, alerting the clinician to be mindful of this important risk factor during this expectant period. Risks of substance use in pregnancy are well established, and alcohol-use is the most common preventable cause of intellectual disability, as reported by the Committee on Substance Abuse and the Committee on Children with Disabilities.

PARENTING AND ADHD

Being a parent with ADHD comes with a unique set of challenges. Due to the hereditary nature of the disorder, the diagnosis is often evident in both child and at least one of the parents. Untreated ADHD

symptoms in either mother, child or both adds its own turbulence to parenting. Despite advances and shifts in historic societal norms, women still carry a large invisible load in motherhood. Dr Lumu highlighted themes of conflict between ADHD symptoms and gender norms and expectations. Concepts such as 'white knuckling' - where females with ADHD actively supress their symptoms in fear of violating norms of feminine behaviour furthermore add to this invisible load.

MOTHERS WITH ADHD MAY DISPLAY INCONSISTENT PARENTING TECHNIQUES, SEEN AS FORGETTING TO FOLLOW THROUGH WITH CONSEQUENCES, ACTING IMPULSIVELY OR INAPPROPRIATELY IN RESPONSE TO UNTOWARD BEHAVIOUR.

This chaotic style of parenting makes for unpredictable home and family environment with consequences that spill over into the lives of their children and spouses. Furthermore, Dr Lumu discussed how literature highlights that mothers who have unhindered impulsive symptoms may be more emotionally reactive and exhibit more difficulty in inhibiting their responses. This could result in the use of more harsh or physical punishment. Maladaptive parenting techniques are risk factors for the development of conduct problems in children with ADHD.

MOTHERHOOD AND RELATIONSHIP DIFFICULTIES

We have all heard of the age old saying 'it takes a village to raise a child'.

BUT WHAT HAPPENS TO THAT MOTHER WHO IS INADVERTENTLY DISSOLVING HER VILLAGE DUE TO IMPAIRED ABILITY TO FORMULATE AND MAINTAIN SUPPORTIVE RELATIONSHIPS?

This is the unfortunate reality of people with ADHD, where the quality of relationships in both intimate partner relationships and friendships may be compromised, leading to poor overall social support.

Having explored the impact of the disorder in both pregnancy and on mothering in her talk, Dr Lumu provided a compelling argument to look at mothers with ADHD in a new light. One sees how these inherent challenges that come with motherhood, coupled with an impairing yet treatable disorder, could make for a perfect storm. Fortunately, with these new insights, clinicians are better equipped to support mothers during this often tumultuous period, improving the outcome for both patient and family.

Siobhan Booysen MBCHB, DMH (SA) is a registrar in Psychiatry at Walter Sisulu University **Correspondence: siobhanbooysen@gmail.com**

FORTHCOMING

SOUTH AFRICAN PSYCHIATRY

CONTENT FROM THE 3RD SOUTHERN AFRICAN MULTIDISCIPLINARY ADHD VIRTUAL CONGRESS

31 AUGUST - 3 SEPTEMBER 2022

WWW.ADHDCONGRESS.CO.ZA

Presented by:

In partnership with:

Stellenbosch Business School

- ➔ **Reports on presentations** – February 2023 issue
- ➔ **Feature Articles** – May 2023 issue (currently available as individual pdfs "May 2023 issue" www.southafricanpsychiatry.co.za)
- *The Here and Wow! Mindfulness, Technology, and the ADHD brain,* Hugo Theron
- *Managing Long COVID 19 Brain Fog,* Michelle King
- *ADHD and Coaching,* Philip Collier
- *Gender Dysphoria and ADHD,* Graham N de Bever
- *Criminality and Attention Deficit Hyperactivity Disorder,* Elsie Amaley Abakisi
- *Attention deficit hyperactivity disorder (ADHD) and eating disorders,* Aleya Remtulla

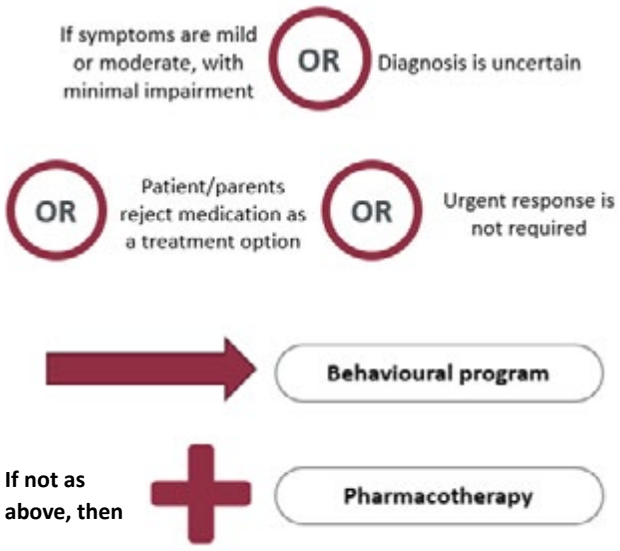
Save the date for the 4th South African Multidisciplinary ADHD Congress, 30 August - 2 September 2023

AN UPDATE ON THE ADHD TREATMENT ARMAMENTARIUM IN SOUTH AFRICA

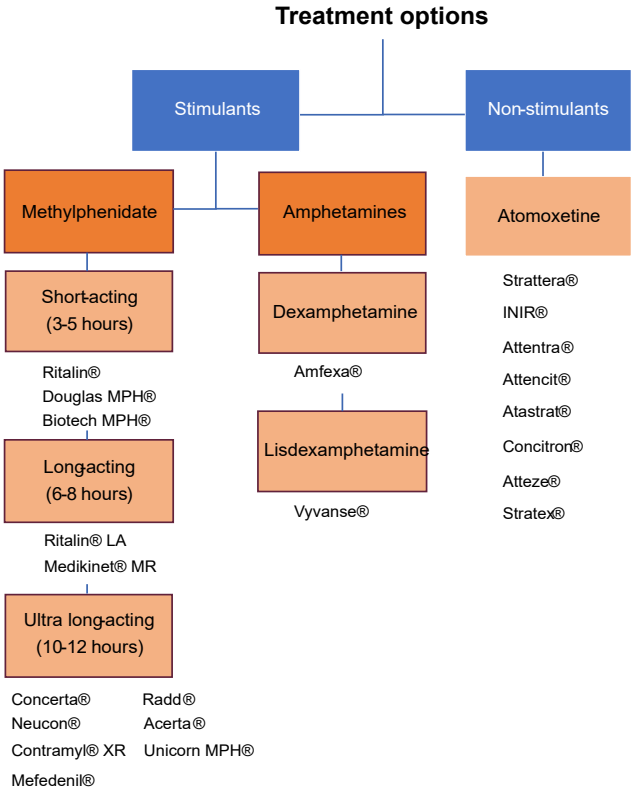
Renata Schoeman

Since the publication of the South African management guidelines for adult ADHD (Schoeman & Liebenberg, 2016), many generics and new formulations of available substances, as well as new molecules have entered the South African market. Please consult the guidelines which emphasise the importance of a comprehensive diagnostic assessment, holistic treatment approach, and individualised care.

GENERAL APPROACH



CURRENT TREATMENT OPTIONS (REGISTERED FOR THE TREATMENT OF ADHD) AVAILABLE IN SOUTH AFRICA



MEDICATION SCHEDULE (REGISTERED, AS WELL AS OFF-LABEL PRODUCTS AVAILABLE)

Substance	Trade name	Formulation	Doses	Dosing strategy
Methylphenidate Immediate release	Ritalin® Douglas MPH® Biotech MPH®		Available in 10mg tablets	Approximately 1mg/kg/dose. Initiate at 5mg bd or tds with daily or weekly increments according to efficacy and tolerability (max 100mg/day po).
Methylphenidate Extended release	Ritalin LA®	Spheroidal oral drug absorption system (SODAS)	Available in 10mg, 20mg, 30mg, and 40mg capsules	Once or twice daily dose at equivalent of total daily dose of IR.
	Medikinet MR®	Modified release pellets	Available in 5mg, 10mg, 20mg, 30mg and 40mg capsules	Once or twice daily dose at equivalent of total daily dose of IR.
	Concerta® Neucon® Mefedenil® Unicorn MPH®	Osmotic controlled release oral delivery system (OROS)	Available in 18mg, 27mg, 36mg and 54mg capsules/ tablets	Once or twice daily dose at equivalent of total daily dose of IR.
	Contramyl XR®	Multi-unit pellet system (MUPS)		
	Radd®	Hydrophilic matrix release system		
	Acerta®	Extended release film coated tablets		
Dexamfetamine sulphate	Amfexa® *registered for children and adolescents aged 6 - 17 years		Available in 5mg and 10mg snap tablets	Initiate at 5-10mg/ day po, with 5mg increase per week, to a max of 20mg/d (40mg for older children in exceptional cases).
Lisdexamfetamine dimesylate	Vyvanse® *registered for adolescents and adults from age 13 years	Amfetamine based pro-drug	Available in 30mg, 50mg and 70mg tablets	Initiate at 30mg per day, with 20mg increase after 2 weeks, to a max of 70mg/d. In patients with severe renal impairment, the maximum dose should not exceed 50mg/kg.
Atomoxetine	Strattera® INIR® Attencit® Attentra® Atteze® Atastrat® Concitron® Strattex®		Available in 10mg, 18mg, 25mg, 40mg, 60mg and 80mg capsules	Initiate at approximately 0.5mg/kg/day in patients <70kg with recommended daily dose 1.2mg/ kg/day. In patients >70kg initiate at 40mg/day with monthly increments of 20mg/day to a maximum of 100mg/day *maintain at least 12 weeks before judging clinical response).

Substance	Trade name	Formulation	Doses	Dosing strategy
Bupropion	Wellbutrin XL® Budep® Weldep XR®	XR (extended release)	150mg and 300mg tabs	Once or twice daily dose at equivalent of total daily dose of IR.
	Voxra XL®	SR (slow release)		Once or twice daily dose at equivalent of total daily dose of IR.
	Bupropion XR Adco®	XR	150mg capsules	Initiate at 75mg – 150mg/day po. Dosage may be adjusted in increments of 150mg at approximately monthly intervals to a maximum dose of 450mg/day.
Venlafaxine HCl	Efexor XR® Venlor XR® Efegen XR® Sandoz Venlafaxine® Venlafaxine Unicorn XR® Venlafaxine XR Adco®	XR	37.5mg, 75mg and 150mg capsules	Initiate at 75mg/day po. Dosage may be adjusted in increments of 75mg at approximately monthly intervals up to a maximum dose of 300/day.
	Illovex XR®	XR	37.5mg, 75mg, 150mg, 225mg and 300mg tabs	
	Odiven®		75mg and 150mg tabs	
Imipramine HCl	Ethipramine® Tofranil®		10mg and 25mg tabs	Initiate at 20mg to 70mg/day (10mg in elderly patients) and increase gradually to a maintenance dose of 100mg to 150mg/day (50mg in elderly patients).
Clonidine HCl	Equi Menoglo Drops®		0.025mg/5ml sol	Initiate at 0.025mg bd po and increase gradually to a maximum dose of 0.075mg bd po.
	Menograine®		0.025mg tabs	
Modafinil	Provigil® Modafinil 100 iPharma®		100mg tabs	Initiate at 100mg/day po. Can be increased to 200mg/day po.
Armodafinil	Nuvigil®		150mg and 250mg tabs	Initiate at 150mg per day po. Can be increased to 250mg/day po.

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Prof Renata Schoeman[1,2,3,4] [1] Psychiatrist, Bellville, [2] Head: MBA in Healthcare Leadership, Stellenbosch Business School,[3] Convenor: SASOP ADHD Special Interest Group,[4] Co-founder: The Goldilocks and The Bear Foundation. **Correspondence: renata@renataschoeman.co.za**

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

DR. REDDY'S PSYCHIATRY ACADEMIC WEEKEND MEETING

4 – 6 NOVEMBER 2022, UMHLANGA - DURBAN

Alicia McMaster

Dr. Reddy's South Africa proudly hosted the 12th annual Psychiatry Academic Weekend meeting at the Radisson BLU hotel in Umhlanga, KZN from 4 –6 November. This event has become a highly anticipated event in the calendar for all psychiatrists. Dr. Reddy's worked in collaboration with the South African Society of Psychiatrists (SASOP), Public Sector (PubSec) and Psychiatry Management Group (PsychMg), to ensure that the meeting was a collaborative effort and considered the needs of all psychiatrists irrespective of the sector within which they practice. Invitations to this meeting were sent out electronically with support from Healthman and PsychMg, due to the completeness and accuracy of their HCP databases. Within 60 minutes of opening of the RSVP platform, the meeting was fully subscribed. This overwhelmingly positive response bears testimony to the high calibre of this event, as well as the desire and willingness of the fraternity to engage face to face, in order to connect and discuss the latest scientific updates in psychiatry.

THE THEME FOR THE 2022 MEETING WAS 'ORCHESTRATING THE FUTURE OF MENTAL HEALTH'.

The Oxford dictionary defines the word "orchestrate" as a plan to coordinate the elements of a situation to produce a desired effect. This is very relevant to how society, media, the medical fraternity, governments, industry stakeholders, patients, payers and advocacy groups should approach mental wellbeing and mental health disorders in South Africa and globally. COVID-19 has brought about an alarming increase in the prevalence of mental health disorders, and a synchronised, orchestrated and collaborative effort is required to effectively address these imminent public health crises. Efforts are required to raise awareness, decrease social stigmatization, support earlier diagnoses, drive access to the right level of care, ensure appropriate healthcare resource allocation and ultimately improved clinical outcomes.

Dr.Alicia McMaster, Dr Reddy's – Opening Address/ Meeting Closure

The global and South African economy has suffered tremendously because of the pandemic. Reductions in manpower costs as well as reduced investments in scientific events and activities have been seen across the pharma industry. It is against this backdrop that Dr. Reddy's has invested significant human and financial resources to optimise impact, reach and engagement through this scientific meeting.

This weekend meeting included three distinct academic programmes:

- On Friday 4 November the Psychiatry Management group and the Public Sector group hosted their independent programs
- The Dr. Reddy's event was opened on Friday evening with a cocktail welcome function and networking opportunity.
- The Dr. Reddy's academic weekend agenda kicked-off on Saturday morning and continued until noon on Sunday.

Dr. Sebolelo Seape, Opening Address – SASOP/ "Schizophrenia in women"

Dr. Ian Westmore, Opening Address - Psych MG

Dr. Viresh Chiman, "Optimizing long-acting therapy use in Schizophrenia"

Prof. Ugash Subramaney, "The relationship between creativity, bipolar disorder and leadership"

Dr. Sanjna Keerath, "What can mobile digital technologies offer in understanding , monitoring and treating mental disorders"

Dr. Pravesh Kassen, "How to make a difference: patients with cognitive impairment, but not dementia yet"

- Saturday evening's gala dinner included an address from the Dr. Reddy's General Manager and also included a teambuilding activity hosted by the silent conductor which aligned to the theme of "Orchestrating the Future of Mental Health".

THE ACADEMIC FACULTY FOR THE DRL MEETING CONSISTED OF PSYCHIATRISTS REPRESENTING BOTH THE PUBLIC AND PRIVATE SECTOR.

The academic faculty recently attended the 35th ENCP meeting in Austria and the agenda for this weekend's meeting included the latest scientific updates from the ECNP congress. Prior to attending the ECNP congress each speaker identified a topic which they would give feedback on at the academic weekend meeting. Each speaker was allocated a 30-minute time slot on the agenda to allow for greater coverage of the ECNP conference content.

Dr. Reddy's and the academic faculty received positive feedback on the approach taken in building the agenda, the quality of the presentations and the diversity of topics. The agenda included topics ranging from the genetic and environmental influences on happiness to the impact of media on suicide and progress made in preventing suicide. A multitude of psychiatric illnesses were covered, and many speakers focused on emerging therapies and sharing updates on management of difficult to treat cases including treatment resistant depression. Some speakers raised some thought-provoking topics like the future of psychiatry and the role that digital therapeutics could play in psychiatry as well as sharing paradigm shifts in terms of the interplay between the brain, lymphatic and immune system.

Alicia McMaster Head of Medical - South Africa, Dr. Reddy's Laboratories. **Correspondence: AliciaMcmaster@drreddys.com**

Dr. Johannes Fourie, "Towards personalised psychedelic applications: understanding its treatment success"

Dr. Kobus Roux, "Novel TAARgets for stabilizing neural circuits in Schizophrenia"

Dr. Henriette Smith, "Spotlight on the management of Treatment resistant Depression"

Dr. Franco Colin, "Microglia – sculpting the brain in health and disease"

Dr. Alma Kalaba, "Cannabis use and youth mental health"

Dr. Anusha Lachman, "Interacting with families in the context of patient care"

Dr. Frans Korb, "Suicide prevention from a global perspective: progress and challenges"

Dr. Eugene Allers, "The value of early intervention and continuity of care in mental disorders"

Prof. Bonga Chiliza, Chairperson of final academic session

Rashem Motilal, Dr.Reddy's General Manager

HARMONY in **MENTAL HEALTH**[2]

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

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PERINATAL PSYCHOPHARMACOLOGY #THEMAMACONFERENCE 2022

INVITATION FROM THE CONVENOR

The *International Marcé Society for Perinatal Mental Health* is a global, interdisciplinary organization dedicated to supporting research and support of healthcare practitioners providing mental health care to mothers during the peripartum period, fathers, and their babies. The overall mission of the society is to sustain an international perinatal mental health community to promote research and high-quality clinical care around the world. The society aims to promote, facilitate, and communicate about research into all aspects of the mental health of women, men/partners, infants, and their families throughout pregnancy and the first two years after childbirth. This involves a broad range of research activities ranging from basic science through to health services and development of best practice care and prevention.

