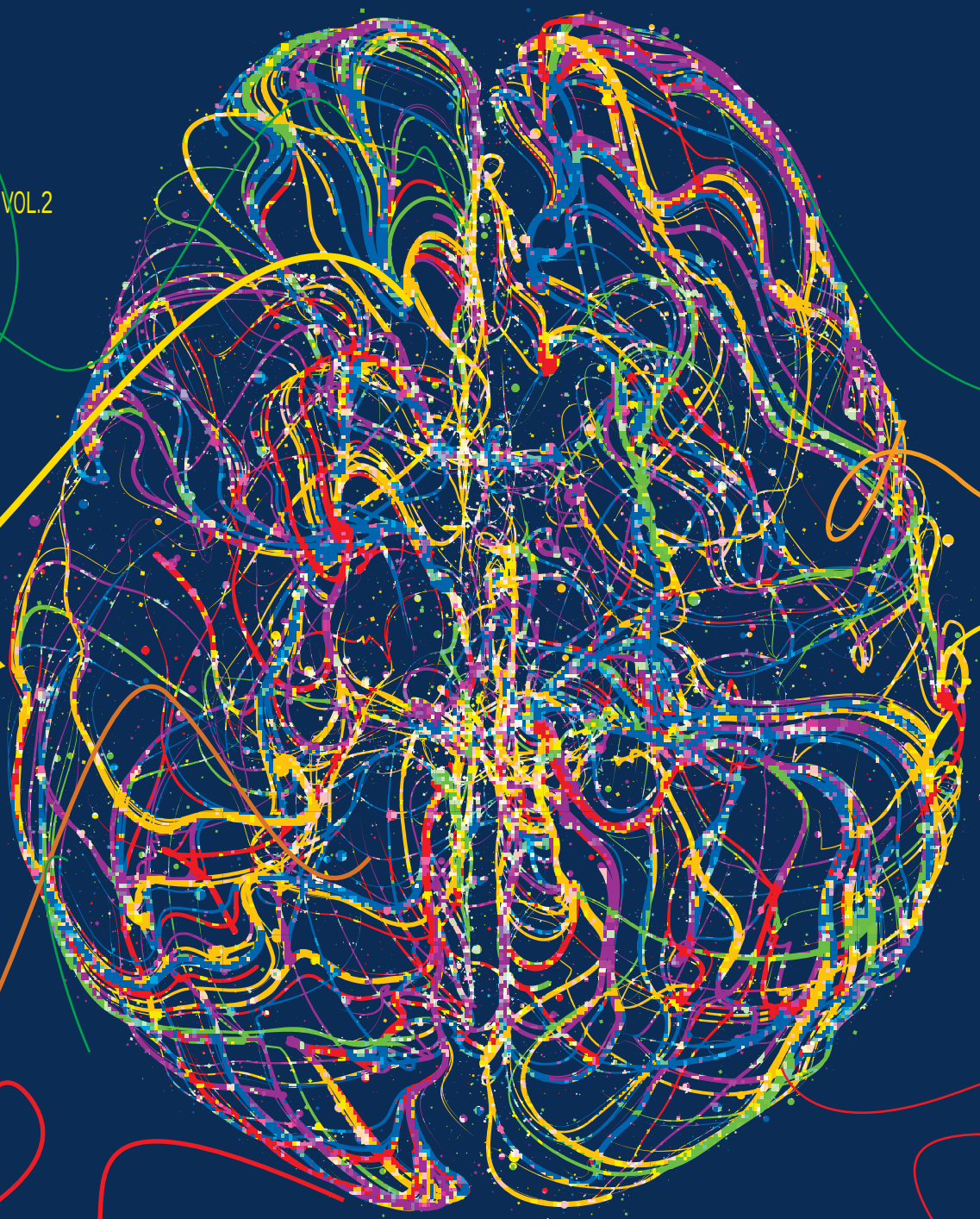
A dOPE MAGAZINE

2019 / VOL.2

DEPARTMENT OF PSYCHIATRY EXPRESSIONS



UNIVERSITY OF KWAZULU-NATAL™

INYUVESI YAKWAZULU-NATALI

INSPIRING GREATNESS

DEPARTMENT OF PSYCHIATRY EXPRESSIONS

Contribute to the magazine

Please email your ideas and contributions for the next edition to:

naseemacassimjee@gmail.com

CONTENT

01 |	MESSAGE FROM THE DEAN	4
02 |	WELCOME FROM THE HOD	6
03 |	ACADEMIC AFFAIRS - **DR K NARSI**	8
04 |	RESEARCH MATTERS - **DR S PARUK**	11
05 |	AWARDS, APPOINTMENTS & ACHIEVEMENTS	22
06 |	CANNA DO'S AND CANNA DONTS - **DR M RAMDEYAL**	25
07 |	THIS IS US - **DR K DOMINGO**	28
08 |	THE CALLING: A MARRIAGE OF WESTERN AND TRADITIONAL MEDICINE - **DR THEJINI NAIDOO**	36
09 |	END OF LIFE PASTORAL CARE: EXTENDING THE TABLE TO INCLUDE THE DYING - **ELIZA GETMAN**	40
10 |	RUNNING: STILLNESS IN MOTION. AN INTERVIEW WITH BLANCHE MOILA - **DR NASEEMA CASSIMJEE**	44
11 |	WHAT THE FIT: CHANGE YOUR GAME. INSIGHTS FROM A PERSONAL TRAINER - **MOHAMMED EBRAHIM**	48
12 |	A REFLECTION ON MINDFULNESS AND WILDERNESS - **DR P MILLIGAN**	52
13 |	PSYCHIATRISTS TAKE ON CHALLENGE OF MOUNT KILIMANJARO - **DR A PORTER**	56
14 |	**PICTURE THIS** DEPARTMENTAL PHOTO SASOP END OF YEAR DINNER PHOTOGRAPHY - **DR N RAYMOND**	62
15 |	**THE UNMASKED HUMAN** ARTWORK - **DR T NAIDOO** KNEADING BREAD - **DR K ROOPUN** CULTIVATING RESILIENCE - **DR B BRAYSHAW**	68
16 |	A TRIBUTE TO A FRIEND AND COLLEAGUE - **DR FAROUK RANDAREE**	72
17 |	**THE LAST WORD:** Q & A WITH **NASEEMA CASSIMJEE** AND **DR FAROUK RANDAREE**	74

ACKNOWLEDGMENTS

Editorial Team

Chief Editor: Naseema Cassimjee, Forensic Psychiatrist, Fort Napier Hospital

Assistant Editor: Professor Bonginkosi Chiliza
Head: Department of Psychiatry, UKZN

Contributors: Dr K Narsi & Dr S Paruk

Proofreader: Dr Navanthree Govender
Forensic Psychiatrist, Sterkfontein Hospital, Wits

Design & Layout
Nhlakanipho Nxumalo & Nomonde Mbhele
Graphic Designer, Corporate Relations, UKZN

Printing
Sponsored by
pharma dynamics
EFFECTIVE AFFORDABLE HEALTHCARE

MESSAGE
FROM THE DEAN

PROF NCOZA DLOVA
DEAN & HEAD OF SCHOOL
UKZN SCHOOL OF CLINICAL MEDICINE

IT GIVES ME GREAT PLEASURE TO WELCOME YOU TO THE DEPARTMENT OF PSYCHIATRY EXPRESSIONS. I AM SO PLEASED TO SEE THE DEPARTMENT'S INCREASING CONTRIBUTIONS TO OUR SCHOOL, PARTICULARLY TOWARDS THE LEADERSHIP OF THE SCHOOL. I AM ALWAYS SO DELIGHTED WHEN I SEE ADVERTS OF RESEARCH WORKSHOPS ORGANISED BY THE DEPARTMENT OPEN TO ALL IN THE SCHOOL, AS WELL AS IN THE COLLEGE OF HEALTH SCIENCES.

Keep up the generosity. As you are aware the School of Clinical Medicine is committed to growing health professionals and researchers to meet the challenges faced by the African child. Our vision is to be globally recognised for excellence in research, education and clinical practice, relevant to our local context, and undertaken in a collegial and effective environment.

In keeping with this vision we have made great strides in improving our physical environment. We have completed a number of important projects that enhanced the learning environments for students, opened the Investec Lounge to aid collegiality amongst academic staff, as well as to make medical school more welcoming. We have expanded our Decentralised Clinical Training Platform in order to accommodate more of the returning Cuban Collaboration medical students into our academic stream. We have also spent a great deal of time and effort in reaching out to our main stakeholder, the Department of Health. We are convinced that we will be able to sign the Joint Health Establishment agreement early in the new year. We are particularly indebted to the Department of Psychiatry for lending us, albeit part-time, Dr Ramlall to take up the role of Academic Leader: Registrar. She has brought so much energy and focus in this new role. She has really been a breath of fresh air to the Dean's Management Team. She has started some fantastic new initiatives that will strengthen the teaching of registrars in our School.

Lastly, I am thrilled that you have decided to focus on wellness this year, as it has also been an important focus for the whole school. A significant amount of time has been spent focusing on student and staff wellness. We have had a number of very successful engagements with our medical students and some of our external partners to look at meaningful interventions to improve student wellness. A number of students took part in campaigns like the 'crazy-socks-for-docs' to raise awareness of the high rates of depression and suicide amongst medical students and young doctors. All our registrar workshops included mindfulness based sessions. Our professional staff have also had a number of information sessions on how to prevent gender based violence in the workplace. They also had a highly interactive session led by the spirited Dr Mashaphu on how to spot early signs of depression and what to do about it. Undoubtedly, one of the School's highlights this year was the launch of yoga lessons in partnership with the Township Yogi Project for students and staff. I personally really enjoyed the yoga lesson as it was both physical as well as a spiritual exercise for me. The Mindfulness Meditation sessions and the yoga lessons were spearheaded by Drs Kalpesh Narsi and Suvira Ramlall, psychiatrists from this department. So, we are looking forward to a great year where the Department of Psychiatry will continue to contribute to a School characterized by excellence in research, education and clinical practice.

WELCOME

FROM THE HEAD OF THE DEPARTMENT

PROF BONGINKOSI CHILIZA
HOD: UKZN DEPARTMENT OF PSYCHIATRY

WELCOME TO THE SECOND EDITION OF THE DOPE MAGAZINE. WE ARE THRILLED TO HAVE HAD ANOTHER SUCCESSFUL YEAR, WITH MANY HIGHLIGHTS TO CELEBRATE. THIS YEAR'S THEME HAS FOCUSSED ON WELLNESS, THE AGE-OLD MANTRA OF 'PHYSICIAN, HEAL THYSELF'. AS MEDICAL PROFESSIONALS, WE ARE ALL GRAPPLING WITH THE REALITY THAT THERE ARE DEFINITELY INCREASING NUMBERS OF COLLEAGUES THAT ARE BURNT OUT, DEPRESSED AND ANXIOUS.

The increasing pressures of having to manage a growing number of patients in our hospitals, which are continuously losing staff members and have a crumbling infrastructure, have taken a toll on many psychiatrists and registrars this year. Our profession has finally woken up to the fact that many colleagues are struggling with severe depression and contemplating suicide. Therefore, we are particularly pleased with Dr Kim Domingo's piece that tries to make sense of why so many of us are refusing or reluctant to get help. I sincerely think that many of us are no longer laughing at doctors that are doing yoga or other important mindfulness based activities. We are all rather celebrating them and joining them on these important life-changing missions.

We have continued to improve the teaching we are offering in the department. We have revamped the basic sciences teaching and roped in a retired Prof of Anatomy, as well as colleagues from the Department of Physiology. We had a successful two weeks of research methodology training at the beginning of the year. The training was done in collaboration with our colleagues from Harvard School of Public Health. We have a fantastic research seminar focussing on Psychiatric Epidemiology in July 2019. We had world-class researchers giving lectures on many aspects of the craft – from genomics to the social epidemiology of psychosis. The research training has borne fruit with two of our registrars (Drs' Busi Bhengu and Thejini Naidoo) receiving research prizes at the Biological Psychiatry Congress as well as the College of Health Sciences Academic Day.

Lastly, our collaboration with Boston University's Department of Psychiatry has continued to grow from strength to strength. We were fortunate to attain funding to send two of our PhD students to visit Boston in September. Drs' Molebatsi and Ntlantsana spent two weeks in Boston. They had research methodology training as well as immersion in the clinical platform offered at BU. This collaboration has culminated in the launch of the Africa Global Mental Health Institute. The Institute will strengthen our work and collaborations with many institutions on our continent. We are indeed working hard to make our department a premier department of psychiatry of African scholarship.

ACADEMIC AFFAIRS

DEPARTMENTAL ACADEMIC DAYS

DR KALPESH NARSI, SPECIALIST PSYCHIATRIST
AND LECTURER, UKZN

PART I AND PART II REGISTRARS IN THE DEPARTMENT OF PSYCHIATRY HAVE DEDICATED ACADEMIC TIME, ONCE A WEEK ON AN AFTERNOON. HOWEVER, THIS FOCUSES PURELY ON CONTENT FROM THE COLLEGE OF PSYCHIATRISTS' CURRICULUM BLUEPRINT. IN 2018, PROF BONGINKOSI CHILIZA, HEAD OF PSYCHIATRY, UKZN, felt there was a need to expose registrars to "non-core" and topical issues in mental health. Thus was the monthly Departmental Academic Day born. Guest speakers from sister-disciplines at UKZN, other universities, visiting external examiners, and private practice psychiatrists were invited to deliver stimulating talks to the Department. These CPD-accredited talks were not only attended by departmental staff and registrars, but often attracted staff and students from the larger campus community.

Dr Mvuyiso Talatala, the past-president of the South African Society of Psychiatrists, and psychiatrist in private practice, delivered the first talk in February 2019. His interactive talk on polypharmacy focused on real-life cases from private practice and the slippery slope encountered when treating patients symptomatically.

The following month saw **Dr Lennart Eriksson**, psychiatrist in private practice and honorary clinical lecturer, run a workshop on the clinical aspects of spirituality. The stimulating programme

PROF JULIE PARLE

PROF NIRMALA GOPAL

DR T MATSHOBA

DR HEMANT NOWBATH

DR K ROOPUN

DR BS BHENGU

DR LEBOGANG PHAHLADIRA

PROF BERNARD JANSE VAN RENSBURG

DR LENNART ERIKSSON

PROF MONIQUE MARKS

DR SOORAJ BAJINATH

DR T NAIDOO

covered medical associations' pronouncements and involvement on issues relating to spirituality and religion, the chronobiology and evolution of spirituality in humans, and the impact of spirituality on clinical practice.

The academic day in April hosted an interesting duo of a historian with an interest in mental health and a psychiatrist with a passion for history and the arts. **Prof Julie Parle**, an associate Prof of History, UKZN, who has a special interest in the history of mental health care services in KwaZulu-Natal delivered a lecture on the history of suicide and euthanasia in the mental health context. She was followed by **Dr Hemant Nowbath**, a psychiatrist in private practice, and "moonlight-historian" whose talk "From Freud to Cognitive Science: Chess and Psychiatry" explored the developmental history of psychiatry and its intercept with the psychodynamic and cognitive-enhancing strategies inherent in the game of chess.

On 6 June 2019, the Department hosted **Dr Lebogang Phahladira**, lecturer and psychiatrist at Stellenbosch University, who delivered a well-attended update on the management of borderline personality disorder. The update focused on clinical features, differential diagnosis, diagnosis in adolescents, and pharmacological management of the disorder. His talk attracted a cross-disciplinary audience from the Psychology Department, and the Departments of Family Medicine and Internal Medicine.

The month of July was dedicated to updates on opioid use disorder. **Prof Monique Marks**, who heads the Urban Futures Centre at the Durban University of Technology and has a background in social work, shared her experiences and lessons with the opioid substitution therapy demonstration project that she leads in Durban. Her talk was followed by a presentation on research done by **Prof. Nirmala Gopal**, associate Prof from the Programme of Criminology and Forensic Studies, UKZN, and **Dr Sooraj Bajinath**, senior lecturer from the Pharmaceutical Sciences Department. Their work, focusing on opioid models in rat brains, and the binding of buprenorphine vs methadone and its clinical implications, drew a robust discussion that ended well after the scheduled time allotted.

Dr Zuber Moola, psychiatrist in private practice, presented case discussions and an approach to formulation and management planning in September. His talk also emphasised the importance of combining pharmacology and psychotherapy, and practical approaches to empower patients to take responsibility for their illness. His talk was followed by a pre-congress practice-run of presentations by registrars, **Dr K Roopun, Dr T Matshoba, Dr BS Bhengu** and **Dr T Naidoo**.

Their hard work and the supportive and constructive feedback given in the session paid dividends as Dr BS Bhengu and Dr T Naidoo were awarded the best poster and best oral presentations respectively at the Biological Congress a week later.

With October being Mental Health Awareness Month, the Academic Day focused on physician wellness. **Prof Bernard Janse Van Rensburg**, past-president of SASOP and associated Prof in Psychiatry, WITS, delivered a talk on "Health Practitioner and Student Wellness: Burnout, Disability and Resilience". His talk garnered robust discussion on the duty of academic departments and regulatory bodies to maintain physician wellness, and the ethics of reporting impaired colleagues and patient-physicians.

The final Academic Day for 2019, in November, was dedicated to psychotherapy. Suntosh Pillay, clinical psychologist at King Dinuzulu Hospital, and honorary lecturer at the Department of Psychiatry, delivered an update on supportive psychotherapy. This was followed by three psychotherapy case presentations by registrars, Dr K Roopun, Dr J Yerriah, and Dr N Hlongwane. The aim of this session was for registrars to present their long- or short-cases from their portfolios and discuss the process of selecting a suitable patient, obtaining supervision, and identifying and addressing their gaps in developing psychotherapeutic skills. The session also aimed to demystify the process, and inspire and reassure younger registrars who are understandably reticent to begin their psychotherapy cases.

The Departmental Academic Days served to not only provide updates with information and knowledge, but helped to expose registrars and staff to complementary paradigms in mental health through dialogue with cross-disciplinary professionals, sister disciplines, and colleagues from other universities. They have also served as great networking opportunities for collaborative work in research, academic and clinical programmes.

RESEARCH MATTERS

TEACHING, LEARNING AND INSPIRING MENTAL HEALTH RESEARCH AT UKZN

DR S PARUK
CHILD PSYCHIATRIST
KING DINUZULU HOSPITAL COMPLEX

ONE OF THE MOST CRITICAL ISSUES IN MENTAL HEALTH SERVICE RESEARCH IS THE GAP BETWEEN WHAT IS KNOWN ABOUT MENTAL ILLNESS, CAUSES, EFFECTIVE TREATMENT, AND WHAT IS PROVIDED TO CONSUMERS IN ROUTINE CARE.

Concerted efforts are required to advance mental health research including focus on implementation science relevant to limited resource settings and to developing research capacity to produce skilled clinical researchers doing clinically and scientifically advanced research in the African context.

The Department of Psychiatry has begun to develop a base of researchers with local and international collaborations. We have several MMed, MedSci and PhD projects, and are keen to develop research capacity and further collaborations locally at institutional level, nationally and internationally.

2019 RESEARCH ACTIVITIES INCLUDED:

The year began with a very informative PANSS (Positive and Negative Syndrome Scale) training workshop for researchers presented by Prof L. Koen from the University of Stellenbosch on the 30th of January 2019. The workshop was critical as the discipline of Psychiatry has a major focus on psychosis research.

The Annual Discipline of Psychiatry Research Capacity Development programme which is aimed at emerging junior registrars and more experienced researchers was held over two weeks at UKZN in February 2019.

The Department of Psychiatry at the Nelson R. Mandela School of Medicine coordinated a two-week research training programme from the 4th to 15th February, focusing on epidemiology and biostatistics with the Harvard T H Chan School of Public Health and the Broad Institute of MIT, US.

The programme was aimed at developing research capacity among staff and students in the College of Health Sciences. The research training programme was part of GINGER (Global Initiative for Neuropsychiatric Genetics Education in Research), an initiative where Harvard teams up with some African institutions to create a global neuropsychiatric genetics training programme; which was launched in July 2017.

Local collaborators from the Department of Psychiatry were led by Prof Bonga Chiliza, the Head of Psychiatry, and Dr Saeeda Paruk, with support from Drs Enver Karim and Kalpesh Narsi.

Two well attended and inspiring programmes were offered. The first was a two-week workshop for established researchers, which was attended by 30 PhD and post-doctoral fellows, titled Interactive Research Methods and Analysis Workshop.

It included a series of neuropsychiatric epidemiology and genetics seminars focusing on epidemiology, genetics, writing, mentoring and building a research programme.

It is aimed at improving research capacity for the individual, but also serves to train researchers to mentor junior researchers, critical in advancing the research platform on the continent. UKZN PhD students based in Botswana and Kenya also joined in to allow for collaboration and sharing of research experiences.

