IT’S A STICK-UP. YOUR MONEY OR YOUR HEALTH!

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The Health Market Inquiry report has been published at a rare moment of opportunity for a new dawn in health reform in South Africa. In the context of a crisis in the public and private health systems, it is the time for active citizenship – or forever hold your peace.

Every month I pay R9,568 for myself and my three dependants for medical aid coverage – insurance, for want of a better word – to cover the costs of access to private healthcare services should we need them. That amount is almost three times the government’s annual per capita expenditure on public health, currently R4,300. It’s my personal contribution to an ever-widening inequality in health, an issue that our Constitution has defined as a human right: everyone’s right of “access to health care services”.

When I use this insurance the medical scheme often only covers a portion of by medical bills. In fact this year, despite being a healthy person in a healthy family, of claims totaling R17,000 just over 60% have been covered by my medical aid. I’m relatively lucky. Touch wood, my family don’t suffer much ill health – we know this could change within a second which is why we pay for the insurance. Medical aid scheme members who get cancer or a mental illness, will tell you a much worse story.

In some instances the costs of medical care for catastrophic illness like cancer can bankrupt a family. The Heart of Private Healthcare, a report compiled by SECTION27 in 2014, told the stories of patients who experienced exactly this. In 2014 as a result of widespread complaints about rising prices and declining benefits the Competition Commission set up an inquiry into the private health care market, called the Health Market Inquiry (HMI). A panel of independent experts was appointed, chaired by former Chief Justice Sandile Ngcobo, and it began a slow, patient process of compiling and studying the evidence about the private health market.

The inquiry has been a mammoth task, involving the study of over 43-million individual patient records, 11-million admissions, numerous written submissions and specially commissioned studies. Over the period 2010 – 2014, the average expenditure per private medical scheme member increased by 9.2% per annum.

At the beginning of July 2018 it published its Provisional Findings and Recommendations in a 479 page report, backed up by lots of mini-reports and annexures. It’s a complex, dense and evidence-heavy report. The recommendations made by the HMI may be a once-in-a lifetime possibility to make private health well again.

According to the Competition Commission nearly nine million people in South Africa (16.9% of the population) are members of medical schemes. Many of them feel resentful. They feel they pay a lot to medical schemes yet have to pay still more out of pocket when they need care. We “choose” to use private health care in the shadow of Africa’s largest public health system, a system that is staffed by some of the best specialists in the world, providing some of the best health programmes in the world. But we do so because the public health system is mismanaged, characterised by long waiting times, drug-stock outs, poor infection control and is stretched beyond the limit. So the truth is that we use private health primarily out of fear and convenience. When you have a health need it needs to be met. The HMI report confirms that premiums are rising and benefits are falling. As we see the grandiose and ostentatious new buildings of medical schemes administrators going up in Sandton, many wonder aloud whether our premiums pay for more than just our health. Similarly, as a new private hospital seems to spring up on every well-heeled corner, suspicions grow that our health insecurities are feeding a highly profitable business that is adding to inequality. Judging by who are the top income earners it’s also making some people very rich.

The HMI report suggests that this
is possible because most medical scheme members don’t know what they are paying for. Neither are they able to judge the quality of care they receive. In fact, they often don’t know whether the healthcare they receive really helps them or even if they need it. Economists call this an ‘information asymmetry’ – put simply, the inequality of knowledge between me, the user, and my health care provider (be it a broker, the scheme itself or a specialist) leaves me vulnerable to exploitation. But it’s not just my personal health or pocket that suffers. The way the private system is run impacts negatively on public health – and vice versa. Expenditure on private health, where R235-billion is spent on nine million people, overshadows the R201-billion the government spends on the other 44-million. Yet the two systems are tied at the hip: they have overlapping staff, overlapping regulatory institutions, and of course an overlapping population for whom healthcare is a right.

So as we talk about giving real meaning to the Constitutional right of access to health care services, it’s important that we address the strengths and weaknesses of both systems and not just the easier-to-target public health system. But before I go there, let me make several points to blow some clouds away from this issue. For the time being, the private sector is an indispensable part of our health system and economy. It has world class facilities and specialists, as well as a dedicated and mostly ethical workforce of general practitioners, nurses, specialists, hospital staff and administrators. Private doctors are feeling picked on and many are fleeing the country so it’s also important to stress that the HMI’s findings are not against the health professionals; they are against the systems that have developed in the absence of adequate regulation and oversight of private health care. The HMI provides evidence of an over concentration in ownership of private hospitals; they point to the power of for-profit medical scheme administrators vis a vis the not-for-profit schemes they manage; the absence of accountability of trustees, consumer ignorance and the collapse of price controls (as one way to keep prices low). All these factors have combined to create a perfect storm that drives up costs. The words the HMI uses are polite: “Supplier-induced demand”, “unexplained expenditure” and “over-servicing”.

Finally, it’s not only the rich that benefit from the private health market. If we count the elite as being the top 5% of earners (and their dependants) in South Africa, they number around two million people. That means that the other seven million of us who use private health are middle class or on low incomes; this includes most members of trade unions, whose leaders negotiated medical aid as an employee benefit many years ago. We spend over R200-billion a year on our health and then another R4-billion on the services medical aids refuse to cover. So, given that it covers so many lives and given the corresponding incapacity of the public system to take us into its arms, it is clear that we need the private for-profit health sector if we are to realise “everyone’s right of access to health care services”.

However, that should not make us hostage to (mis)fortune or overlook the duty on the government to intervene in private markets to protect and advance human rights. And this is where the HMI report becomes very important. Its overall finding is that private health care is characterised by “market failure”. In response, its recommendations are not a “private health grab”, but reasonable, well rationalised, well researched recommendations that will benefit the whole health system. In this respect a vital finding of the HMI concerns the lack of co-operation, planning and sharing of resources between the public and private system. A cold war between these two systems is in nobody’s interests. It means that while hospitals are full to bursting one side of the road (public), they are half empty on the other (private). The public health system turns its demand away, often to die at home; the private system has to specially manufacture demand by ensuring that its much smaller population over-utilises its most expensive services. “While there is excess capacity in most provinces in the private sector, there are widespread shortages in the public sector throughout the country. The national bed population of the private sector exceeds that of the public sector, despite servicing approximately 16% of the overall population... [Thus] the capacity needed in the public sector to increase accessibility to public health care is actually available as excess capacity in the private sector”.

WHAT IS TO BE DONE?
The HMI report has been published at a rare moment of opportunity for a new dawn in health reform in South Africa. In the context of National Health Insurance (NHI), health systems are getting closer and more honest scrutiny. President Cyril Ramaphosa admits there’s a crisis in the public health system and, in the face of the evidence compiled by the HMI, there’s little point denying the crisis of private health. However, now is not the time for blame or political point scoring – too many people are paying the price. Activists need to force a new consensus on health reform, not further divisions. The HMI contains a raft of important recommendations for regulations, systems for effective and fair price control and institutions to oversee the market. But unfortunately the Competition Commission and the Department of Economic Development have done next to nothing to publicise and simplify its findings or to generate debate.