THE SOCIETY IS MULTIDISCIPLINARY AND ENCOURAGES INVOLVEMENT FROM ALL DISCIPLINES INCLUDING PSYCHIATRISTS, PSYCHOLOGISTS, PAEDIATRICIANS, OBSTETRICIANS, MIDWIVES, NURSES, EARLY CHILDHOOD SPECIALISTS AND ANY OTHER HEALTHCARE PRACTITIONERS INVOLVED IN WOMEN'S MENTAL HEALTH AND PERINATAL MENTAL HEALTH. THIS MAKES THE SOCIETY ALL-ENCOMPASSING AND INCLUSIVE.

There are many exciting developments in the *International Marcé Society for Perinatal Mental Health* including the hopes of hosting the international conference in Africa in 2026. This will be the first time in the history of the society. This meeting will ensure the development of awareness and support for perinatal mental health in South Africa and Africa.

Provision and accessing perinatal mental health services are crucial in decreasing the morbidity and mortality of mothers and their offspring and facilitate the improvement of obstetric and neonatal outcomes. The rates of common perinatal mental disorders such as depressive and anxiety disorders are higher in low and-middle income countries, at estimated rates as high as 3 out of 10 women attending an antenatal clinic[1,2,3]. Perinatal mental health services in South Africa and Africa are still limited[4,5,6].

The *Marcé Africa* regional group was created in 2021 to meet the need to create awareness, network and support of perinatal mental health practitioners in Africa. This has resulted in a continental virtual network of perinatal mental healthcare professionals invested in developing expertise in perinatal psychiatry and supporting perinatal mental healthcare practitioners through virtual platforms that became popular during the Covid-19 pandemic, where meeting people physically was restricted. Webinars born out of the inability to connect physically have become a valuable platform to connect, educate and support all healthcare practitioners who provide perinatal mental health services throughout the country and the continent.

The **MAMA (Marcé Africa Maternal Mental Health)** webinars have become a valuable virtual platform connecting healthcare professionals. The first webinar in 2021 showcased research from Africans in the perinatal mental health space and was well attended with over 130 attendees. In

2022, the focus of the webinar was on perinatal psychopharmacology and had over 300 registered attendees from all over Africa and the world from places as far as Thailand and Columbia. The success of the webinars has been possible with the collaboration of the SASOP (South African Society of Psychiatrists) – Women's mental health special interest group.

IN THIS YEAR'S WEBINAR, THERE WAS EMPHASIS ON THE PHARMACOLOGICAL MANAGEMENT OF COMMON PERINATAL MENTAL DISORDERS.

There has been an evolution on how one approaches the psychiatric care of women in their childbearing years and a need for more cognizance and individualized care and management. Due to demand and a thirst for more knowledge in perinatal psychiatry, there are hopes of another conference in 2023.

Warmest regards,

Dr Lavinia Lumu

Convener: MAMA (Marce Africa Maternal Mental Africa) Conference

President-elect: International Marcé Society for Perinatal Mental health

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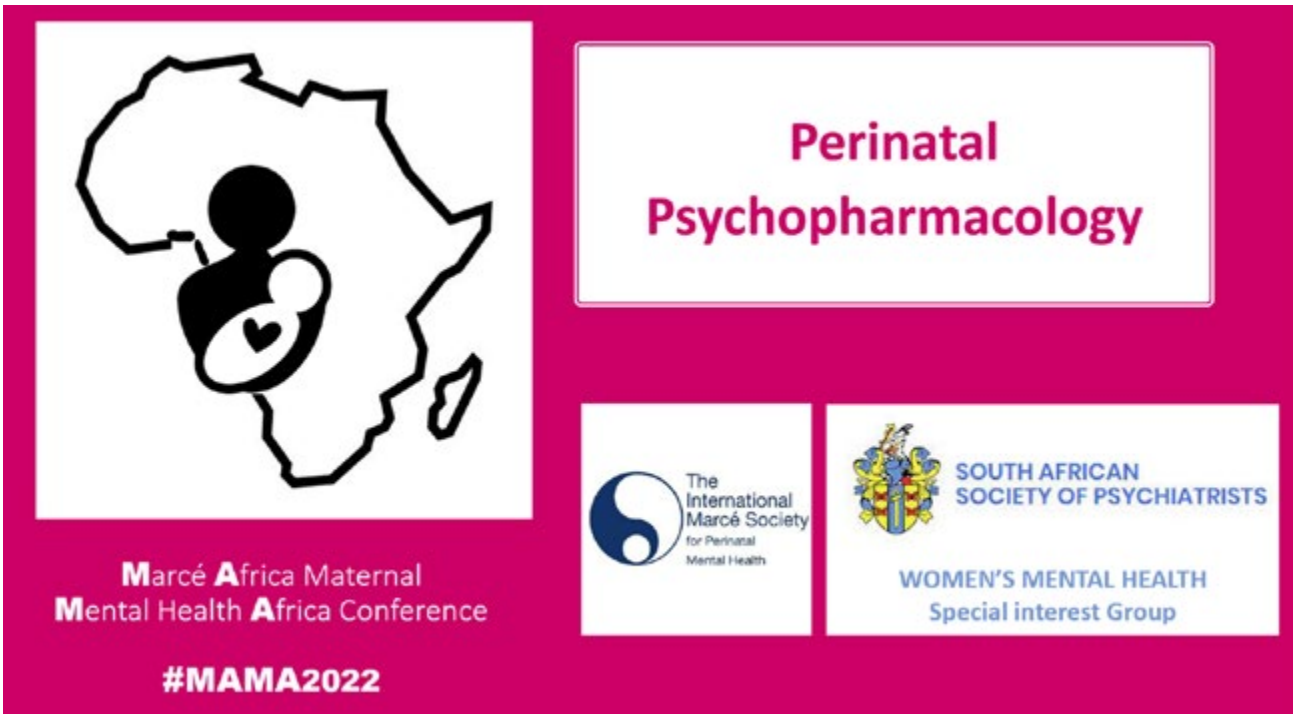

PROGRAMME

CASE PRESENTATION

Dr Lavinia Lumu

Completed the fellowship in psychiatry and obtained the FCPsych (SA) qualification from the Colleges of Medicine in South Africa and a Master of Medicine in Psychiatry (Witwatersrand) in 2014. Currently in private practice with a special interest in perinatal psychiatry and currently running a pro-bono maternal mental health clinic at the Rahima Moosa Mother and Child Hospital. An advocate for maternal mental health and supports the Grow Great - Flourish Foundation in maternal mental health training. Dr Lumu is the president-elect of the International Marcé Society for Perinatal Mental Health 2022-2024.

CHALLENGES IN PRESCRIBING MEDICATION DURING THE PERINATAL PERIOD

Dr Elsa Du Toit

Dr Elsa Du Toit is a psychiatrist specializing in maternal mental health. Her practice at Panorama Healthcare Psychiatry in the Northern Suburbs of Cape Town is aimed at the reproductive female with particular focus on the perinatal period. During 2020 she completed a PhD with the central research theme, Maternal mental health: Unplanned pregnancy and psychiatric illness in a South African context. Dr du Toit regularly facilitates and teaches on the subject of maternal mental health and is an advocate for the wellbeing of mothers, fathers and their children.

NEUROLEPTIC USE IN COMMON PERINATAL MENTAL DISORDERS

Prof Nadira Khamker

A senior lecturer and consultant psychiatrist specializing in maternal mental health in the Department of Psychiatry, University of Pretoria. she is currently the Acting Clinical Manager at Weskoppies Hospital, the training hospital of the Department of Psychiatry, UP and is a current council member of the College of Psychiatrists. They completed my PhD in 2018 with the central research theme: "Psychiatric sequelae and mental health aftercare experiences of women who had a severe life-threatening experience during pregnancy and those with uncomplicated pregnancies: An explorative-descriptive study".

MOOD STABILISERS IN THE PERIPARTUM PERIOD

Dr Bavi Vythilingum

Dr Bavi Vythilingum obtained her MMed (Psychiatry) cum laude from Stellenbosch University. She worked at the Medical Research Council Anxiety Disorders Research Unit, where her work focused on obsessive compulsive disorder and Social Anxiety Disorder. She then went on to establish the Women's Mental Health service at Groote Schuur Hospital in Cape Town. She also ran the eating disorder service and developed the subspecialist degree programme in Liaison Mental Health for the University of Cape Town (UCT). Dr Vythilingum is currently in private practice in Cape Town and remains an honorary lecturer in the Department of Psychiatry, UCT

KZN MENTAL HEALTH ADVOCACY WALK DRAWS IN HUNDREDS TO *STEP UP* FOR MENTAL HEALTH

Lynne Richards

Durban's picturesque North Beach Promenade set the scene for the 7th Annual KZN Mental Health Advocacy Walk, co-hosted by the KZN Mental Health Advocacy Group and the South African Depression and Anxiety Group (SADAG) based in KZN.

The annual walk, free to all, was held on the 9th of October 2022, with over 700 participants *stepping up* for mental health. Patients, healthcare workers, mental health activists, non-governmental organisations and other civil organisations converged on the lawns of the North Beach Amphitheatre to advocate for mental health and destigmatise conversations on mental illness. This is indeed what Prof Suvira Ramlall, specialist psychiatrist, and Mr Suntosh Pillay, clinical psychologist, hoped for when they initiated the first KZN Mental Health advocacy walk in 2016 to commemorate World Mental Health Day.

Despite their busy schedules as public servants, Prof Suvira Ramlall and Mr Suntosh Pillay have found value in inciting change through volunteerism, social activism, and advocacy at the grassroots level. Prof *Suvira Ramlall asserts, "what's really inspiring is that we're creating momentum, advocacy and activism from the bottom up, so that this event is community-driven".* Much of this work is completed through the KZN Mental Health Advocacy Group and the opening of a satellite branch of the South African Depression and Anxiety Group in KZN in 2018.

THE KZN MENTAL HEALTH ADVOCACY GROUP IS A NETWORK OF PATIENTS, PROFESSIONALS, NGOS AND CIVIL SERVANTS WHO IDENTIFIED A NEED FOR QUALITY MENTAL HEALTH SERVICES IN KZN TO ADDRESS THE SPECIFIC DEMANDS EXPERIENCED BY THE POPULATION.

These forerunners' lobbyist actions led to the opening of the first satellite branch of SADAG, which is currently based at the University of KwaZulu-Natal, in Glenwood Durban. Under the leadership of Prof Ramlall and Suntosh Pillay, SADAG KZN seeks to extend the work of the Johannesburg-based organisation. This is done by providing support group leader training and support, collaborating with existing bodies and organisations to create a more robust mental health network, and delivering free community forum talks, as well as talks to private

and public organisations, where resources allow. The yearly walk is one pioneering example of how these organisations unite to promote their various offerings to the public and canvas for support.

THE MENTAL HEALTH ADVOCACY WALK AND WELLNESS FAIR STANDS FOR MUCH MORE THAN A PUBLIC EVENT PROMOTING MENTAL HEALTH THROUGH PHYSICAL ACTIVITY. THE EVENT IS DRIVEN BY VALUES OF HOLISTIC WELL-BEING, SOCIAL ADVOCACY THROUGH VOLUNTEERISM AND COMMUNITY BUILDING.

According to Mr Pillay, *"This is more than a walk. It builds social capital in the province, makes it easier for people to ask for help when they are in distress or suicidal and promotes healthy living. This walk is about solidarity and visibility."* This solidarity saw hundreds of participants of different ages and creeds collectively enjoying dance, fitness, meditation, and yoga side-by-side. Reflecting on the unity witnessed among the participants, it is difficult to reconcile the reality that discrimination and stigmatisation still exist within our communities. Blanche Moile, a retired nurse and 18-time Comrades runner, highlighted the plight of those facing mental health challenges, *"there is still a stigma against mental illness. It can affect anyone, whether you're rich or poor."*

While mental illness does not stigmatise between rich and poor, the unequal distribution of resources and the state of public services within the province does. With the United Nations declaring the theme for World Mental Health Day, *"Make mental health a global priority for all"*, it highlights the dire state of services within the province. Mr Pillay added his voice to the conversation, stating, *"There are still major hospitals in eThekweni that do not have a single psychologist, leaving patients in the lurch when it comes to access to psychotherapy or assessments. Managers must do more. An institution is incomplete without full-time mental health care services"*. In 2014, approximately 956 000 adults were living with a mental illness in the province of KZN, with an 80% treatment gap (Burns, 2014). Docrat et al. (2019) found that KwaZulu-Natal's Department of Health only spent approximately 5% of its budget on mental health care services. The disastrous state of lack of mental leath service necessitates activism from individuals and grassroots organisations.

Just as the over 700 participants added their support to fight against mental health injustice, you too can heed the call by contributing your time or financial support to organisations such as the KZN Mental Health Advocacy Group and SADAG KZN. Add your voice to the call to step up for mental health.

For more information on the work done by the KZN Mental Health Advocacy Group and SADAG KZN please contact MHadvocacygroup@gmail.com or kznsadag@anxiety.org.za

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REFLECTIONS FROM UNIVERSITY OF KWAZULU-NATAL (UKZN) REGISTRARS ON THE 5TH AFRICAN DIASPORA GLOBAL MENTAL HEALTH CONFERENCE

Bonginkosi Mafuze, Siziphiwe Myeni

DR. BONGINKOSI MAFUZE:

Hosted by the Africa Global Mental Health Institute (AGMHI), the *5th African Diaspora Global Mental Health Conference* took place on 13-14 September 2022 in Cape Town, South Africa. The AGMHI's conference was an event I was really grateful to be part of especially after enduring the difficult times during the COVID-19 pandemic, which limited such gatherings to being held on online platforms. This conference brought together notable mental health practitioners and care providers from all corners of the world to come together to address the ongoing mental health challenges facing Africa and the diaspora.

IT WAS VERY ENCOURAGING AND INSPIRATIONAL TO SEE YOUNG PEOPLE PARTICIPATE IN THIS CONFERENCE UNDER ITS THEME "EMERGING VOICES IN MENTAL HEALTH." I MET YOUNG PEOPLE WHO ARE ACTIVELY INVOLVED IN FINDING SOLUTIONS IN CLOSE COLLABORATION WITH MORE EXPERIENCED SCIENTISTS IN THE FIELD OF MENTAL HEALTH.

The conference provided us an opportunity to learn more about evidence-based practices and how clinical trials are conducted from an African perspective with a global mindset. This experience made me feel very optimistic about the future of mental health care that is geared toward addressing the needs of an African community. I got the chance to network with like-minded people and gain valuable information to use in my early career path to being an impactful mental health practitioner in the community. There were four working groups in the domains of research, training and education, clinical care delivery, and advocacy and policy which delivered key concepts that will help achieve the aims and objectives of improving mental health care in Africa and the diaspora. The theme of the conference emerged in most of the presentations and in talks from the young to the experienced through relevant take-home messages such as, "lift as we rise," "it is not a lack of talent, but a lack of opportunity" and "victim narrative, or victorious narrative."

Prof. Jimmy Volmink

As a young African mental health practitioner, such events can only inspire one to do better. The experience made me think of what kind of mental

Drs. Rick Wolthusen and Khanyo Ntokozo Ngcobo

health service I would love to work in the near future that is inspired by global efforts but locally relevant.

We were provided with great insights into the history of South Africa and the continent in its journey to independence and transformation in the academic leadership field, the training of mental health practitioners, and legal systems as a platform of mental health advocacy, in what is called "therapeutic jurisprudence." Further engagements through breakaway sessions and feedback were the backbone of the importance of engagement in the development of tools to address the needs of the African population.

THIS EXPERIENCE WAS POSITIVE BECAUSE IT HELPED ME TO UNDERSTAND THE ROLE OF A MENTAL HEALTH PRACTITIONER AS A MEMBER OF THE MULTIDISCIPLINARY TEAM IN A VERY DIVERSE ENVIRONMENT AS A COMMUNITY LEADER, ACADEMIC, CLINICIAN, OR POLITICAL FIGURE.

It was an incredible event and I learned a great deal! I observed one of the duties of an emerging voice in mental health is centred around supporting and directing care delivery in the most locally relevant manner. After this exciting in-person experience, I look forward to the 6th annual conference perhaps in another country or city. Our wonderful keynote speakers, Prof. Jimmy Volmink and Prof. Laila Asmal, gave us insights into their lives, experiences, and pathways to becoming great researchers and leaders. I found that this was very effective for us as young psychiatrists as it goes to show the completely varied routes that succeed a medical degree.

A massive thank you to the Co-Directors, Dr. Dave Henderson and Prof Bonga Chiliza, and the AGMHI team for organizing this conference for us. I am really looking forward to the next conference.

DR. SIZIPHIWE MYENI:

In 2021, I was fortunate to be a part of the virtual *4th African Diaspora Global Mental Health Conference*. That was my first ever experience of such a conference. Looking back, I don't think that I fully appreciated the depth and the importance of this conference, maybe because it was virtual. It was not until I was part of this year's in-person AGMHI conference in Cape Town that I fully understood the amazing work of this organisation.

Going into the first day of the conference, I did not know what to expect yet I was both excited and nervous. My nervousness quickly changed to a sense of being inspired after listening to Prof. Jimmy Volmink's keynote address. I remember almost being too scared to ask such a powerful man a question, but fortunately I somehow found myself sitting with him during our lunch break; I remember asking him if he thought he had lived his purpose. Prof. Volmink left all of us feeling both inspired and challenged. His words will not be forgotten.

The day was clearly off to a great start and it continued to get more and more interesting and informative with each of the speakers giving presentations on the different AGMHI domains. My personal interest is in advocacy and policy so I found Dr. Mvuyiso Talatala's talk particularly interesting because he spoke about something that for us South Africans, and more specifically for South African mental health care workers, will go down in history as "the greatest cause of human rights violation" in our country. During the breakaway sessions I decided to join the advocacy and policy workgroup. Wow! Advocacy and policy is about so much more than shouting from roof tops or trending #hashtags on social media. Drs. Rick Wolthusen and Khanyo Ntokozo Ngcobo taught us that a lot more thought, planning, and skill goes into advocacy and policy making in order for it to be a success and to reach far and wide to the right people. This was an eye opener.

