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SOUTH AFRICAN PSYCHIATRY

ABOUT the discipline **FOR** the discipline

Issue 45 • NOVEMBER 2025

SASOP INCOMING PRESIDENT'S ADDRESS

ADHD COACHING

ONLINE ADHD COMMUNITIES

DYSLEXIA

GIFTEDNESS & DISABILITY

MOTHERING WITH ADHD

LIFE IN PERSPECTIVE

PSYCHOLOGY OF THE FUTURE

PUBLISHED IN ASSOCIATION WITH THE SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

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

Dear Reader,

A recently published newspaper article had the headline: "Mental health patient sets bed on fire".[1] The hospital in question was one familiar to me, noting there was a fire there some four years ago.[2] That fire rendered the then recently renovated, fit for purpose, psychiatric ward unusable. To date that remains the status quo. The article quoted the Gauteng Department of Health as stating: *"A mental health patient set fire to her bed while demanding to be discharged. Fortunately, there are no injuries sustained as a result of this incident."*, further noting that the incident was reported to have occurred in the *"female psychiatry ward"* of the hospital. In psychiatry there are no "mental health patients", there are "mentally ill patients" albeit that South Africa has a "Mental Health Care Act".[3] Interestingly, the aforementioned Act speaks of *"mental health care users"* i.e. no mention of patients. There was no doubt a logic used that led to this use of terminology and there have been arguments both for and against changing "patients" to "users".[4] Personally, I would prefer to be called a patient and not a user. In accordance with the Act, the Gauteng Department of Health might have more correctly referred to the *"mental health care user"*. That a tragedy of epic proportions was avoided cannot lead to the story remaining as an isolated report. Not only must there be an internal audit that extends beyond what happened i.e. a *mental health* patient setting fire to a bed in a hospital ward, but there must be a detailed investigation that extends back to the loss of a fit-for-purpose ward, due to a fire some years ago. The public have a right to know. There must be full disclosure, accountability and consequence as appropriate. This has implications for something that is fundamental to the practice of medicine: trust. Aligning with the theme of accountability and consequence, the current issue carries content promoting a book published in 2024, but still relevant, "Life Esidimeni: Portraits of Lives Lost" by Harriet Perlman and Mark Lewis, with a more recent publication by Jeff Wicks "The Shadow State" referring to the tragedy on pages 99-100. The South African Society of Psychiatrists played a prominent role in attempting to confront and hold accountable those responsible. It seems there remains work to be done for justice to prevail.

The current issue will be the final hard copy issue, save for the annual Congress issue. In this regard all readers are encouraged to register at the website www.southafricanpsychiatry.co.za to access all future issues and to receive email alerts.

We look forward to seeing you all in the new year.

Take care!

REFERENCES:

1 https://www.citizen.co.za/rosebank-killarney-gazette/news-headlines/2025/10/06/charlotte-maxeke-fire-mental-health-patient-starts-fire-no-injuries-reported/

2 https://fireopssa.co.za/what-really-happened-in-the-charlotte-maxeke-hospital-fire/

3 https://www.gov.za/sites/default/files/gcis_document/201409/a17-02.pdf

4 https://pubmed.ncbi.nlm.nih.gov/10381717/

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INCOMING PRESIDENT'S ADDRESS

21ST NATIONAL CONGRESS OF THE SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS, EAST LONDON, SEPTEMBER 2025

Anersha Pillay

Dear colleagues

Anersha Pillay

I feel privileged and deeply humbled to have accepted the honour and responsibility of the role as President of SASOP, for the 2025-2027 term. After having the presidential chain placed on me on the 22 September 2025 at the biennial SASOP Congress in East London, I was immediately cognizant of the weight that it bestowed upon me as an individual and the board that I must lead, to effectively fulfill the mandate of serving the members of SASOP.

In my 25 years as a SASOP member, I have borne witness to many presidential speeches. I now had to ask myself: what could I bring to this role?

Perhaps what had struck me so vividly is that I was not sure exactly why past presidents would decide to take on such a mammoth task. Whilst it was not possible to obtain clarity from them, it seems important to explain my own journey towards making this decision. Hopefully, in doing this, I will also allow for a better understanding of who I am as a person; a window into the trajectory of my voyage, if you will.

My journey began with my first working experience in Psychiatry in 1997 at Queen Margaret Hospital in Dunfermline, Scotland. Despite being determined to pursue a career in Obstetrics and Gynaecology, I nevertheless ventured into a psychiatry locum MO post on the Edinburgh circuit. Within a month of working, the medical director approached me and offered me a post to specialize on the next rotation in Psychiatry reassuring me that this was a suitable career for me. Uncertain of this commitment, I chose instead to explore and further my exposure by working around the UK for the next 3 years in Psychiatry and primarily the fascinating world of Neuropsychiatry. A seed was definitely planted and my mind was made up – Psychiatry it would be!

But believingly steadfastly that South Africa needed its doctors back during those early years of democracy, I abandoned my decision to specialize in the UK, and returned home to begin my Psychiatry training in the year 2000.

My now late parents, at the time, suggested I work in KZN to be nearer in proximity to them in Pietermaritzburg after having left the nest at the age of 18. I then began my first-year registrar training at the then named King George Hospital. Unfortunately, I did not adapt well to living in Durban and wished to return to Johannesburg. Yet, despite my reservations about continuing to specialize in KZN, that year, brought many wonderful experiences. Great and long -lasting associations and friendships; and my introduction to SASOP.

I confess to not knowing much about the organization expect that attendance at SASOP related events was expected of all trainees.

At these engagements, I was immediately intrigued by the camaraderie and enthusiastic partition of information and knowledge that I encountered. The love, respect and reverence for the clinical practice of good psychiatry felt palpable in the air and the rest as, they say, is history. Yes, I believe I was SASOP hooked!!

On returning to the WITS fold in 2001, SASOP was as embraced and present as in KZN, so I easily immersed myself into its world, discovering a wealth of organizational history that only such a well-established and respected society could offer. I eventually became an active Southern Gauteng subgroup member, firstly as a registrar representative, then subgroup treasurer in 2010, chairperson and Neuropsychiatry representative, culminating in being invited to serve on the SASOP board as an Honorary Treasurer, followed by a nomination for President -Elect and today President.

During my journey as a Psychiatrist, I have spent 17 years including my registrar time in the world of public practice and service, and as an academic joint appointee. I ventured in the world of private practice with a session at the Wits Donald Gordon Medical Centre (WDGMC) in 2005. I continue to participate as an academic honorary lecturer and research supervisor at WITS whilst transitioning into full-time private practice at the Life Riverfield Lodge Hospital and WDGMC. I also serve on the PsychMg Board as a director.
Throughout this wonderful life expedition, SASOP has been my passion so I am hopeful that my extensive

exposure traversing several psychiatric worlds will bring a wealth of experience and understanding during my journey as a SASOP President, yet I also eagerly await the further learning, discovery and challenges that the role is sure to bring.

However, as proud as I am to be the new President, I am neither blessed with naiveté nor the comfort of rose-tinted glasses. Thus, my disappointment at seeing a once robust and respected organization met with comments like – 'I don't believe in joining organisations' or 'what can SASOP do for me' is an indicator of how we have retreated into our individual silos – sometimes in lonely private practices, sometimes solely relating to public sector/ or academic issues; perhaps, forgetting that it should be our love for psychiatry that binds us together, helps us learn, share and bask in the complexity of the brain and mind; and hopefully in our quest for altruism.

Now that I have provided a sense of who I am as an individual, it is an appropriate time to segue into my three fundamental visions for my Presidency:

1. SASOP 2.0

I took the liberty of borrowing this term from the 2025 SA budget speech. Over the years, I have made 2 important observations. The first being the gradual and sad exit of a few university Heads of Departments of Psychiatry, who once played prominent roles in SASOP. With this, seemed to have followed the loss of institutional knowledge and transmission of the value of kinship and camaraderie to the registrars in these departments. Perhaps this may, in part, explain the reluctance of these trainees and young psychiatrists to join SASOP.

I am further aware of the sense of apathy that appears to have pervaded the world of SASOP and other such societies in general. Together and more importantly, the need for SASOP as a society to reinvent itself to meet the needs of all of its members, irrespective of age, gender, race, educational background and practice type is greater than ever before. It may help to be reminded that SASOP is not just for the experienced psychiatrists or those in public practice exclusively. It actually provides a vector for that transition out of our silos and allowing us to embrace our common passion for our craft.

In order to achieve the above, I intend to make the presence of the SASOP President more felt strongly by

1.1 Visiting at least one subgroup event per province per year of my term

1.2 Engaging, where welcome, with University HODs and addressing registrars and young psychiatrists if permitted.

1.3 Attending as many SASOP/PsychMg Roadshows and other events as possible, where I hope to have more personal and face-to face interaction with as many of the SASOP constituents as possible.

1.4 Launching my 'LETTER TO THE SASOP PRESIDENT' initiative.

As I was recently and helpfully reminded, the SASOP Board and myself are merely custodians of the organization during our tenure. As such, I would like to hear directly from members as to how to institute the change that will make SASOP more retentive of existing members and also attractive to the younger and early career psychiatrists and registrars, who may have not necessarily grown up in a SASOP world.

The COVID-19 pandemic further served to reinforce the silos we find ourselves in. The role of social media has in many instances replaced more frequent human contact, often making it more arduous to travel to in-person events; and whilst social media applications are incredible platforms to engage, they don't always replace to feeling of human contact and true camaraderie which belonging to an organization can help to create.

So, as a nod to the past practice of letter writing, a physical suggestion box will be present at all SASOP-related / supported events. In this box I hope to receive suggestions and communication from you the members. I can also be emailed directly via my SASOP email address. The objective of this is really being able to connect again and hear from as many of you as possible so that SASOP 2.0 feels more inclusive and evolved. I endeavor to address as many issues and queries that you raise to the best of my and the board's ability.

2. FURTHER DEVELOPMENT OF THE SASOP/PSYCHMG PSYCHIATRY INSTITUTE

Many past presidents have proposed crucial suggestions as their visions. Unfortunately, due to various reasons, some of the great ones didn't come to fruition. So, 10 years after a few past presidents discussed the formation of a SASOP/ PsychMg Psychiatry Training Institute; we are finally seeing the progression of this vision. It has begun with a focus on registrar and DMH training especially in under-resourced environments and has had great uptake thus far.

During my presidency, I envisage seeing this wonderful initiative grow further into an expansion of training, upskilling and continued learning that will assist in the provision of good psychiatric care across the entire country – a much needed resource in South Africa.

The eventual future aim over time, being that the Institute functions as a main provider of the majority of the CPD-led, high quality, cutting-edge training and continued education for all levels of psychiatrists in South Africa – that is easily accessible, affordable and involves participation by both public sector and private practice psychiatrists alike; as well as the pharmaceutical industry who remain our crucial partners.

3. EXPANDING THE FOOTPRINT OF NEUROPSYCHIATRY

As a Neuropsychiatrist, I am aware that we all practice levels of neuropsychiatry daily. This is particularly against a landscape that sees the rise of Major Neurocognitive Disorders due to an aging population, the greater awareness of complex disorders such as Functional Neurological Disorder, and the almost daily witnessing of the neuropsychiatric impact of elevated levels of substance use, TBI/HIV-AIDS and Neuroinflammation – seen in South Africa and beyond.

Subspecialist Neuropsychiatrists are few and far between,

therefore, my vision here is to firstly expand the accessibility of knowledge and competency in Neuropsychiatry per se to all interested psychiatrists, thereby ensuring a higher standard of patient care. I also hope to entice a few more psychiatrists into training as subspecialist neuropsychiatrists.

Secondly, I aim to encourage the international footprint of South African Neuropsychiatry, which is currently underway via participation in the Global Neuropsychiatry group and the International Neuropsychiatry Association. In fact, Neuropsychiatry featured in the inaugural installment of PAUCES – Pan African/UK clinical educational series – in which a South African contingent led the presentation. That experience in itself reinforced the high level of Neuropsychiatry practiced in a country like ours, with its limited and often unequal resources.

Thirdly, I believe there should be enhanced focus on the initiation and development of SA-led neuropsychiatry research, opportunities for which exist in abundance in SA.

Colleagues, I hope to fulfil my role to the best of my abilities. I am definitely not short on enthusiasm so I certainly look forward to engaging with as many of you as possible during my tenure.

Whenever I experience a shade of disillusionment/or uncertainty about SASOP's future, I recall this:
SASOP is not perfect but it is embellished with a rich tapestry of history, from being established in 1952 almost akin to a club of psychiatrists, to being registered a non-profit company in 2007. SASOP is a well-recognized and respected organization amongst peers and government, locally, on the continent and through the initiatives by many past presidents, also internationally.

In brief, SASOP's mission and profile are what resonate most loudly with me as this is what I believe the society's role and psychiatry in SA should always represent:

a. **To promote, maintain and protect** the **honour and interests of members,** the **discipline of Psychiatry as a medical speciality** and **to serve the community**
b. To **promote the rights of the majority of SA psychiatrists**
c. To **actively fight the discrimination** of those with mental illness and promote de-stigmatisation in every forum

These should not merely be words in a well-constructed constitution but a code by which we practice the craft and art of Psychiatry"We spend so much time focusing of what separates us that we forget what brings us together"

I take this message to heart and I hope that through my experience, thoughtful and open leadership and your participation and feedback, we may be led back to the essence of what unites us as SASOP members.

Correspondence: anersha@sasop.co.za

AUROGEN'S ANNUAL MENTALSPHERE ACADEMIC WEEKEND

16-17 AUGUST 2025, LE FRANSCHHOEK HOTEL AND SPA.

Tebogo Letsitsi

Aurogen hosted its 3rd annual Mentalsphere Psychiatry Academic Weekend on the weekend of 15-17 August at the Le Franschhoek Hotel and Spa. The weekend brought together psychiatrists and mental health professionals for a dynamic program that balanced academic enrichment with meaningful networking and memorable experiences.

Aurogen SA is committed to the field of Psychiatry, hence the invitation was extended to 50 psychiatrists across South Africa and was attended by 48 eminent Psychiatrists across the country.

Throughout the weekend, delegates engaged in expert-led discussions and presentations on key developments in psychiatry. The sessions provided an invaluable platform to share knowledge, explore new perspectives, and strengthen professional collaboration within the field.

In addition to the academic programme, Mentalsphere placed strong emphasis on connection and collegiality. Delegates enjoyed an elegant offsite dinner at a renowned local venue, creating the perfect atmosphere for informal discussion and professional bonding. A highlight of the weekend was the themed gala dinner called "The Light Within", which combined creativity and sophistication, leaving participants with a truly memorable experience that celebrated both community and innovation.

The event successfully combined learning, networking, and leisure, reaffirming Mentalsphere's role as a leading platform for advancing psychiatric practice while nurturing a strong sense of professional community.

Tebogo Letsitsi is the Marketing Manager Aurogen South Africa (Pty) Ltd **Correspondence: tebogo.letsitsi@aurobindo.com**

Aurogen Marketing Manager, Tebogo Letsitsi with Dr Pieter Cilliers during The Light Within dinner hosted by Aurogen.

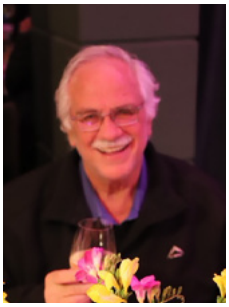
Doctors S Mashaphu, MS Salduker, A Porter, and I Chetty pose for a quick snap during Mentalsphere Meeting

Dr Elsa du Toit delivered a thought provoking ethics talk on addressing negative bias in psychiatric medicine from a perinatal perspective

Sasop President, Dr Anusha Lachman

Dr WJ Landman, Bianca McDermid (Aurogen Sales Representative) and Dr V Chiman

Dr Leverne Mountany during the light within formal dinner



Well-known Welkom Psychiatrist Dr Chris van Jaarsveldt enjoying a moment during The Light Within formal dinner

Dr S Seape and Dr S Mashaphu

Prof Dana Niehaus delivered a talk

Delegates at Aurogen 2025 Mentalsphere Academic Weekend

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S5 **ALEBON 5 mg** (tablet). Reg. No.: 47/2.6.5/1080. S5 **ALEBON 10 mg** (tablet). Reg. No.: 47/2.6.5/1081. S5 **ALEBON 15 mg** (tablet). Reg. No.: 47/2.6.5/1082. Each tablet contain 5 mg, 10 mg or 15 mg of aripiprazole respectively. Contains sugar: 76,00 mg, 66,50 mg or 99,75 mg lactose.respectively.
SAHPRA approved **DEPRETA** professional information. Date of publication: 13 April 2021.
S5 **DEPRETA 30** (capsule). Reg. No.: 47/1.2/0097. S5 **DEPRETA 60** (capsule). Reg. No.: 47/1.2/0098. Each capsule contains 30 mg or 60 mg of duloxetine respectively as duloxetine hydrochloride. Contains sugar: 78 mg or 156 mg sucrose respectively.
SAHPRA approved **DOLIN** professional information. Date of publication: 15 November 2022.
S5 **DOLIN 10 mg** (tablet). Reg. No.: 44/1.2/0952. S5 **DOLIN 20 mg** (tablet). Reg. No.: 44/1.2/0953. Each film-coated tablet contains escitalopram oxalate equivalent to 10 mg or 20 mg escitalopram respectively. Sugar free.
SAHPRA approved **MEDPLOZ** professional information. Date of publication: 21 September 2021.
S5 **MEDPLOZ 5 mg** (tablet). Reg. No: 43/2.2/0247. S5 **MEDPLOZ 10 mg** (tablet). Reg. No: 43/2.2/0257. Each film-coated tablet contains 5 mg or 10 mg zolpidem tartrate respectively. Contains sugar: 43,80 mg or 87,60 mg lactose respectively.
SAHPRA approved **NERGIL** professional information. Date of publication: 21 AUGUST 2023.
S5 **NERGIL 25 mg** (capsule). Reg no.: 48/2.5/1073. S5 **NERGIL 75 mg** (capsule). Reg no.: 48/2.5/1074. S5 **NERGIL 150 mg** (capsule). Reg no.: 48/2.5/1075. Each capsule contains 25 mg, 75 mg or 150 mg of pregabalin respectively. Sugar free.
SAHPRA approved **PRAMISUL** professional information. Date of publication: 10 August 2021.
S5 **PRAMISUL 50 mg** (tablet). Reg. No.: 52/2.6.5/0418. S5 **PRAMISUL 200 mg** (tablet). Reg. No.: 52/2.6.5/0419. Each tablet contains 50 mg or 200 mg of amisulpride respectively. Contains sugar: 50,00 mg or 200,00 mg lactose respectively.
SAHPRA approved **XIPANZ XR** professional information. Date of publication: 14 September 2021.
S5 **XIPANZ XR 0,5 mg** (tablet). Reg. No.: 50/2.6/0094. Each tablet contains 0,5 mg alprazolam respectively. Contains sugar: 255.68 mg lactose respectively.

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AUROGEN/ SASOP Registrar Clinical Masterclass Series

Anusha Lachman

With the support and partnership of AUROGEN (SA), the South African Society of Psychiatrists (SASOP) President Dr Anusha Lachman launched the first pilot Registrar Clinical Masterclass Series held in May 2025 in Johannesburg.

The initiative was created to target mid-level psychiatric trainees with teachings that introduce approaches to manage clinically complex scenarios in ethically responsible ways, helping to navigate challenging situations within evidence-based practices.

While current regulated psychiatric speciality training is focussed on achieving core competencies and safe treatment practices, there is also a desire for preparation of the workforce for scenarios that extend beyond traditional practices. This often includes challenging clinical presentations requiring a practical interpretation of the legal frameworks that govern Mental Health Care in SA, ethical responsibilities towards vulnerable populations and professionalism in relationship to working within environments with unique challenges that include a resource constrained service platform in both public and private sectors.

This pilot weekend offering focussed on 40 registrars who had completed their Part 1 training and were mid way through their registrar program, offering an opportunity to input practical approaches in the foundation of the training. The program over two days offered a collaborative approach between the public sector, private practice, and sub specialities, aligning with the College of Psychiatry logbook, while drawing on experience and expertise of the presenters from across these sectors.

Day one included practical and evidence based approaches to safe prescribing in adults and children, including pitfalls and considerations relating to poly-pharmacy, diagnostic integration and clinical pharmacology updates that were delivered by Dr Mvuyiso Talatala (Adult Psychiatrist, bio-ethicist and council member of the CMSA) and Dr Alicia Porter (Child psychiatrist, representing CAP SIG, trainer at WITS university and in private practice). A focus on understanding and interrogating the legal frameworks governing consenting and capacity assessments as well as navigating the safe and responsible reporting of mental illnesses to employers and regulatory bodies was comprehensively packaged by Dr Indhrin Chetty (psycho- legal expert, chair of Forensic Psychiatry SIG, CMSA council member and academic head at Wits University). The format included an interactive afternoon panel discussion facilitated by Drs Lachman, Chetty and Talatala with case scenario discussions across a variety of ethical and legally contentious topics. These topics included unpacking the professional duty to report, protect and withhold or share information, in the context of mentally ill patients, their families, and employers. There was also a boisterous discussion and engagement with the audience around responsibilities in the reporting of colleagues who are impaired, and the legal process and professional conduct when providing expert clinical feedback, consenting in mentally ill adolescents and roles in custody assessments.