Consequently there is a danger that if we do not pay the recommendations proper attention they will get subverted by those parts of the private sector that do benefit from the status quo, the three very profitable hospital groups, or that they are just overlooked by a faction in government fixated on NHI and ideologically wedded to a different path of achieving universal health coverage. Scheme members can contact their administrators or scheme Trustees about the findings of the report or challenge the Minister of Health to accept and implement the recommendations. The HMI has done its work. Now is the time for your active citizenship – or forever hold your peace. [MHM]

Full opinion piece was published in Daily Maverick https://www.dailymaverick.co.za/opinionista/2018-09-06-its-a-stick-up-your-money-or-your-health/
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For full prescribing information refer to the package inserts approved by the medicines regulatory authority.
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DYNA SERTRALINE 50, 100. Each tablet contains 50, 100 mg sertraline respectively. S5 A43/1.2/0339, 0340. NAM NS3 14/1.2/0627, 0628.

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‘Suicide’ – it’s a word, a term, verb, noun, feeling and a thought. The voice of suicide has been for the most part a silent voice – mute. Often we shy away from speaking about a death which has been self-induced.

“Suicide is an unpleasant topic to speak about. Feelings of uncertainty usually precede any discussion about suicide”

Having open conversations about suicide is difficult for almost everyone – where does one begin to find calm amidst the chaos left in suicides’ wake?

“Tragedies like suicide leave us in a certain state of mind – sometimes the future seems bleak. We find ourselves asking if we can trust ourselves. However, if we all speak up, the different perspectives heard add up and become supportive: For instance groups where there is open discussion, help.”

It’s a hard truth that when you’re involved with the mental health care system, in whichever capacity, you will at some stage be exposed to suicide - either in discussion, debate, or more personally having to handle the suicide of a patient, client, colleague or friend. Even though the authors engage with the mental health care system in different ways and in different capacities, it’s true that all of our lives have felt the tremor the effects of suicide leave, on us personally and on those around us.

When discussing the format of this article there was deliberation regarding on whose opinions and experiences it should be based. We referred to the seeming inattention amongst the mental health care profession to the collective voice of those with mental illness. Mental health care providers tend to talk to individuals or even groups, but rarely find a forum where mental health care provider and user share the same platform. It’s not uncommon for mental health care providers to themselves be mental health care users or visa-versa. Therefore, platforms that offer all participants an opportunity for equal expression, one free of labels, may provide immense insights and explore territories previously deemed taboo to speak openly about. Professional identities aside, all authors of this article are mental health care users themselves. As such, although some professional perspectives are included, this forum has provided a chance for people whose voices are positioned in a manner quite often overlooked to be heard – those of the mental health care user. All contributors to this...
article have experienced suicide in some manner - patients under psychiatric admission, clients who were residents of a psychosocial rehabilitation centre, and fellow mental health care users.

“Everyone involved in the topic of suicide, the consequences of a suicide or their own suicidal feelings need to have coping mechanisms ready at hand. This will assist all of us to deal with suicides and their consequences.”

Recently a poignant and important piece of writing by Professor Lizette Rabé was published that provides a wealth of food-for-thought and reflection. In her open letter to students after the death of Prof Mayosi, dean of the faculty of health sciences at UCT, Prof Rabé, who lost her son, a medical student in his fourth year to depression, suggests that suicide be seen as the terminal phase of a biological disease that claims its victims seemingly anywhere, any time.

“Be alert to those around you and whether you can pick up possible signs they may be in trouble”.

Prof Rabé encourages medical students to speak openly, as opposed to keeping quiet on this topic, which will only perpetuate the stigma and silence around mental illness. This advice extends beyond medical students to the population in general. We’re in complete agreement with Professor Rabé. Only by having an open and honest discourse about suicide, as equals in the aftermath thereof, can we begin to rethink the words we use, breaking the taboo, closing the divide and finding our human connection in the process. And we can’t help wondering about what common themes will emerge.

“Finding a way to cope in the aftermath of suicide is essential. Sometimes though it seems overwhelming and it helps when we can talk in formalised forums, such as support groups or with doctors and counsellors. These discussions prompt us to discover the coping mechanisms that we already possess.”

It’s absolutely true that time should be spent delving into why each individual who chooses to end their lives do so. Understanding or at least attempting to understand a person’s choice of suicide can go some way in helping those left behind make sense of their own feelings and quiet the toxic, yet permeating whisper of guilt. However, when someone takes their life, no matter the setting, it’s not only their family and friends who are affected by their suicide, but all who knew the person, including fellow mental health care users and mental health care providers. The result is that these individuals need to engage with the topic of ‘suicide’ that has been, and largely remains a difficult and taboo territory to traverse. We need to ask those that have been personally affected how to approach this discourse. This includes asking mental health care providers if they are partly to blame for this taboo because they may be blaming themselves in some way for failing the human being that died by suicide?

“When everyone is transparent it helps us to develop trust in ourselves. I think that is true for professionals also being willing to be transparent about their own feelings when dealing with the aftermath of suicide. Perhaps we can just help each other as humans during these times, instead of only professionals helping patients.”

“Finding hope within ourselves helps to understand the dilemma created around us by a suicide.”

It’s agreed by all those who have given input into compiling this article, mental health care users to counsellors, psychiatrists to nurses, that in our studies and experience we have found no manual, no textbook, which provides a fool proof procedure to deal with the aftermath of a suicide.

“We tend to bottle up dangerous issues, so it is very important to share them. By doing this you begin to develop relationships that help you to trust ‘somebody is in your corner’.”

In the absence of a ‘textbook’, the day after a suicide occurred at one mental health care centre an open discussion was held with a group of residents. Each person in the room, mental health care users and professionals alike felt shaken. However, it was this discussion that forms the basis of this article. Due to the nature of their life circumstances many individuals who are residents of a centre that provides mental health-care services have profound insights into suicide as a concept, as well as how suicides reverberate into the world around them. These individuals have a wealth of knowledge about tools that can help others manage the aftershocks of a suicide. The value of the insight and knowledge held by individuals who engage with mental health care in a full-time residential capacity should not be underestimated, and certainly not side-lined by professionals.

“Just as we treat guests with kindness, hospitality and generosity, we need to try and find ways to ‘be guests to ourselves’ – to treat ourselves with those qualities. If we do this, perhaps we won’t chastise ourselves so much if we feel we have had moments of suicidality.”

These residents and co-authors participated with the specific intent of not only passing their insights forward, but also adding to a process, which will hopefully assist in opening up conversations about suicide. Conversations that may begin to chip away at the power of associated stigma and help people speak about difficult thoughts before those thoughts become a threat to their lives.

“We need to remember that regardless of our diagnosis we are all human.”

Everyone involved has to ask themselves: what is the reason for the divide between mental health care provider/mental health care user which seemingly hinders public debate between the two groups? Ironically, it’s known that doctors are amongst the professions in the world with the highest suicide rate...

“The concept of worth seems critical. The gift of life is valuable. If we all work on our ability to notice what is happening in the lives of those around us, we might be able to help them thrive and not just survive.”

Thank you to all Mental Health care users that shared their experiences.
Mental illness can often feel overwhelming to those who struggle to understand the signs and symptoms. General practitioners, psychiatrists, clinical psychologists and other mental health professionals are trained to diagnose mental illness, so having awareness of the subtle signs and presentations of the various disorders can help connect your patient with the proper treatment and improve his/her quality of life.