A second programme was specifically hosted to inspire younger researchers, many of whom are registrars currently registered for their master's degree, and focused on basic epidemiology and introduction to statistics and SPSS (Statistical Package for the Social Sciences).

Distinguished guests from Harvard included GINGER Director Dr Lori Chibnik, the Assistant Prof of Epidemiology, Harvard TH Chan School of public health and Department of Medicine, Harvard Medical School and Associate Director, Dr Bizu Gelaye, an epidemiologist and public health specialist, and Ms K Post, a co-teacher and co-ordinator.

In June we hosted a research seminar with invited guest speaker Prof Rajen Naidoo, whose talk was titled "Optimal Child Growth and Development-Building thriving communities through Risk Reduction from Impacts of Nutrition, Environment and Social Constructs (OrCHID)". The talk was inspirational and allowed us to look at opportunities for collaboration. Prof Rajen Naidoo is the Associate Prof and Head of Department in Occupational and Environmental Health at the University of KwaZulu-Natal, and has been in academic research for over 25 years. His areas of research focus on occupational and environmental respiratory diseases, in particular, childhood asthma. He has over 60 peer-reviewed publications.

JULY PSYCHIATRY EPIDEMIOLOGY SEMINAR

Prof Chiliza and the Department of Psychiatry hosted a cutting-edge mental health epidemiology seminar with renowned local and international speakers in July 2019. The seminar stimulated attendees to consider research epidemiology.

PROF SORAYA SEEDAT

Prof Soraya Seedat of the Department of Psychiatry at Stellenbosch University presented a talk titled "Epidemiology: Through the Lens of Genetics" which was an expert update on research advances in the field of genetic psychiatry. She discussed the fundamentals of genetics and the latest techniques to understand the genetic basis of various psychiatric disorders. Her talk included South Africa's contribution to the field and the need for more research from Africa. Soraya Seedat is a distinguished Prof of Psychiatry and the Executive Head of the Department of Psychiatry at Stellenbosch University. She holds the South African Research Chair in Post Traumatic Stress Disorder funded by the Department of Science and Technology and the National Research Foundation.

PROF HANS W. HOEK

Prof Hans W. Hoek presented research talk titled "Search for risk factors of psychosis" which combined data from his previous studies on the vulnerability stress models, schizophrenia after prenatal famine, psychosis among immigrants, the Amathwasa study in South Africa and, the Global Burden of Disease Study. These studies were conducted in South Africa and some in a global settings, all aimed at understanding risk factors for mental disorders using an epidemiological framework, but also considering local cultural beliefs. Hans W. Hoek is a Prof of Psychiatry at University Medical Center Groningen, the Netherlands, and has an adjunct position as Prof of Epidemiology at Columbia University, New York, USA. He is based in The Hague, where he is the Director of the psychiatric residency programme and Dean of the Parnassia Academy, part of the Parnassia Psychiatric Institute, a large mental health institute with branches throughout the Netherlands.

PROF JONATHAN BURNS

Prof Jonathan Burns, the previous Head of Department of Psychiatry at UKZN, now an Honorary Prof of Psychiatry at Exeter University, spoke on "Mapping psychosis in under resourced settings", with reference to the INCET and PSYMAP-ZN studies conducted in KwaZulu-Natal. Findings on the pilot INCET study were shared, and the study highlighted the need for collaboration with traditional healers in tracing incident psychosis.

Prof James Kirkbride presented data from the UK studies on how they attempted to establish the social epidemiology of psychoses in rural England: findings from the SEPEA study which provided insight on how to assess for different environmental factors that may contribute to psychosis risk, such as immigration and urbanisation. James Kirkbride is a psychiatric epidemiologist with a background in social science, having completed his PhD at the University of Cambridge. He previously obtained an M.Sc. in Epidemiology at the London School of Hygiene and Tropical Medicine.

In addition, the seminar was also attended by researchers from the INTREPID psychosis study who provided valuable insight from their multi-site international study which is based in India, Nigeria and Trinidad. The seminar provided researchers and clinicians with a rare opportunity to have international experts on schizophrenia and mental health share their expertise on genetics and environmental risk factors and the epidemiology of psychosis.

UKZN DEPARTMENT OF PSYCHIATRY HOSTED INTERNATIONAL VISITORS: COLLABORATION WITH BOSTON UNIVERSITY-

An opportunity to learn and be inspired!!

UKZN Department of Psychiatry hosted guests from Boston University in July 2019 for academic development and collaboration on training and research in psychiatry.

OUR GUESTS INCLUDED:

DR MICHELLE DURHAM

Dr Michelle Durham, MD, MPH is a board-certified adult, child and adolescent psychiatrist whose public health and clinical roles have always been in underserved and under-resourced communities. She is dedicated to health equity and advocacy for equitable mental health treatment globally and locally. She spent a week at UKZN sharing her expertise in developing child mental health care and visited several child and adolescent clinical sites. During the week she spent time with community psychiatry key stakeholders to discuss the model of integrating psychiatric care into paediatric primary health care. She also delivered several talks at the UKZN medical school to paediatricians and psychiatrists. Highlights of the programme was a child psychiatry academic seminar on 30 July on assessment and management of trauma related disorders in children. This seminar included a talk by Dr N Vawda (psychologist at King Edward hospital) on suicide. The talks provided registrars with new insight on these very relevant topics. She also delivered talks on depression and ADHD in children to paediatricians and GPs.

Meetings were also held by Dr Mashaphu (psychiatry registrar training portfolio chair) and Dr Durham to review collaboration in training registrars between the two faculties.

PROF CHRISTINA BORBA

UKZN was also fortunate to have hosted Christina P.C. Borba (PhD, MPH) again. Prof Borba is the Director of Research in the Department of Psychiatry and the Director of the Global and Local Center for Mental Health Disparities at Boston Medical Center. She is an Associate Prof at Boston University School of Medicine. Until 2016, she was the Director of Research at the Massachusetts General Hospital Division of Global Psychiatry. As a behavioural scientist who specialises in mixed research methodologies focusing on global mental health, she has extensive research experience that is deeply rooted in contexts of diverse populations.

Prof Borba conducted a two day research workshop covering both qualitative and quantitative workshops with academics from the college of health sciences. She generously shared her research tips and guided new researchers through the different research methodologies.

Prof Borba was accompanied by Carrol Hayley, who is currently on a fellowship in the Global and Local Center for Mental Health Disparities at Boston Medical Center/Boston University School of Medicine. As a fellow in global psychiatry, Dr. Carroll is investigating the influence of migration on mental health in Peru. She joined research meetings and delivered a talk on her research focus titled "Mental health status of migrants entering Peru due to Venezuelan exodus".

UKZN RESEARCHERS VISIT BOSTON UNIVERSITY AND HARVARD:

"Travel is the best education": an unforgettable trip to Boston University

"TRAVEL IS THE BEST EDUCATION ANYONE COULD HAVE".

We were unable to trace the author of that saying, but we certainly have to agree with it.

UKZN PhD candidates Drs Vuyokazi Ntlantsana and Keneilwe Molebatsi embarked on a two week expedition to Boston University in September 2019 to develop their PhD research protocols. Vuyokazi is a medical

officer employed as an Accelerated Academic Development Lecturer by UKZN, and Keneilwe is a psychiatrist and lecturer at the University of Botswana. They were hosted by Prof David Henderson, Head of Psychiatry at Boston University, and spent time with the GINGER research team at Harvard Medical School.

The main objective of the trip was to meet with their supervisor Dr Lauren and to finalise their research protocols. Another important reason for the trip was to attend a training session officiated by Prof Kim Mueser. Prof Mueser and colleagues developed a psychological intervention to manage PTSD among patients with serious mental illness. The pair will culturally adapt and pilot the intervention in their respective settings.

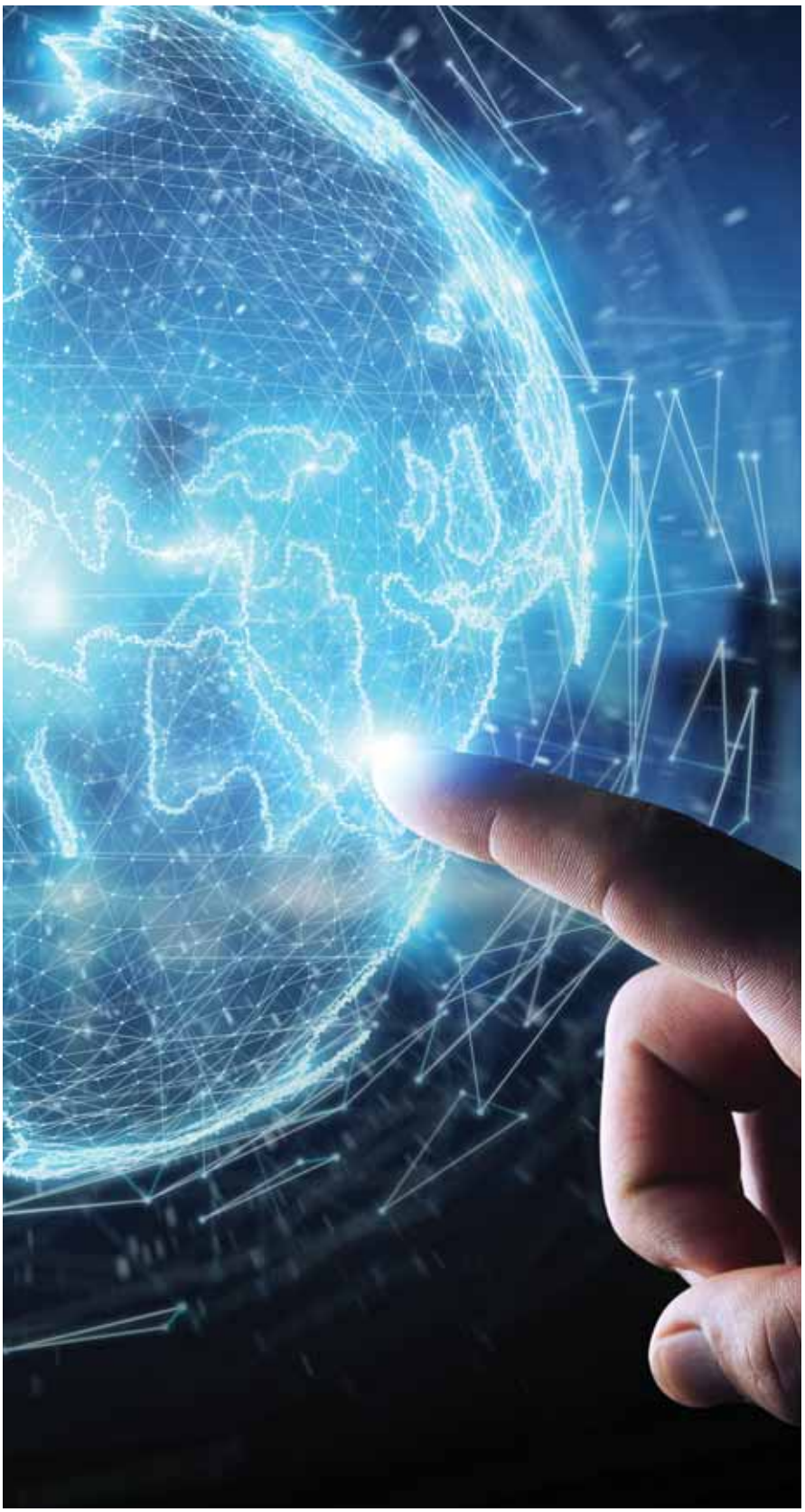
"One of the most exciting experiences of the trip was meeting Kim Mueser in person. His papers take up a substantial portion of the reference section in my protocol."

_ says Keneilwe _

They also had an opportunity to present on their work at the Trauma Epidemiology Meeting at Harvard School of Public Health. The feedback was amazing, they say.

The trip provided an opportunity to meet leading researchers in the field, and experience how research units at Harvard and Boston University are organised, and the training programs offered.

So, watch this space for further UKZN-Harvard collaborations.



2019 CONGRESS ATTENDANCE:

Members of the Department of Psychiatry attended and presented at several local and international congresses in 2019

1. THE CHILD AND ADOLESCENT CONGRESS SA ACAPAP GAUTENG (SA):

The South African Child and Adolescent Psychiatry and Associated Professions held their congress in Gauteng in May 2019. The congress was preceded by a research development workshop for professionals in child psychiatry. Saeeda Paruk attended the very stimulating workshop, which was attended by senior researchers in the field to inspire clinicians to consider child psychiatry research and develop networks.

The child congress over the next two days was host to international and national speakers. Drs E Karim, K Pillay, and S Paruk presented posters from research conducted in KwaZulu-Natal.

2. 3RD AFRICAN DIASPORA GLOBAL MENTAL HEALTH CONFERENCE (CAPE TOWN, SA):

Representatives included Prof Chiliza, Dr Vuyokazi and Dr Paruk, and registrars – Drs Bhengu, Ngcobo and Naidoo

DR BHENGU

DR NAIDOO

DR NGCOBO

The Africa Global Mental Health Institute (AGMHI) was established at the 2nd African Diaspora Global Mental Health Conference in 2016 in Cape Town, South Africa.

The Vision:

To equip those in Africa and the diaspora with the tools and agency to effectively care for those suffering from mental illness.

The Mission:

To fulfil the vision by fostering collaborations, creating accessible training and education programs for both providers and the public, conducting and disseminating culturally-relevant research, and identifying stakeholders to advance mental health care in Africa and the diaspora.

The Goal:

To address the contemporary challenges of mental health disorders and their comorbid conditions through four key components: education, research, services, and policy. These four key components work together to address the mental health gap between Africa and the rest of the world, focusing on reducing the global impact of mental illness.

The 3rd African Diaspora Global Mental Health Conference was held on 18th – 19th September 2019 at the Century City Conference Centre, Cape Town, and was hosted by Boston University School of Medicine (BUSM)/ Boston Medical Center (BMC) and the University of KwaZulu-Natal (UKZN).

This interactive conference entailed workshops and indepth discussions on mental health in relation to the four key components of interest to the AGMHI. Delegates included notable psychiatrists and mental health professionals from all over the world to address ongoing global mental health challenges and to initiate the development of solutions for Africa and the diaspora. Some of the countries represented included Ethiopia, Kenya, Liberia, Mozambique, Nigeria, South Africa and Uganda.

Together with Prof Dave Henderson of BUSM/BMC, our very own Prof Bonga Chiliza is a director of the

AGMHI. Dr Vuyokazi Ntlantsana from the UKZN Psychiatry Department was appointed as part of the AGMHI Steering Committee.

The UKZN team was also part of the ongoing discussions on developing research, training and service priorities.

For more information about the AGMHI and if you are interested in becoming a member, please visit www.agmhi.org

3. SASOP BIOLOGICAL PSYCHIATRY CONFERENCE IN CAPE TOWN IN SEPTEMBER 2019

Several registrars and specialists attended the congress. The Department was represented by several oral and poster presentations:

Patients' attitude and preferences towards oral and long acting injectable antipsychotics in KwaZulu-Natal, South Africa

(Roopun K, Tomita A, Paruk S)

DR K ROOPUN

Adverse childhood experiences, HIV status and substance use in pregnancy at a general hospital in KwaZulu-Natal, South Africa

(Bhengu B, Tomita A, Mashaphu S, Paruk S)

A comparative survey on knowledge, attitudes, practices and beliefs about HIV and AIDS among patients with chronic mental and medical illnesses in Durban, KwaZulu-Natal

(Matshoba T, Mashaphu S, Tomita A, Paruk S)

DR MATSHOBA

Burnout , anxiety and depression in South African doctors working in Kwazulu-Natal training hospitals: an Ethekwini perspective

(Naidoo T, Tomita A, Paruk S)

HIV sero-discordance

DR MASHAPHU

Prof Chiliza was an invited guest speaker and delivered a talk on psychosis.

We were also represented at **international conferences** by:

PROFESOR CHILIZA

P Nyawose N & Chiliza B - Decolonial character of psychology: the silencing of African bioethics.

Oral presentation at the Towards a Decolonial Psychology Conference, February 2019 and

Prof Chiliza - Research collaboration and training between psychiatrists in South Africa, Africa and the USA.

Oral presentation at the American Psychiatric Association Annual Meeting, San Francisco, USA, May 2019

Patients' Attitude and preferences towards oral and long acting injectable antipsychotics in KwaZulu-Natal, South Africa

Roopun K[1], Tomita Andrew[2], Paruk S[1]

[1]School of Clinical Medicine, College of health Sciences (CHS), University of KwaZulu-Natal

[2] KwaZulu-Natal Research Innovation and Sequencing Platform (KRISP)and School of Nursing and Public Health, CHS, University of KwaZulu-Natal

BACKGROUND

Relapse rates in psychosis may be decreased with improved adherence. Patients' medication beliefs should also be considered when prescribing as drug attitudes and preference to psychotropic formulation may influence adherence and outcomes. There is limited literature on patients' drug attitude to oral and long acting injectable (LAI) antipsychotic formulations in Africa.

AIM

To describe patients' attitudes and preferences towards oral versus LAI antipsychotic formulations and to explore factors influencing patients' drug attitudes towards their respective antipsychotic formulation at two psychiatric hospitals in KZN, SA.

METHOD

A cross–sectional survey of adult patients (with schizophrenia spectrum disorder- DSM 5) receiving LAI with/without oral antipsychotics (N=70) compared to those on oral antipsychotics only (N=70) was conducted. A socio–demographic questionnaire and Drug Attitude Inventory scale (DAI–30) were used to assess patient drug formulation preference and drug attitude.

RESULTS

98 (70%) of the 140 participants preferred to remain their current medication formulation they were prescribed, at the time of the study. 132 (94.3%) participants reported a positive drug attitude towards their antipsychotic medication. 4 participants on LAI and 4 on oral had a score of zero or a negative DAI score. Factors associated with a poorer DAI score were divorced/widowed status (p<0.01), lower income (p=0.02), shorter duration of illness (p=0.04) and a clinical diagnosis of schizophrenia versus schizoaffective or other psychotic disorders (p=0.04) based on adjusted regression model. Participants who were currently on a formulation that matches their preference scored better on DAI compared to individuals with mismatch in use and preference. (p<0.01).

Association between socio-demographic and clinical variables and DAI score

		Adj β	SE	t	p
Marital status:	[Never married]				
	Married	-1779.94	1790.82	-0.99	0.32
	Divorced or widowed	**-6386.41***	2041.14	-3.13	**<0.01**
Household income:	[R6000 or higher]				
	R2500 or lower	793.18	1774.71	0.45	0.66
	R2501 - R6000	**3785.97**	1648.11	2.3	**0.02**
Diagnosis:	Schizoaffective Disorder				
	Schizophrenia	**-3844.00**	1509.12	-2.55	**0.01**
Duration of illness:	In years	**193.88**	91.84	2.11	**0.04**
Medication preference:	[Divergent]				
	LAI individual preferring LAI	**4961.07**	2328.88	2.13	**0.04**
	Oral individual preferring Oral	**2735.62**	1353.20	2.02	**0.04**

Sociodemographic and clinical profiles by medication group

		LAI only (n=18)		Oral only (n=70)		LAI and Oral (n=52)		Total	
		n	%	n	%	n	%	n	
Medication preference:	Oral	7	7.3	62	64.6	27	28.1	96	$\chi2(2) = 27.04$, **p<0.01**
	LAI	11	25	8	18.2	25	56.8	44	

CONCLUSION

Drug attitude is influenced by several factors including matched medication use and personal preference and should be considered to improve adherence. Factors associated with a negative drug attitude were divorced/widowed status, lower income, shorter duration of treatment and a clinical diagnosis of schizophrenia versus schizoaffective or other psychotic disorders. The findings suggest the need for considering more intensive or focused psycho-education in groups vulnerable to poor drug attitude and reviewing regimens with polypharmacy. Further research in larger samples is required.

Acknowledgement:

Drug Attitude Inventory; DAI (Hogan et al 1983; Awad, 1993)

References:

1. Robinson D, Woerner MG, Alvir JM, Bilder R, Goldman R, Geisler S, et al: Predictors of relapse following response from a first episode of schizophrenia or schizoaffective disorder. Arch Gen Psychiatry. 1999, 56: 241-247. 10.1001/archpsyc.56.3.241.
2. Taylor, David. "The Maudsley Prescribing Guidelines in Psychiatry."Bookdepository.com, John Wiley and Sons Ltd, 29 June 2015, www.bookdepository.com/Maudsley-Prescribing-Guidelines-Psychiatry-12E-David-Taylor/9781118754603.
3. Kissling, W. (1994) Compliance, Quality Assurance and Standards for Relapse Prevention in Schizophrenia. Acta Psychiatrica Scandinavica Supplementum, 382, 16–24.
4. Tiihonen, J., Walhbeck, K., Lonnqvist, J., Klaukka, T., Ioannidis, J.P.A., Volavka, J., & Haukka, J. (2006). Effectiveness of antipsychotic treatments in a nationwide cohort of patients in community care after first hospitalisation due to schizophrenia and schizoaffective disorder: observational follow-up study. British Medical Journal 333: 224
5. Tiihonen J., Haukka J., Taylor M., Haddad P., Patel M., Korhonen P. (2011) A nationwide cohort study of oral and depot antipsychotics after first hospitalization for schizophrenia. Am J Psychiatry 168: 603–609.