Day 2 focussed on Life course approaches to the practical assessment, early identification and management of Psychosis in Children delivered by Dr Anusha Lachman (Child & Adolescent Psychiatrist at Stellenbosch University,Head clinical unit CAP) and an approach to management of sleep and anxiety disorders in Geriatric Populations presented by Professor Dana Niehaus (Geriatric Psychiatrist at Stellenbosch University, chair of Old Age Psychiatry SIG).

Registrars were encouraged to interact with the trainers and to network with their peers representing provinces from across SA including all major university training programs. Feedback and evaluation surveys post attendance overwhelmingly expressed enthusiastic support for the initiative, with new areas of interest identified and gratitude for the opportunity to interrogate the challenging concepts in a safe and academically sound platform.

SASOP is proud to take forward this initiative with Aurogen as a partner to launch the Clinical Masterclass Series as a standing event on the calendar with the promise and commitment to develop a more engaging and academically enriching program over time.

Anusha Lachman is the former President of SASOP
Correspondence: anusha.sasop@gmail.com

Mr Tebogo Letsitsi (AUROGEN Marketing Manager) ; Mr Vijay Bhaskar (AUROGEN CEO), Dr Anusha Lachman (SASOP) ; Dr Mvuyiso Talatla (SASOP)

Tebogo Letsitsi delivering the opening address

Dr Mvuyiso Talatala with Dr Anusha Lachman.

ADHD Coaching for Adults: Structure, Strategy, and Support

Tamara Rosier

ADHD coaching is an empowering intervention that helps adults with ADHD bridge the gap between intention and action—offering support distinct from therapy, tutoring, or generic productivity strategies. It is grounded in an understanding of executive functioning and neurodevelopmental differences and provides structured, collaborative support for goal setting, emotional regulation, and task initiation. This article discusses core principles of ADHD coaching and distinguishes it from psychotherapy, highlighting its non-clinical but complementary role within interdisciplinary care. The article identifies future research priorities, strategies for integration into formal systems of care, and the need for standardized competencies. For many adults with ADHD, coaching offers not just practical tools, but an opportunity to build lasting self-efficacy and renewed confidence in their abilities.

Tamara Rosier

Keywords: ADHD coaching, adult ADHD, executive functioning, emotional regulation, non-clinical intervention, interdisciplinary care.

INTRODUCTION

ADHD coaching is not about offering advice—it is a collaborative partnership that builds trust, sparks curiosity, and moves clients into meaningful action. The collaborative nature of ADHD coaching ensures that clients are actively engaged in their own progress, fostering a sense of involvement and empowerment. While it shares some foundation with life coaching [1], ADHD coaching is distinct in its purpose, scope, and specialized approach. Life coaching often emphasizes goal-setting and personal growth. ADHD coaching does that, too—but always through the lens of executive functioning, emotional regulation, and the lived experience of ADHD. [2]

COACHING WITH THE ADHD LENS

The ADHD lens, a fundamental aspect of ADHD coaching, invites a shift in how coaches interpret client behaviour. It is not about attributing difficulties to a lack of willpower or character but recognizing behaviour as the visible expression of invisible neurological differences. This perspective underscores the need for tailored support, as it helps coaches interpret challenges with time, memory, or emotional regulation not as irresponsibility but as executive function differences that warrant individualized approaches. [3,4] By staying attuned to context, ADHD coaches are better able to understand not just what their clients struggle with but why—and how to move forward effectively.

Using this lens encourages ADHD coaches to interpret behaviour within its full context, rather than defaulting to surface-level assumptions. A client who repeatedly misses deadlines may be navigating time blindness—a diminished ability to sense the passage of time or predict how long tasks will take. A client who avoids a task may not procrastinate out of disinterest but may be overwhelmed by emotional dysregulation or perfectionism. Recognizing these patterns enables coaches to co-create effective strategies, build tailored scaffolds, and support growth in metacognition and agency.

The ADHD lens applied to coaching is a coaching stance grounded in a deep understanding of executive function and shaped through work that is co-created with clients, not delivered to them. ADHD coaches bring specific expertise in how attention, motivation, and emotion manifest in the lives of their clients. That expertise guides every question they ask, every strategy they co-create and test with the client, and every adjustment they make to foster greater awareness, skill development, and autonomy. Coaching through the ADHD lens provides tools and creates a structured, supportive developmental process, offering clients an experience of being understood, empowered, and believed in. [5,6,7]

DISTINGUISHING ADHD COACHING FROM THERAPY

ADHD coaching and therapy serve fundamentally different purposes, rooted in distinct paradigms. Therapy typically aims to foster insight through emotional reflection and exploration of past experiences. In contrast, ADHD coaching empowers individuals through present-focused experimentation, structured observation, and applied learning. Coaches do not engage in clinical diagnosis or treatment of psychological disorders.

Instead, they draw upon a robust understanding of ADHD and its effects on executive functioning, motivation, and

emotional regulation to help clients move forward in tangible, everyday ways, instilling a sense of hope and motivation.

Therapy tends to ask, "Why is this happening"? Coaching asks, "What now"? Rather than exploring the historical roots of emotional patterns, coaching supports clients in building practical strategies to manage emotions, sustain motivation, and move forward within their daily lives. [5,8,9]

While coaching strategies address emotional regulation and skill development, they do so without engaging in clinical diagnosis, trauma processing, or psychotherapeutic techniques reserved for licensed mental health care providers. While emotional growth frequently occurs in coaching, it arises through the process of developing executive functioning skills, practicing emotional regulation in real-world contexts, and experiencing consistent success, rather than through direct clinical intervention.

Many clients come to coaching with prior therapy experience, having developed self-awareness yet still feeling stalled in day-to-day follow-through. Coaching addresses this disconnect between insight and implementation. A client may understand that perfectionism contributes to their procrastination—but coaching provides a space to test small, imperfect actions, observe outcomes, and iteratively refine what works in practice.

Although coaching and therapy are distinct in purpose and method, they can work effectively in tandem—particularly for clients whose emotional needs or co-occurring diagnoses involve both executive functioning difficulties and emotional regulation challenges. In these cases, clarity of roles is essential. Therapists support healing and emotional processing; coaches provide structure, accountability, skills development, and forward momentum. Clients benefit from more integrated and responsive care when each professional remains grounded in their role.

INTEGRATING COACHING AND PSYCHIATRY IN ADHD CARE

ADHD coaching provides structured, goal-directed support that complements psychiatric care by addressing executive functioning challenges, enhancing treatment adherence, and supporting behavioural change in daily life. [9] Although coaching can strengthen clinical outcomes, it is not a clinical intervention; coaches do not engage in clinical diagnosis, treatment, or management of psychiatric conditions.

Psychiatrists focus on diagnostic assessment, medication management, and the treatment of comorbid conditions, while coaches collaborate with clients to translate clinical recommendations into practical action steps. Coaching strengthens therapeutic outcomes by promoting consistency, building routines, encouraging self-monitoring, and improving communication between clients and healthcare providers.

Effective collaboration between psychiatrists and ADHD coaches depends on mutual respect, clear role delineation, and structured communication protocols to maintain ethical practice boundaries and optimize client outcomes. Psychiatrists may recommend coaching when clients experience persistent difficulties with planning, task initiation, or follow-through—particularly when these challenges remain despite pharmacological intervention. Coaches, in turn, refer clients back to medical professionals when psychiatric symptoms interfere with coaching goals or require specialized evaluation or treatment. This reciprocal relationship works best when all parties share a nuanced understanding of ADHD and collaborate within an integrated model of care.

CORE ELEMENTS OF THE COACHING PROCESS

ADHD coaching is a dynamic, goal-oriented process that supports both executive functioning and emotional regulation. While coaching is individualized to each client, most coaching relationships draw upon five core elements: personalized goal setting, accountability, skill development, mindfulness practices, and ADHD education. These elements are not applied rigidly; rather, they are fluidly integrated and continuously adapted to fit the client's evolving needs, developmental stage, and life context.

Coaching typically begins by helping clients identify goals that are meaningful and actionable. These goals—rooted in personal values and shaped by real-world challenges—may focus on academic, professional, relational, or personal priorities. Together, the coach and client define outcomes, clarify next steps, and break broad intentions into specific, manageable actions. This collaborative structure strengthens engagement and reinforces ownership of the change process.

Accountability in coaching is not externally imposed; rather, it is co-constructed with the client to support consistency, focus, and follow-through. Coaches offer a stable framework for tracking progress, adjusting plans, and sustaining effort over time. This structured accountability also fosters metacognitive awareness, helping clients observe patterns, refine strategies, and increase their autonomy .[7]

As coaching progresses, developing skills that support executive functioning and emotional regulation becomes central. Clients work with their coach to create tailored tools and routines to address challenges in time management, organization, task initiation, emotional self-management, and interpersonal communication.[8,11] Emotional regulation often emerges as both a barrier to progress and a growth area. Coaches help clients recognize emotional patterns, practice coping strategies, and build self-regulation skills through real-world experimentation and reflection.

Mindfulness techniques—such as pausing, grounding, or breathwork—may be incorporated to strengthen emotional regulation and cognitive flexibility. Depending on the client's readiness and goals, these practices support presence, reduce reactivity, and help manage stress during transitions or moments of overwhelm.[5]

A critical component of ADHD coaching is psychoeducation. Coaches provide developmentally appropriate, evidence-informed information that helps clients understand the neurobiological and behavioural dimensions of ADHD. Psychoeducation may include discussions of executive functioning, attention regulation, emotional regulation, and co-occurring conditions. By contextualizing their experiences, clients are better equipped to make informed choices, apply

strategies effectively, and engage more fully with the coaching process.[5,6]

Together, these five elements shape a coaching process that is organized, adaptable, and responsive to real-life complexity. Coaches do not apply them in a set sequence; instead, they draw on them fluidly, adjusting to the client's goals, challenges, and developmental needs. This work occurs within the coaching relationship—a space defined by trust, respect, and shared effort. The coaching relationship is not incidental to change; it is the essential foundation that allows clients to engage, experiment, and grow. At its best, ADHD coaching supports a shift from insight to action, helping clients build the skills, systems, and confidence needed to make meaningful, sustained change.

FUTURE CONSIDERATIONS FOR THE FIELD OF ADHD COACHING

As the field of ADHD coaching matures, it must address key questions about the consistency of its training pathways, the strength of its evidence base, its integration into formal systems of care, and the accessibility of services across diverse populations. Access to ADHD coaching services varies significantly across global contexts, shaped by differences in healthcare infrastructure, socioeconomic factors, and cultural perceptions of ADHD and coaching.

One of the most pressing priorities involves the training and credentialing of ADHD coaches. Pathways into the profession vary widely in rigor, scope, and oversight. While some coaches complete intensive programs grounded in executive function theory, ADHD-specific frameworks, and behaviour change principles, others enter practice with minimal preparation and limited understanding of the neurodevelopmental complexities they aim to support. This inconsistency raises concerns not only about service quality but also about the long-term credibility of the field.

A strong professional framework will depend on clearly defined standards for training, ethical practice, certification, and ongoing development.[1,2,5] Central to this effort is the precise definition of ADHD coaching as a structured, non-clinical discipline—distinct from both therapy and life coaching yet grounded in evidence-based strategies for supporting executive functioning and emotional regulation.

Equally important is the integration of coaching into interdisciplinary models of care.[9] As psychiatrists, psychologists, and allied professionals increasingly recognize the effectiveness of coaching, the need for structured collaboration becomes more urgent. The field must establish clear referral pathways, communication protocols, and role delineation standards to maintain ethical boundaries and ensure coordinated support. For example, a psychiatrist managing medication for a college student with ADHD may refer the client to a coach to address persistent challenges with academic follow-through. In this shared-care model, the psychiatrist oversees clinical treatment while the coach provides executive function support, behavioural strategies, and accountability.

Coordinated models like this allow professionals to operate within their respective domains while providing the client with integrated, responsive care.

Building a rigorous research base is also critical. While early findings suggest that ADHD coaching can enhance functioning in academic and adult settings [7,8,10,11], further investigation is needed to clarify its mechanisms, efficacy, and applicability across diverse populations. Understudied areas—such as adolescent coaching, digital delivery platforms, workplace interventions, and coaching in underserved communities—represent important opportunities for future inquiry. Research should continue to examine how ADHD coaching supports change, why it works for specific individuals, and what conditions shape its impact over time. [10,11]

Finally, the field must confront persistent disparities in access and equity. Despite the flexibility offered by virtual delivery, many individuals who could benefit from ADHD coaching remain excluded due to cost barriers, limited public awareness, and the lack of integration within healthcare, education, and workplace systems. Expanding access is critical for reducing healthcare disparities and ensuring ADHD coaching is positioned as an integral, evidence-based component of comprehensive care.

Together, these priorities represent a call to action. As ADHD coaching moves toward greater professionalization and systemic integration, its leaders must remain grounded in lived experience, guided by empirical evidence, and committed to equity and accessibility. Meeting these challenges will strengthen the field's credibility and expand its capacity to contribute meaningfully to how we understand—and support—individuals with ADHD.

CONCLUSION

ADHD coaching offers a focused, collaborative approach to building skills in executive functioning, emotional regulation, and self-directed change—distinct from therapy and generic productivity methods. It is a discipline grounded in neurodevelopmental science and executive functioning research, delivered through structured, goal-oriented collaboration.

As the field continues to evolve, its value will not rest solely on individual client outcomes but on its ability to uphold rigorous professional standards, integrate into interdisciplinary systems of care, and expand access to historically underserved populations. Achieving this potential will require ongoing role clarity, research investment, and an unwavering commitment to equity.

When practiced with insight, competence, and integrity, ADHD coaching offers more than tools: it fosters growth, resilience, and meaningful transformation. For many adults with ADHD, it affirms capacity, honors lived experience, and supports lasting, self-directed change.

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Online ADHD communities: the Pros and Cons

Hugo Theron

Hugo Theron

Attention deficit and hyperactivity disorder (ADHD) is a highly prevalent neurodevelopmental disorder globally and also in Southern Africa. Evidence-based studies highlight the importance of a multidisciplinary approach – including healthcare, education and community-based support systems – in navigating the unique challenges posed by ADHD. Technology can aid this collaboration across disciplines in various ways, one of which is via online communities. This article explores the role that online communities can play as part of a multidisciplinary approach to support patients with ADHD within a culturally diverse environment like Southern Africa.

Due to resource constraints in the Southern African region, accessing specialised ADHD care can pose a significant challenge. This makes integrated care and interdisciplinary collaboration even more critical. In the face of limited access to specialised ADHD care, online communities can serve as a valuable resource. Such communities come with advantages and disadvantages that ask for an informed and balanced approach in the use thereof.

THE PROS OF ONLINE ADHD COMMUNITIES

The main benefits of online communities for patients with ADHD are access to information and resources, emotional and social support, and the availability of tailored tools and strategies. For practitioners who treat individuals with ADHD, online communities have the advantage of offering continued professional development. Each of these advantages are briefly discussed below.

1. Access to information and resources

Online communities offer an abundance of information on ADHD – from the latest research to strategies for managing symptoms. These resources can be particularly valuable in rural and/or underserved regions. Online platforms can empower individuals and their families to educate themselves about ADHD and treatment strategies, with the benefit of real-time access to information. Some communities offer professional input, ensuring that participants receive expert guidance and clinically sound advice.

2. Emotional and social support

A sense of belonging can be fostered by online ADHD communities in that they provide a supportive environment, reducing the feeling of isolation or "being different" that is often experienced by those with ADHD. These spaces provide peer support and aid in normalising the condition. The global reach of such platforms contributes to the reduction of stigma as users begin to see ADHD as a shared and manageable condition. Social support from others with ADHD helps to improve coping strategies and encourages positive reinforcement.

3. Tailored tools and strategies

Online ADHD communities offer tailored tools for different populations (e.g. children, adults, parents). Such tools may include time-management apps and focus-enhancing strategies. Specific communities may cater to subgroups, such as adults with ADHD in the workplace, women with ADHD, or students with ADHD. Such subgroups can provide relevant, personalised support.

4. Professional development for practitioners

ADHD professionals can benefit from participating in communities that share case studies, emerging research, and evolving therapeutic methods. Online platforms can foster collaboration among professionals from different fields, facilitating a more comprehensive understanding of ADHD.

THE CONS OF ONLINE ADHD COMMUNITIES

The drawbacks of online ADHD communities include the danger of misinformation and unverified advice, the possibility of overreliance and dependency, the risk of toxic interactions and cyberbullying, privacy

and confidentiality issues and the likelihood of information overload and neglect of real-world responsibilities due to time drain. Each of these disadvantages are briefly unpacked below.

1. Lack of quality control

Not all information shared in online communities is accurate and verified. The risks related to misinformation and/or outdated advice are obvious, particularly where medical and/or psychological treatment options are concerned. Although intentions may not be malicious, misguided information – however well-meant – can lead to negative outcomes. Some users may offer advice that could be harmful or inappropriate, which can in turn lead to people trying potentially dangerous approaches.

2. Overreliance and dependency

Some individuals may become overly reliant on online advice and delay seeking professional help, viewing peer guidance as a substitute for professional intervention. Furthermore, users are likely to gravitate towards communities that reinforce their own beliefs, hindering personal growth and better treatment options.

3. Toxic interactions and cyberbullying

Some online communities are prone to toxic behaviour, including cyberbullying, which can further compound the mental health challenges of individuals already dealing with ADHD-related stress. Exposure to hostile online environments can lead to heightened anxiety, depression, and further withdrawal from real-world support systems.

4. Privacy and confidentiality issues

Not all platforms guarantee confidentiality. Individuals may share sensitive details about their condition without realising the potential risks. Some platforms fail to protect the identity of its users, raising concerns about privacy and misuse of shared information.

5. Information overload and time drain

The vast amount of information available in online communities can lead to cognitive overload, particularly for individuals with ADHD. Another very real danger for those with ADHD is that the online environment can become a source of distraction, leading to procrastination or avoidance of more critical tasks.

BALANCING THE PROS AND CONS

When these advantages and disadvantages are considered, it becomes clear that, while online communities may be highly beneficial for individuals with ADHD, an informed and balanced approach is called for. Practitioners who treat patients with ADHD can play a role in educating their patients in the use of online platforms related to their condition.

To navigate online communities safely and effectively, it is imperative that information must be verified. All advice from online communities should be cross-checked with credible sources and/or professionals to ensure that the guidance is safe and appropriate. It is best to seek communities that are moderated by professionals who can help to ensure that advice is accurate and the environment supportive.

As in other areas in the life of a person with ADHD, healthy time management is of the essence when it comes to navigating online communities. The use of time management tools or techniques should be encouraged to limit screen time and promote a healthy balance between online and offline activities. Individuals should, furthermore, be encouraged to not only engage in online communities but also to seek face-to-face support from professionals and peers. Collaboration between professionals and peers can help to foster the creation of online communities that combine professional guidance with peer support, promoting both educational and emotional value.

ADHD practitioners can and should advocate for well-moderated and inclusive environments where users feel safe to share their experiences and receive support.