Most health practitioners have knowledge of schizophrenia and can list some of the symptoms. However, schizoaffective disorder is less well known. Many people with schizoaffective disorder are often incorrectly diagnosed at first with bipolar mood disorder or schizophrenia because it shares symptoms of multiple mental health conditions.

Schizoaffective disorder and schizophrenia are two different disorders, each with its own diagnostic criteria and treatment. They are both defined as psychiatric disorders in the latest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM V).

A schizoaffective disorder diagnosis is given if the patient experiences:
1. Psychotic symptoms, similar to schizophrenia and mood symptoms of bipolar mood disorder
2. Both types of symptoms present in the patient at the same time or within two weeks of each other.

The word schizoaffective has two parts:
- ‘schizo–’ refers to psychotic symptoms and
- ‘–affective’ refers to mood symptoms.

A patient may experience times when they struggle to care for themselves, from basic grooming to lacking insight into their behaviour/awareness of how they’re feeling – this is an indication that they are between episodes. The episodes vary in length. Some patients have repeated episodes but this does not

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WHAT IS SCHIZOAFFECTIVE DISORDER COMPARED TO SCHIZOPHRENIA?
necessarily happen and it may not be a lifetime diagnosis. In essence, schizoaffective disorder is a mental health condition in which a person experiences psychotic symptoms of schizophrenia, such as delusions, hallucinations, disorganized thinking or flat affect, along with symptoms of a mood disorder, such as depression and/or mania.

There are two types of schizoaffective disorder:

1. Bipolar type: characterised by episodes of mania and major depression.
2. Depressive type: characterised by episodes of major depression without mania.

Subtle differences in symptoms can help differentiate between the two disorders. For example, a person who has schizophrenia can become depressed or manic however, these mood-disordered symptoms are not generally a prominent or persistent part of the condition. The time course, prognosis and treatment also differ in minor ways.

**Important differences between schizophrenia and schizoaffective disorder include:**

1. The duration of mood episodes and psychotic episodes are different.
   - A person who has schizoaffective disorder is likely to experience severe mood symptoms accounting for more than half of the total duration of the illness. By contrast, a person who has schizophrenia may also experience mood episodes but the total duration of the mood symptoms is brief compared to the duration of the psychotic symptoms. Furthermore, the duration of psychotic symptoms of schizophrenia tend to be persistent, while in schizoaffective disorder, they tend to come and go.

2. In terms of the course of the disease, most people who are diagnosed with schizophrenia have a chronic and persistent course of illness. By contrast, most people diagnosed with schizoaffective disorder experience episodes of symptoms and are more likely to have symptom-free intervals than people who have schizophrenia. However, this is not a hard and fast rule; in some people, the opposite is true.

In schizoaffective disorder, the psychotic symptoms may or may not be present during the times when a person is experiencing depression or mania. That being said, the diagnosis of schizoaffective disorder requires that the psychotic symptoms be present for a long enough time (at least a few weeks) when a person is not experiencing any serious mood symptoms.

A manic episode requires a period of elevated or irritable mood and increased activity or energy for at least one week and at least three of the following symptoms:
- increased self-esteem or sense of grandiosity
- needing less sleep
- becoming more talkative
- racing thoughts
- being easily distracted
- more goal-directed activity (energy)
- engaging in risky behaviours (i.e., sexual, financial, etc.)

**DIAGNOSIS**

There are no laboratory tests to specifically diagnose schizoaffective disorder. Health professionals therefore rely on a person’s medical history and may use various tests such as brain imaging (e.g., MRI scans) and blood tests to ensure that a physical illness is not the reason for the symptoms.

If the medical practitioner finds no physical cause, they may refer the person to a psychiatrist or clinical psychologist. These mental health professionals are trained to diagnose and treat mental illnesses. They use clinical observation and specific diagnostic assessment tools to evaluate a person for a psychiatric disorder/psychotic disorder.

In order to diagnose someone with schizoaffective disorder, the person must have periods of uninterrupted illness and, at some point, an episode of mania, major
depression or a mix of both – while also having symptoms of schizophrenia. The person must also have had a period of at least two weeks of psychotic symptoms without the mood (depression or bipolar) symptoms.

**Key signs** in clinical presentation for the Medical Practitioner to be aware of when evaluating for schizophrenia or schizoaffective disorder:

- Personal hygiene - good or poor?
- Is the person generally cooperative or easily agitated?
- Do the facial expressions match the mood?
- Does the patient make eye contact?
- Are the movements slow, as if the person is moving through water?
- Do words and sentences follow a normal thought process?
- Does the person appear depressed or manic?
- Does he or she have a grandiose sense of self?
- Does the patient know his/her name? Can he/she tell you the day of the week?
- Does the patient respond to stimuli that are imaginary?
- Does the patient have paranoid thoughts?
- Does the patient have suicidal thoughts?
- Has the patient recently used drugs and/or alcohol?

The presence of these symptoms typically lasts for at least six months, unless mitigated by treatment. They must interfere with self-care, work, or relationships, and cannot be caused by drugs or alcohol.

**CAUSES**

The etiology of schizoaffective disorder is unknown. Factors that may contribute to the disorder include:

- **Brain structure and function**: People with schizophrenia and mood disorders may have problems with brain circuits that manage mood and thinking.
- **Environment**: Factors such as a viral infection, unhealthy relationships, highly stressful situations and/or trauma may trigger schizoaffective disorder in people who are at risk for it.
- **Stressful life events or trauma**: This is more likely to be a cause if the person experienced a stressful or traumatic event/s when they were young and didn’t have adequate coping skills to deal with the experience or the person had not been cared for in a way that helped them to develop coping skills. Subsequently, this person may be particularly vulnerable to a relapse in times of stress.
- **Genetic influences**: A person may inherit a tendency to develop schizoaffective disorder from his/her parents or family members. The psychotic and mood symptoms tend to run in families. The person may be more likely to develop the symptoms if a close relative has a diagnosis of bipolar mood disorder or schizophrenia. However, there is not much research evidence for a genetic explanation and many people who have this diagnosis have no family history of mental health problems.

We don’t know why someone might develop schizoaffective symptoms rather than schizophrenia or bipolar disorder. It may be that all of these conditions are on a spectrum of ways that individuals may be affected by life events.

**TREATMENT**

Schizoaffective disorder and schizophrenia may be treated and managed in the following ways: Through **medication** – including mood stabilizers, antipsychotic medications and antidepressants, depending on the presenting symptoms.

**Psychotherapy** also assists in creating more self-regulation and management of the experienced symptoms. Therapy modalities such as cognitive behavioural therapy and/or family-focused therapy have proven effective.

Psychotherapy helps people with mental disorders to understand the behaviours, emotions and ideas that contribute to their illness and learn how to modify them. Also, the patient has an ability to understand and identify the life problems or events, like a major illness, a death in the family, a loss of a job or a divorce that has contributed to his/her illness and help him/her understand which aspects of those problems he/she may be able to solve or improve on. The patient is able to regain a sense of control and pleasure in life. In addition, they are able to learn healthy coping techniques and problem-solving skills, learn how to form healthy relationships, learn new healthy behaviours and acquire new life skills.

