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ABOUT the discipline FOR the discipline issue 12 • August 2017

UNRAVELLING THE MYSTERIES OF
SCHIZOPHRENIA
AN EPIDEMIOLOGIST'S JOURNEY

**THE MANAGEMENT
OF BORDERLINE
PERSONALITY
DISORDER**
BY GENERAL PSYCHIATRISTS

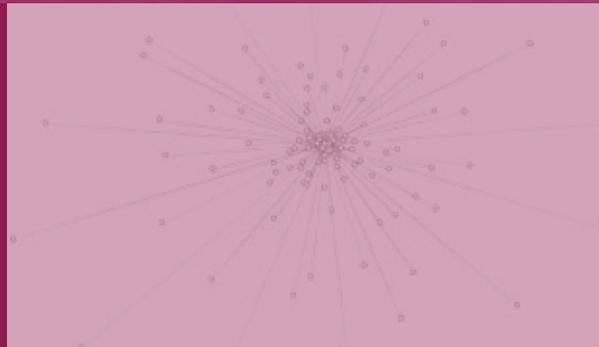
PRACTICAL INTERPRETATION
OF THE ALCOHOLICS ANONYMOUS
**12 STEPS OF
ADDICTION
RECOVERY**

CONSULTATION
**LIAISON
PSYCHIATRY**
CONTRIBUTING TO HOLISTIC
& COLLABORATIVE PRACTICE



PUBLISHED IN ASSOCIATION WITH THE SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

**CONCENTRIC
CIRCLES OF CONCERN**
WORKING WITH THE AFTERMATH
OF COMPROMISED PARENTING



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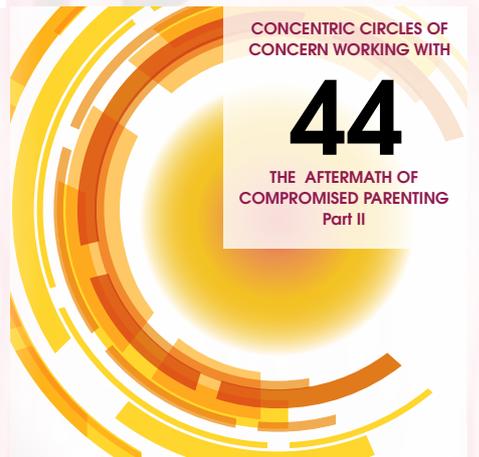
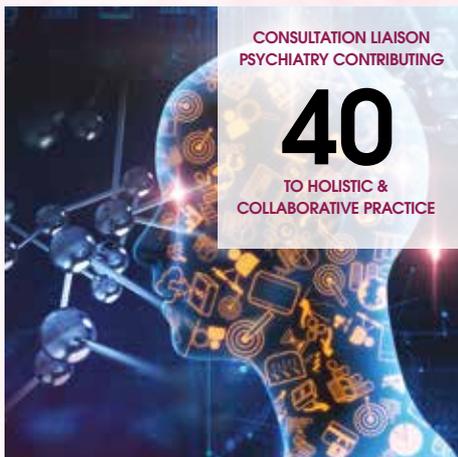
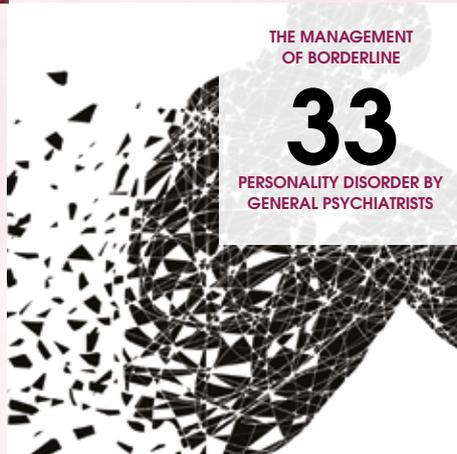
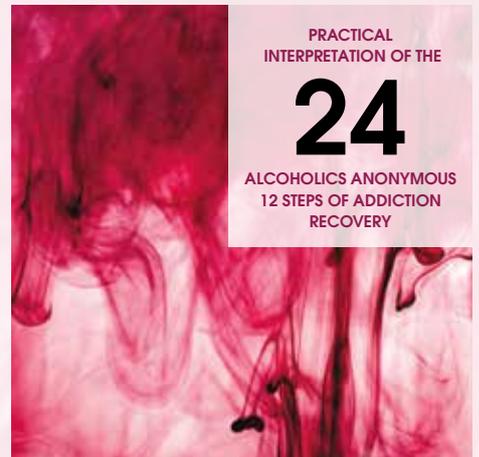
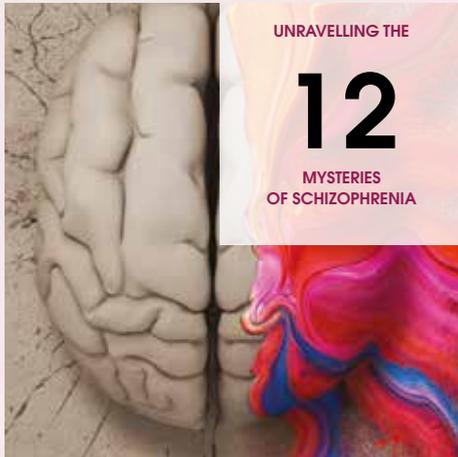
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Dear Reader,

Welcome to this the 12th issue. It is a landmark issue as it represents 3 years of publications starting with the 1st issue in November 2014. I believe we have come a long way and hope that the road ahead will see us continue as a publication hub for the discipline. The current issue sees all *Feature* articles peer reviewed and with full references. This is significant. Based on 3 years of publication we are now eligible to apply for Department of Higher Education and Training (DoHET) accreditation. Having had that intention, we needed to structure certain of the content accordingly. This we have now done and in that sense it is hoped that *South African Psychiatry* will become an accredited publication for review articles of local relevance. Should this happen it will not diminish our current role in providing the range of content we have over the years.



The current issue has an element of sadness as we bid farewell to one of South African Psychiatry's icons, Dr Mike Ewart Smith. We have published a number of personal reflections with each noting the role that Mike has played in the lives of individual psychiatrists as well as his significant contribution to the discipline. His loss is immense but the hope is that his legacy will live on.

Returning to other content, there are 4 *Feature* articles with each one contributing important perspectives on a range of issues and aspects of clinical practice, with selected articles accompanied by commentaries. Of critical importance is the SASOP *media statement* which provides not only a sense of issues facing clinicians in the state sector but also reflects on the organization's efforts to engage authorities accordingly and ultimately impact on patient care. There are a number of *Reports* that acknowledge the involvement of industry and in doing so highlight the important role that industry plays in supporting not only education but also initiatives that form part of packages of care. *South African Psychiatry* is itself a testament to such support.

Finally, I was provided with a copy of the 1st issue (June 2017) of a Royal College of Psychiatrists (UK) publication called *Insight... #RCPsychinsight ...* thanks Bernard. Together with *The Nordic Psychiatrist*, whose existence I discovered in February 2015 after the 1st issue of *South African Psychiatry* appeared, it appears we are part of a growing international fraternity of publications that speak to the discipline. The DoHET application will be in progress by the time you read this and I will update you accordingly. In the interim I trust that you will enjoy this issue.

Christopher P Szabo

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Infants, children and families, and
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Olayinka Omigbodun (Nigeria)
Helmut Remschmidt (Germany)
Christina Schwenck (Germany)
Linda Theron (South Africa)
Mark Tomlinson (South Africa)

PROGRAMME

Don't miss out on the Pre-Congress Workshops on the 7th September 2017. The Congress will also include keynote presentations, symposia, oral presentations, posters and an Award Ceremony and Dinner.

Visit www.saacapap.co.za to view the programme.

REGISTRATION

Congress and workshop registrations are now open. Early registration closes **16 June 2017**
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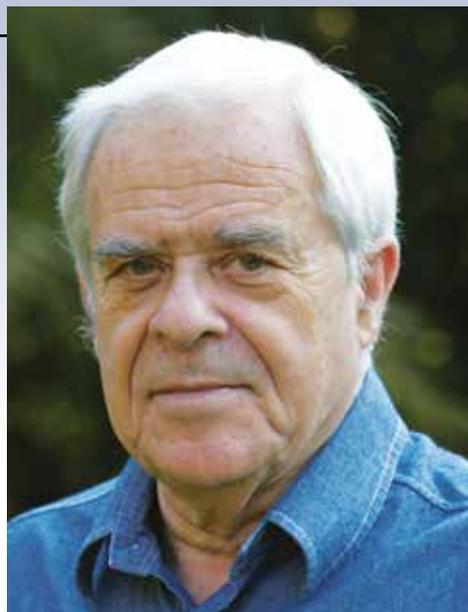
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REMEMBERING MIKE EWART SMITH

11th October 1937 – 3rd July 2017



I last spoke to Mike on the 26th June, at about 12h00. I was heading back from Sterkfontein Hospital and I had seen Jo – his wife – drive past, heading home and had wanted to let him know she was on her way. He was working...and not at home although he had been off work with flu a few days earlier. I was pleased to hear his voice and to know that he was working...Mike passed away during the early hours of the 3rd July. I had smsed him the night before, to chat about the Confederations Cup Final between Germany and Chile. We smsed a lot during sporting events, specifically rugby and football. I did not receive a response that night but did receive 2 calls – which I missed – and 2 messages – which I didn't listen to – from Jo, his wife, the next morning – 3rd July. I knew there was a problem, so I phoned. She told me the news of his death.

MIKE WAS A FRIEND, ALTHOUGH HE STARTED OUT AS SOMEONE I TOOK ISSUE WITH DURING THE FIRST 6 MONTHS OF MY REGISTRAR TRAINING WHERE I WAS ALLOCATED TO STERK FONTEIN HOSPITAL. HE HAD WANTED TO ROTATE REGISTRARS AFTER 3 MONTHS AND I PROTESTED AS I FELT I WAS JUST SETTLING IN WHERE I HAD BEEN PLACED. I DIDN'T ROTATE. MIKE ALWAYS RECALLS MY COMMENCEMENT AS A REGISTRAR, NOTING THAT IN THOSE DAYS (1989) AS I WORE AN EARRING I WAS VIEWED WITH SOME RESERVATION... IN TIME, THINGS CHANGED.