References are available on request

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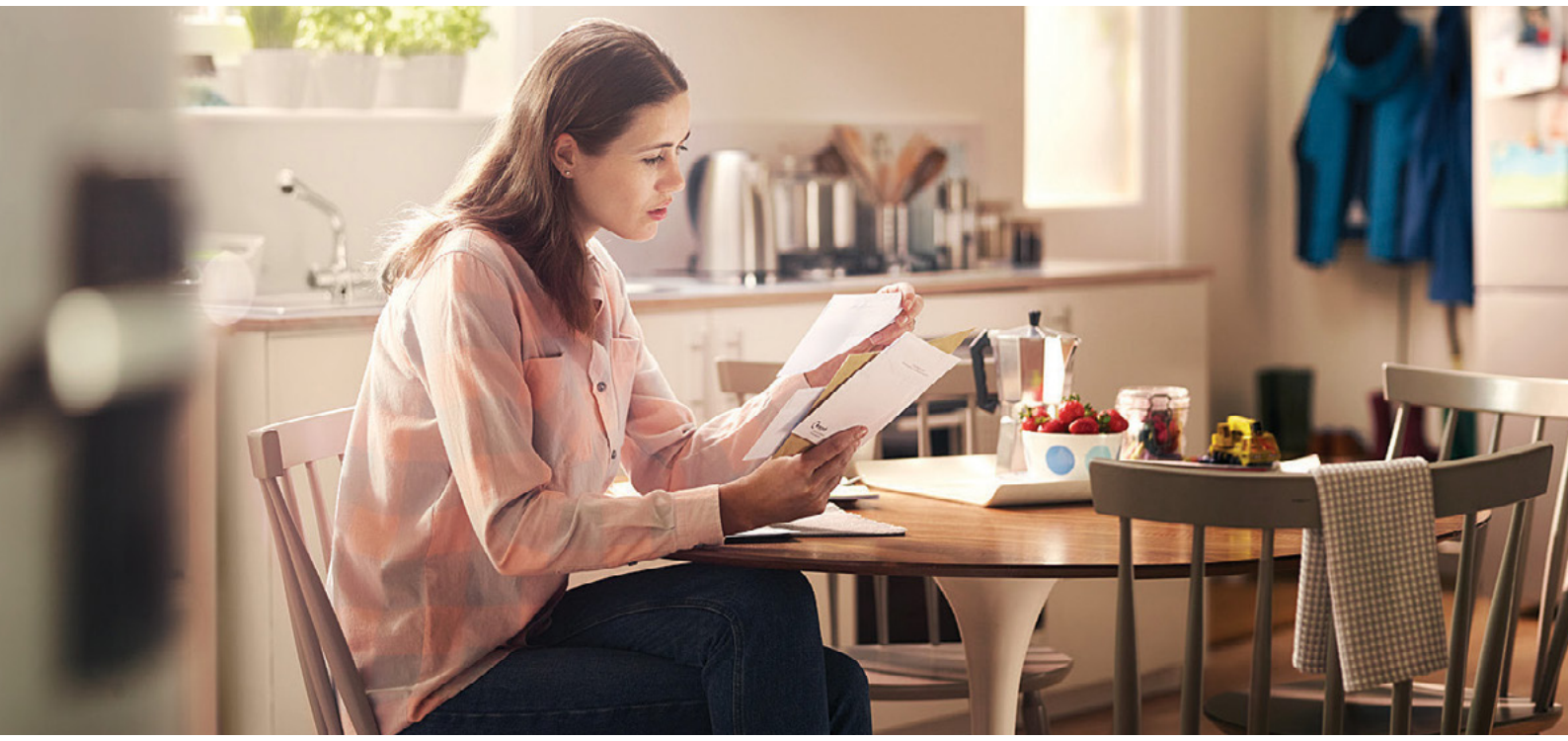

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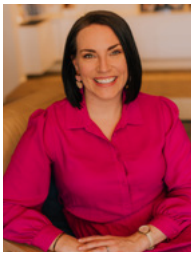
Dyslexia – The Quiet Complicator

Elizma van Milligen

Dyslexia is a neurodevelopmental disorder characterized by persistent difficulties in accurate word recognition, spelling, and decoding, despite adequate intelligence and sufficient educational opportunities. [1,2] It is one of the most common learning disabilities, affecting approximately 5–10% of the population. [3]



Elizma van Milligen

The common signs of dyslexia include:

- **Difficulty learning to read:**
  Struggles with recognising letters, matching sounds to letters or learning the alphabet.
- **Reading below the expected level:**
  Despite normal intelligence, a child with dyslexia may fall behind in reading compared to peers.
- **Letter reversals:**
  Confusing letters that look similar (e.g. 'b' and 'd' or 'p' and 'q') is common, especially in young children.
- **Slow reading:**
  Reading may be laborious, with frequent hesitations, mispronunciations or difficulties sounding out unfamiliar words.
- **Spelling difficulties:**
  Frequent spelling mistakes, including inconsistent spelling of the same word and difficulty remembering how words are spelt.
- **Trouble with word retrieval:**
  Difficulty finding the right word or recalling vocabulary, sometimes leading to avoidance of speaking or writing.
- **Difficulty with sequencing:**
  Struggles with tasks that require ordering steps, such as telling stories in sequence or following multi-step directions

Research highlights the frequent co-occurrence of dyslexia with other neurodevelopmental disorders, particularly Attention-Deficit/Hyperactivity Disorder (ADHD). Studies indicate that 25–40% of individuals with dyslexia also meet the diagnostic criteria for ADHD, suggesting a shared neurobiological basis involving executive function deficits and atypical brain connectivity. [4,5]

The co-morbidity of ADHD and dyslexia complicates both diagnosis and intervention, as ADHD-related deficits in attention, impulse control, and working memory can further exacerbate reading difficulties. [1]

THE READING BRAIN

Reading is a complex cognitive process that requires the coordination of multiple neural systems to decode and comprehend written language. In typical readers, this process is supported by a network of specialized brain regions. However, individuals with dyslexia show distinct differences in the functioning of these neural pathways

In proficient readers, reading engages a left-lateralized network of brain regions:

- **Occipito-Temporal Region:**
  This area, including the Visual Word Form Area (VWFA), is crucial for the rapid recognition of word forms. It enables the efficient processing of familiar words, facilitating fluent reading.
- **Temporo-Parietal Region:**
  Involving the angular and supramarginal gyri, this region is associated with phonological processing and the integration of visual and auditory information. It plays a vital role in mapping letters to their corresponding sounds.
- **Inferior Frontal Gyrus:**
  This area is implicated in articulatory processes and supports phonological and syntactic aspects of reading.

Functional neuroimaging studies have demonstrated that these regions work in synchrony to facilitate efficient reading. The dorsal (temporo-parietal) pathway is primarily involved in the early stages of reading acquisition, focusing on phonological decoding, while the ventral (occipito-temporal) pathway becomes more engaged as reading becomes more automatic and fluent. [7]

Individuals with dyslexia exhibit atypical activation patterns in the reading network:

- **Reduced Activation in Left Hemisphere Regions:**
  Dyslexic readers often show decreased activation in the left occipito-temporal and temporo-parietal regions during reading tasks, which are critical for word recognition and phonological processing.

- **Increased Activation in Right Hemisphere and Frontal Regions:**
  There is evidence of compensatory activation in the right hemisphere and frontal regions, suggesting that dyslexic readers may rely on alternative neural pathways to process written language.

- **Structural Differences:**
  Neuroimaging studies have identified structural anomalies in dyslexic individuals, such as reduced gray matter volume in left hemisphere regions associated with reading and disrupted white matter connectivity, particularly in pathways connecting the thalamus to cortical areas involved in auditory processing.

- **Compensatory Mechanisms:**

Increased reliance on right hemisphere and frontal regions may reflect compensatory strategies that are less efficient, contributing to the persistent nature of reading difficulties in dyslexia. [9]

TYPES OF DYSLEXIA

There are three primary types of dyslexia, but an individual may experience a combination of two or all three, resulting in a total of seven variations. Accurately identifying the type of dyslexia allows for more effective intervention. The different types of dyslexia include:

1. **Dysnemkinesia,** also referred to as motoric dyslexia, is characterized by frequent letter and number reversals. The motor cortex in the left frontal lobe of the brain is affected.

2. **Dysphonesia, also referred to as auditory dyslexia, refers** to the inability to match sounds and symbols. Dysphonetic individuals tend to have good visual processing skills but have difficulty remembering letter sounds, analysing the individual sounds in words, and blending sounds into words.

3. **Dyseidesia, or visual dyslexia,** is the inability to revisualize the gestalt of words. A dyseidetic individual generally has a good grasp of phonetic concepts, but struggle to build a mental lexicon of sight words.

4. **Dysphoneidesia** is a combination of dysphonesia and dyseidesia.

5. **Dysnemkineidesia** is a comination of dysnemkinesia and dyseidesia

6. **Dysnmekinphonesia** is a comination of dysnemkinesia and dysphonesia

7. **Dysnemkinphoneidesia** is a combination of dysnemkinesia, dysphonesia and dyseidesia.

INTERVENTION STRATEGIES FOR DYSLEXIA

Effective support and intervention can help individuals with dyslexia overcome the challenges associated with reading and writing while mitigating the emotional and social impacts of the condition. Early intervention, tailored educational support, emotional support, parent counselling and accommodations are key components in helping individuals with dyslexia build confidence, develop resilience and achieve success in academic, social and personal spheres.

Early intervention plays a critical role in addressing dyslexia, as the sooner the condition is identified, the faster appropriate support can be implemented. Early identification allows educators and parents to provide targeted interventions that can prevent the learning gaps from widening as a child progresses through school. These early measures can reduce the frustration, anxiety and negative self-perception that often accompany undiagnosed dyslexia.

Dyslexic students need intense instruction toward early mastery of core reading skills, including phonemic awareness, decoding skills, reading fluency, vocabulary, and text comprehension.

Accommodations can reduce the pressure on dyslexic students and allow them to focus on their strengths. Accommodations can include extra time, a separate venue, a reader and/or scribe and use of assistive technology.

Emotional support is essential in helping individuals with dyslexia cope with the emotional challenges of their condition. Supportive counselling, mentorship and reassurance can prevent feelings of loneliness, frustration and self-doubt from becoming overwhelming.

Parents play a key role in advocating for their child's needs and creating a supportive home environment.

When parents are educated about dyslexia, they can better understand their child's struggles and provide the emotional encouragement needed to build resilience. Parents can also work with schools to ensure that their child receives the necessary adjustments and specialised instruction.

DYSLEXIA IN SOUTH AFRICA

Accurately determining the prevalence of dyslexia in South Africa is complex due to factors such as poverty, ethnic diversity, and limited access to educational resources. Additionally, the country's linguistic diversity, with 11 official languages, complicates the identification and assessment of dyslexia, especially among learners receiving education in a second or third language. This linguistic complexity can mask dyslexic tendencies, leading to under-diagnosis or misdiagnosis. [10]

Dyslexia significantly affects academic performance. Learners with dyslexia often struggle with reading comprehension, spelling, and writing, leading to lower academic achievement and increased drop-out rates. In South Africa, the lack of resources and support for learners with dyslexia exacerbates these challenges. The 2016 Progress in International Reading Literacy Study (PIRLS) revealed that 78% of South African Grade Four children could not reach the lowest benchmark for reading comprehension across all official languages, highlighting a broader literacy crisis that disproportionately affects learners with dyslexia.11 Beyond academic challenges, dyslexia can lead to social and emotional difficulties, including low self-esteem, anxiety, and social isolation. These issues often stem from repeated academic failures and misunderstandings about the nature of dyslexia among peers and educators. In South Africa, the stigma associated with learning difficulties can further marginalize affected individuals, limiting their social interactions and future opportunities.

The economic repercussions of dyslexias are substantial. Educational systems often fail to provide adequate support, resulting in higher drop-out rates among dyslexic students. This educational disparity contributes to increased unemployment rates among dyslexic individuals. Consequently, there is a heightened reliance on welfare benefits, imposing significant financial burdens on social support systems.

South Africa has implemented policies aimed at supporting learners with special educational needs, including the Screening, Identification, Assessment, and Support (SIAS) policy introduced in 2014. However, the implementation of these policies remains inconsistent, particularly in rural areas where resources are scarce. Many schools lack the necessary tools and trained personnel to effectively support learners with dyslexia, leading to inadequate educational experiences for these students.[12]

To mitigate the impact of dyslexia in South Africa, several measures are recommended:

1. **Enhanced Teacher Training:** Educators should receive specialized training to identify and support learners with dyslexia, utilizing evidence-based teaching strategies.

2. **Resource Allocation:** Increased funding is needed to provide schools with appropriate resources, including assistive technologies and specialized learning materials.

3. **Policy Implementation:** Effective enforcement of existing policies, such as the SIAS, is crucial to ensure that learners with dyslexia receive the support they need.

4. **Awareness Campaigns:** Raising awareness about dyslexia among parents, educators, and the broader community can reduce stigma and promote early intervention.

5. **Creating a supportive environment at home and school** is essential. Understanding and patience from parents, teachers, and peers can make a significant difference in the child's confidence and motivation.

Dyslexia is a complex condition with profound effects on cognitive, emotional, and social well-being. While dyslexic individuals face challenges in literacy acquisition, targeted interventions and support systems can significantly improve their quality of life. Increased awareness, research, and inclusive educational practices are essential in ensuring that individuals with dyslexia can reach their full potential.

Elizma van Milligen is a pediatric optometrist with a passion for helping children overcome visual challenges and learning disorders. As the owner of VDM Optometrists, she not only runs her group of practices, but also actively participates in community projects. Committed to giving back, Elizma has participated in numerous initiatives aimed at improving access to eye care for under-served populations. **Correspondence: elizmavm@gmail.com**

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Twice Exceptional: Exploring the Yin-Yang of Giftedness and Disability

Michele van Niekerk

Michele van Niekerk

In the gradually evolving domain of education, few developmental patterns are as perplexing and captivating as those exhibited by twice-exceptional (2e) learners. These are the children who confound professionals due to their giftedness in one or more domain and significant challenges in another. They are the future engineers who have a meltdown at the mall, the eloquent writers who are fidgety and forgetful, the imaginative artists who see and draw in 3-D, but flounder with reading as the words and sentences refuse to align conventionally in the speech and language regions of their brilliant brains. Their lives, and the lives of those guiding them, vacillate in the tension between brilliance and struggle - a paradox that demands more than that which traditional educational or support systems tend to offer.

DEFINING TWICE-EXCEPTIONALITY: MORE THAN JUST A LABEL

Twice-exceptionality describes individuals who exhibit extraordinary ability in one or more areas while simultaneously contending with one or more neurodevelopmental, emotional, or learning challenges. The term emerged in educational literature between 1970 and 1990 and continues to evolve as our understanding of neurodiversity and neurodivergence grows.

These learners are often described as intellectually gifted, extraordinarily creative or deeply empathic - yet they may also be challenged due to being autistic, having ADHD with or without specific learning disabilities (e.g. dyslexia), an extreme hyper- or hypo-sensitive sensory processing profile, often in conjunction with other battles such as overwhelming anxiety or OCD. Their unique profiles often defy easy categorisation. In fact, 2e learners may perform unevenly across different domains, leading to misdiagnosis, delayed support, or even complete oversight.

When defining intellectual giftedness, it is generally accepted that children with IQ scores of 140+ fall in this category. Giftedness is an innate ability and not a learned skill and as such many experts on intellectually gifted children warn that IQ alone is not a predictor of success in adulthood.

WHEN STRENGTHS CONCEAL STRUGGLES—AND VICE VERSA

The paradox of 2e learners lies in the interplay between their capabilities and their limitations. Sometimes their intellectual strengths mask their difficulties, causing teachers to misinterpret their underperformance as laziness. At other times, their challenges take centre stage, leading educators and clinicians to overlook their areas of giftedness entirely.

This may result in 2e students falling into one of three categories: those whose disabilities are identified but whose gifts remain hidden; those whose giftedness is identified but whose struggles are misunderstood; or those who appear average, neither strength nor struggle fully recognised.

This misalignment has real consequences. Brody and Mills described 2e individuals as “the most misunderstood of all exceptionalities”. Unmet needs and chronic misperceptions can leave these students disengaged, anxious, frustrated or isolated, falling through the cracks of systems designed for either remediation or enrichment, but not both.

THE YIN AND YANG IN PRACTICE: TWO CASE STUDIES

Consider H.A., a 12-year-old boy who excelled academically and athletically but was debilitated by obsessive-compulsive disorder, auditory hypersensitivity, and anxiety. Initially treated with therapy and medication for anxiety and OCD, it was only after a later diagnosis of ADHD and subsequent treatment with stimulants that his academic motivation and emotional balance improved markedly.

The second case pertains to A.M., a 10-year-old girl with exceptional reading and puzzle-building abilities, but significant challenges (for her and all family members) regarding emotional regulation, impulsivity, and acceptable social interaction. Diagnosed with both ADHD and autism, conventional schooling was not an option. She responded paradoxically to most medication used age appropriately in this type of scenario. She was only able to start self-regulating and express her innovative and imaginative talents in a highly personalised homeschooling environment which emphasised structure, interest-based learning, and flexible therapeutic support.

These cases illustrate how nuanced, layered, and dynamic 2e profiles can be.

ASSESSMENT AND IDENTIFICATION: SEEING THE WHOLE CHILD

Accurate identification of 2e learners requires an approach as multifaceted as the children themselves. Standardised assessments like the WISC-V or WIAT can provide insight into cognitive profiles, but often need to be supplemented with qualitative observations, parent and teacher reports, and tests that account for both strengths and various processing difficulties.

Moreover, comprehensive evaluations should include discrepancy analyses - pinpointing where a child's performance diverges dramatically from expectations based on their observed intellectual ability. This helps to uncover hidden learning or other difficulties which might otherwise be eclipsed by strong cognitive, verbal or creative talents.

However, even with tools in hand, educators often lack the training or awareness to accurately interpret these complex profiles. Studies have shown that special education teachers may focus more on deficits than strengths, and are often the least likely to refer a 2e student to gifted programs.

CLASSROOM STRATEGIES: WALKING THE TIGHTROPE

Supporting twice-exceptional learners in the classroom isn't a matter of choosing between enrichment and remediation - it's about balancing both.

Academic interventions for 2e learners should be individually tailored. Individualised Education Plans (IEPs) can incorporate curriculum differentiation, allowing for challenging content alongside accommodations like extra time, reduced distractions, or alternative forms of assessment. Assistive technologies - typing vs. writing, speech-to-text tools, audiobooks, or reader pens are modern methods which may be especially useful for bypassing barriers without compromising intellectual potential.

Executive functioning supports, like visual schedules, checklists, and explicit instruction can help 2e learners prioritise or organize, or manage time or transitions. Executive function challenges are particularly evident in both Autism and ADHD.

Sensory accommodations, such as noise-cancelling headphones or fidget tools, allow for greater comfort and focus in overstimulating environments or may lower overwhelm and anxiety.

Creative modalities, including art, music, and movement-based (kinetic) learning are probably not considered often enough. They not only engage the 2e students' strengths and perceptions but may serve as therapeutic outlets for emotional regulation.

BEYOND THE CLASSROOM: A WEB OF SUPPORT

Effective support for 2e learners extends beyond the classroom and school playground. Collaborative partnerships between parents, educators, psychologists, and therapists are essential. Parents often act as advocates, researchers, and coordinators of care - roles that demand significant emotional and logistical bandwidth.

Counselling and social-emotional support should be integrated, not add-ons. Therapeutic interventions targeting perfectionism, anxiety, or social skills are critical. Group settings where 2e children can connect with like-minded peers can help reduce feelings of isolation and difference.

Importantly, a strengths-based approach - focusing on what students are interested in or excel in (even if outside the conventional 'curriculum'), and not just highlighting challenges - is key to promoting resilience, autonomy, and self-worth.

INCLUSIVE EDUCATION: PROGRESS AND PITFALLS

Globally, the movement toward inclusive education often overlooks 2e learners. While there has been a push to integrate children with disabilities into mainstream classrooms, this rarely comes with the necessary training or resources for educators to support the duality of twice-exceptionality.

According to Gierczyk and Hornby, inclusion only works when teachers are prepared to identify and respond to both giftedness and disability. This requires professional development, interdisciplinary collaboration, and the adoption of flexible teaching models that span both special education and gifted education domains.

Rapid advancement or skipping grades is generally not encouraged, as the risk of further isolating a child who already identifies as 'being different' from their peer group, may be more harmful than beneficial.

RETHINKING SUCCESS: REDEFINING ACHIEVEMENT

2e learners challenge us to revisit our definition of success. Their trajectories may be non-linear, with uneven progress. However, understanding and adequate support may enable these exceptional individuals to potentially become extraordinary innovators, artists, scientists, and game-changers.

In many ways, they embody the essence of human potential - resilient, creative, complex, and paradoxical. Like the yin-yang symbol, their strengths and challenges are interdependent and dynamic. To truly support them, we must learn to see this interdependence not as a barrier, but as a blueprint for deeper understanding and more inclusive education. Peers can help reduce feelings of isolation and difference.

Importantly, a strengths-based approach - focusing on what students are interested in or excel in (even if outside the conventional 'curriculum'), and not just highlighting challenges - is key to promoting resilience, autonomy, and self-worth.

CONCLUSION: EMBRACING COMPLEXITY

Twice-exceptionality is not a problem to be solved, but a reality to be understood. By embracing the complexity of 2e learners - through tailored strategies, interdisciplinary collaboration, and a strengths-based lens - we honour their full humanity.

In doing so, we move closer to educational systems that do not merely accommodate difference but celebrate it.

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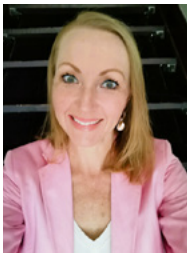
MOTHERING WITH ADHD: CHALLENGES & STRATEGIES TO THRIVE

Gina Rencken

Attention deficit hyperactivity disorder (ADHD) is recognised and treated in children and adults, with a growing number of women entering their reproductive years treated with medication for ADHD or being diagnosed and starting medication for ADHD during their reproductive years.