* Represents statistically significant vales (p<0.05)

UNIVERSITY OF KWAZULU-NATAL ™

INYUVESI YAKWAZULU-NATALI

Adverse childhood experiences, HIV status and substance use in pregnancy at a general hospital in KwaZulu-Natal

Busisiwe Bhengu[1], Andrew Tomita[2], Sibongile Mashaphu[1], Saeeda Paruk[1]

[1]School of Clinical Medicine, College of health Sciences (CHS), University of KwaZulu-Natal

[2] KwaZulu-Natal Research Innovation and Sequencing Platform (KRISP)and School of Nursing and Public Health, CHS, University of KwaZulu-Natal

Introduction

Early adverse experiences may be associated with poorer physical and mental health outcomes later. Substance use disorders and HIV remain major public health concerns in South Africa and globally particularly in young women. Perinatal substance use and HIV status is associated with several negative maternal and foetal outcomes and may have bidirectional associations.

Aim: To describe the prevalence of early childhood trauma and perinatal substance use in females post-delivery and to explore the possible associations between early life trauma and substance use in HIV infected and non-infected pregnant women.

Method

A cross-sectional questionnaire survey was conducted among 223 adult women within one-week post-partum using a socio-demographic questionnaire, the WHO Alcohol, Smoking and Substance Involvement Screening Test-(ASSIST V3.0) and WHO Childhood Traumatic Experiences questionnaire (WHO-ACE IQ V1.).

Results

The mean age was 27.7 years (SD=5.52), the majority were Black African (n=206; 92.38 %) and 54 (24.22%) earned R1 000 ($71) per month. The most common form of childhood adverse experience reported was having one or no parent, parental separation or divorce (n= 119, 53.36%) and the participants mean ACE score was 3.27 (SD =2.76). The most commonly used substance in pregnancy was nicotine (n=27, 12.11%), followed by alcohol (n=18, 8.07%). Lifetime and perinatal nicotine and alcohol use was not significantly associated with HIV status (p=0.35 and p=0.60). There was a significant association between adverse childhood experiences and HIV positive status with no viral suppression (p=0.11), alcohol (p=0.02) and tobacco (p=0.01) use in pregnancy.

Participant response to Adverse Childhood Experience International Questionnaire (ACE-IQ)

	Total	Test statistics χ^2	df	p
One or no parents, parental separation or divorce	n19; 53.36%	0.07	2	0.43
community violence	n=112; 50.22%	5.02	2	0.08
Mother Household member treated violently	n=59.2; 40.8%	0.94	2	0.62
Total ACE score (mean, SD)	3.27 (SD =2.76)	F=4,36	2,220	0.01

Sociodemographic profile and Substance use in pregnancy

		N	%
Race	**Black African**	206	92.38
	Non-African	17	7.62
Age	**Age**	Mean = 27.7	SD = 5.52
Marital status	**Single, divorced,**	183	82.06
	Married	40	17.94
Employment	**Employed**	153	68.61
	Unemployed	70	31,39
Nicotine		n=27	12.11%
Alcohol		n=18	8.07%

Discussion

The purpose of this study was to investigate an association between ACE, perinatal substance use behavior and adverse pregnancy outcomes among HIV positive and HIV negative women in KZN. The most commonly used substances in pregnancy were alcohol and tobacco in our sample population, for both of which we found significant associations with ACE, and for tobacco use with preterm birth delivery. Lastly, we found that unsuppressed viral load during pregnancy was significantly associated with the likelihood of preterm birth delivery.

Conclusions

The association between childhood adverse experiences, alcohol and tobacco use and virally unsuppressed HIV status in pregnant women suggest that negative childhood experiences may influence critical health behaviours and outcomes later.

References

1. Cook JL, Green CR, de la Ronde S, et al. Epidemiology and effects of substance use in pregnancy. *J Obstet Gynaecol Can.* 2017;39(10):906-915.
2. Petersen Williams P, Jordaan E, Mathews C, Lombard C, Parry CD. Alcohol and other drug use during pregnancy among women attending midwife obstetric units in the Cape Metropole, South Africa. *Adv Prev Med.* 2014;2014: 871427.
3. Onah MN, Field S, Heyningen T, Honikman S. Predictors of alcohol and other drug use among pregnant women in a peri-urban South African setting. *Int J Ment Health Syst.* 2016;10(1):38.
4. Khoury L, Tang YL, Bradley B, Cubells JF, Ressler KJ. Substance use, childhood traumatic experience, and posttraumatic stress disorder in an urban civilian population. *Depress Anxiety.* 2010;27(12):1077-1086.
5. Manyema M, Norris SA, Richter LM. Stress begets stress: the association of adverse childhood experiences with psychological distress in the presence of adult life stress. *BMC public health.* 2018;18(1):835.

Funding: The second author was supported by the UKZN Flagship Programme. The content is solely the responsibility of the authors and does not necessarily represent the official views of the funders.

Emotional and Behavioural Problems in Children with HIV Infection

Kusturi Pillay[1], Andrew Tomita[2], Saeeda Paruk[1]

[1]School of Clinical Medicine, College of health Sciences (CHS), University of KwaZulu-Natal

[2] KwaZulu-Natal Research Innovation and Sequencing Platform (KRISP)and School of Nursing and Public Health, CHS, University of KwaZulu-Natal

UNIVERSITY OF KWAZULU-NATAL ™

INYUVESI YAKWAZULU-NATALI

Introduction

Emotional and behavioural problems in HIV-infected children are often neglected.

Aim: To determine the prevalence of parental/caregiver report of emotional and behavioural problems in HIV-infected children and to explore possible associations between socio-demographic/ clinical variables and reported emotional/ behavioural difficulties in HIV-infected children.

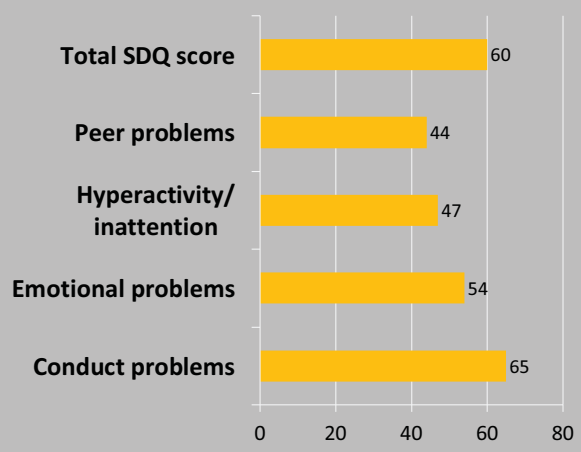
Method

A cross-sectional questionnaire survey was administered to 198 parents/caregivers of HIV-infected children (2-12 years) attending a paediatric HIV out-patient service in KwaZulu-Natal. A socio-demographic questionnaire and the parent version of the Strengths and Difficulties Questionnaire (SDQ) were used to assess emotional and behavioural problems in children. Symptoms of depression, anxiety, hyperactivity/ inattention, conduct and peer problems were screened and scored using sub-scales in the SDQ.

Results

The majority of parents/ caregivers were single, unemployed, HIV-infected females without tertiary education. Sixty (30.3%) parents/caregivers reported abnormal total SDQ scores and 57 (28.8%) reported abnormal sub-scale scores. Lower parental/caregiver educational level was the only parent/caregiver characteristic associated with higher total and sub-scale scores (p= 0.03). A history of delayed milestones was associated with higher scores on the hyperactivity sub-scale (p = 0.02). There was also an association between parental perceived academic difficulty and higher total SDQ , and hyperactivity scores (p = 0.01). Parental HIV status and child gender were not associated with SDQ score report.

Number of children with Abnormal SDQ scores



Significant p value for Variables & Abnormal SDQ scores

	Delayed milestones	Academic Difficulties	Caregiver Highest level of Education	Age at HIV Diagnosis
Total SDQ score	X	0.01	0.03	0.01
Emotional problems	X	X	0.01	X
Conduct problems	X	X	0.04	0.03
Hyperactivity / inattention	0.02	0.01	X	X

Discussion

The key finding of this study was a high rate of parental/caregiver (n = 117, 59.1%) reporting of emotional and behavioural problems in HIV-infected children on both SDQ total and sub-scale scores than in literature. Parent/caregiver lower educational level was associated with higher reporting of emotional, conduct and total difficulties, consistent with other studies. Conduct problems were most commonly reported. Earlier age of HIV diagnosis was also associated with higher scores on SDQ.

Conclusions

The high prevalence of parental report of emotional and behavioural problems in HIV-infected children - and the association with reported delayed milestones and academic difficulties - suggests a need for earlier cognitive screening and cognitive developmental support for HIV-infected children. There is an urgent need for integrated paediatric HIV and mental health screening programs.

References

1. Nassen, R., Donald, K., Walker, K., Paruk, S., Vujovic, M., Duncan, W., . . . Moos, B. (2014). Management of mental health disorders and central nervous system sequelae in HIV-positive children and adolescents. *South African Journal of HIV Medicine, 15*(3), 81 - 96.
2. Scharko, A. M. (2006). DSM psychiatric disorders in the context of pediatric HIV/AIDS. *AIDS Care, 18*(5), 441 - 445.
3. Brown, L. K., Lourie, K. J., & Pao, M. (2000). Children and Adolescents Living with HIV and AIDS: A Review. *Journal of Child Psychology and Psychiatry, 41*(1), 81 - 96.
4. Lowic, S., Sawry, S., & Myers, T. (2012). Neurodevelopmental delay among HIV-infected preschool children receiving antiretroviral therapy and healthy preschool children in Soweto, South Africa. *Psychology, Health & Medicine*, *17*(5), 599 - 610.

Funding: The second author was supported by the South African Medical Research Council (MRC-RFAUFSP-01-2013/UKZN HIVEPI) with funds from National Treasury under its Economic Competitiveness and Support Package. The content is solely the responsibility of the authors and does not necessarily represent the official views of the funders.

pharma dynamics
EFFECTIVE AFFORDABLE HEALTHCARE
A Lupin Group Company

Fast growing CNS portfolio.[1]

zytomil
ESCITALOPRAM 10 mg | 20 mg
THE FINER CHOICE

serrapress
PAROXETINE 20 mg
OPEN THEIR EYES TO FACE
THE COLOUR OF LIFE

DynaSertraline
sertraline 50 / 100
A CLEAR BLUE SKY

For further product information contact
PHARMA DYNAMICS P O Box 30958 Tokai Cape Town 7966
Tel + 27 21 707 7000 **Fax** + 27 21 701 5898
Email info@pharmadynamics.co.za **CUSTOMER CARE LINE** 0860 PHARMA (742 762) **www.pharmadynamics.co.za**

ZYTOMIL 10, 20 mg. Each tablet contains 10, 20 mg escitalopram respectively. S5 A42/1.2/0912, 0914. NAM NS3 10/1.2/0479, 0481. **SERRAPRESS 20.** Each tablet contains paroxetine hydrochloride equivalent to 20 mg paroxetine. S5 A38/1.2/0069 NAM NS3 08/1.2/0101. **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. For full prescribing information, refer to the professional information approved by SAHPRA. **1)** IMS Data, May 2019. **2)** Kasper S, *et al*. "Onset of action of escitalopram compared with other antidepressants: results of a pooled analysis. International Clinical Psychopharmacology. 2006;21:105-110. **CNSRA517/08/2019**.

AWARDS, APPOINTMENTS & ACHIEVEMENTS

2019 CHIEF REGISTRAR: DR THEJINI NAIDOO

THEJINI NAIDOO OBTAINED HER MBCHB DEGREE IN 2010 AND A DIPLOMA IN MENTAL HEALTH IN 2014. SHE IS ALSO A DISCOVERY FUTURE LEADERS AND HEALTHCARE DELEGATE.

Currently, she is the Psychiatry Registrar Representative at the University of KwaZulu-Natal, having assumed this role in March 2019.

> **We could not be more proud of our registrars for sharing inspirational stories. We are so grateful for the village that is raising the next generation of African academic psychiatrists.**

In addition, in November, Dr T Naidoo, a senior registrar in psychiatry scooped the prize for best oral presentation at Master's level at the College of Health Sciences Research Day. This was a huge accomplishment in a very competitive meeting.

Her responsibilities include liaising with the department, the academic leader of registrars, and registrars from other institutions regarding work, support systems and academic related matters. She is passionate about fostering mental health awareness in medical students and doctors, and as a result has assisted with various registrar wellness initiatives.

UKZN WINS PRESTIGIOUS RESEARCH AWARDS:

UKZN psychiatry registrars scooped MS Bell Awards at the South African Society of Psychiatrists Biological Psychiatry Congress held in Cape Town in September.

The awards are sponsored by the College of Psychiatrists of the Colleges of Medicine of South Africa.

Dr Thejini Naidoo's presentation on *"Burnout, anxiety and depression in South African doctors working in KwaZulu-Natal training hospitals: an eThekwini perspective",* received the award for the best oral presentation.

This study established the prevalence of these three adverse mental health outcomes and their associations with practitioner and work-related factors among medical doctors employed at state hospitals in the eThekwini municipality of KwaZulu-Natal. The results of this research, as well as potential modifiable factors and proposed public health interventions were presented at this congress.

The award for the best poster presentation went to Dr Busisiwe Bhengu for her poster titled, *"Adverse childhood experiences, and HIV status and substance use in pregnancy at a general hospital in KwaZulu-Natal".*

Head of Psychiatry at UKZN, Prof Bonga Chiliza said,

GRANTS:

Several grants were secured in the past year, and there are several ongoing projects.

We were particularly proud to begin work on the Psychosis Mapping in KwaZulu-Natal (PSYMAP) UK-SA collaborative research that explores at the epidemiology of psychosis in Umsunduzi district in KZN, SA.

2019 - 2021: MRC, "Psychosis Mapping in KwaZulu-Natal (PSYMAP-ZN) - Prof Jonathan Burns is the co-PI with Prof Chiliza

2019 - 2021:
MRC SIR grant - Dr S Paruk

2019 - 2021:
NRF Thuthuka grant - Dr S Paruk

2019: CHS PHD scholarship - Dr U Chhagan
DRILL PI - Dr Ramlall

2019 – 1ST SEMESTER FC PSYCH (SA) PART II GRADUATES:

DR MERE

DR ROOJEE

2019 - 2ND SEMESTER FC PSYCH (SA) PART II GRADUATES:

DRS' VIDETTE JUBY & NOKUKHANYA NGCOBO

COLLEGE OF HEALTH SCIENCES AWARDS EVENING:

DR KARIM WAS AWARDED THE BEST CLINICIAN TEACHER AWARD

DR ROOPUN TOOK HOME THE BEST FELLOW AWARD

THE CANNA-**DO'S** & CANNA-**DONT'S** OF CANNABIS

DR.MAHENDRA KUMAR RAMDEYAL
SPECIALIST PSYCHIATRIST
ADDINGTON HOSPITAL

THE CONSTITUTIONAL COURT OF SOUTH AFRICA TOOK A LANDMARK DECISION ON THE 18TH OF SEPTEMBER 2018 AND RULED THAT IT IS NOT A CRIMINAL OFFENCE FOR AN ADULT CITIZEN TO USE, POSSESS OR CULTIVATE CANNABIS IN PRIVATE FOR PERSONAL CONSUMPTION. PARLIAMENT WAS GIVEN 24 MONTHS FROM THE DATE OF THE JUDGMENT TO BRING THE RULING IN LINE WITH SOUTH AFRICAN LAWS.

These changes in policy have markedly changed cannabis use patterns and perceived levels of risk.

WHERE CAN IT BE USED?

The Constitutional Court did not define the scope of 'private', rather leaving this to the discretion of those who enforce the law – the police, prosecutors and the courts. One's private space does extend to their person, car, or handbag for example, and searching any of these would be an infringement on the right to privacy. It did however expand on private use, possession, or cultivation of cannabis beyond a home or private dwelling. It may be permissible to use cannabis together with friends and family – provided that they are consenting and over the age of 18. However, this would not extend to spaces used in the broader community such as the park or the street.

HOW MUCH IS ENOUGH?

The Constitutional Court did not prescribe the quantity of cannabis that would qualify for personal use, but has given Parliament 24 months from the date of the judgment to incorporate appropriate provisions into the relevant legislation. Until these provisions are made, South Africa's law enforcement officials have the discretion to decide whether the amount of cannabis in a person's possession could reasonably be believed to be more than what is necessary for private use. If so, the individual could be considered to be 'dealing' in cannabis in contravention of the Drugs and Drug Trafficking Act. According to this Act, anything under 115 grams can be successfully argued as being possessed for personal use. In all cases, police discretion must be exercised in 'good faith, rationally and not arbitrarily'.

CULTIVATION

Some economists have estimated that by 2040 the world cannabis market could reach more than $630 billion in value. It is predicted that by 2023 the SA domestic market for cannabis and related products could be worth up to R27 billion. This excludes the lucrative consumer cannabidiol (CBD) products segment, which could be worth billions more. Legislation around cultivation remains unclear, and the criminal laws for trafficking of and dealing in drugs still apply unless one has a cultivation license from the South African Health Products Regulatory Authority (SAHPRA), previously the Medicines Control Council.

Under the Medicines and Related Substances Act, and in line with the United Nations Single Convention on Narcotic Drugs (1961) - cultivation, production, manufacture and use of medicinal cannabis products may only occur through a license issued by SAPHRA and a permit issued by the Department of Health. These conditions allow Government to limit quantities of cultivated and manufactured products based on quotas from the International Narcotics Control Board. As a signatory to the 'Single Convention', South Africa is committed to comply with its obligations by controlling medicinal cannabis cultivation and reporting to the International Narcotics Drug Control Board (INCB) on volumes of production and manufacture. These obligations require South Africa to minimise the risk of diversion of cannabis and reserve its use for medical and scientific purposes only.

To date, patient access to unregistered pharmaceutical products containing cannabinoids has been enabled by SAPHRA through importation of these products. In order to ensure

the availability of standardised quality-assured medicinal cannabis, the Department of Health and SAPHRA may permit the cultivation of cannabis solely for medicinal and research purposes. Medical practitioners can apply to SAHPRA for permission to access and prescribe unregistered medicines when intended to treat their patients. In exceptional circumstances cannabis products intended for medicinal purposes may thus be made available to specific patients under medical supervision. Only registered, authorised prescribers may apply for permission to prescribe a medicine for a patient. Authorisation is dependent on the submission of an appropriate dosage regimen, an acceptable justification for the proposed use, and regular reporting to SAPHRA. In April 2019 SAPHRA granted the 'House of Hemp' the first license for the commercial production of medical cannabis. The company's research has focused on hemp - a strain of cannabis grown for industrial uses of its derived products. Its concentrations of THC are too low to get you 'high'. It does have high concentrations of CBD - which preliminary clinical research has shown to have some medicinal benefits.

MEDICINES AND HEALTH PRODUCTS.

Cannabis products considered to be health supplements are those containing a daily dose of less than 20mg cannabidiol (CBD), as well as those containing less than 0.001% of THC or less than 0.0075% of CBD. These products may be bought and sold relatively freely as a result of the exemption published in the Government Gazette on 23rd May 2019. It applies only for 12 months and is intended to create an opportunity for the fledgling cannabis industry to engage on a legal framework going forward. These recent developments have fuelled the false impression among many South Africans that the cannabis market is suddenly opening up to any and all products, and that safety in its use is assured.

IS CANNABIS GOOD OR BAD ?

The cannabis plant is complex. It is not a single substance, but contains more than 500 identifiable chemical constituents. More than a 100 of these are cannabinoids that interact with the endocannabinoid system in varying permutations and combinations. These can affect numerous physiological and psychological processes - including gastrointestinal function, appetite, pain, memory, movement, inflammation, and mental health.

Conclusive evidence regarding the short and long term effects (both harms and benefits) of cannabis use remains elusive. A poverty of scientific research has resulted in a lack of information on the health implications of cannabis use, which is a significant public health concern, especially for vulnerable populations such as adolescents and pregnant women. The strongest evidence to date concerns links between cannabis use and psychiatric disorders in those with pre-existing genetic or other vulnerabilities. The potential harms associated with using cannabis depend on two things above all. The first is the age at which one begins to use cannabis, particularly if it is prior to 18 yrs old. Using cannabis during key stages of brain development can impact on synaptic pruning and the development of white matter. The second is the pattern of use - the frequency, dose and duration. With a bigger or more potent dose, a greater quantity of tetrahydrocannabidiol (THC) is being ingested. THC appears to act on an area of the brain involved in the regulation of emotional experiences, and has been implicated in the development of mental health disorders and addictions in vulnerable individuals. There is no beneficial scientific evidence for the recreational use of cannabis. Unlike other substances such as alcohol or tobacco, where use may confer risk, no acceptable standards exist to effectively guide individuals as they make choices regarding the issues of safe, therapeutic and recreational use of cannabis.

