ISSN 2409-5699

SOUTH AFRICAN PSYCHIATRY

ABOUT the discipline **FOR** the discipline

issue 42 • FEBRUARY 2025

ADHD CONGRESS 2024

DR REDDY'S SOUTH AFRICA PSYCHIATRY ACADEMIC MEETING

RELIGION & SOCIAL TRANSFORMATION

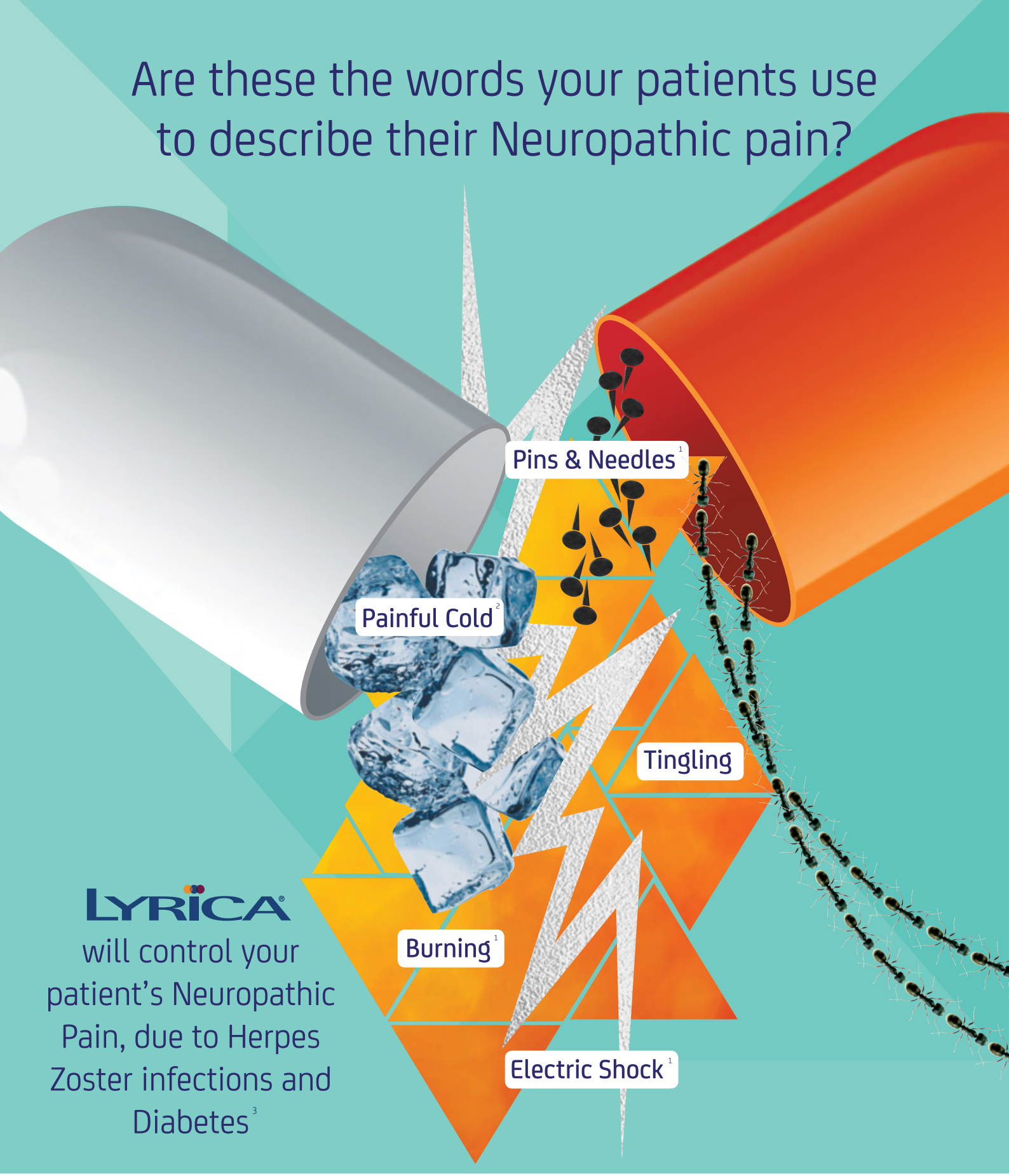
AFRICAN VOICES IN MENTAL HEALTH INNOVATION

THE CASE FOR CULTIVATING COMPASSION

PUBLISHED IN ASSOCIATION WITH THE SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

www.southafricanpsychiatry.co.za

Are these the words your patients use to describe their Neuropathic pain?



LYRICA®
will control your patient's Neuropathic Pain, due to Herpes Zoster infections and Diabetes[3]

VIATRIS

LYRICA® PREGABALIN
Rapid onset.[4] *Sustained relief.*[4,5]

References: **1.** Chetty S, Baalbergen E, Bhigjee AI, et al. Clinical practice guidelines for management of neuropathic pain: expert panel recommendations for South Africa. SAMJ. 2012;102(5):312-325. **2.** Bouhassira D, Attal N, Alchaar H, et al. Comparison of pain syndromes with nervous or somatic lesions and development of new neuropathic pain diagnostic questionnare (DN4). Pain. 2005;114:29-36. **3.** Lyrica Package Insert, 21 December 2022. **4.** Freeman R, Durso-DeCruz E, Emir B. Efficacy, Safety, and Tolerability of Pregabalin Treatment for Painful Diabetic Peripheral Neuropathy. Diabetes Care. 2008 July; 31(7): 1448-1454. **5.** Satoh J, Yagihashi S, Baba M, et al. Efficacy and safety evaluation of pregabalin treatment over 52 weeks in patients with diabetic neuropathic pain extended after a double-blind placebo controlled trial. J Diabetes Invest. 2011 December; 2(6): 457-463.

S5 **LYRICA®** 25 mg, 75 mg and 150 mg capsules (Reg. nos.: A39/2.5/0264, 0266, 0268). Each capsule contains 25 mg, 75 mg and 150 mg pregabalin respectively. **LICENCE HOLDER:** Viatris Healthcare (Pty) Ltd. Reg. No. 1949/035112/07. 4 Brewery Street, Isando, Gauteng, 1609. Tel.: +27(011) 451 1400. For full prescribing information, refer to the professional information approved by the medicines regulatory authority. **LYR-2023-0471.** Exp. 04/2025.

CONTENTS

FEBRUARY 2025

Advertising: The Source Events and Marketing
Design and Layout: Rigel Andreoli and Kirsten Brooks
Web: www.southafricanpsychiatry.co.za
Contact Person: Vanessa Beyers - vanessa@thesourcesolutions.com
COVER IMAGE: Gallo Images I Getty Images "Self-Portrait with a Straw Hat (obverse: The Potato Peeler)" - Vincent van Gogh 1887
Design and layout: The Source **Printers:** Raptor Print
South African Psychiatry is published quarterly by The Source Solutions. It's mission is to communicate the latest news and developments in the area of South African Psychiatry

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

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

Dear Reader,

welcome to the first issue of 2025. The November 2024 issue was a significant landmark in signalling the 10th Anniversary of the publication. As it was a Congress issue there was no opportunity to bring this to your attention. As we enter our second decade of existence it was agreed that it was time for a "rebrand". This included reimagining our covers as well as use of font, colour and layout of content. Ultimately it was decided that our theme for 2025 would involve "icons and mental health".

Specifically, we chose specific artists, and one of their works as a cover for each of the first three issues of 2025. Their selection was based on what each one represents:

- *Vincent van Gogh* – exploring creativity and mental health.
- *Frida Kahlo* – how art can express pain and healing.
- *Pablo Picasso* – the Blue Period and its reflection on depression and isolation.

The first of the three is the cover of the current issue, a self-portrait by **Vincent van Gogh.** He created over 30, reflecting his emotional and psychological state during different periods of his life. These works appear to represent self-exploration and how perceptions, and the experience, of mental health change over time.

We have chosen **Frida Kahlo** for the May 2025 cover, another self-portrait. It has been noted that Kahlo's raw, emotional self-portraits often depict her physical and emotional pain, including themes of identity, trauma, and resilience, making her work profoundly relatable to mental health narratives.

Finally, there is **Pablo Picasso** for the August 2025 issue, where the chosen work is from his "Blue Period" (1901–1904) which features melancholic figures painted in shades of blue. These figures reflect themes of sadness and despair potentially representing emotional struggles linked to depression.

A special thanks to Vanessa Beyers (The Source) for providing source material that guided the abovementioned content related to the chosen theme.

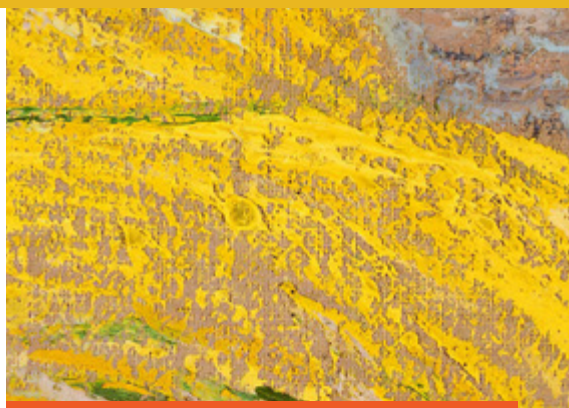
The link between art and mental health is well established, and certainly *South African Psychiatry* acknowledges that in covering the annual event hosted by the University of the Witwatersrand's Department of Psychiatry. Such content is to be found in the current issue.

Also in the current issue, but only available in the online version, is an extensive collection of Reports that provide readers with content from presentations at the ADHD Conference held in late 2024. Many thanks to each of the contributors – all registrars, sub-specialist trainees or medical officers. Further, a special thanks to our Associate Editor, Renata Schoeman, for curating the content and Marida Kroukamp (Londocor) for her assistance in compiling the content. In addition, there are a range of Reports which speak to recent events of note. Finally, we are as always delighted to host content from regular contributors: Volker Hitzeroth (medico-legal), David Swingler (wine) and Claudia Campbell (personal perspectives).

In conclusion, I draw your attention related to an update on the African Association of Psychiatrists (AAP) together with content from the South African Society of Psychiatrists (SASOP) – with whom we have a longstanding association.

And a final acknowledgement in commemorating our 10th Anniversary – thanks Sudier, you inspired the creation of the publication.

Enjoy the read.



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

Acknowledgement: Thanks to Lisa Selwood for assistance with proof reading

NOW PATIENTS CAN FALL ASLEEP FASTER[1,2] AND STAY ASLEEP LONGER[1,2]

NEW, DAVIGO® a dual orexin receptor antagonist, that targets the pathway that is thought to regulate wakefulness in the brain.[3,4]

Studies show that on discontinuation:

- no withdrawal signs or symptoms observed[3]
- not associated with rebound insomnia[3]

The way patients begin their mornings may depend on how they slept the night before.

Davigo® is indicated for the treatment of adult patients with insomnia characterised by difficulties with sleeponset and/or sleep maintenance.[3]

References: 1. Rosenberg R, Murphy P, Zammit G, et al. Comparison of Lemborexant With Placebo and Zolpidem Tartrate Extended Release for the Treatment of Older Adults With Insomnia Disorder: A Phase 3 Randomized Clinical Trial. JAMA Netw Open. 2019 Dec 2;2(12):e1918254. **2.** Kärppä M, Yardley J, Pinner K, et al. Long-term efficacy and tolerability of lemborexant compared with placebo in adults with insomnia disorder: results from the phase 3 randomized clinical trial SUNRISE 2. Sleep. 2020 Sep 14;43(9):zsaa123. **3.** Dayvigo® Professional Information. Approval date, 15 August 2023. **4.** Beuckmann CT, Suzuki M, Ueno T, et al. In Vitro and In Silico Characterization of Lemborexant (E2006), a Novel Dual Orexin Receptor Antagonist. J Pharmacol Exp Ther. 2017 Aug;362(2):287-295

S5 DAYVIGO® 5 mg (film-coated tablet): Reg No: 56/2.2/0571. Each tablet contains Lemborexant 5 mg. S5 DAYVIGO® 10 mg (film-coated tablet): Reg No: 56/2.2/0572. Each tablet contains Lemborexant 10 mg. For full prescribing information refer to the SAHPRA approved Professional Information. Further information is available on request. Eisai Pharmaceuticals Africa (Pty) Ltd. Reg. No.: 2022/487902/07. 2nd Floor, Golden Oak House, Ballyoaks Office Park, 35 Ballyclare Drive, Bryanston, Johannesburg, 2191, Gauteng, South Africa. Tel: +27 10 590 4325. www.eisai.co.za. AR-DG-24F-01 Expiry 01/05/2026

Scan QR code for full Professional Information

Eisai

hhc human health care

Programme

WEDNESDAY 4 SEPTEMBER 2024		
14:00 - 16:10	SCIENTIFIC SESSION 1: Chair: Merryn Young	
14:00 - 14:10	Official welcome and opening	Samantha Walbrugh-Parsadh, South Africa
14:10 - 14:15	Introduction of speakers	
14:15 - 14:50	Controversies in ADHD in the first years of life	Mary Margaret Gleason, USA
14:50 - 14:55	Q & A	
14:55 - 15:30	Transitions through pre primary to primary school for children with ADHD: sensory and developmental challenges and opportunities	Emma Wijnberg, South Africa
15:30 - 15:35	Q & A	
15:35 - 16:05	The multidisciplinary team approach to school readiness and assessing for medication	Androula Ladikos, South Africa
16:05 - 16:10	Q & A	
16:10 - 16:35	Comfort Break / News from the sponsors	
16:35 - 18:00	SCIENTIFIC SESSION 2: Chair: Nerica Ramsundhar	
16:35 - 16:40	Introduction of speakers	
16:40 - 17:15	Transitions into intermediate phase education: regulation and executive function challenges	Elize Janse van Rensburg, South Africa
17:15 - 17:20	Q & A	
17:20 - 17:55	From crayons to curfews	Theonie du Plessis, South Africa
17:55 - 18:00	Q & A	
THURSDAY 5 SEPTEMBER 2024		
08:00 - 09:00	ACINO SWISS SYMPOSIUM Chair: Renata Schoeman	
	Introduction of speaker - Drug holidays: yes or no	David Coghill, Australia
12:00 - 13:00	EASTERN CAPE DEPARTMENT OF EDUCATION SYMPOSIUM Chair: Rodney Sekgobela	
	Introduction of speaker - The impact of attention deficit hyperactive disorder on learners	Punyuzwa Titi, South Africa
13:00 - 14:25	SCIENTIFIC SESSION 3: Chair: Renata Schoeman	
13:00 - 13:05	Introduction of speakers	
13:05 - 13:40	An update on pharmacological treatments for ADHD	David Coghill, Australia
13:40 - 13:45	Q & A	
13:45 - 14:20	New insights on ADHD trajectories	Luis Rohde, Brazil
14:20 - 14:25	Q & A	
14:25 - 15:00	Comfort Break / News from the sponsors	
15:00 - 17:05	SCIENTIFIC SESSION 4: Chair: Gina Rencken	
15:00 - 15:05	Introduction of speakers	
15:05 - 15:40	ADHD and epilepsy Adri van der Walt, South Africa	
15:40 - 15:45	Q & A	
15:45 - 16:20	Transitioning off medication - if and when to stop (whether at end of school career or earlier)	Andrè Venter, South Africa
16:20 - 16:25	Q & A	
16:25 - 17:00	Medication management of difficult to treat ADHD	Renata Schoeman, South Africa
17:00 - 17:05	Q & A	

FRIDAY 6 SEPTEMBER 2024

08:00 - 09:00	DR REDDY'S SYMPOSIUM Chair: Livasha Mudaly	
	Introduction of speaker Consent requirements for ADHD medication	Mirriam Close, South Africa
13:00 - 14:00	VIATRIS SYMPOSIUM Chair: Susan Appelgryn	
	Introduction of speaker Parental challenges with children diagnosed with ADHD	Andrè Venter, South Africa
14:00 - 16:05	SCIENTIFIC SESSION 5: Chair: Lerato Dikobe-Kalane	
14:00 - 14:05	Introduction of speakers	
14:05 - 14:40	Improving outcomes in female ADHD	Jane Indergaard, USA
14:40 - 14:4	Q & A	
14:45 - 15:20	Mothering with ADHD	Gina Rencken, South Africa
15:20 - 15:25	Q & A	
15:25 - 16:00	The influence of reproductive hormonal fluctuations on ADHD	Dora Wynchank, The Netherlands
16:00 - 16:05	Q & A	
16:05 - 16:30	Comfort Break / News from the sponsors	
16:30 - 17:55	SCIENTIFIC SESSION 6: Chair: Kedi Motingoe	
16:30 - 16:35	Introduction of speakers	
16:35 - 17:10	An update on the Child and Adolescent management guidelines for ADHD in South Africa	Brendan Belsham, South Africa
17:10 - 17:15	Q & A	
17:15 - 17:50	The management of comorbidity in ADHD Frans Korb, South Africa	
17:50 - 17:55	Q & A	

SATURDAY 7 SEPTEMBER 2024

08:00 - 09:00	HealthFOX SYMPOSIUM Chair: Kimmo Korhonen	
	Introduction of speaker Behavioural strategies in managing adult ADHD: Beyond medication	Chrisna Ravyse, Finland
10:00 - 12:05	SCIENTIFIC SESSION 7: Chair: Lesley Carew	
10:00 - 10:05	Introduction of speakers	
10:05 - 10:40	The unreached: Eastern Cape Lessons	Luzuko Magula, South Africa
10:40 - 10:45	Q & A	
10:45 - 11:20	A community approach to early intervention for neurodiverse children	Juané du Randt, South Africa
11:20 - 11:25	Q & A	
11:25 - 12:00	Dyslexia - the quiet complicator	Elizma van Milligen, South Africa
12:00 - 12:05	Q & A	
12:05 - 12:30	Comfort Break / News from the sponsors	

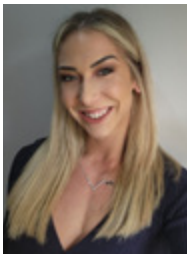
SATURDAY 7 SEPTEMBER 2024 - *CONTINUED*

12:30 - 15:00	SCIENTIFIC SESSION 8: PARALLEL SESSIONS	
	SESSION 8.1: Chair: Gina Rencken	
12:30 - 12:35	Introduction of speakers	
12:35 - 13:05	Internet addiction	Wisani Makomisane, South Africa
13:05 - 13:35	Pornography (in teenagers and adults)	Linda Kelly, South Africa
13:35 - 14:05	Online communities - the pros and the cons	Hugo Theron, South Africa
14:05 - 14:35	The overlap of substance misuse, ADHD, and other health issues	Jason Kilmer, USA
14:35 - 15:00	Discussion	
	SESSION 8.2: Chair: Nerica Ramsundhar	
12:30 - 12:35	Introduction of speakers	
12:35 - 13:05	Obstetric and maternal risk factors for development of ADHD	Nadiya Frank, South Africa
13:05 - 13:35	HIE insults and other insults that manifest with ADHD	Shalendra Misser, South Africa
13:35 - 14:05	Iron deficiency and the impact on neurodevelopment	Nerica Ramsundhar, South Africa
14:05 - 14:35	Neurodevelopmental risk of early elective c sections	André van Niekerk, South Africa
14:35 - 15:00	Discussion	
	SESSION 8.3: Chair: Merryn Young	
12:30 - 12:35	Introduction of speakers	
12:35 - 13:05	The myths and facts re ADHD, autism and AuDD	Merryn Young, South Africa
13:05 - 13:35	Exploring the notion of twice exceptional: a yin-yang between challenges and talents	Michèle van Niekerk, South Africa
13:35 - 14:05	Intellectual disability and ADHD: Support with co-occurring diagnoses and interventions	Kedi Motingoe, South Africa
14:05 - 14:35	Parent support for neurodiverse families	Juazel de Villiers, South Africa
14:35 - 15:00	Discussion	
	SESSION 8.4: Chair: Rykie Liebenberg	
12:30 - 12:35	Introduction of speakers	
12:35 - 13:05	ADHD and career success: The path forward	Andria Gush, South Africa
13:05 - 13:35	Coaching adults with ADHD - strategies that matter	Tamara Rosier, USA
13:35 - 14:05	Pharmacological strategies in older adults	Rykie Liebenberg, Namibia
14:05 - 14:35	When children are grown and flown - transitioning into the older years	RayAnn Cook, South Africa
14:35 - 15:00	Discussion	
15:00 - 15:30	Comfort Break / News from the sponsors	
15:30 - 17:00	SESSION 9: ETHICS, ENTERTAINMENT, PRIZES and CLOSING Chair: Renata Schoeman	
15:30 - 15:35	Introduction of speaker	
15:35 - 16:15	Ethical dilemmas in the management of ADHD	Indhrin Chetty, South Africa
16:15 - 16:55	Entertainment	Quizz - Tara Turkington, Flow Communications
16:55 - 17:00	Prizes and Closing	Renata Schoeman, South Africa

Controversies in ADHD in the First Years of Life

SPEAKER: Mary Margaret Gleason

Juané du Randt



Juané du Randt

The ADHD Congress provided an in-depth exploration of various aspects of ADHD, including its manifestation and diagnosis in early childhood. This report focuses on Dr. Gleason's lecture, "Controversies in ADHD in the First Years of Life," which delved into the debates and challenges associated with diagnosing ADHD in very young children.

Dr. Gleason's lecture addressed the complexities and controversies surrounding the diagnosis of ADHD in children under the age of six. Key points included:

- **Diagnostic Challenges:** Dr. Gleason discussed the difficulty of distinguishing between typical developmental behaviours and ADHD symptoms in very young children. She highlighted how developmental variability in early childhood can complicate accurate diagnosis as well as how early signs of increased hyperactivity and impulsivity may be a precursor for an ADHD diagnosis. She advocated for the use of the DC:0-5 for younger children as opposed to the DSM-V by discussing Overactivity Disorder in Toddlerhood.
- **Early Indicators vs. Diagnosis:** The lecture examined the early indicators of ADHD, such as impulsivity, hyperactivity, and problematic attachment behaviour, and disputed the controversy of whether a young person can present with mental health concerns. As an example, she reframed the diagnostic criteria for Colic, firstly, as an emotional problem and secondly, as a problem inside the context of relationships thus making it a mental health concern and thus showing that very young children can have mental health concerns.
- **Research Evidence:** Dr. Gleason reviewed current research on early ADHD symptoms, noting that while some studies suggest that early signs can predict ADHD later in life, she warned against pathologising typical behaviour patterns. However, she underlined the importance of looking for excessive symptom presentation when compared to developmentally and culturally expected norms and impairment.
- **Differentials:** The speaker emphasised that young children have limited resources to express emotional dysregulation and highlighted the importance that not all dysregulation (hyperactive behaviour) is ADHD. Hence pointing towards an adequate differential diagnosis by looking at developmental history, the presence of trauma, family history, and the caregiver's ability to co-regulate or model emotional regulation.
- **Early Intervention:** Dr Gleason addressed the controversy of medication as the first line of treatment in very young children, by expressing the importance of parent management training, behavioural interventions, and development support as the true first line of treatment. She believes that medication should only be considered for children under the age 6 if they are unsafe due to their symptoms.

RELEVANCE TO ADHD

Dr. Gleason's lecture is highly relevant to the field of ADHD as it addresses critical issues in the early identification and treatment of the disorder. The controversy over diagnosing ADHD in very young children is important because it impacts clinical practices and treatment approaches. Understanding these controversies can help professionals navigate the challenges of early diagnosis and make more informed decisions about intervention and treatment.

REFLECTION

I found Dr. Gleason's lecture thought-provoking. Her balanced approach to the challenges of identifying ADHD in the first years of life provided a nuanced perspective. I was particularly interested in the discussion about the balance between early intervention and the risk of pathologising childhood behaviour and was encouraged by the perspective of supporting the family first. She also addressed the importance of assessing the child inside a system with various contextual influences making her lecture appropriate within the South African context.

CONCLUSION

Her valuable insights into the ongoing controversies in diagnosing ADHD in early childhood underpinned the relevance of ADHD in the first years of life for all mental health providers.

Juané du Randt is a Registered Counsellor & Project Lead at the Goldilocks and the Bear Foundation
Correspondence: juane@gb4adhd.co.za

From crayons to curfews

SPEAKER: Theonie du Plessis

Wanita Botha

Wanita Botha

As members of a multidisciplinary team, professionals working with ADHD patients have the advantage of observing these individuals over an extended period, from childhood through adolescence and into adulthood. This long-term perspective allows for a comprehensive understanding of ADHD's developmental trajectory, which is essential for planning effective interventions at various stages. It is important to keep in mind the developmental level of the child and anticipate changes in relationships with parents, peers, and the treatment team as the patient matures. Tailoring communication to the patient's stage of development is key in maintaining an effective therapeutic alliance.

Adolescence is a particularly critical period for intervention, with long-term implications for both physical and mental health, as well as overall quality of life. While many individuals show improvement, ongoing care, intervention, and careful transitioning of services are crucial for sustained support. The adolescent brain undergoes significant changes, differing both from a child's brain and an adult's brain. MRI studies reveal that the adolescent brain experiences increased connectivity due to neuronal myelination, which enhances processing speed, while unused neural connections are pruned away. The prefrontal cortex—responsible for organizing, impulse control, emotional regulation, and executive functioning—matures later, into the mid-to-late twenties. This maturation process is even more delayed in individuals with ADHD, complicating these key functions.

Simultaneously, the limbic system, which governs emotions, intensifies during adolescence, creating a mismatch between heightened emotional responses and the underdeveloped prefrontal cortex. This mismatch often manifests in novelty-seeking and risk-taking behaviours.

Sleep is another area where adolescents with ADHD face challenges. Adolescents naturally experience delayed-phase sleep disturbances and require about nine hours of sleep per night, but often face sleep deprivation. This exacerbates ADHD symptoms, as individuals with ADHD frequently report sleep difficulties, usually linked to environmental distractions.

ADHD is also associated with poor eating habits, stemming from factors like boredom, distractions, and rushing through meals. There is an overlap between ADHD and eating disorders, as both conditions share impairments in working memory, set-shifting, and inhibitory control. ADHD has been linked to binge eating and obesity, highlighting the complex relationship between impulse control and eating behaviour. Dopamine, a neurotransmitter involved in reward pathways, plays a role in both eating and risk-taking behaviours.

Risk-taking behaviours are further complicated by emotional dysregulation and impulse control deficits, which may lead to overuse of technology, substance abuse, sexual impulsivity, and increased risk of car accidents. Monitoring prescribed stimulant use, is particularly important.

Moreover, 70-80% of individuals with ADHD are estimated to have comorbidities at some point in their lives, which complicates treatment and is typically associated with poorer outcomes. Early onset of comorbidities often signals more significant long-term challenges. While the peak age of ADHD diagnosis is around nine years, two-thirds of individuals continue to experience impairments into adulthood.

Treating ADHD requires a dynamic, evolving approach, adjusting as the individual progresses through different life stages. It is a privilege to continuously refine treatment, ensuring effective support throughout their development.

Wanita Botha is a Child and Adolescent Fellow at the University of Pretoria and Colleges of Medicine of South Africa **Correspondence: Wanita.botha@up.co.za**

Epilepsy and ADHD

SPEAKER: Adri van der Walt

Stephanie Eichstadt

General facts related to epilepsy

- Incidence of epilepsy in paediatrics= 0.5-1% in children
- Up to 10 years, there is a higher incidence and then it settles down closer to adult levels
- 50-80% will have comorbidities
- Approximately 30% with neurodevelopmental disorders
- Often 2-3 comorbidities rather than one, often psychiatric comorbidities

Stephanie Eichstadt

Danger: when a child presents with epilepsy that often becomes the focus of management and the comorbidities get missed.

ADHD diagnosis on average age of 5-6 years, however often later in the inattentive type. In epilepsy, the type most common is the inattentive type.

ADHD IN CHILDREN WITH EPILEPSY

- Up to 4x higher incidence of ADHD
- Increased risk if a mother has epilepsy for the child to have ADHD (independent of whether the mother has ADHD or not)
- Equal ratio of ADHD in boys and girls in epileptic children (as opposed to the general ADHD population)
- Epilepsy syndromes:
  - Frontal lobe epilepsy
  - Absence seizures- very common approximately 22%
  - Sleep related epilepsies- specifically high ADHD risk, up to 40% (may be due to sleep disruption?)
  - Epilepsy encephalopathies/ syndromes- usually multiple comorbidities, add to disease burden

WHAT IS THE IMPACT OF ADHD ON CHILDREN WITH EPILEPSY?

- Poorer prognosis
- Abnormal background EEG rhythm (possibly more seizures?)
- Lower tendency to adhere to antiseizure medication
- Negative outcomes in learning, social behaviours and QoL

FACTORS THAT INCREASE THE DEVELOPMENT OF ADHD IN EPILEPSY

- Age of onset- associated with other NDDs but not ADHD
- Increased seizure frequency
- Less seizure control
- Subclinical epileptiform activity:
  - 1.5-20% of individuals without epilepsy (normal) will have subclinical epileptiform activity on EEG
  - There is a higher incidence in ADHD and ASD patients - could this possibly indicate seizure activity?
  - There is an association between behavioural problems and subclinical epileptiform activity - treatment with an antiepileptic agent reduces behavioural symptoms but not the ADHD

EEGs are not indicated as a routine investigation in ADHD- the subclinical epileptiform activity which may be present will not change clinical management

An EEG is only needed if there is a clinical indication (suspicion of epilepsy)

THEORIES FOR CAUSES OF THE HIGH ASSOCIATION BETWEEN EPILEPSY AND ADHD

- Chance- incidence suggests not due to chance
- Genetics- no current clear pattern of shared genetics, however, both are highly hereditable diseases.
- Cause of seizures- eg neurological damage may cause both conditions
- Impact of medications
- Resultant neurological damage- do frequent seizures cause sclerosis/ damage which then results in the development of ADHD? No clear correlation proven.
- There is a bidirectional relationship between frontal lobe and temporal lobe epilepsy and increased rates for ADHD- possibly the cause for the association
- Inflammation, stress and immune dysregulation

EFFECT OF ANTISEIZURE MEDICATION ON ADHD

- Side effects- many of the antiseizure medications can influence behaviour, cognition and QoL
- These side effects vary from patient to patient (severe to no SEs)
- Levetiracetam
  - Can cause severe irritability
- Phenobarbital
  - Not really used anymore due to the effects on behaviour and worsening of symptoms of ADHD
- Valproate
  - More studies now focused on SEs of valproate, especially with regard to the effect on cognition and concentration.