The first day ended on a beautiful note with an amazing dinner at Durbanville Hills which I thoroughly

Prof. Laila Asmal

enjoyed; it also gave me a chance to connect with people in a more relaxed environment. It is almost natural to migrate towards who you know so when in a more relaxed environment, it becomes easier to mix and mingle.

AT THE END OF DAY ONE, I WAS FEELING LESS NERVOUS THAN I HAD GOING IN AND THERE WAS A FIRE THAT WAS STARTING TO LIGHT UP INSIDE OF ME THAT I CAN ONLY EXPLAIN BY SAYING THAT IT CAME FROM WITNESSING AND REALISING THE BEAUTY OF BEING AFRICAN, OF BEING BLACK AND THAT THERE HAS NEVER BEEN A NEED TO APOLOGISE FOR IT OR HIDE IT.

The second day was even better than the first. I was seated next to Prof. Laila Asmal who gave me great advice about the journey of being a registrar and specifically about research, which I admitted to her was not my favourite thing. My favourite part of day two was listening to the amazing work that is being done across our continent by emerging researchers. I was blown away by the research that these young psychiatrists are doing in their countries and it really opened my mind to just how many interesting questions there are out there that need answers, and that research is in fact cool.

One of the most amazing things I witnessed at the conference was unity. It was how psychiatrists from all over Africa could come together, under one roof, from different backgrounds and have one goal in mind: to improve mental health among people of African descent in Africa and the world. This unity is seen through collaborations and sharing training and education opportunities across the African continent.

Whilst I appreciate that the goal of the AGMHI is to address ongoing global mental health challenges and to accelerate the development of solutions for Africa and the diaspora, this conference was a huge place of personal growth for me as an individual. In a place that I least expected it, I found myself being confronted by my own demons and needing to confront these demons that challenge my own mental health. By doing so, I came out a better and stronger individual. My only criticism would be that two days is way too short, but even so, I would not miss the next one for anything in the world!

All individuals and institutions committed to the advancement of mental health in Africa are welcome to join the AGMHI at www.agmhi.org

Pictured (L to R): Drs. Lihle Mgweba-Bewana, Bonginkosi Mafuze, Claire Kwagala, Siziphiwe Myeni, Lindokuhle Thela

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DRAFTING OF THE CARE PATHWAYS

FOR MAJOR DEPRESSIVE DISORDER, BIPOLAR MOOD DISORDER AND SCHIZOPHRENIA

BY SASOP AND PSYCHMG

Lisa Selwood

In 2013, the South African Society for Psychiatrists (SASOP) published clinical guidelines for ten common mental illnesses. Each chapter was written by a single author and then rigorously and anonymously peer reviewed. The aim was to develop guidelines applicable to the unique circumstances faced in South Africa, in a private care setting, regarding the availability of various psychotropic medications, healthcare settings and resources. It was envisioned that the guidelines would be updated and expanded regularly as new medications became available, and as healthcare settings evolve.

The 2013 guidelines have remained *in situ* since then. In 2022, Dr Eugene Allers, a PsychMg board consultant, and Dr Kobus Roux, the current PsychMg chairman, embarked on the onerous task of drafting care pathways for Major Depressive Disorder (MDD), Schizophrenia and Bipolar Mood Disorder (BMD), in conjunction with a number of colleagues who form a part of a multidisciplinary team for mental health. This was a criticism that was raised in the past, and rectified by inviting key stakeholders from different disciplines

The definition of a clinical guidelines is 'statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options. Rather than dictating a one-size-fits-all approach to patient care, clinical practice guidelines offer an evaluation of the quality of the relevant scientific literature and an assessment of the likely benefits and harms of a particular patient.[1]

Lisa Selwood

The definition of care pathways is 'a set of treatment recommendations that aim to integrate evidence regarding the clinical efficacy, toxicity, and affordability of treatments (weighed in that order of importance) to create optimal standard-of-care recommendations for patients'.[2] A care pathway should include a structured multidisciplinary plan of care, translation of guidelines or evidence into an algorithm, steps within the pathway across and timeframe and standardized care for a specific population.[2]

An important distinction to note, pathways differ from guidelines in that pathways offer one or more specific treatment recommendations based on a hierarchy of selection criteria. Guidelines, on the other hand, offer a set of reasonable treatment options but without prioritizing specific recommendations.[2]

ALTHOUGH IT MAY SEEM LIKE AN IMPOSSIBLE TASK TO KEEP UPDATING AND RE-WRITING GUIDELINES, THE DISCIPLINE STILL NEEDS THE LATEST EVIDENCE BASED INFORMATION AS A BASE FROM WHICH THEY PRACTICE.

In the past decade a plethora of new evidence, terminology and products have become available, and this contributed to the need for an updated

set of guidelines but formulated into the recent concept of 'care pathways'. The pathways are also intended to be used by medical schemes as it has become necessary that clear guidance from the psychiatric profession is required (rather than the other way around) when the annual benefit design process is undertaken, and benefit design should be prioritised based on practice and evidence and not solely on cost considerations.

In July 2022, 61 healthcare professionals (HCPs) including psychiatrists, clinical, counselling and neuro psychologists, dieticians, occupational therapists, physiotherapists, and general practitioners gathered to discuss the care pathways. In addition, there were representatives from various medical schemes and administrators, hospital groups, the Council for Medical Schemes, and medical advisors from the pharmaceutical industry.

ALL GROUPS OF STAKEHOLDERS WERE PRESENT AT THIS MEETING TO GIVE INPUT FROM VARIOUS PERSPECTIVES.

Participants were divided into one of three groups, each tackling a different illness, namely MDD, Schizophrenia and BMD. For the guidelines to be uniform, a spreadsheet was created with the following headings:

- What, who, when, how, where, why
- Outcome Measures
- Benchmark
- Evidence and level of evidence
- Consensus

Staging, levels of care and the clinical application of care were specific focus areas. Evidence for each statement was obtained through a literature search, and where evidence was lacking, consensus within the group needed to be reached. Forty-five national and international guidelines were consulted in total, indicating the truly rigorous nature of the care pathway design process. At the end of the first meeting, a plenary session took place where all three disorders and decisions were discussed, and comments and additional decisions were incorporated.

THE SECOND MEETING TOOK PLACE IN EARLY OCTOBER 2022 WITH THE CONVENORS AND SECRETARIES OF THE MEETING. THE AIM OF THIS MEETING WAS TO CONSOLIDATE THE CONSENSUS AND EVIDENCE INTO ONE DOCUMENT PER ILLNESS.

Following this, each care pathway will be sent to various groups for review, with the goal of publication in a peer reviewed journal, under the supervision of the SASOP president and the board of directors. The authors will be the most recently SASOP president, namely Dr Sebo Seape, Dr Mvuyiso Talatala and Prof Bonga Chiliza.

Again, participants were assigned into break away groups, taking the information from the spreadsheet and organising it systematically into a document, under the headings 'Introduction', 'Classification' and 'Formulation of a Treatment Plan' with various subheadings and categories within each broad, overarching term. Further meetings will take place between the smaller working groups to finalise these individual documents, if not done so during the meeting.

Another indicator of general progression from 2013 to 2022 is that each document is published in an online Word document format, allowing all authors to work on the document, and the changes are automatically updated, eliminating the need for the document to be reviewed via markup, one person at a time, and email circulation, this saving time.

THE TEAM IS CAUTIOUSLY OPTIMISTIC THAT THE CARE PATHWAYS WILL BE PUBLISHED IN THE FIRST HALF OF 2023.

Already, the sheer amount of work that has gone into these pathways is extraordinary, and colleagues are encouraged to become involved in this process, as it affects how we practice both individually and within an MDT, offers recommendations to other groups such as medical schemes and ultimately places placing psychiatry on a par with other medical disciplines. The next step in the process will include input from psychologists, occupational therapists, dieticians and other members of the MDT, which will be incorporated into the final document.

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MANAGING GENDER DYSPHORIA IN CHILDREN
A NEED FOR CAUTION

Reitze N. Rodseth, Roberto D'Angelo

The safety and protection of children is one of societies' highest priorities. It is of paramount importance that any social, psychological, or medical interventions performed on a child should not cause harm and should increase their well-being. Due to children's inherent vulnerability, additional safeguards are put into place to protect their rights and to ensure their welfare.[1] In the USA and Europe there has been a surge in the number of children being diagnosed with gender dysphoria (i.e., clinically significant feelings of discomfort or distress, or functional impairment related to incongruence between the gender that a patient sees themselves as, and their birth classified gender)[2] and then undergoing social and medical transition (i.e., puberty blockers and cross-sex hormones).[3] This dramatic increase has also been noted in South Africa.[4] This raises the question as to whether the medical fraternity are critically assessing the benefits and harms posed by these interventions.

THE EVIDENCE BASE SUPPORTING AFFIRMATIVE TREATMENT OF GENDER DYSPHORIC CHILDREN

The evidence base supporting affirmative treatment of minors (< 18 years of age) with dysphoria due to gender identity is very weak and the risks to children are not clearly understood. Worldwide, reports from national regulatory authorities (Sweden,[5,6] Finland,[7] UK,[8]) and physician societies (The French National Academy of Medicine,[9] The Royal Australian and New Zealand College of Psychiatrists[8] and the Society for Evidence Based Gender Medicine[10]), have raised concerns about the weak level of supporting evidence, as well as the unknown risks posed to children.

1) The Swedish National Board of Health and Welfare (Socialstyrelsen/NBHW) note that:

'Following a comprehensive review of evidence, the NBHW concluded that the evidence base for hormonal interventions for gender-dysphoric youth is of low quality, and that hormonal treatments may carry risks. NBHW also concluded that the evidence for pediatric transition comes from studies where the population was markedly different from the cases presenting for care today. In addition, NBHW noted increasing reports of detransition and transition-related regret among youth who transitioned in recent years.'[5,6]

IN THE LIGHT OF THE POOR EVIDENCE SWEDEN NOW ONLY OFFERS GENDER TRANSITION IN MINORS WHEN IT IS DONE AS PART OF A CLINICAL TRIAL.

2) In Finland, the Council for Choices in Health Care in Finland (COHERE Finland) write that:

'Research data on the treatment of dysphoria due to gender identity conflicts in minors is limited. COHERE considers that, moving forward, multi-professional clinics specialising in the diagnostics and treatment of gender identity conflicts at HUS (Helsinki University Hospital) and TAYS (Tampere University Hospital) should collect extensive information on the diagnostic process and the effects of different treatment methods on the mental wellbeing, social capacity, and quality of life of children and youth. There is also a need for more information on the disadvantages of procedures and on people who regret them.'[7]

3) The Independent Review of Gender Identity Services for Children and Young People (The Cass Review), commissioned by NHS England and NHS Improvement reports that:

> 'Evidence on the appropriate management of children and young people with gender incongruence and dysphoria is inconclusive both nationally and internationally…
>
> … Internationally as well as nationally, longer-term follow-up data on children and young people who have been seen by gender identity services is limited, including for those who have received physical interventions; who were transferred to adult services and/or accessed private services; or who desisted, experienced regret or detransitioned…

… The Review is not able to provide definitive advice on the use of puberty blockers and feminising/masculinising hormones at this stage, due to gaps in the evidence base; however, recommendations will be developed as our research programme progresses.'[8]

4) The French National Academy of Medicine have issued a statement in which they note the following:

> 'However, great medical caution must be taken in children and adolescents, given the vulnerability, particularly psychological, of this population and the many undesirable effects and even serious complications that can be caused by some of the therapies available. In this regard, it is important to recall the recent decision (May 2021) of the Karolinska University Hospital in Stockholm to prohibit the use of puberty blockers.
>
> If France allows the use of puberty blockers or cross-sex hormones with parental authorization and no age limitations, the greatest caution is needed in their use, taking into account the side-effects such as the impact on growth, bone weakening, risk of sterility, emotional and intellectual consequences and, for girls, menopause-like symptoms.'[9]

5) The Royal Australian and New Zealand College of Psychiatrists echo these sentiments as they write:

> 'At present, there is a paucity of quality evidence on the outcomes of those presenting with Gender Dysphoria. In particular, there is a need for better evidence in relation to outcomes for children and young people.'[11]

RESOLUTION OF GENDER DYSPHORIA DURING PUBERTY

These concerns become even greater when we note that in most cases, gender dysphoria in pre-adolescent children will disappear during puberty. In follow-up studies of prepubertal children (mainly boys) who were referred to clinics for assessment of gender dysphoria, the dysphoria persisted into adulthood for only 6-23% of children.[12,13] Thus, the vast majority of children will not persist with gender dysphoria after puberty.

Importantly, as specifically noted by the French National Academy of Medicine, there is 'no test to distinguish between persisting gender dysphoria and transient adolescent dysphoria.'[9] Further, it is common for children with gender dysphoria to have a wide variety of co-existing disorders such as anxiety, depression, oppositional defiant disorder, ADHD, psychosis, eating disorders, suicidal ideation, self-harm and autistic spectrum disorders, including Asperger's.[11,14-16]

In the light of these findings, the Council for Choices in Health Care in Finland emphasize that:

> 'If a child or young person experiencing gender-related anxiety has other simultaneous psychiatric symptoms requiring specialized medical care, treatment according to the nature and severity of the disorder must be arranged within the services of their own region, as no conclusions can be drawn on the stability of gender identity during the period of disorder caused by a psychiatric illness with symptoms that hamper development.'[7]

The Royal Australian and New Zealand College of Psychiatrists again note that:

> 'There is some evidence to suggest positive psychosocial outcomes for those who are supported in their gender identity.[17] However, evidence and professional opinion is divided as to whether an affirmative approach should be taken in relation to treatment of transgender children or whether other approaches are more appropriate…
>
> …Approaches which don't include medical treatments may focus on utilising psychotherapy to aid individuals with Gender Dysphoria in exploring their gender identity, and aid alleviation of any co-existing mental health concerns identified in screening and assessment.'[13]

UNCERTAINTIES AROUND THE BENEFITS AND RISKS OF PUBERTY BLOCKERS AND CROSS-SEX HORMONES TO TREAT CHILDREN WITH GENDER DYSPHORIA

In 2020 the UK National Institute for Health and Care Excellence (NICE) undertook two systematic evidence reviews of the use of Gonadotropin-releasing hormone (GnRH) agonists (also known as "puberty blockers") and cross-sex hormones as treatments for gender dysphoric patients <18 years old.

GNRH AGONISTS (PUBERTY BLOCKERS) WERE FOUND TO CAUSE LITTLE OR NO CHANGE IN GENDER DYSPHORIA, MENTAL HEALTH, BODY IMAGE AND PSYCHOSOCIAL FUNCTIONING.[18]

In the few studies that did report change, the results could be attributable to bias or chance, or were deemed unreliable. The landmark Dutch study by De Vries et al.[16] was considered 'at high risk of bias,' and of 'poor quality overall.' The reviewers suggested that findings of no change may in practice be clinically significant, in view of the possibility that study subjects' distress might otherwise have increased. The reviewers cautioned that all the studies evaluated had results of 'very low' certainty and were subject to bias and confounding.

The review of cross-sex hormones noted 'a fundamental limitation of all the uncontrolled studies in this review is that any changes in scores from baseline to follow-up could be attributed to a regression-to-the-mean,' rather than the beneficial effects of hormone treatment.[18]

NO STUDY REPORTED CONCOMITANT TREATMENTS IN DETAIL, MEANING THAT IT IS UNCLEAR IF POSITIVE CHANGES WERE DUE TO HORMONES OR THE OTHER TREATMENTS PARTICIPANTS MAY HAVE RECEIVED.

The reviewers suggested that hormones may improve symptoms of gender dysphoria, mental health, and psychosocial functioning, but cautioned that potential benefits are of very low certainty and 'must be weighed against the largely unknown long-term safety profile of these treatments.'

These findings echo those from many other systematic reviews and editorials.[18-20] The Society for Evidence Based Gender Medicine notes the following:

> '…the significant uncertainties regarding the long-term risk/benefit profile of "gender-affirmative" hormonal interventions call for non-invasive approaches as the first line of treatment for youth. If pursued, invasive and potentially irreversible interventions for youth should only be administered in clinical trial settings with rigorous study designs capable of determining whether these interventions are beneficial. In addition to undergoing rigorous psychological and psychiatric evaluations, patients and their families should participate in a valid informed consent process. The latter must accurately disclose the limited prognostic ability of the gender dysphoria/gender incongruence diagnosis for young people, and the many uncertainties regarding the long-term mental and physical health outcomes of these poorly studied and largely experimental interventions.'

In addition, there are significant side effects associated with the use of puberty blockers and cross-sex hormones.[21-23] These include: osteoporosis, sexual dysfunction, infertility, poor mental health outcomes including depression or suicide, increased risk of heart disease, regret due to irreversible hormonal or surgical changes. In the light of these side effects and the concerns about the quality of evidence supporting these interventions it becomes essential to ensure that the treating teams obtain comprehensive informed consent from the patient and the family.[24]

CONCLUSION

This short review highlights the inconclusive nature of the evidence supporting the management of children and young people with gender incongruence and dysphoria. It is the constitutional right of each individual to make their own choices with regard to their gender expression and sexual orientation. However, irrespective of political, religious, or ideological differences, the protection of children should be our first priority. The importance of treading slowing, carefully, and humbly has been highlighted with the news that the NHS is facing a class-action lawsuit claiming clinical negligence being brought against the Tavistock gender clinic in the UK.[25]

It is incumbent upon South African clinicians to note the warning of the French National Academy of Medicine when they say that:

> *'…great medical caution must be taken in children and adolescents, given the vulnerability, particularly psychological, of this population and the many undesirable effects and even serious complications that can be caused by some of the therapies available."*[9]

POSTSCRIPT:

Links to content related to the latest publication/statement from the National Health Service, UK (NHS) regarding their approach to gender dysphoric children.

https://www.engage.england.nhs.uk/specialised-commissioning/gender-dysphoria-services/

https://segm.org/England-ends-gender-affirming-care

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Uni-health is focused on providing Mental Health services across a multi-disciplinary team. We strive to build a network that will be regarded as the most respected and trusted provider of healthcare services by patients, medical practitioners, funders, and regulators of healthcare in each of its markets.