Living with schizoaffective disorder is very much like living with schizophrenia, except that there is a prominent mood component with schizoaffective disorder. It’s debilitating to live with when not treated. While these disorders are serious and interfere substantially with daily life, they can be managed with proper treatment, which can significantly, positively impact the quality of life for the person living with the disorder with the adequate pharmaceutical, psychotherapeutic and family support.

**References available upon request**
SCHIZOPHRENIA
Several faces, one therapy.

• Indicated for acute forms or phases of schizophrenia psychoses¹
• Psychotic disorders with manic, paranoid or hallucinatory symptoms¹,²
• Non psychotic disorders to depress excitation and also psycho-reactive or neurotic symptoms¹

RECOMMENDED DOSING
Initial Treatment Normal Daily Dose: 120 - 160 mg¹
• Orally 3 to 4 tablets in 2-3 divided doses
• IM or IV 3 to 4 ampoules in 2-3 divided doses

Walk a day in my ADHD* life...
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* (Attention Deficit/Hyperactivity Disorder)
In a recent radio interview I was asked a version of a now all too familiar question which went something like “Do you still throw ‘Ritalin’ at children for everything, like you did in the old days?” There is still the perception that child psychiatrists, and this question is asked of you as soon as you identify yourself as such, prescribe excessive amounts of this drug for questionable reasons without regard for a host of mythical, yet widely supported, side effects.

These concerns are held significantly by the general public, including parents who present to our rooms and teachers at schools who refuse to administer doses during school time.

They’re supported by the popular press and social media where information is sustained by regular injections from the scientology movement.

Perhaps of greatest concern is the number of our colleagues – allied health professionals, psychologists and even fellow psychiatrists who remain significantly misinformed and continue to delay referral of patients to appropriate avenues of care.

These are some of my concerns.

• ‘Ritalin’ is but one preparation of a base drug called methylphenidate of which there are now a number of other formulations, e.g Concerta, Neucon and Contramy. It’s interesting that many are happy to take other formulations until they’re informed of its constituents.

• Many are reluctant to engage in the diagnosis of ADHD because of its inevitable link to ‘Ritalin’.

• What is so often lacking is a fundamental lack of understanding of ADHD.

What is so often lacking is a fundamental lack of understanding of ADHD

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ADHD – ‘RITALIN’ AGAIN?
an unwillingness to accept that the child psychiatrist does know this.

• Many, including the scientologists, still believe that ADHD doesn’t exist and is merely a set of behaviours which are the product of bad parenting. Hence the uncontrolled child in the supermarket warrants discipline as well as an irritated stare at the already desperate parent in pursuit. According to this belief system ADHD as a biological entity would not exist so a medication would not be necessary and in fact is claimed to have significant negative effects such as causing brain damage and turning children into zombies. The other interesting theory that is proposed against the use of what has become a ‘HATE’ Drug is that ADHD does in fact exist but is caused by either deficiencies of certain trace elements in the child’s diet or the ingestion of certain basic foodstuffs to which the child is allergic. It’s always interesting to me seeing these children in my practice (because that’s where they always land up) on bottles of supplements and capsules of horrible smelling fish oils. They are often very angry children who have been labelled as oppositional defiant surviving as they are on dairy free, gluten free and sugar free diets. Enough to make anyone angry.

• The next problem is even if the parent is able to accept the diagnosis of ADHD they still remain totally resistant to the use of this potentially ‘toxic’ medication. I always have to remind myself that these are the good parents. They care very much about their children and don’t want anything bad to happen to them.

• The ‘good parents’ are ones who have tried the alternatives - the occupational therapy, play therapy, neurofeedback - and come to you as a last resort. They always have horror stories to tell you that they heard from mothers in the parking lot outside the school about relatives of theirs, or which they read in the media, of children who sustained brain damage or became zombies on ‘Ritalin.

I’d like to conclude with one assertive statement. **Methylphenidate** is one of two drugs registered for use in the treatment of ADHD in South Africa. Its efficacy and safety has been demonstrated through extensive research in children. It does have side effects which can be carefully monitored by the child psychiatrist who is generally very experienced in making the diagnosis of ADHD and the use of **methylphenidate** and can be trusted in this regard.

There has been a very positive trend recently in popular press – magazines, social media, radio and television - to increase awareness of mental health issues in children (teen suicide and anxiety for example). Isn’t it about time we put ’Ritalin’ to bed and started educating our parents, teachers (and of course all the adults with undiagnosed ADHD) as well as our colleagues about what ADHD really is and what the real efficacy, safety and potential side effects of the treatments available are. Treatment of ADHD has the potential to change the lives of those affected by ADHD.
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References:
1. IMS TPM December 2017.

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ARIZOFY® 10 mg (tablets). Reg. No.: 46/2.6.5/0875. Each tablet contains 10 mg aripiprazole.

ARIZOFY® 15 mg (tablets). Reg. No.: 46/2.6.5/0876. Each tablet contains 15 mg aripiprazole.

PHARMACOLOGICAL CLASSIFICATION: A 2.6.5 Tranquilisers – miscellaneous structures.

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The association between physical, chronic pain and depression is well established. Research suggests that approximately 50% of patients who suffer from chronic pain suffer from some degree of depression. The bi-directionality of physical pain and depression makes it very difficult to know which one precedes the other. Answering the question ‘did pain cause depression or did depression cause pain?’ is often an onerous task for health practitioners. This is because the same chemicals in the brain that modulate mood are the same ones that affect a number of physical systems in the body, especially pain.

A noteworthy point is that a diagnosis of depression itself can lead to physical pain. Depression frequently causes unexplained pain, such as headaches or back pain, and people who are depressed might struggle to improve or maintain physical health. In turn, chronic pain can lead to trouble sleeping, increased stress, or feelings of guilt or worthlessness associated with depression. These influences can create a cycle that’s hard to break. The intricate link between physical pain and psychiatric illnesses, such as depression, serve as proof that mental and emotional experiences can and do manifest physically.

Pain and depression create a vicious cycle in which pain worsens symptoms of depression, and the resulting depression worsens feelings of pain. It is important to note the most common symptoms of depression, which include:

- lack of interest in activities
- depressed mood or irritability
- changes in sleep patterns
- changes in appetite
- feelings of guilt or despair
- lack of energy
- trouble concentrating
- Suicidal thoughts.

Some of these symptoms of depression often coincide with physical pain in that people who are experiencing pain may have difficulty falling and staying asleep due to the pain; they may have diminished functioning in the times when they do feel physical pain, and perhaps as a result, harbour feelings of guilt or despair about the loss of agility and full capacity due to the feeling of being in pain.

With regards to the biological bases of depression, a useful metaphor is to think about the hormones and neurotransmitters in the body as a monthly budget. For instance, if one has R100 worth of neurotransmitters and chemicals, R50 of that could arguably go towards adequately and
successfully facing the day, leaving the person with about 50% of that capacity to utilise in high stress and challenging circumstances they may encounter. When considering someone who is in physical, chronic pain, the use of neurotransmitters would arguably be R85. The effort and experience of discomfort evidently requires a great deal of both mental and physical resources in order for the person to achieve even the simplest tasks, leaving them with a diminished reserve to tackle the more demanding and challenging tasks.