IN SUMMARY

- You may use cannabis for personal, recreational or medicinal uses, alone or with friends/family over the age of 18, and in spaces not open to groups other than your own
- Grow only as much as is necessary for your personal use; and if unsure of quantities, rather be conservative
- Other than specific health supplements and processed hemp, buying and selling cannabis or any cannabis-containing product is currently not legally permissible.
- So, until legislation is formalised and the medical fraternity is appropriately regulated, be mindful before you "Puff, puff and pass".

REFERENCE SOURCES:

- International review of Psychiatry- Vol30 No3
- Journal of Cannabis Research
- Scientific American.com
- Businesstech interviews
- emedicine. medscape .com
- Cannabis Development Council of South Africa (cdcsa.co.za)

THIS IS US

I AM HOMEGROWN

DR K DOMINGO
SPECIALIST PSYCHIATRIST
PRIVATE PRACTICE

35 YEARS AGO, I WALKED INTO MY 'INTRODUCTION TO PSYCHIATRY' LECTURE FROM THIS DEPARTMENT, AND I HAVE PRACTICED IN THE PRIVATE SECTOR IN DURBAN FOR THE PAST 25 YEARS.

Being a psychiatrist is who I am, but it's not all I am. And it cannot be neatly separated out and kept discrete from who I am as a wife, mother, daughter or friend. Nor can it remain uninfluenced or uninformed by my gender, race, religion or culture. And so this article reflects the sense I have of the triumphs and challenges we face collectively as a discipline and as the unique individuals we are.

Perhaps an appropriate place to start would be to make sense of what it is that we do. Who amongst us believes that our family or even colleagues really understands our working day? Psychiatric illnesses themselves are shrouded in myth and mystery and are so poorly understood that it's no surprise that the very nature of our work is equally misunderstood. How do you explain being exhausted to your very core after a day spent 'just talking'?

The nature of the relationship we share with our patients is deeply intimate. They trust us with their stories and we hold a space for them that is safe enough to share their secrets. We may be the only other person in the world with whom they have chosen to share aspects of their lives. And we in turn are bound by our professional code of conduct to only share this information under very specific circumstances. And so we hold and protect their stories almost exclusively. And these thousands of stories becomes internalised and

integrated as part of our personal story. Not because we have failed to maintain appropriate boundaries, nor because we are oversensitive or overly compassionate, but because this just is the way it is. The experience of being a psychiatrist has at its very core, exposure not only to content of their story, but to the raw, unedited, pain and emotion around the telling and re-experiencing of it. This exposure occurs within the context of an intimate therapeutic relationship that may span decades, and impacts us in ways that I believe cannot be completely understood or quantified.

The people sharing their stories with us are not limited to our index patient. Because of the depth and breadth of our discipline, we gather these stories in our varied roles as adult, child or forensic psychiatrists, or qualitative researchers, as well as through our interventions with the very people who may have perpetrated our patients' trauma and pain. And so we are exposed to psychopathy and evil in a way that fortunately most people seldom face.

But what is known cannot be unknown, and so we struggle to hold onto a world view that reflects an appropriate assessment of the world as mostly safe and sometimes dangerous. And since most of us will enter a registrar training program in our mid twenties, our world view shifts before we have had the years of life experience to formulate a more balanced and grounded perspective.

This is our days work. This is our working world.

And it is a world that is both traumatizing and rewarding to be a part of. The nature of the burden we carry is felt, but seldom spoken of or acknowledged and perhaps only really understood by us as a discipline. We carry cumulative case loads and care for our patients over many years, helping them as they navigate the challenges of different life stages.

The unique role we play in our patients' lives is both a privilege and a burden and the toll this takes on us, is one of our many struggles. Caregiver burnout and compassion fatigue are terms bandied about. But let's at least be fair to ourselves by starting to call it what it is. Because what we sit with after years of doing the work we do, is far more akin to a chronic post-traumatic stress disorder. And until we acknowledge this, we are less likely to make the right decisions required to care for ourselves individually or as a discipline.

Let's try to further understand the nature of our role in our patients healing. All doctor-patient relationships play a significant role in determining a positive clinical outcome. But the dynamics of the relationship in psychiatry is somewhat different. You exist in this therapeutic space not only as a clinician, but as a conduit that facilitates the unpacking and processing of emotion. And you function in the relationship as the container that holds feelings so painful for the patient, that they are projected or displaced onto you, and feelings so split off and not felt, that the patient can't even begin to identify them as their own. A vital part of our days work therefore lies in being this emotional conduit and container, whilst the work of therapy unfolds. This aspect of our work is not an optional extra like add-on car accessories that are nice to have, but not essential to functioning. Without emotional discovery and exploration, the therapeutic space remains an intellectual one, and real healing cannot happen without a shift beyond cognition.

But here's the rub, your own feelings are not grist for the mill. This is not a coffee date with your bestie where you both get to share your feelings

and laugh, cry or vent. In fact to do so with your patient would be inappropriate. So at work, you need to reveal just enough of yourself to be authentic and relatable, but not more of you, than would serve the patient's journey.

How ridiculous a job description is that? And this begins a pattern of learning to disconnect from your own feelings in order to be your most effective at work, whilst not giving yourself permission to express your feelings in your personal relationships, because you forget that these relationships require you to be brave and transparent in revealing your authentic self.

This is our work and our working world, yet we ourselves struggle to understand these effects, let alone explain it to others. All that we may be aware of, is a seemingly inappropriate emotional overlay or an emotional disconnect and depletion. And so you may leave work with a visceral sadness or overwhelming anxiety after a day spent with deeply traumatised children, grieving parents, toxic narcissists and psychopaths, or wildly chaotic personality disordered patients whom you witness reek havoc around them with scant regard for the consequences of their behaviour. How do you explain these feelings to your partner when you can't even share details of your 'day at the office' because you are bound by confidentiality and the stories in any case are not yours to tell? How do you not feel guilty at being so emotionally depleted and unable to connect with all the happiness and joy that may be so abundant in your personal life? How do you cope when you face adversity or challenges in your personal life and feel so depleted? And how do you find the energy to parent your own age-appropriately needy children (who didn't choose to have a 'head whisperer' for a parent) when your day has been spent essentially reparenting patients whose primary deficit has been emotionally unavailable parents? Is there a way to mitigate the fallout for ourselves and our personal relationship? Are there choices that we should be making that are difficult but essential to our well-being?

Life is in essence paradoxical, ambiguous and uncertain and holds the possibility of both pain, suffering, joy and wonder. Until we accept this, we will continue to have unrealistic expectations of life and feel victimised in the face of adverse life events. Accepting that we have no control over events outside of us, but that we do have a choice in how we respond to them, and the person we will become in the face of them, requires a difficult shift in perspective.

Our patients grapple with this, struggling to accept that they have control over their own actions alone, and that blaming others for their adversity or handing over responsibility for their recovery is problematic. It seems preferable somehow to believe that healing and recovery has a tangible, finite end point that you arrive at passively one day so that your intended life can then begin.

As I see it, there is no end point to healing (and it certainly doesn't magically coincide with the completion of 15 outpatient or 21 inpatient psychiatric visits). Rather healing is a commitment to a life-long process of making choices that reflect the life we want to live as our most authentic and resilient self .

This struggle to accept the world as it is; is not unique to our patients. And a world that holds both adversity and endless possibility is the world in which we ALL live. Everyone is fighting their own unique battle with a set of struggles, possibly only known to them. Once we accept that there is no US and THEM and that there really is only one battlefield, we will find comfort in our shared struggle. Because in fact, the very essence of connectedness and compassion, is the recognition of our shared humanity.

So if there is no real us or them, and the relationship between healer and wounded is actually between equals, what is it that we are meant to be doing for our patients. The expectation of our role as a psychiatrist is to deliver a standard of best clinical practice around the diagnosis and management of a psychiatric illness. And the distinction between us and them in the context of a doctor-patient relationship is served by the strict maintenance of professional boundaries. As with any other doctor-patient relationship, the strength of the therapeutic alliance impacts positively on clinical outcome and is built on a foundation of trust and authenticity. But here's the conundrum. What are we using as a measure of our impact as a psychiatrist and how do we actually quantify a positive clinical outcome in psychiatry?

I don't believe that the clinical course of a diagnosed disorder is the true measure of a good outcome, and in fact not every patient we see has a diagnosed mental illness.

My belief is that our role extends beyond diagnosing treatable illnesses and lies in us being part of a journey that facilitates increasing resilience

in our patients and that champions their efforts to live their best lives. A life not defined by their mental illness, but one that is deeply respectful of the effort and commitment needed to manage it.

We help them understand and find the words and feelings for their loss, trauma, and adversity, in the hope that they will shift from repeating a pattern of generational trauma to bravely taking up the challenge of breaking the cycle. We encourage them to seek a life that extends beyond what their illness may seemingly dictate, or their psyche may consider safe and comfortable. We ask them to be intentional in the pursuit of joy and meaningful social connections. We celebrate their wins, big and small, acknowledging that even if nobody else has noticed, their commitment and courage has been noted by us. And in doing all this, we hope that we are helping them build a life that they no longer need to escape from through maladaptive, dysfunctional defences and behaviours or through the devastating and tragic act of suicide.

That probably sounds like a rather exhaustive and exhausting job description and possibly one too idealistic to even contemplate. Yet, there isn't a single day that I don't feel privileged and grateful to do the work that I do. Granted on difficult days, that may feel like a fleeting millisecond of gratitude, but I still wouldn't trade this work for anything. Managing a patient population holistically and seeing the benefits of treatment, that extends far beyond the patients individual experience of their illness and recovery, is hugely rewarding. Being part of a journey that most likely began with pain and adversity and watching the transformation into kindness and compassion is inspiring. In supporting and educating family members, caregivers and bystanders caught up in the chaos and turmoil of our patients lives, we promote a greater understanding of the burden of mental illness and in minimising the pain that our patients unwincingly or intentionally inflict on others, we lessen the negativity and stigmatisation that surrounds psychiatric illness. And mostly, watching our patients love and be loved deeply, despite the hardships and limitations imposed by their illness, is a lesson in itself in the capacity and courage of the human heart.

What other challenges are there as psychiatrists that specifically makes our discipline struggle with self-care. Does public opinion of us as psychiatrists matter? Absolutely! The vital role played by advocacy groups who become the voice for our selectively silenced, marginalised patient population, speaks to the ongoing challenges we face in dispelling the stigma still associated with mental illness. How we are perceived as a discipline and our credibility with key players who will be instrumental in driving change, is important. Whilst we continue to fiercely challenge the negative perceptions of mental illness in the public arena, we understand it in part, to reflect a lack of understanding or experience of our world and that of our patients. But what about closer to home and our own medical fraternity? Does their more intimate knowledge of our world offer us a much needed ally?

Thirty-something years ago, I had just received my 6th year results (anyone remember the old days when they stuck class results on a board in the middle of the quadrangle) and was exuberantly leaving campus, when I bumped into one of my professors who was the Head of Department of a clinical discipline. A man of immense weight and stature in medical school, who had played a significant role in my clinical years. He asked what my plans were and I proudly replied that I intended specialising in psychiatry .

'That's such a disappointment Kim' he said. 'What a waste'.

Eight words, said in an exchange that lasted all of two minutes, and for which I'm certain he has absolutely no memory. Yet I remember the exact corridor we were standing in, and the feeling of walking away like a deflated party balloon, completely gutted by his words. I have heard those words, and replayed that conversation hundreds of times in my head.

Does anyone else have imaginary conversations for years after an event, in which you rehearse the exact response you wish you had pulled off on the day? Over the years, my responses to him have got increasingly braver as I've finally gained a necessary and much needed perspective on the incident. Because on that day, what I didn't hear was 'I am disappointed in your CHOICE'. Nor did I have the maturity or insight to recognise that his words said far more about him than they did about me, the 23 year old who finally felt one step closer to realizing her dream. What I heard on that day, from someone hugely important to me was 'YOU are a disappointment'.

And I have absolutely no doubt that every single one of us as psychiatrists, has felt similarly dismissed and devalued at some point because of what we do. And this goes beyond the stigmatisation of mental illness and the misperceptions of what we

do. There is a hierarchy in medicine that nobody openly acknowledges, but which is absolutely felt. And psychiatrists are evidently really low in the pecking order .This hierarchical structure is reflected in a myriad of ways that over time are devaluing, frustrating, alienating and depleting. From the allocation of training time in undergraduate programs, to the treatment of our registrars by other disciplines as they go about their clinical work in training hospitals, or by the weight and validity given to our clinical assessments in multidisciplinary teams. Far too often, we are the last port of call when all else fails or the first port of call when hasty and dismissive assumptions are made about a patient. Twenty five years later, I still have other specialists changing my scripts without any discussion, because they vaguely recall a marketing blurb highlighting some aspect of the latest psychiatric drug and they decide that this would better serve my patient. And this is often in a stable patient, consulting the specialist for an unrelated issue and the change in the psychiatric medication is made with no insight or regard for the battles hard one and decisions carefully made around my choice of medication. It is not our patients responsibility to defend their treatment.

So why am I raising this? This negative bias from our colleagues clearly has implications for our patients, but what about us? What does it do to us? Does it matter? Are we being petty? Should we just get over ourselves?

A succinct response for the purposes of this article, is that we're only human after all, and being held in positive regard by our colleagues impacts on our sense of self-worth. Any pervasive, uncontested and rigid perception that over time erodes ones sense of self-worth (and which is definitely more damaging when the bias is unspoken, but clearly felt), will contribute to an ongoing inability to value yourself enough to make the right choices around self-care and exercise self-compassion. And so all the knowing 'how to' means nothing if you can't value yourself enough to believe that you are as deserving of the care that you give to the people, or even the things, that you consider of value in your world.

We as a discipline don't ask to be revered, but we certainly deserve to be respected. More importantly, when do we start having brave conversations that hold people accountable for their conscious and unconscious biases that are reflected in their behaviour. The world needs more of these conversations. Deciding that a group is less worthy of belonging or that treats them as 'other' and therefore of less value based on flimsy but rigidly held belief systems, erodes hope for a compassionate society connected through our shared humanity, not separated by our differences.

My intention is writing this article was to facilitate ongoing and transparent conversations around some of the barriers we may encounter as psychiatrists in our quest to be more compassionate towards ourselves. And I'm hoping that these conversations will extend to the climate that exists during the years of undergraduate and postgraduate training that inhibits, rather than facilitates the self-compassion journey. Our efforts need to start much earlier if they are to have a more meaningful impact.

So after all that, what I still don't have for you is a neat action plan or a fool-proof list of self-care strategies, but I will offer these thoughts.

UNDERSTAND YOURSELF WITHOUT JUDGEMENT

Shame, vulnerability and resilience are concepts that need to be introduced early on in our training. Vulnerability is not weakness.

Go back and read that sentence again.

Until we shift and challenge our beliefs around vulnerability, we will struggle with authentic, honest conversations with ourselves, our loved ones and our patients. As long as we judge our less than perfect parts harshly and hide and hold them with shame, we will never believe that we are enough nor that we are okay. And believing that you are both enough and okay, is the starting point of your self-compassion journey. Because acknowledging vulnerability is a statement around your unique make up, not a self-imposed judgement of your defects and deficits.

How can I ask for help, if I won't even allow myself or others to see the parts of me that are struggling? Building your own resilience begins by seeing yourself with the kindest eyes. Our brave, compassionate hearts are there to champion are own lives, not only those of our patients and family. So be your own cheerleader, you really are the very best person for the job.

(Please read everything you can find, watch Ted talks, listen to podcasts, talk to each other and do whatever you need to do, to make yourself comfortable and familiar with these concepts)

GET MOVING AND BE STILL

Get moving most times, but be really still sometimes . As a young, overwhelmed and exhausted mum, I clearly recall reading articles that suggested exercise as a necessary self-care strategy, and feeling like the author clearly didn't get my life, but also feeling genuinely puzzled that anyone would willingly choose physical activity over sleep. So I'm not going to tell you what we all know about the benefits of physical activity and exercise. I am going to say this instead. Building resilience is not a compartmentalised entity in which you move from one aspect of yourself to another.

Physical, emotional and spiritual robustness are intertwined goals and progress is not linear. What was achievable on one day, may be out of your reach on another because that's just how life is. As psychiatrists, the disconnect from ourselves that serves our patients in our professional role, makes self-care that much harder and requires us to consciously and intentionally reconnect with ourselves if we are to get better at looking after ourselves. And so the journey to greater physical resilience begins here.

Allow yourself to register when you are tired, hungry, thirsty or feeling physically unwell. This may sound like a completely ridiculous starting point, but how many of us continue working without stopping to eat or drink. Once you are consistently making better choices around when to rest, sleep, eat and drink, you will have a body that is far better equipped to begin exercising. At that point you can begin to set yourself incremental goals that promote an increasing level of physical activity. And always remember to celebrate the small wins along the way. Walking up the stairs when you have always taken the lift, is you not only moving, but moving forward in your self-care journey and winning.

And for those of you patting yourself on the back because you have always exercised regularly and you think that this step of reconnecting with yourself doesn't apply to you, please understand that too much of a good thing is still a bad thing and that an exhausted, fit body is no more resilient than an inactive unfit one. So if you are exercising when you are too tired, haven't eaten all day and are nursing a sore throat, please go back and read the step that you thought didn't apply to you.

BE INTENTIONAL IN YOUR BEHAVIOUR

Our words are powerful. What is said cannot be unsaid. And whilst we have no control over the stories others tell themselves around our words, we need to be circumspect around the choice and timing of our words in both our professional and personal spaces. Unkind words will never deepen bonds or promote trust and we need to hold ourselves accountable for words said in thoughtless or emotionally charged moments. This doesn't mean that we avoid the difficult conversations, but conflict need not be combative. And if you haven't managed to access the kindest choice of words, an authentic heartfelt apology without defensiveness or justification, and a commitment to trying to do things differently, goes a long way to mending bridges and restoring trust. And fostering, meaningful authentic relationship in our lives is actually an exercise in self-care. We are wired for intimate and social connectedness and our relationships are what sustain us and provide us with refuge though challenging times.

But always remember that just as powerful as our words, are the silences and those moments where words seem unnecessary or inadequate. What is felt but not said, can be excruciating and relationships are eroded not only by the words said, but just as much by the words not said, and the silences not understood.

LEAN ON YOUR PEOPLE

We better than most, understand the struggles unique to our discipline. Let's lean on each other and trust each other enough to share our stories without fear of judgement. And if that still feels too scary, identify a mentor within your group. Someone with whom you can begin a relationship that will allow you to feel safe over time. And someone who will know you well enough to understand your words, your silences, or your tears.

As a young psychiatrist I was deeply grateful to have mentors whom I trusted implicitly. On one occasion, I was exhausted and anxious and really didn't want to be at a subgroup meeting because my kids weren't well and so I sat quietly the entire evening trying really hard not to show my distress. A wonderful, older psychiatrist whom I miss terribly, saw me crying on the way to my car at the end of the meeting, and knew me well enough to understand what was needed. She stopped just momentarily and said 'It gets easier Kim' and then left, knowing that I desperately needed to compose

myself. On a separate occasion, (no tears this time, but far too many words on my part) I was asking an older colleague what to do, because nothing I was doing seemed to be enough for a patient. 'You can't please everyone' he said, and I felt instantly calmed and reassured and free of my self-imposed expectations. Yet again, just eight words, but never forgotten and repeated hundreds of times over the next twenty-five years. And each time, they reminded me of how it feels to be known, understood, heard and comforted by someone who matters to you and I'm so grateful to have had those relationships. Those internalised words have got me though many similar moments over the years. Being understood and heard in one moment, gives us courage in the many challenging moments that lie ahead. But this can only happen if we risk showing our vulnerable selves and nurturing relationships with people who truly understand us.

SHOW UP FOR THE PEOPLE WHO SHOW UP FOR YOU

Unfortunately, all too often we give more of us to the people who are demanding of our time, overlooking the 'constant gardeners' in our lives. These are the people who quietly go about the task of supporting and loving us, easing our burdens and smoothing our path. Life isn't about reciprocity, but don't make the mistake of investing huge energy in relationships that are simply depleting and don't offer any meaningful connection. These relationships will distract and derail you from your commitment to your own self-care. And more importantly, don't give yourself permission to be unavailable for the people who are your real refuge and support. They deserve your presence in their lives and in a way that holds meaning for them. Don't simply decide how and when you would like to show up and then feel hurt and surprised when they're not grateful. Ask them what they need from you and then try really hard to do it. Because once again, relationships are knitted and strengthened when both sides feel valued, heard and understood .