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CRIMINALITY AND THE CARING PROFESSION: CULPABLE HOMICIDE AND MURDER

Volker Hitzeroth

In this article, the fifth in a series of medicolegal articles, Dr Volker Hitzeroth will explain how South Africa's criminal law could impact on a Health Care Practitioner (HCP). This article will also highlight conduct that may result in criminal charges being laid against an HCP.

The subspeciality of criminal law falls within the larger division of South Africa's public law. Its primary purpose is to protect the public, punish offenders and deter future criminal conduct.

The primary organ of the state responsible for a criminal investigation and subsequently bringing such matters to court is the National Prosecuting Authority (NPA). It does so on behalf of the state. A person suspected of a crime and hence charged with criminal conduct is formally known as the "Accused".

UNLIKE A CIVIL TRIAL, WHERE THE BURDEN OF PROOF IS SET AT THE BALANCE OF PROBABILITIES (I.E. 51% PROBABILITY), A CRIMINAL TRIAL'S BURDEN OF PROOF IS SUBSTANTIALLY HIGHER.

The state must convince the judge that the issues at stake have been proven beyond a reasonable doubt. If the accused's legal representatives believe that the state has failed to prove the matter beyond a reasonable doubt they may, prior to embarking on their defense, apply for a discharge. The judge is obliged to consider such an application for a discharge but, if they are not convinced, may order the trial to continue.

At the conclusion of a criminal trial the presiding official must pass judgment. If the accused is found not guilty, they are free to leave and rebuild their lives while also attempting to put this traumatic experience behind them. If the accused is found guilty of the alleged crime the judge will determine the appropriate punishment. A criminal trial is not about paying compensation and, unlike a civil claim in alleged negligence, cannot be resolved by the payment of money to the injured party.

Volker Hitzeroth

THE OUTCOME OF A CRIMINAL TRIAL IS MORE OFTEN SEEN AS A REFLECTION OF THE ACCUSED INDIVIDUAL'S MORALITY OR PERSONALITY AND HENCE, IF FOUND GUILTY, MAY DAMAGE THEIR RELATIONSHIP WITH SOCIETY (TANGIBLY & SYMBOLICALLY).

MEDICAL PROTECTION EXPERIENCE:

Medical Protection has advised, supported, protected and defended numerous HCPs across South Africa and from all specialties, including GPs, after they have been criminally charged. Unfortunately, such matters are very serious and may be career-ending. Such matters are also marked by multiple medicolegal onslaughts where a single adverse outcome triggers numerous medicolegal consequences. In addition to the criminal charges HCPs often have to manage a concurrent and related HPCSA complaint, inquest, and media exposure.

We have found that criminal charges against HCPs can be divided into three broad categories:

1. **Boundary violations leading to allegations of a salacious nature:**

- Cases tend to be very varied in nature
- Mostly female patients and male doctors (with some exceptions)
- Often GPs, but also various specialists across the clinical spectrum
- Patient's initial main complaint may be uro-genital in nature (but can be unrelated too)
- The history taking tends to be unnecessarily focused on intimate personal details
- The physical examination is performed while the patient is (often) fully undressed and (over) extensively examined
- Poor communication and inadequate explanation lead to (occasional) misunderstandings
- HCPs facing criminal charges of this nature tend not to have made use of chaperones. This is unfortunate as chaperones are probably the most robust protection and best defense against allegations of sexual assault or rape.

  The HPCSA and criminal courts understandably take a very dim view and a hard line of such matters

2. **Fraud and theft related matters:**

- Road Accident Fund
- Death certificates
- Medical Aids
- Prescriptions
- Kickbacks
- Private business interests
- Unregistered practitioners
- Theft of medication / equipment

3. **Patient deaths (in both the private and state sector and across all clinical specialties):**

- Culpable homicide
- Murder

In South Africa there are only two crimes related to homicide. These are culpable homicide and murder.

- Culpable homicide is defined as: "The unlawful, negligent killing of a person"
- Murder is defined as: "The unlawful, intentional killing of a person"

Culpable homicide is judged according to an external, objective measure (the standard of a reasonable practitioner in similar circumstances). The death is not intentional. It is merely the result of negligent clinical conduct.

Murder is judged according to a subjective measure as determined by the person's (subjective) intent to reach the desired outcome (being death/murder). The difference between these two crimes is the form of the fault required:

- In the case of culpable homicide, the fault is negligence which has resulted in a person's death
- In the case of murder, the fault is the intention to kill a person

NEGLIGENCE IS ESTABLISHED BY ASKING WHETHER A REASONABLE DOCTOR IN SIMILAR CIRCUMSTANCES SHOULD HAVE/OR OUGHT TO HAVE FORESEEN THE POSSIBILITY OF HARM OR INJURY AND SHOULD HAVE/OUGHT TO HAVE TAKEN REASONABLE STEPS TO PREVENT IT.

The harm or injury may include death in which case it could escalate from clinical negligence to culpable homicide.

Culpable homicide is therefore established by asking whether a reasonable doctor in similar circumstances should have/ought to have foreseen the possibility of death and should have/ought to have taken reasonable steps to prevent this (i.e. foresight of the actual event – death).

Therefore, in summary, if death was an objectively foreseeable outcome as a complication, then a charge of culpable homicide is a possibility.

It would be unusual, in the event of being found guilty of culpable homicide, for the court to consider a custodial sentence.

IN THE EVENT OF MURDER HOWEVER THE COURT IS OBLIGED TO IMPOSE A MANDATORY PRISON SENTENCE OF 15 YEARS WHICH MAY BE REDUCED WITH MITIGATION.

If an HCP faces criminal allegations related to their work, these allegations should be taken extremely seriously and they are advised to contact their Medical Defence Organisation for advice immediately.

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CANYONS, CREVICES AND GATEWAYS TO SMALL VICTORIES

Claudia Campbell

My swat team and I make up an unconventional unit, and we have a common story – one where I am the main protagonist. Recently, one of my practitioners spoke about how, after so many years, my story is not only mine, but ours. This comment came after a massive crash. For years we kept looking at the wins, we acknowledged the challenges but tried to give more airtime to the good moments. The truth is, for months I have felt my body struggling, and with a struggling body comes a struggling mind.

WE HAD BUILT AN IMPRESSIVE HOUSE OF CARDS, BUT ONE MIGRAINE GUST BLEW THE WHOLE THING APART.

For someone who has allergies and resistance to every medication that would be used to treat a migraine at home, I had my whole swat team trying to break this unwelcome intruder from every possible angle. However, at the end of the day I found myself in casualty on a drip, and we realized there is a high probability that casualty and drips may become a frustrating part of my life for a while. Somehow, I felt a little like I was dealing with this reality slightly better than my swat team.

When I reflect on my story it is made up of a constant ebb and flow, highs and lows, periods of health and illness. I feel that we grow as we go and the growing works best when we let the process go as slow as we need it to. An extended period between lows almost fooled us into thinking we were in a state of constant wellness, recovery. For the most part ebbs and flows have characterized much of my journey, with treatment and therapy being adjusted. These adjustments have been hard, but this year the difficulty felt different. This year I felt that my swat team were consistently trying new things, new approaches, in an anguished attempt to keep the wins and wellness going. Week after week my body gradually crumpled into an exhausted, creased heap.

Claudia Campbell

THERE WAS A MOMENT WHEN I REALIZED MY PHYSICAL BODY COULD NOT TAKE ANY MORE MEDICAL INTERVENTIONS – AFTER A DECADE, MY RESERVES OF 'ROBUSTNESS' HAD FINALLY RUN DRY.

I felt okay admitting this, but the tough part was admitting that we had been wrong, I had not won this battle, and I was not well. It brought me back to the chronic vs acute dichotomy. As I understand it, total recovery from an acute affliction is possible,

total recovery from a chronic one is not so easy. 'Able bodied', it's a nice term. 'Disabled' is not a nice term; it is one fraught with fear and stigma. Nobody wants to be disabled. But being disabled is not a choice. It's also not a failure on the part of the patient or practitioners. It simply just is. I admit none of my practitioners have ever said that being disabled is a failure. However, I risk saying that sometimes actions speak louder than words and I feel that often recovery was the goal for all of us. Particularly, because I had become such a 'high functioning' individual. Therefore, for them and I relapse was a type of (dare I say it) failure.

I SUDDENLY FELT THAT FOR A LONG TIME WE HAD BEEN DESPERATE TO SOLVE ACUTE AFFLICTIONS, BUT REALLY, I THINK WE SHOULD HAVE BEEN EXCLUSIVELY WORKING WITH A CHRONIC DISABILITY. MY PRACTITIONERS MAY DIFFER IN OPINION, BUT TIMES OF 'HIGH-FUNCTION' DOES NOT MEAN THAT THE DISABILITY IS AT ALL GONE, IT'S SIMPLY MANAGED IN A WAY THAT FOR A TIME DOES NOT OVERTAKE 'NORMAL' ASPECTS OF LIFE.

To me, treating a chronic disability comes with less expectation, with more patience (on the part of the patient and practitioner), more acknowledgement of limitations, as well as a certain ease that some parts of life will never be 'normal'. And that's okay, it really is. The strange part is that it was me convincing my practitioners that it is okay, and that I'm okay with it.

When I don't achieve recovery from an acute symptom, I have often shrouded my experience with a sense of disappointment. Why is my body not responding? Why has it let me down again? Is my attitude wrong? Have I messed up my treatment? My collections of self-doubt accumulate into a sense of botching things completely. Not achieving recovery from certain treatment for a chronic condition simply points to the fact that was perhaps it was the wrong treatment at that specific time, and that we could try something else, or even simply wait for things to improve on their own.

Perhaps the most dangerous thing about feeling I have recovered from an acute affliction, and not a chronic one is the unexpected crash that comes after an extended period of relative wellness. When a sense of recovery settles in, preparation for relapse diminishes. Why would I lose after I have already won the battle? I remember writing this piece in about 2017:

7 October 2017

The moment I realised the intensity of past trauma had faded, the years of hard work resulted in a voice strong enough to be a voice heard, is one of the greatest victories I have experienced. Perhaps it wasn't just one moment, but a few scattered over days and events that would previously have crushed me, paralysed me. This victory felt more immense than any achievement rooted in the world of work or academics - it was a victory over poisonous, silent secrets. In the last year I have managed to walk away from emotionally charged situations with a stance of strength and objectivity and not fragility and woundedness - I think it was in these moments I realised what worth means, the feeling that I matter. As much as these times made me feel free, they also made me feel rooted - solid. Amongst other things, this solidity created a foundation of trust in myself. This was a very private victory - it was a new feeling, but I felt proud of myself. It was beautiful. I let myself believe the volume of my life story containing all the feelings of heartache, self-loathing, betrayal, worthlessness, and voicelessness had been closed - I really believed it was closed. How wrong I was.

Those last 4 words matter the most in this passage. I had won the gold medal and I appreciated it every day. When the relapse happened, I didn't just experience a sense of failure, but it felt as if everything had been a lie. I didn't feel that anyone treating me had been dishonest, I felt utterly let down by my body and mind. I had lied to myself – perhaps the worst sort of betrayal.

Having this experience 5 years ago, I would have thought I'd have learnt my lesson. Unfortunately, not. So, I ask myself, if this is how my life will most likely always be, how do I avoid the self-deprecating feeling of failure? It really has no use; it only serves negative purposes.

I MUST HUMBLY CONCEDE THAT MY THINKING IS FAULTY, AND I HAVE NEEDED HELP TO BELIEVE THERE IS NO FAILURE, SIMPLY THE PROGRESSION OF LIFE, ITS LEARNINGS, AND ITS CHALLENGES.

When I've seen my own clients struggling with big mountains to climb, I've always sat with them to figure out little goals. Even if it's two steps up and one down, you're still one step up. Eventually you can conquer that mountain bit by bit. However, as life would have it, the next mountain will be faithfully waiting. I think I forgot to apply this advice to myself. I haven't fallen from a victory; the victory was real. It's just that the next mountain is in front of me. Even though it is a much bigger mountain to summit, it doesn't negate the fact that I have just navigated my way up the yawning canyons and crevices of the last one. I guess it's my choice to see this next peak as an ominous challenge or, a gateway to a beautiful view.

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**

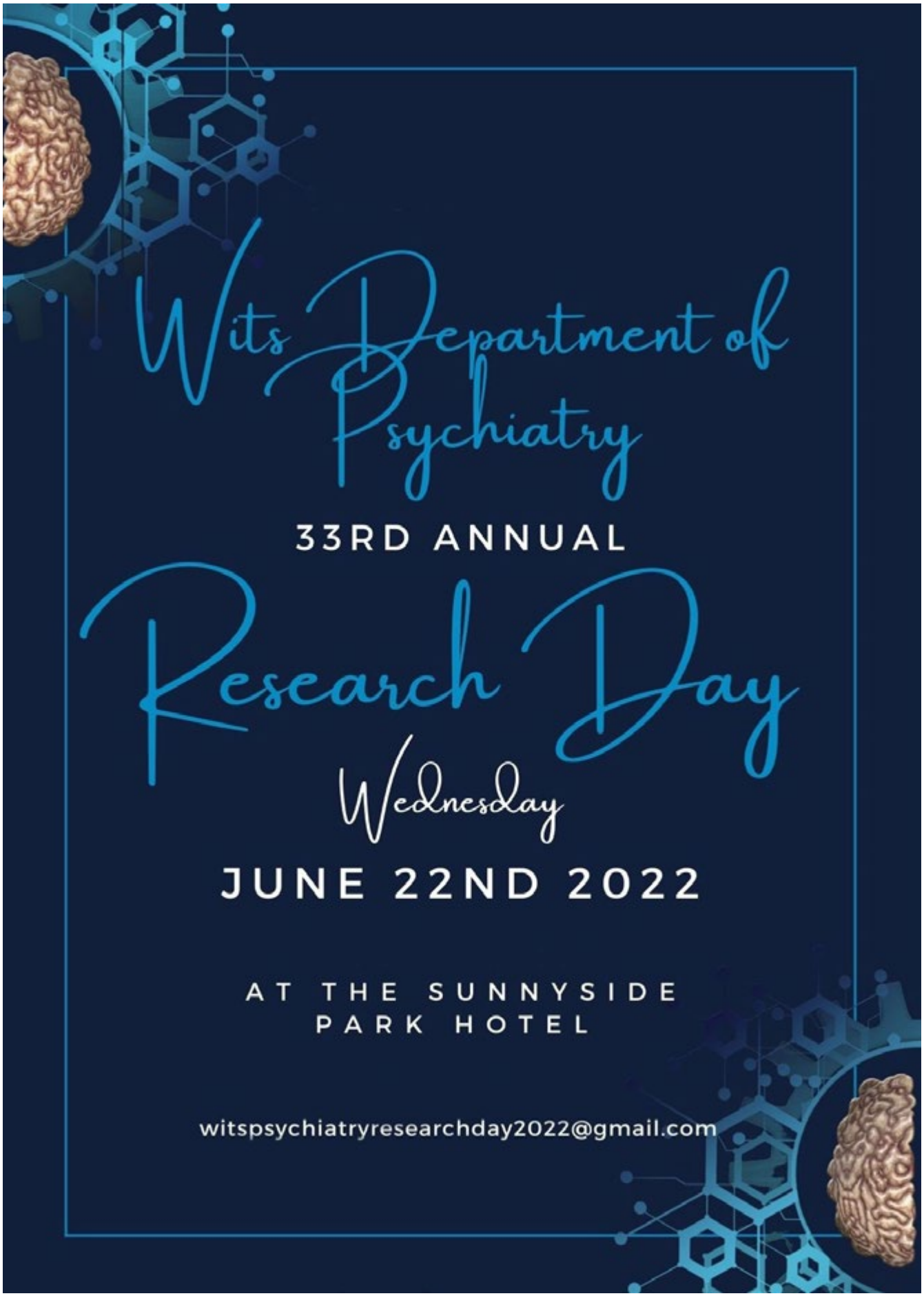
DEPARTMENTS OF PSYCHIATRY

UNIVERSITY OF THE WITWATERSRAND

Attendees at the exhibition

Prof. Ugash Subramaney, Academic Head – Department of Psychiatry, introducing Prof. Deborah Glencross

Prof. Deborah Glencross, guest speaker



Poster for the 33rd Annual Research day.

NO MUD NO LOTUS

WITHOUT SUFFERING, THERE IS NO GROWTH: HOW WE MANIFEST BEAUTY AND DEEPER MEANING IN TIMES OF ADVERSITY

Deborah Glencross

The saying 'No Mud - No Lotus' is a Buddhist teaching that I had not heard of before. I was introduced to the saying by Prof Subramaney of Wits Psychiatry when we first met to discuss her idea of a special art exhibition that would run to coincide with the South African Mental Health Awareness month this October.

I WAS FASCINATED BY THE SIMPLICITY OF THE WORDS - NO MUD, NO LOTUS - AND BEGAN TO LOOK FOR MATERIAL TO HELP ME BETTER UNDERSTAND WHAT IT MEANT.