Gina Rencken

MATERNAL ADHD IN PREGNANCY

Pregnancy is a significant time of adjustment period in the life of a woman, where she transitions from being an individual to being intertwined with a developing foetus in a dyad. The prenatal period is sensitive, characterised by rapid development and psychological and physiological changes in the mother and foetus, and thus also a time where this dyad is particularly vulnerable.[1] The adjustment may be additionally influenced by factors such as whether the pregnancy was planned or unplanned, with an increased number of unplanned pregnancies occurring in women with ADHD.[2] In the interests of maintaining a healthy pregnancy, antenatal visits with health care professionals are required to monitor maternal and foetal health, and nutritional supplementation, dietary, and lifestyle changes may be recommended.[3] Pregnancies in women with ADHD are not without risk, with pre-eclampsia, infection, and increased caesarean section rates being reported, as well as an increased risk of pre-term birth and the need for neonatal intensive care unit admission for newborns.[4] Along with these known risk factors, a decision regarding the continuation or discontinuation of ADHD drug treatment, as well as drug treatment for any co-occurring conditions needs to be taken after consultation with the mother's treating psychiatrist and obstetrician. Treatment decisions are influenced by the severity of ADHD, the presence and severity of other comorbid disorders, and the degree of functional impairment experienced by the woman, with the added responsibility of maintaining a healthy pregnancy to delivery and beyond.[5] The use of stimulant ADHD medication in pregnancy does not seem to have major teratogenic effects on the developing foetus or result in an increased risk for neurodevelopmental disorders, but human data on neurobehavioural outcomes are needed to understand the potential risks.[4-6]

During pregnancy, physical symptoms such as nausea and vomiting, leg cramps, shortness of breath, changes in interoception (including constipation, frequent urination, heartburn and appetite changes), breast tenderness, pelvic pressure, hot flushes and fainting regularly occur.[7] These may range in intensity from being mildly uncomfortable, to distressing to the mother. There are also reports of changes in neurocognitive functions, including memory and executive function.[6] The mother with ADHD, who is already vulnerable to executive functioning challenges and sensory integration difficulties or dysfunction may experience additional challenges during pregnancy.[6] Executive function skills are needed in pregnancy to keep track of additional doctor appointments, to regularly to take prenatal vitamins, to maintain a balanced diet suitable to pregnancy, maintain relationships with significant others, an intimate partner or spouse, and to get ready to welcome a baby into her life and home. The planning and logistical arrangements for applying for maternity leave or accessing UIF benefits carry significant financial implications.

MATERNAL ADHD IN THE POSTPARTUM PERIOD

Birth signals a second major transition to motherhood, with the mother vigilantly looking for confirmation of the survival of the infant, affirmation that they are well and then looking for similarities to family members, psychologically fitting the infant into a space in her family. She is open and vulnerable in this stage, and the hormonal, physiological and psychological transition is immense in proportion.[8,9] The mother is now responsible for the life of the infant outside of her body, which adds to the burden of care. Factors such as infant comfort (temperature, dirty or wet diapers), infant hunger cues, sleep cues and arousal levels need to be correctly interpreted and acted upon to facilitate a smooth transition into the "fourth trimester".[10] In this transition, maternal mental health concerns such as depression and anxiety may need attention.[11] Mothers may feel socially isolated, overwhelmed with the needs of the baby, and experience a loss of previous social support and interaction. Breastfeeding is an additional sensory experience which may be experienced in a variety of ways, from painful, to pleasurable and empowering, or even deeply unpleasant in mothers experiencing dysphoric milk ejection reflex.[12]

Postpartum and mothering during infancy is characterised by disturbed sleep, due to infant feeding and comfort needs as well as physical and physiological changes in the mother's body. One of the largest indicators for parental distress in mothers with ADHD in the first year of the infant's life is associated with decreased sleep quality.[2]

Additional executive function challenges in the postpartum period include inattention, a failure to listen to instructions or guidance given by health care providers, irritability and low frustration tolerance (adding to a challenge in co-regulation with the infant), disorganisation and careless mistakes (with feeds, medication, bath temperature), procrastination with health care visits and medication refills, impaired planning for outings and misjudging the time needed, impulsive spending and potentially distracted or reckless driving.[5]

These challenges compound as children grow, and the mother carries a larger mental load for her family and has to support the sensory, motor and cognitive development of growing children, including their executive function.

CLINICAL IMPLICATIONS AND TREATMENT CONSIDERATIONS

Women may choose to stop ADHD medication during pregnancy, after consideration of the risks and benefits and in consultation with their psychiatrist and obstetrician.[5] Supportive care for women with ADHD in pregnancy and beyond is warranted, with a detailed assessment of sensory reactivity, sensory perception and praxis conducted by an occupational therapist. Her executive function should also be assessed by an occupational therapist or psychologist, and an individualised intervention plan designed. This intervention plan could include approaches like cognitive behavioural therapy (CBT), Dialectical behaviour therapy (DBT) and skills from parent-child training (PCT).[14] In addition to this, awareness of her own arousal levels, appropriate sensory strategies to increase or decrease these appropriately, as well as the arousal levels of her infant and strategies to adapt these are recommended.[11,13] Depending on the functional and occupational challenges experienced, a functional capacity evaluation can be conducted which can inform employment accommodations if necessary.[5,11,13]

Infant assessment and monitoring should be available from birth, with a detailed assessment of infant neurobehavioural functioning across domains of autonomic stability, motor skills, regulation of state, social interaction and reflexes. The Brazelton Neurobehavioural Assessment Scale is one tool that can identify challenges in these areas in the first days of life and is protective of parental anxiety, bonding and caregiving skills when presented as an educational consultation during the assessment.[8] As ADHD has a strong genetic link, early monitoring and assessment of infants with developmentally appropriate assessment can aid in early identification and intervention.[5,13]

With support from health care practitioners, and maternal awareness of challenges in mothering with ADHD, the journey can be fulfilling, fun, responsive and nurturing for the mother and her children.

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LIFE IN PERSPECTIVE

Sundeep Ruder

The content is based on a talk delivered at the Dr Reddy's Psychiatry Academic Meeting, August 2024

Sundeep Ruder

William Osler quotes Plato: *"On account of the intimate personal nature of his work, the medical man, perhaps more than any other man, needs that higher education of which Plato speaks—that education in virtue from youth upwards, which enables a man eagerly to pursue the ideal perfection".* What is that *"education in virtue"* that Plato speaks of? And, what is the *"ideal perfection"* that we ought to seek?

The enquiry into, and answers to these questions can lead a human to the fulfilment of the human mission - eternal happiness or Self Realization. However, the path of enquiry is not easy. Hence, the masses (majority) remain in blissful ignorance. A state of non-knowledge or absence of wisdom. Only a few embrace the often-painful pursuit of true knowledge culminating in Eternal Bliss.

Aldous Huxley said *"If the doors of perception were cleansed everything would appear to man as it is: Infinite. For man has closed himself up, till he sees all things thro' narrow chinks of his cavern."*

The suggestion here is that our perception of the world and what we deem as 'reality' is narrowed by the limited possibilities of our five senses and mental preconditioning. We are dulled into a programmed, automatic life dictated by the senses and the reactions that they initiate within our minds. And the mind, already programmed with preconditioned notions and biases from past experiences, directs the actions of life impulsively. So, we become slaves of the three transactions of life, namely receipt of sensory input, reaction of the mind, and responses through our organs of action.

Humans are the only species with freedom of choice. Choice of action depends on state of mind. All action has the potential to cause a chain of consequences. Therefore, it is important to choose rightly. But on what basis do we choose? The dilemma of human choice is that of being able to regulate the mind's reactions from impulsive to objective. It is only a well-developed intellect that can regulate the reactions of the mind to improve our responses and thus purify our actions. The art of right action therefore requires a well-developed intellect. Right actions help maintain harmony within oneself and the environment. In this approach there is no preconceived list of what constitutes right action or wrong action. It amounts to how a well-developed intellect conceives a situation and directs the mind to act in a way that maintains harmony. When the mind is left to execute actions impulsively, i.e. without the purvey of the well-developed intellect, such actions lead to disharmony within oneself and the environment.

In the modern world, despite scientific progress and the evolution of large volumes of knowledge and information, it appears that humanity still appears in a state of dejection, depression and disease. In a modern scientific era of supposed rationality, brutish wars persist, religious fanaticism and terrorism are consistently featuring, marked economic disparity prevails and the individual remains lost in an overwhelming world. Natural disasters and other global calamities appear to be on the rise. Misinformation is used to manipulate the unintellectual masses and disharmony, and confrontation appear to be the order of the day. If knowledge in its modern format was to produce a mature society, current evidence would negate this theory. Plato's call for that *education by virtue* is a need of the hour.

"THAT HIGHER EDUCATION"

Modern education is servile in its nature. It is slavishly being used for its utility value i.e. to help people earn a living. It does not create free thinking, logical, rational and self-sufficient humans. Rather, through external sources, it infuses students with facts and lists. This develops intelligence but not the intellect. Intellect being the faculty of reason, judgement, discernment. Intellect is the penetrative capacity to be able to see the unseen consequences embedded in every thought and action. With well-developed intellect there is depth and maturity to life. While intelligence deals with the visual, seen world, intellect deals with that which is unseen. In Sanskrit language these are termed *drishta* (seen) and *adrishata* (unseen). Without a well-developed intellect, the unattended mind wreaks havoc and thus even the intelligentsia of today are capable of hysteria and emotional vacillation. Many highly qualified academics can claim their PhDs but are unable to regulate their emotions and addictions. Only the a well-developed intellect can attend to the vagaries of the mind. But how does one develop intellect?

ENTER THE GURU

The author of this article has spent the last fifteen years studying the philosophy of Vedanta through the system of *'guru-shishya parampara.'* Guru means teacher, *'shishya'* means student, and *'parampara'* signifies tradition. A system where a guru (teacher) assumes comprehensive responsibility for a *shishya* (student), providing education, guidance, and support in every aspect of life, following the tradition of *parampara,* the succession of knowledge from one guru to the next.

The word guru has a deeper meaning. He is not like a teacher in the modern traditional sense. *"Gu"* means 'darkness of ignorance' and *"Ru"* means 'the divine light of knowledge'. A person who removes darkness & illusion with divine light of true knowledge is called guru. The etymology of the word further means *"weighty or grave",* in keeping with the fact that true knowledge is difficult to bear initially and the guru's advice appears difficult to follow. The guru is the physical embodiment of the shastras (knowledge). The vedas are the knowledge systems which when used to develop the intellect and guide human choices, help maintain harmony within oneself and the environment.

Vedanta derives from two sanskrit words. *Veda* meaning knowledge. And *anta* meaning end. The knowledge of Vedanta is derived from the end portion of the ancient texts known as the Upanishads, which themselves are a part of the complete Vedas - the primeval source of scriptures. Of interest, is the idea that these knowledge systems are of divine origin. Any knowledge that helps maintain the harmony of creation must be derived from a source prior to the creation. *Vedanta* thus forms the culmination of spiritual wisdom. The end of knowledge so to speak. And such knowledge can only be delivered by one who has realized it, that is, the guru.

The aphorism (*mahavakya*) "*Tat Tvam Asi*" which means "That Thou Art" appears in the Upanishads, and the entire system of knowledge is designed to get the seeker of Truth to realize this aphorism - that perfection of which Plato spoke about. The guru, out of his infinite compassion patiently guides the seeker to the realization of ultimate Truth - Self Realization or the goal of the human mission. Vedanta has a relative and absolute value. To the degree it is imbibed, it will improve the experience of worldly life with less stress and strain. And for those that are well prepared, it offers the opportunity to transcend.

Many Western scholars have alluded to the value of *Vedanta* in enhancing their understanding of their particular field of study. Niels Bohr was quoted as saying *"I go the Upanishads to ask questions."*. And the quantum physicist Erwin Schrödinger mentions in his book - My View of the World - *"Vedanta teaches that consciousness is singular, all happenings are played out in one universal consciousness and there is no multiplicity of selves."* The generally disgruntled Arthur Schopenhauer found retreat in the Vedas saying *"In the whole world there is no study so beneficial and so elevating as that of the Upanishads. It has been the solace of my life, it will be the solace of my death."*

Vedanta is a complete system of knowledge that takes you from the known to the unknown. Reality, Truth, Infinity, Eternal Bliss or God, whichever we wish to call the Ultimate Goal of life, cannot be known by the human material cognitive capabilities. By helping one redefine the common, mundane cognitive perception of the subject-object relationship, *Vedanta* then proceeds to negate this newly established understanding by proving its illusory nature and temporariness. The mind thus cannot hold onto its previous fixed firm pathological notions. This is achieved by a process of *shravana* (gaining knowledge) and *mañana* (reflection & contemplation). When the seeker is firmly established in relative objectivity and is unruffled by worldly vicissitudes, he then proceeds with the guru's direction to *niddhiyasana* (meditation). This is contrary to modern practices of meditation on unprepared minds - putting the cart before the horse.

Meditation, the negation of all notions ultimately leads to the unveiling of the underlying Reality which is experienced by the seeker, Self Realization or the Abode of Eternal Bliss. This is akin to the investigation of an oasis in the desert. The senses are attracted to it, but upon investigation (study and reflection) it disappears, unveiling the vast desert it was masking.

LIFE

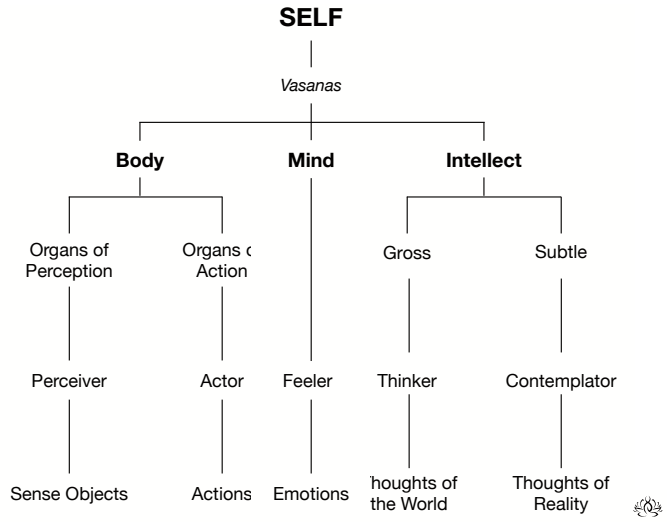
"To change the world, one must change oneself".

Life is a series of experiences. A unit of experience is a meeting between you, the subject and the world, the object. In this equation, the world of objects has been improved through science, economy and policy. Modern technologies of the world have provided push button comforts. Yet the experience of human life remains negative. What has been neglected in this equation is the subject. The rehabilitation of the human being by the development of the intellect is the need of the hour. To do this, one needs to understand the anatomy of a human being.

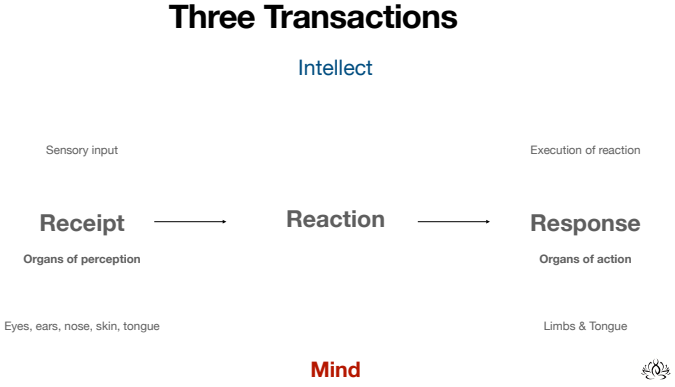
Vedanta offers a user manual on the machinery of life and how to use it to relate to the terrestrial world correctly. Its focus is on building and nourishing the intellect. A well-developed intellect will automatically govern the mind and direct it to a more mature state of existence. Its focus is internal and not the world at large. Thus when harmony is achieved in individual life, it percolates into harmony in the world. It is only ignorance that creates the delusion of suffering and sorrow. The knowledge of Vedanta can clear this ignorance and restore us to our natural state.

THE SUBJECT: WHAT ART THOU?

A human being is a composite structure of three equipments, a physical body (gross body), a mind and an intellect (combined called the subtle body). All three equipments are enlivened by the Self or in common parlance - Spirit. The focus of modern medicine has been on the gross or material vesture of the human being. All anatomy and physiology, neurochemistry, etc. simply study and examine the physical (gross) equipment of a human. The focus of *Vedanta* is on rehabilitation of the subtle body. The diagram depicts the anatomy of a human in its completeness.



THE THREE TRANSACTIONS



The physical body, made up of the organs of perception (OOP), which are the eyes, ears, nose, skin, tongue. And the organs of action (OOA), limbs (movement) and tongue (speech). The senses interact with the outer world. Colour and

form enter through the eyes, sound through the ears, smell through the nose, touch through skin and taste through the tongue. One should consider that all these sensory inputs are a representation of a limited spectrum of vast energy and perception barricaded by limited human senses. We know from scientific studies that perception of species at the depths of the ocean, for example, is very different and the capabilities of perception of species living at that depth is different from that of humans. Humans make the mistake of setting our perception of the universe as the gold standard.

So, limited sensory data enters the sense centres of the human mind. Here, they interact or react with the established mental temperament of the individual. Creating a *'reaction of the mind' (akin to a chemical reaction between two substances in a chemistry laboratory)*

The mind is the seat of desires, emotions and feelings. In vedantic terms, the mind is not conceptualized as a physical structure i.e. the brain. It is a subtler entity along the lines of Carl Jung's characterization of mind. Although Jung may have not differentiated it from intellect.

One would need to reflect on this concept and try to conceive the mind as a subtle collection of energetic wave patterns that are non-physical and non- localized, but nonetheless, material in nature. 'Subtle matter' so to speak. The modern materialist physician may be inclined to think of the mind as a collection of neuro-chemical processes. The reader is invited to expand their imagination to conceive that the mind is subtler than a bundle of neurophysiological (NP) processes. A stance more aligned to idealist theory of perception. Neurophysiological processes are a *downstream effect* of the mind. This may explain the limitation of modern treatments in what are deemed 'mental diseases. Mind controls the downstream physiology and actions of the body and not the other way round. **The subtle controls the gross**. i.e. mind controls the body. Subtle in philosophical terms can be defined as that which is more expansive.

Desires originate in the mind, and if left unregulated, breed like bacteria. The pre-determined endpoint of fulfilling desires is misery. Because one is never *eternally* satisfied once a desire is fulfilled. More desires are bred on fulfilment of a prior one. Further, the object of fulfilment of desire becomes a trigger for stress and agitation. Stress being defined as any mental agitation due to an intercepted or interrupted desire. Countless examples are proof of this. Attaining a degree, getting a job or a promotion at work, getting married, having children, etc. The author is not suggesting that these pursuits are wrong. But highlighting that whilst the goal of life is eternal bliss, such eternal happiness can never be attained from acquisition and enjoyment of temporary objects and beings. This is the delusion that the mind creates, that temporary items of acquisition and enjoyment will deliver *eternal* happiness. Human beings, not knowing this, have created a world of consumerism. We have become consumers not contributors. Preferences and aversions, likes and dislikes are thus formed. The mind is by its nature non-rational and indiscriminate. If left to itself it leads to unregulated emotionality, hysteria and even insanity. It is prone to form attachments. Finally, desires left unsupervised can modify into anger, greed, envy, arrogance, jealousy and lust. So, the deadly sins mentioned in biblical texts are nothing but modifications of desire left unregulated.

The reaction of the mind is thus a sum of the receipt of current sensory data and the previously established mental pattern of the individual. Every human has a unique baseline mental temperament, additionally affected by past thoughts and actions. That reaction translates into a response into the world via the OOA. And every action has embedded in it the consequence of the reaction of the mind, which precedes it. This embedded consequence can be positive (merit) or negative (demerit). If the reaction that led to a response was impulsive, selfish and driven by a modification of desire, the consequence will be negative. Negative meaning the person suffers hell through personal challenges and mental agitation. This state of hell is termed *"naraka"* in Sanskrit.

If the reactions of the mind are well regulated by a developed intellect, and the emotions are chaste, filled with gratitude and unselfish in nature, such actions consequently retrieve positive benefits. Such a person has relative mental peace, is equanimous and experiences less strife in life. This state of heaven is termed *"swarga"* in Sanskrit. So, heaven and hell are not geographical locations but states of mind determined by mental reactions and actions of people.

Only a well-developed intellect has the penetrative capacity required to conceive the embedded consequence in actions.

The intellect is the third, subtlest equipment of a human. As it is subtler than the mind, it has the capability of regulating the mind. The Sanskrit word for intellect is *buddhi,* derived from root *budh* which means 'to know' or to 'be awake'. Intellect refers to the power to understand and analyse, discriminate and decide, think, reason and judge. It has two components, the gross intellect which deals with the mind and its world transactions and the subtle intellect which is able to conceive and reflect on a transcendental reality. The latter is often called the 'third eye' (*gyanachakshu* in Sanskrit) in various religions and philosophical systems, and it becomes more available as the gross intellect stabilizes the mind.