BE CURIOUS AND STAY CURIOUS

Live a life of curiosity and don't ever stop being relentless in the pursuit of new information and experiences. Be open to ambiguity and uncertainty in your life because holding rigid beliefs and being certain about something, precludes the possibility of change and growth. Being an amateur is defined as a person who is incompetent or inept at a particular activity or doesn't earn money from it. You already have a profession, so please go and be an amateur over and over again throughout your life. Be wonderfully inept and incompetent, learn something new, meet new people and have fun. And while you are out there in the real world, outside of your rooms and your patients, you will begin to see that the world is in fact a place that is mostly safe and sometimes dangerous and that most people are good and kind and some people are dangerous and damaging.

I needed to be a braver version of the person I was a month ago, in order to write this article. I chose to be courageous over staying comfortable, because I cannot hope to have credibility and ask my children to be brave as young adults if I stay in the safety of shallow waters.

Self-compassion as I understand it is a life-long practice consisting of daily choices that are respectful of the unique person you are. You deserve to live your fullest life and only you can truly champion that. You must be prepared to make daily and sometimes difficult choices that will make you the most resilient version of yourself. And resilience is not only about surviving adversity, and it is not the stuff we save for weathering storms. Resilience is also just as much about embracing the everyday magic that surrounds us and having what is needed to live a full and adventurous life. But you need to believe that you can start that life right now and that you don't first need to earn the right to happiness or sit waiting for somebody to give it to you.

And if like me, you need a playlist for your self-compassion journey (because every journey needs a playlist), mine has just one track.

AND SO I HAVE CHOSEN TO END WITH THOSE LYRICS BECAUSE,

this is me,
this is us as psychiatrists,
and more importantly
this is all of us.

I am not a stranger to the dark
Hide away, they say

'Cause we don't
want your broken parts'

I've learned to be
ashamed of all my scars

'Run away', they say

No one'll love you as you are

But I won't let them
break me down to dust

I know that there's a place for us

For we are glorious

When the sharpest
words wanna cut me down

I'm gonna send a flood,
gonna drown them out

I am brave, I am bruised

I am who I'm meant to be,

THIS IS ME

KEALA SETTLE, THE
GREATEST SHOWMAN ENSEMBLE

THE CALLING:
A MARRIAGE OF WESTERN AND TRADITIONAL MEDICINE

DR THEJINI NAIDOO
CHIEF REGISTRAR
UKZN DEPARTMENT PSYCHIATRY

SETTING THE SCENE...

WHEN YOU FIRST ENCOUNTER DR. AROSI, HE EXUDES A YOUTHFUL EXUBERANCE THROUGH HIS KEEN SENSE OF STYLE AND LIVELY MANNER OF SPEAKING. HOWEVER, WHEN ONE SITS DOWN TO HAVE A CONVERSATION WITH HIM, HE ALSO HOLDS A WISDOM WELL BEYOND HIS YEARS. I WAS PRIVILEGED TO HAVE THE OPPORTUNITY TO LEARN ABOUT HIM AND THE COMPLEXITIES OF HIS DUAL ROLE AS A PSYCHIATRY REGISTRAR AND A TRADITIONAL HEALER.

Hailing from the small town of Qumbu in the Eastern Cape, he is one of five children born into a supportive, loving family. His birth name, Mhlangabezi, was given to him by his paternal grandmother with a very instructive intention. It is a Nguni name of the isiXhosa dialect that translates to 'One who meets halfway' and 'One who relieves, facilitates, assists and mediates'. He believes that it was bestowed upon him with the purpose of informing and aligning his future spiritual journey and vocation. His Igama leThongo (spiritual name), Makhosi Viz'celo, translates to 'One who hears pleas/heeds calls'. It is a name which he shares with his late paternal aunt, who is directly responsible for his ancestral gift and calling.

In his formative years, his primary caregivers were his paternal grandmother and late aunt because his parents worked in the city. His grandmother firmly believed in the church as a moral compass, and perhaps a form of protection from most societal ills. She raised him in an Anglican home and ensured that he regularly attended church.

At the age of nine, his parents migrated to eThekwini in KwaZulu-Natal, in the hope that moving to the city would better the educational and occupational prospects for their children. It was here that he completed his schooling and obtained his medical degree.

WHAT INFORMED YOUR DECISION TO STUDY MEDICINE AND YOUR CHOICE TO SPECIALISE IN PSYCHIATRY?

The story of becoming a medical practitioner is one that my family still laughs at, whenever it is retold. Apparently, when I was 10 years old, I told my parents that they needed to save up a lot of money, because I was going to go to medical school. I had heard that it was a long and expensive career choice, so they would take away certain privileges if it meant that I would have the opportunity to become a doctor. I think, in retrospect, it was a choice that not only resonated with both my birth and spiritual names, but also one that played to my personality.

I've always been a curious child who was very interested in how things worked, including the human mind. I remember thinking this to myself: what if I could learn how the human body functions and dysfunctions? Further, I thought, imagine if I was able to use that knowledge to relieve that disease and realign and restore functioning. This simply HAD to be the best job in the world.

Having gone through the rotations in the undergraduate years, I remember hearing of and meeting a man named Prof Dan Lamla Mkize and thinking THAT'S the kind of doctor that I want to be.

I later read some of his work and my fascination with mental health was solidified. He had also touched on some of the cultural and spiritual aspects that are often misunderstood or plainly excluded by the (very limited) biomedical model of healthcare and healing practices.

CAN YOU DESCRIBE YOUR EXPERIENCE OF BECOMING A TRADITIONAL HEALER AND WHAT IT MEANT TO YOU?

The realisation that I had a calling to become an indigenous healer came at a time where I was working as a medical officer in Psychiatry. It came through a lot of misfortune in my personal life, and I think this is usually the case with most healers that are called into this kind of work. Often, the experience of ingulo yokubizelwa ukuthwasa (the sickness of being called to be a healer), can mimic what is conventionally

parallel to mental illness. Initiates may have strange and vivid, sometimes lucid dreams. They may see their ancestors in their dreams, who may speak very clearly to them. Sometimes the dreams are of snakes, bodies of water, animals that may be family totems and beads. Each person experiences the dreams individually. Usually they would need a diviner to decode the dreams and what is being communicated to them.

Personally, I don't remember being frightened by the dreams, or the prospect of possibly having a calling, perhaps because I had always had a curious fascination with indigenous forms of spirituality and practices.

I think because of the similarities in how these unusual experiences present, both to families and healthcare workers, it's easier to label them as psychosis and want to medicate the "sufferers".

IN WHAT WAY DOES YOUR DUAL ROLE ENHANCE AND CHALLENGE THE WAY YOU VIEW THE WORLD AND THE WAY YOU PRACTICE THE ART OF HEALING?

It becomes a diagnostic blur when someone believes they have a calling to be igqirha (a healer) and they are labelled as having grandiose delusions that require antipsychotics. It's even a bigger challenge when you are both Dr. Arosi and Viz'celo, and you think that a patient has a spiritual illness that may not respond to medication alone, yet your professional code of ethics requires you to practice using one model of healing.

However, it is not all negative. I have had patients ask me, outside of working hours, for referrals to practising sangomas and they have come back with favourable results, while continuing their treatments.

This is not to say that the two forms of ingulo (sickness) cannot co-exist but perhaps a more sensitive and inclusive therapeutic approach is what needs to be bolstered as their individual "management approach" also differs.

HOW CAN WE FOSTER MORE POSITIVE RELATIONSHIPS WITH TRADITIONAL HEALERS GIVEN THE STEREOTYPICAL VIEW THAT MOST WESTERN PRACTITIONERS HOLD TOWARD THIS PRACTICE OF MEDICINE?

This requires that both belief systems see and respect their mutually inclusive places in terms of holistic healing.

This may mean that the indigenous healers need to demystify their practices while maintaining their sacredness (because they are a gift from our venerated ancestors).

It may also require the western/ biomedically inclined practitioners to

cast their proverbial diagnostic net a little wider and truly tap into different facets of an individual's (and family's) illness and help-seeking behaviour.

WHAT ARE SOME OF THE COMMON MYTHS ABOUT TRADITIONAL HEALERS THAT YOU WOULD LIKE TO DISPEL?

Sangomas cannot see what you are thinking or feeling. They do not read minds. They are not opposed to Christianity or any other mainstream religion.

Like in all trades, there are unscrupulous practitioners. While amagqirha (healers) are respected for their healing powers, there are also those that can misuse their gifts. Interestingly, the IsiXhosa word "amagqwirha" translates to those who practice evil/witchcraft, differing by a single letter from the word amagqirha.

WHAT PRACTICAL WAYS WOULD YOU SUGGEST THAT THESE TWO COMPLEMENTARY METHODS OF PRACTICING MEDICINE BE AMALGAMATED TO IMPROVE PATIENT OUTCOMES?

Open and honest sharing of information would be the first crucial step in this process. This would foster trust and the harmonious practice of holistic healing.

For instance, if a sangoma prescribes ukuphalaza (induced vomiting) as a treatment modality, it would make sense to suggest to the patient that the oral medication be taken after ukuphalaza.

I think we should also allow our patients to consult whomever they feel that they need to, and to perhaps give us feedback as to what was said/proposed as treatment options.

As indigenous healers, we could also advise those who seem to have more than a spiritual illness to seek medical care, like the consultation-liaison system whereby we co-manage patients with a similar end goal - holistic wellbeing.

WHO INSPIRES YOU?

I do not have one specific person that I necessarily look up to. Growing up, I have identified certain qualities in several people that I hope to emulate. My parents remain such people, when it comes to joining forces with the solid collective goal of selflessly giving. There are a few academics from my own university that have always been academic/professional inspirations.

WHAT MESSAGE DO YOU WISH TO SPREAD THROUGH YOUR HOLISTIC PRACTICE OF MEDICINE?

Holistic healing, to me, means being aware of the inclusive nature of achieving wellness. Someone once said that God begins where science ends, so we must always try to educate and sensitise ourselves as practitioners to as many aspects of the patients' health as possible. The opportunity to collaborate with patients and their families, learn from them, and involve them in therapeutic decisions should be welcomed. A trusting alliance must be nurtured, and we must endeavour not to promulgate our own agendas when dealing with the human nature of well-being.

"The cloths (amabhayi) are worn by traditional healer trainees. Different types are worn through the various stages of training (sort of like graduation gowns). We use them whenever we are consulting, or doing any type of healing work. They also have different symbolic meanings. They sometimes represent ones family animal totems. A persons spiritual guide may inform them of what type and colour of amabhayi to wear, and this is usually communicated through dreams. It may also be purely decorative or a fashion statement. The red cloth was used in my earliest days of training".

END OF LIFE PASTORAL CARE:

HOSPISCARE CHAPLAINCY - EXTENDING THE TABLE TO INCLUDE THE DYING

REV'D DR. E GETMAN
CHAPLAIN / SPIRTUAL CARE LEAD
HOSPISCARE

DEATH IS THE GREAT EQUALISER. AT THE END OF THE CHESS MATCH, ALL THE PIECES - THE ROYALTY, THE BISHOPS AND THE PAWNS GO BACK IN THE SAME BOX. WE ARE ALL HEADING IN THE SAME DIRECTION. AS THE FORMER DEAN OF ST GEORGE'S CATHEDRAL IN CAPE TOWN ONCE TOLD ME: "LIFE IS A SEXUALLY TRANSMITTED TERMINAL ILLNESS". BUT THE NEARING DEATH EXPERIENCE VARIES GREATLY.

I have worked as the chaplain at Hospiscare in Exeter for a year now. In the beginning it felt like a conveyor belt of death. It still is. But now it also feels like a vital place of life. It is a safe place where difficult conversations and experiences take place. It is a remarkably peaceful place with a beautiful well-tended garden. It is bustling with employees and volunteers. Our motto is "Because every day matters". And I have learned in this past year what really matters in the end is love and acceptance and attentive care. My job is to listen attentively with no judgment. And to stay wide open to whoever comes through the door - patients and their loved ones. Staff and volunteers. Whoever comes through the door and however they come and whatever they bring.

As a priest, licensed to hatch, match and dispatch, I never could have imagined a season in which so many people would ask me personally to do

the honours for them when the time comes. A lovely couple who had been married for nearly 70 years asked me recently. He was in a wheelchair next to her bed. He asked on her behalf. And then she piped up: "I want it low church. Nothing high faluting!" How could I possibly refuse? Organising their own funeral services can help people feel that they have some control and order during a confusing and frightening time. I told this couple that it would be a privilege to help them plan a fitting celebration of their lives well lived.

She was a war orphan. And proudly Cornish. She said the first time she laid eyes on her husband she knew she would marry him or no one. I visited them separately last week. She was in a nursing home and he was in the hospital. We said the Our Father. And she wanted the Magnificat as well. She died two days after my last visit when I anointed her hands and kissed her cheek. I will bury her next week. I anticipate that soon I will do the honours for her husband.

I provided spiritual accompaniment to another patient who had a strong faith and was very involved with her local church community. Each time I took her bedside Eucharist she told me how important it felt to be included. She was under quarantine due to infection and therefore could not join my little congregation of day hospice patients who gather in the chapel each Wednesday. But I could take her their love and prayers and a piece of the wafer and a sip of the wine. This reminded her that she was part of the body of Christ. I took her blessings and I held her hand. And she held mine.

These weekly chapel services anchor my time at Hospiscare. My ever changing little congregation comes slowly with walkers or in wheelchairs and sometimes even bed-ridden patients are wheeled in from the ward. On Christmas Day it was an amalgamation of patients' families – complete strangers who sang carols together and wept and hugged and found solace during the passing of the peace.

I shift freely around the little central altar – a wooden table covered with a starched white cloth with lace edging. Usually I stand with my back to the door. Once a patient in a wheelchair was in the deacon position and being slightly out of my pole position, I bumped the chalice as I was setting up for the Eucharist. And the wine sloshed onto the corporal and the altar cloth. There was a collective intake of breath. But I reassured them that since the wine had not yet been consecrated I did not need to suck it out of the cloth!! And yes, the stains did come out in the wash.

Recently, I had only one patient in her wheelchair and the nurse parked her right in front of the altar so I sat beside her and held her hand through the service until we came to the consecration when I moved around to the opposite side of the table and sang her the Offertory. It changed everything to be singing and praying and consecrating towards the door that opened in the direction of the corridor between reception and the ward.

Sometimes I look at people in the street and think: "What's the point? We are all going to die."

But most of the time I think: "How extraordinary it is that we can choose to live. Here and now." And in the end the thing that matters most is loving kindness. All people are equal to me in my role as chaplain. Those who want to see a priest and those who want nothing to do with religion. My job is to help them to feel valued, to ask for what they need and to bask in the love.

It is only when we face our own mortality that we are fully aware of our own natality. We are called to be alive for flourishing. I have been reminded recently of GK Chesterton's novel Manalive. The main character, Innocent Smith, is a sharp shooter and an adventurer who is accused of attempted murder and adultery. But in his own defence he says, if he had wanted to kill the man, he would not have missed. And the woman he is meeting at secret trysts turns out to be his own wife. He deals life with both his revolver and his sense of adventure. Hospiscare deals life through the careful attention given to the dying. There is a genuine valuing of the nearing death experience. It is a reminder that: We all are going to die. But first, we are going to live.

The intimacy of sitting with the dying is incomparable. It is a rare privilege. I am tasked with ministering to them. But so often they minister to me. One gentleman prayed fervently for me and my ministry only hours before he took his last breath.

In my ministry I often use the poetry of Rumi and Mary Oliver. And I would be lost without the map of blessings found in The Cure for Sorrow: A Book of Blessings for Times of Grief by the remarkable minister and poet and artist Jan Richardson. I read them to patients and their families. I weave them into my funeral sermons. This one I even said at the graveside of my 100 year old grandmother last January. It is called:

[THE] BLESSING OF BREATHING

That the first breath
will come without fear.

That the second breath
will come without pain.

The third breath: that it will
come without despair.

And the fourth,
without anxiety.

That the fifth breath will
come with no bitterness.

That the sixth
breath will come for joy.

Breath seven: that
it will come for love.

May the eighth
breath come for freedom.

And the ninth, for delight.

When the tenth breath
comes, may it be for us to
breathe together, and the
next, and the next, until our
breathing is as one, until our
breathing is no more.

Because every day matters,
we walk this road as
companions – those with
whom we share our bread.
We breathe and pray and
eat and tell stories
and laugh and weep
together.

Because every day matters,
we pay attention to
what the dying can
teach us about living.

Because every day matters,
we turn and face the mystery
that ultimately we cannot
avoid. Facing death can
encourage us to live well and
to seek peace at the end.

I close with another blessing
that I use as often as possible
by HF Amiel written in the
late 1800s - with a line from
American poet Mary Oliver
thrown in for good measure:

LIFE IS SHORT

And we
do not have much time

To gladden the
hearts of those who
travel the way with us

So be swift to love and
make haste to be kind and
the blessing of God the
compassionate one (Creator,
Redeemer and Sustainer)
who made us and loves us
and goes before us be upon
you and all those whom
you love and may you live
your one wild and precious
life fully and deeply this
day and forever more.
Amen.

RUNNIING

STILLNESS IN MOTION

AN INTERVIEW WITH BLANCHE MOILA

BY NASEEMA CASSIMJEE

"AN ICON", "LEGENDARY ATHLETE", "QUEEN OF THE ROAD": THESE ARE BUT SOME OF THE WAYS SHE HAS BEEN DESCRIBED. A QUICK INTERNET SEARCH REVEALS AN ABUNDANCE OF INFORMATION ON SISTER BLANCHE MOILA'S MANY TRIUMPHS. SHE IS AN ACCOMPLISHED ATHLETE, AND WAS THE FIRST WOMAN OF COLOUR TO HAVE RECEIVED HER SPRINGBOK COLOURS IN 1984.

She is one of us, a nursing professional of the mental health family, and we are extremely proud of her and her lifetime achievements. We were grateful to have her talk to us about her life and undying passion for running.

1. WHO IS BLANCHE MOILA?

I am the youngest of seven kids. I matriculated at the Good Hope College in the Cape, and thereafter pursued my nursing career at Groote Schuur Hospital. I am a psychiatric professional nurse currently working at King Dinuzulu Hospital in Durban. I enjoy running, reading, and spending time with friends. I also love watching live comedy at the threatre.

2. HOW DID YOU GET INVOLVED IN MARATHON RUNNING?

I started running perchance at a hospital sports day event. That's when I met my mentor Dr Shorty Moolla who was a Comrades runner, and a psychiatric registrar at the time. He introduced me to running as a sport. Initially, I only ran socially, and then gradually progressed to competitive running.

3. WHAT ARE SOME OF YOUR MOST MEMORABLE ACCOMPLISHMENTS / ACHIEVEMENTS?

Running afforded me opportunities I had only dreamed of before. I gained so much life experience; met interesting people – including ex-presidents; represented my country internationally, initially as an athlete and later an administrator in sport. The positive aspects of my journey in sport are numerous.

Some of the 'stand out' moments have been, being awarded my Springbok colours in 1984. I won numerous SA titles and broke several records in the 1980's and 1990's over 10 kms , 16 km and 21 km races. I held KZN records and titles in numerous distances on the track, cross country and road running. In 2001, I received the Presidential Sports Awards for Life-Time Sports Achievements. The Shoprite Checkers Women of the year title was awarded to me for my contribution to sports in the community in 2002. I was the face of Comrades in 2004. I was presented with the Andrew Mlangeni Green Jacket Award (Ed. : This award is to honour South Africans who have made immense contributions to sport in the country, and who were never acknowledged during the apartheid regime).

4. DID RUNNING DURING THE APARTHEID ERA AFFECT YOU? IF SO, HOW DID YOU DEAL WITH ANY DISAPPOINTMENTS OR NEGATIVE IMPACTS OF APARTHEID ON YOUR MARATHON RUNNING?

The social structures of the time presented some challenges. I was fortunate enough to have had sound support from my family and community. I had a healthy concept of who I was and what I could achieve. When life gave me 'lemons', I made 'lemonade' with my legs, and ran with my heart. Having said that, I received more positive than negative feedback from people of different cultures. I was able to shrug off the negativity, which was more about my melanin enriched complexion than my personality. The true beauty of the sport lies in the lasting friendships fostered with people of all cultures and language backgrounds. The negative comments were never from other runners, but rather some of their supporters who seemed to take offence that the young brown girl was sometimes out-running their favourite melanin deficient athlete.

5. DO YOU STILL COMPETE PROFESSIONALLY?

I still enjoy competitive running relative to my age group (masters division). There is less pressure to excel now. It's more fun and enjoyable now, and I feel a greater degree of sisterhood with my fellow runners. I competed in my 16th Comrades Marathon in 2019. Looking forward to 2020.