Owing to the analogy, it’s clearer to see how the experience of physical pain may masquerade as or lead to symptoms of depression. An individual who is suffering from chronic pain may lack the energy to participate in activities once enjoyed because of the pain that they feel, or they may feel irritable and have a low mood due to lack of or poor quality sleep due to being in pain. The lack of energy may also be as a result of having to manage and cope with the pain. Things such as withdrawal, sleeping more (perhaps due to sedation from analgesics), over-or-under eating, abusing substances etc., may tick all the boxes for a depressive episode or disorder, however, it’s worth noting that if someone is in chronic, physical pain, the above symptoms may well serve as coping mechanisms that one employs to try to cope with the physical pain.

To this end, to think of chronic physical pain conditions and psychiatric disorders as two manifestations of a singular process can help doctors effectively treat and take note of both. Assembling of a comprehensive treatment team and treatment is of utmost importance. Patients benefit the most when chronic pain and depression are treated together and utilise a team of people. This team of experts may include:

• **Physician.** A physician can provide a thorough examination and evaluation, give a diagnosis, and, if necessary, prescribe both pain and psychiatric medications.

• **Pain specialist.** A pain specialist can educate the patient about the relationship between chronic pain and depression and help design a treatment plan.

• **A psychologist/psychotherapist.** Regular sessions with a therapist trained in any form of psychotherapy, can help address anxious or negative thinking patterns and teach coping skills that reduce symptoms of both pain and depression.

They can also work with patients’ families to help them better understand chronic pain and depression.

• **A Physical Therapist.** A physical therapist who can help improve mobility, reduce pain, and increase low mood by introducing helpful exercises and muscle relaxation techniques.

Other professionals such as nutritionists, acupuncturists, and occupational therapists can provide special knowledge to help curb chronic pain and depression.

References available upon request.
Consider defining *addiction* (Latin: *addicere*, meaning, “devotion”, “enslavement”, or “compulsion”), as a kind of excessive relationship, superseding all others. This excessive relationship is dedicated to *narcotics* (Greek: *narke*, meaning, “numbness”, “deadness”, or “stupor”), in order to instil a liveable state of semi-unconsciousness. Narcotics, therein, involve both legal and illegal substances (e.g. alcohol, cocaine) and processes (e.g. gambling, prostitution). The problematic nature of this relationship is reflective of the negative duration and severity upon health; safety; criminality; progression in life; and/or, relations with partners, family or friends. In sum, this excessive relationship to substances or processes, to provide a semi-unconscious state, may exist with severe multifaceted outcomes.

The excessive use of substances and processes reinforce the psychodynamic structure of the person with an addiction, which in turn, propels further misuse. That structure is briefly envisaged as:

- **Dichotomy:** The intolerability toward boredom and stagnation (often ironically) and repulsion from the realities of being human and average, in most ways, is commonly witnessed in a ‘go-big-or-go-home’ attitude, described aptly by family and friends as ‘Dr Jekyll and Mr Hyde’.
- **Emotional Avoidance:** The limited feeling-word vocabulary and conflict avoidance approach highlights the tremendous difficulty in honest, meaningful, long-term relationships, as well as, coping with internal feelings of loss, rejection, failure, grief, guilt and shame, for example.
• **Entitlement** (i.e. "I want, what I want, when I want it, which is now"): The ‘king baby’ need for short-term, immediate gratification of reward (or even punishment) – presenting often as a “know-it-all” sense of self-absorption and/or apathy toward others – negatively impacts dedication to treatment and other meaningfully, long-term positive behaviours and investments.

• **Omnipotence**: The frequent (and self-protective) need to puppeteer the thoughts, behaviours and emotions of others, in conjunction with initial superficial charm (and ‘illusory attachment’ on behalf of the practitioner), often prevents the depth required in sober, healthy, long-term relationships.

• **Self-Destruction**: In spite of the paradoxical egocentrism, the capacity to disavowal the healthy and good aspects of assistance (and even that of themselves), bolsters the readily available employment of the ‘f@#k-it’ button, often confusingly and frustratingly sabotaging progression.

**MECHANISMS TO PROTECT THE ADDICTION**

Persons with an excessive relationship to substances and processes, accordingly, may protect the vitality of that relationship by multiple deceitful means, such as:

**Actual Behaviours**

• **Concealment**: Intentional omission of addiction-related events (e.g. "I drove away from an accident I caused while high")

• **Fabrication**: Intentional false retelling of events (e.g. "I booked a session with the psychologist, that psychiatrist recommended, mother")

• **Half-Truths**: Intentional exploitation of linguistic loopholes to retell events (e.g. A: "Did you use the money I gave you for petrol?" B: "Yes, I did [technically, but also on drugs. You didn't ask if I used all the money for petrol]")

• **Nice-isms**: Intentional accommodation to others with the expectation of having one's own needs met immediately (e.g. "I'm on time for my appointment and taken all my meds... I was wondering if you could book me off work... or consider temporary disability... Why not?! I do everything you ask! Please!")

• **Tanutrums**: Intentional injury to person or property when a boundary has been set (e.g. "Why can't I use my cellphone in groups?! I'm gonna leave, if you don't let me! This place is so unfair!")

**Cognitive Biases:**

• **Availability (Heuristic) Bias**: To use a single, overvalued, readily available example, to contradict a multitude of opposing examples (e.g. "I knew this one guy who drank and smoked into his 90s, so I'll be fine")

• **Backfire Effect**: To be further entrenched into one’s own position directly due to a challenge to that position (e.g. "You keep insisting otherwise, but actually, I'm so much more productive on cocaine")

• **Confirmation Bias**: To search for, interpret and/or recall information, to confirm one’s pre-existing beliefs (e.g. "I never see an elderly crack-addict walk around, so they must be able to quit it sooner or later")

• **Fundamental Attribution Error**: To judge others on their character or behaviour, but oneself on the situation (e.g. "So the drugs made me behave unpredictably – but I've been clean for three weeks – why don't they trust me? What's wrong with them?")

• **Reactance Bias**: To over-compensate against a feeling of restraint by performing the opposite action of the one proposed (e.g. "I hate authority-figures. I do the opposite of what I'm told, even if it's bad for me")

**Psychological Defences:**

• **Externalisation**: To blame one's behaviour on outside circumstances (e.g. "My wife fought with me, which she knows triggers me to use!")

• **Minimisation**: To fuse denial and rationalisation to distort the significance of a behaviour (e.g. "I only occasionally drink to take the edge off, like most people, so could there be another reason for my failing liver?")

• **Moralisation**: To use morality to justify one's own inappropriate behaviour (e.g. "My wife found empty bottles under my car seat, after I said I quit, but what kind of person looks there? Trust is vital!")

• **Perfectionism**: To protect oneself against the pain of making a simple human mistake (e.g. "I accidentally took a sip – my sobriety was done. So, I just drank the rest of night")

• **Withdrawal**: To physically avoid or escape situations that are experienced as emotionally challenging (e.g. "This place is awful – I'm leaving this facility!")

**Argumentation Fallacies:**

• **Ad Hominem**: A distracting personal attack rather than legitimately defending one's own position (e.g. "Maybe I use sleeping pills, but at least I'm not too busy to attend the kids' soccer matches!")