The intellect is developed through questioning everything and never taking anything at face value. Intellect is further developed by the study of and reflection on scriptural ordinance. Combined with higher values of selfless action, objectivity, gratitude, giving and not taking and practicing duties rather than claiming rights, the intellect is perfected and matures a human to the pinnacle of their capability. 'Education by virtue' is that knowledge by which the *'narrow chinks of our cavern'* are widened to appreciate the spectrum of life beyond our limited, constricted, current vision of material existence, and then to ultimately experience *True Reality.*

This article is a call in the dark for the re-establishment of *education by virtue* within our medical education system. The residual thinkers within our ranks ought to engage this knowledge and by their own evolution let it percolate into the medical curriculum and patient care.

Liberation (*Moksha* in Sanskrit) is a bold experiment, but it is the only way to the Abode of Eternal Bliss. With reason, judgement and discernment well developed, one overcomes body consciousness, narrow mindedness, fear and sorrow. The result is a fearless human who becomes generosity incarnate and a source of power and spiritual holiness for the larger community.

The author is available for further information and direction. References on request.

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Invitation to Weekly Online Study Group

The Fall of the Human Intellect

by A. Parthasarathy

Facilitated by Dr Sundeep Ruder

Weekly Sessions

- **When:** Every Wednesday, 7:00 PM – 8:00 PM
- **Starting:** 1st October 2025
- **Where:** Online via Zoom
- **Format:** Interactive study group for sincere seekers, exploring ancient wisdom based on the book Fall of the Human Intellect.

What You'll Gain

- Develop your intellect beyond mere intelligence
- Engage with practical Vedantic insights
- Enhance critical thinking skills for everyday life
- Connect with like-minded seekers of wisdom

> *"Let noble thoughts come to us from all directions."*
>
> — Rig Veda

Facilitator: Dr Sundeep Ruder, disciple of Swami A Parthasarathy brings 15 years of experience in Vedantic philosophy and intellectual development, guiding participants through transformative discussions and practical applications of timeless wisdom. Dr Ruder is also a clinical endocrinologist and lecturer at Wits School of Clinical Medicine.

The Psychology of the Future: Scenarios, Minds, and Philanthropy

Koffi M. Kouakou

South Africans are no strangers to uncertainty. In psychiatry, it is called anxiety; in strategy, it is called risk; in philanthropy, it is called bets. But the future does not arrive in a straight line—it arrives as a cloud of possibilities, messy, surprising, and often unsettling.

Koffi M. Kouakou

The psychology of foresight is about how minds—individual, collective, institutional—learn to think and feel across that cloud.

Five years ago, my curiosity peaked in philanthropy when I did some scenario planning strategy work for a client. I found puzzling the relationship between long-term giving also called sustainable giving, foresight, psychology, psychiatry and philanthropy. It seemed almost out of mind or crazy to keep giving money and resources and see no return for years, if not decades especially in fields such as education, poverty alleviation and health. Many compelling self-questions arose in my mind.

How does uncertainty shape the way philanthropists imagine and commit to the future?

This question helped me to explore the tension between anxiety, risk, and hope. It unpacks whether philanthropists are motivated more by fear of loss or by a vision of possibility to ease the pain and suffering of others.

What psychological biases cloud or sharpen philanthropic decisions about tomorrow?

In Daniel Kahneman's Prospect Theory, anchors such as loss aversion, overconfidence, and availability bias all affect how philanthropists assess scenarios of future impact.

Are philanthropies funding solutions, or are they funding options across multiple possible futures?

This question reframes the notion of giving as a form of "futures portfolio" management—how to hedge bets in a way that embraces plural tomorrows rather than a single imagined outcome.

How do collective emotions—fear, hope, trust—shape the scenarios we build and the futures we choose to act upon?

Here, I interrogate the role of affect where foresight is not just rational; it is deeply emotional and social. Philanthropy mirrors that psychology.

And finally, **what does it mean to practice psychologically wise philanthropy in a time of radical uncertainty?**

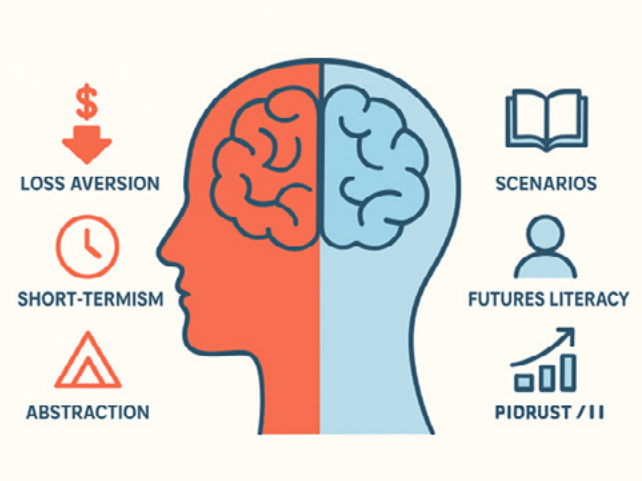
It is a reflective question with a sense of an almost ethical inquiry that goes beyond strategy. It explores how do we cultivate foresight as a discipline of humility, empathy, and resilience when investing in future change?

Incidentally, I have been asked to discuss these issues on a panel at this year's October Independent Philanthropy Association of South Africa Symposium in Stellenbosch.

The answers to these five questions serve as narrative anchors for this essay, with each one leading into a section that blends theory, psychology, and philanthropic practice. And moreover, they tease out a few speculative scenarios that create the bridge between human psychology and foresight.

As such in this essay, I explore five psychological building blocks that shape how we see, feel, and act toward the future—particularly through the lens of scenario planning and philanthropy.

When philanthropies fund change, they are not only buying outcomes; they are buying options in multiple tomorrows. The challenge is less about guessing which future is "right" and more about making psychologically wiser choices amid deep uncertainty.



HOW OUR BRAINS PRICE TOMORROW: BIAS, TIME, AND THE "NEAR–FAR" MIND

Human beings are not built to see the future neutrally. Psychologists Daniel Kahneman and Amos Tversky showed that we consistently overweight losses relative to gains. This is called loss aversion. Losing R100 hurts more than winning R100 pleases. Add to this hyperbolic discounting—the tendency to treat next week as cheap and next year as distant and irrelevant—and we have a cognitive recipe for short-termism.

Construal Level Theory adds another twist. The further away an event seems in time, the more abstractly we imagine it. Next week's flu vaccination is about pain, logistics, and transport. A pandemic five years from now is imagined as a grand policy challenge, not a bodily one.

Philanthropic decisions are equally vulnerable. A foundation may choose a "quick win" programme over a structural reform not because the latter is less effective, but because the brain mis-prices time and risk.

However, scenario planning can offer a corrective. By forcing leaders to inhabit alternative futures, it stretches time horizons and surfaces biases. One useful technique is episodic simulation: writing two vivid reports from 2030—one triumph, one stumble. Seeing those narratives side by side rebalances emotions, loosening the grip of loss aversion.

FUTURES AS IDENTITY WORK: WHO WE THINK WE ARE SHAPES WHAT WE THINK IS POSSIBLE

Every organisation carries a story about itself. Some philanthropies see themselves as risk-takers breaking new ground; others as field-builders holding institutions steady; still others as safety nets catching those who fall through cracks.

As such, narrative psychology reminds us that these identities are not peripheral—they are central filters shaping what futures are visible. If a foundation's story is "we provide immediate relief," it will struggle to imagine futures of long-term systemic transformation. Conversely, a "change the system" identity may dismiss short-term interventions as beneath it.

Scenarios are mirrors for these identities. In one imagined future, the philanthropy may be a hero; in another, a bystander; in a third, an unintended obstacle. Each scenario holds up an unflattering but invaluable reflection.

A simple but powerful exercise is the identity diary. In every scenario, one could write a one-paragraph diary entry from the perspective of the foundation, and another from a grantee. Where the two narratives clash—say, the foundation sees itself as empowering but the grantee experiences bureaucracy—you have located a seam of dissonance. That seam is tomorrow's implementation challenge.

FROM PREDICTION TO FUTURES LITERACY: UPGRADING THE MENTAL MODELS WE USE TO IMAGINE

UNESCO's Riel Miller argues for Futures Literacy, the skill of using the future to understand the present. The future is not simply a place to be predicted; it is a tool for rethinking our assumptions today.

Interestingly, cognitive psychology shows why this matters. Our capacity for episodic future thinking—mentally pre-experiencing events—uses the same neural machinery as memory. We imagine forward by remembering backward. That is why our futures are so often impoverished versions of our past.

Fortunately, foresight methods intervene here. By deliberately crafting scenarios that are strange, uncomfortable, or unloved, they force us to confront hidden assumptions. For example, a philanthropic board may assume that digital health adoption will inevitably increase access. A deliberately uncomfortable scenario might show technology deepening inequality—if rural clinics remain under-resourced and digital divides persist.

The test of a scenario exercise is not whether it "predicts" correctly but whether it catches a critical anticipatory assumption in the act. Philanthropies that treat assumption-spotting as a core output—tracking reframed beliefs alongside grant outputs—are better positioned to avoid blind spots.

THE SOCIAL MIND OF FORESIGHT: GROUP DYNAMICS AND DIVERSITY OF IMAGINATION

Foresight is never a solitary act; it is always social. And groups, as Irving Janis taught us, are prone to groupthink—the drive for consensus that silences dissent. Hierarchies and status dynamics can reduce the range of imagined futures, privileging senior voices over lived experience.

Phil Tetlock's work on expert judgment shows that accuracy improves when groups are forced into adversarial collaboration, when predictions are tracked, and when diversity of perspective is embraced. In philanthropy, this means scenario exercises must be designed for psychological safety—a space where dissenting views are not punished but valued.

One method is to assign roles in a workshop i.e. a risk skeptic who pushes on fragilities, an equity advocate who centres justice, a field historian who recalls past cycles, and a beneficiary proxy who grounds the conversation in lived experience. Each role must provide at least one disconfirming datapoint and one vignette of lived reality.

The result is not a single neat consensus but a map of disagreements. That map is far more useful than false harmony, because it reveals the true contours of uncertainty that help to inform effective, insightful and foresightful philanthropic decision-making.

PHILANTHROPY AS REAL OPTIONS: PORTFOLIOS, EMOTIONS, AND ROBUST CHOICES

In deeply uncertain environments, robustness matters more than precision. RAND researchers have pioneered Robust Decision Making (RDM) that stipulates that instead of optimising for one forecast, design strategies must work across many futures.

However, psychology complicates this. Moral emotions—care, compassion, fairness, loyalty—pull philanthropies toward causes in ways that sometimes override robustness. Identity-protective reasoning tempts boards to cling to familiar strategies, even when fragility is exposed.

Here, scenarios reveal fragilities by showing where a strategy breaks. The solution is not better prediction but better portfolio design. One useful approach is the Barbell Portfolio: put 70–80% of resources into robust, low-regret bets (capacity building, basic services), and 20–30% into exploratory, high-variance bets (policy pilots, tech-enabled interventions).

Crucially, exploratory bets are tied to signposts—specific signals that indicate when it is time to scale. For example, a pilot project in youth mental health using digital platforms might remain small until three signposts converge: affordable data, government regulation, and measurable engagement from rural youth. Pre-defining these signals helps boards avoid emotional overreaction in the heat of the moment.

THE COURAGE TO FEEL SEVERAL TOMORROWS AT ONCE

In conclusion, psychiatry teaches us that anxiety shrinks imagination. Foresight teaches us that imagination can widen agency. The future is not something we predict into submission; it is something we learn to feel more wisely.

For South African philanthropy, the task is to become more emotionally literate with the future: less captured by loss aversion, more curious about identity, more deliberate in group imagination, and more disciplined in building robust portfolios.

If we can cultivate the courage to hold several tomorrows in mind at once, we can act with greater wisdom today. That courage—psychological, strategic, and philanthropic—is perhaps the most valuable gift foresight can offer.

References available from the author

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The Healing Power of Gratitude

Volker Hitzeroth

The concept of gratitude has recently entered the wellbeing discourse. Research has emphasised the physical, mental and social benefits of gratitude and has also elaborated on various gratitude practices in order to reap the benefits associated with a grateful manner. Sincere gratitude for the goodness in our lives may lead to a deeper insight into our own nature, our relationships, and our place in the world.

Volker Hitzeroth

The concept of gratitude has been analysed for a long time. More recently, and especially since the COVID pandemic, gratitude has received much attention and become well entrenched within the popular wellbeing literature. As the study of gratitude has entered the mainstream health arena there have been a flurry of articles, podcasts and self-help videos emphasising the positive outcomes of a thankful disposition. Gratitude has thus become another helpful contender in our search for happiness. It is one of the most common wellbeing strategies to be considered when stressed and burnt out, and its practice is likely to improve one's wellbeing, mental state and outlook on life.

DEFINITION

Most of us have an intuitive understanding of what gratitude entails but it remains difficult to define. Many scholars have attempted to do so, but disagreements persist. A general definition might describe gratitude as a feeling of appreciation and thankfulness, usually in response to something good happening or upon receiving something of value and meaning to us. Gratitude is an appreciation of the positive things that are experienced in life and is often associated with grace, humility, empathy, generosity and kindness.

CONCEPTUAL DIFFERENCES AND ONGOING UNCERTAINTY

Already 2,500 years ago the Buddha believed that gratitude was an important virtue and that its practice increased joy, happiness and peace. In Eastern philosophy Confucius believed in societal harmony and the cultivating of harmonious relationships. He emphasised the importance of gratitude to do so. In the ancient West it was the early philosophers who wrestled with the concept of gratitude. Most classical Greek thinkers opined on gratitude, emphasised its practice and advocated for its benefits. The Roman philosopher Seneca authored a text entitled "On Benefits" which interrogated the giving and receiving of benefits within human and societal interactions. More recent and contemporary philosophers have contributed to the field and critically interrogated the concept of gratitude by actively debating various aspects thereof, its meaning and its different components.

Furthermore, the faith-based literature has a rich tradition regarding the study of gratitude. Within all major religions there are prominent leaders, past and present, who have thought about, explored and added significant depth to the concept of gratitude, thankfulness and appreciation.

Similarly, the recent field of positive psychology has produced much helpful and stimulating work on gratitude. Dr Robert Emmons and Dr Michael McCullough collaborated in their studies about the effect of gratitude on subjective wellbeing while Dr Martin Seligman has studied happiness and emphasises gratitude as an important contributor thereto.

Despite the abundance of writing and contemplation, study and research, there remain conceptual differences and epistemological disagreements about gratitude, its meaning and its practice which will continue to provide for thought-provoking discussions and lively exchanges going forward.

TYPES OF GRATITUDE

Gratitude has variously been considered as an emotion, a virtue, a state or a trait. Despite comprehensive commentary, the various approaches remain complex and confusing.

Gratitude classed as an emotion is deemed to be a subjective positive emotional experience or mental response. It is a feeling characterised by thankfulness and appreciation. Gratitude classed as a virtue is thought to be a moral quality or character strength that guides good behaviour and moral decision-making. It is associated with goodness and an affirmation thereof. Interestingly, gratitude is not grouped together with the four classic virtues (prudence, justice, fortitude and temperance), yet it is often referred to as being a "timeless virtue". Gratitude as a state refers to a brief period of being grateful. It is of relatively short duration and hence a temporary experience of thankfulness. It is usually felt in response to receiving a benefit or experiencing something positive. Gratitude as a trait refers to a more enduring personality attribute. It is a lasting character trait and disposition marked by gratitude, thankfulness and appreciation. It is associated with a grateful outlook in which positive aspects of life are regularly acknowledged and savoured.

- **Dr Robert Emmons's model of gratitude:**

Dr Emmons and some colleagues in the field of positive psychology have spent many years studying the psychology of gratitude. They have developed a two-stage model of gratitude:

1. ***Affirmation of goodness:*** This first stage refers to a conscious recognition, awareness and appreciation of positivity. It involves an active recognition that there are positive things around us and in our lives, whether they be tangible or not. We just have to look for them, notice them and savour them. By acknowledging these events as a positive development and to be grateful for them affirms and savours the goodness experienced. This first step is not a passive waiting for positive developments to occur but rather an active acknowledgement and recognition that they are present all around us in the here-and-now.

2. ***Recognising the source:*** This second stage involves identifying where the goodness comes from, then acknowledging it and attributing it to its source. It refers to the process of understanding that the origin of the goodness does not come solely from within yourself. Rather, it originates from outside oneself and is a gift given to you from elsewhere. It is an appreciation of the genesis of life's positivity and may lead to humble dependence and a sincere sense of thankfulness and joy.

Dr Emmons's model illustrates that gratitude is different to mere happiness, contentment and satisfaction. It is a deeper, all-enveloping and pervasive state-of-being which is other-orientated in that it acknowledges that gratitude does not originate solely from us but has an external source. This could be the contribution and effort of other people, the beauty of the natural world, or the belief in a beneficent spiritual presence. His model suggests that gratitude can become a way of life and a lodestar which adds positivity and purpose, abundance and joy to our lives.

BENEFITS OF A GRATEFUL ATTITUDE

Despite there being some conflicting evidence, it seems that a grateful attitude has substantial health benefits.

From a mental wellbeing perspective, the practice of gratitude is thought to have some protective qualities. There is evidence to suggest that gratitude improves depression and anxiety as well as stress and burnout. It also increases happiness, optimism and resilience. Gratitude can be beneficial to counter unrealistic and distorted thought patterns. Finally, gratefulness may improve self-esteem and self-confidence.

Thankfulness also seems to promote better physical health. Being grateful relaxes the body and resets vital functions. It may reduce blood pressure and ease breathing. It also seems to reduce pain and assist with poor sleep. Gratitude might even improve the body's immune response. A grateful demeanour often results in healthier behaviour such as regular exercising and a better diet.

Gratitude also enhances social interactions and strengthens relationships. It encourages prosocial behaviour and leads to less loneliness. Genuine and deep thankfulness usually cultivates empathy and compassion. Expressing gratitude to a partner is likely to enhance the relationship, increase mutual understanding and deepen rapport.

Lastly, sincere gratefulness and profound appreciation is likely to lead to increased life satisfaction.

GRATITUDE FOR DOCTORS

The concept of gratitude, but also the impact of gratitude giving and receiving is very relevant to busy and stressed healthcare practitioners.

Being grateful, practicing gratitude techniques and having a grateful demeanour are said to reduce burnout and improve wellbeing. There is little doubt about the uplifting experience and positive effect that the giver of gratitude experiences. Similarly, the receiving of gratitude in the form of a complimentary thank you, a genuine and kind acknowledgement, or a grateful comment, has a positive effect on the receiver.

Receiving gratitude signals that one is seen, acknowledged, and appreciated - and usually triggers pleasure, joy and more goodwill. It is a powerful experience that conveys more than just thankfulness. It signals approval and affinity and may set off a virtuous cycle of positive emotions and good deeds. Receiving a word of thanks triggers a positive affective response mediated by neurochemistry and neuroplasticity which ultimately leads to increased self-esteem and self-worth resulting in more contentment, compassion, and feelings

of connection. Interestingly, some studies seem to suggest that it is the receipt of gratitude rather than the giving of gratitude that has a more positive effect on neurological circuits.

Healthcare practitioners are no different to the general population and tend to thrive on positive feedback, recognition, and approval. Such positive sentiments enhance motivation, encouragement and wanting to please.

The giving and receiving of gratitude would demonstrate appreciation and would counterbalance the stress and pressure within the healthcare system. It would show gratitude and signal that one is appreciated, wanted, and needed. It may even make the practice of medicine more rewarding and prevent practitioner burnout and stress.

Encouraging a culture of gratitude within the healthcare setting may therefore help promote wellbeing and reinforce the deeper meaning of medical work.

HOW TO ENHANCE YOUR GRATITUDE

The popular psychology literature provides much advice about how to nurture and improve one's gratefulness. Various gratitude interventions have been identified and can be used alone or in combination. The most common recommendations include:

1. *Gratitude journal:* a regular recording of things for which you are appreciative and thankful for. This is usually done in a journal or notebook but could also be electronic.

2. *Gratitude letter:* a letter or card containing a written expression of gratitude to someone who you feel indebted to, who made a positive impact on you, and who you would like to thank.

3. *Gratitude visit:* a meeting with someone during which you express your gratitude to them. During the meeting you may wish to further convey your thanks by giving them a gratitude letter or card.

4. *Gratitude box:* a box (or jar) in which you store notes about things for which you are grateful. A gratitude box is a physical reminder of positive events and by re-reading the notes you can easily remind yourself of the positive aspects in your life.

5. *Gratitude ritual:* a conscious and personal ritual or practice, usually practiced regularly, reminding you of the positive things in your life with a sincere and deep acknowledgement thereof such as meditation, or the keeping of a daily gratitude journal.

6. *Glimmers:* a brief positive moment in your day during which you experience a "micro-moment" of comfort and joy.

7. *Savouring the moment:* completely attending to, and fully immersing yourself, in a positive experience by engaging all your senses and then savouring and prolonging the moment by introspection, reflection and sharing it with others.

8. *Wonder and awe experiences:* a deep and overwhelming recognition of the beauty, vastness, sublime and mystery in the world around us which usually results in a feeling of insignificance and powerful connection to our surroundings. Examples may be as small as a raindrop on a leaf or momentous natural phenomena such as a powerful thunderstorm.