6. HOW OFTEN DO YOU RUN/ TRAIN NOWADAYS? HOW DO YOU MANAGE TO FIT IT IN WITH YOUR BUSY WORK SCHEDULE? PEOPLE OFTEN MAKE EXCUSES ABOUT NOT HAVING THE TIME TO ESCAPE THE RAT RACE - WHAT WOULD YOUR ADVICE BE TO THEM?

I run daily, about 5-9 km. It's not as regimented as before. Most runs are at a relaxed pace. Twice a week, I do quality runs like hill repeats or fartlek sessions (Ed. : fartlek sessions are interval speed plays, periods of fast running mixed with periods of slow running). I cycle twice a week, and do strength training twice a week in the gym. I do a long run on Sundays, about 35km. Balance in life is important! We have 24 hours in the day. All one needs is a 40 minute session, 4 to 6 times a week. It is inactivity that renders our bodies susceptible to diseases. Exercise has enormous benefits to mental and general health. Running is an ideal anti-depressant since it is almost impossible to run and wallow in sorrow at the same time. Nobody is too old to be active!

7. WHAT DO YOU THINK ABOUT WHILE RUNNING MARATHONS?

Relaxed running affords me time for clear thinking. I am able to work out issues, resolve problems etc. However, during marathon running I usually pay attention to the 'now', how I am feeling at that point in time, and working on a positive mantra, which is usually "I Can".

8. DURING LONG DISTANCE RUNNING, DO YOU EVER HEAR A VOICE IN YOUR HEAD TELLING YOU TO QUIT?

Quitting has never been an option for me. I always visualise my marathon finish, even before the race has started. And yes, everyone goes through some sort of fatigue and discomfort during a race, but during my visualisation I always see myself enduring these periods with a positive outcome.

9. RUNNING CAN BE A VERY INDIVIDUAL SPORT, BUT ONE THAT ALSO FOSTERS A SENSE OF COMMUNITY. HOW DO YOU FEEL ABOUT RUNNING IN TERMS OF INDIVIDUAL VS GROUPS?

I am an introvert and most of my training is done solo; that's what I am comfortable with. I do however enjoy the occasional group runs with friends.

10. WHO WERE/ARE YOUR ROLE MODELS?

My mother (a community nurse) has always been my number one role model. She instilled self-confidence, compassion, respect for others, and was very generous towards those less fortunate. In the sporting world, I admired Tegla Loroupe (Kenyan long distance and track runner, the first African woman to win the New York City Marathon) and Joan Benoit (American marathon runner- first ever women's Olympic Games marathon champion). I have loads of respect for every sport where women compete under challenging circumstances. A safe environment for training in South Africa is still a huge concern for women in general.

11. DO YOU HAVE ANY MEMORABLE RUNNING EXPERIENCES TO SHARE?

Yes. Meeting the leadership of the country after their release from Robben Island. I was unaware of the impact my running had on those incarcerated in Robben Island, until I met some of them post-1994. They informed me that they were able to watch TV and were always rooting for me, and that my performance had given them hope that change was imminent. A humbling experience indeed! Also, meeting so many people daily that tell me they have been inspired to lead a healthier lifestyle by seeing me running for decades - this

motivates me to continue running.

12. DO YOU HAVE ANY THOUGHTS ON MANAGING PAIN DURING MARATHON RUNNING?

I have never experienced pain as such. I do feel some discomfort from fatigue, but no cramps or pain. I handle the fatigue through repeating my mantra, which is usually 'I Will Finish, I Can Do This'.

13. RUNNING GEAR (ESP SHOES) HAS BECOME QUITE TECHNICAL AND CAN BE VERY EXPENSIVE. WHAT ARE YOUR VIEWS ON THAT? DOES HAVING ADVANCED TECHNOLOGY IN SHOES GIVE ONE AN ADVANTAGE?

Yes, gear is very expensive, but the functionality of the shoe is very important. One needs to find a shoe that suits your running style. I pronate, so a neutral or antipronation shoe works best for me. The advantage of advanced technology is that the shoe is designed for a lighter feel with more cushioning under foot. A shoe that wraps comfortably around your foot should not pinch or feel sloppy. And your choice would also depend on your running style, whether you're a heal striker or a forefoot striker.

14. YOU'RE QUITE PASSIONATE ABOUT CHAMPIONING WOMEN'S CAUSES IN SPORT. CAN YOU TELL US ABOUT THAT?

I work with SAWASF [South African Women In Sport Foundation]. As women aiming to take our rightful place as players, administrators, coaches and leaders in sport, we must take the initiative in transforming sports so that our needs and aspirations are met for women by women. We need to stop blaming our circumstances where we are able to change things. I'm also concerned about the high teenage pregnancy rate in South Africa. I have driven the campaign 'Achieve before you conceive.' I visit schools in the area,

encouraging the youth to take up sports and enhance their life skills. I have several talented youth whom I mentor and assist with sports apparel.

15. SPEAKING OF GENDER RELATED ISSUES, HOW DID YOU FEEL ABOUT THE CASTER SEMENYA VERDICT AND THE IAAF RULING THAT SOME FEMALE ATHLETES REGULATE THEIR TESTOSTERONE LEVELS?

Testosterone by itself does not a winner make. The perception that it does undermines the work ethic, preparation, discipline involved in training, and the natural skills of the athlete. Caster prepares well, perfecting her skills and tactics, and that is why she is a champion athlete. The height of absurdity of the IAAF wanting to 'level the fields of play'!! Caster does not hold the 800m record. There are other females who run fast - just to name a few, the record is held by Jamila Kratochvilova: 1.53, Nadezhda Olizarenko: 1.53, Pamela Jelimo: 1.54. Can the athletes at coastal regions complain about disadvantages when competing with those from high altitude regions? I am 1.5 m tall. Can I complain about running with female athletes who are much taller? Look around competitive fields. How often do we see female athletes finish ahead of male athletes. If testosterone levels were so important in winning, then in any given marathon, all male runners should finish ahead of the female runners. The bottom line is that the IAAF rules, based on the European genetic disposition, are totally unethical. Trying to regulate athletes' natural testosterone level could affect their health at large.

16. WE HAVE TO TALK ABOUT ELIUD KIPCHOGE RUNNING A SUB-2 HOUR MARATHON. WHILE WATCHING THE INEOS 1:59 CHALLENGE, ONE OF THE THINGS THAT STUCK WITH ME WAS THE PACE SETTERS (MOST OF WHOM WERE VERY ACCOMPLISHED ATHLETES AND LEADERS IN THEIR INDIVIDUAL CATEGORIES) AND THEIR SENSE OF COMMUNITY AND CAMARADERIE - ALL SELFLESSLY DOING WHATEVER THEY COULD TO ENSURE THAT A FELLOW ATHLETE MAKES HISTORY. WHAT DID YOU THINK ABOUT THAT?

Africa in general has naturally gifted athletes. The genetic dominance of certain tribes such as the Maasai in Kenya is evident. Eliud Kipchoge holds the official world record, which is two hours, one minute and thirty nine seconds. In 2017, he attempted to break the two hour barrier in Italy, but fell short by 26 seconds. This was his second attempt. Impressive indeed! It is not just about a shoe that he trained with in order to achieve a running pace of 2 minutes and 50 seconds / km. My favourite African proverb is, 'if you want to go far, go together. If you want to go fast, go alone'. The camaraderie of the pace setters endorsed this proverb. They were in this together, and shared the euphoria at the finish line. Camaraderie amongst distance runners is the norm.

17. IF YOU COULD OFFER A SINGLE PIECE OF ADVICE TO NEW RUNNERS, WHAT WOULD IT BE?

A strong motivation to run is to get fit and be healthy. I would like to encourage

the older generation to get into running. It is doable. Age has no penalties. I once met an Australian lady who only started running at age 62, post-chemotherapy. At 65 she completed her first Comrades. Many marathon runners are over 40. My advice is to start slowly, and pace yourself wisely. You need mental strength to run a marathon. Sleep more, eat healthy (I'm vegetarian since my youth for humanitarian reasons), drink plenty water, and have fun. Don't sweat the small stuff. Laugh often, and take time away from the daily grind to do something that you enjoy. I have learned how running can liberate women, and it has given me a platform on which to reach the youth. Exercise also boosts the immune system. I have been working for 40 years in a hospital environment, and not a single day off sick from work. #Healthy-lifestyle.

WHAT THE FIT

CHANGE YOUR GAME

BY MOHAMMED EBRAHIM

MOHAMMED EBRAHIM (MO) IS A PERSONAL TRAINER WITH MANY YEARS OF EXPERIENCE IN THE FITNESS INDUSTRY. HE IS A UKZN GRADUATE, AND HOLDS A B.SC SPORT SCIENCE AND B.SC HONS EXERCISE SCIENCE DEGREE. MOHAMMED IS ALSO A NSCA CERTIFIED STRENGTH AND CONDITIONING SPECIALIST. HIS AREAS OF INTEREST INCLUDE BODYBUILDING, SPORTS SPECIFIC TRAINING, WEIGHT MANAGEMENT, FUNCTIONAL TRAINING, AND HEALTH AND WELLNESS.

EMBARKING ON YOUR FITNESS JOURNEY

IDENTIFY YOUR "WHY" SO YOU CAN BE CLEAR ABOUT YOUR GOALS

As with many things in life, understanding the purpose behind a particular task makes fulfilling it so much more rewarding. Take a minute and ask yourself why are you embarking on this journey. Is it for a healthier you, is it to shed a few excess kilos, or maybe it's to look in shape for an upcoming event on your calendar? Everyone has a unique "why" which is specific to them and the goal they would like to achieve.

PUSH BEYOND THE INTIMIDATION AND JUST GO FOR IT

The gym can be an intimidating environment for someone starting off. It's filled with unfamiliar faces and strange looking pieces of equipment. The clatter of weights over the music playing in the background, interrupted by banter of other gym members and the occasional grunt under exertion can altogether be an intimidating experience at first. Just remember, contrary to popular belief, people aren't there to judge or ridicule you. Just like you, everyone else is there to work on bettering themselves and getting a step closer to reaching their goals.

PACE YOURSELF - TRY STARTING WITH 30 MINUTE WORKOUTS, THREE TIMES A WEEK

This is good way to start off - from a practicality point of view and also from a sense of enjoyment. Even if you planned to work out during your lunch break, a focused 30 minute session will not only leave you feeling great, but also allow for freshening up and travel time. A 30 minute session on alternating days will provide sufficient training to start you off, and also allow for adequate rest time between sessions.

PRIORITIZE CONSISTENCY OVER INTENSITY

Consistency is key! If you asked any successful athlete or fitness individual what they found to be fundamental in reaching their goals, they would tell you that apart from the effort and hours put in, it's consistency that's key to getting you to where you want to be. It is more productive to work out three times a week for 30 - 45 minutes, than to spend 90 minutes once a week. Consistency will help you to establish a workout split and increase your likelihood of following through with it.

FIND OTHER ACTIVE PEOPLE TO SUPPORT YOUR EFFORTS

Take a friend, family member or even a colleague to the gym. Not only will having a familiar face around make you feel more comfortable, but it will also be a positive factor to provide motivation. Enlisting the services of a qualified personal trainer will also be a great support to you. The trainer will teach you how perform exercises safely and effectively, and will also employ their expertise to help you reach your goal and achieve results sooner than you think.

TO AVOID BURNOUT AND INJURY, START SLOW AND WORK AT YOUR OWN PACE

Slow and steady does it! Remember- Rome wasn't built in a day. Your journey to fitness is an ongoing process, so start off slow. Work at your own pace, but progressively increase the intensity as the workout sessions go by. A common mistake made by many is an aggressive approach. Even though rooted from good intentions, this often results in soreness and stiffness which can be a deterrent to returning for the next workout session. Training should not be within your comfort zone as you will start to plateau, but at the same time it should be within reasonable limits.

MASTER FUNDAMENTAL MOVEMENTS LIKE SQUATS AND LUNGES BEFORE GETTING FANCY

Basic compound movements have stood the test of time simply because they work. There is no need to perform fancy variations of movements when starting off. Keep your movements simple and basic, focusing on proper form, breathing and technique. This will lay a solid foundation and ensure proper muscle activation while reducing your risk of injury.

DON'T COMPARE YOURSELF TO PEOPLE WHO ARE FURTHER ALONG IN THEIR FITNESS JOURNEY

All too often beginners compare themselves to the achievements of more experienced individuals. There's nothing wrong in aspiring and being motivated to be like others, but just remember to use your own yard stick. Know that results don't happen right away. It is important to

keep this in mind as your patience may be tested at times. Just remember that your efforts will not be in vain. You will reap the rewards of your consistency and hard work.

IF YOU'RE INTO NUMBERS AND STATS, TRY WEARING A HEART-RATE MONITOR TO SEE HOW YOUR BODY'S WORKING IN REAL TIME

This will allow you to monitor your vitals during training, and will also serve as a way to track your fitness levels. Fitness trackers and smart watches have the feature to store and recall your workout data. These devices are a good investment - they are purposeful as they are fashionable.

BALANCE YOUR BODY

Build good posture, and ensure that you have strength for your favourite activities. Choose exercises that are purposeful and specific to your needs. Ensure to work opposing muscle groups. This will help to strengthen muscles appropriately and help to reduce your risk of injury. It's easy to focus on the muscle groups we can see working, such as the biceps, but one should not neglect the other muscle groups that are less visible. We should adopt a holistic approach to training the body.

And remember – a healthy body houses a healthy mind

INSTAGRAM HANDLE:
mo_ebrahim_09

DON'T BE IN THE DARK ABOUT WORKING OUT
SHED THOSE MISCONCEPTIONS
CARRY THAT LOAD

MINDFULNESS AND WILDERNESS

WHAT DO YOU DO FOR FUN?

DR P MILLIGAN
HEAD OF THE PSYCHIATRY DEPARTMENT
NGWELEZANE HOSPITAL

SO MUCH HAS BEEN WRITTEN RECENTLY ABOUT STRESS AND BURNOUT AMONGST HEALTH WORKERS, BUT MUCH LESS ABOUT WHAT TO DO TO PREVENT IT. HEALING THE HEALER HAS BECOME A CATCHPHRASE, BUT MANY OF US FIND IT DIFFICULT TO PRACTICE SELF-COMPASSION AND TO MAKE THE TIME TO DO THOSE THINGS THAT NURTURE AND RESTORE US.

A lifeline for me has been my journey into mindfulness practise over the last fifteen or so years, and a particularly exciting part of this has been my involvement in leading mindfulness walking retreats in wilderness areas. The journey started about twelve years ago when Dr Ian McCallum a well-known psychiatrist and environmentalist approached a colleague and me to lead a mindfulness training for the field guides of the Wilderness Leadership School in the Imfolozi. Since then, I have been regularly involved in leading mindfulness trails in the Imfolozi and more recently in the vast Mphongolo wilderness in the northern Kruger National Park.

The wilderness areas in our national parks are paradises, teeming with wildlife and completely pristine with no roads or any other human infrastructure. The five day and four night wilderness trails are conducted on foot led by two highly skilled field guides and a maximum of eight participants. Participants walk in silence in single file carrying all they need for five days in a backpack. At night, the group sleeps out under the stars. A highlight of the trail is the night-watch where participants take it in turns to sit up alone around a small fire and keep watch for any dangerous animals.

A typical day in the wilderness starts with awakening to the dawn with its chorus of bird calls and other animal sounds. The day begins with a guided yoga, breathing and meditation practice followed by a careful pack-up of camp ensuring that we leave no trace of our presence there. We walk in silence in single file led by the guides, stopping if we encounter any wild animals or other interesting sightings. After a leisurely lunch, participants spend time alone in silent reflection. When we arrive at our overnight camp, we break silence and do the simple chores of washing, collecting firewood and water and preparing the evening meal. The day ends with a group reflection around the fire and then retiring to bed leaving the first person on night-watch to keep watch while the rest sleep.

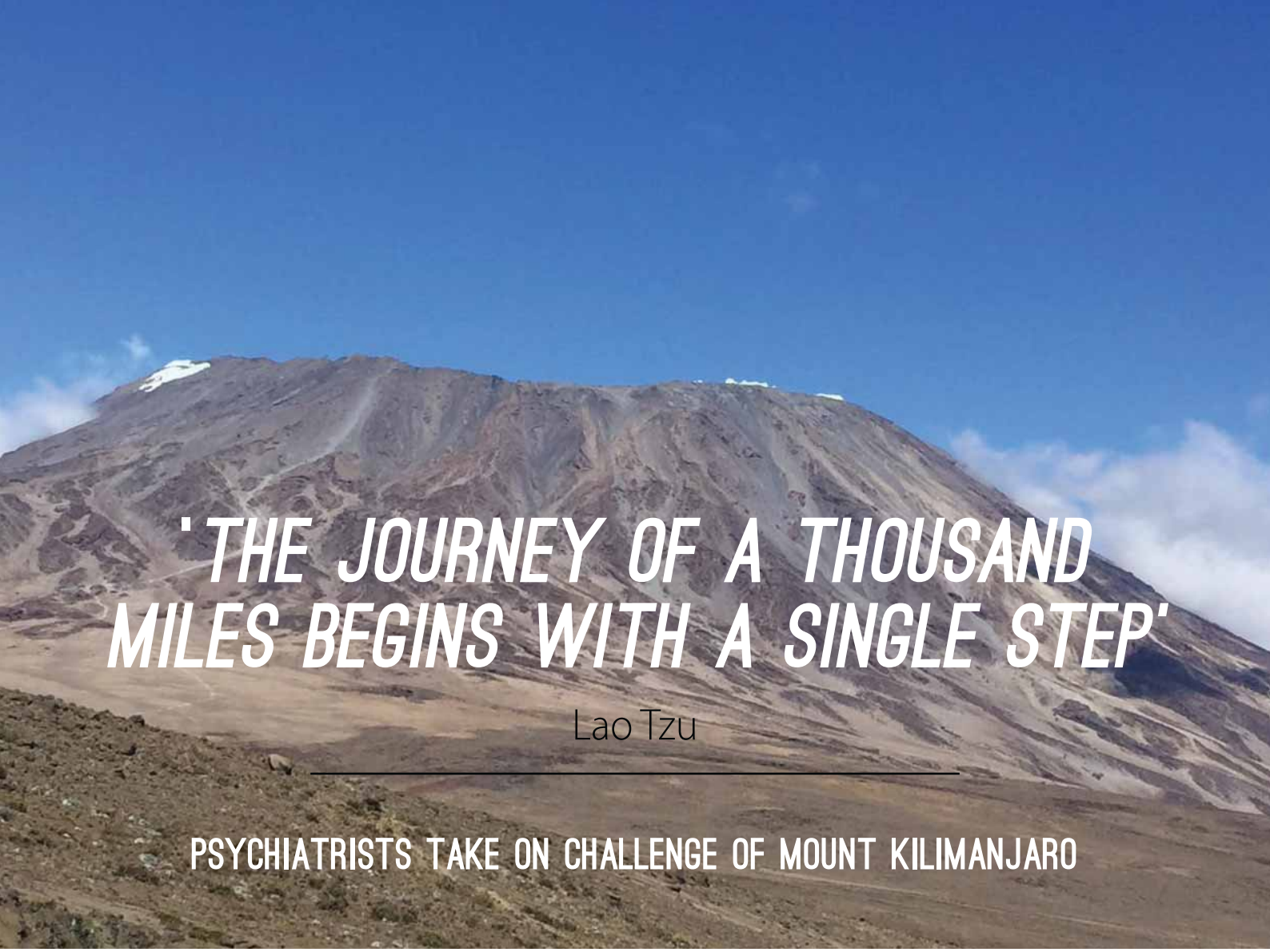
What is it about the wilderness experience that speaks so powerfully to us? Aside from the natural beauty and the opportunity to encounter wildlife at close quarters, there is a natural and almost effortless 'return to our senses'. Walking in Big 5 territory brings a real awakening and alertness and we become much more aware of sights, sounds and smells than we are in our everyday urban existence. We move away from our endless cognitions and preoccupation with everyday life to a much more present-focused awareness. As the trail progresses, the inner stillness deepens and we become more

conscious of both our internal and external wilderness. Perhaps there is something about a return to our evolutionary adapted environment and our hunter gatherer roots that teaches us who we really are. As Janine Benyus put it 'For 99 percent of the time we've been on earth, we were hunters and gatherers, our lives dependent on knowing the fine, small details of our world. Deep inside, we have a longing to be reconnected with the nature that shaped our imagination, our language, our song and dance, our sense of the divine.'