  - May cause increased activity levels- usually happens within the first 3-4 weeks of initiating the valproate
  - Use in pregnancy- significant increased risk for ADHD in the child, 8.4% vs 3.2% in unexposed children.
- Phenytoin
  - Impact on cognition

Individual medication side effects are important to consider- for eg. Use of phenytoin in absence seizures may result in increased seizures and symptoms (inattention, checking out etc) and may be attributed to ADHD

DIAGNOSIS OF ADHD IN CHILDREN WITH EPILEPSY- MUST COVER ALL BASES

- Is this an effect of the ASM?
- Age of onset of epilepsy
- Family history of ADHD
- Impact of the ADHD symptoms
- Do they fulfil symptoms criteria?

NB- the increased risk of ADHD makes it important to screen children with epilepsy more frequently

WHICH TREATMENT IS APPROPRIATE FOR ADHD IN EPILEPSY?

- Methylphenidate
- Atomoxetine- not as effective for attentional symptoms which are the more common symptoms in epilepsy
- Lisdexamphetamine- less effective in children with epilepsy, seems to be more effective in adults

EFFECT OF ADHD MEDICATION ON EPILEPSY?

- No worsening of seizure activity on ADHD medication- it may in fact improve seizure control due to better compliance.
- NB to make sure that stimulants do not affect sleep- poor sleep may influence seizure levels

A COMMENT ON DISCONTINUATION OF EPILEPSY MEDICATION- CAN IT BE DONE?

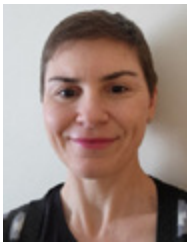
- Can discontinue if a child is 18-24 months seizure free (22% may have recurrence)
- Not for children with epilepsy syndromes or abnormal EEG
- Positive effect: possibly may reduce side effect burden of the ASM.

Stephanie Eichstadt is a Psychiatry registrar, University of Pretoria **Correspondence: stepheichstadt@gmail.com**

Medication management of difficult to treat ADHD

SPEAKER: Prof Renata Schoeman

Leigh-Ann Wood-Pottle



Leigh-Ann Wood-Pottle

Individuals with ADHD show high rates of intra and inter individual variability in their symptoms. ADHD is known to be associated with high rates of comorbidities which can make presentation atypical. It has been shown that untreated or insufficiently treated ADHD is linked to poor long-term outcomes as well as increased morbidity and mortality. ADHD guidelines advise an individual approach and not an algorithmic approach and highlight the importance of a multidisciplinary team with holistic intervention.

Pharmacological management shows good tolerability. However not everyone responds as expected. There are several reasons why this occurs that can be explained by tachyphylaxis (acute tolerance) where there is a rapid decrease in response to an agonist drug following repeated administrations within a brief period. Tolerance is where you need to have more to get the same effect or response. Response which is measured after a 3-month trial on medication and where there is a 25-50% reduction in symptom scores on rating scales or general disease condition improvement of less than 3 or a clinical global improvement less than 2.

REMISSION DEFINITIONS:

1) syndromatic remission (failing to meet DSM 5 ADHD criteria)
2) symptomatic remission (fewer than 36% symptoms: score less than 18 on SNAP, no active symptoms)
3) functional remission (fewer than 18 on SNAP score and GAF score is more than 60).

(Biederman et al 2000)

Or

1) total score on SNAP less than 18
2) and general disease condition and improvement (CGI -I score less than 2).

(Chen et al 2019)

Difficult to treat ADHD is where clients fail to achieve remission on 2 different ADHD medications (either 2 stimulants or 1 stimulant and 1 non-simulant), each medication given for at least 12 weeks. Most clients do well, 75% of children improve and 25% don't improve or get worse. In adults 25-40% will not achieve full remission.

Predictors of clients that may be difficult to treat are those with combined type, symptoms before the age of 7 years, more severe at baseline and more emotional dysregulation, comorbidities, psychosocial and biological factors together with lifestyle issues. Medical disorders that may contribute are sleep apnoea, restless leg syndrome, epilepsy, iron deficiency, inflammation, and stress responses. Predictors of good response are those with inattentive subtype, good response after first dose of methylphenidate, ADHD behaviours, personal characteristics such as young boys, adult females, better baseline cognitive functioning, baseline academic and work performance, greater baseline weight, expectations, and personal accountability.

To limit difficult to treat ADHD, we can ask about adherence, is the dose optimised and have we addressed and appropriately treated co-morbidities. Thereafter you can consider combining or switching treatment. Pharmacogenetic testing is not recommended as a rule but may be helpful in particular circumstances.

In **conclusion**, "difficult to treat" ADHD can stem from various sources, adherence issues, client and parental expectations, misdiagnosis, missed diagnosis and comorbidities. Only after going through the above should you consider adjusting medication dose or augmenting with other treatments.

Leigh-Ann Wood-Pottle is a Senior registrar at Stellenbosch University **Correspondence: woodpottle@sun.ac.za**

Community Approach to Early intervention for Neurodiverse Children:

Insight From the Goldilocks and The Bear Foundation

SPEAKER: Juané du Randt

Nothando Shandu

Nothando Shandu

Ms. Juané du Randt is a registered counsellor who has a strong passion for empowering neurodiverse children. She is currently in a leadership role and now serves as the Project Lead at the Goldilocks and the Bear Foundation and is dedicated to empowering neurodiverse children through early interventions and support.

Africa is home to 1,4 billion people, with a remarkably young population, with over 50% under the age if 18 years. South Africa has a population of 60 million with the median age being approximately 28 years and is no exception. It has been said that about 17% of children face mental health challenges, yet only 1% of psychiatric services are dedicated to child mental health. About 50% of mental health disorders typically develop before the age of 14. This highlights the critical importance of early interventions.

ADHD affects 5% of school aged children. South Africa continues to face high levels of inequality and poverty which further increases the risk for the general population to developed mental health disorders.

BACKGROUND

According to Ms. du Randt, there are several barriers that prevent early interventions:

- Lack of awareness and knowledge
- Stigma
- Overburdened health care facilities,
- Complex referral pathways
- Financial constraints limiting access to health care

Mental health issues if left untreated, will get worse. That is why early intervention is crucial. Childhood and adolescence are very important periods for brain development, with significant growth occurring before puberty. Life experiences during these stages shape brain connections. Brain plasticity allows for continuous learning and memory formation. The brain undergoes its most profound changes during infancy, childhood, and adolescence – which are known as sensitive periods. During these sensitive periods, experiences shape the development of various brain systems. Over time, these experiences become more refined and harder to modify. Early interventions are crucial to support optimal brain development, and to prevent long-term mental health consequences.

The Goldilocks and the Bear Foundation was established in 2017 and it addresses the alarming statistics and barriers surrounding mental health. As Joel A. Barker once said, *"Vision without action is merely a dream. Action without vision just passes the time. Vision with action can change the world."* This initiative exemplifies a community driven approach, empowering, supporting, developing, and growing with the community.

THEIR COMMUNITY APPROACH

- Raising awareness through South Africa's first children's book on ADHD, available in English, isiZulu, Xhosa, and Afrikaans
- Hosting the "Run for GB4ADHD" event to further promote ADHD awareness
- Providing training for parents, teachers, and children
- Offering free screenings for ADHD and other mental health conditions

TAKE HOME POINTS

Early interventions and community driven initiatives can make a significant impact in addressing mental health issues.

Nothando Shandu is a Final year Psychiatry Registrar at the University at the Witwatersrand **Correspondence: nothando.shandu@gmail.com**

The management of comorbidity in ADHD

SPEAKER: Frans Korb

Moroko Moipone Mojela

Moroko Moipone Mojela

In his presentation, Dr. Frans Korb, who is an adult psychiatrist and clinical psychologist in the Johannesburg region, primarily focused on ADHD comorbidities in adults, though he also touched on ADHD comorbidities in children. For children, Dr. Korb grouped these comorbidities into several categories: externalizing disorders, internalizing disorders, cognitive disorders, special populations, and other problems. Only a third of children have been reported to present with pure ADHD, thus suggesting about two-thirds of children with ADHD have some form of comorbidity, with the most common being oppositional defiant disorder, conduct disorder, mood and anxiety disorders, and tic disorders.

For adults, Dr. Korb grouped the comorbidities into somatic/physical and psychiatric types. The predominant somatic comorbidities discussed were obesity, sleep disorders, and asthma. He noted that 10% to 32% of individuals with ADHD had comorbid obesity. Usage of stimulants to treat ADHD might mitigate the impulsivity related to eating behaviours in obesity, thereby aiding treatment. Concerning sleep issues like insomnia, excessive daytime sleepiness, and disrupted sleep-wake cycles, evaluation for sleep disorders is critical before beginning any treatment in order to differentiate true comorbid sleep disorders from possible side effects of stimulants. With regards to asthma, it is postulated that the fact that both asthma and ADHD are childhood illnesses with a chronic course might suggest a comorbid relationship. There are no specific guidelines for treating ADHD and asthma together.

With regards to psychiatric conditions, ADHD is often comorbid with substance use disorders, depressive disorders, bipolar disorders, anxiety disorders, and personality disorders. Most of these conditions are more prevalent in the ADHD population compared to the general population, except for depressive disorders which are somewhat less common in ADHD compared to the general population. The overlapping of symptoms between ADHD and these psychiatric conditions makes them not only comorbidities but also differential diagnoses of ADHD. Making the correct diagnosis is thus important. These comorbidities tend to predict a poorer prognosis, emphasizing the importance of early treatment of ADHD to prevent further complications, especially comorbidities in later life.

According to guidelines from the Canadian Attention Deficit Hyperactivity Disorder Resource Alliance (CADDRA), the most impairing disorder should be treated first in cases of comorbidity, and this usually means starting with the comorbid disorder. Exceptions are noted where a mild comorbid disorder exists, such as a mild depressive disorder, which even on its own does not necessitate medication, thus leading to ADHD being treated first. Following treatment of the comorbidity, ADHD treatment can proceed with stimulants, if not contraindicated. The presence of comorbidities in itself is not a contraindication to stimulants use. Dr. Korb endorsed a multimodal approach to treatment, combining psychoeducation, behavioural management strategies, and educational and workplace interventions. This approach has proven more effective than medication alone. Effective treatment not only alleviates symptoms but also improves the patient's social, academic, and occupational functions, enhancing overall quality of life.

Moroko Moipone Mojela is a final year registrar at the University of Limpopo, currently stationed at Mankweng Hospital. **Correspondence: moipone.mojela@gmail.com**

The influence of reproductive hormonal fluctuations on ADHD

SPEAKER: Dora Wynchank

Thozama Xhama

Thozama Xhama

Dora Wynchank from the DIVA Foundation in the Netherlands, delivered this lecture, discussing how reproductive hormonal fluctuations influence Attention Deficit Hyperactivity Disorder (ADHD). Studies indicate that ADHD is among the most prevalent neurodevelopmental disorders in childhood. However, it was highlighted that ADHD developmental trajectories persist throughout an individual's life. Historically, ADHD was thought to primarily affect boys, leading to fewer studies conducted on girls (Ohan and Johnston, 2005). Community studies reported the prevalence of ADHD for boys to girls being 3:1, while clinical studies were reported as 10 to one. Other studies described prevalence as 13% for boys and 5,6% for girls.

The question asked was whether hormone-related mood disorders were more common in women with ADHD or if reproductive hormonal fluctuations also influence ADHD in females. It was noted that affective disorders such as depression affect more females than males, with the risk of depression being twice as high in women as in men. In contrast, seasonal depression is five times higher in women than in men. Females with ADHD were noted to suffer more severe and frequent forms of depression. However, research on this subject was limited. Vulnerability periods were noted during stages when oestrogen levels were low, including premenstrual, postnatal, and perimenopausal periods (Soares and Zitek, 2008; Steiner et al., 2003).

Women who suffer from ADHD and Premenstrual Dysphoric Disorder (PMDD) often report worsening symptoms during the premenstrual period. This week is sometimes referred to as the 'danger week' as women experience worsening mood swings, low self-esteem, suicidality, impulsivity, anxiety, and sleep disorders (de Jong et al., 2023). Additionally, decreased concentration span, brain fog, and impaired productivity were reported (Hantsoo et al., 2015). Interestingly, psychostimulant medication was found to be less effective during the luteal stage of the menstrual cycle (Kok et al., 2020). Both ADHD and depressive symptoms were reported to worsen during this period. In a study conducted on nine consecutive women with ADHD and other comorbid conditions in the ages of 24 - 48 years (de Jong et al., 2023) it was reported that increasing doses of psychostimulants during the luteal stage of the menstrual cycle resulted in an improvement in mood symptoms as well as ADHD symptoms, including inattention, irritability, and energy levels (de Jong et al., 2023). The psychostimulant drugs utilised included lisdexamfetamine (LDX) dose range of 30mg – 70mg in the follicular phase to 40–90mg or 100mg in the luteal phase of the menstrual cycle. Similarly, other psychostimulants included methylphenidate extended-release (MPH) ER at 72mg and dexamphetamine immediate-release (DEX Amp IR) at 20mg. The patient's initial doses of SSRIs and contraceptives were kept at minimal doses without dose adjustments. However, these results correlated with other studies which noted reduced response to psychostimulants during the luteal phase of menstrual cycle thus supporting evidence of improved symptoms when doses are increased. Such study results usually have limitations such as reliability, validity, and ability to generalize findings which might prompt further such studies..

Thozama Xhama is a Psychiatry Registrar at the Free State Psychiatry Complex (Bloemfontein), University of Free State. **Correspondence: thozamaxhama@gmail.com**

Improving outcomes for females with ADHD

SPEAKER: Jane Indergaard

Rosette Mamadi-Moshidi

The topic was presented by Dr Jane Indergaard who herself along with her daughter were diagnosed with ADHD later in life. This put her in a unique position to give both personal and professional insights into the topic. In the talk, she focused on the sex related differences in ADHD presentation, the impact of late diagnosis of ADHD in females as well as what can be done to improve outcomes of girls living with ADHD.

Rosette Mamadi-Moshidi

Dr Indergaard highlighted that the symptoms of ADHD often go unrecognized in girls because even though girls experience both inattention and hyperactivity these symptoms manifest differently in that their hyperactivity looks different. Girls are usually hyper verbal or have hyper relational behaviour and during adolescence they may also be hypersexual. Inattentiveness often appears as distractedness, disorganized behaviour and a lack of motivation. These symptoms are often attributed to behavioural problems such as laziness or just willful dismissal of tasks.

Girls with ADHD are often adept at masking their symptoms and internalising their feelings, which can lead to misdiagnosis of anxiety or depression. This is because ADHD is often not considered in the differential diagnosis. Research indicates that 50% of the time clinicians miss ADHD in girls. This is partly because the current criteria used to diagnose ADHD is biased against females. The research used to make the criteria is based on the male clinical population.

Dr Indergaard then remarked that teachers are referring boys more often than girls, because they tend to be more disruptive in classrooms, while the girls are overlooked because they usually do not show overt disruption. Teachers also often compare girls to the problematic boys, while parents are more likely to recognize the ADHD symptoms in girls because they compare girls to other girls. Girls are often high achievers because of their ability to mask their symptoms; this masking is often difficult and takes a toll on them, leading to the development of imposter syndrome, anxiety disorders and depression. All of this contributes to the frequent misdiagnosis of anxiety and depression. Girls are often treated for the mood disorder, however the treatment for the depression does not manage the disorganization and their feeling overwhelmed if there's underlying ADHD.

CONSEQUENCES OF LATE ADHD DIAGNOSIS IN FEMALES:

- Lost time and potential- they spend many years struggling, often without support.
- Emotional and mental trauma- stemming from years of blame, shame, and failure.
- Academic, financial, occupational, and relational difficulties.
- Increased suicidal attempts and completion.
- Riskier sexual behaviours.
- Increased BMI and other health problems.

Females compensate initially until the demand on executive functioning increases. This tends to happen when there's specific major life changes, for example the transition from teens to young adult. These transition periods tend to unmask unidentified ADHD. Women with ADHD are often disorganized, overwhelmed by everyday activities and struggle to manage their households. These patients tend to have parenting problems, especially those with children who also have ADHD.

Dr Indergaard also highlighted some of the health and lifestyle outcomes for untreated ADHD, some of which included substance use disorder, risky sexual behaviours, difficulties in the work force, as well as marital and other relational problems. Health concerns found included metabolic syndrome, self-harm, and suicide behaviours. There has been noted to be an improvement in the diagnosis of females with ADHD, with the CDC statistics showing that the prescription rates have increased to 700% among women aged 25 to 39 years of age and 560% in woman aged 30 to 34.

In her conclusion Dr Indegaard touched on the implications and actions to improve the outcomes of females with ADHAD. If clinicians and providers pick up the following symptoms, they should consider that the patient may have ADHD.

LOOK FOR GIRLS WHO:

- Have to repeat grades and are struggling academically
- Take longer to do homework.
- Have comorbid mood disorders, somatic complaints and even eating and sleeping complaints.

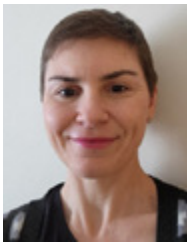
These girls may need screening for ADHD. Indicators of symptom masking such as over planning, obsessive list taking, and perfectionism should not be overlooked. For the hyperactivity, they should check for behavioural problems and conduct features. In conclusion, Dr Indergaard reminded us that success and academic achievement does not exclude ADHD, and she also reminded us that it is never too late to diagnose ADHD.

Rosette Mamadi-Moshidi is a 4th year psychiatry registrar at the University of Witwatersrand. **Correspondence: Rosette.mam@gmail.com**

The multidisciplinary team approach to school readiness and assessing for medication

SPEAKER: Androula Ladikos

Leigh-Ann Wood-Pottle



Leigh-Ann Wood-Pottle

A child's introduction to school is a crucial period in both their and their parent's lives. Each child's journey is an individual one and of vital importance to the family and community. The key to school readiness is normal early development. To assume there is a natural progression from pre-school to school is not entirely true.

There is no universal definition for school readiness. But whatever definition is used it should be not only based on academic achievement abilities. We need to see it as a measure of how prepared a child is to succeed cognitively, as well as socially and emotionally. A good level of development is when a child has reached the expected level in the prime areas of learning (personal, social, emotional, physical, communication and language). School readiness at age 5 has a strong impact on future educational attainment and chances in life.

Factors that influence positive development are a positive environment (both home and school). Those that negatively influence development are factors such as trauma (loss or personal rejection), poor nutrition, safety, infections and toxins, drug exposure, chronic stress or abuse and neglect. Birth to 5 years is a crucial period for development and a period where the most rapid development takes place. Not only is the development in this early period robust, but it is also when it is the most vulnerable.

WHY SHOULD WE SCREEN FOR SCHOOL READINESS?

Differences in children's abilities are noticeable prior to formal schooling. Thus, early intervention is key to improving not only academic achievements later but also quality of life. This is particularly true for language delays. Long term improvements in reading and maths decreases the likelihood of being retained in a grade. School completion and tertiary education are more likely when challenges are identified early.

WHO SHOULD BE PART OF THIS MULTIDISCIPLINARY TEAM?

Paediatricians, psychiatrists, occupational therapist, speech and language therapist, audiologist, psychologist, dietician, optometrist, social workers, community-based support, and teachers. This team can monitor physical and mental health as well as monitor and evaluate development.

The occupational therapist has the skills and training to identify developmental delays, identify sensory challenges and provide early therapeutic intervention. The speech and language therapists can screen language skills and assist with therapeutic intervention. The dietician can provide valuable information to parents about the value of good nutrition. The optometrist can screen for visual abnormalities. The educators can provide valuable information about the children in a group setting and how they interact socially. Social workers are needed to identify and address socio-economic factors and support families. All team members play a role in educating parents. It is important that the team shares a common vision.

There is a role for medication in pre-school aged children. However, it should only be considered once all other avenues have been assessed and tried. The key is an individualised, multimodal treatment approach which includes psychoeducation, pharmacological interventions, and non-pharmacological interventions.

Leigh-Ann Wood-Pottle is a Senior registrar at Stellenbosch University **Correspondence: woodpottle@sun.ac.za**

The Unreached: Eastern Cape Lessons

SPEAKER: Luzuko Magula

Nothando Shandu

Nothando Shandu

This talk delved into the complexities of diagnosing, treating, and supporting individuals with attention deficit hyperactivity disorder (ADHD), particularly in rural communities like the Eastern Cape. Our speaker, Dr. Luzuko Magula, a child and adolescent psychiatrist, and the current Head of the Child and Adolescent Unit at Fort England Hospital in Grahamstown shared his valuable expertise and insights. The talk explored the challenges of reaching patients with ADHD, the shortcomings in receiving and caring for these individuals, and highlighted lessons for improving diagnosis, treatment, and support. Dr. Magula drew on experiences from other initiatives and proposed recommendations for enhancing access to effective treatment, ultimately improving the lives of those affected by ADHD in rural communities."

BACKGROUND

The Eastern Cape is divided into eight municipal regions, namely: Sarah Baartman, OR Tambo, Joe Gqabi, Chris Hani, Amathole, Alfred Nzo, Nelson Mandela Bay and Buffalo City. Whilst most of these regions are predominately rural, Nelson Mandela Bay and Buffalo City are considered Metropolitan areas. Particularly, despite these areas being metropolitan, these two areas are densely populated, with 645 per people per square meter and 304 people per square meter, respectively. Whereas Sarah Baartman is the largest municipality covering approximately 58 245km^2, it has a sparse population of only 8 people per square. Furthermore, the scarcity in mental health care services is inadequate with only a sole psychiatric facility in Makana serving the entire region of Sarah Baartman, and similarly limited resources in Or Tambo, Buffalo City, and Nelson Mandela Municipalities.

Dr. Magula identified **several challenges** including:

- Late diagnosis: Many individuals remain undiagnosed until adulthood, often due to limited contact with mental health professionals.
- Lack of awareness and information: Insufficient knowledge about ADHD can lead to misdiagnosis and delayed interventions.
- Cultural and Societal beliefs: Stigmatizing beliefs, such as labeling individuals with ADHD as "the naughty child" or "disrespectful," can hinder acceptance of the diagnosis and seeking help
- Resource scarcity: Limited access to trained professionals who can identify, diagnose, and treat ADHD hinders early identification and appropriate management.
- Long waiting times: Families face long waiting periods for access to psychiatrists or child and adolescent psychiatrists, further delaying necessary care.
- Financial barriers: Cost of diagnosis and therapy (medication and specialized educational programs) can be expensive for some individuals

IN SUMMARY

- The Multidisciplinary teams involving parents is crucial for managing ADHD symptoms and improving academic outcomes.
- Understanding cultural context is vital to tailor interventions to local beliefs thus improving engagement and outcomes.
- Having community-based interventions engaging families, teachers and community leaders can raise awareness and reduce stigma.
- Developing low- costs groups such as grandparents' and parents' groups can provide support and care.

Some **key takeaways** from this talk:

- The importance of early identification and intervention
- The need for increased awareness and education.
- The impact of culture and society on ADHD diagnosis and treatment
- The critical role of access to trained professionals and resources,

A holistic approach, involving multiple stakeholders is important for effective management of ADHD.

Nothando Shandu is a 4th year psychiatry registrar at the University of Witwatersrand. **Correspondence: nothando.shandu@gmail.com**

Dyslexia, the quiet complicator

SPEAKER: Elizma van Milligen

Thozama Xhama

Thozama Xhama

This session was conducted by Elizma van Milligen, a paediatric optometrist with a special interest in behavioural optometry and learning disorders, focusing on dyslexia. The session aimed to discuss the link between ADHD and dyslexia, which are two commonly diagnosed neurodevelopmental disorders in the paediatric population. She noted that emerging research has revealed a significant overlap between these two conditions, which affects both learning and behaviour. It is estimated that there is a bidirectional relationship regarding the diagnosis of these two conditions accounting for 25% to 40% of children diagnosed with dyslexia meeting the criteria for ADHD diagnosis and vice versa. In addition, the risk of developing these conditions is linked to a common genetic predisposition. Dyslexia affects one in five children, both males and females in a similar pattern and has familial occurrences.

The neuro-imaging studies have revealed atypical brain structure and functions in both conditions, an example being similar abnormalities in the frontal lobe, which is responsible for the executive functions of the brain. The two conditions were reported to have similar symptomatology, which included inattention, poor concentration, and learning difficulties, which can result in challenges concerning differential diagnosis. The speaker noted that when healthy children are exposed to a particular language through talking to them or around them, they will learn to speak that language. However, reading to a child or with the child will not automatically mean that this child can read because the brain has to be programmmed in order function in a way which enabeles the individual to read.

Many regions in the brain are responsible for reading. However, dyslexic children depend mainly on the right side of the brain within the Broca's areas and inferior frontal gyrus which are responsible for articulation and word analysis. However, this area is overactive in these children, resulting in them having slower and laborious reading patterns. There are three main types of dyslexia, dysnemkinesia, dyseidesia, and dysphonesia. The individuals may have any combination of these three types, thus yielding seven subtypes. An individual who has dysnemkinesia writes words and numbers in reversed format and are classified as motoric dyslexia. The dyseidesia cannot identify sight words within two seconds and recognise simple trigger words. These children rely heavily on phonetic reading and spelling they would spell words like "position" as "pozishun". Lastly, the dyphonesia type is unable to match sounds and symbols and has difficulties with syllabication and order of sounds in words.

Dyslexic children are often referred to as being visually deaf as they can see the word but are unable to hear it and auditory blind as they can hear a word but cannot see it. It is advised that screening for all barriers to learning should be addressed before referring children for dyslexia testing. Such children should undergo visual and hearing screening tests, including IQ tests, to assess for other neurodevelopmental disorders affecting reading and writing. Currently, there are two tests for dyslexia, which include junior testing for grade 0 to grade 2 and formal diagnostic testing for grade 3 to adults using the Stark Griffin Dyslexia Assessment. The interventions include therapy with occupational therapy, brain scan rewiring with neuroplasticity, an individual support plan for classroom accommodation and teacher support, and educational psychologist reports for accommodation and concessions. Early identification and intervention by parents and teachers yield better outcomes and good prognoses.

Thozama Xhama is a Psychiatry Registrar at the Free State Psychiatry Complex (Bloemfontein), University of Free State. **Correspondence: thozamaxhama@gmail.com**

New guidelines for the management of ADHD

SPEAKER: Brendan Belsham

Moroko Moipone Mojela

Moroko Moipone Mojela

The special interest group for ADHD, established in 2015 was tasked with updating the guidelines for the management of ADHD that were initially published by Flischer and Hawkridge in 2013. The team was led by Dr Linda Kelly and Dr Brendan Belsham, assisted by Prof Renata Schoeman. Input was also received from various organizations such as the child and adolescent psychiatry special interest group (CAPSIG), the paediatric neurology and development association of southern Africa (PANDA-SA) and were also sent to SASOP and PsychMg for further review and endorsement. The guidelines are currently under review for publication in the South African Journal of Psychiatry (SAJP). The development of these guidelines was conducted independently from any influence of pharmaceutical companies.

The guidelines cover key aspects like ADHD diagnosis, comorbid conditions, as well as pharmacological and non-pharmacological management approaches. They provide detailed processes for making a diagnosis based on DSM 5 criteria and identify appropriate diagnosticians, such as child psychiatrists. The limited availability of specialized professionals in our South African setting is acknowledged, and the role of general practitioners with a special interest in bridging this gap is thus highlighted. Although emphasis is made on ADHD being a clinical diagnosis, the role of various rating scales in screening for and monitoring ADHD symptoms is discussed.

Discussions within the guidelines include various comorbidities like oppositional defiant disorder, autism spectrum disorder, learning disorders, epilepsy, and the newly recognized excessive digital media use disorder (EDMU), which is noted for its bidirectional relationship with ADHD. Dr. Belsham discussed this interaction, referencing Thorn et al., 2022, emphasizing the importance of addressing comorbidities which often clarify diagnostic ambiguities when treated, as the comorbidities are often also differentials of ADHD.

In accordance with most literature, the guidelines reiterate that “medication remains the cornerstone of treatment for most children and adolescents with ADHD”. The guidelines do not offer a strict algorithm pathway, and clinicians are encouraged to “use different recipes for different patients”. Newly available medications in South Africa, such as amphetamines, are included and specific details about lisdexamfetamine and dexamfetamine sulphate are provided in a comparative table discussing their actions, dosages, and effectiveness. The selection between methylphenidate and amphetamines should consider various factors, including availability and individual comorbidities. Most non-pharmacological treatment options including exercise, brain stimulation, diet and complementary and alternative medicine unfortunately lack evidence base support.

The role of various allied professionals in managing developmental difficulties is addressed in the guidelines. In transitioning from adolescent care to adult care, the guidelines suggest a gradual transitioning, with a period of parallel care, which involves continuing with a new doctor while still being seen by the previous doctor to facilitate continuity of care.

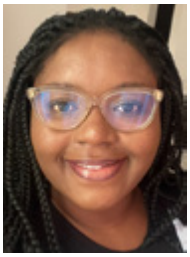
Although the guidelines are ideal and gold standard, in South Africa, they should be used only as a guide, and not strict protocols. They should be evaluated against other international standards and adapted to fit local contexts in South Africa and similar environments where optimal conditions may not be practical.

Moroko Moipone Mojela is a final year registrar at the University of Limpopo, currently stationed at Mankweng Hospital. **Correspondence: moipone.mojela@gmail.com**

Mothering with ADHD

SPEAKER: Gina Rencken

Rosette Mamadi-Moshidi



Rosette Mamadi-Moshidi

This presentation was given by Mrs Gina Rencken who is an occupational therapist. Her talk was focused on ADHD in the post-partum period and raising children from the perspective of a mother with ADHD.