• **Appeal to Authority**: Insisting one's own position is valid simply by referring to an authority or expert connected to the matter (e.g. "If cocaine is so bad for my mental health, why did Sigmund Freud use it all the time, huh?")

• **Appeal to Emotion**: Structuring an argument to manipulate the recipient’s emotions in order to win that argument (e.g. "Alcohol helps me sleep. It’s torturous being awake all night. I'll lose my job if I don't get sleep")

• **Appeal to Nature**: Structuring an argument as that which is naturally-grown is legitimate, and thus, correct (e.g. "marijuana is natural, and people have used it for thousands of years, so it can’t be that bad")

• **Black-or-White**: Structuring an argument in a false ‘either/or’ situation, when there is at
least one other option (e.g. “Would you prefer I died in the streets, or, stayed with you, and used heroin?”)

FOR ADDICTION PRACTITIONERS

For those noble practitioners taking on the challenge of treating persons with addictions, a few suggestions are:

• **Approve of Positive Behaviours**: Any attempts at sobriety (e.g. titration, ‘cold turkey’, poly- to mono-abuse), as well as, any constructive and healthy (vs destructive and unhealthy) activities, reward systems, non-deceptions, non-procrastinations, self-care, and expressions of positive autonomy, are to be directly, or nonchalantly, commended (despite disavowal).

• **Enhance Patient Understanding**: It is important to normalise mediocrity and boredom, help identify emotions, explore positive entertainment, stoically clarify short- and long-term gains and losses, highlight routine and socialisation, identify emotions that trigger, and, localise rejection to specific behaviours (versus entire self).

• **Enhance Practitioner Understanding**: It will likely help to read addiction literature, visit self-help groups (e.g. AA, OA), note secular resources (e.g. The Fix), increase rehabilitation training or ask a colleague, and, understand milestone challenges (e.g. “It’s nearing 6 months, so now I can definitely moderate”).

• **Limit Practitioner Expectations**: One may expect self-defeating behaviours and self-sabotage, inebriated attendance, boundary violations (e.g. non-payment), and poor prognosis. In addition, one may expect superficial charm, distrust, blaming, impatience, frustration intolerance, deception, and limited attention-spans.

• **Retain Practitioner Awareness**: Be aware of patient, partner, or family boundary-pushing, co-occurring Axis I and II disorders, various family addictions, past (e.g. childhood sexual abuse) or current (e.g. marital discord, financial issues) traumas, ‘illusory attachment’, and patient sensitivity to shame, guilt, rejection and failure in treatment. Additionally, be aware of one’s own feelings of inadequacy, moralisation, dejectedness, and, martyrdom. Respect the initial protective development of addiction relationships.

**Recommended Readings**


The fine art of mental health treatment
HOW TRAUMA AFFECTS KIDS IN SCHOOLS

Case study: M is an 11 year old boy who recently experienced a smash-and-grab on the way to school. His mother and younger sister were in the car with him. When the window shattered and the knife was pointed in the car M’s mother shrieked in fear, frightening both M and his sister and bringing them to tears. At first it seemed like M was coping well and that the experience did little to affect him. However, after a few weeks M’s school work started to suffer. He had difficulty concentrating in class and he demanded help on tasks he previously managed. During break he started to withdraw and isolate himself. After a while his peers started to tease and pick on him, leading him to fight on the playground. M became easily irritated and often acted out. When his teachers tried to speak to him and ask what was going on he could not give an answer. M’s teacher wasn’t sure what to do and sought help from trauma experts.

Trauma is experienced when a deeply distressing event or experience occurs, overwhelming the individual’s ability to cope. For example crime, abuse, separation, loss, near death experiences, and violence can be some of the causes of trauma. In the case of M, the trauma was the smash-and-grab experience where he, his mother and sister became vulnerable to crime and fearful for their lives.

The increased rates of violence and crime in South Africa have contributed to the increased prevalence of trauma experienced across the country. Trauma is not isolated to children but is an important topic as it can have significant impact on their development, personality formation, behaviour, and learning. Since children are still developing they often do not have the skills required to address or work through trauma on their own and they are particularly vulnerable to trauma.

IDENTIFYING TRAUMA

Children often leave clues that all is not well. These clues act as messages to adults and caregivers for help. After the smash-and-grab M’s behaviour started to change. His withdrawal, poor peer relationships, acting out and poor academic performance were key signs that M was experiencing discomfort. Changes in demeanour and behaviour will often indicate if a trauma has been experienced. Be cognisant of behavioural, physical and emotional signs.
BEHAVIOURAL CHANGES:
- Avoidance
- Clinginess
- Aggression
- Hyperactivity
- Sadness
- Tearfulness
- Numbness
- Hypervigilance / easily startled / hyper focused on threat
- Forgetfulness

PHYSICAL SIGNS:
- Appetite changes
- Eating difficulties
- Headaches
- Stomach aches
- Sleep difficulty
- Night terrors
- Bedwetting

EMOTIONAL SIGNS:
- Withdrawal
- Detachment
- Fear
- Anxiety
- Anger
- Self-blame
- Guilt
- Distorted reality
- Panic
- Obsessions

Traumatic experiences, both immediate and long-term, can be overwhelming for children. Sometimes children believe they are responsible for the trauma. The anticipation of traumatisation itself can initiate its own anxiety. As a way to cope with these overwhelming thoughts and feelings children often develop defence mechanisms. These mechanisms can provide an escape or immunity to the pain experienced when traumatised. For example numbing and detachment can aid the child in reducing any pain they feel, in a sense ‘shutting-off’ the experience, for their own survival. Sometimes defence mechanisms can be helpful and protective whilst others can be destructive and impact relationships and functioning.

THE BRAIN
Common reactions to trauma can be understood through the development of the brain. If we consider the three parts of the brain, the reptilian brain developing first, the limbic system developing second and the neocortex developing last, we can understand the progression of behaviour related to trauma. It’s common for the brain to react to trauma by reverting to the older, more instinctive part of the brain, the reptilian brain. This part of the brain maintains bodily function necessary for survival.

The limbic system can also be engaged as it’s also concerned with survival. In the primary stages of trauma it’s difficult to engage the neocortex. The instinctive parts of the brain (reptilian brain and limbic system) override the more conscious and logical part of the brain (neocortex). As survival becomes the brains focus, the amygdala activates the fight, flight or freeze response. When this happens adrenalin floods the body and parts of the body unrelated to survival become inactive.

The hippocampus, which usually manages memory shifts its function to pump cortisol in order to stop any feelings of pain. This can explain why memory can be affected during trauma. The most important task is self-preservation. Every time a trigger is experienced the instinctive brain is activated. M’s acting out and fighting can be seen as an instinct for survival in a time where he feels under attack.