I picked up whatever I could read, listen to or watch on YouTube about this teaching. As it always happens, and so often in our lives, serendipity and synchronicity will collide to take one on a new path. Recently I decided to take an early retirement (more a 'freedom' to pursue an art career than retirement) from the National Health Laboratory Service after working with the organisation for 35 years. And so, what began with some research into - no mud, no lotus - I was introduced to the teacher I needed at this time, as I embark on a new phase of my life and career; reminding me of another famous, and I believe it also to be a Buddhist teaching, that 'when the student is ready, the teacher will appear'.

The teacher that I found, and to whom the phrase itself, "no mud, no lotus," is most attributed, is the Buddhist teacher, Thich Nhat Hanh. He was the most remarkable man, not only a peace activist and poet, but global spiritual leader who was widely known for his convincing and persuasive teachings and influential writings on mindfulness and peace. He was born in Vietnam in 1926, now amazingly nearly 100 years ago, and made the decision to become a novice monk, in Hue city, at the tender age of sixteen and entered as bhikshu (novice monk). By the early 1950s he had become actively engaged in the movement that sought to revitalise and renew Vietnamese Buddhism. He certainly was an innovator and pace setter from what I have read about him – Thich Nhat Hanh was one of the first bhikshus to study at university in Saigon, and one of the first six monks to ride a bicycle in his early years at the monastery.

When war came to Vietnam in the 1960s things changed dramatically for the monks and nuns of Vietnam. Confronted with the question of whether to adhere to the contemplative life and meditation, stay in the monasteries, not leaving, not questioning, or to help fellow countrymen in need, those suffering under the turmoil of Vietnam war. Thich Nhat Hanh chose to do both. He founded what he called - the Engaged Buddhism movement – described in his book, entitled 'Vietnam: Lotus in a Sea of Fire'. Around this time, he founded the School of Youth and Social Service, a grassroots relief organization of 10,000 volunteers based on the Buddhist principles of non-violence and compassion. He began travelling to the United States during the 1960s; in 1961, he received a scholarship to study Comparative Religion at Princeton Theological

Seminary. The following year, he went on to teach and research Buddhism at Columbia University.

Because of his teachings and activities, and his outspokenness about the Vietnam war, Thich Nhat Hanh was exiled from Vietnam. During a trip in 1966 to the US and Europe, where he actively campaigned to end the war in Vietnam and called for peace, he first met fellow social activist Dr. Martin Luther King, Jr. I watched an interesting YouTube interview where Thich Nhat Hanh explained that he was thrilled at the opportunity to meet with Dr King; he further explained that after just 45 minutes of talking together, he convinced Dr King to speak out against the Vietnam war. The story goes - as he tells it - that immediately after their chat, Dr King decided himself to speak against the Vietnam war in the US, calling immediately for a press conference to denounce the Vietnam war. It was for these actions and dedication to peace that Dr King apparently nominated Thich Nhat Hanh for the Nobel Peace Prize in 1967. As a result of what transpired in the US, both North and South Vietnam denied him the right to return to his beloved Vietnam, and he thus began a long exile of 39 years.

Thich Nhat Hanh unfortunately died earlier this year in January, after suffering a stroke in 2014 that left him in poor health. But this did not seem to hold him back. He really lived his teaching – no mud – no lotus – his life was truly dedicated to his work of inner transformation, to better society. I believe his life was testimony to what he believed and taught. He authored more than 100 books in his lifetime that were translated into more than 40 languages. His last book I believe was published in October 2021, despite his difficulties and ill health.

So, what did I learn from reading about Thich Nhat Hanh and his teaching – no mud – no lotus.

I realised as I started that perhaps I had already understood the meaning. In those difficult moments of my life, I have often turned to a favourite line from the song 'Anthem'. The song is written by singer-songwriter, Leonard Cohen, who also reflected on human pain and suffering in his very distinctive way. He wrote/sang heart rendering words …"there is a crack, a crack in everything. That's how the light gets in...".

The idea is universal. While I was teenager and just starting university in the late 1970s and early 1980s, the actress Jane Fonda (who was a renowned Vietnam peace activist) also had her unique take and voice on the idea. Of course, it concerned aerobics and colourful leg warmers. She said, "No pain. No gain".

So, what does "no mud – no lotus" mean?

Thich Nhat Hanh says: in our minds we tend to discriminate. We discriminate against. And we discriminate between. This he believes is the source where all 'ill-ease' arises. We discriminate, he explains, between mind and matter. He asks the question whether we can - in fact – separate the two? Can we discriminate between mind and matter? Are they different from each other? Are they separated?

So, then he asks: is the mind a product of matter? Or is matter a product of the mind? There are different and conflicting interpretations around mind and matter, depending on what you read. Firstly, is the view in materialism; here the theory is that one's mind exists because of matter.

THEN THERE IS THE ALTERNATIVE VIEW OF NIHILISM WHICH ARGUES THAT REALITY IS ESSENTIALLY MENTAL, AND THAT EVERYTHING, THAT IS CONSIDERED MATTER, DOES NOT EXIST. IT IS ONLY IN THE MIND.

Thich Nhat Hanh on the other hand offers a Buddhist interpretation. In the tradition of Buddhism, he says; "there is no separation of mind and matter - one cannot exist without the other". He says that in Buddhism, they are one and the same thing. So, he teaches that, it is not mind or matter, or even mind over matter, but mind and matter. The one cannot exist without the other. *"Sometimes in your being – you, as a human being - you will manifest as mind - and other times, you will manifest as matter. But you still one and the same thing, the same person. In you, you are one, mind and matter - and the same thing".*

The idea of mind and matter being the one and the same thing is not unique. In quantum mechanics, for example, the duality of the sub-atomic electron is similar. In one instance, an electron may present itself as a particle. In other instances, it presents itself as a wave. To say it is only a particle, or wave, is incorrect. An electron does not exist as either - but is one and the same thing. It is both particle and wave. German physicist Albert Einstein further theorised that light, is both electromagnetic wave and particle-like, as packets of discrete energy.

I was captivated by the example Thich Nhat Hanh used in one of his YouTube videos I watched; he used of a piece of paper, flipping it over to show two sides. Ho goes onto explain that the piece of paper demonstrates that mind and matter cannot be separated but are of the same thing. One side of the piece of paper cannot be taken out, away from the other side. Both sides are one thing. The top side (perhaps with text) cannot be taken away from the underside (which perhaps is blank). Either side of the paper cannot be taken separately to different places. If the piece of paper is taken anywhere, it goes with both sides. This he says is how mind and matter work together.

He refers to this as the Buddhist teaching of 'inter-being'; poignant and beautiful. I understand interbeing to mean that each of us does not exist in a vacuum. We, you, me – we exist as mind and body - mind and matter. And we are not alone – in your mind and body – together there is no separation. Just like the duality of mind and the matter, the separate but joined sides of a piece of paper, are dependent on each other – one side is part of the other side. Likewise, the body has to lean on the part that is the mind, and the mind has to lean on the body.

This is the mind/body of non-discrimination. It is the pause of, the separation he says - of mind to matter and matter to mind, body and mind and mind and body - that discrimination occurs. It is in this place, this space, that things become distorted and separated. And this manifests as you are, will be. Who you are. What you are feeling. How you act. What you do. It all leads to ill-ease, disease, and discomfort. He says: this is the consequence of the separation of suffering from body and mind – or body and matter.

And so, with the same philosophy and through further teaching, Thich Nhat Hanh reveals - no mud, no lotus, the theme of this exhibition. This is his teaching and understanding that there cannot be enlightenment and happiness without struggle and suffering. He says – in Buddhist teaching - we all 'inter - are'. So, in all people and communities, there will be some sort of suffering. However, where there has been suffering, you will find happiness and where there is happiness, there must have been suffering. If there is no suffering, then there is no happiness too. He says – *"you cannot grow a lotus flower without mud. If there is no mud, then there is no lotus. After the lotus has bloomed, it returns to the mud".*

"So, one needs to look into the lotus (the growth) to understand the mud. And looking into the mud, one can see the future of the bloom, the lotus. Suffering is like this". This essentially translates to mean that one needs to have the capacity to go into oneself, to listen, to connect, to understand that one's happiness, enlightening or healing can only be because of what one had been feeling, his or her own suffering. Healing can only emerge from this place of difficulty, of pain. He also says that a person's suffering carries with it a promise of happiness, of hope, of relief. But the suffering needs to be put in touch, connected, acknowledged before it the struggle can be relieved, for the lotus – the relief - the bloom, to grow and emerge.

It is from this place that compassion happens and emerges, for oneself, for also for others. Listening I took this also to mean that the distortion – of mind and matter - the separation of struggle and happiness, mind, and matter – which leads to a separation of body and mind; the ill-ease, mental anguish, pain and suffering and even disease. So, in essence, Thich Nhat Hanh teaches us that if we can have a mind that can be one of non-discrimination, where we don't separate body from mind – left from right – pain from happiness - struggle from relief - we can begin to find true compassion. I think this is especially important for us as health care workers. All of us need to look within and acknowledge our struggles to understand others; find the compassion. This is crucial, not only so that we can be effective and compassionate to others, especially in our jobs in patient care, but towards ourselves too. Thich Nhat Hanh says that he believes that this how the relief of suffering transforms into enlightenment and happiness; the compassion leads to, and attenuates, mitigates, and relieves the suffering, all towards a path of transformation and healing. So, if you have understood the root and the nature of your, of your patient's suffering, this will take you to the path that leads to the cessation of suffering. This is particularly importance for one's spiritual, mental, and physical health, so that one is no longer afraid of suffering but know we can use it to grow, to find happiness.

SO, THE BOTTOM LINE AS I RECOGNISE IT, IS THAT WE NEED SUFFERING. IT IS PART OF THE HUMAN CONDITION, AND THE SAYING – NO MUD, NO LOTUS- IS A METAPHOR FOR SUCH.

In other words, there is usefulness in suffering. It is a tool which can give rise to the birth of compassion and love. I have no doubt that our much beloved Madiba was fundamentally, the essence of – "no mud - no lotus". I must wonder if he had been exposed to the special teachings of Thich Nhat Hanh. I do believe that Mandela, certainly for the latter part of his life, lived his life with the understanding of the duality of the inter-being and inter-are and the Buddhist philosophy of - no mud - no lotus. Mandela had suffered enormously at the hands of the South African government. Yet, through his understanding of his own pain and struggle, he was able to see and recognise the pain and struggle in others. This enabled him to truly understand, and remarkably, show the incredible compassion he did. This profoundly humble way of being, way of thinking, way of - and living - his life, led him to be able to truly forgive, show compassion and love for us all, irrespective of race, creed or colour.

As doctors, we need to acknowledge and understand our own personal struggles and challenges so that we can find relief through accept the mud. It is critical. Not only for our patients, but for ourselves. But to recognise pain and suffering in others, one has to, before this, look after ourselves, not only our physical health, but, as is the theme of this exhibition, our mental health too. This is key to having compassion as medical people. It is the same reason that an airline will ask you to affix your oxygen mask before helping other passengers.

I have learned a lot and thought about this philosophy a lot in the past few months. I have understood and learned much from - no mud – no lotus. It is a pity that only now, as I turn 60, that I am beginning to fully understand what this means, and what it can mean to me, personally; that it is only through living, acknowledging and accepting, and facing my own demons, my personal spiritual and physical challenges, struggles, difficulties and previous painful experiences, that I have learned, become resilient and grown and evolved to become the person I am today. It is only though my labour (my mud) (and yours as individuals) that we can reach enlightenment; find relief, escape suffering, come to a place of calm; resolution, perhaps contentedness, working into the mud, to grow our lotus of happiness and peace of mind. I believe therefore, that it is the personal work we do, both mental and physical, to relieve the pain, whatever this is, that brings about growth in us as human beings. So, I also now understand the phase to mean another old wise saying, that the journey is as important as the destination. This is how we learn. The process of doing. The labours of love to find our way.

Which brings me to art – and medicine – both close to my heart.

The exhibition of artworks by members of the Faculty of Health Sciences is the initiative of Prof Ugasvaree Subramaney, Head of Department of Psychiatry in the Faculty of Health Sciences and a resurrection of the original Medical Arts Society, brainchild of fellow psychiatrist, Dr Bernard Levinson. This exhibition runs intentionally during October, during our South African Mental Health Awareness month, to bring awareness to the importance of our collective mental health, ourselves, our patients, our family, our friends, our communities. The past two and more years have placed unprecedented stress and anxiety on us all, but especially those of us who are health care workers. The mental health of our local health-workforce has taken enormous strain, not only through the perils faced with the Covid-19 pandemic but also the many parallel daily challenges, especially those that public health-care workers face as they fight for basic resources for patient care, every day.

FOR MANY OF US, MYSELF INCLUDED, ART HAS BEEN A PLACE OF SAFETY AND PROTECTION, A SPACE TO QUIETEN MY MIND DURING THIS DIFFICULT TIME; THIS IS REFLECTED AND EVIDENT IN MY AS WELL AS THE MANY ARTWORKS AND INSTALLATIONS OF COLLEAGUES PRESENTED ON THIS EXHIBITION.

You, all in your own way, have expressed the mud that comprises your personal struggles, challenges, and pain. You are all lucky to have a special gift of expression, one which enables you to create a work of art. Nurture and cherish your gift. This is the tool that will guide you to your lotus.

I am proud to have been invited to open this exhibition and exhibit work alongside many talented colleagues. I'd like to thank Prof Subramaney for the honour and privilege of opening this special exhibition, to David Sepeke Segkwele, our Adler curator and his very lovely and able bodied, assistant curators, Mfundo Hlangani and Lydia Pila. Your enthusiasm and hard work were a pleasure to witness. Let us raise a glass to celebrate our mental health and all your talents. I hope you all enjoy the exhibition.

Thank you

Deborah Glencross is a Research Professor in the Faculty of Health Sciences at Wits University and is also a practicing artist. Prof Glencross believes her creative energy is synergized by the dichotomy of her dual practice, both as a medical doctor, pathologist and researcher, but also as a visual artist. She has participated in numerous group shows since the 1990s and her artworks can be found in numerous private collections. At Wits university, her work is in the permanent exhibition of the Adler Museum and at the Origins Centre on main campus, where her large-scale print installation, 'One Being' can be seen looming large over the court-yard at the main entrance to the museum

"RESEARCH IS SEEING WHAT EVERYBODY ELSE HAS SEEN AND THINKING WHAT NOBODY ELSE HAS THOUGHT." - ALBERT SZENT-GYÖRGYI

On the 22nd of June 2022 the Department of Psychiatry at the University of Witwatersrand held its 33rd Annual Research Day. Consultants, Registrars, Psychologists and allied health workers from the department gathered to share their knowledge gained in the past few years through their research. Countless hours of protocol preparation, ethics approval and data collection, all condensed into 15-minute windows in which our candidates delivered their gained knowledge to us, the audience, their colleagues.

Professor Subramaney, the head of the Wits Department of psychiatry gave us all a warm welcome, and proceeded to introduce the guest speaker for the day. We were fortunate enough to have Professor Palesa Motshabi Chakane, who is the head of Anaesthesia at the school of clinical medicine, university of Witwatersrand, be our keynote guest speaker. Prof Motshabi collaborates both nationally and internationally and was the recipient of the 2021 female academic leadership fellowship. She gave an excellent experiential talk around her career, and emphasized that there are no strict timelines or age limits with regard to furthering yourself in academia. It was both informative and inspirational to all in attendance. A standing ovation.

A total of 9 registrars presented their research. Mention must be given to each of the doctors that contributed their knowledge to the day (see attached program for the day). The presentations highlighted the incredible journeys each registrar took on in order to further our knowledge in psychiatry, and within the Wits circuit.

The presenters were adjudicated by Professor Christopher Szabo, Professor Rita Thom as well as Professor Deirdre Kruger. A special mention to Dr Wium Erasmus who was awarded the prize sponsored by the SASOP Southern Gauteng Subgroup, for his presentation on '*Gender comparison in murder accused referred for mental observation to Sterkfontein Psychiatric Hospital*', supervised by Dr Samantha Naidoo and Dr Danie Hoffman.

The research committee was lucky enough to be led and guided by Dr Belinda Marais, whose hard work and master organizational skills are unmatched.

We were honoured to have the SASOP sponsored prize for the day to be announced by Associate Professor Ariane Janse van Rensburg, in honour of the late Professor Bernard Janse van Rensburg, whose impact will never be forgotten and whose legacy will live on at Wits and within the discipline of Psychiatry.

PSYCHIATRY IS AN EVER-CHANGING, EVER-EVOLVING SPECIALTY, WITH TRAILBLAZING DISCOVERIES HAPPENING CONSTANTLY.

Each person in the multidisciplinary team forms a vital and indispensable part to the machine, well-oiled with new research and ways of thinking. The research that was presented and will be presented in the future forms part of a much larger picture that we hope to understand more of in the future. Research day is not only a vital tool to present new research to colleagues, but a reminder that there is still much to learn, which can motivate us to continually move forward.