Mike was a mentor. He challenged and provoked. He was a man of experience, both clinically and personally – an accomplished man. An avid reader he knew much about many things and always ventured an opinion, or confessed ignorance. He was not pushy or arrogant. On the contrary, but he was persistent. He was also open to debate – which he loved – and capable of reconsidering an opinion in the face of

a reasoned argument. Mike had many medical problems and I had been to see him on numerous occasions over the years at Olivedale Clinic. I hated going there but was always pleased to see him alive and battling it out. He always pulled through and I marveled at, and respected, his ability to bounce back – maybe not quite as he was before but ready to push himself to whatever the new limit might be.

His contribution to my personal development cannot be measured, but it was significant. Likewise to the discipline of Psychiatry. Mike was a devoted husband to Jo, a father to Cameron and Hamish and a grandfather to 3 boys... I have no doubt they will miss him...wherever you are my friend, know that you were a special man, in your time – and will remain so.

THEY DON'T MAKE THEM
LIKE YOU ANYMORE.

Christopher Paul Szabo



REMEMBERING MIKE

Mike Ewart Smith has gone from our lives. My thoughts are with his family, whose loss must be even greater than ours. And ours is enormous. For my generation of psychiatrists, Mike was a light in an increasingly clouded firmament – not a flashy, fast-moving comet, but the steady, clear, illuminating sort of light.

A man of sharp wit and gentle courtesy, a profound thinker, a master wordsmith and a lucid teacher. He was a Scot, and to me embodied the virtues of my great Scottish heroes – courage, probity and kindness, generosity of spirit, resourcefulness and loyalty. He had a presence far disproportionate to his slight frame, and his beautiful accent and infectious laughter were always to be found at the centre of disputatious groups wherever psychiatrists gathered. He was a raconteur supreme. And he was a friend.

Born in Scotland, educated in Edinburgh, as a young doctor he followed in the intrepid footsteps of the Scottish explorers of the 19th century and headed for Africa to help his fellow man with medical skill and genuine concern. His adventures in “the hinterland” are legend amongst those of us who gather in the bar when the congress dinner music gets too loud for our aging ears. Always self-deprecating, never malicious, the stories gave us a glimpse into medical practice at its finest, informed by compassion and integrity. Mike was a good doctor. There were of course times when he thought he had fallen short of his own high standards, and he told those stories as frankly as the others. He did not dwell on the negative, though; he wove it into entertaining anecdotes and we all learned from his experiences.

Not that Mike could not be critical. He was unerringly principled, and was unhappy with many aspects of our current practice of psychiatry. He did not hesitate to say so and most of us have collections of Mike’s eloquent articles and editorials to which we refer when perplexed and with which we try to inform the generations that succeed us. He had an acute radar-like capacity for spotting illogicality, intellectual deceit and political flimflam, and the last time we spoke I was promising to send him an article I was hatching so that he could “keep me honest”, as it were. Mike disliked jargon and sloppy thinking, and was severe in his editing. He was a bulwark against substandard penmanship and also against the creeping industrialisation of psychiatry and the medicalisation of daily life.

MIKE WAS COMMITTED TO UPHOLDING HIGH STANDARDS IN THE MENTAL HEALTH PROFESSIONS. HE GAVE UNSTINTINGLY OF HIS TIME AND ENERGY TO THE COLLEGE OF PSYCHIATRISTS, BOTH IN TRAINING AND EXAMINING.

He lectured for university departments and psychiatrists’ groups. He was one of the doyens of psychiatric disability assessment in our country, and often the court of final appeal when it came to disputed claims.

BUT HE WAS ALSO DEEPLY KNOWLEDGEABLE ABOUT THE JAZZ GUITARIST DJANGO REINHARDT, TUDOR HISTORY AND MANY OTHER COLOURFUL AND UNEXPECTED SUBJECTS. CASUAL CONVERSATIONS WITH MIKE WERE DELIGHTFULLY EDUCATIONAL.

I find I cannot remember exactly when or where I first met him. He seems always to have been there. I suspect that I knew the writing before I knew the man, and perhaps that contributes to the (sadly unrealistic) sense I had of his permanence. Having Mike around was like having constant access to a cross between an encyclopaedia, a philosopher and a stand-up comic. We went to him with the knotty ethical problems, the abstruse hairy canary diagnoses and the daily sorrow of the work we do, and always found solace and wisdom, delivered with blunt directness or gentle humour, as the occasion required.

I FIND IT HARD TO CONTEMPLATE A WORLD IN WHICH I CAN NO LONGER REACH OUT TO HIM.

In recent years Mike had become increasingly frustrated by his effort intolerance and his fatigue, but he did what he could and relied with grace and gratitude on Jo, his wife (his “better half” as he had no hesitation in admitting), for care and support through some really difficult times. But eventually even the most mighty heart must fail, and Mike’s has finally given up the struggle, after a life well lived. We have missed him at congresses and College exams for some time now, and we shall miss him even more, now that we can no longer speak to him. There are few of his kind left among us, and there will never be anyone quite like him. His passing fills me with profound sadness, but I am glad to have known him, privileged to have been counted his friend, and hopeful that his legacy of rectitude and erudition will continue to enlighten our “darkling plain” long after the pangs of separation have faded.

Sue Hawkrige



Hamba Kahle, Mike!

I was so sorry that I was unable to be present at this celebration of Mike's life, and deeply saddened by his death. My sincere condolences to Jo, Hamish, Cameron and their families. We have lost a truly wonderful person. I last spoke with Mike on the Thursday before he died, to discuss yet another patient we had in common. So it was a terrible shock to hear the news that he had died the following Monday.

I first met Mike at my interview for a registrar post in 1985. He was a consultant at Sterkfontein at the time, and my first rotation at the beginning of 1986 was to Sterkfontein. For some time, I was without a consultant in my wards, and Mike was always available to assist me when I needed help. Over the past thirty-plus years, he has been a mentor and a friend, and Tom and I have also got to know Jo, and to enjoy quite a few meals together, with many discussions about the state of psychiatry, the world, religion in general and the Catholic church in particular! Anyone who knew Mike well, will have experienced his wicked sense of humour, and his ability to see through hypocrisy and political correctness for its own sake. But nevertheless, he was a gentle soul, who cared deeply about his fellow man (and woman!) Mike played a huge role in the psychiatric community, through Wits university, the College of Psychiatrists, and SASOP. His interest and care for people with mental illness, particularly those with serious mental illness, was outstanding. He always placed great emphasis on the need for high standards of clinical and ethical practice in our field and he was often outspoken in this regard.

The fact that he continued working and providing an extremely valuable service in the field of disability in South Africa, right up to the time that he died, attests to his deep commitment and interest in this work. I think the greatest tribute that we can pay to Mike is to take the standards he set seriously and to always practice our profession with care and humility.

So in the words of Anne Bronte:

FAREWELL TO THEE!
BUT NOT FAREWELL

TO ALL MY FONDEST
THOUGHTS OF THEE:

WITHIN MY HEART THEY STILL
SHALL DWELL

AND THEY SHALL CHEER
AND COMFORT ME.

Hamba Kahle, Mike!

Rita Thom



When I was a registrar at Sterkfontein Hospital in 1988 Mike was the principal specialist. He lived on the grounds and often would invite the registrar on call over. Hence I learnt of his passion for model wargames and deep knowledge of famous battles and history.

HE WAS AN ELOQUENT RACONTEUR WHO SEEMED CONSTANTLY AMUSED BY EVERYTHING, FROM THE SHENANIGANS OF COLLEAGUES TO THE UNFOLDING OF WORLD EVENTS. WATCHING HIM INTERVIEW A PATIENT WITH HIS EASY GOING CONVERSATIONAL STYLE WAS SOMETHING I ASPIRED TO IMITATE.

Every Tuesday a forensic observation case would be presented to all in the auditorium and one of us would be selected to interview the hapless offender. When it was my turn I decided to emulate Mike's body language and on settling into the chair on stage I casually cupped my chin in my hand, leant forward, affected a bemused grin just like he used to and promptly fell over onto the stage floor. Mike's mirth was the loudest and I heard him admonishing me in his distinctive Edinburgh brogue that I should try imitating someone else in future.

He was always helpful and in his company one never felt like just a colleague. Although I moved to the Cape I encountered him regularly at various conferences, where he was often a sought after speaker, because he would address the audience as if he were having a nice glass of wine with each and would use amusing turns of phrase that made difficult topics sound so straightforward.

HE WAS PROBABLY THE FOREMOST EXPERT ON IMPAIRMENT IN THE WORKPLACE AND HE ASSISTED ME IN ENTERING THIS ARENA. WE HAD MANY INTERESTING EMAIL EXCHANGES, AND HE ESPECIALLY WAS BOTH OUTRAGED AND BEMUSED AT THE INCREASING POPULARITY OF THE BIPOLAR 2(PMB) DIAGNOSIS THAT OUR COLLEAGUES HAVE EMBRACED WITH FERVOUR.

He was a lovely man; soft spoken but entrancing in what he had to say. He had a very productive career that will influence many for a long time. We will miss him and offer our condolences to his family who know better than us what a special man he was.