Pregnancy is a significant adjustment period, more so for women with ADHD. Their pregnancies are often unplanned, and they tend to carry a level of guilt and concern that they may have done something that may harm their baby or that they will forget to do something important during the pregnancy. Mrs Rencken highlighted the fact that women with ADHD often must decide on whether to continue their medication or not, which they should discuss with their treatment team. A Danish cohort has done a study that showed that babies born to mothers who have ADHD and took their treatment throughout pregnancy have no neurodevelopmental and growth differences when compared to the infants whose mothers did not take their ADHD treatment.

Mrs Rencken highlighted the sensory and executive function challenges that pregnant moms often face that prevent them from being able to do activities that they could previously do.

SOME OF THE SENSORY CHALLENGES EXPERIENCED INCLUDE CHALLENGES IN THE FOLLOWING SYSTEMS:

Tactile system-They often get tactile hypersensitivity, leading them to be uncomfortable in certain clothes.

Olfactory system - heightened sensitivity to smells.

Gustatory system- specific food cravings and aversions that are different to how they were prior to pregnancy.

There are usually slight changes to visual and auditory system, however some people do get sensitive to loud sounds and the light.

The executive functioning challenges that are most common in females with ADHD were explored. These included planning, self control, memory, initiation and monitoring, emotional and inhibitory control.

In the post-partum period, the sensory reactivity and perception is significantly influenced by hormones. Sleep disturbances and interruptions have a significant impact on women's sensory systems, making them more reactive. Often the executive functioning challenges persist or even worsen causing moms to not be able to appropriately care for their children. Mrs Rencken then gave a quick breakdown of what needs to be done for these mothers when they are seen on follow up. She detailed the assessments that need to be done, such as the adult and adolescent sensory history and the adult sensory measures. These give an idea of the mother's sensory reactivity, perception and how she uses that to function. Depending on the level of dysfunction more tests such as the functional capacity evaluation may be needed.

Mrs Rencken further discussed the availability of literature on the impact of stimulant use in pregnancy. Literature, although limited, shows that stimulant use in pregnancy is safe, however there are subtle differences in these babies, and they need neonatal neurological exam. She recommended the neonatal behavioural assessment scale which gives you an idea of the baby's functioning and behaviour outside the uterus, which affects their overall development. These assessments can also be used to educate the mothers how to read their babies' arousal levels and cues.

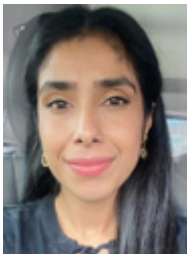
To conclude the talk, she spoke on the executive functioning support and sensory support for mothers as well as their ADHD treatment. She suggested ways to help mothers manage their sensory difficulties, which are unique to each mom. Mothers are also taught how to regulate themselves and their children.

Rosette Mamadi-Moshidi is a 4th year psychiatry registrar at the University of Witwatersrand. **Correspondence: Rosette.mam@gmail.com**

Internet addiction

SPEAKER: Wisani Makhomisane

Lisha Narayan



Lisha Narayan

Behavioural addiction involves things people do. In the Diagnostic and Statistical Manual of Mental Disorders (DSM) 5, *internet gaming disorder*, is noted as a behavioural addiction, and a condition for further study. It involves pre-occupation with gaming; withdrawal; unsuccessful attempts to stop; excessive time spent on gaming and deception regarding the amount of time spent.

There is a question if terming it an addiction may be too strong, as it may be pathologizing human behaviour. There is a lack of consensus if terminology should state the problem as pathological internet use or internet addiction. Additionally, unlike substances, there is a question about how fast the internet reaches the brain.

The sub-types of internet addiction considered are *online gambling disorder, online video gaming addiction, social media misuse, internet pornography, compulsive online shopping, and smart phone dependence.*

Previous research on the topic is noted to start from around 1995 by Goldberg, who recognised dependence on the network as a pathological, obsessive-compulsive disorder which drives a person to overuse technology. Major recent research is noted to come from South Korea.

Silicon Valley is a global centre of technological innovation located in California, in the United States of America. It is one of the wealthiest regions in the world. Silicon Valley is home to many technology, software and internet companies, including Apple, Google, Meta and Visa. They are known as behaviour architects, persuasive designers or user-experience specialists as they design our urge to keep using technology. Tech companies use the intermittent variable reward schedule, the most addictive reward schedule.

Risk factors for internet addiction include ADHD, hostility, withdrawal, anxiety, depression, parent-child conflict, not living with a mother and use of the internet to play games. The symptoms of ADHD may make those affected more vulnerable to internet addiction. These symptoms include inattention, impulsivity, time blindness, emotional dysregulation, social anxiety, choice paralysis, sleep disturbances, addictive behaviours and distractibility.

There however may also be a positive side of digital technology for those with ADHD. They may use certain applications to assist with storing, organising, planning and timing work and activities.

Regarding treatment of internet addiction, prevention may be important. This may include limiting time spent on technology, considering the child's age. From birth to 3 years old there should be no screen time; from age 3 to 6 years old 1 hour a day; from 6 to 9 years old 2 hours a day and supervised; from 9 to 12 years old to consider with the child the type of content consumed and from age 12 to employ a digital diet and monitor digital logs. Psychoeducation about how technology influences mental health is important. It is also important to consider possible co-morbidity with someone with internet addiction, including ADHD, anxiety and depression. Pharmacological management of these conditions are important.

It has been over 30 years since the term internet addiction was coined however there is still limited consensus about it being a formal disorder. There is consideration whether this is by design so as not to limit use of technology. Multidisciplinary teams need to know about the techniques employed by the 'Silicon Valley' to psycho-educate patients that nothing on the internet is by chance.

Lisha Narayan Department of Psychiatry, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa. **Corresponcence: lishanarayan20@gmail.com**

Hypoxic-Ischaemic brain injury and other insults that can manifest as ADHD

SPEAKER: Shalendra Misser

Phatheka Ntaba

Phatheka Ntaba

The speaker spoke about his research on MRI and Hypoxic ischaemic injury. He described basic patterns hypoxic injuries found on emerging, their timing and the structures involved. The subtypes described are acute profound ischemia, partial prolonged ischemia, mixed injury, type 1 cystic encephalomalacia, type 2 cystic encephalomalacia. He explained that hypoxic injury affects the flow of Tumour necrosis factor and glutamate which leads to necroptosis and apoptosis. He described that the brain uses autoregulation to try to protect itself from hypoxic injuries however if the hypoxia occurs quickly then it is unable to protect itself. The brain tries to protect the high metabolic rate areas such as the basal ganglia and the midbrain to name a few at the expense of the cortex which is under perfused in hypoxia. He then showed images showing the types of hypoxic injuries to these areas which often leads to cerebral palsy.

He also noticed a new hypoxic injury that was not discussed before at the paracentral lobule in the supplementary motor area and published that article. They graded the injury to Mild, Moderate, severe and massive paramedian (associated with prolonged 2nd stage of labour) and came up with a new classification system. He also looked at the watershed areas hypoxic injury and also developed another classification system. They also found a biomarker which was the Thalamus l-sign for prolonged hypoxic injury or hypoglycaemia. Another area he did research on was on neuroquantification where he used AI to read scans, where the AI was able to determine the pattern of hypoxic injury.

OUTCOMES OF HYPOXIC INJURY

Hypoxic injury can lead to cerebral atrophy, cognitive impairments, speech and language delays, learning disabilities, behavioural and emotional disorders, seizure disorders, sensory impairments, motor skills impairments, autism spectrum disorders, feeeding and swallowing difficulties. In one of the studies they showed that disability from hypoxic injury might appear to be mild at age 2 but later worsen during school ages.

ADHD BRAIN SCANS

The studies showed that not all ADHD cases are the same. A child might have other psychiatric conditions associated. Neuroimaging shows that children with ADHD have smaller structural indices than controls. Areas of interests are the ventricles, corpus collosum, white matter, gray matter, hyppocumpus, cerebellum,brainstem and other structures. Children with leucomalacia can present with ADHD later on in life. A child with subclinical seizures presented with ADHD symptoms and a scan showed thining of the corpus collusum. The other child who had aggression and ADHD symptoms also showed Corpus collosum abnormalities. ASD also had some corpus collosum injuries on MRI. Studies on diffusion studies found that children with ADHD are wired differently. They found consistant decreased volume of the right caudate nucleus. On functional MRI they found pronounced dysfuncton in the lateral frontal region (hypofrontality). The cerebellum was also mentioned in the functional MRI study. In another study using functional MRI the prefontal cortex and globus palidus showed abnormal activity.

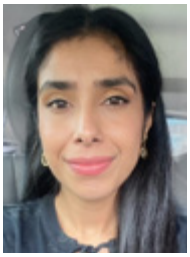
There was a neuroquantification study using AI that showed that radiomic-based classification models provided discrimination of patients with ADHD as well as differentiating the two subtypes.

Phatheka Ntaba is a Senior registrar from the University of Kwazulu-Natal. **Correspondence: phathekantaba@gmail.com**

Pornography in teenagers and adults

SPEAKER: Linda Kelly

Lisha Narayan



Lisha Narayan

The symptoms of ADHD may result in lower relational satisfaction, impaired quality of romantic relationships, higher rates of separation or divorce and increased risk of intimate partner violence. Although ADHD has no direct influence on individual development and sexual maturation, evidence of psychological development of sexual identity and functions. Hypersexuality is a frequently occurring co-morbidity in ADHD. Impulsivity, hypersexuality and inattention may be related to sensation seeking and difficulty tolerating boredom. Some findings suggest that sexual activities may serve as a mood altering 'self-medication' process in some individuals with ADHD. The proposed mechanism is thought to be reward deficiency that is typical of ADHD. It is also related to addictive impulsive, compulsive and risky sexual behaviour.

Hypersexual behaviour was considered for the DSM-5 but rejected due to lack of empirical evidence. It is conceptualised as a sexual desire disorder characterised by increasing frequency and intensity of sexually motivated fantasies, arousal urges and enacted behaviour. Compulsive sexual behaviour disorder (CBSD) is proposed in ICD-11 as an impulse control disorder.

A highly prevalent form of compulsive sexual behaviour in ADHD is problematic internet pornography use. Emotional dysregulation, sensation seeking, impulsivity and poor self-control capacity in ADHD predisposes individuals to impairments in intimate relationships and risky sexual behaviours. Factors that may increase the likelihood of exposure to negative peer groups and risky situations includes academic impairment, family conflict, low involvement in school and decreased parental involvement. Some studies show that individuals with ADHD report increased sexual desire, higher masturbation frequency and lower sexual satisfaction. Development of sexual identity is a major process of transition mainly established during adolescence. There has been a noted increase in online pornography consumption in pre-adolescents and adolescents. This may be unmonitored due to unlimited access to material on the internet. Many young people may learn about sex from the internet and internet pornography frequently distorts normal sexual boundaries and behaviours. This may result in an increase in sexual aggression and violence, decrease in social interaction and bonding and increase in delinquency, depressive symptoms, and emotional maladjustment.

During clinical assessment a detailed clinical interview should be conducted including pattern, extent, consequences and impairments related to pornography use. Additionally psychiatric and medical comorbidities should be identified, and a biopsychosocial formulation will provide information about factors impacting pornography use. Available rating scales can be used to assess problematic use.

An approach to management should include normalising the sensitivity of pornography to minimise shame; having a non-judgmental attitude; supportive guidance to establish sexual boundaries, safety and trust; psychoeducation; and inclusion of family members in treatment by education surrounding manging device usage. Non-pharmacological treatment includes individual, and school based cognitive behavioural therapy, motivational interviewing, reality testing and multimodal psychotherapy.

Methylphenidate is the agent of choice for comorbid ADHD and internet gaming addiction *("Internet Gaming Disorder" DSM-5).* Preventative strategies include open communication between parents and adolescents regarding internet use and sexual behaviour; promotion of school-based and family-based programs for education and prevention; filtering devices by parents and changes in governmental policies and laws regarding internet pornography.

With regards to adult pornography consumption and ADHD, there is evidence for a high rate of ADHD in men with hypersexuality with noted rates between 17 -19%. There are limited studies about management in adults. Treatment approaches identified cognitive behavioural therapy, 12 step programs, experiential therapy and pharmacological treatments like SSRIs and stimulants. There is limited literature on treatments for women, sexual minorities and treatment of ADHD and problematic internet pornography use.

Lisha Narayan Department of Psychiatry, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa. **Corresponcence: lishanarayan20@gmail.com**

From Haemoglobin to playgrounds

SPEAKER: Nerica Ramsundhar

Phatheka Ntaba

Phatheka Ntaba

A quarter of the world's population has anaemia and the greatest burden is on females of reproductive age, pregnancy and children of 6 months to 5 years. Iron deficiency is the commonest cause of anaemia. Stats from 2021 showed that Sub Saharan African had the majority of cases. The brain usually becomes iron deficient before the onset of anaemia. The iron deficiency in the brain causes the neurodevelopmental impacts. Our focus should be on the impact not on the deficiency.

A study showed that iron deficiency in neonates can lead to poor immediate recall, delayed recall and slower working memory later in children aged 3.5 years. Facilitating memory tasks improved outcomes. The critical periods of iron deficiency in studies are neonates to infants produce long lasting irreversible neurocognitive effects that progress to adulthood. Neuroimaging has shown decreased myelination and poor development of the basal ganglia which leads to psychomotor dysfunction in screening tools. Those with iron deficiency in infancy had lower IQ scores in studies.

IRON DEFICIENCY (ID) AND AUTISM

ID is common with eating disorders in ASD. ASD with iron deficiency leads to more severe ASD. Prenatal reduced iron intake is linked with high risk of developing ASD. ASD and sleep disorders improve with iron supplementation leading to better quality of sleep. ASD and irritability improved with iron supplementation. Always do iron studies in ASD.

ID AND ADHD

Iron deficiency doesn't cause ADHD according to DSM-5 it is a common comorbidity. Those with sleep disorders have a higher risk of iron deficiency. Anaemia reduces efficacy of psychotropic medication. In patients who have both ID and ADHD they tend to have severe symptoms of ADHD. Iron profile must be done in children with ADHD.

PREVENTION STRATEGIES

- Iron supplementation and monitoring iron in pregnancy
- Delayed cord clamping
- Use of ferritin as a marker of iron status
- Screening and management at 6 months to six years
- Fortification of foods
- Developmental screening at all well baby clinic visits

Phatheka Ntaba is a Senior registrar from the University of Kwazulu-Natal. **Correspondence: phathekantaba@gmail.com**

Neurological outcomes associated with elective caesarean section

SPEAKER: Andre Van Niekerk

Phatheka Ntaba

Caesarean section deliveries have become more common than before. Studies showed an increase from 6% in 1990 to 19% in 2014. Some of the highest rate of C/Ss were in South America and Egypt >50% and lowest in Northern Europe at <20%. In the SA private sector, we have up 90% C/Ss. This translated to more ICU admissions for the neonates at around 20% in 1 hospital. NICUs predispose babies to more adverse side effects. It has been observed that most of the babies were born preterm without any real indications. They stressed that foetal pulmonary maturity doesn't equate to foetal maturity. The long-term effects were lower performance scored on cognitive tests and educational measures compared to full term babies. There is a move to try to reduce the high caesarean section rates especially avoiding nonmedical early term deliveries (37-39 weeks). There were more risks to the baby in elective c-sections than those who had a c-section while in labour. The 1st C-section has multiple ripple effects on the mother and the child.

C-SECTION AND IMMUNITY

A study on C-section birth and the immune system showed that there was a link. There were increased odds of having asthma and immune deficiencies in younger children. C-sections can also affect the neurodevelopmental outcomes.

GESTATIONAL AGE AT DELIVERY

In a study looking at gestational age and special educational needs it showed that the earlier the birth was the more likely that the children will need special education. Children born at > 39 weeks -41 weeks showed increased cognitive scores compared to children born earlier.

METHODS OF BIRTH

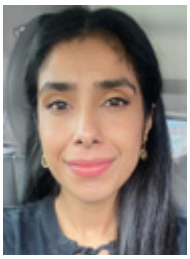
In a large systematic review, it was found that children born by C-section had increased odds of ASD and ADHD. In a cohort study they found that ASD was increased in those who had an elective C-sections (20% more likely than vaginal deliveries) when not controlling for confounders such as genetics. In South Africa there is lack of reporting in the private sector. There was a study that also showed that in mice delivered by C-section there was more cell death than in those born normally. Multiple factors which include C-section, gestational age and ICU stays increases the risk of ADHD.

Phatheka Ntaba is a Senior registrar from the University of Kwazulu-Natal. **Correspondence: phathekantaba@gmail.com**

Online communities – the pros and cons

SPEAKER: Hugo Theron

Lisha Narayan



Lisha Narayan

Evidence-based studies highlight that ADHD presents unique challenges that require a multidisciplinary approach involving healthcare, education and community-based support systems. Due to resource constraints in the Southern African region, accessing specialised ADHD care can be a challenge. This makes integrated care and a collaborative interdisciplinary team approach even more critical. Where people face limited access to specialised ADHD care, online communities can serve a valuable resource.

THE PROS OF ONLINE COMMUNITIES

Online communities provide access to information on ADHD, research updates and curious coping strategies which may be difficult to access otherwise, especially in rural and underserviced areas. It affords the opportunity for family and those with ADHD to educate themselves about it. Some online communities have professional input from experts who offer advice and guidance. People with ADHD may often feel isolated in their experiences and online communities offer a space where they can connect with others who understand their challenges and share similar experiences. This can help reduce the stigma. Peer support is important and can sometimes come from these online communities. Personalised support and subgroup communities can offer tailored tools and support to those affected. Furthermore, professionals involved in the management of ADHD can access information for continued education as well as using online platforms to collaborate with each other.

THE CONS OF ONLINE COMMUNITIES

Not all information shared online is accurate or verified. Some online users may offer advice that could be harmful or inappropriate which could lead to people trying potentially dangerous approaches. Overreliance on online communities for advice can lead to limited professional input or even bypassing evidence-based treatments. Users may also seek out specific information and communities that validate their own experiences or beliefs which could hinder adoption of more evidence based effective strategies. While some communities are supportive, others may have members who engage in toxic behaviours such as cyber bullying, negativity or shaming. This may happen especially in unmoderated spaces. Individuals already struggling with anxiety or low self-esteem, being a part of an overly critical and hostile community may worsen their mental health. Furthermore, there is a risk that personal and sensitive information may be misused or accessed by unintended parties. Online communities often have vast amounts of information, that might lead some to feeling overwhelmed, particularly individuals with ADHD who already struggle with attention and focus. The online environment itself can become a source of distraction, leading to procrastination and task avoidance.

Given the pros and cons of online communities, a balance needs to be struck to navigate them safely and effectively. It is important to verify information by cross checking with reliable sources or consult with professionals when it comes to medical advice or treatment recommendations. Communities that are well moderated with professional input should be chosen. Be mindful of the platforms' privacy settings and avoid sharing too much personal information. There should be a limitation on the time spent on online communities to avoid distraction and procrastination. Tools like timers and social media breaks can help stay focused on real world priorities. Users should be encouraged to seek support from both online and offline communities if possible. Real-life connections and face-to face consultations with professionals are essential for a well-rounded support system. There should be advocacy for professional and peer support group collaboration and moderation of online communities.

Lisha Narayan Department of Psychiatry, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa. **Corresponcence: lishanarayan20@gmail.com**

The myths and factors regarding ADHD, autism and ADHD

SPEAKER: Merryn Young

Kirsten Rowe

Kirsten Rowe

There are a number of common myths that exist when it comes to the comorbidity of attention-deficit/hyperactivity disorder (ADHD) and autism spectrum disorder (ASD). In editions of the DSM prior to DSM-5, ADHD could not be diagnosed simultaneously with ASD, however we now know that the comorbidity is common. They also have a number of shared features. They are both neurodevelopmental conditions with childhood onset. They have some overlapping risk factors (e.g. complicated pregnancy and birth) and early signals (e.g. self-regulation difficulties).

The second myth is that it is easy to diagnose ADHD and ASD. In fact, it is challenging to diagnose them. There are multiple possible combinations of symptoms that can all meet diagnostic criteria for these conditions; 116220 possible combinations of symptoms can meet criteria for ADHD. They are both heterogenous conditions. This may complicate the assessment and diagnosis of these conditions.

The third myth is that it is easy to distinguish ADHD from ASD. In reality, although the core symptoms differ, they may both present with challenging behaviour, difficulties in social interactions and heightened sensory responses. They may also have similar neuropsychological profiles. Children with both of these conditions have similar pragmatic language difficulties. Children with ADHD may also have certain socio-emotional difficulties with social perspective taking, emotion recognition, and social communication. They may also both have executive functioning deficits, although sometimes with differences in which subtypes are affected. They may also both experience obsessive-compulsive traits, special interests and hyperfocus, enhanced creativity, masking of symptoms, and higher rates of comorbid depressive, anxiety, eating, sleep-wake and substance use disorders. Care needs to be taken to ensure the validity of measures used to assess ASD in those with ADHD as there may be greater rates of missed or incorrect diagnoses.

The fourth myth is that having the two disorders occurring comorbidly does not result in additional morbidity or disability. In fact, the whole is greater than the sum of the two parts with greater emergent morbidity from the combination of these two conditions. Dual diagnosis is associated with higher rates of impairment, greater severity of psychosocial difficulties, decreased quality of life, lower adaptive functioning, greater cognitive deficits, and poorer response to standard treatment.

The final myth is that the treatment of ADHD is the same no matter whether or not there is comorbid ASD. Atypical brains may respond atypically to medications. In reality, there are often lower response rates to stimulants for ADHD symptoms in patients with ASD compared to those with ADHD alone, and a greater susceptibility to adverse effects. Methylphenidate use has been associated with some positive social outcomes including improved initiation of joint attention, improved response to bids for joint attention and self-regulation. Atomoxetine has better tolerability but lower response rates. Risperidone may help for hyperactivity. Alpha-2-agonists may help for impulsivity. There is limited literature on psychosocial interventions for those with comorbid ADHD and ASD. There are, however, similarities in the approaches to treating both disorders. Many studies have stressed the importance of combining psychosocial interventions with medications. Multidisciplinary team involvement is essential and families may need additional support.

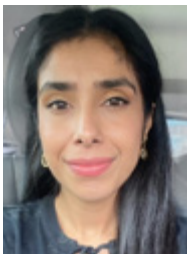
Kirsten Rowe Chief Psychiatry Registrar, Department of Psychiatry, University of Stellenbosch, Cape Town, South Africa. **Correspondence: kirstenrowe@gmail.com**

The overlap of substance misuse, ADHD and other health issues

SPEAKER: Jason Kilmer

Lisha Narayan

Alcohol related risk factors for suicide identified by Hufford (2001) include distal risk factors which are relatively stable characteristics occurring in the time preceding suicidal behaviour and proximal factors which are variables that increase suicide risk in moments immediately before suicide behaviour. Examples of d**istal risk factors** include *alcohol dependence, co-morbid psychopathology* and *negative life events* such as interpersonal loss. **Proximal risk factors** include *suicide behaviour during alcohol intoxication, psychological distress, aggression and constricted thinking.* Constricted thinking is also known as alcohol myopia, which describes how alcohol impairs information processing, narrowing attention to the most salient internal and environmental cues. It can also interfere with inhibition conflict, leading to more excessive responses than would have occurred while sober. Acute intoxication with alcohol increased the risk of suicide greater than habitual alcohol use. Given the above, alcohol prevention can be suicide prevention.



Lisha Narayan

Cannabis use is associated with a risk of psychiatric disorders. Those who used cannabis ten times by age 18 were 2-3 times more likely to be diagnosed with schizophrenia. 13% of schizophrenia cases could be averted if cannabis use was prevented. Depression and suicide require attention in those who are cannabis dependent.

It is important to consider motives for substance use that could exacerbate unwanted symptoms. Substance use can be related to sleep quality and have subsequent unwanted outcomes such as next day increase in daytime sleepiness, anxiety, irritability and jumpiness. Cannabis has effects on cognitive abilities. The hippocampus may be affected resulting in issues with attention, concentration and memory. The use of high potency cannabis is associated with increased risk of developing cannabis use disorder or addiction especially among adolescents. It is also associated with increased risk of psychosis and generalised anxiety disorder.

There are several noted motivations for cannabis use including enjoyment, conformity, experimentation, social enhancement, relaxation, coping, activity enhancement, rebellion, food enhancement, anxiety reduction and medical use.

There should be caution regarding individuals who state they want to use cannabis for medical purposes such as for anxiety, depressed mood and sleep difficulties. **The only noted benefits for medical cannabis use** are for *neuropathic pain, palliative and end-of-life pain, chemotherapy induced nausea and vomiting, and spasticity due to multiple sclerosis and spinal cord injury.* And this is only after traditional medical therapies were tried first. Symptoms of cannabis withdrawal overlap with motivation of use, including anxiety, sleep difficulty, decreased appetite and depressed mood.

Approach to management should include screening to assess use, severity and risk. Brief interventions should be employed such as motivational intervention to prompt contemplation of or commitment to change. Subsequently there should be referral to speciality care. Motivational interviewing techniques that should be employed including asking open ended questions. It is important to note that when you address substance use you address mental health and vice versa.

Lisha Narayan Department of Psychiatry, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa. **Corresponcence: lishanarayan20@gmail.com**

Maternal and obstetric risk factors for ADHD and other psychiatric conditions

SPEAKER: Nadya Frank

Phatheka Ntaba

Phatheka Ntaba

Environmental factors (infections, obesity, gestational diabetes, hypertension and substance use etc.) before birth and during the early days can lead to poor health outcomes later in life. The maternal gut microbiome can also affect the developing foetus. By age 6 the brain has developed up to 95% of its adult brain and is fully developed by age 25. The plasticity of the brain makes it vulnerable to environmental factors leading to neurodevelopmental disorders.

MATERNAL FACTORS

South Africa has a very high number of obese pregnant women which increases obstetric complications to the mother and developing foetus. Obesity can also cause poor mental health in pregnant women. Pregnancy increases insulin resistance. Diabetes in pregnancy can cause multiple problems including inflammation in the foetus resulting in brain changes that can lead to neurodevelopmental disorders. There was a high risk of ADHD in mothers who had gestational diabetes. Neurodevelopmental disorders were higher in the children of women with gestational hypertension and preeclampsia.

ADHD is a highly heritable condition. Maternal stress leads to high cortisol and changes in microbiome and leads to poor brain development in the foetus. Prenatal and postnatal depression also has been linked to ADHD and other neurodevelopmental disorders. Preterm labour and low birth weight can affect brain development and predispose the infants to other insults such as infections. Preterm labour was found to increase the chances of being diagnosed with ADHD in childhood.

Being born by Caesarean section has been linked to ADHD at a rate of 11% due to increased HPA axis activation in the neonate and the anaesthetic exposure at birth. Caesarean sections are higher in women with metabolic syndrome which adds to the overall risk of children developing ADHD .

Prenatal maternal alcohol use and other substances can result in neurodevelopmental disorders such as foetal alcohol syndrome which is linked to a high risk of ADHD. Smoking can result in foetal chronic hypoxia and brain damage. Smoking can also increase the chances of developing ADHD directly and indirectly.

FOETAL FACTORS

Congenital heart disease, low birth weight, low APGARS < 7 at 5mins and not breast feeding was associated with ADHD.

PREVENTION AND RISK REDUCTION

Contraception and abstinence would prevent many of these complications as there are many unplanned pregnancies. Counselling women before pregnancy about a healthy lifestyle, diet, exercise and drug use is also important. Maternal mental health needs to be promoted and medical conditions need to be prevented and treated early. Treating infections, promoting natural births at term can also help. Breast feeding needs to be promoted.

Phatheka Ntaba is a Senior registrar from the University of Kwazulu-Natal. **Correspondence: phathekantaba@gmail.com**

Parent support in neurodiversity including ADHD

SPEAKER: Juazel de Villiers

Kirsten Rowe

Kirsten Rowe

A child's unique profile, skills, and environmental support affect their behaviour. The child is part of larger systems e.g. family, community. The team supporting the child with ADHD includes various health and educational professionals, and caregivers. Parents need to be equipped with knowledge and practise applying it.

Parental involvement is one of the biggest predictors of children's academic success. Parents of neurodiverse children often have lower rates of parental efficacy. The principles we need to teach parents are: talk to and listen to your children; share your ambitions; be emotionally warm; teach your children letters and numbers; take them on excursions; read to them daily and encourage them to read for pleasure; have a regular bedtime.

Validate and encourage parents. After the diagnosis, parents may undergo a grieving process. They need support and empowerment. Teach parents about the child's neurological profile, equip them with skills in supporting and parenting their child, and advocating for and accessing the right support system for their child. Promote a strengths-based approach. Highlight ways the parents can assist the child to grow, thrive, and encourage positive identity development. Acknowledge and respect the parents' experience and process. Involve parents in the children's appointments where possible.

When discussing the diagnosis, choose your words carefully. Partner with parents during the discussion. Set a positive, warm tone. Express empathy. Be honest and hopeful. Consider how the interventions are presented in terms of cost, impact and motivation. Consider intersectionality, including their past experiences, cultural beliefs etc. Address the caregivers' support needs.

There are multiple needs within the family system. Include siblings when possible. Recognise and validate them. Assist siblings to be part of the therapeutic supports where possible. Encourage engagement and quality time. Siblings may need additional social support. They may have subthreshold ADHD symptoms themselves.

Explain neurodivergence to families in a simple way by explaining that everyone has a unique brain; the role of the brain in thinking, feeling and doing; everyone's brain has strengths and things it finds difficult; everyone thinks, feels and does things differently.

Introduce visual supports to families including visual schedules. Parents need to teach their child to self-regulate through first co-regulating with them. Energy accounting, through balancing activities that drain energy and those that energise us, is another useful concept to teach parents and families about. We need to ensure we are doing enough things that energise and replenish us. We can also assist families through helping them build a toolbox for each family member, including photos, key words, strategy reminders etc. Introduce families to the concept of sensory tools e.g. chewing.