Marc Stopford Registrar and Research Day Committee Chair **Correspondence: marc.stopford@wits.ac.za**

UNIVERSITY OF THE WITWATERSRAND JOHANNESBURG

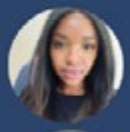
FACULTY OF HEALTH SCIENCES

WITS SCHOOL OF CLINICAL MEDICINE

ORDER FOR THE DAY

7:30-8:30	Registration, Tea
8:30-8:35	Welcome by Academic Head of Department- Prof. Subramaney
8:35-8:40	Welcome and "house rules" by Research Committee
8:40-9:10	Keynote Guest Speaker: Prof. Motshabi
9:15-9:30	Dr. Wium Erasmus *Gender comparison in murder accused referred for mental observation to Sterkfontein Psychiatric Hospital.*
9:35-9:50	Dr. Mmaphuti Kaaka *The views of black South African doctors working in psychiatry about teaching their children indigenous African languages and if they think this will affect the children's mental health.*
9:55-10:10	Dr. Natsai Nhiwatiwa *The occurrence of hyponatraemia amongst patients with severe mental illness admitted at Solomon Stix Morewa Memorial Hospital, Johannesburg.*
10:15-10:30	Dr.Boitumelo Mokgatle *Post traumatic Stress Disorder in Anti-Apartheid Veterans in South Africa.*
10:35-11:20	Tea break
11:20-11:35	Dr. Marcia Tsakani Ntimani *A comparison of Anticholinergic Use by Schizopnhrenic patients on polypharmacy and those receiving mono therapy.*
11:40-11:55	Dr. Juanita Subrayadoo *The severity of depressive symptoms in the mothers of paediatric oncology patients.*
12:00-12:15	Dr. Sonali Valabdass *Characteristics of persons accused of intimate partner homicide amongst forensic psychiatric observations.*
12:20-12:35	Dr. Gagu Matsebula *The experiences of bereaved contemporary African women in the context of cultural funeral rites.*
12:45-13:00	Vote of Thanks, Prize-giving and Closing by Prof Subramaney
13:00	Lunch








REPORT

KEYNOTE SPEAKER PROFESSOR PALESA MOTSHABI CHAKANE

Assoc. Prof. Palesa Motshabi Chakane is the Head of Anaesthesia at the School of Clinical Medicine, University of the Witwatersrand. She holds a PhD in Cardiac Anaesthesia from the University of the Witwatersrand and is the current President of the Cardiothoracic and Vascular Anaesthesia Society of Southern Africa (CASSA).

She serves on the International Committee of the Society of Cardiovascular Anaesthesiologists (SCA) (American) and is a member of the Regional Anaesthesia for Cardiothoracic Enhanced Recovery Special Interest Group. She is the Founder of the CASSA Joint Perioperative Cardiothoracic and Vascular Congress. She is also the Chairperson of the upcoming 19th International Congress of Cardiothoracic and Vascular Anaesthesia - CASSA - JPC Congress to be held in 2023.

She is a regular speaker at the national South African Society of Anaesthesia Congresses and international cardiothoracic congresses. She collaborates nationally and internationally including having a long-standing collaborative mentorship by the Harvard University's Brigham and Women Hospital's Professor Stanton Shernan. She is a recipient of the 2021 Female Academic Leadership Fellowship (FALF) which has been established by the University of the Witwatersrand's Chancellor, Dr Judy Dlamini. She is an avid researcher with a special interest in perioperative outcomes in general paediatric, paediatric congenital, cardiothoracic and vascular anaesthesia, with published work in all these fields.

GENDER COMPARISON IN MURDER ACCUSED REFERRED FOR MENTAL OBSERVATION TO STERKFONTEIN PSYCHIATRIC HOSPITAL

Dr Wium Erasmus
Supervisors: Dr Samantha Naidoo & Dr Danie Hoffman

Background: Extant literature has identified significant gender differences in murder accused in both general and forensic populations. There is a paucity of such studies, specifically comparing male and female murder accused in the forensic setting, in South Africa.

Aim: The aim of this study was to compare several accused characteristics, offence characteristics and evaluation outcomes in male and female murder accused referred for mental observation to the Sterkfontein forensic psychiatric unit.

Method: A retrospective record review was conducted on a sample of 62 male and 61 female murder accused referred for observation to Sterkfontein Hospital, Gauteng, South Africa from 1 January 2009 to 31 December 2019.

Results: Males were 5.7 times more likely than females to have a history of a prior arrest ($p<0.001$), and a greater proportion of females had a history of previous contact with mental health care services ($p=0.042$). The victim for females was mostly their offspring, with victims of males being predominantly strangers and other relatives ($p<0.001$). Most of the murders by women occurred in the home environment, using methods of poisoning, burning and suffocation, while most men murdered in public spaces or the home of the victim ($p<0.001$), by stabbing ($p<0.001$). The majority of both men (75.8%) and women (75.4%) accused had a psychiatric diagnosis made during evaluation. Seventy-seven-point four percent of males and 68.8% of females were found fit to stand trial. Men were 2.8 times more likely than females to be found criminally responsible.

Conclusion: This study identified significant gender differences in murder accused referred for mental evaluation, consistent with international findings. These differences are a valuable guide to clinicians in the identification and subsequent intervention of gender-specific violence risk factors in both general and forensic psychiatric populations.

THE VIEWS OF BLACK SOUTH AFRICAN DOCTORS WORKING IN PSYCHIATRY ABOUT TEACHING THEIR CHILDREN INDIGENOUS AFRICAN LANGUAGES AND IF THEY THINK THIS WILL AFFECT THE CHILDREN'S MENTAL HEALTH

Dr Mmaphuti Kaaka
Supervisors: Mr Barry Viljoen & Dr Kagisho Maaroganye

Background: Young black parents recognise the need to maintain the ability to speak one's mother tongue for matters of personal identity, intergenerational communication and potential cognitive/ academic advantages. This study investigated the views of black South African doctors who work in psychiatry and can speak indigenous African languages regarding teaching their children these languages.

Aim: To explore whether black South African doctors working in psychiatry teach their children indigenous African languages and to understand the challenges of their choices. The study participants worked at community psychiatry clinics around Johannesburg, South Africa.

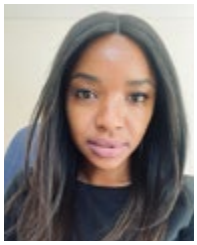
Methods: A qualitative, exploratory, descriptive research design was used. 12 purposively sampled black South African doctors whose home language was not English participated in one-on-one interviews. Data were analysed using thematic analysis.

Results: Four themes were generated. The participants reported that it was mandatory to teach their children indigenous African languages at home. The choice of 'white' English-medium schools by the participants was reported to contribute to the loss of mother tongue by their children. Visitation of South African rural areas by these urban parents with their English-speaking children resulted in feelings of

alienation from the black majority population. The doctors reported that they were worried about the future of their indigenous languages.

Conclusion: This study highlighted the distress experienced by black South African psychiatry doctors whose children presumably lose the ability to speak indigenous African languages due to infrequent exposure.The parents are concerned that their children might face social alienation/ discrimination in rural South Africa.

THE OCCURRENCE OF HYPONATRAEMIA AMONGST PATIENTS WITH SEVERE MENTAL ILLNESS ADMITTED AT SOLOMON STIX MOREWA MEMORIAL HOSPITAL, JOHANNESBURG



Dr Natsai Nhiwatiwa
Supervisors: Dr Mvuyiso Talatala & Prof. Yosuf Veriava

Background: Morbidity in patients with severe mental illness is known to be higher than in the general population. Numerous factors contribute to this, including the propensity to have comorbid conditions and the effects of long-term treatment with psychotropic medication. Hyponatraemia is the most common electrolyte abnormality diagnosed in hospitalised patients. Patients with severe mental illness are vulnerable to the development of hyponatraemia due to psychogenic polydipsia, comorbid conditions and the use of psychotropics.

Aim: To quantify the occurrence of hyponatraemia in patients with severe mental illness. This includes assessing whether the patients at Solomon Stix Morewa Memorial Hospital were adequately monitored for the development of hyponatraemia. This in an effort to establish whether hyponatraemia is recognised as a significant adverse event in patients with severe mental illness.

Results: 31.90% of the sample had hyponatraemia on admission to Solomon Stix Morewa Memorial Hospital. This was significantly higher than that of the general population. Females and patients on antihypertensive medication were most prone to the development of hyponatraemia. Type 2 diabetes mellitus and hypertension were significant comorbidities in the sample. Patients on a combination of antipsychotics were significantly more prone to developing hyponatraemia than those not on a combination of antipsychotics.

Objectives: To quantify, assess and establish the occurrence of hyponatraemia in patients with severe mental illness. To establish the trends, grades of severity, and clinical profiles of patients found to have hyponatraemia. To make possible associations between the development of hyponatraemia and various clinical profiles.

Conclusion: Hyponatraemia is a significant occurrence in patients with serious mental illness. Patients with serious mental illness are more likely to have comorbid illnesses that can be overlooked. The comorbid illnesses make the patients more likely to develop hyponatraemia which worsens their long-term outcomes. More research is required to establish the role of combined antipsychotics as a possible cause of the development of hyponatraemia in psychiatric patients. More recognition of hyponatraemia, as a significant adverse event, is required in patients with severe mental illness.

POST TRAUMATIC STRESS DISORDER IN ANTI-APARTHEID VETERANS IN SOUTH AFRICA

Dr Boitumelo Mokgatle
Supervisor: Dr Laila Paruk

Background: The prevalence of PTSD in military veterans is well studied and varies in several countries. However in South Africa there is a specific group of military veterans who were involved in fighting against South Africa's apartheid regime. They were not only exposed to military combat trauma but the additional challenge of fighting against their government and law enforcement.

Aim: The aim of the study is to explore PTSD in veterans who participated in the fight against apartheid, and to assess their current functional level.

Methods: Military veterans were sourced from the Gauteng province in the Johannesburg area. A simple random sampling technique was used. Military veterans who were part of the apartheid related conflicts between 1960 and 1991 were included in the study. Each participant was provided with a 24 item questionnaire to complete. A total of 89 military veterans were included in the study.

Results: The mean PTSD score was 49.8 and the prevalence rate of PTSD 91%. Although 57.6% of the sample reported military combat as their index trauma, 6.7% reported it as physical assault. Furthermore 11.3% reported multiple traumatic indicators and had the highest mean, however this was found to be statistically insignificant ($p< 0.05$). This also had an impact on their interpersonal and social functioning, with the total unemployment in the sample being over 80%.

Conclusion: There is a high rate of PTSD in military veterans who fought against apartheid. Furthermore there is associated functional impact in relationships and occupational functioning.

A COMPARISON OF ANTICHOLINERGIC USE BY PATIENTS WITH SCHIZOPHRENIA ON POLYPHARMACY AND THOSE RECEIVING MONOTHERAPY

Dr Marcia Tsakani Ntimani
Supervisor: Dr Wendy Friedlander

Background: Schizophrenia is one of the most debilitating mental disorders globally and one of the most challenging illnesses to treat. Although guidelines consistently caution against the use of Antipsychotic Polypharmacy

(APP), in practice APP is still significant, leading to a greater side effect burden in patients. Therefore, this study aimed to document the prevalence of anticholinergic use related to APP compared to monotherapy in patients with schizophrenia in the community psychiatric clinics in Soweto.

Methods: A retrospective record review was conducted. Data from clinical files of patients diagnosed with schizophrenia (aged 18 years and above), attending four clinics in Soweto in September, were extracted and analysed.

Information such as age, gender, presence of Extra-Pyramidal Side Effects (EPSEs), comorbid conditions, and record of current treatment was collected. Logistic regression was conducted to assess the association between APP, anticholinergic use, and socio-demographic and clinical characteristics.

Results: A total of one hundred files that met the inclusion criteria were reviewed. There were significantly more males (n=73, 73%) than females. The average age of selected patients was 47.6 years, with an average illness duration of 18.5 years.

Of the one hundred selected patients with schizophrenia, 35% were on APP. 57.7% of those on APP were prescribed an anticholinergic agent. 92% of the patients on anticholinergic agents had a prescription of a single first-generation antipsychotic (FGA) or an FGA in combination with a second-generation antipsychotic (SGA). The most prescribed antipsychotics were risperidone and flupentixol decanoate either as monotherapy or in combination.

Conclusion: The findings correlated with most literature conducted globally. APP is still highly prevalent and is associated with high anticholinergic use. Anticholinergic use is associated with FGAs rather than an antipsychotic combination. Clozapine prescriptions and other psychosocial strategies in patients with schizophrenia might help to reduce the use of APP and anticholinergic agents.

THE SEVERITY OF DEPRESSIVE SYMPTOMS IN THE MOTHERS OF PAEDIATRIC ONCOLOGY PATIENTS

Dr Juanita Subrayadoo
Supervisor: Dr Wendy Friedlander

Introduction: Parents and caregivers of children who have cancer endure a great deal of emotional, physical and financial distress. This task can be profoundly taxing and is often associated with varying degrees of depressive symptoms. Therefore, this study aimed to explore the sociodemographic data and perceived levels of depression of mothers of paediatric oncology patients at Chris Hani Baragwanath Academic Hospital (CHBAH), Soweto, Paediatric Outpatient Department.

Methods: This cross- sectional study was undertaken from 01/09/2020 until 28/02/2021. Mothers whose children were patients at the Paediatric Oncology Outpatient Department at Chris Hani Baragwanath Academic Hospital (CHBAH) participated in this study following an inclusion and exclusion criteria evaluation. After consenting to participation, each mother completed a survey that included socio-demographic data related to the mother and her child and the Hamilton depression scale.

Results: A total of 75 mothers of paediatric oncology patients at CHBAH participated in this study. Significantly, 50 (66.7%) of the women were considered depressed (>7 score) on the Hamilton depression scale scores. Significantly more women suffered from mild depression in the study sample (χ^2=35.85, df=2, p<0.001).

The participants were found to have completed Grade 10 mostly or higher schooling, have no formal employment, be married and earn less than R1000 per month. Family size tended to vary between two and six, and the sex ratio of children did not differ significantly.

Younger and unmarried mothers were more likely to be depressed. However, the level of education, employment and income levels were not significantly different between the depressed and non-depressed mothers. There were no significant correlations between socio-demographic data of the children and their mother's depression states.

Conclusion: Most of the mothers who participated in this study experienced mild depression. This study provides further evidence for early psychiatric and social intervention in mothers of children with cancer and their families.

THE EXPERIENCES OF BEREAVED CONTEMPORARY AFRICAN WOMEN IN THE CONTEXT OF CULTURAL FUNERAL RITES

Dr Gagu Matsebula
Supervisors: Prof. AB Janse Van Rensburg & Dr Amanda Edge

Introduction: Across Africa, diverse cultures have different beliefs surrounding death rituals. Women remain subject to repressive attitudes in mourning. This is a descriptive phenomenological qualitative inquiry into experiences of contemporary African women's grief in context of the cultural practices they adhere to.

Methods: A purposive sampling method was used. Data was accumulated through interviews using a semi-structured questionnaire, which were audio recorded and transcribed with consent. Data saturation was strived towards. Data analysis was done using thematic analysis.

Results: Analyses rendered three main categorical themes, namely, funeral rites, consequences, and managing expectations/beliefs. The first main category, 'funeral rites', is concerned with the description of the types of funeral rites and

associated beliefs encountered by the women during mourning. This main theme was divided into three sub-themes, namely, a) pre-funeral rites; b) funeral ceremony rites; and c) post-funeral rites. The second theme, 'consequences', is concerned with the bereaved women's emotional experiences due to funeral rites. The following subthemes were identified, namely, a) facilitation of grief; b) exploitation; c) loss of control; d) objectifying; e) uncertainty; f) isolation; g) support needs; h) lacking emotional support, i) receiving emotional support; j) practical needs; k) exclusion; l) feeling uninvolved; and m) loneliness. The third main theme reveals the women's level of engagement with respect to the funeral rites performed.

Several associated sub-themes were identified, with some having sub-categories. The sub-themes are a) enforcing rules; b) attitude of adherence; c) socio-economic circumstances; d) municipal regulations; and e) complications. The sub-theme 'complications' has several sub-categories, namely, a) unscientific; b) religion; c) mixed families; d) family dynamics; and e) work responsibilities. The participants differed in the degree to which they acquiesced to the cultural rites surrounding death.

Conclusion: The findings reveal that the social isolating effects of the cultural practices around death may have an adverse effect on the grieving process. The bereaved highlighted a need for their experiences, following funeral rites, to be known by society.

CHARACTERISTICS OF PERSONS ACCUSED OF INTIMATE PARTNER HOMICIDE AMONGST FORENSIC PSYCHIATRIC OBSERVATIONS

Dr. Sonali Valabdass
Supervisors: Prof. Ugasvaree Subramaney & Dr Amanda Edge

Background: Intimate partner homicide (IPH) is a global public health problem. One study conducted over 66 countries found that 13.5% of all homicides and 38.6% of female homicides were committed by an intimate partner. In South Africa, there were no published studies that examine alleged perpetrators of IPH that were referred for forensic psychiatric observation.

Aim: To describe the profile of accused persons referred for forensic psychiatric observation for a charge of murder or attempted murder of their intimate partners. Certain characteristics were further examined according to the psychiatric observation outcomes.

Methods: A retrospective record review of accused persons referred for forensic psychiatric observation for a charge of murder or attempted murder of their intimate partners was conducted. The period of the review was 19 years. The definition of intimate partners included current or former spouses and partners, same-sex partners and rejected suitors.

Results: One hundred and sixty-three files, which included forensic psychiatric reports, were reviewed. The findings related to the profile of accused persons and offence characteristics indicated that: (1) history of violent behaviour is prevalent; (2) homicides mostly occur in private homes; (3) knives and firearms are most often used; (4) infidelity, separation and jealousy are common motives; (5) psychotic disorders, personality disorders and substance use disorders feature prominently.

A total of 88% of the sample were found fit to stand trial and 82% were found criminally responsible. Factors significantly associated with being found fit to stand trial and criminally responsible following the forensic psychiatric observation were: male gender, having received a tertiary education, employment prior to the offence, earning a salary of more than R10 000, having no previous psychiatric or medical illness, a positive forensic history, previous intimate partner violence (IPV) perpetration, indicating a motive for the homicide, having no psychiatric illness at the time of the offence which would impact fitness to stand trial and criminal responsibility.

Factors significantly associated with being found not fit to stand trial and not criminally responsible following the forensic psychiatric observation were: female gender, having received a primary education, unemployment prior to the offence, having a previous psychiatric or medical illness, no forensic history, no previous IPV perpetration, not indicating a motive for the homicide, having a psychiatric illness at the time of the offence which would impact fitness to stand trial and criminal responsibility.