Sean Kaliski



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UNRAVELLING THE MYSTERIES OF SCHIZOPHRENIA

AN EPIDEMIOLOGIST'S JOURNEY

Sumaya Mall

INTRODUCTION

Schizophrenia, a chronic neuropsychiatric disorder, presents challenges to several disciplines including the field of epidemiology. Epidemiologists who work in the area of schizophrenia integrate principles of several cognate disciplines including sociology, biology, genetics, neuroscience and biostatistics to seek to describe disease aetiology and distribution. In addition to the goals of measurement and establishing causality, psychiatric epidemiologists wish to understand the trajectory of mental illness to see when it is best to intervene.¹

AETIOLOGY AND PATHOPHYSIOLOGY OF SCHIZOPHRENIA IS COMPLEX WITH THE ONSET OF THE DISORDER PREDICTED BY COMPLEX GENE-ENVIRONMENT INTERACTIONS², SEVERAL ASSOCIATIONS WITH STRUCTURAL BRAIN ABNORMALITIES³ AND GENETIC RISK CONFERRED BY A LARGE NUMBER OF ALLELES.⁴

Interventions, based on understanding of causality could focus on treatment (e.g. first or second generation long acting injectable or oral antipsychotic⁵, psychosocial support⁶, adherence to medication^{7,8} and reducing risk of readmission to a psychiatric hospital.^{8,9}

In working towards causal inference, a hallmark of an epidemiologist's journey is to establish the population attributable risk proportion (PARP) of risk factors associated with disease. The PARP gives epidemiologists an indication of the proportion of a particular risk factor e.g.traumatic event associated with disease onset and more importantly how much of disease could be alleviated if a particular risk factor is eliminated.¹⁰ Epidemiologists are well placed to initiate analyses that explore phenotypes



Sumaya Mall

but also take into account the impact of confounding and interaction variables that may influence the relationship between exposures and the onset of schizophrenia.¹¹⁻¹³ This article maps the contours of a psychiatric epidemiologist's journey in understanding schizophrenia. These include

highlighting the conceptual and empirical contributions of epidemiologists to the field, identifying challenges in establishing burden of disease measures and describing possible directions towards interventions tailored to the context of the African continent. The article also describes how best to translate the illumination of individual level risk factors for schizophrenia to population level through calculating the PARP.

HISTORICAL CONTOURS IN THE FIELD OF PSYCHIATRIC EPIDEMIOLOGY AND SCHIZOPHRENIA

The origins of the field of epidemiology and its sub discipline, psychiatric epidemiology are not entirely clear. Experts in the field of history of epidemiology consider a period after 1800 when in the United States of America (USA), social analysts and psychiatrists became concerned with collecting statistical data of disease phenomena as central to the origins of psychiatric epidemiology. These included morbidity and mortality.

Psychiatrists in the USA described social and demographic characteristics of patients and basic results of therapy. A psychiatrist, Edward Jarvis conducted an early study of the relationship between social causation and mental illness, which today is still a prominent issue in the sub-field of psychiatric epidemiology and its co sub-field social epidemiology¹⁴, described in further detail below.

SCHIZOPHRENIA

Halfway through the 19th Century, psychiatrists, Emile Kraepelin and Eugene Bleuler working in the European region also noticed through longitudinal approaches patterns in schizophrenia particularly prominent among adolescents or young adults. What was striking was a surprising cognitive decline among this younger population. Early research attempts then explored heritability, gender and adolescence as potential risk factors for the onset of schizophrenia.^{15,16}

IT WAS DURING THE 1990S IN THE USA THAT THE BROADER DISCIPLINE OF EPIDEMIOLOGY INTEGRATED BOTH THE TASK OF MEASUREMENT AND CAUSALITY AT ALL LEVELS FROM INDIVIDUAL BIOLOGICAL EXPOSURES TO BROADER SOCIETAL STRUCTURAL INFLUENCES. AS A SUB-DISCIPLINE, SOCIAL EPIDEMIOLOGY THEN GREW TO ENGAGE WITH MULTILEVEL STATISTICAL ANALYSES TO ELUCIDATE SOCIAL EXPERIENCES E.G. POVERTY, DISCRIMINATION AND SEGREGATION.¹¹ SEVERAL NATIONALLY REPRESENTATIVE STUDIES OF THE PREVALENCE OF MENTAL ILLNESS HAVE SINCE INTEGRATED SOCIAL FACTORS E.G. HOUSEHOLD FUNCTION, EDUCATIONAL GRADIENT OR SOCIO ECONOMIC STATUS IN THEIR ANALYSES.^{17,18}

CONTRIBUTIONS OF EPIDEMIOLOGISTS TO THE STUDY OF SCHIZOPHRENIA

Contemporary epidemiology, has contributed to the study of schizophrenia most notably in the areas of measurement and causality. The majority of studies have been conducted in Europe and North America with a minority conducted in Asia. There is a paucity of epidemiological research of schizophrenia on the African continent.

During the early 1980s, the World Health Organization commissioned studies of incidence and early course of schizophrenia across both high income and low and middle income countries (LMIC). Ascertainment of schizophrenia cases is challenging in LMIC contexts where the majority of persons may not access formal treatment.^{19,20} A diagnosis would need to be based on precise criteria from the Diagnostic and Statistical Manual (DSM 5). This would entail psychiatric

evaluation, brain imaging, evaluation of family history and exclusion of additional psychiatric disorders and in some cases HIV infection.²¹ In a systematic review conducted by McGrath and colleagues in 2008, the incidence of schizophrenia was found to differ between country sites possibly due to a range of causal factors that are yet to be identified.²²

There have been notable attempts to derive measurement of schizophrenia on the African continent. A community prevalence study of mental disorders conducted by Alem and colleagues in Butajira, a rural region of Ethiopia, found that the vast majority of ascertained cases of schizophrenia were not receiving treatment.²³ In South Africa, there is a paucity of robust epidemiological data of schizophrenia. However, a study of the incidence of hospitalization for non-affective first episode psychosis revealed an incidence measure 31 per 100 000 person years in a sample of age range 15-49. The result should be interpreted as a minimum because the sample excluded those who had not accessed hospital treatment.²⁴

With regard to the area of causality, there have been several genetic studies of schizophrenia that have integrated epidemiological principles e.g. investigating causality using Mendelian randomization.^{25,26} In addition to examining genetic risk for the onset of schizophrenia, a body of research has also examined environmental risk factors. Environmental factors that might increase the risk of the onset of schizophrenia include: neurodevelopmental factors such as prenatal brain insults and trauma during childhood or adolescence.²⁷ Other environmental factors include migration, nutritional deprivation and cannabis use^{28,29} with the incidence of schizophrenia thought to be higher among offspring of older fathers and migrants in Europe.³⁰

THERE HAVE BEEN NUANCED ANALYSES WHERE SOCIAL FACTORS E.G. DISADVANTAGE AND SOCIAL DEPRIVATION ARE THE KEY FOCI.^{24, 31-34} KEYES AND SUSSEY DESCRIBE EXCITING DEVELOPMENTS IN RESEARCH OF EPIGENETIC, INFLAMMATORY, PSYCHOLOGICAL AND NEUROBIOLOGICAL PATHWAYS WHEREBY THESE KEY SOCIAL EXPERIENCES CAN PREDICT THE ONSET OF MENTAL ILLNESS.

AN EPIDEMIOLOGIST'S JOURNEY

These pathways can be modifiable, offering clues about the trajectory of mental illness and when best to intervene³⁵ and there is a need to integrate epidemiological principles within epigenetics research.³⁶ Susser and colleagues tested the hypothesis that food deprivation during the first trimester of pregnancy could be related to onset of schizophrenia in offspring. This hypothesis was tested in a historical Dutch birth cohort who experienced great nutritional deprivation due to a Nazi blockade between 1944 and 1945. Results suggest elevated risk for the onset of schizophrenia in those who were nutritionally deprived.³⁷

A similar hypothesis was tested in a historical Chinese cohort exposed to famine during the period between 1959-1961.³⁸ Again, findings suggest a high risk of developing schizophrenia in a rural sample after the experience of famine.³⁹

CHILDHOOD TRAUMA, WHICH IS POTENTIALLY ASSOCIATED WITH THE ONSET OF SCHIZOPHRENIA DURING ADOLESCENCE AND ADULTHOOD HAS BEEN THE SUBJECT OF INTERNATIONAL EPIDEMIOLOGICAL ENQUIRY. VARESE AND COLLEAGUES UNDERTOOK A META-ANALYSIS OF STUDIES THAT EXAMINED ASSOCIATIONS BETWEEN CHILDHOOD ADVERSITY (INCLUDING SEXUAL, PHYSICAL OR EMOTIONAL ABUSE AS WELL AS EXPERIENCING THE DEATH OF A PARENT OR BULLYING) AND SYMPTOMS OF PSYCHOSIS.

For eligibility in the review, childhood trauma would have to be measured at the individual level and the trauma had to occur before the age of 18. Their overall measure of effect or Odds Ratio (OR) was 2.78 (95% CI = 2.34-3.31).⁴⁰ However Susser and Widom interpret their results with caution suggesting the review cited few prospective studies and that there is difficulty in asking people to report traumatic childhood experiences.⁴¹ A recent cross sectional study by Killian and colleagues in South Africa suggests that childhood trauma may be related to premorbid adjustment in schizophrenia.⁴²

There are few studies investigating the PARP of risk factors related to schizophrenia to translate individual level findings to population level. PARPs take into account that highly prevalent risk factors related to low individual-level risk may be important.^{43,44} A societal level approach, which has been achieved in studies of suicide^{45,46}, could be valuable in examination of several risk factors in the onset of schizophrenia. As mentioned, key to the field of epidemiology is intervention after causality is understood. Schizophrenia requires several approaches including pharmacological, psychoeducation and psychosocial to improve the quality of life of individuals with mental illness. There are several ongoing interventions in high and LMIC including mobile phone interventions to support adherence⁸, cognitive behavioural therapy to target comorbid smoking⁴⁷, focus on early intervention⁴⁸ and psychosocial and family interventions.^{6,49} A recent body of research of family interventions for schizophrenia tailored to the African continent led by Asmal and colleagues recommended cultural considerations and understanding of disease before these interventions are implemented.⁵⁰

CHILDHOOD TRAUMA

CONCLUSION

THIS ARTICLE HAS MAPPED THE CONTOURS OF AN EPIDEMIOLOGIST'S JOURNEY IN UNDERSTANDING SCHIZOPHRENIA AND HAS OUTLINED KEY ISSUES IN THE FIELD INCLUDING CHALLENGES IN DETECTING MEASUREMENT. A RECOMMENDATION IS THAT SEVERAL, WELL DESIGNED, EPIDEMIOLOGICAL STUDIES SHOULD CONTINUE TO INVESTIGATE CAUSALITY IN RELATION TO SCHIZOPHRENIA PARTICULARLY ON THE AFRICAN CONTINENT INTEGRATING BIOLOGICAL AND SOCIAL DETERMINANTS OF THE ILLNESS. ONE POSSIBLE RISK FACTOR POSSIBLY ASSOCIATED WITH THE ONSET OF SCHIZOPHRENIA IS THAT OF CHILDHOOD TRAUMA. CHILDHOOD TRAUMA COULD BE BEST ELUCIDATED WITH REGARD TO THE ONSET OF SCHIZOPHRENIA THROUGH WELL DESIGNED PROSPECTIVE AND RETROSPECTIVE STUDY DESIGNS.