Finally, it is useful to teach parents that behaviour is a form of communication. Your response to behaviour depends on your understanding of it. Every child does the best that they can given the situation and their current abilities to deal with it. If the child is not doing their best, they may not understand what is expected or not be able to meet the expectations. Parents can first modify the demands, provide greater support, then teach better skills.

Kirsten Rowe Chief Psychiatry Registrar, Department of Psychiatry, University of Stellenbosch, Cape Town, South Africa. **Correspondence: kirstenrowe@gmail.com**

When children are grown and flown - transitioning into the older years

SPEAKER: Ray Anne Cook

Unathi Tefo

Unathi Tefo

Mrs Ray Anne Cook provided practical tips for adults transitioning into the older years. Similar to previous speakers in this session, Mrs Cook began her engaging talk by describing strengths and challenges of ADHD in older years. One of these challenges is empty nest syndrome. Empty nest syndrome is an emotional experience that parents commonly have when their children leave home to pursue tertiary education, find employment or travel. The sudden change in routine and the absence of children to look after, may cause parents to feel like there is a void in their lives.

Parents with empty nest syndrome can be overprotective and often struggle with balancing the need to supervise versus giving independence to their children. Parents may battle with depression and feelings of loneliness. They may feel like their lives lack purpose or are meaningless. Anxiety can result from parents' inability to control every aspect of their child who has relocated. The relocated child with ADHD should be allowed to check in whenever they feel overwhelmed by their new environment at university or the workplace. Mrs Cook advised parents experiencing empty nest syndrome to use their free time to reconnect with old friends and to reconnect with their spouse. Parents were encouraged to seek professional help, to take up new interests or hobbies, to focus on positive aspects, to keep in touch with children and to practice self-care.

Practising self-care is about helping parents rediscover themselves. The time taken to practice self-care allows healing of the mind, spirit and body. It allows restoration of function from the traumatic fight or flight experience that many parents with ADHD have when raising children. Finding the right professional who understands your strengths and challenges as a parent with ADHD is essential. The right professional, together with optimal medication, adequate psychological counselling and effective occupational therapy can improve quality of life. Moreover, tailor-made multi-disciplinary interventions ensure a smoother transition for the ADHD adult into the older years.

Unathi Tefo is a 3rd year Psychiatry registrar affiliated with the University of Limpopo. **Correspondence: ujtefo@gmail.com**

Coaching adults with ADHD - strategies that matter

SPEAKER: Dr Tamara Rosier

Unathi Tefo

Dr Tamara Rosier used her invaluable personal experience as an ADHD Coach to provide practical strategies that can be used to manage adult ADHD. ADHD Coaches do not come in to suddenly solve pre-existing problems but they walk alongside the adult with ADHD. Coaches "walk the walk" by listening and observing, they make comments on how to improve and they impart current knowledge as well as best ADHD practices. ADHD practitioners have a responsibility to create a safe and non-judgmental environment in which clients can understand how their particular strengths or challenges interact with their environment. One of the key elements of an ADHD Coach is to help clients make behavioural adjustments in order to align their environment with their particular strengths or challenges.

I really enjoyed how this talk linked back to the first speaker. Dr Rosier highlighted, just as the previous speaker had, how much of a struggle time management is for adults with ADHD. She considered how clients will keep checking and rechecking time, how they are constantly nervous about being late or missing appointments, and how they typically double book themselves. It is important to keep in mind that clients with ADHD feel overwhelmed by the concept of time, they avoid it, they may have anxiety about it, and will often procrastinate. When teaching time management skills to adults with ADHD, Coaches should be aware that linear thinking strategies (such as planning, monitoring and evaluating) do not work. These clients view time and tasks differently.

Unathi Tefo is a 3rd year Psychiatry registrar affiliated with the University of Limpopo. **Correspondence: ujtefo@gmail.com**

Ethical Dilemmas in the management of ADHD

SPEAKER: Indhrin Chetty

Sarah Wawa

Sarah Wawa

As ethical dilemmas form the core of patient decision making, healthcare workers need to be aware of ethical and legal issues that can arise during the diagnosis and management of ADHD. These issues may impact both clinical and non-clinical areas. Many of them are similar to the ethical issues that would be considered in the treatment of other illnesses but some of them are unique to ADHD. It is therefore very important for clinicians to be familiar with treatment guidelines and to manage patients within the accepted clinical framework.

As clinicians, we take responsibility for the patient diagnosis and management, and it is therefore pertinent that we have a strong evidence base before embarking on treatment. Clinicians should only recommend treatment that is evidence based and should be open with their patients when they are not trained to make recommendations about alternative treatments.

The basic ethical pillars should be kept in mind when treating ADHD and it is important that clinicians look at each of them and consider how they may apply to their practice. These principles include autonomy, beneficence, non-maleficence, justice, informed consent and confidentiality.

AUTONOMY

Clinicians need to be aware of the age of consent to medical treatment, how comorbid conditions may impact one's competence to consent and carefully consider before disclosing information to one's employers, parents and schools.

BENEFICENCE

This principle is intertwined with autonomy and is helpful in decision making, which is the expected treatment outcome and ensures prevention of harm. It is important to build a therapeutic alliance with the patients, and the priority of treatment should always remain the patient's best interest. It is important at the beginning of treatment for the clinician to be clear about the patient's expectations to avoid the patient's expectations not being met later on in the treatment process. There should be ongoing monitoring and reassessment of symptoms during each visit.

NON-MALEFICENCE

The clinician should always weigh the benefits versus harm of treatment options. It is their duty before commencing treatment to warn the patient about common adverse effects and other important/ serious adverse effects that may occur as a result of the treatment. This will aid the patient to make an informed decision and makes the patient an active participant in their treatment. The healthcare worker should be available for patients to get information about their treatment process. While weighing the risks vs benefits, the clinician should always keep co-occurring conditions in mind. It is important that clinicians closely monitor stimulant prescriptions, and it is the law to prescribe monthly and keep copies of the scripts in the files for reference.

JUSTICE

This involves the use of resources effectively and optimally, especially in resource limited settings, such as the public health care system.

Clinicians must fall back to these basic pillars of ethics to help guide their decision-making process as ethical difficulties may arise at any point of the patient's treatment journey. It is important to actively look for and correct any misperceptions the patient may have early in the treatment process.

Sarah Wawa is a Senior Registrar in Child and Adolescent Psychiatry, University of Cape Town. **Correspondence: katarawawa@gmail.com**

Parental challenges with children diagnosed with ADHD

Viatris Symposium

SPEAKER: Andre Venter

Khomotso Modiba

Khomotso Modiba

Married couples with an ADHD child under the age of eight have a 23% risk getting divorced as opposed to 12% who did not have a child with the condition. Parents are prone to stress due to the distractibility, lack of focus & impulsivity of the child. The child being out of control with bouts of anger, crying and temper tantrums, leads to a chaotic life for parents. These parents have fewer, positive interactions with the child's school, they are 3 times more likely to receive phone calls from the school, twice as likely to receive notes and 3 times more likely to meet with the teacher which makes them 77% more likely to attend parent-teacher conferences-displaying a high level of engagement and commitment. On the other hand, they were less likely to attend a school or class events.

Stigmatizing attitudes from family & community members adds to the burden and parental stress is also elevated if the children are not medicated. Families encounter greater difficulties such as family conflict, negative parent-child relationships and higher rates of parent psychopathy.

The consequences of these challenges include generalized stress, marital stress, isolation especially among single parents, boredom and feelings of guilt, social anxiety, depression and impaired occupational functioning among others. Where there is parental ADHD there is a much higher prevalence of criminal behaviour, aggression, conduct disorder, emotional instability and substance abuse in the child. There is also a higher association with negative emotional relationships and low warmth in their reaction to their offspring-especially when the mothers have ADHD. Levels of maternal hostility were higher in families where mothers have ADHD but reduced when fathers have ADHD.

Research shows that mothers with milder ADHD cope better with children with milder ADHD and those with severe ADHD symptoms cope better with children who have severe ADHD (opposite is true for fathers). Parents are more likely to experience emotional dysregulation.

TIPS FOR PARENTS

Be organized in all day-to-day activities, be one step ahead, do not spring surprises and do not give warning too far in advance. Make time for yourself, yourself and your spouse. Of importance do not neglect the other children in the family and remember that you are not the teacher but the parent and be reasonable with your expectations. Get your child involved in extramural activities that they enjoy if possible. Join a support group, it can be real or virtual and don't forget to keep educating yourself on ADHD.

FOR PARENTS WITH ADHD

Obtain a diagnosis and treatment; reach out to a support network and other parents. Learn organization skills, structure and time management. Find out what your child is struggling with; monitor your emotions and keep healthy communications.

In conclusion, both parents must be involved in the disciplining of these children, and they have to discuss and agree on disciplining them. Both must be consistent and decide which specific behaviours must be targeted. Corporal punishment has little effect.

Khomotso Modiba Sefako Makgatho Health Sciences University **Correspondence: k.modiba@ymail.com**

HealthFOX iCBT solution for ADHD management

HealthFOX Symposium

SPEAKER: Chrisna Ravyse

Grace Lehnerdt

ADHD affects millions of people globally, with persistent symptoms in adulthood that can hinder daily functioning. At the ADHD Symposium, attention was drawn to HealthFOX's innovative internet-based Cognitive Behavioural Therapy (iCBT) solution for ADHD.

Grace Lehnerdt

HEALTHFOX AND ADHD

HealthFOX has created an app-based iCBT program to provide flexible, accessible ADHD treatment. With 2.58% of adults worldwide affected by ADHD, symptoms such as missing deadlines and financial struggles overlap with depression and anxiety, complicating diagnosis. HealthFOX's iCBT aims to bridge this gap by offering a structured, self-paced program monitored by therapists, making therapy accessible anytime, anywhere.

KEY FEATURES OF HEALTHFOX ICBT

The program consists of eight phases, typically completed over 2 to 4 months, with one-hour independent sessions weekly. Personalized therapist support helps to ensure that patients stay on track. The key features of the program include:

- **24/7 access:** Patients can use the iCBT modules anytime.
- **Self-paced learning:** Interactive tasks and exercises help patients progress at their own speed.
- **Remote therapist support:** Therapists can intervene when needed based on real-time monitoring.
- **Progress tracking:** Questionnaires enable patients to monitor their improvements.

The key strategies in ADHD management that are focused on are time management techniques, breaking tasks into smaller streps, setting clear and achievable goals, structuring the environment, physical exercise and mindfulness.

CLINICIAN PERSPECTIVE AND PATIENT MONITORING

HealthFOX emphasizes the crucial role of therapists in digital care. Through its digital dashboard, therapists can easily track patient progress, identify who needs the most support, and intervene when required. This model provides therapists with a balanced workload, allowing them to manage a larger caseload without sacrificing quality. Clinicians appreciate how the program enables more personalized, data-driven interventions and reduces waiting times for therapy, especially in regions where mental health resources are stretched thin.

SUCCESS IN FINLAND

The program has seen significant success in Finland, where it is a primary treatment for ADHD, with over 5,000 patients using the platform. A survey of 1,667 users found that 89% reported improvements, highlighting the effectiveness of iCBT. The program also significantly expands access to therapy, increasing availability by 3 to 4 times compared to traditional in-person care.

CHALLENGES AND THERAPIST INTEGRATION

Despite its benefits, maintaining patient engagement in asynchronous iCBT can be a challenge due to ADHD symptoms like procrastination and distraction. While therapists help keep patients accountable through personalized feedback, 11% of users do not complete the full program. However, many still report improvements even with partial completion.

Therapists play a key role in maintaining patient motivation and offering personalized care. HealthFOX's integration of therapists into the program ensures that patients receive the support needed to overcome these challenges, combining human expertise with the scalability of digital tools.

CONCLUSION

HealthFOX's iCBT app offers a comprehensive digital solution for ADHD management, integrating behavioural strategies with personalized care. Its success in Finland and its expansion to new regions, including South Africa, demonstrates its potential to transform ADHD treatment, particularly in areas with limited access to traditional therapy.

Grace Lehnerdt Tintswalo Hospital, Mpumalanga. (Medical studies undertaken at the University of the Witwatersrand, Faculty of Health Sciences).
Correspondence: graceleh@gmail.com

ADHD and career success: The path forward

SPEAKER: Andria Gush

Unathi Tefo

Unathi Tefo

Ms Andria Gush began this thought-provoking session by asking attendees to think of the worst jobs for a person with ADHD. Some of the suggestions included being an accountant, a clerk or any job that involves intense administrative duties. The worst jobs for an adult with ADHD is in fact any work that provides too much or too little stimulation; that is too flexible or inflexible; and that is very predictable or completely unpredictable.

Ms Gush explained the work challenges faced by adults with ADHD: they struggle to find a job, if they do find a job they do not perform well at interviews, if employed they struggle to reach their full potential, they are often overlooked for big promotions, are frequently absent, are prone to injuries on duty and earn less income. These individuals are also prone to make careless mistakes due to inattention; suffer from burnout due to their hyperfocus on one task and neglecting other activities; and are unable to manage their time. Their poor time management skills cause them to miss work meetings, to double or even triple book themselves for appointments and to procrastinate important tasks. In addition, workers who have ADHD have poor emotional regulation which can manifest as anger or anxiety, and suffer from a constant fear of failure which manifests as perfectionism. Although neurodiverse adults face many challenges, they have exceptional attributes that make them an asset in the workplace. Their strengths include but are not limited to: their infectious enthusiasm and eagerness to learn, their high energy levels, resilience, spontaneity and creativity.

Management of ADHD in the workplace consists of reducing stigma by increasing employee awareness, ensuring medication is optimised and partnering with occupational therapists to effect accommodations. Accommodation involves making changes to the workplace or the role of the employee at work in order to support their executive functioning and sensory profile. The role of the occupational therapist is integral in managing adult ADHD as therapists screen and assess employees; they teach essential life skills like finances and nutrition; they encourage behaviour modifications strategies like prioritising self-care and they collaborate with the employer to implement environmental modifications to match the individual's sensory profile. Occupational therapists advocate for reasonable accommodation for adults with ADHD. Reasonable accommodation refers to equitable adjustments, which are not imposing and can also benefit other adults in the workplace. Ms Gush reminded us that an employee has no legal obligation to disclose their diagnosis to the employer, unless the symptoms affect job performance or compromise safety. Working adults who have ADHD should know that if they choose to disclose, their diagnosis must be kept confidential, they have the right to be protected from harassment and should not be discriminated against due to their diagnosis.

Unathi Tefo is a 3rd year Psychiatry registrar affiliated with the University of Limpopo. **Correspondence: ujtefo@gmail.com**

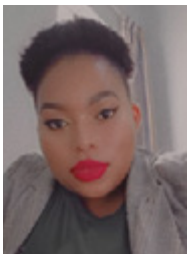
Consent requirements for ADHD medications

Dr Reddy's Symposium

SPEAKER: Miriam Close

Naledi Gwam

When treating patients, we need to do what's best for them. We do so by abiding to the legal and ethical principles. In this session, aspects of consent with regards to parents, children, adults, refusal of consent, withholding and withdrawing consent were addressed. Legislation is the main means by which we ensure that we follow proper legal procedures with regards to the above. We have important legislations that give us guidance to ensure that our consents are legally valid.



Naledi Gwam

LEGISLATION

Several Acts are in place to guide with providing consent. These include the following:

- The National Health Act 61 of 2003
- Children's Act 38 of 2005
- Protection of personal information Act 4 of 2013
- The promotion of Access to information Act 2 of 2002
- Mental Health Care Act 17 of 2002

CONSENT

For one to give valid informed consent, they need to have the capacity to understand the information provided, which should be adequate. They need to understand this information and not be coerced. Then they can agree to the proposed treatment. These can be gauged during the assessment of the person.

Consent can be given the patients themselves, by someone with proxy mandated in writing, by someone appointed by the court, by a spouse, parent, grandparent, adult child, sibling and healthcare practitioner in that order.

With regards to children, they have the same rights as adults but require additional protection. Guidelines as per the Children's Act 38 of 2005 need to be followed. Children 12 years and above can consent to their own medical treatment provided they meet the maturity criterion. Which means they can understand information and act in accordance with appreciation. They are cognitively, physically, emotionally and morally developed. The Vinelands Social Maturity Scale can be applied to assess this as well. In the Children's Act, section 129 deals with refusal of consent. A 12-year-old may refuse treatment. However other parties such as the Minister or high court or children's court may override that decision if the child unreasonably refuses to give consent.

Healthcare professionals must follow the provided ethical guidelines for good practice. They do so by providing adequate information about the condition in an understandable manner. Acting in the best interests of the patient and apply these as a continuing process. They may not withhold information unless this could cause serious harm. Even if the patient insists on not knowing, basic information must still be provided. Should the decision be made to withhold information, it must be documented in the clinical notes with clear reason to justify such.

CONCLUSION

This session highlighted aspects of obtaining consent, especially with regards to the ethical and legal aspects. The best interest of the patient is always to be considered. These are very important and not always universally known by health care practitioners. ADHD treatment is very helpful but like most medications, especially in psychiatry, it has serious implications. Obtaining consent, i.e. valid informed consent is pivotal in the treatment of ADHD.

Naledi Gwam is a Final year Registrar at University of Pretoria. **Correspondence: drnaledigwam@gmail.com**

Drug Holidays: Yes or No

Acino Swiss Symposium

Chair: Prof. Renata Schoeman

Speaker: Prof. David Coghill

Keagan Clay

The concept of "Drug-Holidays" in the context of ADHD psychopharmacology has long been a topic of debate and discussion both in academic as well as clinical settings. According to NICE 2018, a drug-holiday is "an agreed cessation of medication for a period of time".

Keagan Clay

We were privileged enough to receive an erudite presentation by Prof. David Coghill on this hot-button issue especially considering media and public perception. Prof's short, if tongue-in cheek, initial answer was a resounding "maybe". However, he went into detail to explain when and when not to consider drug-holidays.

Firstly, it must be stated that the evidence for and against drug-holidays is lacking, therefore, Prof. Coghill began by working through the evidence of ADHD treatment discontinuation and persistence across the life span of our patients and commented on a retrospective observational study done across multiple high-income countries by Brikell et al from Lancet Psychiatry in 2024. Results indicated that within 1 year of initiation 65% of children, 47% adolescents, 39% of young adults and 48% of adults remained on treatment. At 5 years, with re-initiation considered, 50-60% of children and 30-40% of adolescents and adults were still on treatment. Discontinuation rates are high, but it must be noted that many people that discontinue medication do re-initiate later. Challenges with the selection of medication are most likely the cause of the steep reduction in medication use within the first year of initiation.

Prof. Coghill then enlightened us on the NICE (2018) review on drug holidays which indicate that the quality of evidence on the effects of medication withdrawal have been downgraded due to concerns over risk of bias, imprecision and indirectness. Therefore, the NICE committee agreed that it would be inappropriate to make strong recommendations regarding cessation of ADHD medications. Prof. highlighted that the only evidence found was for weekend breaks and that this was only seen for methylphenidate. There was an agreement by the committee that drug-holidays may reduce adverse effects, however, that the committee expressed concern that these may lead to worsening overall adherence. NICE recommend focusing on at least yearly patient reviews looking at whether to stop or reduce medications in individual patients. NICE states that: *"The appropriateness of discontinuation or dose reduction will vary from person to person and that this could only be decided on an individual level".*

The Australian Guidelines and Prescribing Manual advice on drug-holidays states that this is patient specific and should be a clinician's decision if it may be beneficial to the patient. A break from medication may be helpful in a few specific situations such as if there is an impact on appetite and subsequent growth, and dietary modifications are not working. The guidelines recommend that if a patient's growth rate in height has significantly decreased, a planned break to allow catch-up is reasonable.

Prof. David Coghill reminded us that ADHD is not only confined to being a school-based disorder and that the impact of ADHD over time is far reaching. There is increased risk of criminality, substance abuse, premature death, poor academic performance as well as high socioeconomic costs attached to the burden of ADHD. Furthermore, the evidence shows that ADHD medications positively impact on all these outcomes. Regarding weight maintainance and growth, the evidence is split. Slowing of height velocity and transient weight loss is common with optimal psychostimulant treatment.

Prof importantly commented on the lived experience perspectives on ADHD medication and provided suggestions for maintaining weight, such as: having a main meal for breakfast, providing high calorie yet healthy snack foods for lunch and adding a large tablespoon of whole milk powder into milk-based drinks.

In conclusion, drug-holidays could be considered as a last resort in specific circumstances as untreated ADHD can have major impacts on a child's functioning overall and not simply at school.

Keagan Clay is a Psychiatrist and Senior Registrar in Child Psychiatry, Division of Child and Adolescent Psychiatry, Red Cross War Memorial Children's Hospital, Cape Town. **Correspondence: keaganclay@gmail.com**

Exploring the notion of 2-e: a yin-yang between challenges and talents of twice exceptionality

SPEAKER: Michele van Niekerk

Kirsten Rowe

Kirsten Rowe

The concept of '2-e' or 'twice exceptionality' refers to the combination of giftedness or in one or more domains (e.g. intellectual, creative, perceptual) and simultaneous special needs in other domains (e.g. specific learning disorders; neurodevelopmental conditions such as ASD, ADHD; sensory impairments or sensory processing difficulties; anxiety spectrum disorders; obsessive-compulsive disorder (OCD); oppositional defiant disorder (ODD)). Due to the presence of their exceptional strengths or talents, children with 2-e may mask their difficulties.

There are various possible presentations of 2-e in the classroom. The first presentation is as a child with a diagnosis of challenges or disabilities who often then has below average classroom performance. Their giftedness remains hidden and their potential underestimated. Support is required for their giftedness, but it has not been recognised. By only focusing on their difficulties, educators miss their strengths, do not develop them adequately and thus are not able to help the child to reach their full potential. The second presentation is the child in whom neither challenges nor giftedness are recognised. They may have average academic performance. Their strengths mask their weaknesses. They are thus not accessing services for their difficulties nor having their above-average abilities nurtured. Finally, they may present as the gifted child with adequate performance, but their difficulties are missed or masked by their talents. They may be labelled as underachieving, unmotivated or have a poor self-concept.

Assessment of the 2-e child requires an integrated approach. A variety of scales should be used to assess intellectual, emotional and behavioural domains. Assessment should be done by a psychologist who is 2-e aware. Discrepancy scoring may reveal significant variation.

A qualitative study of the 2-e child's educational needs was shared. Teachers revealed that they were inadequately prepared and often lacked awareness of 2-e due to the school environment and culture. They usually focused more on weaknesses than on strengths. They felt that appropriate courses would help them to better meet these children's needs. Students felt that the school environment was flawed and were dissatisfied overall with their school experience. It impacted negatively on their personal capacity. They felt there was a focus on remedial interventions, but not comprehensive programmes that fostered their strengths too.

In terms of interventions for the 2-e child, treatment matching is crucial. Not all interventions are suitable for all types. It is vital to tailor the treatment to the unique profile of strengths and difficulties of the child. Individual support is necessary to nurture the 2-e child's strengths while supporting their social and emotional needs and providing remediation for their challenges. Enrichment of educational opportunities is necessary to cater to different learning styles. Access to learners with special educational needs (LSEN) programmes with individual education plans (IEPs), accommodations, curriculum differentiation and the appropriate use of technology are essential. Educator support is also necessary. Supportive school and home environments with positive attitudes towards inclusion, celebration of diversity, and a strengths-based approach will help these children to thrive. The focus should be on building confidence, nurturing talents, supporting challenges, and maintaining motivation.

Kirsten Rowe Chief Psychiatry Registrar, Department of Psychiatry, University of Stellenbosch, Cape Town, South Africa. **Correspondence: kirstenrowe@gmail.com**

The impact of attention deficit hyperactive disorder on learners

Eastern Cape Department of Education symposium

SPEAKER: Punyuzwa Titi

Thabo Mukwena

ADHD is a **neurodevelopmental disorder** that can be characterized into hyperactive type, inattentive type and mixed types.

Thabo Mukwena

There are **comorbidities** that are usually missed in patients with ADHD e.g. anxiety disorders, as well as conduct and autism spectrum disorders.

Symptoms of ADHD can interfere with daily functioning, academic performance, as well as social and occupational activities. Symptoms should have been present for 6 months and other medical and mental conditions need to be excluded.

There are **mimickers** of ADHD e.g. thyroid problems that can cause symptoms like those of ADHD.

ADHD has been linked to a decrease in the volume of the cerebellum on **neuro imaging**. Learners with ADHD also have problems with sustaining attention and concentration which makes it difficult for them to follow instructions and to complete tasks.

The **symptoms of this disorder** should be present in two different settings noting that symptoms cause distress to teachers, other learners and the family as a whole.

Some of the **ways to help children with ADHD** to adapt will be by giving clear routines for speaking and listening, turns at talking, working in small groups and starting and completing tasks. Children with ADHD may also be hyper responsive in their environments. They may be highly sensitive to physical and emotional stimuli such as sound, sight, touch and smell.

Secondary symptoms in children with ADHD include poor coordination, disorganization and poor self esteem.

Children with ADHD have a **smaller hippocampus and amygdala** as well as r**educed volume in the prefrontal cortices**. This has a negative impact on their working memory, executive functioning and their ability to regulate their emotions.

Working memory is responsible for following and remembering instructions, organizing a working schedule and prioritizing activities.

There are deficits in short and long-term memory. Short term memory allows us to retain information over short periods of time. Impairment in short term memory results in a loss of the ability to retain information over short periods of time, e.g. it makes it difficult to understand long sentences or to follow a long conversation.

Long term memory is memory that can persist for years; we have **explicit and implicit memory** which are different yet important. Implicit memory is memory of facts, events, people and places. Explicit memory is memory of learned skills like riding a bicycle or typing.

Assessments include early identification and referrals for assessments and interventions. Identification of comorbid medical and psychiatric problems and addressing them helps the overall outcomes of the patient being treated.

Other interventions that can be added would be social skills training, family therapy, self-regulatory interventions and sensory integration therapy.

For **accommodation** of learners with ADHD additional time, scribing, separate venue and handwriting stickers can be used to assist them. Learners can be at a normal school or special school depending on the level of severity and impact of this disorder on the learner.

Documents needed to place a learner include a medical report, a psychoeducational assessment, a psychiatrist's report, and a report from the Multi-Disciplinary Team.

ADHD is a mental disorder that should be identified early so that children are assessed and appropriately placed.

Thabo Mukwena is a final year registrar at Sefako Makgato University. **Correspondence: mukwena1989@gmail.com**

Transitions into intermediate phase education: regulation and executive function challenges

SPEAKER: Elize Janse van Rensburg

Wanita Botha

Wanita Botha

The transition from third to fourth grade is a critical phase for pre-teens with ADHD, often accompanied by heightened anxiety due to several changes in academic and social expectations. During this transition, students move from handling fewer subjects to navigating eight or more, increasing the complexity of their daily routines. This shift not only amplifies the academic load but also requires significant organizational adjustments, such as rotating between different classes, managing multiple textbooks, and handling more homework. For children with ADHD, whose challenges with working memory, executive functioning, and attention-switching are pronounced, these changes can be particularly overwhelming, often resulting in the need to take work home.

An additional challenge for learners with ADHD is the transition from having a single, familiar teacher who can make tailored accommodations to having multiple teachers throughout the day. Each of these teachers may have different teaching styles and classroom rules, which can lead to inconsistencies in the support and accommodations offered. Furthermore, these learners now receive feedback from multiple sources, which can complicate their ability to gauge their performance and adapt accordingly. ADHD symptoms such as attention-seeking behaviour, frequent movement, and a need for emotional regulation become more pronounced when faced with these new challenges. Playtime, which is essential for emotional regulation, is often sacrificed due to increased homework demands, exacerbating the difficulties ADHD learners face.

The transition to fourth grade typically occurs during the latter part of Erikson's "Industry vs. Inferiority" developmental stage, where children begin to assess their competence in academic and social arenas. For children with ADHD, this phase is particularly sensitive, as negative feedback from multiple teachers may lead to a feedback loop that erodes their self-confidence and academic motivation. This can result in feelings of incompetence, increasing the likelihood of a negative self- perception. Furthermore, social dynamics become more complex at this stage, with peer relations playing a significant role. Unfortunately, children with ADHD often face peer rejection due to their behavioural differences, further compromising their social-emotional well-being.

In South Africa, resource limitations add another layer of difficulty, particularly in foundational subjects such as mathematics, which are rarely taught in the students' mother tongues. This language barrier may lead to gaps in understanding, which are carried forward into the intermediate phase, complicating the learning process even further.

The environmental context during this transition is also crucial. Positive, structured environments with smaller classrooms, adequate supervision, and physical exercise can facilitate smoother adaptation for learners with ADHD. Conversely, unstructured classrooms with high demands and low support exacerbate the challenges these children face.

In South Africa, accommodations for learners with ADHD typically include preferential seating, allowing physical movement breaks, and incorporating peer learning. However, more advanced interventions such as curriculum differentiation, individual education plans (IEPs), and assessment adaptations are not consistently practiced. This raises concerns about whether educators are adequately equipped to implement these more complex accommodations.

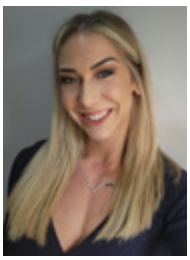
Ultimately, the transition to fourth grade for children with ADHD requires careful attention to their unique needs to support their academic and emotional development during this critical phase.

Wanita Botha is a Child and Adolescent Fellow at the University of Pretoria and Colleges of Medicine of South Africa **Correspondence: Wanita.botha@up.co.za**

Transitions through Pre-Primary to Primary School for Children with ADHD: Sensory and Developmental Challenges and Opportunities SPEAKER: Emma Wijnberg

Juané du Randt

INTRODUCTION



Juané du Randt

The ADHD congress offered valuable insights into various aspects of ADHD, including how children with the disorder manage transitions between different educational settings. This report focuses on Ms Wijnberg's lecture, "Transitions through Pre-Primary to Primary School for Children with ADHD: Sensory and Developmental Challenges and Opportunities," which explores the unique challenges and opportunities faced by children with ADHD during this critical transition period.