Conclusion: The characteristics highlighted in this study can contribute to the development of risk assessment tools which can be used to identify likely perpetrators of IPH. Other interventions, for example controlling access to knives and firearms, reducing substance abuse and improving mental health services, are also important in the prevention of IPH

RESEARCH DAY COMMITTEE:

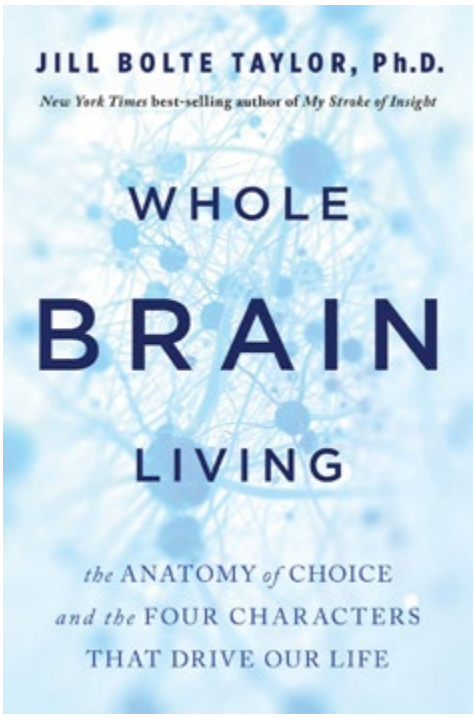
Dr M. Stopford & Dr B. Marais with thanks to: Dr A. Badat, Dr L. Narayan, Dr K. van Niekerk, Dr C. Herold, Dr R. Moshori, Dr J. Breedt, Dr N. Shandu, Dr N. Hlongwane, Dr Z. Dlamini

RESEARCH DAY SPONSORS:

WHOLE BRAIN LIVING

THE ANATOMY OF CHOICE AND THE FOUR CHARACTERS THAT DRIVE OUR LIFE

Koffi Kouakou



Title: Whole Brain Living: The Anatomy of Choice and the Four Characters that Drive our Life

Publisher: Hay House

Author: Jill Bolte Taylor, PhD

ISBN: ISBN-13: 978-1788 176989

Koffi Kouakou

Whole Brain Living is about the deliberate choices humans can make to fully use their brains via the four characters that drives their lives. Dr. Jill Bolte Taylor's goal is to help readers achieve inner peace with a deeper understanding of the brain, its functions, and abilities to make better decisions in life.

For decades, the prevailing neuroscience dogma believed that the human "right brain hemisphere was the emotional brain, while the left brain houses our rational thinking." Most recently, the right-left brain dichotomy has given way to a more complex understanding than scientists had known.

THE SUPPOSED ARTIFICIAL HEMISPHERIC DIVISION INTO TWO, HOSTS AT ONCE OUR EMOTIONAL AND THINKING LIMBIC TISSUES EVENLY.

In her book, Dr. Taylor attempts to reflect this new neuroscience discovery and introduces four distinct cells as four characters that make up humans: Character 1, Left Thinking; Character 2, Left Emotion; Character 3, Right Emotion; and Character 4, Right Thinking.

She emphasizes our total dependence on brain cells to think and feel. And the four characters she

singles out come from specific sets of unique cells in our body. Each of them helps to perform skills, think, and feel emotions with unique thoughts.

In her categorization of the four characters, she shares the recipes on how to get acquainted with them, identify them in ourselves and others, pay attention to how they unfold in our lives. As such, she prescribes a "practice called the Brain Huddle-a tool for bringing our Four Characters into conversation with one another so we can tap their respective strengths and choose which one to embody in any situation."

She advises that the more familiar we are with them, "the more power we gain over our thoughts, our feelings, our relationships, and our lives." Even better, we become masters of our thoughts and feelings with the power to "choose who and how we want to be in every moment." When used effectively and in tandem, the Four Characters balance one another as a whole brain, and "we gain a radical new road map to deep inner peace."

"WE HAVE THE POWER TO CHOOSE AND HOW WE WANT TO BE IN THE WORLD EACH AND EVERY MOMENT, REGARDLESS OF WHAT EXTERNAL CIRCUMSTANCES WE FIND OURSELVES IN," SHE BOLDLY CLAIMS.

Her remarkable recovery story from brain injury has given her the supporting evidence to share her brain life experiences and draw conclusions and recommendations to large audiences in book forms, TEDx and other social media platforms.

In 1996, she had a stroke and a severe hemorrhage in the left hemisphere of her brain which caused her to lose the ability to walk, talk, read, write, or recall any of her life. In her brilliant memoir, *My Stroke of Insight*, she details her eight-year recovery with a stroke.

EVEN AS A HARVARD-TRAINED AND PUBLISHED NEUROANATOMIST, SHE REALIZED HOW REMARKABLY HER BRAIN WORKED AND THE DIFFERENT REGIONS THAT MAKE US THINK AND FEEL TO HELP US CHOOSE.

The book became a bestseller on the New York Times nonfiction bestseller list. Furthermore, her fame came suddenly, following the TED Talk she gave in 2008 titled *My Stroke of Insight* which went viral on the internet with over 27 million views and counting. She became an instant celebrity in describing the beauty of the human brain and in its capacity to renew itself from traumatic events.

Ever since, she has been known for helping audiences to deeper understand the paramount role of the brain and how to use it better in their lives.

IN THIS BOOK, SHE SMARTLY MAKES THE LINK BETWEEN THE BRAIN FUNCTIONS AND OUR FOUR PERSONALITIES SHE CALLS CHARACTERS, GOOD AND BAD. THE ROADMAP AND EASY-TO-FOLLOW INSTRUCTIONS ARE HELPFUL AS THEY STEM FROM HER EXPERIENCE. BUT SHE SEEMS TO ASSUME, GIVEN HER SUCCESSFUL BRAIN MANAGEMENT, THAT HER EXPERIENCE IS REPLICABLE BY HER AUDIENCES.

Moreover, the instructions to follow are overwhelming in numbers and may lack prioritization to people unfamiliar with stroke experiences. They also sound like self-help spiritual guidance.

Nevertheless, Dr. Taylor's fascinating account of the whole brain living falls short for me. Her great assumptions that four characters drive our lives are based on whimsical evidence and flawed - there may be many more we don't know of.

Her mechanical descriptions don't seem convincing to me. It seems she is trying too hard to use neuroscience, psychology and even some new age spirituality to present her explanations about brain functions. Her science and neuroscience approaches to examine the brain are too mechanical and reductionist.

While it is scientifically fashionable to dissect the brain, its functions and a new way of whole brain living, much of this new compartmentalizing language doesn't make much sense and is not very convincing with plenty of cute neuroscience jargon. The book seems repetitive and technically unappealing. The writing is loose.

Her personal brain injury story is perhaps the most captivating, at the beginning of the book. The rest of the book, a bit difficult to follow, attempts to find jargon-laid justifications to describe the brain, its biological nature and the character functions that could be used to make choices and life decisions. It's not convincing to me.

Her first book *My Stroke of Insight* was a masterstroke - fascinating and more inspiring.

Koffi M. Kouakou is Managing Director of Stratnum Futures, a foresight consulting and advisory company in Pretoria. . He is the former director of the Unilever Mandela Rhodes Academy for Communications and Marketing (UMRA), a Storyteller, Social Commentator, Business Strategist, Author and Futurist. He specialises in information communications technologies for development and telecommunications adapted to environmental issues in Africa. He has been a regular contributor to international, local media and business magazines on the BBC, VOA, Deutsche Welle, The People Daily, eNCA, Africa 360 degrees, SAFM, 702 Radio, Power FM, China, Brainstorm, The Media, CIO.COM and Intelligence in South Africa. He co-authored a book titled AfricaDotEdu: IT Opportunities and Higher Education in Africa, 2003. **Correspondence: koffizulu@gmail.com**

GOOD LUXURY

FOR SOME, IT IS NOT A SECRET ANYMORE

David Swingler

A cheeky smile edged its way across the impish face of young Francois Philipponnat, 16th generation of the family to live and work the land making wine at Le Leon since 1522, when asked what plans there were for the 17th generation. With tousled hair and in jeans more suited to a tractor seat than a boardroom, he was presenting the range of Champagne Philipponnat in its 500th year at the stylish *Auslese* venue in the Cape Town Gardens.

This stuff is not cheap. It never was. Never will be. It's squarely luxury, often marketed on pillars of high quality (usually), rarity (sometimes) and exclusivity (depends…). And while most can neither access nor afford it, luxury fizz is an economic driver. It fuels tax coffers, employment, and a business of accoutrement on the side.

WHETHER IT IS THE HOUSE OF BNG ON THE STRIP AT CAMPS BAY, OR PHILIPPONNAT ROYALE RESERVE BRUT AT TABLE AT *AUBERGINE*, THE ECONOMICS GLOW.

Despite having been around half a century, Philipponnat is not a Grande Marque (Great Brand) house like Bollinger, Krug, Laurent-Perrier, Moët & Chandon or Veuve Clicquot. It is better aligned with the new wave (ironic for such an old producer) of grower champagnes.

Based in Le Leon between Ay and Dizy since 1522, its 20 hectares of Premier and Grand Cru vineyards are well placed to supply the best chardonnay and, particularly, pinot noir, for the base wine. This sets the House Style of black-grape dominated blends; fully structured with grippy traction in the mouth, a match for fine food. Philipponnat also manages a 'Perpetual Reserve', a solera system whereby one third of the reserve is drawn off to provide consistency ('wine echo') for the new blend, to be replaced by the equivalent in fresh base wine. A third defining practice is to minimise malolactic fermentation [MLF] (that converts malic into less intense lactic acid) to retain freshness, by limiting MLF (that can be controlled with numerous ambient cellar manoeuvres) to the wine that is barrel fermented. The end result? The house style: grippy power of ripe black grape, consistency year after year ('wine echo') with striking freshness regardless of up to seven years of the less.

David Swingler

That's the epitome of Champagne; how the Champenoise have managed the extreme weather of their home. But, at best, that leaves the producer (especially the smaller family) with a limited range of Brut NV, Brut Rose NV and, in rare, good-climate years when grapes ripen properly, a Vintage wine. Which can wear thin over 500 years…

GEOGRAPHY, HISTORY AND VITICULTURE HAVE LEFT THE PHILIPPONNAT FAMILY WITH AN UNUSUAL, FOR CHAMPAGNE, SINGLE VINEYARD SITE – THE WALLED CLOS DES GOISSES.

It is indeed 'very steep', a 45 degree slope that faces due south (ripeness) and is pure chalk, perfect for pinot noir. They are thus able to ape the classic 'blending' regions like Champagne and Barolo and Barbaresco - now producing single vineyard sites that offer rarity, novelty and command a premium, in the Burgundy tradition.

The Philipponnat range thus consists of an entry-level NV tier, the vintage wines, two vintaged tiers given to single vineyard greatness (Cuvee 1922 & Clos des Goisses) and three (less famous), also vintaged, single plot cuvees.

I found the visiting card Royale Reserve Brut to be broad and powerful with a late fresh clip, its Non-Dosage (no added sweetness) stable mate everything like an early morning splash in the sea. The all-chardonnay Grand Blanc Extra Brut 2014 was superbly elegant and the 2016 Blanc de Noirs Extra Brut sublime in its power. The Cuvee 1522 Extra Brut brought down the curtain. Goisses? Another day…

In a luxury wine market that I sense may be overtraded, I sometimes wince when faced with another newbie. Not so Philipponnat. Venerable in its own right, but with a fresh verve offering power without force, just my style. Yum…

Philipponnat is imported and distributed by Premier Cru Wines www.premiercru.co.za

Tiffany Hurst
Western Cape Business Development Manager
tiffany@premiercru.co.za, +27 (0) 66-094-3934

As an introductory offer on its entire portfolio, use the coupon code IWFS on the Premier Cru online platform for a 5% discount.

I have no personal financial or other interest in any of the luxury goods purveyors mentioned on these pages.

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

WRESTLING WITH FOXCATCHER

Kim Laxton

Let us consider these sports quotes: *"Overpower. Overtake. Overcome."* – Serena Williams , *"An athlete cannot run with money in his pockets. He must run with hope in his heart and dreams in his head."* – Emile Zatopek

Sport has been a human experience for centuries. The first known Olympics were held in the summer of 776 B.C. at Olympia, a site in southern Greece where people went to worship their gods. The different types of sports speak of the diversity of the human being, its body, form, and spirit.

However, one should question what might happen if "…overpower…" were to trump "…hope…"; "overtake…" was deemed more important than to simply "…run…"; and to "…overcome…" split the "… hearts and dreams…" of opponents?

The 1988 Olympic Games was a focal point in the mind of wealthy John du Pont, an heir to the du Pont family fortune. Not only was du Pont a sports enthusiast, he was a published ornithologist, philatelist, and conchologist. In the 1980s he established a wrestling facility at his *Foxcatcher* estate after becoming interested in the sport and thereafter became a notable supporter of amateur sports in the United States and a sponsor of USA Wrestling.

The story of *Foxcatcher* sees Steve Carell emulating a gaunt, wiry, and wrestling-preoccupied du Pont building a wrestling academy for a group of young men, two of whom become what one might call his obsessed protégés, Mark Schultz (played by Channing Tatum) and Mark's magnetic brother Dave (Mark Ruffalo).

On the surface du Pont appears to be a benign, rather sweet but odd character whose mind drifts in the realm of persistent and relentless training for Olympic victory. As the film weaves a rich story of these three men - the trainer and the two athletes - and as Mark sees a way to step out of the shadows of his brother, the movie's director, Bennett Miller, takes the audience into the perpetuous, fanatical, and dark mind of the increasingly obscure character that is du Pont. The story becomes dramatic as does the division of the audience. Beautiful filmography is only trumped by one flawless masterpiece of storytelling, the beguiling development of the mind of du Pont. Subtle questions regarding his mental state and stability become apparent as the characters interact with one another. Training and competition reveal a more ominous demeanour in this apparently passionate coach. Du Pont's erratic behaviour, attitudes toward the various athletes, erupt questions regarding his underlying personality structure, the questionable use of substances, seemingly bizarre past, and ultimately his motivations for others and himself.

It is a true story told with as much passion as du Pont himself, and weaves a storyline amongst the sweat and blood of deeply developed characters. However, the psychological battle within one's own mind, the viewer, is what brings this beautifully crafted film to life.

Carell, Channing, and Ruffalo play their characters with a whole and deep conviction. They are the people they represent. They live, du Pont, Mark, and Dave Schultz and breathe into the film suspenseful drama and (almost diagnostic) questions.

ONE MIGHT SEE WRESTLING AS A SPORT OF BRUTE STRENGTH, STAMINA, AND COURAGE, BUT AS A PSYCHIATRIST WRESTLING WITH *FOXCATCHER* IS A STATE OF PURPOSE.

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**

MOVIES

Title: Survivor, The
Release Date: 04 Nov 2022
Director: Barry Levinson

After World War II, Harry Haft is a boxer who fought against his peers in concentration camps. Haunted by memories, he tries to use fighting legends as a way to find his love.

Title: She Said
Release Date: 18 Nov 2022
Director: Maria Schrader

New York Times reporters Megan Twohey and Jodi Kantor break one of the most important stories in a generation — a story that helped launch the #MeToo movement around the subject of sexual assault in Hollywood.

Title: Amsterdam
Release Date: 04 Nov 2022
Director: David O. Russell

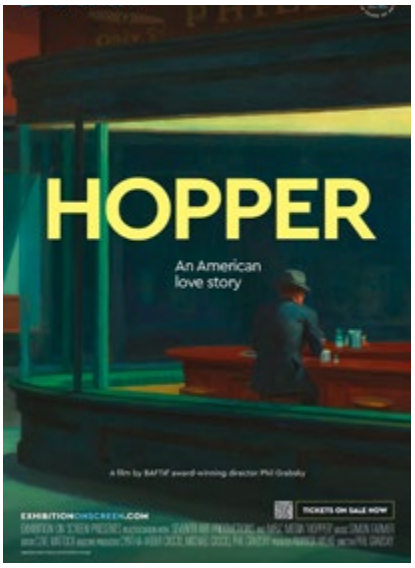
In the 1930s, three friends witness a murder, are framed for it, and uncover one of the most outrageous plots in American history.

Title: The Fabelmans
Release Date: 25 Nov 2022
Director: Steven Spielberg

Growing up in post-World War II era Arizona, a young man named Sammy Fabelman discovers a shattering family secret and explores how the power of films can help him see the truth.

Title: Notre-Dame On Fire
Release Date: 11 Nov 2022
Director: Jean-Jacques Annaud

A recreation of the gripping events that took place when the cathedral suffered the biggest blaze in its history. Retracing how heroic men and women put their lives on the line to accomplish an awe-inspiring rescue.