CONNECTION WITH OTHERS AND THE WORLD AROUND US

Our modern world is characterised by egocentrism. Our struggle to make ends meet, to provide for ourselves and our families, and to advance our careers, mostly relates to ourselves, our own interests and our own preferences. We tend to think, speak and act as if we are the most important person around and are at the centre of the universe. Sadly, very little of our contemporary lifestyle leads us to focus on anything but ourselves and our narrow and self-centred interests.

However, by instilling a sense of gratitude into our busy lives we may be able to rehabilitate this egotistical manner and attitude. Gratitude may aid us in showing appreciation for something that happened to us, that we yearned for, or that involves something greater than us. In most instances this may be a kind and generous benefactor, a beautiful or valued gift, the wonder of the world around us, or our rootedness within an anchoring faith. By its very nature gratitude therefore shines a light on something outside ourselves. It forces us to identify and concentrate on someone or something that is other than us, that is beyond and greater than us.

Gratitude is thus a pathway that leads us out of ourselves towards something bigger than our inconsiderate desires and self-serving existence. It is a bridge that strengthens not only our bonds with other people but also connects us to the world around us. It can heal painful relational fractures, build bridges across great divides and can span across time and distance. Gratitude is the thread that binds us all together and that creates a sense of belonging and togetherness. It could lead to an acknowledgement of our affiliation and interdependent nature within a global community and an underlying humanity.

A genuinely grateful mind will usually lead to a deep reflection on one's place and role in the world and may create an intuitive awareness of one's debts to others, one's vulnerabilities, and one's own insignificance. In so doing it may lead to a more authentic self, a profound sense of humility, a gentle awareness of life's purpose and could even assist in finding meaning in life.

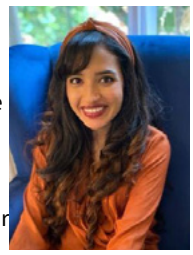
Disclaimer

This article is based on a collation of existing articles, textbooks and internet sources. References are available from the author

Volker Hitzeroth is a Medicolegal Consultant at Medical Protection Society.
Correspondence: Volker.Hitzeroth@medicalprotection.or

Introducing the Academic Doctors Association of South Africa

Tejil Morar



Tejil Morar

The rekindling of the Academic Doctors Association of South Africa (ADASA) marks a critical period in the South African Medical Association (SAMA), with renewed focus on the three pillars of academia: research, teaching and service. As the newly-elected chairperson of ADASA, I hope to serve medical doctors in South Africa by assisting them in pursuing their own academic goals and interests.

As a psychiatrist, mental health remains at the forefront of my agenda and I hope to use the ADASA platform to spotlight the mental health of medical doctors in South Africa .

The ADASA committee's aims include to raise awareness and increase visibility of ADASA, collaborate with both national and international organisations (including institutions of higher education) and produce our own robust research which is culturally and context specific.

The diverse ADASA committee includes medical doctors from across the country with unique experiences and expertise. Various specialties and universities are represented. However, we welcome any medical doctors who are interested in contributing to ADASA to connect with us and improve national and departmental representation and visibility. Historically, some institutions, departments and specialties enjoy more academic support than others and ADASA would like to address these inequities.

Collaboration is a cornerstone of the ADASA agenda, both locally and internationally . Established collaborations include the South African Registrars' Association and the Junior Doctors' Association of South Africa. Internationally, previous connections included the Taiwanese Medical Association and we believe that ADASA deserves a voice on international platforms.

In the long-term, ADASA hopes to become a network of medical doctors who produce high-quality research that translates into clinical practice and evidence-based medicine. While South Africa lacks resources in some respects of healthcare, we also provide cutting-edge and advanced innovation in others. ADASA aspires to be the platform which medical doctors can use to help document both the challenges and achievements in South Africa Medicine formally in credible peer-reviewed journals.

IN CONCLUSION

ADASA has aspirations to uplift medical doctors in South Africa academically and we commit to serving our medical community. If you share these sentiments and would like to be part of initiatives, please contact **members@samedical.org**

Tejil Morar is a psychiatrist and the ADASA Chairperson.
Correspondence: tejilmorar@gmail.com

THE ACADEMIC DOCTORS ASSOCIATION OF SOUTH AFRICA

The South African Medical Association (SAMA) is proud to introduce one of its key internal committees, the **Academic Doctors Association of South Africa (ADASA)**.

ADASA represents the interests of academic doctors across South Africa, including those involved in teaching, research, academic leadership, and clinical training in medical schools and affiliated institutions. As a vital voice within SAMA, ADASA is committed to strengthening the role of academic medicine in shaping the future of healthcare in South Africa.

Through advocacy, collaboration, and thought leadership, ADASA aims to:

- Champion the professional interests and wellbeing of academic doctors
- Influence national health and education policy to support academic medicine
- Promote excellence in teaching, research, and clinical supervision
- Address systemic challenges facing the academic medical workforce
- Serve as a forum for engagement between academic professionals across institutions

The ADASA Committee is made up of **dedicated academics who are deeply invested in the future of medical education and research** in South Africa. Their work not only uplifts the academic community but also enhances the overall quality and sustainability of our healthcare system.

We invite all SAMA members in academic roles, and those passionate about the future of medical training and research, to connect with ADASA, support its work, and participate in its ongoing initiatives. Email members@samedical.org

TOGETHER, WE ARE SHAPING THE NEXT GENERATION OF HEALTHCARE PROFESSIONALS.

Chairperson

DR T MORAR

Vice-Chairperson

DR OC HARBOR

Committee Members

PROF D BASU

DR MM CHIDI

DR SS MORE

DEPARTMENTS OF PSYCHIATRY

University of The Witwatersrand

CONDOLENCES

Ugash Subramaney

Dr Sheila Lutaaya; 27th September 1983 – 8th September 2025

It is with deep sadness that we have learned of the passing of our colleague, Dr Sheila Lutaaya.

Dr Lutaaya was a dedicated psychiatrist who loved her work, especially her clinical work with patients at Chris Hani Baragwanath Hospital. She was an integral part of the department of Psychiatry, bringing not only skill and commitment to her work but also, compassion and support to those around her. She was not only a valued member of our team as a teacher, mentor and research supervisor but also a kind and thoughtful person who touched the lives of many.

We are grateful for the time she shared in teaching and training our students and registrars and serving the needs of a very special part of our training circuit, Chris Hani Baragwanath psychiatry department and the Seketela Clinic in particular.

Her dedication, professionalism, and warmth will always be remembered, and her absence will be deeply felt by all of us.

With deepest sympathy, to the Bara Psychiatry family who loved her dearly, other professional colleagues, her family and friends, the junior doctors she taught and her patients.

SASOP NATIONAL CONGRESS 2025

Dr Maya Jaffa won the SASOP prize for “best registrar oral presentation”.

Photo L to R : Dr Indhrin Chetty, Dr Maya Jaffa, Prof. Ugash Subramaney

UNIVERSITY OF THE WITWATERSRAND DEPARTMENT OF PSYCHIATRY’S 36TH ANNUAL RESEARCH DAY

Natasia Marques

This year, the University of the Witwatersrand held their 36th Annual Research Day at the Killarney Country Club. The event, on 16th June 2025, was organised by a committee of registrars, supervised by Dr Belinda Marais. The event aims to showcase the research being conducted by the Department, and inspire further research. The keynote speech was given by Dr Xulu, a research scientist at the School of Molecular and Cell Biology at Wits University. He completed his PhD at Stellenbosch University and was a visiting PhD candidate researcher at the Semel Institute for Neuroscience and Human Behaviour at the University of California. Dr Xulu spoke passionately about his own research in psychiatric genetics and neuro-immunogenetics. His presentation was inspiring and highlighted the potential for cross-faculty collaboration.

Ten registrars presented their MMed research, ranging in topics from forensic psychiatry and neuropsychiatry to maternal mental health. Dr Maya Jaffer won the best presentation for her research titled, “Assessing knowledge attitudes towards transgender and gender diverse people among South African mental health workers in a tertiary psychiatric hospital setting”. Her research was supervised by Dr L Paruk and Dr B Marais. The South African Society of Psychiatrists awarded

her a sponsorship to attend the 2025 SASOP congress in East London. Second prize was awarded to Dr Ahmad Peerbhay for his research titled, “Assessing sleeping using the PSQI among comorbid HIV and psychiatric outpatients”.

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

Opening by the Academic Head, Department of Psychiatry, Prof. Ugash Subramaney

Research Day Committee (From left to right) Dr Padiachy, Dr Schaup, Dr Robinson, Dr Marques, Dr Madlala and Dr Marais (Chair of committee)

Keynote speaker: Dr K Xulu

Best presentation winner Dr Maya Jaffer (left) receiving prize from Dr Anersha Pillay

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Wits Faculty of Health Sciences Department of Psychiatry

FACULTY OF HEALTH SCIENCES

WITS DEPARTMENT OF PSYCHIATRY

RESEARCH DAY 2025

PROGRAMME

08:00 - 08:30	**Registration, Tea and Coffee**
08:35 - 08:45	**Welcome by Academic Head of Department** *Prof Ugasvaree Subramaney*
08:50 - 09:10	**Keynote Speaker** *Dr Khethelo Xulu*
09:15 - 09:30	**Assessing sleep using the Pittsburgh Sleep Quality Index (PSQI) among comorbid HIV and psychiatric outpatients** *Dr Peerbhay*
09:35 - 09:50	**Psychopharmacotherapy trends in patients with personality disorders in an inpatient psychotherapeutic unit in Johannesburg: a retrospective review** *Dr Barnard*
09:55 - 10:10	**The attitudes of Christian leaders and congregants in Soweto, South Africa, towards mental illness and the mentally ill** *Dr Dlamini*
10:15 - 10:30	**Tea and Coffee Break**
10:35 - 10:50	**Complex psychotropic polypharmacy in Soweto based community psychiatry clinics** *Dr Mabulwana*
10:55 - 11:10	**Assessing knowledge and attitudes towards transgender and gender diverse people among South African mental health workers in a tertiary psychiatric hospital setting** *Dr Jaffer*
11:15 - 11:30	**Psychosocial profile of adolescents at a community-based urban boxing and mindfulness programme** *Dr Tripp*
11:35 - 11:50	**Mothering with a serious mental illness: a retrospective review** *Dr Marques*
11:55 - 12:10	**Tea and Coffee Break**
12:15 - 12:30	**Perceptions of final year medical students towards psychiatry at a university of South Africa** *Dr Tayob*
12:35 - 12:50	**Malingering in awaiting trial defendants in South Africa: prevalence, patterns and associative factors** *Dr Gouws*
12:55 - 13:10	**Describing the demographic and diagnostic profile of neuropsychiatric outpatients at Tara Hospital** *Dr Breytenbach*
13:15 - 13:30	**Vote of Thanks, Prize Giving and Closing** *Prof Ugasvaree Subramaney*
13:30	**Lunch**

Navigating the Crossroads

Culture, Ethics, and Law in South Africa's Evolving Mental Health Landscape

Join us for a one-day conference hosted by the Wits Circuit Psychology Department exploring the complex intersections between culture, ethics, and legal frameworks in mental health care in South Africa

Key Note Speaker

Nokulunga Nene-Mokgele

Senior Clinical Psychologist, Chris Hani Baragwanath Academic Hospital

&

Chairperson of the South African Psychoanalytic Initiative (SAPI)

Topics

The Mental Health Care Act in Practice
The Children's Act in Practice
Mental Health and Marginalisation
Integrating Cultural Formulation Interviewing in Practice

Date: 22 October 2025
Time: 08h30 for 09h00 until 13h00
Venue: Tara H. Moross Rec Hall

ART FOR MENTAL HEALTH EXHIBITION

02 - 31 October 2025

Theme: "Glimmer"

A glimmer is the opposite of a trigger. It is some kind of cue, internal or external, that brings us back to a sense of joy or safety

It can be anything.... from memories, photos, coffee breaks with your friends, a hug, to a tight, feeling or physical expression of joy and peace

Healthcare students and professionals have been burdened of late with all that is going on, directly or indirectly. Let's focus on our glimmers as we celebrate mental health month in October

SCAN THE QR CODE OR CLICK HERE TO SUBMIT YOUR ARTWORK

EXHIBITING AT THE ADLER MUSEUM OF MEDICINE OPEN DAILY FROM 9AM TO 4PM

ART FOR MENTAL HEALTH EXHIBITION

Prof. Maria Papathanasopoulos, Assistant Dean of Research and Postgraduate Support and guest speaker

Wits Students Physicians Society Musicians Group, at the opening

Prof. Ugash Subramaney and Hester Cloete, at the opening

University of Cape Town

This content was compiled by Jade Bouwer. Jade.Bouwer@westerncape.gov.za

NEW SHORT COURSE: PSYCHOLOGICAL FIRST AID

Roxanne Pelteret

In March 2025, the Division of Neuropsychiatry launched a new short course in collaboration with the Faculty of Health Sciences Continuing Education Unit: Psychological First Aid.

Psychological First Aid (PFA) is a simple yet powerful approach to support someone in distress. It involves paying attention to emotional reactions, active listening, and, where appropriate, offering practical assistance to help address immediate problems and basic needs. PFA provides individuals with the tools to assist others — or themselves — until a crisis resolves or professional care becomes available.

This CPD-accredited PFA course was developed to address the urgent and growing need for accessible mental healthcare in South Africa, where specialist services remain limited. Designed for relevance across a wide range of professional and everyday settings, the 6.5-hour training equips participants with practical, evidence-based skills to recognise signs of emotional distress and provide effective stabilising support during psychological crises. The advert for the course is pictured above.

The course begins with an introduction to the principles and ethics of PFA. Subsequent modules are grounded in the Acknowledge–Contain–Refer (ACR) framework and focus on core

PFA skills and their application for individuals, children, and groups. The final module addresses the importance of self-care for support providers. Together, these modules provide a comprehensive introduction to the theory and practice of Psychological First Aid in the South African setting.

The first PFA course was held at the Neuroscience Institute on 28 March, with further dates scheduled throughout the year. For more information or to register, visit https://health.uct.ac.za/continuing-education-unit/psychological-first-aid

LAUNCH OF PRACTICE GUIDELINES FOR PSYCHOLOGY PROFESSIONALS WORKING WITH SEXUALLY AND GENDER-DIVERSE PEOPLE

Waseem Hawa

The 18th of March 2025 represents a day which Valkenberg Hospital, the Division of Psychotherapy and the Transformation Committee of the Department of Psychiatry and Mental health (University of Cape Town) can remember with pride. It was an honour to serve as the host for the launch of the Practice Guidelines for Psychology Professionals Working with Sexually and Gender-Diverse People (2nd Editon, 2025). The event saw an audience comprised of members of the private, and public health system as well as the members of the general public.

The guidelines are published by the Sexuality and Gender Division of PsySSA and the LGBTQIA+ Human Rights project team. The guidelines provide comprehensive guidelines in supporting persons from the LGBTQIA+ community. The program included an address by Prof Ronelle Carolissen; president of PsySSA and Mr Suntosh Pillay; Chief Clinical Psychologist for eThekwini District Health. Speakers also included Thembi Dlamini, Rev Chris McLachalan, Jenna-Lee de Beer-Proctor, all who are key members of the LGBTQIA+ Human Rights project team. A panel discussion moderated by Gita November of Gender Dynamix, exploring the de-pathologising and de-colonising of Trans identities, was also part of this groundbreaking event.

The launch highlighted the University of Cape Town's and Western Cape Department of Health and Wellness's commitment to diversity and inclusion. It foregrounded the South African goal of creating and sustaining a just and safe society for all South Africans

Key stakeholders in the recent launch of the practice guidelines

THE PERINATAL MENTAL HEALTH PROJECT UPDATE

Thanya April, edited by Jade Bouwer

Some highlights of Perinatal Mental Health Project's (PMHP) work over the past six months are described below.

ANNUAL REPORT 2024

The Annual Report 2024 was published, highlighting achievements and stories from the past year and emphasising PMHP's ongoing commitment to integrating mental health services into maternal care.

INTERVENTIONS AND OUTCOMES FOR INFANTS AND CHILDREN

The Maternal Support Service (MSS) team compiled a report of the long-term impacts of the multicomponent, stepped-care service model and our growing engagement with infant mental health and responsive parenting.

CHIME PROJECT NEW GRANT

A new phase of the Community Health Intervention through Musical Engagement (CHIME) project in was launched in The Gambia. This NIHR Global Health-funded project will include music-based universal maternal wellbeing interventions developed and tested in The Gambia, South Africa and Lesotho.

INDIAN CONNECTIONS

Simone conducted a workshop on Respectful Maternity Care (RMC) using PMHP's Secret History training method at the Ramalingaswami Centre on Equity and Social Determinants of Health at the Public Health Foundation of India (PHI),Bengaluru. This workshop was held in collaboration with Professor Aditi Iyer and her team to adapt the method for the Indian context and will be incorporated into LaQshya Smriti, a PHI-led quality improvement programme for maternal and newborn health in public maternity facilities.

CAPACITY BUILDING ACTIVITIES

PMHP provided a tailored three-day workshop for the Mma we Nnete project run by NGO Right to Care in Limpopo. The project, to which we advise, is designed to use trained peers to provide a comprehensive mental health prevention and promotion intervention to pregnant women. The training focussed on maternal mental health and empathic engagement skills and led to the team being invited to deliver additional seminars for fourth-year medical students in their O&G rotation on respectful maternity care.

PMHP collaborated with the Association for Dietetics in South Africa (ADSA) on the Care2Care project to develop a training programme aimed at improving the mental health and workplace wellbeing of healthcare practitioners in South Africa. The first component of the programme is an open-access, self-directed learning course for healthcare practitioners. It is available on the ADSA Learn platform.

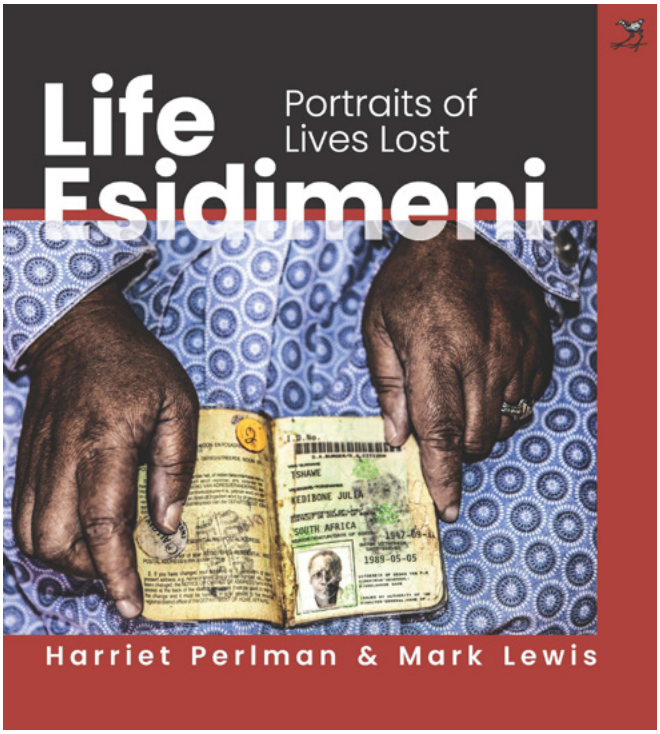
WORLD MATERNAL MENTAL HEALTH MONTH: MAY

Simone Honikman was invited by Philani Maternal, Child Health and Nutrition Trust to speak to over 100 community healthcare workers about maternal mental health. PMHP held a seminar on kindness with staff at Hanover Park Midwife Obstetric Unit, to celebrate International Day of the Midwife. The PMHP team participated in the March for Mothers, a global campaign to celebrate World Maternal Mental Health Day.

More detail on these updates and links to resources can be accessed through the departmental newsletter here.

LIFE ESIDIMENI: PORTRAITS OF LIVES LOST

Harriet Perlman & Mark Lewis



ISBN 978-1-4314-3520-3
GENRE Photographic History
FORMAT Paperback
SIZE 230x210mm
EXTENT 136pp
PRICE R320
RIGHTS World Rights
RELEASE August 2024

In late 2015 and 2016, South Africa witnessed a horrific tragedy. 144 people entrusted to the Gauteng public health system died from neglect, starvation and cruelty. This book examines the Life Esidimeni tragedy, offering a powerful narrative built on the stories of those most affected.

When writer Harriet Perlman and photographer Mark Lewis set about documenting the lives of the families whose loved ones had died in this catastrophe, they were determined to honour the dead, and to recognise the sufferings of those left behind. They travelled far and wide, and listened to their stories. These heartbreaking stories, accompanied by powerful portraits by Mark Lewis, help the reader to forge a deep connection with the victims. These photographs are not just faces on a page, but a testament to the human cost of this tragedy.