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COMMENTARY

Henk Temmingh

We start with theory and falsify, but we are doomed to remain just with theory in the end.

We have a natural fascination with causality. Questions about the causes of mental disorders such as schizophrenia pervade in the mental health field, and are constantly on the mind of psychiatrists, their patients and families. To a great extent learning about the world in childhood consists of experiencing the constant pairing of events; hence we inductively reason the one must cause the other. We bounce a ball onto the floor and it bounces up. We conclude that throwing a ball against a surface will cause it to bounce back. We are somewhat annoyed at our findings when the inflation of the ball is reduced. No longer does the ball bounce back! Our theory about the cause for the ball bouncing is no longer valid.

MANY FACTORS INFLUENCE THE AETIOLOGY OF PSYCHIATRIC DISORDERS SUCH AS SCHIZOPHRENIA. MEDICAL STUDENTS ARE TAUGHT THAT SCHIZOPHRENIA HAS A "MULTIFACTORIAL AETIOLOGY", YET THIS DOES NOT DAMPEN OUR TEMPTATION TO SEEK FOR THAT ONE ELUSIVE CAUSE OR MAGIC BULLET CURE FOR CONDITIONS SUCH AS SCHIZOPHRENIA (SCZ).

The philosopher David Hume in his writings on causal reasoning noted that all we can conclude about causality is the constant conjunction of two events, but that we cannot (empirically) observe a cause taking place in nature.

Karl Popper was also a fierce critic of inductive reasoning (generalisation/causal theories based on our particular observations) and reminded us that science is all about falsification of hypotheses, and that what we remain with is not a cause, but durable hypotheses that withstand falsification. We start with theory and falsify, but we are doomed to remain just with theory in the end.¹ The public however, are not satisfied with scientific communities' love of doubt and uncertainty, which some psychoanalysts have even described as an "obsessive mode" that pervades through medical psychiatric research.² People (including patients and their families) want



Henk Temmingh

certainty, characteristic of religious faith, even delusional conviction accompanied by authoritative judgements that instil confidence in experts. On the other hand, hang out for a few hours with evidence-based practitioners and Cochrane collaboration authors, highly trained in clinical epidemiology and research methods, and you will often hear openly critical even sarcastic jokes and cartoon depictions about omniscient "experts".

Epidemiologists are trained in quantifying and describing doubt and balancing it with certainty. Masters courses in epidemiology are also characterised by a harmonious diversity of disciplines, ranging from anthropologists to biostatisticians, a rarity in medical psychiatric practice. Dr Mall mentions the concept of PARP (population attributable proportion).

THE PARP OF CANNABIS IN THE AETIOLOGY OF SCHIZOPHRENIA IS ESTIMATED TO BE 8%. THAT IS, IF CANNABIS IS ELIMINATED FROM THE PLANET (THIS COULD BE A NEW PROJECT FOR THE RISING WORLD-WIDE CONSERVATIVES) WE COULD PROBABLY PREVENT 8% OF ALL SCHIZOPHRENIA CASES. NEVERTHELESS, CANNABIS IS NEITHER A NECESSARY OR SUFFICIENT CAUSE FOR SCHIZOPHRENIA, BUT MERELY A COMPONENT CAUSE, AND ITS EFFECT CAN GREATLY VARY DEPENDING ON THE PREVALENCE OF OTHER COMPONENT CAUSES (SUCH AS GENETICS, NEURODEVELOPMENT AND NUTRITION, CHILDHOOD TRAUMA, NOT TO MENTION MAJOR CONFOUNDERS SUCH AS METHAMPHETAMINE AND NICOTINE) THAT COULD (BIOLOGICALLY) INTERACT WITH CANNABIS USE TO ULTIMATELY RESULT IN SCHIZOPHRENIA.

“CANNABIS INDUCED PSYCHOSIS”

For some cannabis would be greatly contributing to the development of schizophrenia; for other individuals it would play no role. However, varying background prevalence as well as biological interaction and mediation among component causes means that component causes cannot add-up to 100%, evidence of the somewhat flawed nature of PARP.¹

WHAT THEN ARE WE LEFT WITH?

For non-harmful outcomes such as medication effects, experimental evidence in randomised trials, the highest level of evidence for causality? Not if we cannot observe a cause. So perhaps we are left with only risk estimates, with varying degrees of certainty. The pooled relative odds for schizophrenia after cannabis use in late adolescence has been estimated to be 2.3, with a lower confidence limit of only 1.6 (actually quite low).³

Many cohort studies have been criticized as suffering from serious methodological problems, casting some doubt on the exact role of cannabis as a causal factor in SCZ.⁴ Then there is the “atheoretical” DSM concept of “substance induced psychosis”, where clinicians are asked to judge whether a particular substance is capable of producing certain symptoms, then reifying it as a separate condition from schizophrenia (as opposed to an early phase of the illness).⁵

ANYONE WHO HAS ATTENDED AN INTRODUCTORY COURSE IN EPIDEMIOLOGY, WHO WOULD HAVE LEARNT ABOUT THE BRADFORD HILL’S CAUSAL CRITERIA OF STRENGTH OF THE ASSOCIATION, TEMPORALITY, BIOLOGICAL GRADIENT, BIOLOGICAL PLAUSIBILITY, SPECIFICITY, CONSISTENCY, COHERENCE, ANALOGY, EXPERIMENTAL EVIDENCE, WILL FIND IT ODD THAT WE TALK OF “CANNABIS INDUCED PSYCHOSIS”, AFTER ALL CARDIOLOGISTS DON’T TALK ABOUT “TOBACCO INDUCED MYOCARDIAL INFARCTIONS”...

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All we have is psychosis and risk factors for psychosis with various levels of risk. Cannabis psychosis may just be phase one or two in an “At Risk Mental State”, on the path to schizophrenia. Causal criteria of course, devised by Bradford and Hill are also in themselves inductive, hence conjectural. So in the end we only have hypotheses...

NONETHELESS, THE SEARCH FOR CAUSES OF MENTAL DISORDERS SUCH AS SCHIZOPHRENIA IS AN EXCITING ONE, MUCH LIKE DEPICTIONS OF GLAMOUR AND EXCITEMENT INVOLVED IN THE PROSPECTING FOR PRECIOUS STONES AND METALS LIKE DIAMONDS, GOLD AND COPPER. ALL WE CAN HOPE FOR IS FOR NOT FINDING TOO MUCH FOOL’S GOLD AND FOR THE UTILITY OF THESE GEMS TO HOPEFULLY EXTEND BEYOND THEIR SOCIALLY CONSTRUCTED VALUE! AND NO ONE LIKES TO HEAR, AT THE END OF A LONG DAY’S WORK, “ACTUALLY WE DON’T REALLY KNOW WHAT CAUSES IT” ...

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SASOP NORTHERN GAUTENG MINI-SYMPOSIUM: NEUROPSYCHIATRY

Carla Kotze

The SASOP Northern Gauteng Subgroup hosted their annual mini-symposium on 8 July 2017 at the CSIR.

It was very well supported with 173 registrations and 15 sponsors/ exhibitors (see attached list). The presentations were of a high standard and the feedback received has been extremely positive.

The first speaker of the morning was **Dr Anersha Pillay** speaking on the topic of "Epilepsy – what psychiatrists should know". She started her presentation with a few definitions, classifications and assessment principles that are beyond the scope of this Report. What is considered essential is that once a seizure disorder is confirmed an underlying cause should be investigated and treated if present. After this the type of seizure should be confirmed, because of the varying responses to anti-epileptic drugs (AED). Of note here is that for simple/complex partial seizures valproate is only considered as a second-line treatment and first line treatments will include carbamazepine, phenytoin, lamotrigine, topiramate, gabapentin and levetiracetam. For other seizure types valproate will be a first line treatment option.

Another very interesting consideration is the possibility of teaching patients to control their seizures. Being able to control the seizures does not imply that there seizures are pseudoseizures. The control strategies include: counteracting the movement of motor seizures, distraction techniques, relaxation techniques, counting backwards and use of a seizure diary with positive reinforcement.

The neuropsychiatric aspects of epilepsy are numerous and can include somatic symptom disorders, anxiety disorders, affective disorders, psychosis, personality disorders and disorders of impulse control. These manifestations are not uncommon, but are frequently overlooked. It is important to establish the relationship of the neuropsychiatric symptoms to the ictal process to assist with appropriate management. The neuropsychiatric symptoms can settle when seizure control is achieved, but if it persists concomitant



Carla Kotze

psychotropic medication and psychotherapy should be used. A multidisciplinary team approach is essential to address all the occupational and legal implications of epilepsy together with appropriate use of psychotropic medication to avoid unnecessary harm.

Prof Mandisa Kakaza then gave a background about the development of neuroimaging. She started with the development of the x-ray in 1896, through the period when ventriculography was used, to the present day of functional imaging and its applications. The CT scan was invented in 1972 and although it is still frequently used its use is limited because contrast medium is required, it is contraindicated in pregnancy and does not have the best resolution with frequent artefacts.



From left to right: Bernard Janse van Rensburg, Anersha Pillay, Mandisa Kakaza, Lennart Eriksson Inset Photo: Eide Francke

Whenever it is available, MRI is the preferred imaging method. It has better resolutions, no need for contrast and can be repeated on the same patient without fear of radiation. MRI does however also have its own limitations, including the problem with claustrophobia and the utilization of magnets. It only shows structural pathology and may not be used to predict degeneration.



From left to right: Pierre Malherbe, Riaan van Collier, Gian Lippi

To predict preclinical degeneration SPECT/PET scans can possibly be of use if the correct biomarker is used. It is unfortunately still prohibitively expensive and may not be used to repeatedly follow up progression, because of the minimal radiation risk. Functional MRI (fMRI) does not have any radiation risk and is non-invasive, but it is dependent on blood flow / oxygen levels that are dependent on cardiovascular responses. This can result in temporal delays between the stimulus and the output. Brain mapping that is currently underway to advance the understanding of the relationship between structure and function in the brain. The results might assist with better understanding and treatment for psychiatric disorders.