SUMMARY OF THE LECTURE

Ms Wijnberg's lecture provided a detailed examination of the transition from pre-primary to primary school for children with ADHD, focusing on changes in expectations, and sensory and developmental demands. Key points included:

- **Diagnostic Challenges:** the difficulty of distinguishing between typical developmental behaviours and ADHD symptoms in very young children was discussed. She highlighted how developmental variability in early childhood can complicate accurate diagnosis as well as how early signs of increased hyperactivity and impulsivity may be a precursor for an ADHD diagnosis. She advocated for the use of the DC:0-5 for younger children as opposed to the DSM-5 by discussing Overactivity Disorder in Toddlerhood.
- **Expectations:** Ms Wijnberg highlighted the drastic change in expectations from preschool – which is more unstructured and play-focused in comparison to grade 1 which is more structured and requires executive functioning for academic success. Some examples of the increased demands of Grade 1 learners are, sitting still, focusing for long periods of time, following complex instructions, and managing their own belongings.
- **Importance of Play:** The lecture emphasized that play is not only a form of energy release, but a method of learning and engaging with peers which provides valuable insights for children with ADHD regarding emotional regulation, and social interactions, and it also stimulates brain activity for improved memory. Play-based learning, movement, and experiences are more applicable to the learning style of a child with ADHD. Therefore, children with ADHD tend to struggle with the transition to more structured, listening-based learning styles.
- **Sensory Challenges:** Ms Wijnberg discussed how sensory processing issues common in ADHD can be exacerbated during transitions. Changes in the classroom environment, such as noise levels and seating arrangements, can affect these children's ability to concentrate and adapt.
- **Developmental Considerations:** The speaker highlighted developmental differences in children with ADHD, including variations in attention span, impulse control, time blindness, and executive functioning difficulties due to having neurological developmental delays in comparison to neurotypical children.
- **Support Strategies:** Ms Wijnberg emphasised the importance of tailored support strategies to facilitate a smoother transition. This includes using flexible seating options, using textured or fidget toys, providing sensory breaks to help manage sensory overload, and using active learning activities to engage children with ADHD in the classroom.
- **Cumulative effects:** Ms Wijnberg warned that the effects on development can persist and cause a fixed mindset limiting the potential to grow and inhibiting social skills which can all lead to social withdrawal. Children may also internalise their struggles as a reflection of their capabilities.

RELEVANCE TO ADHD

This lecture was highly relevant to ADHD professionals as it addressed a crucial transition period in a child's educational journey. Understanding the sensory and developmental challenges can help educators and parents better support children with ADHD, making the transition from pre-primary to primary school less stressful and more successful. The strategies discussed can be implemented to create an environment that supports the unique needs of these children and create a systemic change in the educational system to provide an inclusive learning environment.

REFLECTION

I found Ms. Wijnberg's lecture informative and insightful. I was particularly drawn towards the importance of play integration as well as the heavy demands placed on children with ADHD to conform to a societal expectation that they are not developmentally ready for. This automatically sets them up for internalised self-doubt which undermines their natural resilience and unique skills and attributes. I further found her support strategies to be easily implementable, which means a systemic change can be possible without major disruption to the system.

CONCLUSION

Ms. Wijnberg's lecture offered a comprehensive overview of the challenges faced by children with ADHD during their transition from pre-primary to primary school. The discussion on both challenges and strategies provided valuable insights that can inform educational policy and provide an inclusive learning experience for children with ADHD.

Juané du Randt is a Registered Counsellor & Project Lead at the Goldilocks and the Bear Foundation **Correspondence: juane@gb4adhd.co.za**

Intellectual Disability and ADHD: Support with co-occurring diagnosis and intervention

SPEAKER: Kediemetse Motingoe

Kirsten Rowe

Kirsten Rowe

There are high rates of comorbidity between ID and ADHD. ADHD is 2-3 times more common in children with ID. The rates of diagnosis and treatment of ADHD in ID are extremely low. This population faces multiple challenges including: stigmatisation, neglect, insufficient health services and barriers to accessing care. Caregivers experience high stress levels.

There are various reasons ADHD may be underdiagnosed in children and adolescents with ID. Some of the core symptom criteria are not applicable in more severe levels of ID e.g. talking excessively in non-verbal children. There is a lack of validated diagnostic tools for young people. Certain clinical factors also make diagnosis challenging, including: difficulties in obtaining a full developmental history; the lack of objective tools for measuring inattention, hyperactivity and impulsivity; difficulties assessing the young people's subjective experience of their difficulties; limited published research on the ADHD-ID comorbidity in young people; ambivalence amongst clinicians about the existence of ADHD in people with ID.

ADHD in people with ID may also present differently with the hallmark signs being behavioural disinhibition, hyperactivity and impulsivity. Challenging behaviour may be seen in 15-50% of people with ID. It is defined as culturally abnormal behaviour of such an intensity, frequency and duration that it puts the physical safety of the person or others in serious jeopardy or is likely to limit or deny their access to the use community services. Challenging behaviour in ID may be a possible presentation of ADHD, however there are various other possible causes, including physical illness and other psychiatric illnesses, e.g. psychotic, mood and anxiety disorders, or other neurodevelopmental disorders e.g. autism spectrum disorder (ASD).

The treatment principles for ADHD in young people with ID include: a child- and family-centred approach considering the patient's unique characteristics and the strengths of each individual and family; health promotion; a lifespan perspective with maximisation of the windows of opportunity for intervention; evidence-based approach to care with management plans and protocols informed by research; contextual, collaborative perspective of care; the involvement of the full multidisciplinary treatment team. The role of specialists is the management of complex cases including diagnostic assessment, psychiatric evaluation, medical management, training and supporting non-specialists, and psychoeducation. Involvement of allied health professionals is vital for individual supportive therapy, behavioural management therapy, and parent management training. The placement of these young people in appropriate schools and training centres is also key.

Be vigilant for ADHD in young people with ID who present with persistent challenging behaviour. Be aware of overprescribing of psychotropics. Review the benefit of psychotropics and deprescribe when necessary. Stimulants have the most evidence, but people with ID may be more sensitive to medication adverse effects. Support caregiver mental health. Do extensive family psychoeducation. Behavioural therapy is effective in younger children and those with mild-moderate ADHD with smaller effect sizes than medications. Parent management training is important for reinforcing behaviour.

In summary, ADHD is more common in people with ID and may be an aetiological factor in challenging behaviour. Screen for ADHD in ID. Managing ADHD in ID can improve behaviour and contribute to better adaptive functioning.

Kirsten Rowe Chief Psychiatry Registrar, Department of Psychiatry, University of Stellenbosch, Cape Town, South Africa. **Correspondence: kirstenrowe@gmail.com**

International Research Training on Religion and Social Transformation Annual Summer School 2024: Keynote Address on Mental Health

Maheshvari Naidu

In January 2022 a new German–South African International Research Training Group (IRTG) *'Transformative Religion: Religion as situated knowledge in processes of social transformation"* began its work. Funded jointly by the South African National Research Foundation (NRF) and the German Research Community (DFG) with a gross total of roughly € 4,9 million (ZAR 82 million), the project investigates, through the lens of transdisciplinarity, the influence of religion in processes of social transformation and the impact of these transformations on religion in contemporary global societies with an intercontinental perspective. It seeks to contribute to recent academic research and public debates on the complex relationship between religion and society.

This project is the second IRTG in the history of German-South African academic cooperation, currently the only German IRTG in cooperation with an African country and the first one to focus on issues of religion. For the next five years, the IRTG will present the opportunity for extended transdisciplinary research training to up to 54 doctoral candidates under the guidance of more than twenty interdisciplinary principal and associate researchers from a variety of academic disciplines in the cooperation of four academic institutions: Humboldt-Universität zu Berlin (FRG), Stellenbosch University, University of the Western Cape and INyuvesi yakwaZulu-Natali(UKZN)(all RSA).

There are four research focus areas; the fourth research domain is the question of **how local healing practices**, determining and being determined by religious habits and practices, **are impacting social transformation processes.** One of the prominent foci within this IRTG field is on religiously motivated healing practices in relation to mental suffering, as well as how mental health and suffering are constructed outside of the biomedical discourse. It thereby relates to the increasing literature on religion and mental health and psychosocial support, particularly in contexts of rapid social change and conflict and migration. The 'healing' research area offers the opportunity to examine how everyday (healing) practices, in their historically and socially developed localities, impact on social transformation processes in global societies and are simultaneously impacted by these processes.

Dr Suvira Ramlall, Associate Professor in the Department of Psychiatry at INyuvesi yakwaZulu-Natali, was invited to deliver a Keynote Address at the IRTG's annual September Summer School at INyuvesi yakwaZulu-Natali (UKZN), at the UNITE Conference Centre (Howard College Campus) where doctoral students, as well as international and local established scholars were hosted. The international research training group (IRTG) is jointly funded by South Africa's National Research Foundation (NRF) and Germany's Deutsche Forschungsgemeinschaft /German Research Foundation (DFG) and engages in transdisciplinary research over three years, with approximately 32 doctoral candidates and two postdoctoral students under the guidance of 20 principal researchers from Humboldt-Universität zu Berlin, Stellenbosch University, University of the Western Cape, and UKZN. One of IRTG's aims is to stimulate and support multidisciplinary and transdisciplinary research in the field of religion and the wider humanities, social sciences and health sciences. The 2024 summer school was organised by UKZN Humanities academics, Professor Maheshvari Naidu, Dr Cherry Muslim and Professor Federico Settler. The delegation and summer school was visited by UKZN Vice-Chancellor and Principal, Professor Nana Poku, and Dean of Research, Professor Vivian Ojong. The focus of this year's summer school was on "Religion, Healing and Power" through multidisciplinary and decolonial reflections.

The organisers saw Professor Ramlall as the perfectly positioned academic to deliver one of the two Keynotes, given Professor Ramlall's sustained work (among other areas), in mental health within wider contexts of worldviews and belief systems and critical (non-normative) health and wellness seeking beliefs and

practices. Professor Ramlall's shared research also unveiled situated, local understandings, indigenous aetiologies and health protocols that go unnoticed or are ignored and marginalized within wider normative bio-medicalised discourses on mental health, illness and healing.

Professor Suvira Ramlall shared her practices as a diagnostician, also challenging the normative allopathic approaches to health, and mental health by introducing evidence based Indian Vedic perspectives and approaches to wellbeing and healing. Her presentation sat in tandem with the other Keynote presentation delivered by Professor Nokuzola Mndende, which focused on natural health and medicine and indigenous healing practices.

Professor Nokuzola Mndende is an adjunct professor in the Sociology and Anthropology department. With an extensive career in the areas of African Culture, Feminist/Womanist theology, African Spirituality, and Indigenous Knowledge Systems, she is leader in Africa-Centred Knowledge Systems. Dr Mndende received her PhD in 2002 from the University of Cape Town, specialising in African Traditional Religion. She is a qualified diviner/Spirit medium (iGqirha). Dr Mndende thus straddles between two systems of thought as uGqirha (Dr) and iGqirha (qualified diviner) and uses the combination of these two systems to educate and consult for the national government, media houses, and legal fraternity on issues regarding indigenous institutions of health, gender, and religious systems.

These two powerful Keynotes set the tone for a series of presentations where doctoral researchers from the four partner universities reflected on how their research may benefit from and contribute to fast-evolving fields of health, health-seeking behaviours, and self-care, and how in particular it relates to religion, religious life and beliefs in postcolonial communities.

Prof Ramlall's powerful presentation was titled *'Mental Health: A Bio-Spiritual Quest for Identity and Meaning.'* Through evidence-based scholarship, it introduced to the audience of doctoral fellows and the local and international German scholars, discourses, understandings and practices in mental health. Her presentation made apparent that there are cherished (and often exclusionary) bio-medical models on mental health constructions as being the sole repository of health and wellness, and spoke to the important place that indigenous aetiologies hold in the communities of patients that seek help within the context of South Africa and within her own patient community. These in turn influenced patients' own adherence behaviours, as well as shaped their self and identity in their search for wellness and wellbeing. Her expertise and intellectual prowess shone through also in her expert and deft nuanced responses to the extensive range of questions posed by the attendees, in her characteristic charismatic and charming style. Her amiable presentation style belied a formidable intellect and expertise and made clear that she was not hesitant to both challenge and transgress normative and mainstream (and sometimes straightjacketed) models of health.

The IRTG is a dynamic platform that affords academics and practitioners an opportunity to break intellectual silos; the field of mental health lends itself particularly well to multi-and trans-disciplinary research and practice.

Dr Kennedy Owino (UKZN- School of Religion, Philosophy and Classics-RPC), Dr Cherry Muslim (UKZN-RPC), Prof Suvira Ramlall (UKZN), Prof Torsten Mereis (Humboldt-Universität zu Berlin - Theology), Prof Maheshvari Naidu (UKZN-School of Social Sciences), Prof Federico Settler (UKZN-RPC)

Zikhona Kokoma-SA PhD ;Suvira Ramlall-Associate Professor (Psychiatry) UKZN; Sina Benyamina -German /Humboldt PhD

Maheshvari Naidu is a Full Professor in Anthropology and Liaison for Global Partnerships in School of Social Sciences-University of KwaZulu Natal (UKZN).
Correspondence: naiduu@ukzn.ac.za

Dr Reddy's South Africa Psychiatry Academic Meeting 2024

Rashem Mothilal

The annual Dr. Reddy's Laboratories Psychiatry Academic Meeting, took place from 16-18 August 2024, at Zimbali Estate in KwaZulu Natal. This event gathered 130 psychiatrists from across South Africa for an event filled with knowledge sharing, topical clinical discussions, and collegial networking.

Dr. Rashem Mothilal, Country Head for Dr Reddy's South Africa, opened the meeting with an overview of the company's journey to date and roadmap ahead, and underscoring that Neuroscience will continue to be a dominant focus area for the company.

Dr Rashem Mothilal

Dr. Sundeep Ruder, a renowned endocrinologist, delivered the keynote address during the gala evening in which he combined modern evidence-based medicine with the philosophy of life and health, encouraging attendees to think critically about life.

Dr Sundeep Ruder

The academic presentations were delivered by the Psychiatrists who were sponsored to attend the 2023 ECNP Congress. They shared with their colleagues knowledge they had gained and covered topics which included: The Use of Psychedelics in Treating Mental Health Disorders, Challenges of Depression in an Aging population, The Impact of Lifestyle Choices on Mental Well-Being, Suicide Prevention Using Biomarkers, Stress Neurobiology, Challenges in Managing PTSD, Anhedonia in MDD, Impact of Nutrition in Mental Health, Rational Prescription of Antidepressants, and Differences Between Neurological and Psychiatric Conditions. Dr. Johan Smuts, Vice-President of the SA Headache Society, also discussed Neuromodulation Techniques for Managing Migraines in the Modern Era.

All presentations were exceptional and delivered with passion, inspiring each attendee. As Nelson Mandela wisely said, "Education is the most powerful weapon which you can use to change the world." This is especially true in Psychiatry, where our evolving understanding of mental health can profoundly impact lives. At Dr. Reddy's Laboratories, we are committed to improving mental health in South Africa because we truly believe that **GOOD HEALTH CAN'T WAIT**.

For further information:
Jessie Venketsamy - jessievenketsamy@drreddys.com
Dr Livasha Mudaly - livasha.mudaly@drreddys.com

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

Redilev
LEVETIRACETAM
When Seizures Fade, Dreams Flourish

REDILEV INDICATIONS:[1]

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

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

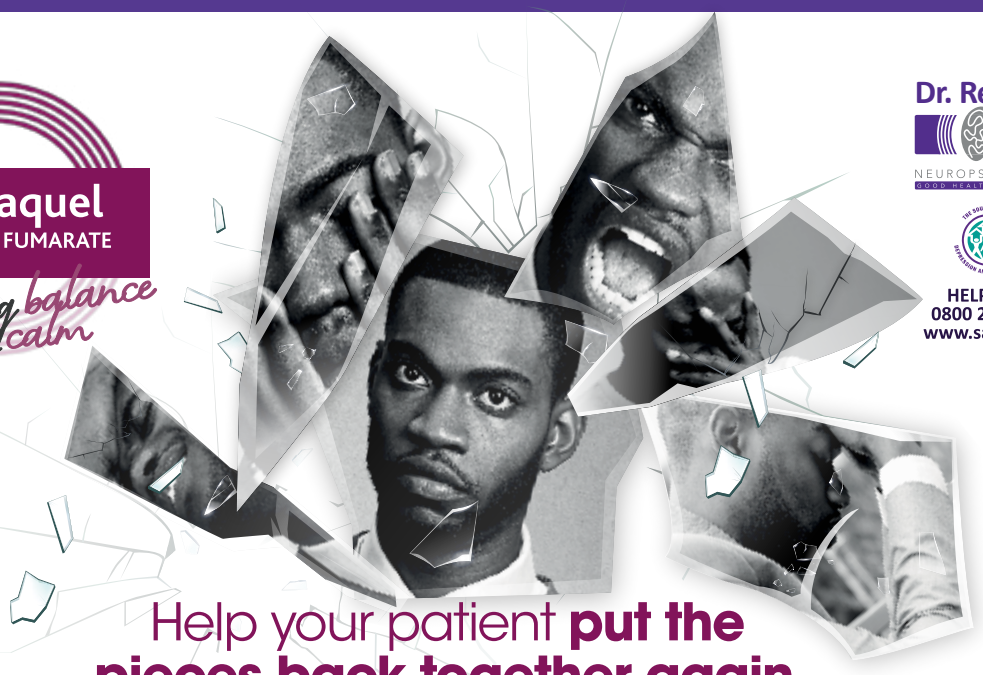
Redilev is also indicated as adjunctive therapy in the treatment of:

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

References: 1. Redilev [Professional Information]. Sandton, South Africa: Dr. Reddy's Laboratories (Pty) Ltd; November 2016.

SS REDILEV 250. Reg.No.: 41/2.5/0460. Each film-coated tablet contains levetiracetam 250 mg.
SS REDILEV 500. Reg.No.: 41/2.5/0461. Each film-coated tablet contains levetiracetam 500 mg.
SS REDILEV 750. Reg.No.: 41/2.5/0462. Each film-coated tablet contains levetiracetam 750 mg.
For full prescribing information please refer to the professional information approved by the Medicines Regulatory Authority.
Dr. Reddy's Laboratories (Pty) Ltd., 204 Rivonia Road, Block B, Morningside, Sandton, 2057. Reg.No.: 2002/014163/07. Tel: +27 11 324 2100.
www.drreddys.co.za. R1164079-ZA-CO-02052023-001-31 May 2025
THIS INFORMATION IS INTENDED FOR HEALTHCARE PROFESSIONALS ONLY.

Dr.Reddy's Building Balance Together



SS Dopaquel
QUETIAPINE FUMARATE
Restoring balance & calm

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

THE SOUTH AFRICAN DEPRESSION AND ANXIETY GROUP

HELPLINE:
0800 21 22 23
www.sadag.org

Help your patient **put the pieces back together again.**

Dopaquel is indicated for the treatment of **adult patients with schizophrenia** or for the treatment of **manic episodes associated with bipolar disorder.**[1]

Quetiapine is recommended as a **first-line treatment** in the management of **acute mania** associated with bipolar disorder[2]

1. Dopaquel [Professional Information]. Sandton, South Africa. Dr. Reddy's Laboratories (Pty) Ltd; 2017. **2.** Yatham LN, Kennedy SH, Parikh SV et al. Canadian Network for Mood and Anxiety Treatment (CANMAT) and International Society for Bipolar Disorders (ISBD) 2018 guidelines for the management of patients with bipolar disorder. *Bipolar Disorders, 2018*; 97-170.

SS Dopaquel 25. Reg.No.:25. 43/2.6.5/0429. Each tablet contains quetiapine fumarate equivalent to quetiapine 25 mg. Contains sugar (lactose).
SS Dopaquel 100. Reg.No.: 43/2.6.5/0430. Each tablet contains quetiapine fumarate equivalent to quetiapine 100 mg. Contains sugar (lactose).
SS Dopaquel 200. Reg.No.: 43/2.6.5/0431. Each tablet contains quetiapine fumarate equivalent to quetiapine 200 mg. Contains sugar (lactose).
SS Dopaquel 300. Reg.No.: 43/2.6.5/0432. Each tablet contains quetiapine fumarate equivalent to quetiapine 300 mg. Contains sugar (lactose).
For full prescribing information refer to the professional information approved by the Medicines Regulatory Authority.
Dr. Reddy's Laboratories (Pty) Ltd., 204 Rivonia Road, Block B, Morningside, Sandton, 2057. Reg.No.: 2002/014163/07. Tel: +27 11 324 2100. www.drreddys.co.za.
R1146479-ZA-CO-25022023-0709-31 Mar 2025
FOR HEALTHCARE PROFESSIONALS ONLY

Dr.Reddy's Building Balance Together

Breaking Barriers:

African Voices in Mental Health Innovation

Thejini Naidoo

Thejini Naidoo

Attending the African Global Mental Health Institute's (AGMHIs) 7th Annual Conference (4th-6th November 2024) on "Closing the Gap: Innovations in Mental Health" was an enlightening and inspiring experience, further accentuated by the warmth and kindness of the Kenyan people.

The conference started off with an interactive poster session, providing one of many invaluable networking opportunities with leaders, educators, researchers, innovators and advocates. Engaging with individuals from various backgrounds fostered a rich exchange of ideas and collaboration opportunities. Amidst the many stimulating conversations, the one that struck me the most was that with Tina Masai who researched gender-affirming care services (GACS) in the context of the Kenyan public sector. She spoke passionately about stigma at multiple levels and limited accessibility of GACS, proposing a comprehensive competency framework with an emphasis on community involvement. In my opinion, the value of local context in developing mental health solutions was one of the most salient aspects of the conference.

The following two days began with mindful movement sessions which set the tone for thought-provoking presentations and stimulating discussions. It was motivating to hear about work being done under the four key domains of the AGMHI: training and education, advocacy and policy, research and clinical care delivery. Attendees were encouraged to participate in these working groups with the view to meaningfully contribute to the advancement of mental health care in Africa.

The presenters provided insight into the amazing work being done despite the myriad of challenges faced in the African context. Wanjiku Waibochi, from the NGO Green String Network, delivered a powerful presentation about the development and implementation of African community-led, culturally rooted solutions to "rekindle individual and communal healing, using social reconciliation as a strategy for building resilience and breaking cycles of violence". Some of the key messages that her presentation highlighted for me was the importance of:

- decoloniality from a societal to individual level;
- collaborating with communities and traditional leaders to facilitate the development of "sustainable, locally-owned solutions";
- not indiscriminately pathologisng people; and
- not solely utilising Western models of treatment.

Innovative solutions presented ranged from traditional approaches to scalable technologies, with the view to bridge the gap between mental health services and underserved populations.

Prof. Xanthe Hunt's keynote address underscored the disparities in access to mental health care, exacerbated by factors such as stigma, lack of resources, and insufficient training for healthcare providers. She illustrated some of the digital mental health technologies for youth in the African context, outlining the promises, pitfalls and potential solutions.

It was inspiring to see a collective commitment to advancing mental health in Africa, which left me with a renewed sense of purpose and motivation to contribute to this vital field. The conference served as a powerful reminder of the importance of innovation, collaboration, and cultural sensitivity in mental health initiatives. It reinforced my belief that closing the gap in mental health care requires a concerted effort from all stakeholders, and I am excited to apply the insights gained to my own work in this area. The conference not only provided a platform for sharing knowledge but also ignited hope for a future where mental health is prioritised and accessible to all through community, collaboration and connection.

"Umoja ni nguvu." ("Unity is strength.")
– Swahili proverb

Thejini Naidoo works as a psychiatrist in full-time state clinical practice at Dr. Pixley Ka Isaka Seme Memorial Hospital (DPKISMH) and is an honorary clinical fellow at the University of KwaZulu-Natal (UKZN). In addition to her clinical work, she enjoys teaching, mentoring and research. Her interests include mental wellness in medical students and doctors (in which she is published); severe mental illness; and the use of virtual reality in the realm of mental health. She is currently enrolled for her PhD which explores mechanisms of psychosis with virtual reality in KZN. She is passionate about bridging the gap between research and patient care and advancing the field by engaging in interdisciplinary and global collaborations aimed at improving mental health outcomes in the South African context.
Correspondence: thejini.naidoo@gmail.com

Zydus

DEPARTMENTS OF PSYCHIATRY

University of KwaZulu Natal

UKZN Academic and leadership Regsitrar Camp
A reflection

Akeela Hoosen


Akeela Hoosen

"The growth and development of people is the highest calling of leadership." —Harvey S. Firestone

As I write this article, I reminisce fondly on the University of KwaZulu Natal (UKZN) Psychiatry registrar academic, leadership and team building symposium; which took place from the 6th – 8th of September 2024. A first of its kind and hopefully the first of many; certainly left me with a sense of pride and accomplishment in knowing that I am surrounded by illustrious leaders and remarkable colleagues within the field of psychiatry.

The two-day symposium spearheaded by Professor Bonga Chiliza, orchestrated by our very own registrar representative Dr Precious Dimba and sponsored by the SunPharma team; was nothing short of remarkable! The aim of this weekend was to "learn something new and get to know each other" – I'd say mission accomplished.

Kicking off the weekend at Sicas' Guest House in Durban, KwaZulu Natal, we lunged straight into academics with a senior-led panel case discussion to set the scene. Psychiatry related themes, neuropsychiatry, ethics and psycho-pharmocology were unpacked, to name but a few. This was a wonderfully engaging experience fronted by some of UKZNs' finest consultant psychiatrists. As a junior registrar, it was incredible to be able to immerse myself in the realm of psychiatry with such like-minded and passionate individuals. The end to a very productive first day was concluded with a three-course dinner at Grimaldis' located at the prestigious Durban Country Club.

Day two provided an in-depth discussion on the topic of forensic psychiatry, led by specialist psychiatrist Dr Indhrin Chetty, the academic head and senior lecturer at Sterkfontein hospital. I was in awe of how simply he laid down the complexities of South African law with regards to civil and criminal proceedings, in relation to mental health. This was followed by another luminary specialist psychiatrist, PHD graduate and lead clinician at the Lentegeur psychotherapeutics unit in Cape Town, Professor Lebohang Phahladira. He opened Pandoras box on schizophrenia and left us all startled at how little we actually know on the most common psychiatric condition. I was left utterly speechless by the end of another prolific day! Our team building exercise consisted of a light-hearted quiz and games night, which certainly allowed us colleagues to engage on a personal front.

The final day of the symposium was met with a bittersweet undertone, although this did not detract from our last academic discussion, piloted by our very own esteemed Dr Lindokuhle Thela. He is a specialist neuropsychiatrist and the head of clinical unit at Victoria Mxenge Hospital. The area of focus delved into the essentials of neuropsychiatry and neuro imaging with clinical application and case vignettes. This is always an exciting time to showcase our presentation skills in an informal setting. The weekend ended off with a reflection "pits and peaks" session.

In addition to the various academic points that were learnt and the memories that were made, I've bonded with compatible souls. The camaraderie and sense of kinship that I've attained is priceless! It is safe to say that even as psychiatrists we need to actively re-evaluate, recharge and restore the balance within our lives. This weekend has truly emphasized the essence as to why I had chosen to venture off into psychiatry.

"We do what we love, and we love what we do" – Confucious.

I'd like to extend my heartfelt gratitude to all who had made this weekend a reality. I am fairly certain that I can vouch for all when I say that we're looking forward to what the next one has to offer.

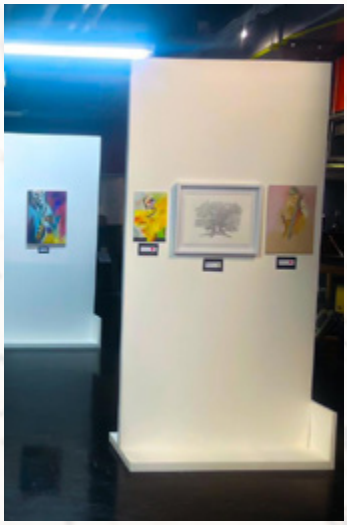
Thank you

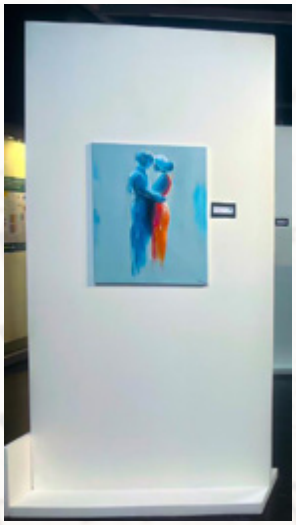
Dr Akeela Hoosen is currently a second-year psychiatry registrar at the University of KwaZulu-Natal (UKZN). Her topic of interest is looking at assessing the wellbeing of South African registrar doctors.
Correspondence:akeela.23.hoosen@gmail.com

University of The Witwatersrand

Prof. Subramaney, Dr Price-Hughes, Dr Chetty

Dr Ranchod, Prof. Subramaney, Prof. Cook





University of Cape Town

This content was compiled by Toni Abrahams toni.abrahams@uct.ac.za

LECTURE ON BLACK PEOPLE WITH LEARNING DISABILITIES

Sharon Kleintjes

The Division of Intellectual Disability hosted a lunchtime lecture on the 3 December 2024, the United Nations International day for Persons with Disabilities. The lecture, entitled "Being part of history, being part of activism: Exploring the lives and experiences of Black people with learning disabilities" was presented by researcher and historian activist, Paul Christian, with co-researcher, Susan Ledger, Visiting Research Fellow and member with Paul, of the Social History of Learning Disability Research Group at the Open University, UK.