This book shines a light on the tireless efforts of organisations like SECTION27, SADAG and the Life Esidimeni Family Committee who have fought for truth, justice and accountability, holding those in power responsible for their actions. It is also a stark reminder of how wrong things can get with an arrogant, callous and unaccountable political leadership.

The book explores the ongoing struggle for better mental healthcare in South Africa and the urgent need to ensure such a tragedy never happens again. This is a call to action, urging readers to engage with the ongoing fight for mental health reform.

Extracts of 'Life Esidimeni: Portraits of Lives Lost'

"That is not my son"

Jabu Nqgondwane

Christian Nqgondwane smiles when he tells us that his late son Vuyo 'was a good-looking boy. He doesn't look like me,' he laughed. But he and his wife Jabu want to cry when they look at the photo of their son after he had been moved to Cullinan. 'I said that is not my son. He was so very, very thin.'

Jabu Nqgondwane with her late son Vuyo

Vuyo Nqgondwane was Jabu and Christian's firstborn child. He was unable to do anything for himself and was admitted to Life Esidimeni in 1992. They tried to visit him every weekend. And every Christmas they took their son home for the holidays.

In June 2016, Vuyo was moved from the Life Esidimeni facility in Randfontein to Cullinan Care and Rehabilitation Centre. They were told that he had been moved to Takalani Home in Soweto. But when they went there, their son wasn't there. They went back and forth asking for help. 'We don't know where our son is,' they said repeatedly. Eventually they found Vuyo at the Cullinan Care and Rehabilitation Centre, a long way from Soweto, past Pretoria.

On the 7 February 2017, they received a call. The person said that Vuyo was dead. She said that Vuyo had gone to bed, active as always, but had died during the night. The Ngqondwanes borrowed R500 from a neighbour to get from Soweto to Cullinan as fast as they could – a journey of an hour and a half.

The staff at Cullinan told them Vuyo had died of 'aspiration pneumonia'. No one explained to them what that was. But later a pathologist's report revealed that in Vuyo's stomach was 'what appeared to be part of an orange plastic bag or plastic sheet'. Was Vuyo so hungry that he swallowed the contents of the plastic and the container, and choked and died?

'I am a citizen of this country. I'm born and bred here. But my heart will never be at peace with Qedani Mahlangu until she tells us why she had to do this traumatic thing to the citizens of this country. At Randfontein, Vuyo was well off. He was fat. Why did they take him to Cullinan to be killed?' says Christian.

ABOUT THE AUTHORS

Harriet Perlman has worked in film, television and publishing for over 30 years, as a producer, scriptwriter, story editor and writer on a number of pioneering South African projects. These include Yizo Yizo, Soul City, and the award winning Vaya, which was both a film and a book based on stories from the Homeless Writer's Project. Perlman has worked on entertainment and education projects and initiatives that combine the two. She is co-producer of the documentary film and writer of the accompanying book, The Colour of Wine. She is currently working with Heartlines on their Fathers Matter campaign and with the composer Philip Miller to create a vogue-opera on the life of gay anti-apartheid activist Simon Nkoli.

Mark Lewis is an urban photographer based in Johannesburg. For the past ten years he has traversed the dense inner core and the constantly shifting edges of Johannesburg. His images are an interplay between people and space. At root they are tales of lives carved in the search for economic opportunity and the stories of the impacts of those lives on the spatial fabric of the city. His work has been widely exhibited and published, and he has completed the tenth book in the popular series of Johannesburg stories called Wake Up, This is Joburg with writer and urban planner, Tanya Zack which formed part of the South African pavilion on the 2015 Venice Biennale.

Scan here to purchase Life Esidimeni

ENQUIRIES

Contact Janine Daniel at janine@jdoubledpublicity.co.za to request a review copy and to schedule an interview.

Giveaways are available on request.

Independent Publishing Since 2002

LIFE ESIDIMENI: PORTRAITS OF LIVES LOST

Harriet Perlman & Mark Lewis

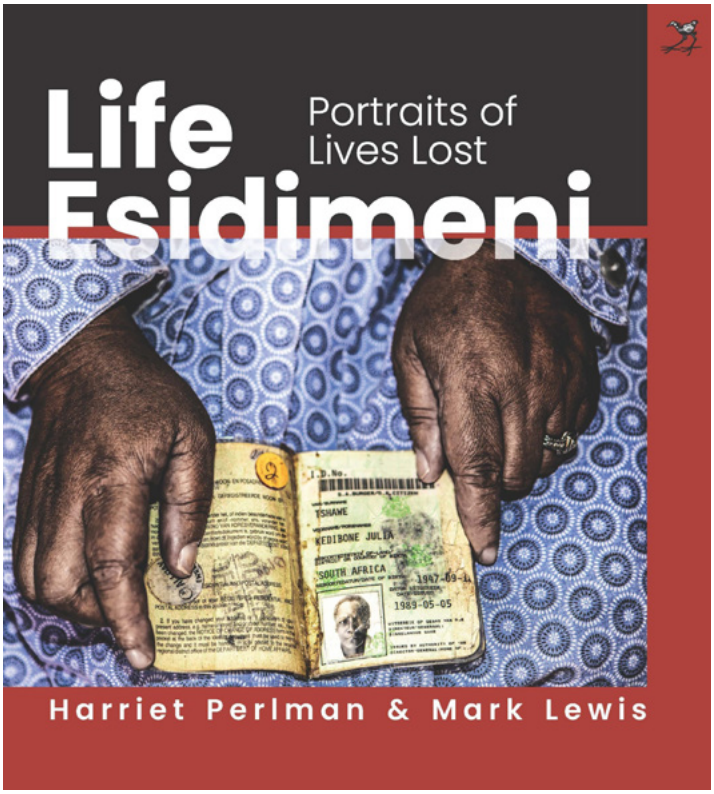
In 2016, 144 people with mental illness lost their lives. They died, in the care of the public health system, from neglect, torture and starvation. They died at the hands of those who were supposed to protect them.

Life Esidimeni, Portraits of Lives Lost pays tribute to the people killed in the Life Esidimeni tragedy. Harriet Perlman and Mark Lewis document the testimony of those left behind, to honour the dead and tell their stories.

The Life Esidimeni story is one of unimaginable horror and hardship, yet also a story of courage and tenacity, where ordinary people work tirelessly to seek justice. This October, Mental Health Awareness Month, it is important to remember that the fight for just mental health care is not over.

Sasha Stevenson, attorney and Executive Director of Section27, recently wrote:

> *Bringing a culpable homicide prosecution would be an important step towards justice. To secure a conviction, the onus is on the NPA to show, beyond reasonable doubt, that Mahlangu and Manamela [in the Gauteng Department of Health] caused deaths. The evidence is there ... The police, the pathologists, the families and their lawyers have done their job. It is now for the NPA to do the same.*



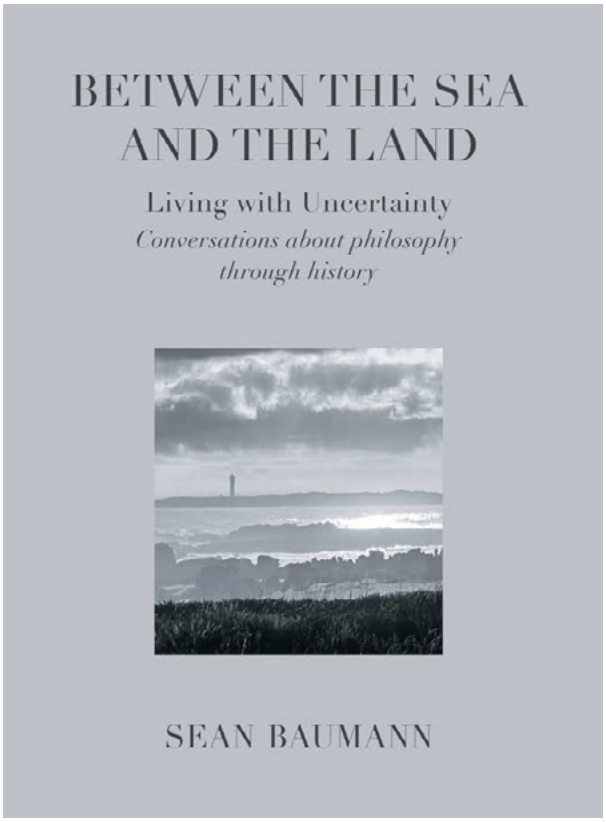
For every copy of Life Esidimeni bought during October, one book will be donated to Gift of the Givers to distribute to community libraries

Click here to purchase Life Esidimeni

Independent Publishing
Since 2002

Between the Sea and the Land

Sean Baumann



ISBN 978-1-0672662-1-9
GENRE Philopsophy
FORMAT Trade Paperback
SIZE 235x155mm
PRICE R 380
RELEASE March 2025

ABOUT THE BOOK

Between the Sea and the Land is an extended conversation about philosophy. Throughout the long days of the Covid pandemic, Tomas and Sara, who are confined to an isolated coastal peninsula, walk daily along the shore.

Tomas has decided to use the time to study the history of philosophy and this interest forms the basis of the conversations that he and Sara have while walking.

They discuss in an inquisitive and sometimes playful way the difficulties of understanding the nature of the crisis in which they find themselves, the fallibilities of language and science, what can be known and not known, how to find a balance between individual needs and public safety, the anxieties provoked by intolerance and political strife, and how to cope with the unpredictability and precariousness of life.

The book encompasses a broad history of philosophical ideas from the pre-Socratics to the present day, and the search for answers in shifting contexts of fear and wonder, from the mysteries of the beginnings of consciousness to quantum physics and the accelerating developments in machine learning and artificial intelligence.

In discursive and meandering conversations that reflect the coastal paths in the beautiful wilderness between the sea and the land, Tomas and Sara tackle fundamental philosophical problems that culminate in the overarching question: How does one live with uncertainty?

ABOUT THE AUTHOR

Sean Baumann is a retired doctor and specialist psychiatrist with a philosophical interest in the neuroscience of madness and chronic pain. After approximately thirty years teaching and working as a clinician in a busy public hospital he has become preoccupied by the limits of our knowledge, and the pursuit of illusory certitudes. Sean believes that the yearning for certainty can lead us astray and contribute significantly to the conflicts and intolerance characteristic of phenomena such as ideology nationalism and fundamentalism. The acceptance of incertitude inclines us more to the acceptance and celebrations of diversity,and the creativity of imagining other ways of being. These preoccupations are a recurrent theme in the book

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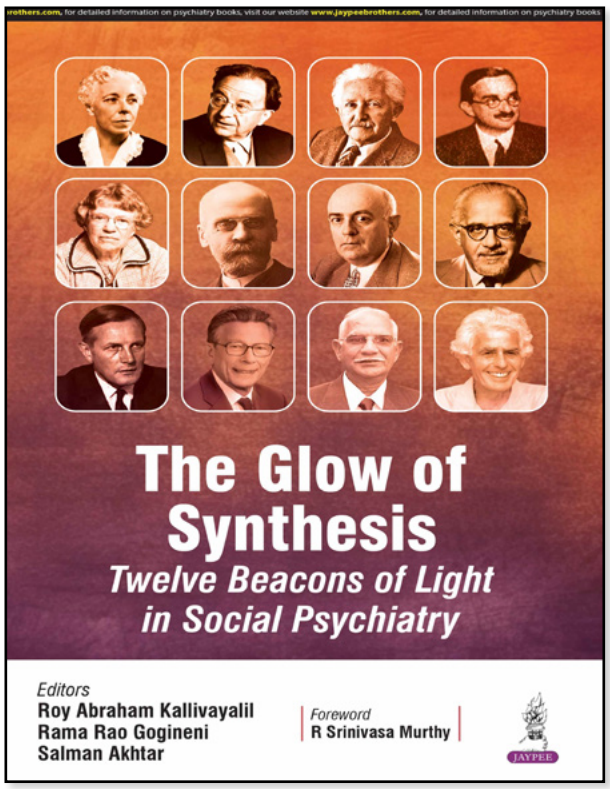
The Glow of Synthesis: Twelve Beacons of Light in Social Psychiatry



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What a privilege it was to be asked to review this new book about social psychiatry. I learned so much, even about social psychiatrists I already knew, as well as the global history of social psychiatry that I thought I knew well enough.

The book lives up to its creative and inspiring name. It glows with the light of its portraits, 12 long chapters and 15 shorter ones in the Appendix, supplemented by a very helpful summary Foreword by R. Srinivasa Murthy. The publisher seemingly lovingly designed an attractive cover of personal photos with a background as if the sun was coming up, or in the case of psychiatry, insight emerging of the darkness. The layout has each chapter following a similar and easily followed outline. The text and font is reader friendly, even for someone with aging eyesight like myself.

The portraits are mainly historical, somewhat like eulogies, and mostly from the time that psychiatry was developing in the first half of the 20th century. What is unique and ingenious is that the portraits not only include some identified social psychiatrists, but those from the fields connected to social psychiatry: culture, anthropology, sociology, social work, psychoanalysis, psychology, and more. These various but overlapping fields are where the glowing synthesis comes from. That wide focus makes this volume of potential interest to any mental health professional.

This book makes a great pairing with another new book on social psychiatry, The WASP Textbook on Social Psychiatry. What does that say about two of the lead editors that have guided both, Drs. Kallivayalil and Gogineni?

Both the editors and chapter writers are well-known beacons of light in their own right. Most of the major portraits are of those from Europe and the United States, but the Appendix gratefully adds some briefer portraits from many from other countries.

One of these portraits in the Appendix I knew very well Frederick (Fritz) Redlich, covered by Salman Akhtar, was the Dean of Yale University School of Medicine when I was a medical student there. Medical schools are unique social systems in their own right and crucial for contributing to future caregivers and research. Among other accomplishments, he modeled how psychiatry (and psychoanalytic principles) is so important and connected to the rest of medicine. Given the importance of social systems becoming destructive, Akhtar reminds us of the dangers in increasing authoritarian leaders with Fritz's masterful biography of Adolf Hitler: Diagnosis of a Destructive Prophet (Oxford University Press, 1998).

You will have your own revelations depending on your own knowledge base, interests, and social contexts. Here are some of my social contexts as I read and reviewed this book.

I have continued to wonder why social psychiatry gets short shrift in our bio-psycho-social model. I usually think it is because there are less direct treatments, although social prescription is emerging. Debasish Basu, in his chapter on perhaps the most prominent living psychiatrist of our time, Norman Sartorius, provides a tongue-in-cheek conundrum and riddle about why Dr. Sartorius thinks we might be better off without social psychiatry! For now, just this teaser:

". social psychiatry could be taken as a proof that good psychiatry can exist without its social component" (p. 149).

In addition, I view social relationships as starting in one-on-one relationships, first the infant with a parent and caregiver, and in psychiatry in the crucial therapeutic relationships. In the profiles, I found some new insights.

Take the portrait of Ravi L Kapur, who I did not know. He studied sanyasis (holy men) in India and established research relationships by sitting cross-legged on the ground talking with them while they sat in chairs. In a sabbatical year of yoga with guru supervision, as a way to study himself, he wrote copiously in his journal every day of his reactions.

Another fascinating discovery for me was in the chapter on Julian Leff by Tom Craig. Leff was well-known for his research on schizophrenia, especially the effects of Expressed Emotion. Later, before he died in 2021, he came up with an innovative study and promising AVATAR therapy, using sophisticated technology, of the relationship of a patient with their verbal hallucinations. Using the 3-chair approach, there was a patient, an "avatar" of the hallucinating voice, and the therapist behind the scene, who gradually guided the "avatar" to becoming kinder and less controlling. If only this had been available to the famous songwriter, Brian Wilson of the Beach Boys, who recently died, but was plagued with accusatory voices for all of his adult life.

However, these intimate social relationships are inevitably extended on up to the very varied relationships in and between large groups and countries, with the added complexity of group processes and potentially mixed ethical priorities of different organizations. As I read this book in one day-a reflection of its interest-it was day 2 in what is looking like an existential war between Israel and Iran, alternating with coverage of President Trump's military parade in the United States, the counterprotests, and a cold-blooded killing of a Minnesota lawmaker in her home. I finish this review on Father's Day in the United States, a country where the role of men is being challenged.

Can social psychiatry make a difference in these larger social relationships, conflicts and dangers? Well, we get hints of how it can do so in these portraits. We are reminded in the chapter on Theodore W Adorno by Jyoti M Rao that his 1950 book The Authoritarian Personality is still relevant. In addition, the portrait of Erich Fromm by Frank Tisano reminds us of how it is possible for a psychiatric expert to achieve mass appeal and thereby be able to inform and advise the public and national leaders.

The editors did not explain why these particular portraits were chosen, but I concluded that did not matter. There are so many more that deserve to be profiled that this should just be Volume 1. I recommend new volumes to come out every year, and who knows when that should stop. One of the portraits I would like to see is a colleague who has-or is-addressing what I have come to call the social psychopathologies, you know, the isms, antis, and social phobias like antisemitism, racism, and Islamophobia, which reflect the undue fear of the other and quest for power over them.

May this unprecedented and very welcome volume have the widest distribution, and inspire our social psychiatry troops in the quest for more peace and prosperity for all. I will also look forward to the next one.

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Conflicts of interest
There are no conflicts of interest.

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Jung the Mystic versus *Jung & the Story of Our Time*: A Comparative Commentary

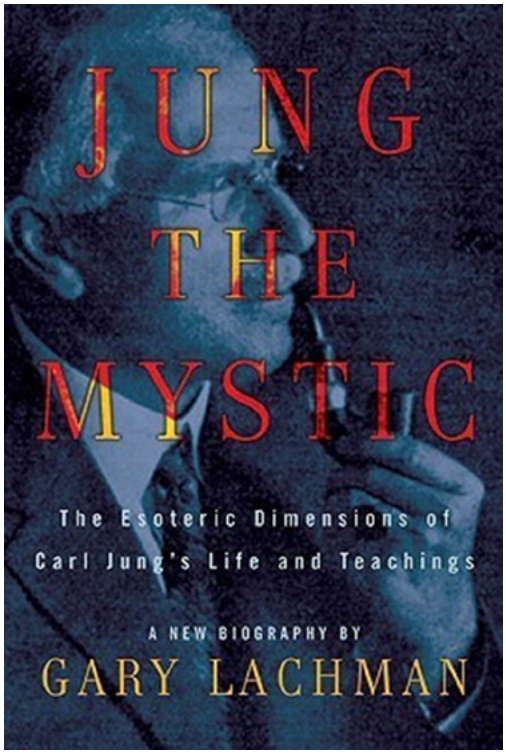
Koffi M. Kouakou

Koffi M. Kouakou

While strolling along a second-hand bookshop in Pretoria many years ago, I came across two intriguing biographies of Carl Gustav Jung I had studied so much in my university psychology classes. I had also heard unsubstantiated rumours that in his later years, Jung whispered that "Freud was a fraud." At any rate, I thought these convergent works deserved some scrutiny. Here it is—a comparative commentary, somewhat richly academic.

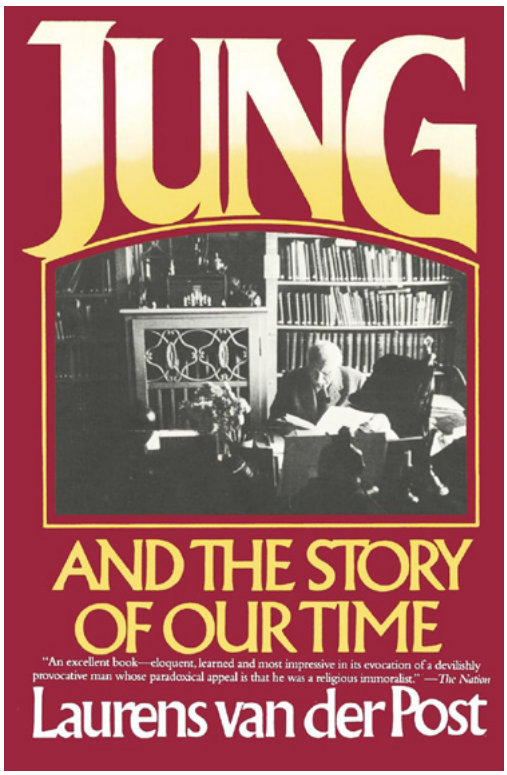
The two major portraits of Jung define his posthumous reputation. **Gary Lachman's *Jung the Mystic* (2017)** presents Jung as a disciplined visionary whose psychology is inseparable from the Western esoteric tradition. **Laurens van der Post's *Jung and the Story of Our Time* (1976)**, written by a close friend and admirer, portrays Jung as a moral sage whose discoveries offered modern humanity a way out of nihilism. Van der Post was one of the more fascinating, controversial, and cosmopolitan South Africans of the twentieth century. His philosophical outlook and worldview blended Jungian psychology, Christian mysticism, and African spirituality. He believed Western civilization had lost its connection to the unconscious and could recover balance through engagement with primal, indigenous wisdom. He often romanticised Africa as a repository of humanity's spiritual origins — a view that drew both admiration and criticism for its paternalistic overtones.