When working with a child who has experienced trauma, meet them on an instinctual, bodily level moving towards a more logical and cognitive level. It’s also important to remember that events can often be misperceived or catastrophised when one is functioning on the instinctive brain. The longer the brain is in survival mode, the harder it is to return to logical thought.
LEARNING

The impact of trauma on the brain can have significant effects on the ability to learn. As seen in the case of M, trauma significantly affected his concentration. He would often drift off into thought or begin to ruminate. His need for extra attention and help also impacted his school performance. The focus on survival and instinct draws energy away from logical thought, making learning very difficult. Children are better able to learn when they feel safe and supported and not focused on survival or danger. Providing a safe environment where an interest and attention is shown is helpful for learning. Trauma may not only have immediate effects as mentioned above, but may also have long-term effects where completion of school is impacted. Impact of trauma on learning:
- Trouble forming relationships with teachers and peers
- Poor self-regulation
- Negative thinking

WORKING WITH CHILDREN WHO HAVE EXPERIENCED TRAUMA

Children who have experienced trauma will often look to caregivers/adults for reassurance and safety. Those working with children who have experienced trauma need to offer the security, predictability and refuge that promotes healing. Consider the child’s developmental phase and approach them at the appropriate level.

Interventions:
- Active listening and being engaged
- Identify and acknowledge emotions instead of jumping to behaviour management
- Answer questions and clarify misunderstandings
- Be mindful of expectations placed on the child
- Create routine and predictability, less ambiguity
- Encourage expression (they are likely to feel afraid of making mistakes)
- Normalise feelings

References available on request.
“How beautifully leaves grow old. How full of light and colour are their last days.”

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**COGNIMET (MEMANTINE HYDROCHLORIDE)**

**INDICATIONS**

For moderately severe to severe Alzheimer’s disease.

Efficacy has not been established beyond 6 months.

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For full prescribing information refer to the package inserts approved by the medicines regulatory authority.
Patients with OCD report profoundly diminished quality of life and social isolation. Not surprisingly, OCD was recently ranked as the 10th leading contributor to the global disease burden.

Across countries and cultures, obsessions and compulsions cluster into certain common themes known as symptom

**BRAIN SIGNATURES OF OBSESSIVE-COMPULSIVE PROFILES**

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**Obsessive-compulsive disorder (OCD)** is a prevalent and disabling neuropsychiatric disorder, and leads to clinically significant anxiety, functional impairment and distress in a number of life-domains (work/school, relationships and family life). The hallmarks are obsessions (repetitive thoughts, images, or urges that generate distress) and compulsions (repetitive behaviors or mental acts that the individual feels driven to perform). There is evidence to suggest that OCD is poorly recognized and commonly underdiagnosed, but it is currently estimated that the lifetime prevalence of OCD is about 2.3%. OCD usually is a chronic and relapsing illness associated with substantial comorbidity with anxiety and mood disorders, as well as with Tourette’s disorder and tics, and substance use disorders, and remission is uncommon. **There is little doubt that OCD is one of the most disabling of all psychiatric conditions.** The symptoms of OCD can progress to the point that the person’s life becomes consumed, inhibiting their ability to attend school, keep a job, and/or maintain important and significant relationships. Patients with OCD report profoundly diminished quality of life and social isolation. Not surprisingly, OCD was recently ranked as the 10th leading contributor to the global disease burden.
dimensions. These include: contamination (fears of contamination with cleaning compulsions); harm (fears of harm with checking compulsions); symmetry (symmetry obsessions and repeating, ordering, and counting compulsions); and forbidden or taboo thoughts (aggressive, sexual, religious obsessions and compulsions). Notably, despite similarities in the core symptoms of OCD, individual OCD patients can also differ from each other in several ways. This includes their age of onset, degree of insight into the rationality or excessiveness of their symptoms, and the presence of comorbidity, all of which may be reflected in the brain.

Abnormalities in different brain circuits have been implicated in many OCD imaging studies. The brain circuit abnormalities that underlie the core features of OCD include dysregulation of corticostriatal-thalamo-cortical (CSTC) circuits. Imaging studies have identified structural and functional abnormalities in multiple nodes of these CSTC circuits in patients with OCD, including the frontal cortices, different parts of the striatum, and the thalamus. Abnormalities in limbic and frontoparietal circuits have also been identified, and recent studies also implicate the cerebellum. Despite the significant extent of progress in brain imaging research in OCD in recent years, prior brain imaging studies have several limitations. First, most have been single-site studies in relatively small samples. Existing meta- and mega-analyses have a different problem: although the samples are very large, the data were collected independently, with each site using different inclusion criteria, clinical measures, and imaging procedures. Second, most studies thusfar have been anatomical. Only a few studies have used diffusion tensor imaging (DTI) to assess structural connectivity or resting-state functional MRI (rs-fMRI) to assess functional connectivity, and these studies have used different methods and produced discrepant results. Third, many studies included OCD subjects on psychotropic medication, even though data show that medications can affect both DTI and rs-fMRI. Last but not least, how different circuit abnormalities lead to the clinical phenotype of OCD remains unknown. In summary, brain abnormalities in OCD patients have been identified, but large knowledge gaps remain. It is unclear how these brain abnormalities develop, what brain abnormalities underlie which symptoms, and which brain abnormalities to target with the available interventions. The need for a large well-powered multimodal imaging study in well-characterized unmedicated OCD patients that transcend countries/cultures was expressed. In addition, the need for identifying robust biosignatures of core OCD features across countries/cultures was also highlighted. It was argued that these signatures can then be used to chart how the disease develops and to develop tailored treatments for populations across the globe.

These expressed needs lead to a successful NIH (R01) grant, with lead researcher Blair Simpson, Professor of Psychiatry at Columbia University Medical Center and Director of Center for Obsessive-Compulsive and Related Disorders (columbia-ocd.org). This grant supports work on a project that will test for the first time whether there are specific brain circuit abnormalities that can be linked to neurocognitive deficits and OCD clinical profiles across countries/cultures. Study procedures include harmonization of clinical, imaging, and neurocognitive methods across sites on different continents, both to build research capacity in 3 low to middle income countries (South Africa, Brazil, India) and to enable the researchers to then test whether there are robust biosignatures of core features of OCD that transcend countries/cultures and can lead to treatment targets with relevance to populations around the globe.

Study methods and procedures
The project was launched earlier this year, and will be conducted over a period of approximately 5 years. The researchers acquire morphometry (using T1-weighted MRI), Diffusion Tensor Imaging (DTI), and resting-state fMRI (rs-fMRI) scans, as well as interview, self-report and behavioral data from 250 unmedicated adults (18-50 years, 50 per site) with OCD and 250 matched healthy control participants (50 per site), over 5 years. In SA, the research is done at the MRC Unit on Risk and Resilience in Mental Disorders, a cross-university unit between the University of Cape Town (UCT) and Stellenbosch University, under the leadership of Profs Dan....
J. Stein and Christine Lochner, respectively.

1. **Screening and Intake**: After providing written consent, subjects undergo a psychiatric and diagnostic evaluation by a trained clinician, and a physical review of history (including BMI and history of Tic Disorders).

2. **Assessments**: Participants are interviewed using scales to assess OCD, depression, anxiety symptoms, symptom severity and improvement, quality of life, and functional impairment. Participants also complete a number of self-report questionnaires to assess IQ, response inhibition (cognitive control), and reward processing mechanisms.

3. **MRI scans**: Neuroimaging consist of 45 minutes of 3D T1 Weighted structural 1 mm scan, rs fMRI and DTI.