I am often asked if we have had any dangerous encounters with wildlife and the answer is 'yes and no.' We have walked unknowingly into a pride of lions, been chased by a black rhino, had a huge python slither in between two hikers, walked into a leopard, stepped over a black mamba, and once had our water container snatched by a huge crocodile while collecting water from the river. But we also feel very safe in the hands of the guides who are hugely skilled in reading the signs of the wild and guiding the group to safety. There is certainly something about the danger in the wild that awakens us. In fact, if you are not alert in the wilderness, you might get eaten! Realising that you are part of the food chain reminds us that we are interconnected with all of nature. Alan Watts reminds us, 'You did not come into this world. You came out of it, like a wave from the ocean. You are not a stranger here.'

I am convinced that we desperately need our wilderness areas and importantly, we need to spend time in nature. Recent studies have demonstrated that people living close to trees and green spaces are less likely to be depressed. Providing access to nature is an important public health intervention particularly for those living in deprived urban environments.

So, take care of yourself, do those things that nurture you and take time to connect with the natural world.



'THE JOURNEY OF A THOUSAND MILES BEGINS WITH A SINGLE STEP'

Lao Tzu

PSYCHIATRISTS TAKE ON CHALLENGE OF MOUNT KILIMANJARO

DR A PORTER
SPECIALIST PSYCHIATRIST
RAHIMA MOOSA HOSPITAL
UKZN ALUMNA

AS ADVENTURES GO, OURS STARTED ON A RANDOM FRIDAY AFTERNOON, IN OUR OPEN PLAN OFFICE IN THE FORENSIC UNIT AT STERKFONTEIN HOSPITAL. WE WERE HAVING YET ANOTHER ROBUST DISCUSSION, AND THE TOPIC OF 'BUCKET LIST STUFF' WAS ON THE AGENDA. INDHRIN CHETTY AND MYSELF, ALICIA PORTER HAD LONG SINCE BEEN IN DISCUSSION ABOUT CLIMBING MOUNT KILIMANJARO 'ONE DAY'. AFTER THIS DISCUSSION, WE DECIDED THAT IT WAS TIME TO TICK THIS ITEM OFF OUR BUCKET LIST, AND RALLY ANYBODY WHO HAD AT SOME POINT OR OTHER CONFESSED THAT IT WAS INDEED THEIR DREAM TO CLIMB THIS FORMIDABLE MOUNTAIN.

We set out recruiting for this adventure, which we planned for September 2019. After countless calls, conversations, emails, we managed to recruit Naseema Cassimjee (Fort Napier Hospital), Mpogi Mashile (Akeso Alberton) and five of our friends and family. We did not all know each other but were connected by our spirit of adventure and desire to conquer this mountain.

The journey to the summit of Mount Kilimanjaro begins long before you set a single foot on the mountain. We selected the six day Rongai Route, and the months leading up to the climb was an adventure all on its own. We set about learning a new language of 'mountaineering' as most of us were not hikers, we were mental health care professionals, who were daring to venture far from our usual comfort zone in taking up the challenge. There were months of gym, weekend hikes, multiple trips to Cape Union Mart, physios, biokineticists, altitude chambers, YouTube videos and more YouTube videos, medication research (what can and can't be used at altitude), shopping on Amazon for anything and everything that could save us from the discomfort. This was also a futile attempt to try to control the uncontrollable, and plan for all and every eventuality. The one thing that created the most amount of anxiety in the group was the concept of altitude. It was the one variable that could not be controlled or prepared for. Altitude is a respecter of no person-not your level of fitness, not your experience, or present level of mountaineering - nothing. The other variable that created lots of discussion was cleanliness. I now know all sorts of varieties of wet wipes, dry shower gels and dry shampoos from every supplier. The idea of cleanliness and mountaineering seems almost contradictory, but we were determined to overcome this challenge.

Months ticked on, and the mountain challenge finally arrived, amidst much excitement mixed with apprehension and a fear of the great unknown. We started our climb on 24th September 2019, after a long drive to the Rongai gate for registration and our first day of walking. The adventure had finally begun, and we were ready to take on this mountain. Mount Kilimanjaro is the highest peak in Africa. It sits at 5896m of altitude. The next five days were among the most challenging and often gruelling as we gained altitude each day. We learn as a fundamental in geography that' ***the higher you go the colder it becomes and the thinner the air becomes'***. We were experiencing a practical lesson in this regard. The more gain in altitude in a day, the more difficult it became. We were above the clouds after the second day and arrived at our overnight camp on the night after day two. We were flattened, and a simple task like removing your hiking boots and eating proved to be very difficult. I have often told my patients not to underestimate the value of a good night's sleep, and on the mountain a good nights sleep is a remedy for altitude, as after a good nights rest, the feeling the following morning is quite

different from the previous night. Where the night before the thought of continuing was sometimes difficult to imagine, the morning brought with it new hope and energy.

As days progressed, 'summit night' was fast approaching and the mystery that comes with it. The group also started out as a random collection of people, and we were forging great bonds of friendship, as we realised that it was not just the adventure that connected us. It was an amazing experience to share with a special group of people who did not start out as friends. On the mountain there is an equality that exists as we are in a common struggle, with the same variables that we can't control, with the same challenges and the same mountain that we seek to conquer.

The frenzy and anxiety started to build the closer we got to 'summit night', and on day five we finally arrived at Kibo Hut, which is the base camp for Kilimanjaro, and is at 4750m of altitude. At this stage we had been walking the entire day. We arrived late afternoon. We were instructed by our guides to eat and rest as we were scheduled to set out for the summit at 23h00. The anticipation of the summit was overwhelming, and rest was minimal. We prepared our gear, and this night was the culmination of months and months of preparation. We started out with our group and guides at 23h00 and we were kitted with multiple layers of clothes, (which made even the simplest of tasks difficult) and a headlamp to illuminate the way. We started walking in utter darkness, only sure of the very next step that you will take and nothing else, trusting that the guides were showing us the correct way. The entire mountain is lit up at this point as four of the six routes up Kilimanjaro gather at base camp for the ascent to the summit. The lights stretch for kilometres, and the mood is sombre at this time as each person goes ***'pole, pole'***- '***slowly slowly'*** up the mountain, each person needing to conquer their own mountain. There is nothing that we researched, read, watched or talked to others about that prepares you for the steep ascent to the summit. It can only be done at night, in darkness, as I am not sure how many would begin

the first step if one was able to see the extent of the mountain by day. It is a test in perseverance and endurance as it is physical, mental, emotional and spiritual. The scenes as you ascend are also frightening, five thousand metres is considered extreme altitude and as you ascend, scenes of people sometimes confused, sometimes struggling to breathe, being carried hurriedly down the mountain, leave one feeling exposed and vulnerable.

Our group spilt into three at this stage, as we were going at different paces and our guides decided that it would be sensible to do that. We continue to ascend and stop briefly at strategic point during the night. Our stops were not very long, as cold easily sets in, and we must keep moving. During the night, one of the members of our group was forced to turn around at 5400m as the dreaded altitude sickness set in, and she had difficulty breathing. The only cure for altitude sickness is to descend quickly, no negotiating, no bartering, no discussion. The guides are very serious in this regard, as safety is their priority. As day broke and we watched the sunrise on Kilimanjaro, our group has reached an altitude of 5300m and it is time for a discussion and decisions. We still have a long way to go and the weather conditions change with the sun coming up. As we are above the clouds, there is no protection from the elements and according to the guides calculation, it would take us another six hours to get to the summit. It is at this point that I took a rational decision that 5300m is as far as I was prepared to go, given the outcome explained and I started my descent. Naseema who was with me, decided to dig a lot deeper and was willing to continue despite the odds. Naseema, together with Mpogi arrived at Gillman's Point which is 5685m. Three of our group managed to summit at Uhuru peak, and Indhrin was among the three who summited. Uhuru stands at an altitude of 5895m. Congratulations and well done.

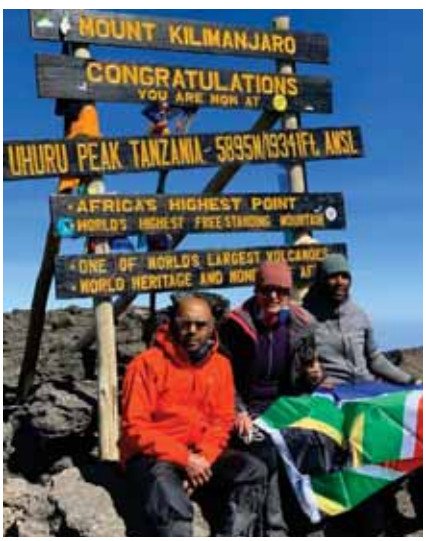
The experience has many lessons to impart and these are a few reflections from the mountain:

1. There are things - circumstances and situations that are beyond our control, and no matter

how we attempt to control them, they remain uncontrollable - lean into that discomfort.

2. Do not underestimate the power of a good night's rest - you will feel better in the morning
3. Keep walking - sometimes it's literally just putting one step in front of the other that will get us there. However slow it may seem, just keep walking
4. 'Pole Pole' which means slowly in Swahili goes against everything inside of us, but slowly slowly allowed us to acclimatise better and sometimes to just breathe.
5. The guides were an amazing part of our journey. This highlighted the value of help and assistance and allowing somebody to come alongside you and help you. They often carried us when we thought we were not able to go on.
6. The sun always follows - even after the darkest night, the sun will rise.
7. Lastly, it's not as much about the destination as it is about the journey, and the journey on Mount Kilimanjaro has been nothing short of amazing. It will be an experience that will forever be etched in my mind.

The mountain offers not only an adventure, and an item to tick off on a bucket list, it leaves one with lessons that will always be remembered, as it is not often that we get to learn new lessons in our often-busy lives.



MOUNT KILIMANJARO
CONGRATULATIONS
YOU ARE NOW AT
TANZANIA

Botshabelo

KILIMANJARO NATIONAL PARK
HOROMBO HUT
ELEVATION 3720M

PICTURE THIS

2019 DEPARTMENTAL PHOTO

REGISTRARS CLOWNING AROUND

CAMERA SHY CONSULTANTS

THE ELDERS MINUS A FEW

Pictured left to right: *Drs S Paruk, M Ramdeyal , N Cassimjee, B Mashaphu , A Sukool, E Karim*

PROFESSOR BONGINKOSI CHILIZA

LOOKING REGAL AS EVER

BRIGHT-EYED AND BUSHY TAILED
SOME OF THE 2019 REGISTRAR CREW

Pictured left to right: *Drs K Roopun, M Mwelase, T Matshoba, M Daniels, Z Shozi, T Naidoo, B Bhengu, L Moodley, M Gangai-Singh, N Prosad-Singh, S Hain*

2019 SASOP END OF YEAR DINNER
AN ELEGANTLY NAUTICAL EVENING

1. *Pictured from left to right: Drs M Ramdhial, V Maharaj. K Singh, T Govender*

2. *Pictured: Naseema Cassimjee, Fatima Davids*

3. *Dr M Ramdeyal delivered an enlightening talk titled 'Decluttering the mind' F bombs were dropped Cover was taken No casualties reported*

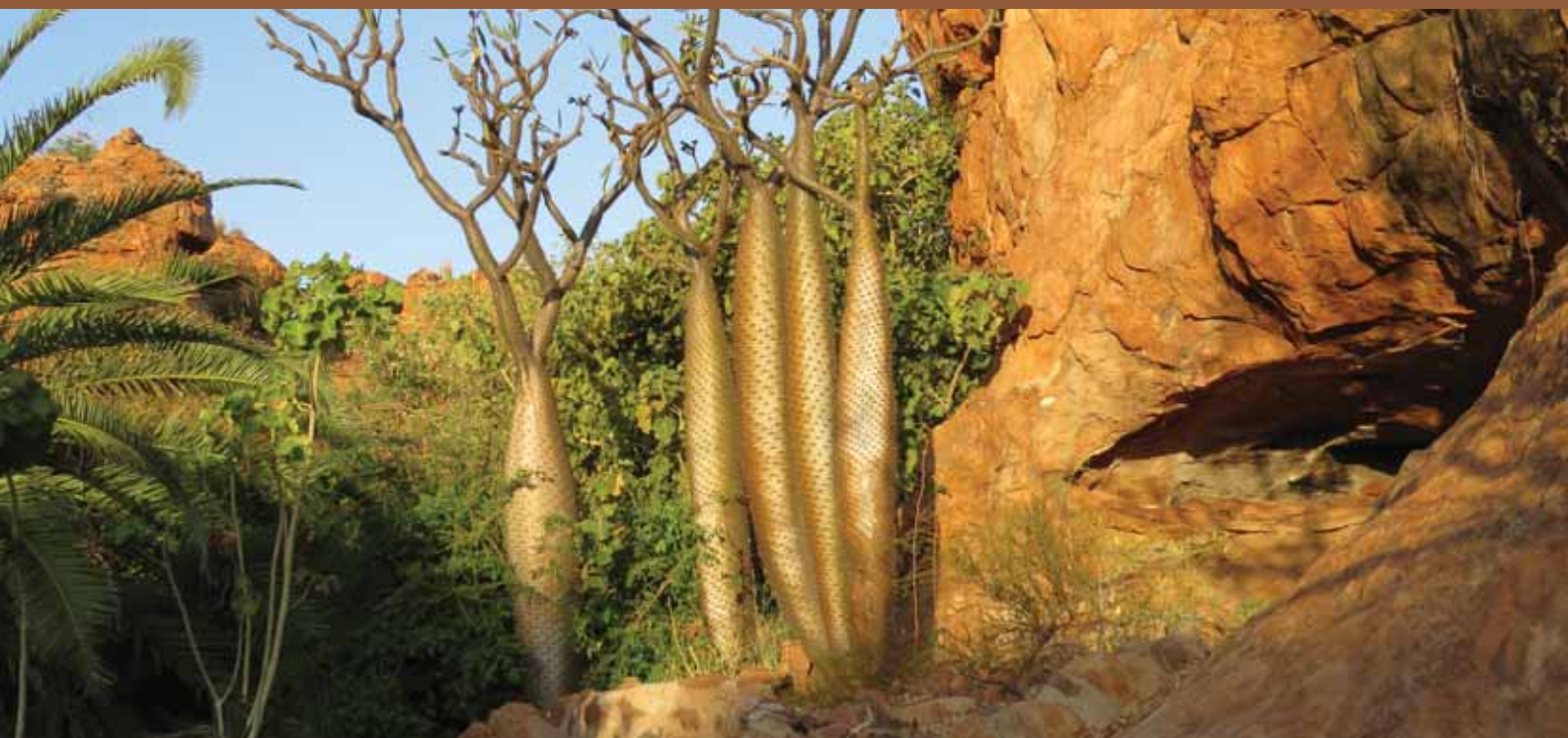
4. *Pictured: Dr K Singh, Fiona Clark, Helen Parent*

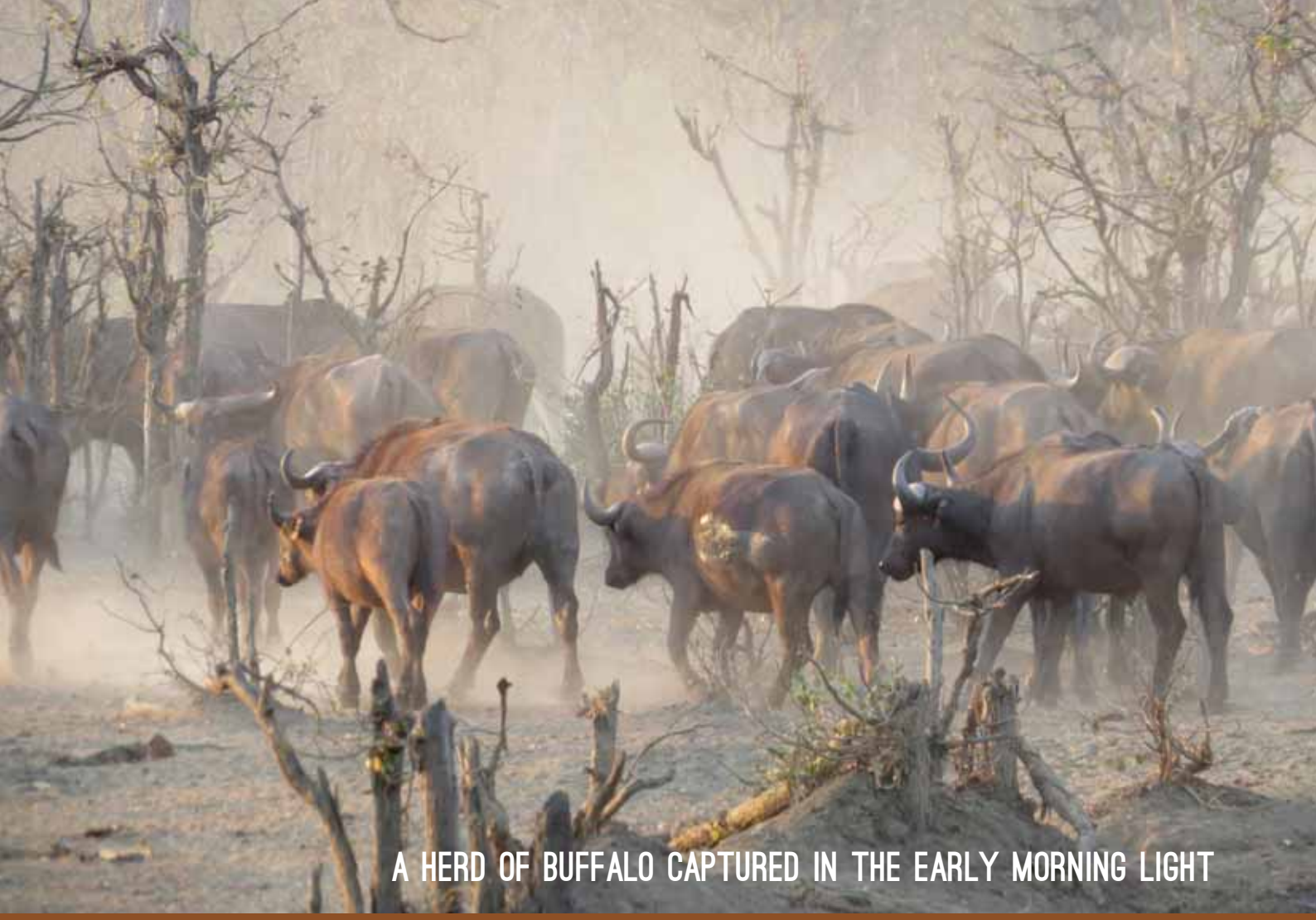
ROCK PIGEON

PHOTOGRAPHS TAKEN BY

DR NEVILLE RAYMOND

"While travelling, I always enjoy photographing the places that I have visited and the things that I have seen – to forever capture the memories. South Africa has an abundance of beautiful sites that must be experienced. One of them is the Kruger National park, where I visited earlier this year. The northern region of the park has a diverse range of birds, game and vegetation. Here are a few images captured during my visit".





A HERD OF BUFFALO CAPTURED IN THE EARLY MORNING LIGHT

GROUNDSCRAPER THRUSH

THE UNMASKED HUMAN

ART WORK BY UKZN CHIEF REGISTRAR DR THEJINI NAIDOO
A DEDICATION PIECE...
FOR SIS ZO...

"BREAK THE SHELL"
"This wax crayon art is an amalgamation of the silhouette of Nina Simone and the words of India Arie, created on stretched canvas in honour of a dear friend. It serves as a reminder that pain is an inevitable part of the human condition, but once we have the courage to overcome our fears, we will then be able to attain peace by leading a self-defined life".

KNEADING BREAD

BY REGISTRAR DR KRISH ROOPUN

" It was around 10pm on an unusually chilly November evening, and I was driving around Durban. A light rain pattered down, and the roads were dimly lit. I noticed a small controlled fire by the side of the road. As I neared it, I saw a lonely image of a homeless man taking shelter under a bus stop and warming himself next to the fire. He wore two jackets and a few plastic bags covered his head. That image of him reminded me of some of the patients we treat and care for. Is this where they come from, or where they return to after they leave us? I wanted to meet the man without having the barrier of a table between us. To meet on his grounds rather than ours. So being Krish, budding photographer and future Pulitzer prize winner, I swiftly made a U turn and stopped to ask him if I could capture the moment with my phone camera. He appeared slightly curious and baffled by my request, but agreed. He asked if I would buy him bread as a token of kindness. I left to get the bread. When I returned with the requested goods in hand, I could tell by his grinning facial expression that he was happy, albeit surprised. I don't think he expected me to return. I handed him the bread; I captured the moment; we said our goodbyes. I got into my car and drove away. And as I drove off, I saw him eating his bread in the cold embrace of that night. The image of him grew smaller in my rear view mirror, until he was no longer visible".

CULTIVATING RESILIENCE

DR B BRAYSHAW

DR BERTRAM BRAYSHAW WAS A GP IN THE EASTERN CAPE FOR 17 YEARS BEFORE HE SPECIALIZED IN PSYCHIATRY. AFTER 20 YEARS IN PRIVATE PRACTICE IN PIETERMARITZBURG, HE CLOSED HIS PRACTICE IN 2013. HE CONTINUES TO DO FORENSIC PSYCHIATRIC ASSESSMENTS FOR THE COURTS, AND HAS A SESSIONAL POST AT FORT NAPIER HOSPITAL.