Title: Hopper
Release Date: 09 Dec 2022
Director: Phil Grabsky

Hopper's work is the most recognizable art in America. How did a struggling illustrator create such a bounty of notable work? This new film takes a deep look into Hopper's art, his life, and his relationships

S3 Redilev
LEVETIRACETAM

Redilev
Indications[1]

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

- **Monotherapy** for the treatment of newly diagnosed partial onset seizures with or without secondary generalisation

- ***Adjunctive therapy to treat partial onset seizures,*** with or without secondary generalisation

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

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

Dr. Reddy's

THE SOUTH AFRICAN DEPRESSION AND ANXIETY GROUP

HELPLINE : 0800 21 22 23
www.sadag.org

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

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. ZA/05/2022-24/Redi/014

Dr. Reddy's
NEUROPSYCHIATRY
GOOD HEALTH CAN'T WAIT

HOW TO DO A PHYSICAL EXAMINATION IN 5-MINUTES FOR PSYCHIATRISTS

by Dr Angelique Coetzee

This webinar was broadcast on Wednesday 19th October 2022 at 19:00. Details for accessing the recording are available from Joey Swart. Contact her via phone: 083 279 5920 or email: events@healthman.co.za

SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

Southern Gauteng

OCD VIRTUAL SYMPOSIUM

'A SEARCH FOR PEACE OF MIND'

This webinar was broadcast on Saturday 23rd July 2022 from 09:00 - 11:30. the symposium content is available at the link: https://youtu.be/yfz3k2lta5k

PROGRAMME

TIME	TITLE	SPEAKER
09:00 - 09:10	Opening & Welcome	Dr Thuli Mdaka - Psychiatrist
09:10 - 09:40	OCD: A Revew of the Evidence for Treatment Resistance	Dr Alexandra Maisto - Psychiatrist
09:40 - 09:50	Q & A	
09:50 - 10:20	CBT Management of OCD: The Old and the New	Mr Jaco Rossouw - Clinical Psychologist
10:20- 10:30	Q & A	
10:30 - 10:45	COMFORT BREAK	
10:45 - 11:15	OCD: The Journey to Recovery?	Dr Marcelle Stastny – Psychiatrist
11:15 - 11:25	Q & A	
11:25	Closing	Dr Thuli Mdaka & Dr Alexandra Maisto

SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

ADHD SPECIAL INTEREST GROUP

ANNUAL GENERAL MEETING 2022

Notice is hereby given of the Annual General Meeting of the ADHD Special Interest Group to be held online on Tuesday, 22 November 2022 from 18:00-19:00

AGENDA

1. Welcome
2. Attendance Register
3. Personalia
4. Chairperson's Report
5. Goldilocks and The Bear Foundation
6. WFADHD
7. Update on Medical Scheme Benefits
8. Planning
   a. Online Clinical Meetings
   b. Training Workshops
   c. Guidelines
   d. Rescheduling of MPH
   e. Congress 2023
9. Succession Planning
10. New Matters
11. Close

SCAN BELOW TO JOIN

5TH AFRICAN DIASPORA GLOBAL MENTAL HEALTH CONFERENCE: **EMERGING VOICES IN MENTAL HEALTH**

This preceded SASOP's biological psychiatry congress at the same location - 13 - 14 Sept 2022 | Century City Conference Centre | Cape Town, South Africa..

AGMHI

PRE-CONFERENCE CONTEST

FOR *EMERGING RESEARCHERS*:

I.E., EARLY TO MID-CAREER AFRICAN MENTAL HEALTH RESEARCHERS UP TO 10 YEARS OUT OF DOCTORAL/CLINICAL TRAINING OR FELLOWSHIP. NO SPECIFIC DEGREE REQUIRED.

PRIZE:
UP TO 12 TRAVEL AWARDS (APPROX. $1,000 USD EACH) TO ATTEND THE *5TH AFRICAN DIASPORA GLOBAL MENTAL HEALTH CONFERENCE*

JUDGES

David C. Henderson, MD

Saeeda Paruk, PhD, MBChB, FCPsych

Bonginkosi Chiliza, PhD, MBChB, FCPsych

Michelle P. Durham, MD, MPH

Entrants were asked to submit a brief video of their mental health research using Pecha Kucha's 20x20 format (20 images x 20 seconds each) to agmhi@ukzn.ac.za by 18 July. Judges selected the top submissions to be presented live at the conference

SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

DEPARTMENT OF HEALTH AVAILABLE POSITIONS: MEDICAL SPECIALISTS

MEDICAL SPECIALIST: PSYCHIATRY

NUMBER OF POSTS: 03
DIRECTORATE: Clinical Services

SALARY NOTCH :

Grade 1: R1 122 630.00 - R1 191 510 per annum

Grade 2: R1 283 592.00 - R1 362 363.00

Grade 3: R1 489 665.00 - R1 862 412.00 per annum (all inclusive package)

CENTRE: Dr. George Mukhari Academic Hospital

REQUIREMENTS:

Appropriate qualification in Psychiatry which allows Registration as a Specialist Psychiatrist with the Health Professions Council of South Africa (HPCSA). Current Registration with the HPCSA as a Specialist Psychiatrist. Sound knowledge and skills in Psychiatry. Ability to work in a multi-disciplinary team. Knowledge of Legislation, Policies and Procedures pertaining to Mental Health Care Users. Computer literacy. A valid driver's license.

DUTIES:

In the General Unit: The provision of Care, treatment and rehabilitation to Mental Health Care Users within the framework of the Mental Health Care Act (No 17 of 2002);involvement in other General Psychiatric work as needed. In the Forensic Unit: to conduct Mental observations in terms of the Criminal Procedure Act (No 51 of 1977); care, treatment and rehabilitation of State Patients in terms of the Mental Health Care Act (No 17 of 2002); involvement in other Forensic Psychiatry work as needed. Teaching and training of Medical Students, Medical Officers and Psychiatric Registrars, as well as other personnel (e.g. Nurses, etc.). To stimulate, assist with and conduct research in the field of Psychiatry. To Supervise and Manage Junior Staff, which would include disciplinary responsibilities if and when necessary. Administrative duties. Active participation in Hospital Committees. To assist with the development of Policies and Protocols of the Hospital. Active participation in quality improvement programs including Clinical Audits, morbidity and mortality meetings and continuous Professional Development activities. To liaise with external stakeholders when appropriate. To always maintain Professional and Ethical Conduct.

ENQUIRIES: Dr. LK Ndhlovu Tel: 012 529 3433/3201

PERIODIC MEDICAL SPECIALIST: PSYCHIATRY

NUMBER OF POSTS: 04
DIRECTORATE: Clinical Services

SALARY TARIFFS:

Grade 1: R 532 per hour

Grade 2: R 608 per hour

Grade 3: R 706 per hour

CENTRE: Dr. George Mukhari Academic Hospital

REQUIREMENTS:

Appropriate qualification in Psychiatry which allows Registration as a Medical Specialist Psychiatrist with the Health Professions Council of South Africa (HPCSA). Current Registration with the HPCSA as a Medical Specialist Psychiatrist. Sound knowledge and skills in Psychiatry. Ability to work in a multi-disciplinary team. Knowledge of Legislation, Policies and Procedures pertaining to Mental Health Care Users. Computer literacy. A valid driver's license.

DUTIES:

In the General Unit: The provision of Care, treatment and rehabilitation to Mental Health Care Users within the framework of the Mental Health Care Act (No 17 of 2002) involvement in other General Psychiatric work as needed. In the Forensic Unit: to conduct Mental observations in terms of the Criminal Procedure Act (No 51 of 1977); care, treatment and rehabilitation of State Patients in terms of the Mental Health Care Act (No 17 of 2002); involvement in other Forensic Psychiatry work as needed. Teaching and training of Medical Students, Medical Officers and Medical Psychiatric Registrars, as well as other personnel (e.g. Nurses, etc.). To assist the Psychiatry Department in other areas of clinical service delivery as may be needed.

Enquiries: Dr. LK Ndhlovu Tel 012 529 3433/3201

SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

AVAILABLE POSITION AT NEW SOMERSET HOSPITAL

A FULLTIME SPECIALIST POST IN PSYCHIATRY IS AVAILABLE FROM 1 OCTOBER 2022 AT NEW SOMERSET HOSPITAL, CAPE TOWN.

The post is a joint appointment of the Department of Psychiatry & Mental Health, University of Cape town and the Provincial Government of the Western Cape.

DUTIES INCLUDE:

- The clinical assessment, management and supervision of adult patients referred to a general adult psychiatry unit.
- Provide a direct clinical service and manage a psychiatric adult inpatient unit.
- Clinical governance and administrative organization of a general psychiatry team.
- Provide outreach services to District Health services and District hospitals.
- Teaching of under- and postgraduate students in relevant degrees and diplomas in psychiatry.
- Manage the medical intern program for psychiatry at the hospital.
- To stimulate, assist with and conduct research relevant to the Western Cape Department of Health and University of Cape Town Department of Psychiatry & Mental Health.

REMUNERATION PACKAGE:

Grade 1: R 1 106 040 per annum

Grade 2: R 1 264 623 per annum

Grade 3: R 1 467 651 per annum

(A portion of the package can be structured according to the individual's personal needs).

The position does come with commuted overtime. Approval to conduct Remunerative work outside the employee's employment (RWOEE) may also be applied for.

REQUIREMENTS:

1. Specialist registration with the HPCSA to practise as a Specialist Psychiatrist
2. FC(Psych)SA, MMed(Psych) or equivalent recognised by HPCSA
3. Clinical, teaching, research, management and communication skills
4. Ability to serve patients in at least two of three official languages of the Western Cape

Please submit applications including the following documents by 16 October 2022 to Nadine Wyngaard at **Nadine.Wyngaard@westerncape.gov.za** by post/courier to The Chief Executive Officer, New Somerset Hospital.

REQUIRED DOCUMENTS:

1. CV
2. Certified Copy of ID and Driver's License
3. Z83 completed - use 'as per block advert' for specific post
4. Certified Copy of Matric Certificate and Degrees
5. HPCSA Registration

ENQUIRIES:

Dr Jacques Hendricks
Jacques.hendricks@westencape.gov.za
082 773 0978

SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

POSITION STATEMENT

SASOP STATEMENT ON USE OF IVI KETAMINE AND INTRANASAL ESKETAMINE FOR TRD

Despite the proven efficacy of monoamine based antidepressants, many treated individuals fail to achieve full syndromic and functional recovery, especially with repeated episodes. Ketamine and Esketamine represent novel treatment opportunities in the management of patients with treatment resistant depression (TRD) in Major Depression*.

Ketamine is registered in South Africa for anaesthetic induction, maintenance of general anaesthesia in combination with oxygen and nitrous oxide, and in children, management of minor surgery and diagnostic procedures.

Several studies and systematic reviews provide a good level of evidence for efficacy in the treatment of TRD, however concerns remain regarding long-term effects, side effects and safety issues.

THERE IS UNCERTAINTY REGARDING THE POSITION OF NOVEL TREATMENTS IN TREATMENT ALGORITHMS DUE TO A LACK OF EVIDENCE IN THIS REGARD.

Nevertheless, there is a rapid increase in the number of community-based clinics boasting the use of Ketamine in psychiatry. There are no guidelines or regulations available in the use of Ketamine in psychiatry in South Africa. This prompted the South African Association of Anaesthesiologists (SASA) to publish a statement regarding safety concerns and measurements to be put in place to ensure safe administration. SASA's concerns are regarding the administration and post administrative monitoring of patients. SASOP support the SASA statement.

SASOP has additional concerns regarding the selection of patients and long term follow up post treatment. Further concerns are around the psycho-memetic effect of Ketamine, especially in high-risk patients, and maintenance treatment. It is known that the antidepressant effect of administration of Ketamine wears off over time.

SASOP advises that the choice and initiation of treatment as well as follow up should be supervised by a psychiatrist. If the treatment is done by independent clinics the patient should be referred and followed up by a psychiatrist and referral notes and a discharge report should be kept for future reference. The use of IVI Ketamine and Esketamine in Psychiatric Disorders should be limited to TRD until more evidence is available for other disorders.

SASA guidelines have been drawn and approved for Ketamine implementation at point of care.

KEY MESSAGES

- Ketamine is emerging as a new treatment in psychiatry, but further active research is required to understand how to optimally use ketamine for treating mental illness. There is lack of evidence on its long-term effects, side effects and safety.

SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

- At present there is sufficient evidence only for use in **treatment-resistant depression**, and not any other psychiatric conditions.
- Treatment-resistant depression needs to be managed on **level 2-7 care pathwa**y i.e by a **specialist psychiatrist.**
- At present the evidence is only sufficient for IV ketamine. There is not sufficient evidence to support the use of IM Ketamine, SC ketamine or Ketamine lozenges.
- IV Ketamine is registered in South Africa as an anaesthetic drug. According to a position statement by SASA, it must be administered by an **anaesthetist or a GP with a diploma in anaesthetics** in an environment where it is possible to monitor the patient and potentially resuscitate.

IN SUMMARY

Ketamine is a scheduled drug in South Africa. There is some evidence for the off-label use in managing Treatment Resistant Depression.

TREATMENT RESISTANT DEPRESSION IS MANAGED ON LEVEL 2-7 CARE PATHWAYS - THAT IS THE DIAGNOSIS, MANAGEMENT AND FOLLOW-UP IS DONE BY A SPECIALIST PSYCHIATRIST.

To protect practitioners and patients, SASOP recommends the following:

1. The diagnoses, acute management and chronic management of Treatment Resistant Depression is managed on level 2-7 care pathways, led by a psychiatrist.
2. The administration of IV Ketamine is done by an anaesthetist or anaesthetically trained GP according to SASA protocols at the point of care.
3. There is no evidence for IM nor SC nor oral ketamine

Esketamine (Spravato) has been released in South Africa as an intranasally administered treatment. This is registered for treatment resistant depression (level 3 care) and has clear evidence-based guidelines for its use in the acute and maintenance phase.

GLOSSARY:

SC = Subcutaneous
IM = Intramuscular
GP = General Practitioner
SASOP = South African Society of Psychiatrists
SASA = South African Association of Anaesthesiologists

REFERENCES:

* Jolien K.E.Veraart, Sanne Y.Smith-Apeldoorn, Harm-Pieter Spaans, Jeanine Kamphuis, Robert A.Schoevers; Is ketamine an appropriate alternative to ECT for patients with treatment resistant depression? A systematic review; *Journal of Affective Disorders*; Volume 281, 15 February 2021, Pages 82-89.
https://www.sciencedirect.com/science/article/pii/S0165032720330573

* The Canadian Network for Mood and Anxiety Treatments (CANMAT) Task Force Recommendations for the Use of Racemic Ketamine in Adults with Major Depressive Disorder; Recommandations Du Groupe De Travail Du Reseau Canadien, Pour Les Traitements De L'humeur Et De L'anxiet´ e (Canmat), Concernant L'utilisation De La Ketamine Rac ´emique Chez, Les Adultes Souffrant De Trouble Depressif Majeur´ Jennifer Swainson, Alexander McGirr, Pierre Blier, Elisa Brietzke, Stephane Richard-Devantoy, Nisha Ravindran, Jean Blier, Serge Beaulieu, Benicio N. Frey, Sidney H. Kennedy,Roger S. McIntyre, Roumen V.Milev, Sagar V. Parikh, Ayal Schaffer, Valerie H. Taylor, Valerie Tourjman,Michael van Ameringen, Lakshmi N.Yatham.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7918868/pdf/10.1177_0706743720970860.pdf

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https://www.ketamind.co.za/wp-content/uploads/2021/06/American-Psychiatric-Association-Guidelines-on-Ketamine-use-for-Depression.pdf

* Roger S. McIntyre, Joshua D. Rosenblat, Charles B. Nemeroff, Gerard Sanacora, James W. Murrough, Michael Berk, Elisa Brietzke, Seetal Dodd, Philip Gorwood, Roger Ho, Dan V. Iosifescu, Carlos Lopez Jaramillo, Siegfried Kasper, Kevin Kratiuk, Jung Goo Lee, Yena Lee, Leanna, Rodrigo B. Mansur, George I. Papakostas, Mehala Subramaniapillai, Michael Thase, Eduard Vieta, Allan H. Young, Carlos A. Zarate, Stephen Stahl, Synthesizing the Evidence for Ketamine and Esketamine in Treatment-Resistant Depression: An International Expert Opinion on the Available Evidence and Implementation; ajp.psychiatryonline.org 1
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SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

POSITION STATEMENT

SASOP POSITION STATEMENT ON

TMS

(TRANSCRANIAL MAGNETIC STIMULATION)

BACKGROUND

SASOP and members of the multidisciplinary team met in July 2022 to review evidence and reach consensus on the clinical care pathways for Depression, Bipolar Mood disorder and Schizophrenia.

THE CLINICAL CARE PATHWAYS ARE CURRENTLY UNDER REVIEW AND WILL BE PUBLISHED SOON. THIS POSITION STATEMENT REFLECTS THE MEETING CONSENSUS ON TMS.

SUMMARY

Transcranial Magnetic Stimulation (TMS) is an effective treatment for major depressive disorders. It involves the focal application of a localised, pulsed magnetic field to the cerebral cortex, inducing small electrical currents which stimulate or inhibit nerve cells.

KEY MESSAGES

TMS is a safe and effective and evidence-based treatment for depression. It has a very favourable side effect profile.

It has robust evidence as an augmentation strategy for treatment resistant depression (TRD).

In the SASOP guidelines TRD will be managed by level 3 care pathway, thus by a specialist psychiatrist.

TMS should be offered in clinical settings with appropriate stimulation protocols, delivered by trained technicians, on SAHPRA approved magnetic stimulators.

MONITORING FOR TREATMENT RESPONSE, NON-RESPONSE AND TREATMENT-RELATED SIDE EFFECTS SHOULD OCCUR ON A REGULAR BASIS THROUGHOUT TREATMENT.

For patients with depression that is very severe, associated with psychotic features, highly treatment resistant, or requires a rapid response due to acute risk, psychiatrists need to consider whether treatment with ECT is required instead.

REFERENCES:

Fitzgerald PB, George MS, Pridmore S. The evidence is in: Repetitive transcranial magnetic stimulation is an effective, safe and well-tolerated treatment for patients with major depressive disorder. Aust N Z J Psychiatry. 2022 Jul;56(7):745-751. doi: 10.1177/00048674211043047. Epub 2021 Aug 28. PMID: 34459284.

Papadimitropoulou K, Vossen C, Karabis A, Donatti C, Kubitz N. Comparative efficacy and tolerability of pharmacological and somatic interventions in adult patients with treatment-resistant depression: a systematic review and network meta-analysis. Curr Med Res Opin. 2017 Apr;33(4):701-711. doi: 10.1080/03007995.2016.1277201. Epub 2017 Feb 6. PMID: 28035869

INSTRUCTIONS TO AUTHORS

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

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

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* Issues

FEATURES

* Related to a specific area of interest
* Related to service development
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REPORTS

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

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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

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* 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.

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

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

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