Dr Lennart Eriksson spoke on neuropsychiatry and institutionalisation, specifically recognising the need to care for persons with a serious and persistent mental illness (SPMI). A significant section of our patients who have SPMI, and who are unable to live in the community require, as is the case in all countries with a humanitarian ethos, state support and, in many cases, institutionalisation. The presentation focused on what is required by the state to care for this patient population. The recent Life Esidimeni disaster highlights the consequence of an autonomous political decision making process assuming legislative control of a necessary and complicated process. The management of the SPMI is a complex and financially expensive process.

THE PRESENTATION HIGHLIGHTED:-

1. The history leading to the establishment of the 2 Esidimeni facilities created and tasked with the Care and Rehabilitation of legally “certified” mental health care users (MHCU) with a Serious and Persistent Mental Illness (SPMI).
2. The importance of creating an environment – physical, clinical and administrative - that is able to care and rehabilitate the SPMI population was explored. The speaker highlighted the role of having multidisciplinary team (MDT) input with the goal of formulating legislative provisions that will support and protect the SPMI population from exploitation and inferior care.
3. Sections 27(5) and 33(5) of the MHCA 2002 demands that a yearly periodical be completed. The cost of this provision, the role of feedback from the Mental Health Review Board and how this provision fails to protect the SPMI population was discussed.
4. The future – which includes Non-Governmental Organisations (NGOs) and Community Care Facilities – must also include institutions able to fulfil the operational and legal responsibilities as are required by law for the care of the SPMI population.

The presentation remembered the words of Steven Biko, a UKZN Medical Student –

“GREAT POWERS OF THE WORLD HAVE DONE WONDERS IN GIVING THE WORLD AN INDUSTRIAL LOOK, BUT THE GREAT GIFT STILL HAS TO COME FROM AFRICA - GIVING THE WORLD A MORE HUMAN FACE”.

We, as Psychiatrists, and people caring for the mentally ill, must be included in any legislative process. The many stakeholders – Psychiatrists, Psychologists, Social Workers, Academics, Accountants, Politicians and the management of facilities – must ensure that we achieve Africa’s gift to the world. We must ensure that we achieve the gift of giving the world a more human face!

Dr Riaan van Collier spoke about Deep Brain Stimulation (DBS). DBS refers to the chronic electrical stimulation of a certain target in the brain by a programmable, implantable pulse generator. It is reversible, differentiating it from previous techniques of lesioning that was permanent. DBS is a well-established treatment option in the treatment of Parkinson’s disease, tremor and dystonia. For successful outcomes appropriate patient selection, accurate implantation in the appropriate target, optimal programming

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15 SPONSORS/EXHIBITORS

and skilful long-term management is important. Possible complications include surgical, hardware or stimulation complications. The surgical complications include haemorrhage, epilepsy, air embolism, infection and poor placement of the lead outside the target area. Skin erosion, malfunction of the DBS system with mechanical failure, lead migration or breakage are some of the hardware complications that may occur. Possible stimulation related complications include psychiatric complications like depression, mania, suicide, binge eating and cognitive changes.

Psychiatric indications where DBS have been investigated with varying degrees of success are Alzheimer's disease, obsessive-compulsive disorder, Tourette syndrome, depression, addiction and neuropsychiatric features of Parkinson's disease. An incomplete understanding of the complex pathophysiology, the complex and heterogenic symptomatology and lack of comparable animal models still limit the use of DBS in psychiatry.

Ms Eidde Franke pointed out that neuropsychology is still in the process of being recognised by the HPCSA as a specific registration category. Despite this there is a definite role to play for clinical psychologists with a special interest in neuropsychology in the evaluation and management of patients. Tests of neuropsychological function are often able to detect subtle cognitive deficits that are undetected by electro-physiologic or imaging methods. These evaluations can be especially helpful for differential diagnosis where the neuropsychologist can recognise specific profiles of various neurodegenerative conditions.

With cognitive rehabilitation therapeutic activities can improve a patient's ability to think, use judgment and make decisions. Repeat evaluations can assist with monitoring of disease progression or of treatment effects. It is important to note that accurate administration and interpretation of neuropsychological assessment instruments depend on the expertise of the psychologist. The correct instrument must be used for a specific evaluation and the neuropsychologist must assess motivation, effort and cooperation of the patient. The multi-disciplinary team and patient can benefit from the input of a neuropsychologist and their evaluations are best applied in the context of a multi-disciplinary team.

Dr Gian Lippi was the last speaker of the morning and he spoke about traumatic brain injury (TBI). The medico-legal consequences of TBI can include anything from referrals in terms of the Criminal Procedures Act when an individual is accused of a crime, to civil litigation like custody evaluations, testamentary capacity, disability evaluations and commonly third party evaluations. When the TBI affects the orbitofrontal cortex it can have various clinical consequences ranging from tactlessness, impulsiveness, loss of social skills, irritability, lack of empathy, aggression, sexual disinhibition or other inappropriate behaviours. It is quite evident how these behavioural changes can easily lead to medico-legal ramifications.

TBI affecting the dorsolateral prefrontal cortex can cause impairment in attention, concentration, planning, constructional abilities, sequencing, set shifting, visuospatial perception, abstract thinking, judgment and executive functioning. The anterior cingulate is involved with motivation, interest, impulse control, decision-making and error detection. Damage in this area can present with amotivation, abulia and error detection difficulties. When the hippocampus and amygdala is involved it can result in memory difficulties, anterograde or retrograde amnesia.

The most common psychiatric syndromes after TBI include cognitive impairment, personality changes, depression, mania, anxiety, obsessive-compulsive symptoms, posttraumatic stress disorder, somatic preoccupation and rarely psychosis. When doing medico-legal evaluations post-TBI there are multiple variables that have to be kept in mind. These include the mechanism of injury, severity of injury, area of brain injured, period of amnesia and initial Glasgow coma scale score. The maximal neuronal healing occurs in the first 18 months post injury, but recovery can still take place for up to three years in younger patients. Symptoms present after this period should be considered permanent in nature. All these factors, together with prognostic factors, treatment received and the relationship between the traumatic incident and the onset of symptoms should be taken into consideration when performing medico-legal evaluations after TBI.

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Change in
appetite

Suicidal
ideation

Decreased
concentration

Irritability

Tearfulness



Pain

Feelings of
guilt

Lack of
energy

Brooding

Anxiety
phobias

Change in
sleep



Depressed
mood

Obsessive
rumination

Excessive worry
over physical
health

Depression is more than
just mood symptoms¹

Change in
psychomotor
skills

Loss of
interest

**CYMGEN works on a broad range of symptoms to help your patient
recover and stay well^{2,3}**

References: 1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington VA, American Psychiatric Association 2013. 2. Fava M et al. *J Clin Psychiatry* 2004; 65(4):521-530. 3. Hirschfeld RMA et al. *Depress Anxiety* 2005; 21: 170-177.

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Trazodone is a Serotonin Antagonist and Reuptake Inhibitor (SARI) indicated for treatment of MDD* with or without anxiety¹

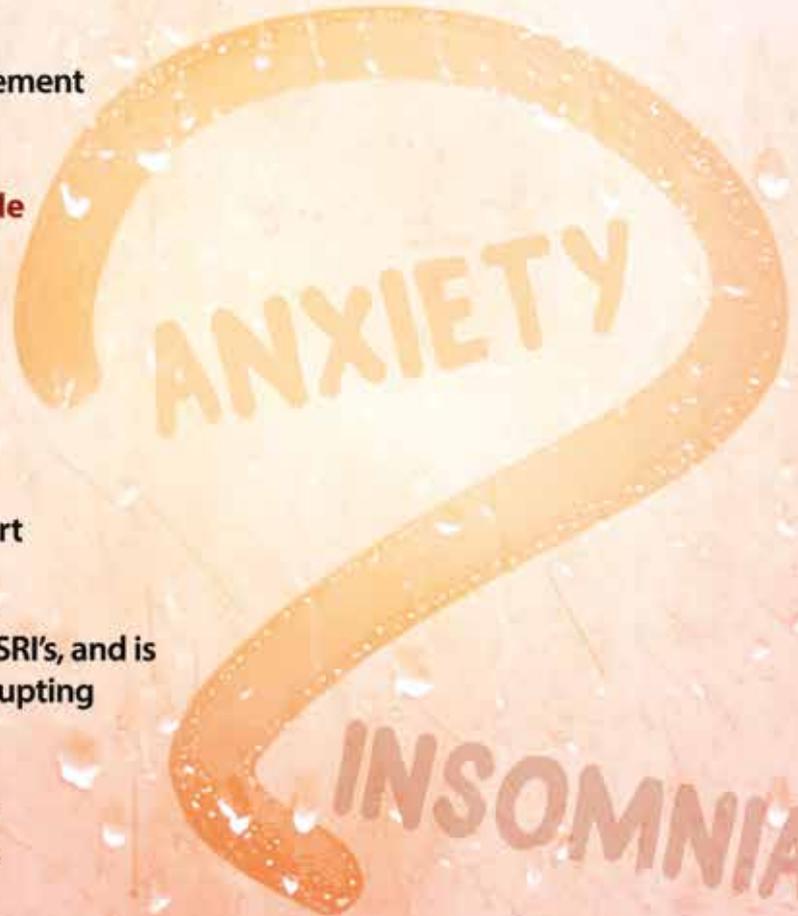
Main goals of treatment for MDD* is the achievement of symptomatic remission & function recovery¹

- Trazodone is effective in controlling a wide range of symptoms of depression, while avoiding the negative effects on sleep seen with SSRI anti-depressants¹
- Patients with major depression have a high rate of insomnia²
- The majority of depressed patients report difficulty initiating or maintaining sleep²

Trazodone is pharmacologically distinct from SSRI's, and is frequently prescribed to alleviate the sleep-disrupting effects of stimulating antidepressants.²

- Many patients recovering from alcohol or other addictions are prescribed Trazodone because it is without abuse potential²

Trazodone has minimal anticholinergic side effects



DEPRESSED



*MDD - Major Depressive Disorder

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Date of publication of promotional item: August 2016
Promotional material reference number: BL0331/08/16