**Data Analysis**
The idea is to examine multiple brain circuits thought to underlie OCD behaviors, focusing on morphometry (using T1-weighted MRI), structural connectivity (using DTI), and functional connectivity (using rs-fMRI). The aim is to identify neuroimaging signatures that distinguish individuals with OCD from HCs by analyzing each modality with standardized protocols and by using multimodal fusion with modern machine learning statistical methods. The researchers will then examine how these imaging signatures are linked to behavioral performance on cognitive tasks that probe these same circuits and to a range of clinical profiles that are common to OCD. Finally, the way in which specific environmental features (i.e. childhood trauma, socioeconomic status, and religiosity) may moderate this brain-behavior relationship, will be examined.

**In summary...**
The short-term goal of this study is to identify brain signatures associated with cognitive and clinical profiles common in individuals with OCD that are reproducible across countries and cultures of OCD, leveraging global collaboration both to recruit a very large unmedicated sample and to prove these signatures’ reproducibility. The long-term goal is to identify brain signatures for measurable behaviors and clinical symptoms that cut across traditional diagnostic categories and to use these signatures to transform how we conceptualize, diagnose and ultimately treat mental illnesses like OCD. This multinational project allows the researchers to gather a wealth of data on the brain functioning and structure of people with OCD, rendering a significant contribution to existing knowledge about the brain of people with OCD from different cultures and nationalities.

Individuals with OCD, and siblings of individuals with OCD, and healthy controls, between the ages of 18 and 60 years, who are physically healthy, and not taking psychotropic medications, are invited to take part.

For more info:
Email: ocdrsa@sun.ac.za
Website 1: mrc.ac.za/extramural-research-units/risk-resilience-mental-disorders
Website 2: mentalhealthsa.org.za/research/

For more information regarding the Research study & Sites, please email ocdrsa@sun.ac.za
Dopaquel is indicated for the treatment of schizophrenia and manic episodes associated with bipolar disorder.
I am sure now that I was born with bipolar mood disorder. I understand that this condition runs in families. I know that two of my siblings and two other relatives also live with bipolar. My father lived for over 20 years with it and was never diagnosed, but now I recognise all the common signs. I don’t think it was even recognised 40 years ago.

My parents were divorced when I was 10 years old. It was a complicated divorce and, I think, triggered my condition into what it is today. I attended 5 primary schools, and this did not help me adjust to having friends. I was a loner and enjoyed my own company.

In high school my condition evidenced itself in me often running away from home and behaving in antisocial behaviour. I was more depressed than most of my classmates.

After leaving school, going through national service and getting a job I enjoyed, I noticed periods when I would be excessive in doing things at work, often working well into the night, even though it was not expected.

After I met the girl who became my wife, she noticed my unusual mood swings. Fortunately, she accepted me as I was.

I entered the ministry when I was 23. I served a congregation in Port Elizabeth for two years and was transferred to Walvis Bay. Due to the stress of work, I attempted suicide. Fortunately, I did not succeed. I was referred to a psychologist in Windhoek who managed to get a script from a doctor for depression. I was on this medication for about a year.

After two years, things went better for me when we moved to Vryheid. The small community and country living helped me get my life back in order. I exercised regularly and had a wonderful circle of friends. I put the past behind me and put my suicide attempt to bed.

When we moved to Cape Town, stress again led me to the point of attempting suicide. This time it was taken a lot more seriously. My wife and I were separated for six months while I visited a psychiatrist on a weekly, then monthly, then six monthly basis. I was put on medication which, I was told, I would be on for the rest of my life. Once again, my life went back to fairly normal, and I thought my problem was sorted out.

Leaving Cape Town was a relief and, once again came to a close-knit community in Vanderbijlpark. Life was good. I was energised to do creative and bold things. But my condition did not remain stable for long. I think I overdid things. One day I decided that life was too much and drove to Durban where I once again attempted suicide. After time in hospital, I returned home and was referred to a new psychiatrist.
Fortunately for me, his diagnosis was more accurate than before. I was diagnosed with bipolar and put on an anti-depressant and mood stabiliser.

**ON MEDICATION**

What a relief! I was finally a better self now that a correct diagnosis had been made. I did not have the usual denial that often accompanies diagnosis. Instead, I was grateful. I was encouraged to exercise to lose weight that would release endorphins, a “feel good” chemical, in my brain. I was taught to recognise the warning symptoms and the cycles of hyper activity and depressive states.

This does not mean that I was immune to having relapses. Once our family moved to the East Rand, an almost extra marital affair brought about another bout of depression. I repeated my attempt to commit suicide.

This time I was admitted to the psychiatric ward of a local hospital for three weeks. This was the real turning point in my life. During my stay there, I went through a treatment of informative lectures and therapy. The lectures covered areas like boundaries, anger, understanding medication, handling money responsibly amongst others. Here I discovered that living with bipolar is not only a condition but a lifestyle. It affects every area of your life. The wholistic approach was lifechanging.

**LESSONS LEARNED**

**Family**

I would not have survived my journey without my wife. Not only has she stood beside me, but she has accepted me with my condition. We now embrace a life together as fellow sufferers with this condition. She lives and suffers as much, if not more, than I do. After hospitalization our family sat down and had a conference where my sons were able to ask any questions about my condition. We explained how it runs in families, how to recognise mood swing, etc. Often my family notices changes in my mood long before I am aware. The support of my family means the world to me.

**Support**

I attend a weekly support group in Alberton. Here we are a community of people who all live with mental illness in all its different forms. We accept each other and laugh together. Our identity is not our condition. Rather, we are normal people who live with different conditions. One feature of our group is that our spouses or support people are encouraged to join the group. Many have spoken about how the information that is shared has helped them to understand their loved one’s condition. Our group leader encourages confidentiality, acceptance and a non-discriminatory attitude to those of no faith and differing faiths. We do not prescribe, but share our insights in an attempt to help others. We discuss many issues that we face and learn from her as she has lead our group for over ten years. Her experience is invaluable.

My psychiatrist is part of my support structure. Keeping him informed of my moods allows him to ensure that my medication is the right “mixture” for me. He has had to change it on one occasion.

Compliance when it comes to medication is essential. Having a routine of taking medication no matter how you feel helps minimize the risk of not taking it regularly. Maintaining the right levels of serotonin in the brain is the key to medication. This avoids the highs and lows that bipolar brings.

**A lifestyle**

Living with bipolar is exactly what it says. It is not just one part of my life, but an integral part of who I am. My medication is only one way of helping my condition. I have to help my medication to work by living a healthy, balanced life. This involves having boundaries, learning to relax, dealing with conflict, exercise, and keeping healthy relationships with my family, friends and congregation. Recognising early warning signs and doing something about it has resulted in living a productive life.

**Diagnosis**

I realize how important the early and correct diagnosis and treatment is. For so many years I lived a miserable life because of an incorrect diagnosis. I realize that doctors, like all of us, are not perfect. It was necessary, and fortunate, that due to moving around, I was diagnosed by different doctors each time. With each new doctor, a more accurate assessment was made. Medication has also changed over the years and lead to better treatment.

**CONCLUSION**

I have lived a good life for the past eight years. There is good news. There is hope. Bipolar is not a death sentence for me. It has become one part of the interesting life I live. I have had the good fortune of being able to encourage others in our support group. Some have come after just being diagnosed or having been discharged from hospital. They come with no hope and feel their lives will never be the same. Whilst this may be their present experience, it does not have to be the case.

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**Mental Health Matters**

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