The theme of the 2024 International Day was "Amplifying the leadership of persons with disabilities for an inclusive and sustainable future", recognizing the central role that persons with disabilities can play in creating a more inclusive and sustainable world for all. Paul's research on Black Lives Matter exemplifies this theme. His lecture focused on his work with co-researcher, Susan Ledger, who provided an intersectional lens on the experience of race and disability by bringing to life the missing stories of Black British people with lived experience of learning disability in the context of their history of institutional care, and activism post institutional care, the need for meaningful inclusion of black people with learning disabilities in documenting disabled people's history in Britain, and the importance of ensuring that this history is documented in formats accessible to people with learning disability. Co-presenter, Liz Tilley, Professor of Learning Disability Studies in the School of Health, Wellbeing and Social Care, Faculty of Wellbeing, Education and Language Studies at The Open University noted how Paul's work contributes to the Open University's commitment to bringing greater diversity and inclusion to its research and practice . A publication on Paul and Susan's work can be accessed at: Christian, P., & Ledger, S. (2022). Being part of history, being part of activism: Exploring the lives and experiences of Black people with learning disabilities. British Journal of Learning Disabilities, 50, 239–251. https://doi.org/10.1111/bld.12459 and at https://www.georgepadmoreinstitute.org/news-and-events/launch-of-george-padmore-collection-easy-read-series

Paul Christian *Susan Ledger* *Liz Tilley*

ANNUAL DEPARTMENTAL RESEARCH DAY 2024: "RESEARCH IN TIMES OF AUSTERITY""

Stephan Rabie and Nastassja Koen

The Departmental Research Committee (DRC) hosted the annual Departmental Research Day on the 20 August 2024. This year's theme was "Research in Times of Austerity", and we invited speakers to share their experiences and perceived impact of recent austerity measures on their clinical work, their research execution, and the effects of austerity on our participants' livelihood.

We had several distinguished guest speakers who shared their stories with us. Prof Crick Lund started proceedings with an

Prof Tracey Naledi

inspiring, yet data-driven opening plenary entitled "Mental health research in resource-limited settings: art of the possible (and beyond)". The morning session concluded with a panel discussion facilitated by Dr Yolande Harley (Director of Research: Health Sciences), Dr Philip Smith (Desmond Tutu Health Foundation), Dr Jacqueline Bracher (Neuroscience Institute), and Dr

Lenny Naidoo (City of Cape Town), which focused on conducting research in resource-constrained settings, and acquiring research funding in times of austerity. This session invited considerable engagement from the online and in-person attendees, exploring topics such as funding planning for early-career researchers, and engaging clinical research partners early in the research process to plan for the most feasible research outcomes.

Prof Crick Lund

A/Prof Stephan Rabie (DRC Research Day Organising Sub-Committee) & Prof Crick Lund.

Two postgraduate students in the Department showcased their respective research during the "rapid-fire" session. Alexa Soule (PhD candidate) presented her work, "Socioeconomic and psychosocial correlates of cognitive performance on a dementia screener in a peri-urban elderly population"; and Nicole Chetty (Masters' candidate) presented her research, "Enhancing caregiver and adolescent mental health in LMICs: pilot findings and RCT protocol of the ParentApp Digital Intervention in Tanzania".

Both presentations were excellent – to such an extent that the DRC awarded both the 'Best Presentation' award for the day. The event concluded with an outstanding closing plenary from A/Prof Tracey Naledi, which focused on the status of research in the Faculty, and the need for continued support for the University's research portfolio, both from local and international funders.

The DRC would like to thank the organising sub-committee, as well as all who attended – we had close to 100 attendees online and in-person. This year's Research Day represented not only an opportunity to showcase research in the Department, but also for colleagues to engage around their own research. We look forward to welcoming you back in 2025!

TRANSFORMATION AWARD FOR DECOLONIAL AND TRAUMA-INFORMED RESEARCH METHODOLOGIES

Lane Benjamin

Through the Division of Psychotherapy, we are initiating two new short courses at UCT next year. The first is a five-day course on Trauma-informed Practice. The second is focused on Decolonial and Trauma-informed Research Methodologies. This second course was offered a Transformation Award of R52000 which will be a valuable contribution towards the course.

The trauma-informed approach is one which mirrors the values of decoloniality and aims to rehumanise people and systems. A trauma-informed approach requires knowledge of the ubiquitous impact of the intersections of trauma and is an ethical approach to engaging with the themes of power, transparency, autonomy and flexibility.

By proactively engaging with the multi-layered complex nature of trauma, we are encouraging researchers to become better equipped to support the psychological safety of research participants, of themselves and to improve the quality and contextual value of our research studies.
The trauma-informed approach has emerged globally as a critical framework within various fields, including social work, psychology, education, healthcare, and criminal justice, amongst others. There is a critical need to challenge the historical dominance of imperialism in shaping scientific inquiry. Research Methodology that is both trauma-informed and decolonial, recognises that traditional research methodologies have often perpetuated trauma and further marginalised those already vulnerable to oppression and discrimination.

Through sharing trauma-informed research methodologies the course aims to challenge thinking about the structures that have historically privileged certain perspectives while disregarding others.

This course aims to cultivate an environment where diverse voices and methodologies are not only acknowledged but celebrated, and to pave the way for a more inclusive, equitable, and just approach to academic inquiry.

Please encourage student and staff researchers from various fields in your networks to contact us if they would like to attend this course or the Trauma-informed practice short course.

The case for cultivating compassion

Volker Hitzeroth

Compassionate behaviour aids not only the receiver but also enhances the giver's wellbeing. It can elevate our mental state and often generates further compassionate conduct. It is therefore not amiss to say that compassion often begets further compassion. By acknowledging a global humanity, we open the possibility to collective compassion which in turn may lead to a common, and greater, good.

Volker Hitzeroth

This is the first article in a new series on wellbeing and was also the subject for a keynote presentation at Medical Protection Society's Ethics for All event in October 2024.

When we consider famous compassionate people, we may think of a handful of well-known and eminent individuals such as the 14th Dalai Lama, Archbishop Desmond Tutu, Mother Theresa, St. Francis of Assisi, Emperor Ashoka or Mahatma Ghandi. Some lesser-known choices may be Harriet Tubman, Dr Denis Mukwege or Claiborne Ellis. These role models often had to overcome much hardship and many difficulties - and yet continued to be compassionate when dealing with others. Their conduct should inspire us to care for one another and to remain compassionate even when faced with adversity.

Our world is characterised by a multitude of formidable challenges, many of which seem daunting and disheartening. Faced with such significant global concerns it is often the natural inclination to narrow the focus and become insular, to shut the metaphorical doors and let no one enter, and to become increasingly inward-looking.

Yet, counterintuitively, the contrary response may be the better one as human suffering can also inspire many people to reach out, to open their hearts, to connect with others and to alleviate their anguish by engaging in acts of compassion.
By becoming more compassionate, we not only help others, but we commonly also experience the mood enhancement that makes us feel better. Seeing others conduct themselves compassionately, or being compassionate ourselves, can elevate us to higher action, a greater good and a common purpose.

Although empathy, sympathy, and compassion are often used interchangeably, there are certain linguistic and phenomenological differences. One such difference is the fact that both empathy and sympathy are self-related and inward focused, while compassion is other-related and outward focused.

Empathy refers to the ability to understand and share the feelings of another person; the ability to share someone else's feelings or experiences by imagining what it would be like to be in that person's situation.

Sympathy on the other hand refers to the experiencing of feelings of pity and sorrow for someone else's misfortune; a feeling or expression of understanding and caring for someone else who is suffering or has problems that have caused distress.

Compassion, however, is often believed to be derived from the Latin meaning "to suffer with". Hence, compassion is described as a deeper awareness of another person's suffering coupled with a wish to relieve this. It is the feeling or emotion experienced when one is moved by the distress and suffering of another and has a subsequent desire to alleviate this. Much has been written about the definition of compassion and numerous articles and textbooks have attempted to elucidate the concept. A useful working definition of compassion might be the following:

1. To recognise, and become aware of, someone else's suffering;
2. To feel connected with the person who is suffering, and being moved by it; and
3. To be motivated to act and alleviate the suffering so as to help that person.

It is often understood that, to feel genuine compassion, there would also have to be an understanding of the universality of human suffering and hence recognition of a commonality with the sufferer – akin to a common humanity. Furthermore, to be truly compassionate one should be able to tolerate disagreeable emotions that arise in oneself (for example disgust, dislike, frustration, anger) when facing a situation that one would usually disapprove of or find distasteful.

Traditionally it was philosophers and theologians who had an interest in the study of compassion. However, more recently, the study of compassion has attracted attention from neuroscientists and psychologists.

Recent studies seem to suggest that empathy, which is about feeling the emotions of the sufferer, highlights the brain centres relevant to distress, pain and suffering. Compassion on the other hand, relating to the alleviation of another's pain and discomfort, highlights the brain centres related to connecting, caring and reward – and thus seems to have a more positive and pleasurable effect on the practitioner.

INDIVIDUAL / PERSONAL COMPASSION

Sir William Osler, a Canadian physician (often named the father of modern medicine) stated that "the good physician treats the disease; the great physician treats the patient who has the disease".

A basic tenet of healthcare is that practitioners should be compassionate when treating patients who are afflicted by disease and who are struggling with discomfort, pain and suffering. Healthcare practitioners accept that compassion is central to patient care and the therapeutic relationship. This is also enshrined in various professional codes of conduct, ethical guidance, numerous best practice guidelines and patient rights charters.

Unfortunately, in our modern consumer-driven society - where healthcare has become merely another commodity to be demanded and expected, bought and sold, managed and governed - it is not surprising that healthcare practitioners become increasingly jaded, frustrated and burnt out, which often manifests in compassion-fatigue. This seems to be the case not only in South Africa but also in other countries.

A group of physicians in the United States were faced with such a problem, namely, how to improve patient care and doctor wellbeing in a hospital that was struggling with doctor burn out.

Drs Stephen Trzeciak and Anthony Mazzarelli, reviewed many scientific articles and research studies, the findings of which they published in their book 'Compassionomics: The Revolutionary Scientific Evidence that Caring Makes a Difference'. The authors ultimately concluded that it was the addition of compassion to the clinical consultation, for a mere 40 seconds, that contributed to a significant improvement not only in the patient's clinical outcome but also in the prevalence of doctor burn-out.[1]

Further research seems to confirm this. Many articles also suggest that an increase in compassionate behaviour improved not only physical health (for example reduced cardiac disease, reduced need for pre-op sedation and less post-op pain relief) but also improved mental wellbeing (reducing feelings of depression, anxiety and burn-out, and improving cognition and enhancing relationships).

The evidence seems to suggest that the act of giving is as pleasurable as the act of receiving, and that acts of compassion subsequently generate further acts of compassion.

This raises the question as per Anstiss, Passmore and Gilbert (2020): *"But one question remains unanswered. Can the human race cultivate compassion at sufficient scale and pace – at both individual and collective levels? We are embedded in a fast-changing world full of uncertainty and threat ... Discovering how we can fast-track the conditions for compassion is surely one of our species' greatest challenges, and one (of) the most urgent tasks."* [2]

COLLECTIVE / GLOBAL COMPASSION

We are all part of a global and common humanity. Our experiences are the result of a universal human condition rather than a personal, isolating or shaming one. We have common bonds, similar needs and congruous desires. Do we not all want what is best for our family and friends as well as our communities?

No one wants to struggle or suffer. It is within this collective context that seeing someone help another creates a state of elevation, an uplifting and positive emotion we feel when we are in the presence of goodness. Such elevation can, in turn, motivate and inspire others to perpetuate compassionate action. This suggests that acts of generosity and kindness beget further generosity and kindness – leading to a chain reaction of goodness and compassion.

Extending the virtue of compassion to the larger collective could lead to a kinder and more peaceable humanity, and in the process foster a sense of connection, unity and shared kinship. It is up to us as individuals to act and make the world a better place. Compassion may be the pathway to get us there.

CAN WE BECOME MORE COMPASSIONATE?

Many studies suggest that it is not only rats and chimpanzees but also human infants that are born with an innate neuronal network that makes us naturally compassionate. We might therefore be intrinsically compassionate beings. This does not mean that we are always kind and compassionate, nor that we cannot enhance our compassionate nature even further.

Multiple compassion-based interventions have been developed, studied and evaluated. Some of the more prominent interventions include:

i. Compassion Focussed Therapy (CFT)
ii. Mindful Self-compassion (MSC)
iii. Compassionate Mind Training
iv. Compassion Cultivation Training (CCT)
v. Cognitively based Compassion Training (CBCT)
vi. Compassion-Centred Spiritual Health (CCSH) interventions
vii. Various types of meditation (such as "loving-kindness" meditation)

Becoming more compassionate is a worthy challenge. It will

likely improve not only our own mental state, but also benefit our friends, families and patients, as well as provide a more authentic and mature perspective on the world around us.

IF ALL ELSE FAILS ...

A more immediate and practical technique to increase one's capacity for compassion is to follow a three-step approach:

- Make a choice: self-chosen and voluntary compassionate helping behaviour improves your mental wellbeing the most.
- Make a connection: connecting with, investing in, and spending time with the receiver of your compassionate action further enhances your happiness.
- Make an impact: witnessing the real-world, and palpable, impact of your compassionate action will continue to assist in transforming good deeds into good feelings.

Finally, there is supportive evidence to suggest that when time is precious and one is feeling ill-humoured and irascible, positive non-verbal interaction, and specifically a friendly and warm smile, bestows multiple benefits on not only the giver, but also on the receiver. A pleasing and heartfelt smile is likely to make you, your patients, and your clinical team feel better, more rejuvenated and contented.

Disclaimer:
This article is based on a collation of existing articles, textbooks and internet sources.

REFERENCES

1. Trzeciak, S., & Mazzarelli, A. (2019). Compassionomics: The Revolutionary Scientific Evidence that Caring Makes a Difference. Studer Group.
2. Anstiss, T. Passmore, J. & Gilbert, P. (2020). Compassion; The essential orientation. *The Psychologist*, May, pp38-42.

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

Rock Martins screaming – Me and Me and Me and only more for Me!! So much that is happening in our world that is no different from these Rock Martin fledglings. But they are at least a lot cuter than the rest of us.

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

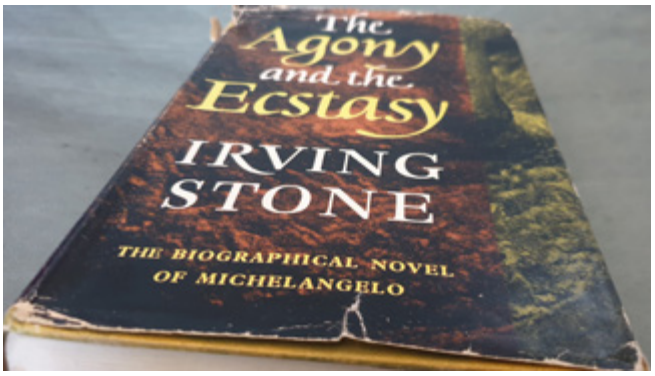
All we need is art. Art is all we need.

Kirti Ranchod

On returning to Wits Medical School, my first memory is almost always associated with my first impression as a student being confronted by a dreadful concrete block with a separate solitary tree some distance from the entrance. The aesthetic offered only containment with nothing to suggest comfort, welcome, or joy. What is fascinating as I return, is that I now have a sense of nostalgia. This mostly unchanged, cold, grey block gets reshaped into something gentler by memory (and forgetting)- of friends, of learning, and books...

In his book, *Reductionism in art and science*, Eric Kandel states 'The most remarkable aspect of human behaviour...is our ability to generate new ideas from experience. Learning is the mechanism whereby we acquire new knowledge about the world, and memory, the mechanism to retain knowledge over time. We are what we are as individuals in great part because of what we learn and remember.' It is a privilege to return here, to reflect on my experience with art and how these have shaped me and my journey as a neurologist to support brain health.

After spending first year at Main Campus, I started second year in this grey building. At some point during that year, I began reading *The Agony and the Ecstasy* on the life of Michaelangelo by Irving Stone (Image 1). The choice was inspired by having seen his work in Italy and by reading Lust for Life by the same author. As I read, I meet Michaelangelo, doing what I am doing, dissecting- to understand the complexity and nuance of the human form, to create perfection as he imagines it to be. The very-young-second-year me is impressed by his focus, determination, passion and desire to excel. This unexpected synergy made me value the



The Agony and Ecstasy by Irving Stone

opportunity and resources made available to me so that I could become a good doctor. It made me understand that what I was doing was training not just for a doctor but for an artist, and that this training came with the seemingly super-human ability to create imagined beauty. If Michaelangelo could dissect to draw better, I would draw to understand better. With it, there was a profound appreciation of the architecture of the human form- of bone sculpted by movement, the fragility of impermeable skin, the considered arrangement of muscle, nerves, arteries and veins. I loved anatomy. As I reflect now, I wonder if Michaelangelo possibly had a role to play in me becoming a neurologist which is anatomical at its core.

My love of art is a response to the experiences my parents provided with trips to galleries, markets, city streets, and temples providing exposure to traditional African, Indian and European art forms. A long time before I started medicine, I remember standing in awe at the stone sculpture of David, whose blood vessels seemed to pulsate and whose muscles were on the verge of moving. As a child, I also painted with my exceptionally busy and exceptionally patient GP father on Friday nights where he shared his knowledge on colour, form, proportion, focus, discipline and joy. This meant that I never had a separation between art and science that many people in the field seem to have. I have used art in various ways throughout my medical career. As a student, I used drawing to understand microbiology, pathology, and anatomy. The thalamus required a lot of drawing. As a clinician, art has helped me to consider different perspectives, support people living with illness, and understand the illness itself differently. For that I am grateful.

In my current role, as a health entrepreneur focused on practical, science-backed solutions to support brain health, I use art in different forms. Various studies have shown the impact of visual art on certain biological markers of stress, on psychological resilience, and improving health outcomes or quality of life in people living with certain neurological and psychiatric conditions. This

has helped me to appreciate the value of art for health and with that, consider the value of indigenous, or cultural resources for health where art has been used across generations.

On one of my visits to the Wits Art Museum, I was introduced to the sculptures of the artist Phutuma Seoka (Image 2). His biography described that he started sculpting on the advice of a traditional healer from his village who recommended that he sculpt to help him to deal with recurrent and distressing nightmares. Given what we now understand about art, its potential to help with stress, improve psychological resilience, and promote self-awareness, this traditional healer potentially had the best possible treatment for nightmares and the related insomnia with minimal side effects. The neuroscience in this setting is complementary to the traditional healers' knowledge. It helps us to understand. The traditional healer understood the potential of art to help Phutuma Seoka. This knowledge, and the people with this knowledge, often get overlooked as a resources for health, and are not included in discussions on improving health systems. We do this to the detriment of creating equitable health systems in South Africa.

Sculpture by Phutuma Seoka, Stars on the North Exhibition, Wits Art Museum

To shift the narrative on this cultural resource for health, and to make brain health knowledge accessible, I host a monthly mental wellness walkabout at the Origins Centre, Wits. This work takes me to the beautiful tapestry room with tapestries that uses a traditional art form, often undertaken by women, to share the history of South Africa (Image 3). The tapestries start with the spiritual practices of the San, moving through colonisation, immigration, and formalised systems of learning, and ending with a panel that invites the visitor to imagine the future. These tapestries always bring questions or perhaps make me reflect on problems I am trying to solve:

1. Do we (working in health) perpetuate harm without a conscious attempt to address these violent histories?
2. Do we dismiss/ minimise what we don't understand?
3. What does a healthy health system actually do?

At the centre of these panels stands Sarah Baartman- exploited in life, where she was exhibited in London, and in death. On her death, her body was dissected by Georges Cuvier, described by some as the 'founder of vertebrate palaeontology', the 'best anatomist of his time', and 'one of the finest minds in history'. Cuvier went on to preserve parts of Sarah's body which he then displayed at *Musée de l'Homme* in Paris until as late as 1974 (or later according to some reports). On the request of President Nelson Mandela and the government at the time, her remains were finally returned in 2002 and buried in the Cape. This art makes me reflect on the power dynamic that allowed this, the privilege that this dynamic still offers, and the responsibility to prevent exploitation. In the tapestry, Sarah is surrounded by flowers which was a conscious choice by the artists to surround her with beauty, nurture her spirit, and protect her memory. Perhaps these flowers serve to remind us that there is the potential for healing within this system and that this requires conscious and critical reflection from us as a collective.

Origins Centre, Tapestry Room. Photographer: Zivanai Matangi

As health professionals, the value of art extends across personal, professional, and structural spheres. By supporting self-understanding, art helps us to navigate sometimes exceptionally challenging days (and months and years). It also provides a different understanding of the people we care for, potentially making us better at what we do. As important, art can challenge our biases and confront our blind spots inspiring excellence in our field. Given the multiple crises currently leading to a brittle health system, and our stubborn desire to support better health, perhaps what we need is art.
References available on request.

Dr Kirti Ranchod *is a neurologist and founder of Memorability; co-founder and Chair of the African Brain Health Network, and Global Atlantic Fellow for Equity in Brain Health.* ***Correspondence: k.ranchod@atlanticfellows.org***

More on her work is available at www.memorability.co

The NHI Act: A flawed execution of a laudable idea

Prelisha Singh, Martin Versfeld and Alexandra Rees

Robust contestation on how to best fulfil the fundamental rights of South Africans complements and strengthens our constitutional democracy. Recent debate has centred on the effective realisation of the right to access healthcare, which the state is required progressively to realise for all South Africans, irrespective of their background and income.

The right to access healthcare came into sharp focus on 15 May 2024, when President Cyril Ramaphosa signed the National Health Insurance (NHI) Act into law, prompting the initiation of constitutional challenges by concerned stakeholders. The most recent of these was filed on 1 October 2024 in the North Gauteng High Court, Pretoria by the South African Private Practitioners Forum (SAPPF), represented by Webber Wentzel.

According to the government, the NHI Act is intended to generate efficiency, affordability and quality for the benefit of South Africa's healthcare sector.

An assessment of South Africa's current healthcare landscape shows a stark difference between private and public healthcare. The country has a high quality, effective private healthcare offering. However, it is currently inaccessible to the many South Africans who cannot afford private care or medical aid payments. Public healthcare, on the other hand, is understaffed, poorly managed and plagued by maladministration and limited facilities.

The NHI Act has been positioned as the vehicle to address this disparity and a desire to take steps towards achieving universal healthcare in South Africa. But a closer reading of the Act highlights numerous problems with its content and implementation design. The absence of clarity, detail or guidance contained in the Act makes it impossible to assess how the Act will be implemented (or, by extension, what the effects of this implementation will be).

This is particularly concerning given that years have passed since the economic assessments, on which the Act was based, were undertaken. Also problematic is the apparent lack of consideration given by the government to submissions made by affected stakeholders during multiple rounds of constitutionally required public participation.

SAPPF underscores these deficits in seeking both to have the President's decision to assent to the Act reviewed and set aside, and the Act itself declared unconstitutional.

President Ramaphosa was obliged, in terms of sections 79 and 84(2)(a) to (c) of the Constitution, not to assent to the Act in its current form. Section 79 requires the President to refer back to Parliament any bill that he or she believes may lack constitutionality. In this case, it is difficult to conceive how the President, or any reasonable person in the President's position could not have had doubts regarding the constitutionality of the NHI Bill. The decision by the President to sign unconstitutional legislation into law, instead of referring it back to Parliament for correction, is also irrational.

The President's duty properly to have referred the NHI Bill back to Parliament is affirmed by the fact that the President is enjoined, by section 7(2) of the Constitution, to respect, protect, promote and fulfil the rights contained in the Bill of Rights.

SAPPF's application demonstrates that the NHI Act, in its current form, infringes upon the rights to access healthcare services, to practice a trade, and to own property. Patients, including those using private healthcare, will be forced to use a public healthcare system that currently fails to meet its key constituents' needs. Practitioners' rights to freedom of trade and profession will be infringed upon, and the property rights of medical schemes, practitioners, and financial providers will be unjustifiably limited.

On its current text, the Act could make South Africa the only open and democratic jurisdiction worldwide to impose a national health system that excludes by legislation private healthcare cover for those services offered by the state – notwithstanding the level or quality of case.

Concerns regarding the rights infringements in the NHI Act are exacerbated by its lack of clarity and the fact that crucial aspects of its implementation are relegated to regulations, with no clear guidance provided in the Act

itself.
For example, section 49 provides that the NHI will be funded by money appropriated by Parliament, from the general tax revenue, payroll tax, and surcharge to personal tax. However, this stance does not reconcile with section 2, which provides that the NHI will be funded through 'mandatory prepayment', a compulsory payment for health services in accordance with income level. Crucially, the extent of the benefits covered by the NHI's funding mechanism and its rate of reimbursement, which impact affordability and the provision of quality healthcare, remain unknown.

The Act is, at best, a skeleton framework, seemingly assented to in haste. It is conceptually vague to the extent that the rights it seeks to promote will, in fact, be infringed if implemented. This renders the Act irrational, in addition to its other constitutional defects.

The NHI Act represents a radical shift of unprecedented magnitude in the South African health care landscape. This should be – and is required to be – underpinned by meaningful public participation, up-to-date socio-economic impact assessments and affordability analyses and final provisions that provide a clear and workable framework for implementation.

It is not sufficient for these vital issues to be addressed after the fact. Further engagements with stakeholders and the solicitation of proposals by the government cannot be used to splint broken laws. Collaborative engagement, including the solicitation of inputs for meaningful consideration, should take place during the law-making process, not after its conclusion.

A shift of the magnitude proposed by the Act, absent compliance with the structures of the law-making process and adherence by the state to constitutional standards, including rights protections, would be detrimental to the entire healthcare sector – public and private – and not in the best interests of patients and practitioners.
Notwithstanding the legal contestation surrounding the Act, it and the laudable goals underlying it can also be a watershed. The achievement of universal health coverage is an opportunity for the different stakeholders in South Africa's healthcare system to meaningfully collaborate and inform well-supported, factually informed, rational and genuinely progressive legislative steps by the state.

Given the questions surrounding the Act and the evident need it seeks to address; the space exists for healthcare stakeholders to align around shared goals and values. They can leverage their available resources to design a healthcare system that serves all of South Africa's people fairly and equitably, using the significant existing resources invested in the country's healthcare sector.


Prelisha Singh


Alexandra Rees


Martin Versfeld

Prelisha Singh and ***Martin Versfeld*** are Partners and ***Alexandra Rees*** a Senior Associate at Webber Wentzel
Correspondence: Nadine van Tonder / TS

Of looking up, out & beyond

Claudia Campbell

Claudia Campbell

For so many years I have fought a battle and tried to make peace with the uncooperative flesh and brain I live in. Often it's a tough job. In that process, I've learnt the need to strip life down to the smallest components and take notice of things which give me moments of reprieve - perhaps just a smile from someone in a shop. The thing is, I have to recognise at times I need a helping hand even with the smallest things, sometimes the energy and mental fortitude required to reach out my hand for help feels beyond my capability. The consequences of not asking for help can be catastrophic - mentally and physically.

After a particularly intense period of self-berating thinking a long time ago, my therapist helped me with the analogy of hiking a mountain peak. I know exactly where I want to end up and with some preparation I might even think I know how to get there. The thing is I'll never really know how until I start walking.

At some stage the climb will get tough, almost impossibly so. At this point I need to stop thinking about the summit, it's obvious where I'm headed - I can only think of the one step in front of me. I'll never ever get up that mountain in one jump, I will only ever summit it with slow, sometimes painful individual steps and breaks in between. The thing is even if I stop for a while, simply facing the right direction is progress. Although not a certain cure for the demons of a self-berating and self-deprecating narrative, it's an analogy that almost always gets the tempestuous storm down a notch or two. Not only that, but at times it frees up enough head and energy to behold the mountains and their sometimes intimidating majesty.

It's tough for those of us who have heads that whirl with a dozen concepts all the time to only focus on one step. However when your body and mind are burnt out, the thought of just getting through one day can feel impossible. Often though the thought of getting through one minute feels okay. So that's what you do, take it down to a minute at a time. As you manage that you'll see 2 minutes become possible and then 4. I used this technique in the most practical way recently. My body had dished up a nasty episode and my mind was struggling to contain the trauma. I agreed with my doctor to check in with an sms at two particular times. This simple agreement contained the storm enough to for me to feel sufficiently capable of navigating two short periods of time. It wasn't about two simple text messages, it was about holding something manageable and sharing it in the most basic form with a person I trust.

I also have to remember I have some days which feel much better than others. For these the rule is to simply enjoy them for what they are. Don't think they're a manifestation of brilliant progress - that takes more time than one day. The bad days take endurance but I must never forget to stay in the moment in the better days. Getting successfully through one minute gives me the fortitude to take on the next one. Even if the next one is a fail, it's simply one minute, and the next minute might be a little better. Personally, this system helped me to not beat myself up so much and reduce the disappointments and setbacks, but importantly give my body and mind a chance to stop and properly take in the beauty of the smallest things. I have begun to realise how much being 'normal' makes one take things for granted.

'Be kind to yourself' - it can seem a trite phrase. I think tenderness and gentleness carry more weight with regards to myself. I can falter at the door of conscious perfectionism. Land myself in a bit of a fury with my body when I feel it's throwing an unnecessary tantrum. I can berate myself, feel immense frustration, and try to push my body unfairly. It might seem to work for a while, but almost unfailingly I fail and am set back. Most often this needs to be pointed out to me by a member of my treatment team. At those times I'm forced to take stock, to work out how to be tender and gentle with myself. I usually need help and suggestions in this regard. But implementing those suggestions almost always leads to some kind of healing and recovery, even if it's for short times. But some days a reprieve is all I need to catch my breath.

So I ask: "What is the point of this Perspective?" As you are well aware, treating chronic illness is a lifelong process often fraught with the unexpected as well as tedium. But sometimes, maybe often or not so often, there are wins. They might be tiny, they might be fleeting, or be longer. Whatever the case, please live them with your patient. Remember that often you are the only person who will know something is actually a win. For instance, aside from my doctor, it's difficult for anyone in my life to understand what a win successfully reducing a medication by a quarter of a tablet is. It's huge, it deserves a moment of celebration. It was really important for my doctor to acknowledge this and do a figurative happy dance with me. It made me feel less alone, and much lighter. It made me feel I had succeeded and that, in an existence so defined by an unreliable body, is truly significant.

So please, please take a minute to enjoy these moments together. Honestly this matters as much as treating the problem. It doesn't need to 'take time you don't have', it just needs to take a moment of happy-focused thinking, not problem-focused.