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1. Fagiolini A, Comandini A, et al. Rediscovering Trazodone for the Treatment of Major Depressive Disorder. CNS Drugs. 2013 July 2:27(8): 677
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3. Package insert, published 10 April 2014

PHARMACOLOGICAL CLASSIFICATION

A 1.2 Psychoanaleptics (antidepressants)

- SS BIOTECH Trazodone 50: Reg. No. 43/1.2/0698
- SS BIOTECH Trazodone 100: Reg. No. 43/1.2/0699

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PRACTICAL INTERPRETATION OF THE ALCOHOLICS ANONYMOUS 12 STEPS OF ADDICTION RECOVERY

David Webb

Recovery from addiction has been described as a 'voluntarily maintained lifestyle characterised by sobriety, personal health and citizenship'.¹

While, in the right setting, such as a rehabilitation clinic, many addicts have little trouble stopping drinking or using drugs, most, if not all, find maintaining sobriety, especially after reintegration back into society and return to normal life, much more difficult. For the majority, without long-term support and constant vigilance to curtail impulsive behaviour, it is impossible. In some addicts incentive salience driven by changes in the limbic brain presents a lifelong vulnerability to relapse.^{2,3}

FURTHERMORE, THE HORRENDOUS CONSEQUENCES AND CHAOTIC LIFE CREATED BY YEARS OF ACTIVE ADDICTION, SOMETIMES COUPLED WITH LOSS OF FAMILY AND SOCIAL SUPPORT, FURTHER COMPOUNDS PRE-EXISTING LOW SELF-EFFICACY, LOW SELF-ESTEEM, POOR EMOTIONAL REGULATION AND HOPELESSNESS. IF ADDICTS ARE TO REMAIN SOBER, THEN THESE ASPECTS OF THEMSELVES NEED TO BE ADDRESSED AND THEIR THINKING STYLE AND SOCIALITY NEED TO CHANGE SO THAT THEY ARE MORE FUNCTIONAL.

The 12 steps of addiction recovery (Table 1), originally described by Alcoholics Anonymous in 1939, is a framework for a learned lifestyle characterised by self-awareness, self-compassion, self-development, improved resilience and enhanced psychological wellbeing.^{2,4-6} By encouraging social participation and working with other recovering addicts, the 12 step process provides the recovering addict with a sense of common humanity and belonging, motivation to remain sober and an opportunity to find meaning and purpose.



David Webb

12 STEPS OF ADDICTION RECOVERY.

From Alcoholics Anonymous (4th ed). New York: Alcoholics Anonymous World Services, Inc; 2001.

1. We admitted we were powerless over alcohol - that our lives had become unmanageable.
2. Came to believe that a power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

Table 1

At first sight, the 12 steps appear to be overtly religious, as is the Christian-based approach of the original text.⁴ The process has been criticised for this, along with (inaccurate) perceptions that recovery through the 12 step process requires admissions of powerlessness and to moral character defects or failings.⁷ Nevertheless, a contemporary interpretation of the 12 step process does not necessitate religious identification or belief in a god. Furthermore, some of the words from the 1939 text are used differently in the present day and it is helpful to understand the original context in which they were intended.

The following is a brief non-religious interpretation of the 12 step process, which forms a practical adjunct to treatment of addiction to alcohol and other drugs and an ongoing lifestyle to help maintain a less chaotic life and long-term sobriety.

THE STEPS

STEP 1: Alcoholics Anonymous points out that alcoholism is characterised by two behaviours.⁴ Despite a conscious desire to abstain, the alcoholic is unable to leave alcohol alone for any extended period of time, and once they take a first drink, he/she cannot stop. The drinking episode culminates in blackout and loss of consciousness. In other words, the addiction hijacks the addict's sense of free will, in that they are no longer free to choose whether or not to drink or how much to consume. This view is consistent with dopamine reward prediction error, incentive salience and post-use dysphoria mechanisms of addiction neurobiology.^{3,6,8-14} In contrast to being addicted to the high, in the absence of anticipated reward, the brain 'wanting' (distinct from 'liking') the addictive substance and post-use dysphoria, drive repeated, compulsive and excessive consumption. In this context, incentive salience, in which emotions are powerfully salient, also explains why addicts may relapse after even many years of sobriety. Therefore, in these respects, the alcoholic is powerless over (his addiction to) alcohol. He/she cannot stop drinking by him/herself (without assistance). The addiction to alcohol is more powerful than the willpower of the individual.

It is important to note that, in contrast to the concept of 'powerlessness' in general that is too often mentioned as a criticism of this step, step 1 does not suggest that the individual is powerless. Clearly one retains considerable efficacy over one's own life, whether or not to seek and be open to assistance and whether to participate in the recovery process. Clearly the alcoholic's life is unmanageable when they are drinking. However, due to poor coping skills, low self-efficacy and self-defeating thinking characteristic of the addictive psyche, and chaotic consequences of repeated intoxication, the alcoholic's life is almost certainly unmanageable in between drinking episodes as well. This sets up a vicious cycle of adverse consequences and negative

emotions, and drinking to escape those that further contributes to chronic alcohol use.

STEP 2: What is a power greater than myself? Simply put, it is not me. I need assistance to recover. Even if the alcoholic is able to sustain sobriety for short periods, they inevitably return to drinking. They may tell themselves that now they have it under control, that they will be able to moderate their drinking. The AA text describes this inability to learn from past experience and the conviction that, despite all evidence to the contrary, this time will be different, as 'insanity'.^{4,5} There is no suggestion in the 12 steps that alcoholics should blindly accept from the outset that the 12 step process will enable them to recover. It is merely suggested that, with assistance, they give it a chance. Through seeing the benefits of the program in the sobriety of others, and in experiencing the positive changes that occur in their own lives as a consequence of implementing this lifestyle, they gradually come to understand (we came to believe) that a sober, rewarding life is achievable and sustainable.

STEP 3: If life is to change, and relationships and consequences of behaviour are to improve, and if one is to break the cycle of chaos and drinking, then it is intuitive that the alcoholic should have at their disposal a functional reference framework within which to act in future. Self-centered motives that inform impulsive decisions and behaviours need to be replaced with more mature functional thinking and actions. Step 3 offers the alcoholic a framework from which to start.

Although many alcoholics may identify with a God, others do not. The 12 step program refers to "God as I understood him". Regardless of religious or spiritual convictions, alcoholics are invited to define for themselves what God, if he/she were to exist, might be like. A typical list of 'godly' characteristics (or principles) might look like that presented in Table 2. It is then suggested that they begin to make decisions and act based on these characteristics that they have identified as desirable. They are invited to "act like the person you want to become".

PRINCIPLES

• PATIENT	• MODEST	• CALM	• PROTECTIVE
• KIND	• POSITIVE	• FORGIVING	• TRUSTING
• HUMBLE	• CONSIDERATE	• HONEST	• GENEROUS
• POLITE	• SENSE OF HUMOUR	• DEPENDABLE	• PERSEVERING

Table 2

STEP 4: In contrast to criticisms of this step that suggest that alcoholics are made to admit to 'moral failings', the 'moral inventory' referred to in step 4 is not intended as a judgement on character. Step 4 is an invitation to 'discover the truth' where unawareness and pursuing one's own motives has led to negative consequences, dysfunctional relationships, resentment and reactionary drinking. The alcoholic is asked to identify episodes of past

anger, regret, guilt or embarrassment and where they were responsible in these situations. Note that they are not asked to identify their 'part'. If I have a part, then you must have a part, and if you have a part, then my part is justified: "Putting out of our minds the wrongs the others had done, we resolutely looked for our own mistakes. Where had we been selfish, dishonest, self-seeking and frightened? Though a situation had not been entirely our fault, we tried to disregard the other person entirely".⁴ Through identification of self-seeking motives, the alcoholic is in a position to adjust future behaviour by substituting these motives with the principles identified in step 3. Introspective, carefully considered decision-making based on principles rather than motives informs more functional behaviour with less chaotic consequences. Life becomes more manageable. Furthermore, compassion for others facilitated by step 4 may increase the capacity to accept compassion from others and the ability to show greater compassion to self.¹⁵

STEP 5: Talking to another person about the inventory established in step 4 is helpful in a number of ways. It helps to establish a sense of common humanity, to put events into perspective and to invite an opportunity for counsel. Addiction is characterised by dysfunctional thinking and behaviour, associated with shame and a sense of isolation. Talking to another (recovered) addict, discovering that one is not alone, is cathartic, reduces feelings of isolation, fosters self-acceptance and opens the door to healing. It engenders a sense that one can be forgiven and can forgive. It creates a sense of humility, honesty and willingness to change without descending into self-pity.⁵ Although there is no substitute for one addict talking to another, other appropriate people who may be helpful in step 5 include addiction counsellors, healthcare professionals, friends, family members and religious advisors. Steps 6 and 7 represent, with humility, a commitment to maintain the framework for decision-making that has been outlined in step 4.

STEPS 8 AND 9: Active addiction is characterised by behaviours that are self-centered and dishonest. Almost inevitably during that time others are maltreated, harmed or compromised in various ways. By carefully reviewing where their behaviour may have caused harm to others or society and, where possible making amends for that, the alcoholic is able to free themselves from associated guilt and shame and pre-empt or avoid repercussions of past activities that may adversely affect their life in future and compromise efforts at sobriety.

Decisions about who to approach, how to approach them and how it may be possible to make amends should be objective and carefully considered. Consequently, discussion with appropriate counsellors is encouraged before approaching others.

STEPS 10 AND 11: As previously implied, the steps, rather than being discrete actions, are a framework for a maintained lifestyle. They are separated and numbered so that the lifestyle can be taught, understood and learned. Steps 10 and 11 inform a daily practice of a non-judgemental, carefully considered review (mediation) of emotions, thoughts and events, and planning for the day ahead, based on the principles of steps 3, 4, 8 and 9.

"WHEN WE RETIRE AT NIGHT, WE CONSTRUCTIVELY REVIEW OUR DAY...";

On awakening, let us think about the twenty-four hours ahead".⁴ The intention is to non-judgementally identify where motives rather than principles continue to inform behaviour and to proactively correct errors before they occur or are allowed to escalate.