Each writer responds to the same civilizational crisis—modernity's loss of meaning—but offers different remedies: mystical gnosis versus ethical integration. Their contrasting emphases illuminate the ambivalence at the heart of Jung's legacy: scientist or seer, healer or hermeticist?



JUNG THE MYSTIC
Esoteric Dimensions of Carl Jung's Life and Teachings
by Gary Lachman

Publisher: Tarcher/Penguin, January 24, 2010, 258 pages
ISBN-10: 1585427926



JUNG AND THE STORY OF OUR TIME
by Laurens van der Post

Publisher: Pantheon Books, New York: 276 pages
ISBN-10: 0394492072

LACHMAN'S MYSTIC: JUNG AS EMPIRICAL GNOSTIC

Lachman situates Jung within the lineage of Western esotericism—alchemy, Hermeticism, and Gnosticism—and argues that his psychology evolved from personal revelation rather than laboratory research. The pivotal evidence lies in *The Red Book*, Jung's illuminated record of visionary dialogues from 1913 to 1916. For Lachman, these inner experiences constitute a modern form of mystical initiation: Jung "descended into the depths" not to escape reason but to *expand* it toward direct encounter with the numinous (Lachman 2017, 56–59).

Lachman highlights Jung's lifelong use of occult technologies—active imagination, astrology, the I Ching, and alchemical symbolism—as methods of communication with the unconscious. Concepts such as **synchronicity** and the **collective unconscious** are treated not as speculative metaphors but as empirical observations of metaphysical order (Lachman 2017, 131–138). Jung's resistance to the label *mystic,* Lachman argues, stemmed from professional caution: he wished to preserve credibility in an age hostile to the irrational. Yet in practice, his work "bridged the psychic and the cosmic," placing him closer to Meister Eckhart or Jakob Böhme than to Freud.

Lachman's method is part biography, part cultural archaeology, part rebellious psychology and rebel psychiatry. He rescues Jung from the sanitised halls of academic psychology, situating him instead within the **continuum of Western esotericism** alongside Swedenborg, Steiner, and Yeats. His thesis: Jung's enduring relevance lies in his re-sacralisation of the psyche—a form of *scientific mysticism* that restores transcendence to modern consciousness.

Fourty-one years earlier, Van der Post eulogised Jung.

VAN DER POST'S SAGE: JUNG AS HEALER OF THE MODERN SOUL

Writing only fifteen years after Jung's death, Laurens van der Post composed a reverent yet heartfelt memoir. His Jung is not the magician of Lachman's study but a **prophetic humanist**, a physician of the Western soul traumatised by war and materialism. Van der Post interprets Jung's theory of individuation as a moral pilgrimage toward wholeness, reconciling conscious and unconscious, masculine and feminine, reason and imagination (van der Post 1976, 42–48). The focus is therapeutic, ethical, and relational.

Rather than exploring séances or alchemy, van der Post emphasises Jung's presence—his empathy, humility, and gift for listening. Mystical experience appears only as metaphor for self-knowledge; revelation is psychological, not supernatural. Van der Post's narrative domesticates the numinous, transforming it into moral insight accessible to all.

Stylistically, the work is devotional and elegiac. Jung becomes the archetypal *old wise man*—a guide for a wounded civilization. This portrait safeguards Jung from charges of occultism that might have discredited his legacy in the rationalist climate of the 1970s. Where Lachman excavates the esoteric underground, van der Post builds a monument to the healer and mentor.

POINTS OF CONVERGENCE AND DIVERGENCE

Both authors acknowledge Jung's confrontation with the "spiritual crisis of the modern world," yet they diverge in diagnosing its source and cure.

Theme	Lachman (2017)	Van der Post (1976)
Nature of Jung's Quest	Mystical initiation; empirical gnosticism	Moral renewal; psychological integration
Method	Visionary practice, alchemy, occult symbolism	Dialogue, empathy, mythic storytelling
Tone	Investigative, revisionist, esoteric	Devotional, autobiographical, ethical
Audience	Readers of Western esotericism, cultural historians	General humanist audience, admirers of Jung
Goal	Restore the sacred dimension of psyche	Humanise psychology and restore meaning to modern life

Lachman's Jung is **radical**—a mystic scientist exploring the metaphysical structure of reality. Van der Post's Jung is **pastoral**—a wise elder guiding humanity toward reconciliation. The first uncovers the shadow that scholarship repressed; the second illuminates the persona Jung offered the world.

In conclusion, taken together, the two portraits reveal the double image that defines Jung's enduring fascination. Van der Post presents the *acceptable Jung*: a moral visionary compatible with Christian humanism and post-war liberal values. Lachman retrieves the *unacceptable Jung*: the hermetic explorer who conversed with archetypes and sought knowledge through visionary ordeal. The truth likely lies between them. Jung's genius resided in holding the tension of opposites—science and mysticism, psyche and spirit—without collapse into either.

Thus, *Jung the Mystic* and *Jung and the Story of Our Time* are complementary myths: one exposes the esoteric roots of modern psychology, the other secures its ethical fruits. Together they chart the evolution of Jung's reputation from the margins of occultism to the mainstream of moral philosophy, reminding readers that the modern psyche still hungers for both explanation *and* revelation.

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HEALTH OMBUD
SAFEGUARDING QUALITY HEALTHCARE

MEDIA STATEMENT

For Immediate Release
30 July 2025

To All Editors/Health Journalists

THE HEALTH OMBUD RELEASES INVESTIGATION FINDINGS INTO THE TREATMENT, COMPLICATIONS AND DEATHS OF PSYCHIATRIC PATIENTS IN THE NORTHERN CAPE HOSPITALS

Pretoria - The Health Ombud, Professor Taole Mokoena, has released the findings of an investigation into the treatment, complications, and deaths of psychiatric patients at the Northern Cape Mental Health Hospital (NCMHH) and the Robert Mangaliso Sobukwe Hospital (RMSH). The investigation revealed that two patients died, and another underwent craniectomy and remains bedridden.

The investigation was initiated following a complaint filed by the Honourable Minister of Health, Dr. Aaron Motsoaledi (MP), regarding the Northern Cape Mental Health Hospitals in October 2024. The reported incidents took place in July and August 2024, during which it was alleged that two patients died at NCMHH, and two others were admitted to RMSH in critical condition.

In response to the Minister's request, the Health Ombud deployed a team of two investigators in accordance with Section 81(3)(c) of the National Health Amendment Act (NHAA). This investigation report is issued based on Section 81A (11) of the NHAA, 2013 (Act No. 12 of 2013), pertaining to the functions of the Office of Health Standards Compliance and the handling of complaints by the Health Ombud. The report is intended to inform both the complainant and the health establishments as well as the general public of the findings and recommendations derived from the investigation.

ISSUES INVESTIGATED

The investigation was carried out through a detailed analysis and triangulation of information and documentary evidence obtained from the NCMHH and RMSH, as well as through on-site visits. The following issues were identified for investigation based on the analysis of the complaints, allegations, and engagement with both health establishments:

- The circumstances surrounding Mr Cyprian Mohoto's care at NCMHH and his subsequent death at RMSH;
- The circumstances surrounding Mr Petrus De Bruins's care at NCMHH and his admission to RMSH;
- The circumstances surrounding Mr Tshepo Mndimbaza's care and death at NCMHH; and
- The circumstances surrounding Mr John Louw's care at NCMHH and his admission to RMSH.

The investigation revealed that, at the time of the incidents, NCMHH and several neighbouring health facilities were facing challenges with their electricity supply due to cable theft and vandalism at their power substation. This power loss impacted the communication infrastructure, leaving the hospital without telephone lines.

Electricity supply was restored within days at two of the neighbouring hospitals; however, it took an entire year for the electricity to be restored at NCMHH. The investigation found that the delay in repairing the electricity supply to NCMHH was due to dysfunctional Supply Chain Management processes within the Provincial Department of Health. This delay rendered the hospital's Heating, Ventilation, and Air Conditioning (HVAC) system nonfunctional, exposing patients and staff to extreme weather conditions during the summer and winter. Additionally, because of the lack of electricity, the available resuscitation equipment was not operational, as it could not be charged, and other necessary equipment was unavailable for use. NCMHH procured poor quality pyjamas and blankets which were inadequate to provide warmth to patients during the severe winter's cold, especially at night.

It was established that the Clinical Manager at NCMHH had written a complaint letter to the Acting Head of the Provincial Department of Health, detailing the adverse conditions which patients at NCMHH were being subjected to. These circumstances negatively impacted their health and violated their human rights.

FINDINGS

The investigation uncovered several findings regarding the medical care of four patients:

1. **Circumstances surrounding Mr Cyprian Mohoto's care and admission to RMSH:** The investigation revealed gross mismanagement surrounding Mr. Mohoto's care, which ultimately led to his death. He was admitted to RMSH on 13 July 2024, with a suspected abdominal or bowel obstruction following complications at NCMHH on 12 July 2024.

   Admission abdominal X-rays ruled out bowel obstruction while the chest X-ray revealed multi-lobar pneumonia. The pneumonia was never treated during the 3 days that the patient stayed in the Surgical Recovery Unit until his death. His deteriorating clinical status was never attended to by either the nursing personnel nor the doctors. Mr. Mohoto died on 16 July 2024, in the Emergency Centre at the Surgical Recovery Unit at RMSH.

2. **Mr. De Bruin was transferred from NCMHH to the Emergency Centre at RMSH on 30 July 2024,** after collapsing and being unresponsive in Ward M2 at NCMHH. He was stabilised and later admitted to the RMSH Medical Recovery Unit for hypoglycemia, the medical care and investigations conducted in the Emergency Centre were appropriate. However, the monitoring by nursing personnel was found to be inadequate.

3. **The Circumstances Surrounding Mr. Tshepo Mdimbaza's Death:** Mr. Mdimbaza was discovered unresponsive in his bed on 3 August 2024, at NCMHH. The resuscitation process was delayed due to the unavailability, malfunction, or unpreparedness of resuscitation equipment. There was also a lack of monitoring of the patient's vital signs before and during resuscitation by medical or nursing personnel. Mr. Mdimbaza did not survive the resuscitation attempt. The post-mortem report indicated that he died due to "exposure to the elements" at NCMHH.

4. The investigation into the **circumstances surrounding the care and admission of Mr John Louw** to RMSH revealed that he had an acute subdural haemorrhage. An emergency craniotomy and craniectomy were successfully performed on 07 July 2024 and 23 July 2024, respectively, and he was discharged back to NCMHH on 28 October 2024. Mr Louw remains bedridden.

5. The investigation also established **additional findings,** including leadership instability in the Northern Cape Provincial Department of Health, which negatively affected service delivery, safety, and the quality of patient care at NCMHH and RMSH.

6. Northern Cape Mental Health Hospital was found to have poor governance and systemic lack of leadership and poor management at all levels, unpreparedness for emergency cases, crumbling infrastructure, poor pharmacy and medicine control management, shortage of staff, poor quality assurance management, non-compliance with patient record keeping, and poor laundry services.

7. Robert Mangaliso Sobukwe Hospital was found to be experiencing critical staff shortage across the board; lack of oversight with nursing supervision; communication breakdown of reporting systems, non-compliance with guidelines on principles of good record keeping and overcrowding at the hospital emergency centre, aggravated by the absence of a district or regional hospital.

8. The investigation concluded that the general care provided at the Northern Cape Mental Health Hospital and the Robert Mangaliso Sobukwe Hospital to the patients was substandard, and patients were not attended to in a manner consistent with the nature and severity of their health condition, as required by Regulation 5 (1) of the Norms and Standards Regulations Applicable to Different Categories of Health Establishments, 2018 (Norms and Standards Regulations).

RECOMMENDATIONS

The Health Ombud made clear, actionable recommendations to address the systemic failures observed at both health establishments to improve the overall safety and quality of patient care. Key recommendations include; the Provincial Head of Department of Health must immediately appoint a Task Team to monitor the implementation of the recommendations as outlined in the report, hold accountable officials found to be in breach through formal disciplinary processes, the National Department of Health should initiate a forensic investigation into the procurement processes for the NCMHH, priority should be given to the development, reinstatement, and implementation of an effective and efficient reporting system for continuity of care and effective communication, and the development of comprehensive Standard Operating Procedures (SOPs)/Protocols/Guidelines to guide healthcare personnel in providing healthcare services. The complete set of recommendations is included in the report.

A detailed report is available on the Health Ombud's website at www.healthombud.org.za

End.

Issued by the Health Ombud.

Media Enquiries: *Ricardo Mahlakanya* - Cell: 066 473 8666

Call for Abstracts

Pre-Conference Workshop Abstracts
Submission Deadline: 31 October 2025

Oral and Poster Abstracts
Submission Deadline: 28 February 2026

The International Marcé Society for Perinatal Mental Health warmly invites all members, colleagues, and professionals with an interest in perinatal mental health to participate in this landmark event, which marks the first time in the Society's history that the conference will be hosted on the African continent.

In Daniel Kahneman's Prospect Theory, anchors such as loss aversion, overconfidence, and availability bias all affect how philanthropists assess scenarios of future impact.

SCAN QR CODE TO VIEW GUIDELINES AND SUBMIT YOUR ABSTRACT:

Abstract submissions are now open, and the Society encourages clinicians, researchers, and other healthcare providers from around the world to contribute. The conference will provide a platform for sharing knowledge, exchanging ideas, and advancing efforts to improve perinatal mental health globally.

The theme for the 2026 conference is Ubuntu—an isiZulu word meaning humanity. Expressed in the phrase "Umuntu ngumuntu ngabantu" ("I am because we are"), the theme reflects the spirit of interconnectedness and collective responsibility that underpins the society's mission.

Join us in Cape Town as we come together to strengthen our shared commitment to perinatal mental health for all.

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The International Marcé Society for Perinatal Mental Health

POSITION STATEMENT: TRANSPORT OF PATIENTS

Dear SASOP Member,

Emergency services are often contacted by family or the public to transport acutely ill psychiatric patients who refuse treatment.

In terms of the Mental Healthcare Act, 17 of 2002, the rights of patients must be protected. At that times the person and the property of a person with mental disorders or mental disabilities may require protection and those members of the public and their properties may similarly require protection from people with mental disorders or mental disabilities.

To address this issue, please see below for the official SASOP position statement

POSITION STATEMENT ON THE TRANSPORT OF PATIENTS BY EMERGENCY SERVICES TO ESTABLISHMENTS THAT CAN PROVIDE MENTAL HEALTHCARE.

Emergency services are often contacted by family or the public to transport acutely ill psychiatric patients who refuse treatment.

In terms of the Mental Healthcare Act, 17 of 2002, the rights of patients must be protected and that at times the person and the property of a person with mental disorders or mental disabilities may require protection and those members of the public and their properties may similarly require protection from people with mental disorders or mental disabilities.

Regarding the acute care for persons with mental disorders, the Mental Healthcare Act specifies in sections 9(1), 9(2) and 40 the care for such persons.

Section 9(1) and 9(2) specifies the following:

"Consent to care, treatment and rehabilitation services and admission to health establishments

9. (1) A health care provider or a health establishment may provide care, treatment and rehabilitation services to or admit a mental health care user only if-

a) the user has consented to the care, treatment and rehabilitation services or to admission; authorised by

b) a court order or a Review Board; or

c) due to mental illness, any delay in providing care, treatment and rehabilitation services or admission may result in the-

i. death or irreversible harm to the health of the user,

ii. user inflicting serious harm to himself or herself or others, or

iii. user causing serious damage to or loss of property belonging to him or her or others.

(2) **Any person or health establishment** that provides care, treatment and rehabilitation services to a mental health care user or admits the user in circumstances referred to in subsection (1)(c)-

a) **Must report this fact in writing in the prescribed manner to the relevant Review Board;** and

b) may not continue to provide care, treatment and rehabilitation services to the user concerned for longer than 24-hours unless an application in terms of Chapter V is made within the 24-hour period."

The Mental Healthcare Act definitions:

*"**"health establishment"** means institutions, facilities, buildings or places where persons receive care, treatment, rehabilitative assistance, diagnostic or therapeutic interventions or other health services and includes facilities such as community health and rehabilitation centres, clinics, hospitals and psychiatric hospitals"*

*"**"health care provider"** means a person providing health care services;"*

*"**"mental health care practitioner"** means a psychiatrist or registered*

medical practitioner or a nurse, occupational therapist, psychologist or social

worker who has been trained to provide prescribed mental health care, treatment and rehabilitation services;"

*"**"mental health care user"** means a person receiving care, treatment and rehabilitation services or using a health service at a health establishment aimed at enhancing the mental health status of a user, State patient and mentally ill prisoner and where the person concerned is below the age of 18 years or is incapable of taking decisions, and in certain circumstances may include-*

(i) prospective user;

(ii) the person's next of kin;

(iii) a person authorised by any other law or court order to act on that person's behalf;

(iv) an administrator appointed in terms of this Act; and

(v) an executor of that deceased person's estate and "user" has a corresponding meaning;"

The Mental Healthcare Act states further that:

"Provision of mental health care, treatment and rehabilitation services at health establishments

*6. (1) Health establishments **must-***

a) provide any person requiring mental health care, treatment and rehabilitation services with the appropriate level of mental health care, treatment and rehabilitation services within its professional scope of practice; or

b) refer such person, according to established referral and admission routes, to a health establishment that provides the appropriate level of mental care, treatment and rehabilitation services.

Unfair discrimination

10. (1) A mental health care user may not be unfairly discriminated against on the grounds of his or her mental health status.

(2) Every mental health care user must receive care, treatment and rehabilitation services according to standards equivalent to those applicable to any other health care user.

(3) Policies and programmes aimed at promoting the mental health status of a person must be implemented with regard to the mental capacity of the person concerned.

Intervention by members of South African Police Service

40. (1) If a member of the South African Police Service has reason to believe, from personal observation or from information obtained from a mental health care practitioner, that a person due to his or her mental illness or severe or profound intellectual disability is likely to inflict serious harm to himself or herself or others, the member must apprehend the person and cause that person to be-

a) taken to an appropriate health establishment administered under the auspices of the State for assessment of the mental health status of that person; and

b) handed over into custody of the head of the health establishment or any other person designated by the head of the health establishment to receive such persons.

(2) If a mental health care practitioner, after the assessment referred to in subsection (1), is of the view that the person apprehended is-

a) due to mental illness or severe or profound intellectual disability, likely to inflict serious harm to himself or herself or others, must admit the person to the health establishment for a period not exceeding 24 hours for an application to be made in terms of section 33; or

b) unlikely to cause harm, he or she must release the person immediately.

(3) If an application is not made within the 24-hour period, the person apprehended must be discharged immediately.

(4) If an assisted or involuntary mental health care user has absconded or is deemed to have absconded or if the user has to be transferred under sections 27(10), 33(9), 34(4)(b), 34(6) and 39, the head of the health establishment may request assistance from the South African Police Service to-

(a) locate, apprehend and return the user to the health establishment concerned; or

(b) transfer the user in the prescribed manner.

(5) The South African Police Service must comply with the request.

(6) When requesting the assistance, the South African Police Service must be informed of the estimated level of dangerousness of the assisted or involuntary mental health care user.

(7) A person apprehended in terms of subsection (4) may be held in custody at a police station for such period as prescribed to affect the return or the transfer in the prescribed manner.

(8) A member of the South African Police Service, may use such constraining measures as may be necessary and proportionate in the circumstances when apprehending a person or performing any function in terms of this section.

In terms of the Mental Healthcare Act, 17 of 2002, any **person or health establishment** can render emergency services for treatment or care to any healthcare user in need of health services for a mental illness that is so severe that a delay in rendering services could or may cause death, or harm to the user, inflicting serious harm to the user or others or cause serious damage to or loss of property belonging to the user or others.

The regulations to the Mental Healthcare Act states under the section

"Emergency admission or treatment without consent

*8. **Any person or health establishment** that provides care, treatment or rehabilitation services to a mental health care user or admits such user in circumstances contemplated in section 9(1)(c) of the Act must report that fact in writing in the form of form 01 of the Annexure to the relevant Review Board."*

The person or health establishment that renders services without the users' consent must report this to a mental health review board on Mental Healthcare Act form 01.

Emergency services **must** transport mental healthcare users who need emergency services, even if they do not consent, to the most appropriate facility for care and treatment. They need to complete MHCA Form 01 and either send the form to the relevant review board or hand the form over to the hospital to where they took the patient for the hospital to send the form to the review board.

If the SAPS, through observation or being informed by a mental health care practitioner that a person needs emergency care, such a member of the SAPS **must** take the person to a hospital under the auspices of the state or have the person held in custody and transfer the user to an appropriate facility.

INSTRUCTIONS TO AUTHORS

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

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

LETTERS TO THE EDITOR

- Novel experiences
- Response to published content
- Issues

FEATURES

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

REPORTS

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

PERSPECTIVES

- Personal opinions written by non-medical contributors

NEWS

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

ANNOUNCEMENTS

- Congresses, symposia, workshops
- Publications, especially books

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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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