In the opposite moments, when your patient is sunken in a chronic gloom, help them look up and look out. It takes focus and willpower to live beyond one's illness and not be defined by one's struggles. This doesn't mean denying they exist, or feeling all is fine. Remind your patients of this and lead by example. And, if there genuinely don't seem like any, step across to your practice window and look out and beyond, there will be something to 'live' in that moment. There is more to life for everyone, even if it's simply 2 minutes of noticing others and gifting them a smile.

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

WORLD PSYCHIATRIC ASSOCIATION

New Year's Greetings 2025

On behalf of the World Psychiatric Association (WPA) President, Prof. Danuta Wasserman

Dear Friends,

As 2024 drew to a close, we reflected on a year of resilience, collaboration, and renewed commitments to addressing global mental health challenges, guided by the EDIT principles - Equality, Development, Inclusivity, and Transcultural awareness.

Through united efforts, we move beyond psychiatry by mobilising the best possible resources and advice worldwide, addressing mental health crises comprehensively, and rebuilding connections across diverse regions to create a lasting impact on overall mental health around the globe.

While the world continues to grapple with profound crises and wars in many corners of the globe, mental health must be given the highest priority for traumatised populations, especially children and young people.

The ACRE (Advisory Committee on Responses to Emergencies) publishes evidence-based educational materials on the WPA website to equip mental health professionals with the knowledge and skills to respond effectively to crises and challenging situations around the world.

The WPA sections mobilise to provide practical online training and supervision for colleagues supporting victims of violence, torture, terrorism, and war atrocities, as well as their families.
The vision for global psychiatry goes beyond borders. It embraces the richness of cultural diversity, leverages shared resources, and acknowledges unique regional challenges.

Together, we will continue to build globally resilient mental health communities, creating safe spaces and empowering individuals to make meaningful changes. Through our collective efforts, we will drive growth, foster innovation, and develop support systems that touch lives worldwide.

Thank you for all you do.

Wishing you and your loved ones a year of peace, health, and fulfilment.

Warm regards

Danuta Wasserman

Prof. Danuta Wasserman, President, WPA

WORLD PSYCHIATRIC ASSOCIATION

The World Psychiatric Association (WPA) meetings provide unparalleled forums at which psychiatrists and other mental health professionals, patients, carers, and interested parties can meet and discuss some of most important issues in our industry.

As such, we would like to ensure all our members are inform of our upcoming World and Regional Congresses and Co-Sponsored Meetings that will take place over the coming year:

25TH WPA WORLD CONGRESS OF PSYCHIATRY

5-8 October 2025
Theme: *The Role of Psychiatry in the Changing World*
Place: Prague, Czech Republic
Website: https://wcp-congress.com/

In partnership with WPA member society:
Czech Psychiatric Association and
Slovak Psychiatric Association (SkMA)

WPA REGIONAL CONGRESS 2025 - EGYPT

Theme: *"Embracing the Complexity of Mental Health: Neuroscientific Foundations and Novel Interventions"*
Place: Alexandria, Egypt
Dates: 11-14 April 2025
Organiser: The World Psychiatric Association (WPA) In collaboration with: The Egyptian Psychiatric Association
Website: www.wparegional2025.org

UPCOMING WPA CO-SPONSORED MEETINGS

WPA ZONE 15 - COORDINATION COMMITTEE (PSYCHIATRIC ASSOCIATIONS OF SOUTH ASIA)

Theme: *"Indigenous Mental Health Resources in South Asia"*
Place: Bodhgaya, Bihar, India
Dates: 20 December 2024
Organiser: WPA Zone 15 Coordination Committee and Co-Sponsored by the Association of Industrial Psychiatry of India (AIPI)
Contact: Dr. Vinay Kumar, Secretary of AIPI
Email: dr.vinaykr@gmail.com
Website: aipiindia.org/index.html

21ST ANNUAL NATIONAL CONFERENCE OF ASSOCIATION OF INDUSTRIAL PSYCHIATRY OF INDIA (AIPI) - 2024

Theme: *"Mental Health & Productivity"*
Place: Bodhgaya, Bihar, India
Dates: 20-23 December 2024
Organiser: Association of Industrial Psychiatry of India (AIPI)
Contact: Dr. Vinay Kumar, Secretary of AIPI
Email: dr.vinaykr@gmail.com
Website: aipiindia.org/index.html

WPA CO-SPONSORED MEETING (ZONE 16): BIOPSYCHOSOCIAL ADVANCES IN EVIDENCE-BASED THERAPIES IN PSYCHIATRY

Theme: *51st Annual Convention of the Philippine Psychiatric Association & Regional Meeting of the World Federation for Psychotherapy*
City and Country: Manila, Philippines
Dates: 21 - 24 January 2025
Organizer: Philippine Psychiatric Association & World Federation for Psychotherapy (Other organization)
Contact: Constantine D. Della, M.D. – (Psychotherapy Section)
Email: cddella@up.edu.ph
Website: https://philippinepsychiatricassociation.org // https://wfpsychotherapy.org/

THE 121ST ANNUAL MEETING OF THE JAPANESE SOCIETY OF PSYCHIATRY AND NEUROLOGY

Theme: *Enhancing and Developing Psychiatry and Neurology: Issues To Be Addressed*
City and Country: Kobe, Japan
Dates: 19-21 June 2025
Venue: Kobe International Conference Center, Kobe International Exhibition Hall, Kobe Portopia Hotel
Organiser, Department of Neuropsychiatry, Neuroscience, Ehime University Graduate School of Medicine, Ehime / President of the Annual Meeting: Shuichi Ueno (Professor, Department of Neuropsychiatry, Graduate School of Medical Sciences, Ehime University)
Contact: Secretariat of the Japanese Society of Psychiatry and Neurology
Email: jimu-kokusai@jspn.or.jp
Website: https://www.congre.co.jp/jspn121/

FRESH BREEZES & NEW WAVES ON THE CAPE SOUTH COAST

David Swingler

David Swingler

When Prof Tuviah Zabow retired after decades of service, despite remaining involved in Hospital Boards, he said he 'went from Who's Who! to Who's He?' in a day. I understood this when I slipped out of State hospital service after 36 continuous years during Covid-19. A sweet card signed by (absent) colleagues was left in my pigeonhole, but nary a cup of tea. And then, when gatherings were allowed again, my long considered 'valedictory' personal professional reflection: 'The suicides of my career', was rejected by the SASOP Conference Scientific Committee which called it a prospective study and thus ethically non-complaint.

Enough of woke, what of winemakers? It's 45 years since I put a bottle of wine aside to see how it would develop over time. And what has struck me during the ebbs and flows of the wine trade since, is the insatiable appetite of the market for novelty. Fresh breezes and new waves…

In the old days, winemaking was intergenerational: grandpa to father to son. Land and improvements were long-owned and costs of entry to newcomers prohibitive. Eben Sadie, vinous rockstar supreme, gets the accolades for new wave SA wine, but Neil Ellis was the first to break the mould. While working at Zevenwacht he sourced grapes from distant vineyards to launch his own brand. Remember Whitehall Sauvignon Blanc? It was revolutionary! That Neil has recently sold out to volume brand Van Loveren is wry irony.

After Roland Peens launched 'Young Guns' – an annual tasting of new wave rockers – while MD of Wine Cellar some years ago, we got see the new rising stars, and the new business model. The newbies had no money, to speak of. No land, no improvements. They secured co-farming agreements with grape farmers, often sharing crops.

They rented cellar space, sharing the facilities and the energy. [At one stage Peter-Allan Finlayson made father-in-law's Gabrielskloof alongside his own Crystallum, hosting John Seccombe of Thornes & Daughters, Marelise Niemann of Momento and Anysbos and Albert van Niekerk making his eponymous brand in the ample cellar. They worked and shared together; it was wild. They use (cheaper) seasoned oak, making small (saleable) volumes. And have to price around R350/bottle to balance tenuous books…

The freshest new wave is also collaborating, blowing sea breezes off the Cape South Coast. I visited their 'Exhibition' over Christmas. Mark Stephens was hardly destined for wine, the scion of a lawyer and a PhD pharmacist. But, armed with a (somewhat sanitised) degree in Viticulture and Oenology, he packed 13 harvests around the world into 7 years. Finding his niche as a 'regenerative viticulture consultant' he launched Deep Rooted Wines to translate the intricate complexities of nature into vibrant 'natural' wines that express their origin. His wind-swept, salty sauvignon blanc is in (now fashionable again) wooded Blanc Fume mode as 'Journey to the Centre of the Universe' but 'Free the Bubble', a 'Pet-Nat', is his best seller.

'Pet-Nat'? This rediscovery of an ancient tradition is uber-fashionable. 'Petillant Natural' is sparkling wine made with just one (not two) fermentation in the ancestral method in the bottle. It yields 3 atmospheres of pressure (half of MCC) and is supposed to be sold in a flint bottle under crown cap with a funky label. Not always crystal clear, and for not a lot of money. 'Supposed to'…

'Methode Ancestrale's' keynote flint bottle under crown cap gets leveraged across a trio of 'Brunch Club' wines – PetNat from sauvignon, a Dry White and a Dry Rosé – at Maanschijn by Douglas Mylrea and Paul Hoogwerf. Having schooled and trained together, they went different ways until reconnecting in the moonlight under Maanschynkop at Stonefields on the R43. There is also a 'Herbarium Collection' (a nod to the cellar's prior use) duo of blends but Brunch Club excited me.

Bobby Wallace says it best: 'To continue the family legacy of making premium quality, individually unique, small-batch wines, sourced from premium vineyards.' Father Paul is a legend in the SA vineyard, having crafted Stellenbosch Farmers Winery grapes for decades before launching his own brand with indomitable wife Nicky, marketer of note, in Elgin. Bobby now forges ahead, adding 'Off the Record' as a companion to Paul Wallace Wines. The Syrah, a collaboration with De Grendel's Charles Hopkins from Ceres Plateau vines, is particularly spicy. [At time of writing, Bobby was victim of a violent farm attack; we wish him a speedy recovery.]

Albert van Niekerk works with Crystallum and Thorne & Daughters at Gabrielskloof, but here he teams up with wife Anmar to celebrate their Overberg heritage with the Van Niekerk Vintners label. Sonwater is a fresh, balanced wine from chenin with 10% clairette, Goue Rif a barreled Chardonnay and Rebellie an almost pinot-like grenache. None are second class to their illustrious cellar siblings.

Now PJ Geyer is not, well, a young gun (having been at Alain Moueix's erstwhile Ingwe and Bot River's Barton), but he's now embraced polyculture farming, tending to sheep in between the vines at Thamnus. Named for a rare mountain rose – Orothamnus Zeyheri – it's a spread at the top end of the Hemel-en-Aarde Road R320 overlooking Shaw's Pass. His generous chardonnay and brightly fruited pinot noir were, I'm told, runaway best sellers on show. Good they were, but you gotta like this bloke!

And then there's Stanford royalty. Jessica Saurwein has Bouchard Finlayson, Klein Constantia and Kleinood on her CV, but chose her family name – 17th century forefathers made "sour"/'dry' wine for the Emperor of Austria – for her trio of wines now homed on Waterfal Farm in Stanford. Riesling Chi (Chiuta, an African rain god) is supported by Pinots Noir Om (universal creation) and Nom (gratitude). World-renown British writer Jancis Robinson recently proposed the 2022 Nom (@ GBP 45.21) as an alternative to soaring red Burgundy prices. On the map!

David Swingler was a writer and taster for Platter's South African Wine Guide for 27 years until retiring in 2024. He has over the years consulted to restaurants, game lodges and convention centres, taught wine courses and contributed to radio, print and other media. A psychiatrist by day, David is intrigued by language in general, and its application to wine in particular.
Correspondence: ddswingler@gmail.com

AFRICAN ASSOCIATION OF PSYCHIATRISTS

Mvuyiso Talatala

The African Association of Psychiatrists (AAP) previously known as the African Association of Psychiatrists and Allied Professionals (AAPAP) was formally established in 2002 in Nairobi, Kenya and launched at the World Psychiatric Association (WPA) conference in Yokohama, Japan, that same year. The founding president of AAPAP was Dr. Frank Njenga and the then WPA president, Professor Norman Sartorius, facilitated the establishment of AAPAP. Prominent African Psychiatrists from several Anglophone African countries participated in shaping AAPAP, namely Professors. Atalay Alem and Mesfin Araya from Ethiopia, Dr. Frank Njenga from Kenya, Prof. Oye Gureje from Nigeria, Prof. Robin Emsley from South Africa, Prof. Abdalla Abdulrahman from Sudan, Dr. Fred Kigozi from Uganda to name a few. This continental professional body for psychiatrists was established to promote collaboration amongst African psychiatrists on various areas such as training, research and fight against stigma in mental health. AAPAP's notable achievements include hosting the first WPA Africa Regional Congress in sub-Saharan Africa in 2007 which was held in Nairobi, Kenya. This congress was the culmination of the experience acquired after holding annual meetings in the continent for several years prior to 2007. Subsequent WPA regional meetings have been held in Nigeria, Uganda, and Ethiopia to name a few. Besides conducting regional meetings, AAPAP embarked on training of young psychiatrists in leadership and professional skills supported by Prof. Norman Sartorius and senior experts from Africa and beyond. Young psychiatrists who were mentored were put in what they called the Extended Executive Committee of AAPAP. These young psychiatrists have been gradually entering the leadership of AAPAP and eventually took over most of the leadership positions of AAPAP when it reformed to AAP in a meeting held in 2016 in Mombasa, Kenya. AAP is a platform for African Psychiatrists to lobby for better professional and ethical standard of practice of psychiatry in Africa as well as better financing for mental health care and expansion of training of psychiatrists across the continent.

The African continent has a shortage of psychiatrists with Sub-Saharan region reported to have about one psychiatrist in every 1.5 million people.1 This shortage of psychiatrists makes it difficult for psychiatrists to have a national professional association of psychiatrists in their respective countries. Even in countries where there is a society or an association of psychiatrists, these are usually composed of very few psychiatrists. This leaves psychiatrists in various countries in Africa not formally organised which constrains the sorely needed public voice of psychiatry. AAP is a platform that brings African psychiatrists together and offers a voice for African psychiatry.

AAP had a biennal general meeting on the 13th September 2024 where the following members of the executive committee were elected:

President: Dr. Mvuyiso Talatala (South Africa)

President elect: Prof. Solomon Teferra (Ethiopia)

Immediate past president: Dr Juliet Nakku (Uganda)

Secretary General: Dr. Emmanuel Mwesiga (Uganda)

Treasurer: Dr. Boniface Chitayi (Kenya)

East Africa representative: Dr. Azeb Asaminew Alemu (Ethiopia)

North Africa representative: Prof Amine Larnout (Tunisia)

Southern Africa representative: Prof Dan Stein (South Africa)

West Africa representative: Prof. Sheikh Tiago Latiff (Nigeria)

Ex-Officio member for publications: Prof. Christopher Paul Szabo (South Africa)

The term of this executive committee is from 2024 to 2026 in line with the prescriptions of the constitution of the AAP. The focus of this executive committee in this term is to strengthen the governance of AAP, promote collaborations amongst psychiatrist and to establish an African journal.

Strengthening the governance of AAP is important for psychiatrists to trust the association. This is going to entail strict financial management and accountability to the membership. The president intends to engage the Presidents of the various associations of psychiatry in Africa to unpack the accountability mechanisms that AAP intends to implement so that there is full compliance with the prescripts of the constitution.

Collaborations amongst psychiatrists is essential for the future of African psychiatry in a rapidly evolving environment. We are in a digital age where communication is faster, and meetings can be held virtually. Information technology and artificial intelligence are here to stay and must be leveraged by the psychiatrists to improve opportunities for collaborations as well as access to care. AAP is going to play a leading role in collaborations on education, research and access to care. Discussions are already ongoing with other organisations that have common interests with AAP including African College of Neuropsychopharmacology (AfCNP) and Africa Global Mental Health Institute (AGMHI) in this regard.

Africa needs an African journal that will promote African research and innovation in mental health. There are existing good journals in Africa, but these are not enough for the continent. While journals are available at a global level, Africa needs a journal that will focus on the mental health needs of the global south and Africa in particular. In this term, efforts will be made to start the process of starting a new African journal on mental health. This will start with small steps such as reinvigoration of the AAP brand, establishment of a website and publication of any project that is happening in Africa that is of interest to African Psychiatrists.

AAP executive is calling on all psychiatrists to join AAP and contribute to the future of African Psychiatry.

REFERENCES

1. Lund C, Alem A, Schneider M, et al. Generating evidence to narrow the treatment gap for mental disorders in sub-Saharan Africa: rationale, overview and methods of AFFIRM. EpidemiolPsychiatr Sci 2015; 24: 233-40.

Dr Mvuyiso Talatala – President of the African Association of Psychiatrists (2024-2026)

Prof Solomon Teferra – President Elect of the African Association of Psychiatrists

Dr Juliet Nakku – Immediate Past President of the African Association of Psychiatrists

Dr. Emanuel Mwesiga – Secretary General of the African Association of Psychiatrists

Dr. Boniface Chitayi – Treasurer of the African Association of Psychiatrists

Correspondence: mvuyiso@talatala.co.za

CONSTITUTION FOR THE AFRICAN ASSOCIATION OF PSYCHIATRISTS

1. NAME

1.1. The name of the association is the AFRICAN ASSOCIATION OF PSYCHIATRISTS, abbreviated as AAP

2. STATUS

2.1. The African Association of Psychiatrists is a group of psychiatrists or psychiatric societies in Africa and is affiliated with the World Psychiatric Association

3. DEFINITIONS

In this Constitution unless inconsistent with the context:

3.1. The Association shall mean the African Association of Psychiatrists;
3.2. Constitution shall mean the Constitution of the African Association of Psychiatrists;
3.3. Executive Committee shall mean the Executive Committee constituted in terms of Clause 7.2 of the Constitution;
3.4. Member shall mean a member of the African Association of Psychiatrists as defined in Clause 6 of the Constitution;
3.5. Special Interest Group shall mean a Special Interest Group constituted in terms of Clause 7.5 of the Constitution;
3.6. Task Term shall mean a team appointed in terms of Clause 7.6 of the Constitution.

4. PRINCIPLES

4.1. To remain independent of national and regional bodies, while encouraging their programmes and activities;
4.1 Membership to be by invitation of suitable professionals or professional societies in the relevant field in Africa.

5. OBJECTIVES

5.1 To promote positive interaction among African psychiatrists
5.2 To identify areas of most urgent need
5.3 To identify areas of inter- and intra-regional collaboration, research and training.
5.4 To encourage the use of scientific evidence in clinical practice of psychiatry in the region.
5.5 To promote training and educational opportunities with a view to establishing professional and ethical standards of practice.
5.6 To encourage regional programs for fighting stigma.
5.7 To act as a continental lobby group for mental health at the national, regional and international levels, including World Psychiatric Association, World Health Organization and other United Nations agencies.

6. MEMBERSHIP

6.1 Membership shall be at the discretion of the General Assembly, the Executive Committee shall provide provisional membership to be approved by the General Assembly.
6.2 Membership of the Association shall consist of the following:
6.2.1 INSTITUTIONAL MEMBERSHIP
In countries where there is a Psychiatric Association (Society), membership shall be institutional. Member Institutions shall be required to pay membership fee and their delegates shall have voting powers. Details shall be determined by by-laws.
6.2.2 FULL INDIVIDUAL MEMBERS
Any person who is a Psychiatrist residing in an African country where there is no Psychiatric Association (Society), and is registered with the regulatory authority in his/her country Full members shall be required to pay membership fee and shall have voting powers
6.2.3 ASSOCIATE MEMBERS
Any person who is a Mental Health Worker practicing in Africa registered with the regulatory authority in his/her country is eligible for associate membership. Associate members shall be required to pay fees with NO voting powers.
6.2.4 HONORARY MEMBERS
Honorary membership of the Association may be conferred on a person at a General Assembly on the recommendation of the Executive Committee. Honorary members shall not be required to pay membership fee and shall have NO voting powers
6.2.5 LIFE MEMBERS Life membership may be granted on application to the Association to a Full Member over the age of 60 years and who has been a member of good standing for at least 15 years. For the first 10 years of existence of the Association, exceptions can be made to this rule at the discretion of the Executive Committee. Life members shall not be required to pay membership fees but shall have voting powers.
6.2.6 INTERNATIONAL ASSOCIATE MEMBERS
Psychiatrists residing outside of Africa and registered with an appropriate professional body, may apply for International Associate Membership. International Associate Members shall be required to pay membership fees but shall have NO voting powers.
6.3 Applications for Institutional, Full, Associate and Life membership shall be submitted, on a specified application form to the Secretary of the Association and shall be accompanied by:
6.3.1 Personal and professional details as set out in the application form; and
6.3.2 Membership fees in respect of the year in which the application is made.
6.3.3 Every member of the Association shall remain a member until his or her membership is terminated by:
6.3.3.1 Resignation in writing addressed to the Secretary of the Association;
6.3.3.2 By a decision of the General Assembly; or
6.3.3.3 Failure to pay the prescribed membership fees for two consecutive years.
6.4 Reinstatement may be granted on application to and approval by the General Assembly after the payment of dues.
6.5 The Secretary shall keep and maintain a register of all members of the Association.

7. EXECUTIVE COMMITTEE

7.1 The general direction and control of the policy and affairs of the Association shall be vested in the Executive Committee.
7.2 THE EXECUTIVE COMMITTEE

The Executive Committee shall consist of the following members:
- 7.2.1 The President
- 7.2.2 The Past President
- 7.2.3 The President Elect (Vice President)
- 7.2.4 The Secretary
- 7.2.5 The Treasurer
- 7.2.6 At least one member from each of the 4 WPA Regions in Africa
- 7.2.7 Convenors of Special Interest Groups and Task Teams – ex officio

7.3 All ex officio appointments shall be subject to the approval of the General Assembly following consultation with the nominating group.

7.4 SPECIAL INTEREST GROUPS

7.4.1 Members of the Association may, as the need arises, form Special Interest Groups. Such groups shall elect a convenor and shall have a constitution, which is not in conflict with the Constitution or Policies of the Association.

7.4.2 Convenors of Special Interest Groups shall be members of the Executive Committee subject to Clause 7.3 of the Constitution.

7.5 TASK TEAMS

The President may appoint Task Teams, allocate tasks to them and appoint the Convenor and members thereof.

7.6 TERMS AND CONDITIONS OF OFFICE

7.6.1 The term of office of all elected and ex officio members shall be two years.

7.6.2 The maximum uninterrupted term in the same office shall not normally exceed four years.

7.6.3 The terms of entrance to the office of members of the Executive Committee shall, as far as is possible, be staggered to ensure continuity.

7.6.4 There should be no conflict of interest in relation to the office held.

7.7 MEETINGS

7.7.1 The Executive Committee shall, as far as possible, meet once every month, more frequently when needed.

7.7.2 Notice of all meetings shall be given in writing to members at least ten days prior to the date of such meeting.

7.7.3 MINUTES OF MEETINGS:

7.7.3.1 GENERAL ASSEMBLY, AND EXECUTIVE COMMITTEE MEETINGS

7.7.3.1.1 The Secretary shall, in a book kept for this purpose, record the proceedings of all meetings.

7.7.3.1.2 The minutes shall be submitted to the succeeding meeting for approval and be signed by the Chairman.

7.7.3.2 TASK TEAM, AND SPECIAL INTEREST GROUP MEETINGS

7.7.3.2.1 The Convenors of Task Teams and Special Interest Groups shall cause to be recorded, in a book kept for this purpose, theproceedings of all meetings of the Task Teams, and Special Interest Groups.

7.7.3.2.2 The minutes shall be submitted to the succeeding meeting of the Task Teams, or Special Interest Groups for approval and be signed by the Convenor.

7.7.3.2.3 A copy of the minutes of such meetings shall be submitted to the Executive Committee within 30 days of the date of the meeting for information and action, if necessary.

8. GENERAL ASSEMBLY

8.1 The general assembly shall elect one of its members present at the meeting toact as Chairman.

8.2 A General Assembly of the Association shall be held biennially.

8.3 Members of the General Assembly are President and Secretary General of Member Associations and Individual Members where there is no Psychiatric Society.

8.4 Special General Meetings may be held from time to time and shall be called by the Executive Committee on the written request of six members of the Association.

8.5 A quorum at the General Assembly is 20% of the current total membership.

8.6 The business of a General Assembly shall be set forth in a notice convening the meeting subject to the following conditions:

8.6.1 The notice of the meeting shall be sent to members at least Twenty Eight (28) days prior to the meeting.

8.6.2 No business, other than that for which the original meeting was called shall be discussed without written notice thereof having been given to the Secretary at least seven (7) days prior to the meeting. Under exceptional circumstances, the Executive Committee can decide to add items to the agenda. Any other matter for discussion shall only be considered if sanctioned by two-thirds of the members present at the meeting.

8.6.3 The President may table any matter of urgency.

8.6.4 The majority of members present and eligible to vote shall decide all matters coming before any general assembly. The Chairman may exercise a deliberative vote and shall give a casting vote in all equality of voting.

8.6.5 The President shall submit to the General Assembly:

8.6.5.1 A report setting out the activities of the Executive Committee since the last biennial meeting; and

8.6.5.2 The reports referred to in Clause 11.4.2

9. VOTING

9.1 Except in the case of ex officio members, all members of the Executive Committee shall be elected by open ballot.

9.2 Nominations must be received by the Secretary prior to the deadline and must carry the signature of the candidate and two voting members (a proposer and seconder) and accompanied by a manifesto and curriculum vitae.

9.3 The credentials of all candidates shall be presented to the members.

10. MEMBERSHIP FEES

10.1 An annual membership fees shall be payable by members of the Association to provide funds for the achievement of the aims and objectives of the Association.

10.2 The General Assembly of the Association shall determine the membership fees to be levied and shall include the levy payable to the World Psychiatric Association.

10.3 Membership fees are payable not later than the 31st day of January of each year.

11. FINANCE

11.1 FINANCIAL YEAR

11.1.1 Unless otherwise decided at a General Assembly, the financial year of the Association shall commence of the 1st day of July and end on the 30th day of June of each and every year.

11.2 BOOKS OF ACCOUNT AND RECORDS

11.2.1 The Executive Committee shall ensure that the Treasurer keeps and maintains proper and

adequate books of account and records so as to fairly explain the transactions and financial position of the Association, including:

11.2.2 A budget for the affairs of the Association

11.2.3 A record of assets and liabilities of the Association.

11.2.4 A record of all sums of money received and expended by the Association and the matters in respect of which such receipts and expenditure occurred; and

11.2.5 A register of all members of the Association and the payment by them of membership fees.

11.3 AUDIT

11.3.1 The Association shall, at a General Assembly, authorize the Executive Committee to appoint an auditor for the purpose of auditing the financial statements of the Association.

11.4 FINANCIAL REPORTS

11.4.1 The Auditor shall annually, within two months from the end of the financial year, submit to the Executive Committee his audit report on the finances of the Association and a copy of the audited financial statements.

11.4.2 The Executive Committee shall, at the first succeeding General Assembly of the Association after the receipt of the auditors' report, submit a copy thereof, together with its comments thereon (if any), to such meeting for approval.

11.4.3 The Secretary shall submit to the Executive Committee quarterly reports on the financial position of the Association.

11.5 COMPLIANCE WITH FINANCIAL PROVISIONS

11.5.1 Special Interest Groups shall comply with the financial provisions of the Association laid down in this Clause.

12. AMENDMENTS TO THE CONSTITUTION

12.1 Amendments and addition to the Constitution shall be approved by a twothirds majority of members present at a Biennial General Assembly.

12.2 Proposed amendments and/or additions to the Constitution shall be submitted to the Executive Committee at least 56 days prior to the date of the Biennial General Assembly.

12.3 Notice of proposed amendments and/or additions to the Constitution shall be included in the notice convening such Biennial General Assembly.

13. DISSOLUTION OF THE ASSOCIATION

13.1 Should the Association be dissolved, the assets of the Association shall be dealt with in accordance with a resolution adopted at a General Assembly specially convened for this purpose.

13.2 Such disposal of assets shall be in the best interest of the members of the Association.

14. GENERAL PROVISIONS

The Association is a member of the World Psychiatric Association and is committed to the declarations of Tokyo and Madrid.

15. BY-LAWS

The General Assembly may make, alter or revoke by-laws for the efficient management of the Association.

15.1 THE DISTINGUISHED AWARD FOR MERITORIOUS SERVE TO PSYCHIATRY IN AFRICA.

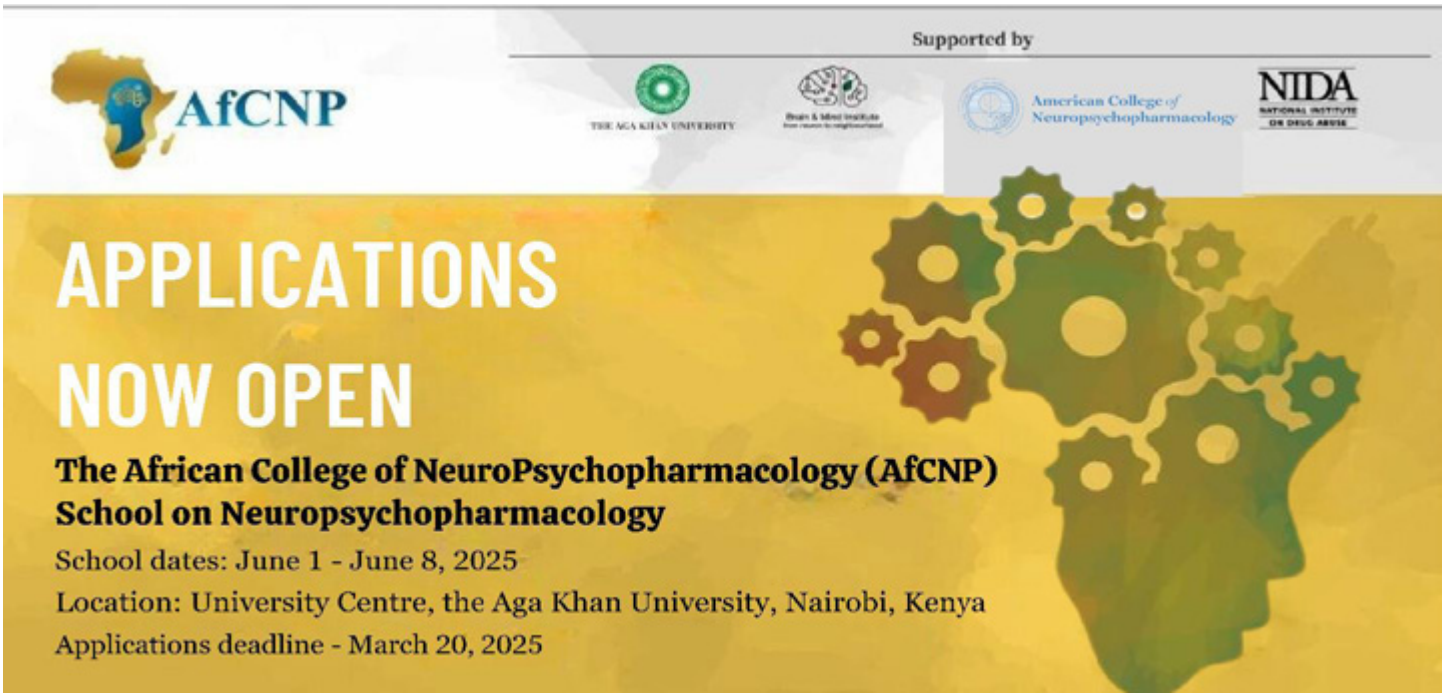
15.1.1 This award shall be created and shall take the form of a scroll.