STEP 12: The result of the 12 step lifestyle is a personality change (spiritual awakening) to a happier, more capable individual who is able to grow and flourish. Assisting and guiding other recovering alcoholics to achieve the same provides a sense of purpose and meaning that supports long-term sobriety.^{2,4-6}

FINAL WORDS

Participation in 12 step-based social groups, such as Alcoholics Anonymous or Narcotics Anonymous, provides valuable support for long-term sobriety. Although a 12 step process may not be appropriate for all addicts, it is helpful for clinicians to have an informed working knowledge of the 12 step process so that they may encourage it where it is appropriate and support those who are already participating in such groups.

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COMMENTARY

Tiaan Schutte

12 Step Programmes - A Dual Diagnosis Perspective

The utility of 12 Step based mutual aid or “self-help groups”, such as Alcoholics and Narcotics Anonymous, together with the active facilitation of engagement into such groups from both in-patient and out-patient substance rehabilitation programmes, forms a key component of reinforcement of the basic principles of long term sobriety and relapse prevention in the life of the recovering addict. Indeed, there is now significant evidence from numerous studies, highlighting these benefits.^{1,2,3,4}

Unfortunately, due to the eligibility criteria, those with dual diagnoses or co-occurring disorders are often excluded, hence the relative paucity of knowledge of the effectiveness of 12 Step programmes in these patients, especially amongst those suffering from severe and enduring forms of mental illness.⁵

Although the literature varies greatly, it appears that dually diagnosed patients tend to have equal attendance rates, but derive less benefit from such attendance, when compared to their substance use disorder-only counterparts.^{5,6} This, however with the exception of those diagnosed with schizophrenia and schizo-affective disorder, who show a significantly lower attendance rate as well. The latter is of particular concern as these individuals make up a large component of those with severe mental illness and are considered especially vulnerable to develop a substance use disorder at some point throughout their lifetime.^{5,7}

TYPICALLY, DUAL DIAGNOSIS PATIENTS WOULD REPORT NUMEROUS DIFFICULTIES WITH ENGAGING AND FEELING ACCEPTED BY THE GROUP. RESIDUAL FEELINGS OF PARANOIA AND ANXIETY, OFTEN EXACERBATED BY THE RATHER CONFRONTATIONAL STYLE OF INTERACTION EMPLOYED BY SOME GROUPS, AS WELL AS BEING TOLD THAT THEY ARE NOT REALLY “CLEAN” AS THEY MAY VERY WELL BE PRESCRIBED THE SAME “DRUG” THAT A FELLOW MEMBER HAS BEEN BADLY ADDICTED TO.^{5,7,8}



Tiaan Schutte

The experience at Sterkfontein Psychiatric Hospital’s Dual Diagnosis Unit has also highlighted some peculiar difficulties in terms of the 12 step facilitation process. For example, explaining to a patient, who has recently recovered from a severe episode of bipolar mania—often with some residual overvalued religious preoccupation—that the 12 step programme is actually non-religious and “...does not necessitate religious identification or a belief in a god”, can indeed prove challenging.

This may also lead to an inappropriate and unhelpful religious discussion which at best, de-focusses the whole group-process, or at worst, may precipitate relapse (in terms of the mental illness) in some vulnerable individuals.

Furthermore, as patients with severe mental illness often have limited capacity for abstract reasoning and reduced mental flexibility, the ‘take-home message’ from their perspective, may be that religion and prayer is the only effective coping strategy they need. Although possibly helpful for some, it may become a barrier to the acquisition of new coping skills for others.

With these and other obvious limitations to the utility of traditional 12 step models, several bespoke dual diagnosis specific 12 step mutual aid programmes have been developed, such as the ‘Double Trouble in Recovery (DTR) mutual aid programme.’^{9,10} These programs aim to augment and add to the traditional 12 steps, specifically to accommodate vital aspects in the sobriety and mental well-being of these most vulnerable patients.

“DTR creates a safe environment where a person can discuss the issue of mental disorders, medication, medication side-effects, psychiatric hospitalizations and experiences with the mental health system openly without shame or stigma.”¹¹

**References below Willie Pienaar’s commentary.*

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COMMENTARY

Willie Pienaar

A contemporary interpretation of the AA 12 steps of addiction recovery

The author has made a positive contribution to our understanding and treatment of addiction using the AA 12-step program. Maybe the heading should have been 'Contemporary interpretation of the AA 12 steps of addiction recovery'. The author helps future therapists and potential patients by making a clear distinction between religion and spirituality in therapy, adds to the 12-step program our current understanding of the role played by the neurobiological changes of addiction and confirms the relevance and benefits of the program in modern addiction care. Clinically accredited alcohol and drug rehabilitation programs have positive outcomes. Most therapists in health care can cope and manage chronic relapsing illnesses, but somehow find it difficult with relapsing addicted patients. Too many health care therapists become disillusioned with patients' failure to achieve ongoing sobriety. Addiction is mostly a chronic relapsing disorder. I am a strong advocate for the AA program and have experienced many, many lives and families that have benefitted from the program. Of course, no one-size (program) fits all. Health carers mostly want to know (understand) why certain treatment modalities work. Likewise, addiction therapists want to identify the very essence of a program to initiate sobriety and motivate ongoing sobriety. Alas, to this day this knowledge escapes us. Different people are motivated in different ways. Most importantly, the 12-step program motivates the patient (1) to take ownership of his/her illness by finally admitting being 'powerless'. (2) The program teaches the patient about 'limitedness'.

THE FIRST IMPORTANT STEP TOWARDS SOBRIETY - "IT IS REAL (HUMAN) TO BE LIMITED, TO BE LIMITED IS TO BE REAL (HUMAN)".

What a wonderful discovery! To be human and have limitations, like everyone else, makes it possible to challenge this illness, to make free choices and to take ownership of the illness. (3) The strong group adherence, support and group dynamics within the 12-step program motivates ongoing sobriety. Once a 'winner' and 'belonging to a winners' group brings



Willie Pienaar

stability into the life of an addict and prevents giving up what was gained. (4) The opportunity to build new memories in a sober life may be very rewarding. One must remember that in real life there are only two kinds of people; those who are victims of themselves, others and situations, or those who challenge life, weaknesses, situations and results of addictions. (5) The 12 steps make one aware of a power greater than oneself and by this confirm one's bio-psycho-social-spiritual being.

THE AA PROGRAM BINDS US WITH OTHERS LIKE US TO SHARE, SUPPORT AND NURTURE. (6) THE PROGRAM PROVIDES THE NOW SOBER ADDICT WITH NEW FOUND MEANING IN LIFE BY HELPING OTHERS WITH ADDICTION. AGAIN, THANK YOU TO THE AUTHOR WHO HAS MOTIVATED HEALTH CARERS AGAIN TO TOUCH THE LIVES OF OTHERS IN NEED.

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FAREWELL

ELAINE MILNE



It is with great sadness that we bid farewell to Elaine. Elaine reached retirement age earlier in the year but we were fortunate enough to be able to hold on to her till the end of this year.

Elaine's energy and passion have been the power behind Cipramil, Cipralex and a part of the shared responsibility with Brintellix. She has contributed greatly to Lundbeck's success and reputation over the last 20 years.

WE TAKE THIS OPPORTUNITY TO THANK ELAINE FOR THE OUTSTANDING CONTRIBUTION SHE HAS MADE TO LUNDBECK AND TO THE PSYCHIATRIC COMMUNITY AS A WHOLE.



Go well Elaine, you will leave an enormous hole in our lives. Enjoy a well-deserved break and more than anything, spend some precious time with your brand new grandson, Thomas!

WE WILL MISS YOU MORE THAN YOU WILL EVER KNOW!

From all your colleagues at Lundbeck



CORPORATE MENTAL HEALTH AWARENESS

Renata Schoeman

Following the success of the Corporate Mental Health Awareness day held 9 September 2016 at the University of Stellenbosch's Business School (USB) in Bellville, USB hosted a follow up event at the Radisson Blu Hotel in Port Elizabeth on 12 May 2017.

With more than 65 delegates, this event highlighted the need in organizations to break the "culture of silence" surrounding mental health problems. Employers and employees, although still hesitant to openly talk about anxiety and depression in the workplace, are eager to participate in these conversations, and also to develop impactful interventions at work.

Prof Piet Naude (*Director, USB*), focused on the theoretical approaches to the ethical obligations of leaders as it applies to staff wellness and staff development. With his easy conversational style and humour, he discussed different aspects of staff mental wellness.

HE PRESENTED A MULTI-DIMENSIONAL "MODEL" (WELLNESS FOUNDED ON A HEALTHY SELF-RELATION, INTERPERSONAL WELLNESS, WELLNESS IN RELATION TO ORGANIZATIONAL OTHERS, WELLNESS IN RELATION TO "PLACE", AND WELLNESS IN RELATION TO PURPOSE AND THE FUTURE) AGAINST WHICH DELEGATES CAN EVALUATE CURRENT HUMAN RESOURCES PRACTICES OR CAN PLAN FUTURE INTERVENTIONS.

Dr Renata Schoeman (*Senior lecturer: Leadership, USB; Psychiatrist in Private Practice*) focused on the impact of stress-related conditions (such as "burnout", anxiety, depression and substance abuse) in the workplace. The cost to the economy is calculated



Renata Schoeman

at 2.2% of the GDP, with the cost of presenteeism alone exceeding the value of the tourism industry! She discussed the factors contributing to the development of burnout (such as lack of control, unclear job expectations, dysfunctional workplace dynamics, poor job fit, extremes of activity, lack of social support and work-life imbalance) as well as preventative measures to address it.

EMPLOYEES AND EMPLOYERS SHARE RESPONSIBILITY: IN TERMS OF SELF-CARE, AND THE DEVELOPMENT AND UTILIZATION OF WORK-PLACE INTERVENTIONS AND SUPPORT.