What adjectives best describe the modern world? I have no idea, but two candidates must be high on the list: INSTANT and EXTREME.

We live in a world of INSTANT everything, from instant noodles and instant coffee to instant service and instant gratification; instant news and instant sensation, instant fame, instant wealth and instant forgetting; the list goes on and on. But surely, among the worst are the demands for ***instant decisions*** and ***instant cures.*** There is simply no time for quiet contemplation, calm reflection and the recharging of one's batteries.

It is also becoming a world of EXTREMES: extreme emotions, extreme demands, extreme wealth and extreme poverty; most of all, extreme climate change.

Practically every journal, newsletter and medical paper nowadays features some article or discussion on "Burnout in Doctors". A few decades ago the great topic was "Compassion Fatigue". The overwhelming workload, and unconscionable hours expected of interns and other doctors working in hospitals and clinics are compounded by coping with appalling bureaucracy. Private practitioners are confronted with the patients' demands for instant cures, and the ever-present worry about litigation: ambulance-chasing lawyers hanging like the sword of Damocles over their heads. No wonder we hear of a paediatrician running the spares

department of a large motor agency, or an anaesthetist selling Tupperware.

Why don't we all burn out? Nearly all of us are vulnerable. Sport may be a life-saver, if you have the talent and don't let the competitiveness get to you. Nothing "calms the savage breast" like music. At one time there were over twelve qualified doctors playing in the Pietermaritzburg City Orchestra, whose Director is an anaesthetist. So many health workers are wonderfully creative: artists, writers, photographers, craftsmen of all kinds.

In my case, "getting back to nature" has kept me sane. We are fortunate to live close to an old abandoned municipal plantation, and next to a lovely stream. Huge areas covered with formidable invasive alien plants like Lantana, Bugweed, Mauritius Thorn and Cestrum replaced the natural vegetation and the old plantations, and formed an impenetrable thicket. A few years ago I started clearing small areas, by hand - heavy physical work. The reward was unexpected - the emergence of seedlings of some wonderful indigenous flowers, grasses and trees from a natural seed bed which must have been dormant since the original gum trees were planted in the late 19th century. A couple of enthusiastic friends, one a retired psychologist, have joined in, and we have now cleared a large area, created over a kilometre of paths, planted hundreds of trees, and encouraged the original plants which are recovering. Many of the faster-growing trees are already starting to form a canopy, and parts are beginning to feel like a real natural forest. Best of all is the haven it is providing for birds and other wild-life. We have bushbuck, wild pigs, duiker, water mongoose, caracals, leguaans, porcupines, and many others, all within a few hundred metres of a major shopping mall.

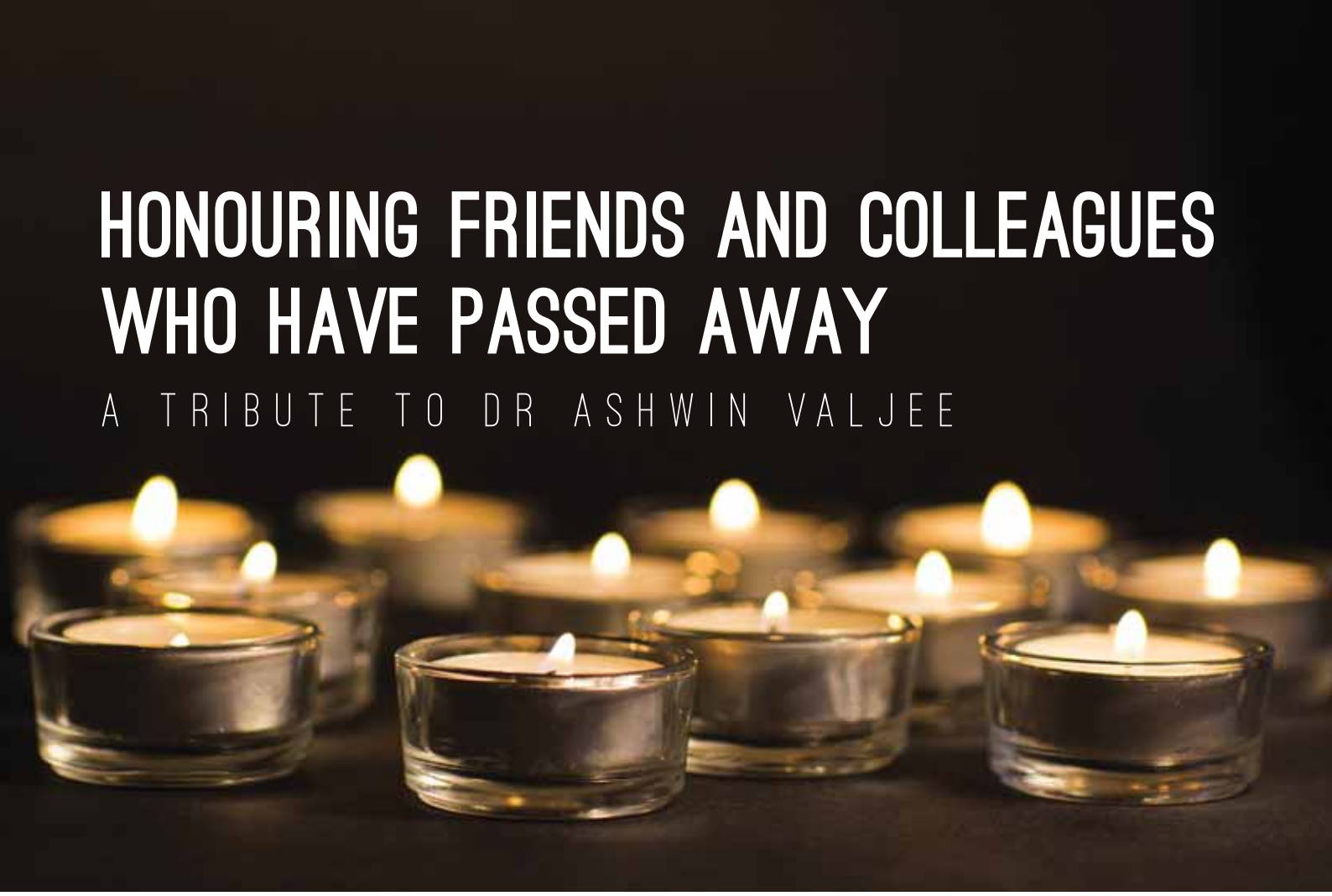
When you are uptight, nothing gets your mind off your worries like a few hours hard work in the wilds, planting trees, getting scratched by thorns, bitten by ticks and being stung by bees: minor nuisances compared to the satisfaction of being able to climb a tree you have planted yourself or even grown from seed. There's no need for sleeping tablets after a day like that.

Other like-minded people are doing similar things in a number of places around the city and around the globe. More and more lovely little oases are developing. Getting back to nature by joining in with them, or even starting your own little project is a wonderful way of combating burnout.

Bill Mollison, the father of the concept of Permaculture, gave a series of lectures and demonstrations in Pietermaritzburg in the early 1990s. At one of them, someone said that if every person on earth planted two trees a year, climate change could be reversed within our lifetime. An unrealistic pipe-dream, probably, but we have to start somewhere. It reminds me of the story of the origin of the name of the Starfish Foundation. A man was walking along the beach at high tide. A starfish washed up on the sand, and would have perished out of the water. He picked it up and gently put it back into the sea. A passing cynic sneeringly said, "There are millions of starfish in the sea. What difference does that make?" He replied, "It made a difference to ***that*** starfish".

HONOURING FRIENDS AND COLLEAGUES WHO HAVE PASSED AWAY

A TRIBUTE TO DR ASHWIN VALJEE



BY DR FAROUK RANDAREE

IT IS AN HONOUR AND A PRIVILEGE TO PAY TRIBUTE TO MY DEAR FRIEND. ASHWIN AND I ENJOYED MANY YEARS TOGETHER AS FRIENDS AND COLLEAGUES – MORE THAN 60 YEARS. HE WAS A REMARKABLE INDIVIDUAL, AND HAD A PROFOUND EFFECT ON SO MANY DURING HIS TIME HERE WITH US.

Ashwin grew up right here in Durban. He attended Sastri College, and then the University of Natal medical school. After completing his internship and following a short stint in Zambia, he began private practice as a general practitioner in Durban. He also did sessional work as a medical officer at the Durban Neuro Clinic in Soldiers Way. It was during his time as a GP that his interest in psychiatry was sparked. Soon, Ashwin's general practice consisted mainly of patients burdened with psychiatric illnesses. He decided to pursue a career in psychiatry, and in 1976 joined the Department of Psychiatry, University of Natal, as a trainee and my colleague. In 1979 he obtained the FF Psych (SA) degree, and was the first person of colour to do so in KZN. He then entered specialist private practice where he remained active; until shortly before his demise 39 years later.

Not many in our psychiatric community know about Ashwin's earlier days and earlier successes. Ashwin was an accomplished table tennis player. At the age of 16, he achieved the unique feat of becoming the junior as well as the senior South African Open singles champion. He was part of the first

South African non-white team that participated at the World Table Tennis Board Championship in Stockholm, Sweden in 1957. The team consisted entirely of non-whites who were subsequently barred from participating internationally by the Apartheid government. As a result, South Africa's recognition was rescinded from the international table tennis association. Memories such as these personified Ashwin, and his life well lived.

Ashwin cut an elegant, flamboyant figure in the Durban psychiatric community. He was popular with colleagues and patients alike, and he will be sorely missed by all. We extend our heartfelt condolences to his beloved wife and partner, Sheila.

Ed: We also extend our deepest sympathies to the family and friends of:

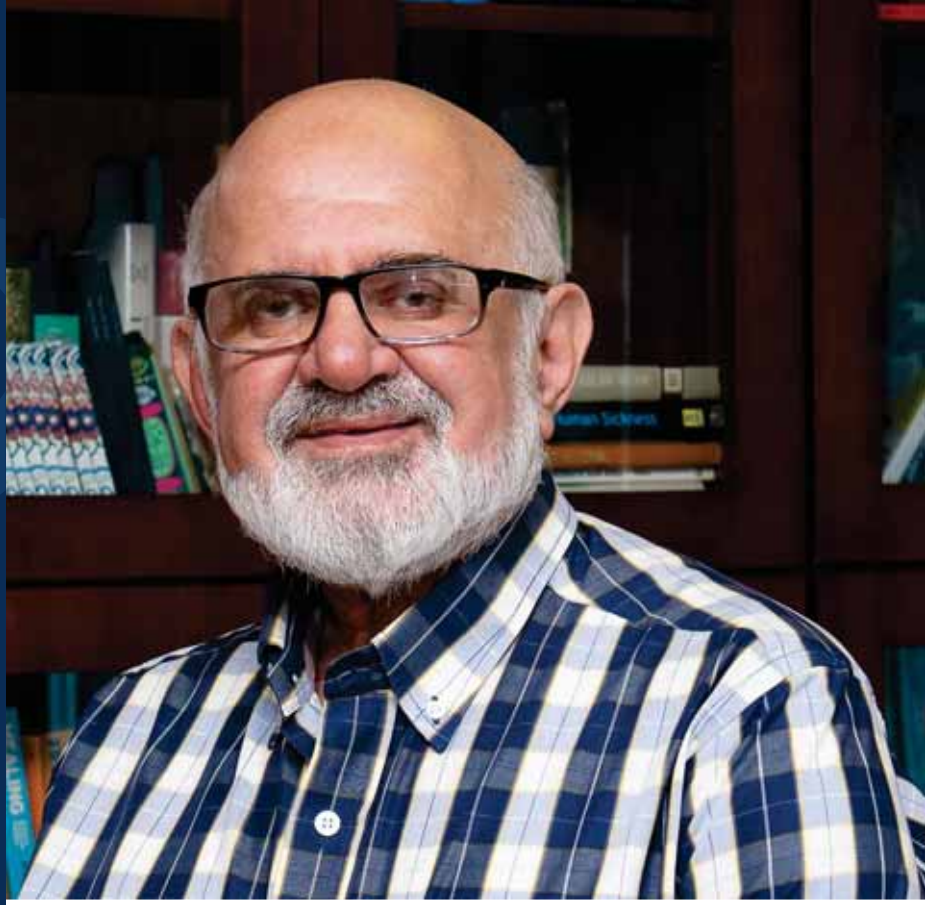
Dr Fawzia Moola, treasured friend and colleague to many in our community

Mrs Moodley, beloved wife of Dr DP Moodley

Mr Anton Lasich, cherished son of Professor Lasich

May their souls rest in eternal peace

THE LAST WORD?



Q and A

WITH NASEEMA CASSIMJEE & DR FAROUK RANDAREE

A few of my colleagues suggested that Dr Farouk Randaree be interviewed for 'The Last Word' this year. I contacted him and asked if we could meet. He happens to be my neighbour, my neighbour who has a parking bay directly next to mine - so avoiding me was never an option. He said yes. It was a Monday evening when I made my way up to his apartment, anticipating a brief half an hour or so chat. 'Three hours, a comfy sofa, and an exchange of Bee sting cake' later, I left his home; with an appreciation of why it was that my colleagues wanted Farouk Randaree to be featured. He is a wealth of knowledge and experience. Dr Randaree qualified as a specialist psychiatrist in the 1970's. After a three year stint in Oxford, he returned home to South Africa in 1979. He spent a few years working at King Edward VIII hospital, before finally deciding to take the plunge in 1987 and set up in private practice. During the course of our captivating conversation, 'ideas took flight'. I learned about 'ash cash' cremation payments, the Pegging Act of 1943 and 'masturbation insanity' theories dating back to the 1930's. More importantly, I learned about Farouk Randaree.

Q1.) WHAT PROMPTED YOU TO SPECIALISE IN PSYCHIATRY?

I enjoyed psychiatry and psychology as an undergraduate student, and I wanted to be an all-rounder. So when the first post in psychiatry (clinical assistant / junior lecturer) was advertised, I applied and was accepted. I liked it and decided to stay on.

Q2.) YOU WERE AMONG THE EARLY GROUP OF SPECIALIST PSYCHIATRISTS TO QUALIFY IN KZN. TELL US ABOUT THAT?

I was the first 'non-white' to start training in psychiatry in South Africa (1974). There was no formal training towards a post graduate degree in Natal at the time. We approached the departments of anatomy and physiology at the University of Natal, and the department of psychology at Fort Napier Hospital - to assist us in preparing for the part one of the FF Psych exam. It took two years to set it up. Wits and UCT had refused me a post to train towards the FF Psych degree, so in 1976, after passing the part one exam of the FF Psych, I applied for posts in the UK. I was accepted and 'emigrated' in November 1976. However only one year of my training in SA was accepted and the part 1 exam was not recognised, so I had to write the part one of the MRC Psych exam. I did so in March 1977. Another obstacle awaited in that I had to work as a registrar for a further two years before being allowed to write their final (part two) of the MRC Psych.

Following my pioneering venture into the field of psychiatry, other 'non-whites' were also encouraged to join the department. Dr Cassim Schreuder (now a psychiatrist in Australia) was next. Then Dr Parimala (Pam) Moodley joined – now a retired consultant psychiatrist in London. Dr Ismail Moola followed. He was to continue his post graduate career in Canada where he had obtained a diploma in child psychiatry, before returning to Durban. Dr Rohan Ramsunder (now in Canada) and Dr Ashwin Valjee (recently deceased) followed. The department which initially consisted of Prof Cheetham, and his wife Rosemary (psychologist) and myself, rapidly expanded in the 1980's when Drs' M.G. Nair, D Meeran, DP Moodley, A.E. Gangat, Basil Buntting, Dan Mkhize, SK (Khalil) Kader, Anne Barrett, J Govender and J Dunn joined. They all graduated from the department.

Q3). YOU STUDIED AND PRACTICED DURING THE APARTHIED ERA. WHAT WERE SOME OF YOUR EXPERIENCES PRACTICING UNDER THAT OPPRESSIVE REGIME?

Being a (medical) student in the apartheid era would require a whole book to describe. Our medical school was built in the 1950's due to the efforts of liberal Whites - who had to reassure the apartheid government that no White student would be admitted. So we had an exclusive non-White medical school, and it was the only university where Black, Coloured and Indian students were fellows. Stereotypes soon collapsed and the medical school became the source of activism against apartheid. In 1970, when I was a 4th year medical student, we organised a protest for equal salaries for doctors. At the time White interns earned R110 / month, Indian and Coloured interns earned R55/month, and Black interns were paid R35 /month. Accommodation for White doctors was separate from other race groups (in the white part of Umbilo, across the road from the medical school). Food and accommodation for our White colleagues was of course far superior for the same price. In addition, the White doctors were paid an 'inconvenience allowance' – the inconvenience of working with Black patients. I also recall that Black people had to carry identity wallets (dompas) at all times. It was not unusual for colleagues to be arrested and incarcerated by White policemen if they happened to venture into town without their 'dompas'.

This is just a taste of what growing up, studying, working and living during apartheid times was like. All non-Whites suffered under that regime, but our Black brothers and sisters suffered the most by far.

Q4). OVER YOUR LONG AND DISTINGUISED CAREER, YOU MUST HAVE MET AND INTERACTED WITH SOME INTERESTING INDIVIDUALS. NAME DROP.

Among my colleagues were Steve Biko, Mamphela Ramphele, Ben Ngubane, Ebrahim Sooliman and Charles Sibisi.

Steve Biko was intelligent and mature beyond his years. He was always very concerned about the plight of the disadvantaged. I recall that he was a bit of a 'ladies man' as well.

Q5). OVER THE COURSE OF YOUR LENGTHY CAREER, WHAT HAS BEEN THE MOST EXCITING CHANGES / DEVELOPMENTS IN THE FIELD OF PSYCHIATRY FOR YOU?

I was a full time consultant / lecturer in the Department of Psychiatry from February 1981 to July 1987, before I commenced private practice. I had to get a special permit from the government to practice from my rooms in Durdoc Centre in Smith because I was a 'non-white' practising in a white group area. There have been a number of developments in the field of psychiatry since I entered 45 years ago:

1. The shift from custodial to community care, though there still remains much to be done.

2. The psychotherapy emphasis has changed from psychoanalytical to behavioural and cognitive therapy.

3. There have been a number of advances in pharmacotherapy:

- The discovery of benzodiazepines in the 1960's allowed one to treat anxiety disorders safely.
- The advent of depot neuroleptics soon thereafter aided the development of community psychiatry.
- In the late 1980's Selective Serotonin Reuptake Inhibitors (SSRI's) made their appearance. This significantly improved the management of anxiety disorders
- In the 1990's the advent of 'atypical' antipsychotics was also an important development
- In 1980 the 3rd edition of the Diagnostic and Statistical Manual of Mental disorders (DSM III) was published. This introduced standard empirical data and the multi-axial system. This was a major advance.
- Around 1975, computerised axial tomography (CAT scan) became available for the first time. This was subsequently followed by magnetic resonance imaging in the 1980's and functional imaging (positron emission tomography) later. Other parallel advances in medical technology have also aided diagnosis and treatment.
- Although stigma surrounding psychiatric illness still exists, there has been a shift and people are more knowledgeable now.

Q6). ONE OF YOUR SPECIAL INTERESTS OF PRACTICE IS SEXUAL MEDICINE. HOW DID THIS DEVELOP. TELL US ABOUT YOUR WORK IN THAT FIELD?

My interest in sexology developed in parallel with my psychiatry interest. It was the only discipline that dealt with the issue at undergraduate level. Advances in medicine have allowed us to recognise the multi factorial aetiology of sexual disorders. In my opinion, major advances have been the work of Masters and Johnson, and the discovery of sildenafil (Viagra) in 1998. However, there is still too much ignorance surrounding sexual matters in the general public and even in the medical profession!

Q7). WHAT DO YOU DO TO UNWIND?

Chill! I have a wide range of interests. Reading has always been a passion. This included languages and etymology. I belong to a group that meets weekly to study Urdu poetry and listen to Urdu / Hindi music. Once a week a Quran study group convenes. I'm part of that as well, and I join a discussion group on Sufism. I'm fortunate in that I still have contact with friends from my childhood, school and university days. My large extended family all live in Durban and surrounds. My nuclear family is also close by. I enjoy surfing the internet and watching sport on tv.

Q8). WHAT WOULD YOUR ADVICE BE TO A YOUNG DOCTOR THINKING OF SPECIALISING IN PSYCHIATRY?

Be interested in people! The practice of psychiatry affords us a unique opportunity to get to know our fellow human beings. Devote time to family, friends (outside of the profession), and give something back to the community.

This is us

"Our human compassion binds us the one to the other - not in pity or patronisingly, but as human beings who have learnt how to turn our common suffering into hope for the future"

- Nelson Rolihlahla Mandela