15.1.2 It shall be awarded at a Biennial General Assembly of the Association on the recommendation of the Executive Committee.

15.1.3 The award shall signify a high honor and shall not be awarded for regular or valuable services.

15.1.4 The award shall be made only to persons who have made a significant contribution to Psychiatry in Africa and they need not be members of the Association.

31st March 2017



Application deadline: March 20, 2025

School dates and location: June 1- June 8, 2025, University Centre, the Aga Khan University, Nairobi, Kenya.

About school
The African College of Neuropsychopharmacology (AfCNP) School on Neuropsychopharmacology will run for 1 week starting June 1, 2025. This will feature intensive lectures by distinguished international faculty and participant-led poster sessions, offering a balanced approach to deepen students' insight and expertise in neuropsychopharmacology. The course will also cover various aspects of neuropsychopharmacology, including the neuropsychiatry consequences of infectious diseases such as HIV/AIDS. It will delve into the neurobiology of mental disorders, exploring brain circuits, genetics, and environmental factors. The use of neuroimaging techniques to study brain structure and activity will be discussed. The importance of collaborative teams involving psychiatrists, psychologists, and neuroscientists in research and clinical applications will be emphasised. Ethical considerations will also be addressed, including informed consent, patient autonomy, and reporting of serious adverse events (SAEs). AfCNP is supported by Aga Khan University's Brain and Mind Institute, the American College of Neuropsychopharmacology (ACNP), and the US National Institute of Drug Abuse (NIDA).

Apply today to reserve your spot. Application begins on Thursday, January 23, 2025, and closes on Thursday, March 20, 2025.

Eligibility / Who should apply to this school?
Early career scientists and researchers (within 5 years of completing a postgraduate degree), Postgraduate students and trainees in psychiatry, psychology, pharmacology, and the neurosciences, from any African country.

What cost will be covered for the selected participant?

- Accommodation and meals
- Travel expenses
- Training costs

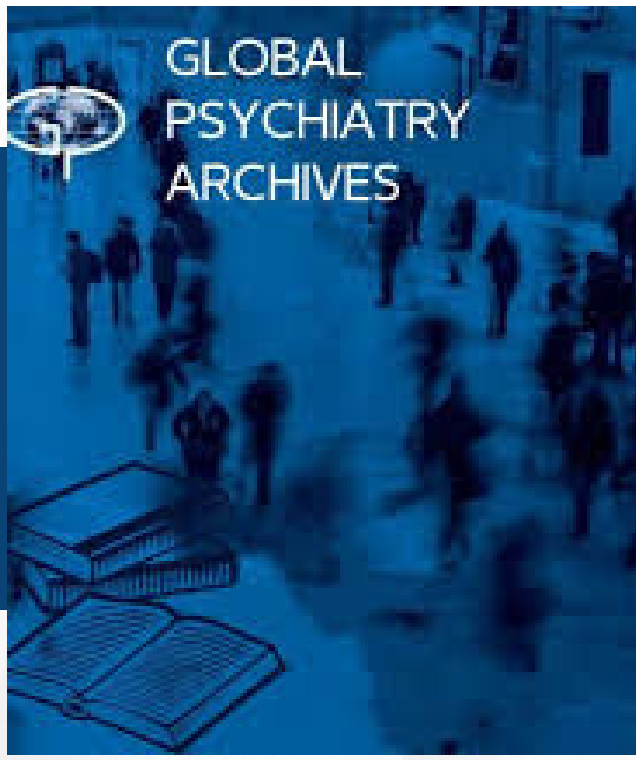
To apply:
https://docs.google.com/forms/d/e/1FAIpQLSeqqvy2GPKmQ4qbQCZrgHC8m6lTGTZH1CswAhCEp1HRiybJuw/viewform?usp=header

For any inquiries, please contact us at:
leonard.liposhe@aku.edu

GPA

GLOBAL PSYCHIATRY ARCHIVES

globalpsychiatry@gmx.com



OBJECTIVES

Global Psychiatry Archives aims to advance global mental health by making relevant scientific knowledge accessible to all. We help authors from across the world publish their research, especially on neglected areas of mental health.

We help them with careful and supportive reviews of their submitted papers. We particularly want to enable new and young researchers and authors from developing economies to contribute their work to the academic community.

AIMS & SCOPE

Global Psychiatry Archives is a self-published, peer-reviewed scientific psychiatric journal that aims to advance global mental health by making relevant scientific psychiatric knowledge easily accessible to all, i.e., mental health professionals, patients, families, and relatives from countries throughout the globe.

We accept original papers, systematic reviews, meta-analyses, case-reports, global perspectives, and editorials in English language on general, biological, social and clinical psychiatry, clinical psychology, psychiatric epidemiology, global mental health issues, neuroscience and related fields relevant to psychiatry and global mental disorders.

BENEFITS

1. Open access with low APC
2. Two issues in a year
3. Rapid & rigorous review
4. Promotion of the published articles on social media

PROFESSOR DR.REINHARD HEUN

EDITOR-IN-CHIEF

- ORCID: 0009-0009-0392-8959
- h-index: 60
- globalpsychiatry@gmx.com
- www.globalpsychiatry.co.uk

GLOBAL PSYCHIATRIC ASSOCIATION

The Global Psychiatric Association (GPA) was founded in 2020 by like-minded psychiatrists and clinical psychologists and is the official publisher of the GPA Journal.

SASOP CONGRESS

17 – 21 September 2025

East London
International Convention Centre
Eastern Cape, South Africa

SAVE THE DATE

For additional information or assistance, please contact:

Londocor Event Management:

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

Bronwyn Rossiter
bronwyn@londocor.co.za
+27 (0)71 048 2343

www.sasop2025.co.za

SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

WEBSITE LAUNCH: JANUARY 2025

Dear Member

1. The secure member section of the SASOP website will no longer be available. Members need to download the In-A-Nutshell App to access all member content.

   Download the App and register, or visit the website to register: Register - In A NutShell

2. The SASOP website has been updated with a new public section to enhance public-facing resources.

DEADLINE EXTENDED

Call for Abstracts and Award Nominations: Don't Miss Out!

SUBMISSION INFORMATION

Don't miss the opportunity to share your work on a global scale. Submit your symposia, workshop, poster, or free communication today!

Symposia
Due 27 January 2025
90-m inute sessions led by up to 4 presenters from different countries. Build a diverse dialogue on critical themes.

Workshops
Due 27 January 2025
Hands-on, interactive 90-minute sessions to share experiential learining and case studies. Ideal for fostering real-world skills.

Posters & Free Communication
Due 10 January 2025
Highlight your research and engage with global experts in a dynamic poster hall.

Submission link:
https://wfsbp.societyconference.com/v2/
Submiossion guide:
https://pmg.joynadmin.org/documents/1064/670dacc302ea290a1c34ac73.pdf

RECOGNIZE EXCELLENCE: NOMINATE FOR WFSBP AWARDS

The WFSBP Awards celebrate achievements that inspire and innovate in biological psychiatry. Take the opportunity to nominate a colleague or yourself for:

- Young Invertigatior Award: Funding for emerging researchers to attend the 2025 congress in Berlin
- Award for Excellence in Education: Showcasing innovative contributions to education.
- Lifetime Acievement Award: Commemorating a legacy of transformative impact in the field.
- Research Prize: Highlighting groundbreaking scientific work that advances biological psychiatry.

EXCITING OPPORTUNITIES AWAIT AT THE 2025 WFSBP WORLD CONGRESS IN BERLIN!

Join us in Berlin - Shaping the Future of Biological Psychiatry
Dates: 9-12 September 2025
Venue: Estrel Berlin Hotel & Conference Centre
Theme: From Innovations to Improved Healthcare for ALL

Why Attend?
Step into the forfront of biological psychiatry at the 2025 congress, where science meets collaboration. Engage in transformative workshops, groundbreaking discussions, and build connectins with international experts. Whether presenting, attending symposia, or learning through workshhops, this is the event to inspire progress..

Register: https://wfsbp.societyconference.com/v2/

DISCOVERY TIERED CONSULTATION RATES 2025

2025 Kicked off with a bang for all Psychiatrists. After 20 years, PsychMg wishes to announce that Discovery Health has finally implemented tiered consultation rates for Psychiatry. Until now, Discovery Health has been the only Funder/Administrator who did not honour tiered consultations for Psychiatrists.

Fortunately, and unfortunately, this introduction has an impact on the remuneration of all Psychiatrists using codes 0161 to 0164 and 166 to 0169. PsychMg, with the assistance of Insight actuaries, released a report a few years ago when the new Procedural Coding System (PCS) was introduced. The report included predictions regarding the utilisation of both the old and new PCS. Discovery Health used the utilisation and predictions, applied it to their own schemes and considered the impact of introducing tiered consultations into the Discovery Health administered schemes.

To ensure the scheme remains sustainable, and that such a change has a zero financial impact on both the scheme and psychiatrists, Discovery Health reduced the remuneration rates of codes on codes 0161 and 0166. Rates remained the same for 0162 and 0167, whereas the rates for 163, 0164, 0168 and 0169 were increased.

PsychMg agreed with Discovery Health that the utilisation and trends will be monitored over a 2-year period, in six monthly intervals. Annual adjustments will be made for 2026 and 2027 to ensure Psychiatrists and Discovery Health gains remain neutral. Theoretically, this change should bring Discovery Health's remuneration for longer consultations in line with other funders.

It is important to take note that PsychMg did not agree on the remuneration rates, we only supplied the actuarial predictions and utilisation through an independent party. The remuneration rates were calculated by Discovery Health.

Should you have any questions, please do not hesitate to contact us on: querypsych@healthman.co.za.

Regards,
Dr Kobus Roux
PsychMg Chairman

UPDATED POSITION STATEMENT ON MOOD STABILISERS

PsychMg has released a document stating the society's position on what is considered as a mood stabiliser for the treatment of Bipolar Disorder.

Please note that Lurasidone was officially launched in South Africa at the 2024 Biological Congress.

POSITION STATEMENT ON WHAT IS CONSIDERED A MOOD STABILISER FOR THE TREATMENT OF BIPOLAR DISORDER

A mood stabiliser is used therapeutically for the acute and long-term treatment of patients with Bipolar Disorder.

Mood stabilisers are defined as medication that:

1. Should have therapeutic effect on manic and/or depressive symptoms during the acute phase.
2. Should prevent manic and/or depressive relapses.
3. Should be effective as monotherapy and be proven to have been effective for at least one year.
4. Should not aggravate or exacerbate manic and/or depressive episodes or mixed states.

Some authors propose that there are first-generation and second-generation mood stabilisers according to when they were introduced. The first-generation mood stabilisers were introduced in the 1960's and the 1970's. The second-generation mood stabilisers were introduced in the 1990's.

The first-generation mood stabilisers (FGMS's) include Lithium, Valproate and Carbamazepine. The second-generation mood stabilisers (SGMS's) include Clozapine, Olanzapine, Quetiapine, Aripiprazole, Risperidone, Lamotrigine and Lurasidone.

Registration of FGMS's in South Africa:

1. Lithium: Treatment and relapse prevention of mania and manic-depressive illness.
2. Valproate: Controlled Release tablets also for treatment and prevention of mania associated with Bipolar disorders.
3. Carbamazepine: Acute mania and maintenance treatment of Bipolar disorders to prevent/attenuate recurrences.

Registration of SGMS's in South Africa:

1. Clozapine: Not registered in South Africa or anywhere in the world for the treatment of Bipolar Disorder. There is though evidence that it is effective in the treatment of Bipolar Disorder.
2. Olanzapine: Moderate to severe mania, prevention of recurrences of mania/depressive episodes of Bipolar Disorder.
3. Quetiapine: Manic episodes associated with Bipolar Disorder.
4. Aripiprazole: Manic episodes associated with Bipolar 1 Disorder, prevention of recurrence of new episodes in patients experiencing predominant manic episodes and who respond to Aripiprazole therapy.
5. Risperidone: Mania in bipolar disorder. These episodes are characterised by symptoms such as elevated, expansive or irritable mood, inflated self-esteem, decreased need for sleep, pressured speech, racing thoughts, distractibility, or poor judgment, including disruptive or aggressive behaviours.
6. Lamotrigine: Adults >18 years, mood episodes and the prevention in Bipolar Disorder, predominantly by preventing depressive episodes.

7. Lurasidone: Monotherapy treatment of adult patients with major depressive episodes associated with bipolar disorder (bipolar depression).

Reports suggest that more than 80% of patients with Bipolar Disorder receive a combination of an antiepileptic and antipsychotic mood stabiliser. 40% of patients receive three or more medications at once and 18% of patients receive four or more medications at once.

The Council for Medical Schemes published the Bipolar Disorder PMB Definition Guideline on the 05 April 2024. This Guideline specifies the benefits that should be available to beneficiaries of medical schemes. This guideline specifies that *"Medication or combinations of mediations that have been effective during episodes of acute mania or bipolar depression should be continued in the maintenance phase."*

The Guideline states: *"Pharmacologic treatment of BD is divided into three categories: manic phase, depressive phase, and maintenance."* The treatment thus that was started during any of the phases should be continued in the maintenance phase.

For the manic phase the medications that the document specifies are: Lithium, Valproate, Aripiprazole, Olanzapine, Quetiapine and Risperidone. For the depressive phase the medications that the document specifies are: Olanzapine combined with Fluoxetine, Quetiapine, Aripiprazole, Risperidone Lamotrigine, Lithium and Valproate. Even Clozapine is mentioned in the document as a second line treatment for acute mania without and with psychosis.

The document specifies the following medications for maintenance therapy: Lithium, Valproate, Quetiapine, Olanzapine, Aripiprazole, Lithium and an antipsychotic, Valproate and an antipsychotic, 2 Mood Stabilisers and an antipsychotic, 2 antipsychotics and another mood stabiliser.

Mood stabilisers for the treatment of Bipolar Disorder include Lithium, some antiepileptic and some antipsychotic medications.

REFERENCES:

a. Rybakowski, J.K. Mood Stabilizers of First and Second Generation. *Brain Sci.* 2023, 13, 741.

b. Kim AM. A Systematic Review of Complex Polypharmacy in Bipolar Disorder: Prevalence, Clinical Features, Adherence, and Preliminary Recommendations for Practitioners. *J Clin Psychiatry* 2021;82(2):20r13263.

c. Michele Fornaro. Prevalence and Clinical Features Associated with Bipolar Disorder Polypharmacy: A Systematic Review. *Neuropsychiatry Disease and Treatment* 2016:12 719-735.

d. Council for Medical Schemes publication. Bipolar Disorder PMB Definition Guideline, 5 April 2024. https://www.medicalschemes.co.za/publications/#2009-3569-wpfd-mental-health

POSITION STATEMENT ON THE USE OF THE SAMA MEDICAL DOCTORS CODING MANUAL CODES FOR PSYCHIATRY

PsychMg has worked tirelessly since 2016 to rectify the Relative Value Unit (RVU) problems associated with the SAMA MDCM psychiatric codes (referred to as the "old procedural coding system"). The last time the old procedural coding system was published in the SAMA MDCM was 2020. The new corrected version of the psychiatric codes ("new procedural coding system") was published in SAMA MDCM since 2021.

Since the new procedural coding system has been circulated for the past 4 years, and 2025 will be the fifth year, medical schemes have had the option to either use the old or implement the new procedural coding system. In this interim period, PsychMg has verbally negotiated with some medical schemes some adaptions to the old procedural coding system that would be in line with international coding rules, to have the RVU at the midpoint, to assist with the auditing of psychiatric practices.

This arrangement had various problems. This has meant that:

- Code 2957 was from 10 to 20 minutes.
- Code 2974 was from 30 to 40 minutes.
- Code 2975 was from 50 to 60 minutes.
- Between the times 21 to 30 minutes and between 41 to 50 minutes there were no codes to use.

In light of the recent ruling by the CMS, there appears to be a choice to use either the old or the new procedural coding system, the need to honour verbal agreements to fix the RVU problem of the old procedural coding system is obsolete. The new procedural coding system fixes that problem. The choice now is whether to use a problematic old procedural coding system or a corrected new procedural coding system.

PsychMg hereby wants to inform its members, medical schemes, medical scheme administrators, managed healthcare organisations, forensic investigators and any other organisations or persons who use the psychiatric procedural coding system, that if the old procedural coding system is used, that the rules as specified in the SAMA MDCM will apply. Likewise, if using the new procedural coding system, the SAMA MDCM 2025 rules will apply. This would mean that if the code 2957 is used, the time would be from 10 to 20 minutes with an RVU of 20, the code 2974 would be from 21 to 40 minutes with an RVU of 40 and the code 2975 will be from 41 to 60 minutes with an RVU of 60. No RVU rule at the midpoint would apply as it is not stated in the SAMA MDCM 2020.

If the new procedural coding system is to be used, it should be implemented in its entirety. PsychMg advises its members to consider not utilising the new procedural coding system for those medical schemes that do not implement the "new procedural coding system" in its entirety.

Please provide your feedback by 16 February 2025 so that we can proceed with finalising the statement.

Should you have any queries or require further clarification, please do not hesitate to contact us: querypsych@healthman.co.za

INVITATION TO SASOP MEMBERS TO JOIN THE BIOLOGICAL PSYCHIATRY SIG

We are setting up a database of members of the South African Society of Biological Psychiatry/Biological Psychiatry SIG.

Individuals who want to join the South African Society of Biological Psychiatry/Biological Psychiatry SIG can do so by completing the registration form below.

Existing members must also please complete the form as we are updating our records.

To register on the database please use the below link:
https://redcap.sun.ac.za/surveys/?s=9LD3KRWK4AL44TYC

IMPORTANT UPDATE: PUBLICATION FEES FOR THE SOUTH AFRICAN JOURNAL OF PSYCHIATRY (SAJP)

We wish to inform you of an important update regarding the publication process in the *South African Journal of Psychiatry (SAJP).* All authors intending to publish in the SAJP will be required to pay 50% of the Article Processing Charge (APC) and SASOP will pay the other 50%. The APC covers the cost of publication of an article with no profit to SASOP or SAJP.

We encourage authors to plan accordingly and to submit any requests for publication as early as possible. Sponsorships will be granted on a first-come, first-served basis, and SASOP cannot guarantee funding for every article that is accepted due to an annual limit. Once the annual limit is reached, the author will be informed and the author will be required to cover the full APC or wait until the next financial year.

Should you have any questions or require further clarification, please do not hesitate to contact us.

PUBLICATION OF ALTERED MOI: PSYCHIATRISTS MANAGEMENT GROUP (RF) NPC

It has come to the attention of the Board that the registered Memorandum of Incorporation ("MOI") contains a few inadvertent errors where the name of the company appears in the MOI and the Company Rules, more specifically that the abbreviation "RF" (indicating that it is a ring-fenced company) was omitted.

The registered name of the company is: PSYCHIATRISTS MANAGEMENT GROUP (RF) NPC and needs to be reflected as such with the inclusion of the "RF" in the MOI and Company Rules. Section 17 of the Companies Act, 71 of 2008 read with Article 2.3.7 of the MOI permits a correction of a patent error in spelling, punctuation, reference, grammar or similar defect.

The Board has resolved to proceed to alter the MOI by aligning the registered name and the reference thereto in the MOI and the Company Rules.

- We herewith attach for publication and for your records: a notice of the alterations indicating the changes together with the relevant provisions from the Companies Act; and
- a copy of the altered MOI as it will appear following the changes at the CIPC.

PUBLICATION OF THE ALTERATION OF MEMORANDUM OF INCORPORATION AND COMPANY RULES IN TERMS OF SECTION 17 OF THE COMPANIES ACT, READ WITH ARTICLE 2.3.7 OF THE MOI

WHEREAS the Company resolved, by special resolution on 13 July 2019 to convert the Company from a public company to a non-profit company and adopted a new Memorandum of Incorporation **("MOI")** and Company Rules **("Rules")**, which conversion and MOI and Rules were subsequently registered with the Companies and Intellectual Property Commission **("CIPC")**;

AND WHEREAS the registered MOI and Rules inadvertently contained a patent error by omitting the abbreviation "(RF)" in the Company's name in certain portions of the said MOI and Rules;

NOW THEREFORE:

NOTICE is hereby given to all Members that the MOI and the Rules of the Company will be altered in terms of Section 17 of the Companies Act, 71 of 2008 read with Article 2.3.7 of the MOI in the following manner:

1. By altering the incorrect name which presently appears on the cover page of the MOI, namely ***"PSYCHIATRIST MANAGEMENT GROUP (NPC)"*** to the correct, registered Company name, namely **"PSYCHIATRIST MANAGEMENT GROUP (RF) (NPC)"**;
2. By altering the incorrect name which presently appears in the definition section of the MOI at Article 1.1.4 on page 2, namely ***"PSYCHIATRIST MANAGEMENT GROUP (NPC)"*** to the correct, registered Company name, namely **"PSYCHIATRIST MANAGEMENT GROUP (RF) (NPC)";**
3. By altering the incorrect name which presently appears at the top of the cover page of the Rules and which presently state ***"RULES OF THE PSYCHIATRIST MANAGEMENT GROUP (NPC)"*** to the correct, registered Company name, namely **"RULES OF THE PSYCHIATRIST MANAGEMENT GROUP (RF) (NPC)";**
4. By altering the reference to the incorrect name which presently appears under the heading ***"INTRODUCTION AND INTERPRETATION"*** section of the Rules at paragraph A. thereof, namely ***"PSYCHIATRIST MANAGEMENT GROUP (NPC)"*** to the correct, registered Company name, namely **"PSYCHIATRIST MANAGEMENT GROUP (RF) (NPC)"**; and
5. By altering the reference to the incorrect name which presently appears at clause 2.9 of the Rules, namely ***"Psychiatrist Management Group (NPC)"*** to the correct, registered Company name, namely **"Psychiatrist Management Group (RF) (NPC)".**

NOTES

Members are referred to Annexure "A" to this Notice which contains an extract from the Companies Act, specifically Section 17. Members are specifically referred to Section 17(2) which sets out the rights of members in respect of the alteration.

Members are further notified that the Directors intend to file a Form Corr 15.3 with the CIPC to give effect to the abovementioned alteration.
Members are invited to approach the Company Secretary, C/O Healthman, should you require any further information or documentation.

CASPER VENTER
Company Secretary
Unit 16 Northcliff Office Park,
203 Beyers Naude Drive,
Northcliff
2195
Tel: 011 340 9000
Dated: 22 January 2025

ANNEXURE "A"

Section 17 of the Companies Act

17 Alterations, translations and consolidations of Memorandum of Incorporation

(1) The board of a company, or an individual authorised by the board, may alter the company's rules, or its Memorandum of Incorporation, in any manner necessary to correct a patent error in spelling, punctuation, reference, grammar or similar defect on the face of the document, by-
   (a) publishing a notice of the alteration, in any manner required or permitted by the Memorandum of Incorporation or the rules of the company; and
   (b) filing a notice of the alteration.

(2) The Commission, or a director or shareholder of a company, may apply to the Companies Tribunal for an administrative order setting aside the notice of an alteration published in terms of subsection (1), only on the grounds that the alteration exceeds the authority to correct a patent error or defect, as contemplated in that subsection.

(3) At any time, a company that has filed its Memorandum of Incorporation may file one or more translations of it, in any official language or languages of the Republic.

(4) A translation of a company's Memorandum of Incorporation must be accompanied by a sworn statement by the person who made the translation, stating that it is a true, accurate and complete translation of the Memorandum of Incorporation.

(5) At any time after a company has filed its Memorandum of Incorporation, and subsequently filed one or more alterations or amendments to it-
   (a) the company may file a consolidated revision of its Memorandum of Incorporation, as so altered or amended; or
   (b) the Commission may require the company to file a consolidated revision of its Memorandum of Incorporation, as so altered or amended.

(6) A consolidated revision of a company's Memorandum of Incorporation must be accompanied by-
   (a) a sworn statement by a director of the company; or
   (b) a statement by an attorney or notary public,

stating that the consolidated revision is a true, accurate and complete representation of the company's Memorandum of Incorporation, as altered and amended up to the date of the statement.

INSTRUCTIONS TO AUTHORS

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

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

LETTERS TO THE EDITOR

- Novel experiences
- Response to published content
- Issues

FEATURES

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

REPORTS

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

PERSPECTIVES

- Personal opinions written by non-medical contributors

NEWS

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

ANNOUNCEMENTS

- Congresses, symposia, workshops
- Publications, especially books

The format of the abovementioned contributions does not need to conform to typical scientific papers. Contributors are encouraged to write in a style that is best suited to the content. There is no required word count and authors are not restricted, but content will be subject to editing for publication. Referencing - if included - should conform to the Vancouver style i.e. superscript numeral in text (outside the full stop with the following illustration for the reference section: Other AN, Person CD. Title of article. Name of Journal, Year of publication; Volume (Issue): page number/s. doi number (if available). Where referencing is not included, it will be noted that references will be available from the author/authors.

All content should be accompanied by a relevant photo (preferably high resolution – to ensure quality reproduction) of the author/authors as well as the event or with the necessary graphic content. A brief biography of the author/authors should accompany content, including discipline, current position, notable/relevant interests and an email address.

Contributions are encouraged and welcome from the broader mental health professional community i.e. all related professionals, including industry. All submitted content will be subject to review by the editor-in-chief, and where necessary the advisory board.

REVIEW / ORIGINAL ARTICLES

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

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

Acceptance of submitted material will be subject to editorial discretion

All submitted content will be subject to review by the editor-in-chief, and where necessary the advisory board. All content should be forwarded to the editor-in-chief, Christopher P. Szabo - **Christopher.szabo@wits.ac.za**

www.southafricanpsychiatry.co.za

THE SOURCE OF EXCEPTIONAL

Established in 2001, we pride ourselves as specialists, creatively energised to deliver successful results, with efficiency and reliability. As leaders in the field of Meetings, Incentives, Conferences, Events and Exhibitions, The Source is a resourceful hub where inspired ideas transform into perfect solutions with impeccable execution. Tailor-made event solutions from concept to development through to implementation rests you, our client, assured of our ability to deliver on our promise - adopting a sophisticated blend of innovation delivered by our professional and enthusiastic team! We listen to understand your vision and objectives, create, innovate and solve, delivering exceptionally, with impact, every single time.

YOUR ULTIMATE SUCCESS • OUR GREATEST REWARD!

OUR PURPOSE

We see ourselves as an invaluable partner to your company, part of your team, part of your success! Whilst we are that familiar face, the face of order and the face of reassurance, we are the face of possibility, being creative innovators in the MICE and exhibition space. Our intricate familiarity with your business ensures seamless coordination from concept to execution. We are a dependable part of your strategy, solidifying your relationships with Key Customer's and Stakeholders, driving your growth, so that we could celebrate with you your success in achieving your goals.

ENGAGE, EMPOWER, EVOLVE!

THE SOURCE
EVENTS · MARKETING
Immersive Multi-Channel Marketing

CONTACT US

+27 (0) 11 469 4591
info@thesourcesolutions.com
www.thesourcesolutions.com

CONNECT

PostNet Suite No. 24
Private Bag X11
Honeydew
2040

SERVICES

EVENT MANAGEMENT:

In-person, Hybrid & Virtual Meetings • Incentives • Conferences • Events • Exhibitions

MARKETING SERVICES:

Digital & Traditional Multi-Media • Graphic Design & Production • Corporate Collateral Publishing • Public Relations • Social Media

ASSOCIATIONS

South African Association for the Conference Industry
A governing body to improve the standards in conference facilities, meeting venues and allied services

Southern Africa Tourism Services Association
A member-driven credibility association that strives to set the highest standards in the Tourism Industry

The PCO ALLIANCE NETWORK
A network of Professional Event Organisers with extremely high professional standards

Event Greening Forum
A non-profit organisation that aims to promote sustainability within the events sector.

Association of African Exhibition Organisers
A collective platform of address and representation for professional exhibition organisers throughout Africa.

Marketing Code Authority
a self-regulatory body which defines ethical rules for the marketing of medicines by its voluntary members.

WEConnect International
Is a global network that connects women-owned businesses to qualified buyers around the world.

Women Owned
An international initiative to create a movement of support for Women Owned businesses.

Women Presidents' Organisation
Formed to improve business conditions for women entrepreneurs, accelerate business growth, enhance competitiveness, and promote economic security

Managing Director: GV Beyers
The Source Public Relations (Pty) Ltd Trading as The Source Events and Marketing
Level 2 B-BBEE | Reg. No. 2018/19583/07 | VAT Reg. No. 4290193772

IN-PERSON, HYBRID & VIRTUAL MEETINGS • INCENTIVES • CONFERENCES • EVENTS • EXHIBITIONS