Dr Tienie Stander (*CEO: TCD Outcomes Research*) emphasized that mental wellness in the workplace remains a significant indicator of work performance. He presented findings from a recent study in which metrics of mental wellness were explored along three axes: anxiety, work stress and depression. The results illustrated the value of understanding the mental wellness diagnosis in the organization (sources of stress, as well as the manifestation of symptoms and impact on cognitive functioning and impact on other aspects of life) in order to quantify the impact of mental wellness in an organization. This tool will enable employers not only to be able to do a base

line assessment, but also to be used as a way in which they can measure the outcomes of interventions as well as calculate a return on investment on these interventions.

Prof Christoffel Grobler (*Clinical Head, Elizabeth Donkin Psychiatric Hospital; Associate Professor at Walter Sisulu University, Medical School*) concluded the day by presenting an approach to disability prevention. He addressed why “work is good for you”: work absence tends to perpetuate itself - the longer someone is off work, the less likely they become ever to return. By not appreciating the urgency, the individual concerned may inadvertently be pushed into ending up permanently disabled.

HE CAUTIONED PSYCHIATRISTS (AND GENERAL PRACTITIONERS) TO STOP ASSUMING ABSENCE FROM WORK IS “MEDICALLY REQUIRED” AND QUOTED THAT “A SICKNESS CERTIFICATE IS ONE OF THE MOST POWERFUL AND POTENTIALLY DANGEROUS TREATMENTS IN A DOCTOR’S ARMAMENTARIUM”. ONLY CORRECT MEDICAL DIAGNOSIS AND TREATMENT CAN REDUCE DISABILITY!

Return-to-work and Stay-at-work strategies, and vocational rehabilitation, as well as a collaborative approach between all role players (including the insurance industry) are crucial in the prevention of permanent disability.



From left to right: Prof Christoffel Grobler, Prof Piet Naude, Dr Tienie Stander, Dr Renata Schoeman, Mr Owen Mbundu, Ms Gail Vertue

INVESTING IN A MENTALLY HEALTHY WORKFORCE IS GOOD BUSINESS: IT CAN LOWER TOTAL MEDICAL COSTS, INCREASE PRODUCTIVITY, DECREASE ABSENTEEISM, AND PREVENT AND DECREASE DISABILITY COSTS. INVESTING IN MENTAL HEALTH ALSO IMPROVES EMPLOYEE MOTIVATION, STAFF RETENTION RATES AND COMPETITIVENESS.

THANK YOU TO THE SPONSORS

Dr Reddy’s, Lundbeck, and Adcock who made this day possible, as well as the excellent Chair, Owen Mbundu (Head: Marketing, USB) and Gail Vertue (USB: coordinator)

Renata Schoeman has been in full-time private practice as a general psychiatrist (child, adolescent and adult psychiatry) since 2008, with practices in Somerset West and Oude Westhof (Bellville). As a psychiatrist, she has special interests in cognition (i.e. disorders affecting attention, concentration, learning and memory – such as ADHD and dementia), eating disorders, mood disorders and anxiety disorders. Renata also holds appointments as senior lecturer in Leadership (USB), as a virtual faculty member of USB Executive Development’s Neuroleadership programme and an associate of the Virtual Learning Platform. She serves on the advisory boards of various pharmaceutical companies, as a director of the Psychiatric Management Group (PsychMG) and is the co-convenor of the South African Society of Psychiatrist (SASOP) special interest group for adult ADHD. She is passionate about corporate mental health awareness and uses her neuroscience background to assist leaders in equipping them to become balanced, healthy and dynamic leaders that take their own and their team’s emotional, intellectual, social health and physical needs into account. Renata is academically active and enjoys research and collaborative work, has published in many peer-reviewed journals, and has presented at local and international congresses. She is regularly invited to present at conferences and to engage with the media. During her post-graduate studies, she trained at Harvard, Boston in neurocognition and neuroimaging. Her awards include, amongst others, the Young Minds in Psychiatry award from the American Psychiatric Association, the Discovery Foundation Fellowship award, a Thuthuka award from the NRF, and a MIRC Fellowship. She also received the Top MBA student award and the Director’s award from USB for 2015. She was a finalist for the Businesswomen’s Association of South Africa’s Businesswoman of the Year Award for 2016, and received the Excellence in Media Work award from SASOP during 2016. **Correspondence:** renata@renataschoeman.co.za

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THE MANAGEMENT OF BORDERLINE PERSONALITY DISORDER BY GENERAL PSYCHIATRISTS

Manfred Böhmer

About 50% of all psychiatric patients suffer from a personality disorder.¹ It is for many reasons important not to miss such a diagnosis. Personality disorder is a predisposing factor for other psychiatric disorders, as well as for medical problems.^{1,2}

Data suggests that life expectancy for those suffering from a personality disorder is shortened by 18 to 19 years.² Factors that play a role in this are not only increased incidence of suicide, but also increased mortality from cardiovascular and respiratory problems.² Communication problems with health care providers can also contribute to poor quality of care.² Patients can receive inappropriate treatment if this diagnosis is missed. Personality disorders could be one of the main reasons why patients relapse and why acute disorders become chronic.^{2,3}

Fifteen to 20% of psychiatric in- and outpatients suffer from a borderline personality disorder (BPD), yet it is underdiagnosed.⁴ A major reason for this is the perception that the recurrent crises, volatility and self-injury that form part of BPD are deliberate and manipulative, rather than signs of an illness.⁴ It is often misdiagnosed as major depressive disorder or bipolar disorder and treated with medication. BPD is characterized by hypersensitivity to rejection and a fearful preoccupation with expected abandonment. Sufferers feel that life is not worth living unless connected to someone who really "cares", meaning unrealistic levels of availability and validation.⁴

Genetic and environmental influences combine in the development of BPD.⁴ Insecure or disorganized attachment and childhood trauma play a significant role. In about 60% of patients, childhood sexual abuse appears to be an important etiological factor.⁵ MRI and PET scans of patients with BPD show a hyper-responsive amygdala and impaired inhibition from the prefrontal cortex.⁴

Recent data suggest a high remission rate of about 45% by two years and 85% by ten years.⁴ This, however,



Manfred Böhmer

refers to patients not meeting DSM criteria any more. There is no convincing evidence that the core domains of interpersonal functioning, identity problems and social dysfunction improve significantly or reliably with treatment.⁶ Furthermore, the suicide rate is 8 – 10 % and after remission most still suffer from functional impairment; only 25% are employed full time.⁴ Yet, state Bateman et al.,⁶ there is reason for optimism, since serious symptoms such as suicide attempts, risk taking and aggressive outbursts can improve markedly with treatment.

TREATMENT

The primary treatment for BPD is psychotherapy.⁴ The goals are to reduce acute life-threatening symptoms, to improve distressing mental states and to help with identity formation and social functioning, as well as mentalizing. Pharmacotherapy is only an adjunct to psychotherapy and unrealistic expectations about pharmacotherapy may undermine the patient's work on self-improvement.

PHARMACOTHERAPY

For affective dysregulation in BPD, mood stabilizers (topiramate, valproate and lamotrigine) are suggested as first-line treatment; second generation antipsychotics (aripiprazole and olanzapine) and haloperidol also show positive results.⁷ For impulsive-behavioural dyscontrol symptoms, mood stabilizers (lamotrigine, topiramate) are advocated and to a lesser extent flupentixol decanoate. Aripiprazole can

be beneficial for overall impulsivity. SGAs (aripiprazole and olanzapine) should be first choice for treating cognitive-perceptual problems.⁷

Comorbidity, however, is extremely common. Over time most patients with BPD will meet criteria for mood, anxiety, eating, or stress-related disorders, as well as substance use disorders.⁸ While SSRI's are not recommended as first line choice for borderline symptoms, in comorbid conditions the appropriate treatment guidelines should be followed.⁷

Medication is used very frequently for BPD, despite the scarcity of evidence for their use.⁶ During a six-year period Zanarini et al.⁸ found that over 50% of patients were taking two or more medications and over 35% three or more. The use of medication should be time-limited as an adjunct to psychosocial treatment and to manage specific symptoms.⁶ Medication can also be considered in an acute crisis, but should be withdrawn once the crisis is resolved.⁶ The NICE guidelines of the UK suggest short term use of a sedative drug during a crisis but preferably only for up to one week.⁹ These guidelines also state that if patients have no comorbid illness, efforts should be made to reduce or stop medication.⁹ Prescribers furthermore need to be cautious with potentially lethal drugs or misuse of drugs.

In the NICE Guidelines, a patient who went through a crisis is quoted stating: "I was desperate for connectedness ...that someone was aware of how desperate I was feeling. ...I didn't need anything done, nor crisis admission or referral...I just needed a caring human response" (p. 300).⁹

PSYCHOTHERAPY

When undertaking psychotherapy it is important to keep in mind the three different levels of personality organization - neurotic, borderline and psychotic - since the therapeutic approach will differ according to the level of pathology.¹⁰ McWilliams states that most DSM personality disorders will likely be in the borderline range of personality organization.¹⁰ The concept of a borderline personality organization stems from Kernberg.¹¹ Coming from a psychoanalytic perspective, he coined this term to describe a group of patients who showed characteristic patterns of ego weakness (e.g. an inability to control impulses and affects such as anxiety), psychotic-like thinking, primitive defences (e.g. splitting, idealization, devaluation, projective identification) and pathological object relations (seeing others in extremes, having serious interpersonal problems).⁵

Patients functioning on the neurotic or highest level of psychopathology present with mostly mature defences and have an integrated sense of identity. They are able of a "therapeutic split", that is to observe their own psychopathology. Patient and therapist feel they are on the same side, a therapeutic alliance can be quickly established and countertransference feelings are not overwhelming.¹⁰ It is like a mechanic looking together with the owner of the car at the engine and trying to figure out what is broken.

Patients functioning on the level of a borderline personality organization will have a background of insecure or disorganized attachment and use primitive defences.¹⁰ Their ability to observe their own pathology is very limited and they lack a reflective functioning that finds meaning in behaviour, in other words they cannot "mentalize". Interventions intended as helpful are received as attacks. They evoke a strong and upsetting countertransference and it can take a very, very long time to establish a therapeutic alliance.¹⁰ Instead of the mechanic and the owner trying to find out what is broken in the engine of the car, the mechanic and owner are in each other's hairs.

Mentalizing, or reflective functioning, helps regulating feelings and helps to resolve trauma. In a study of predominantly female inpatients Fonagy et al.¹² found that in patients with a history of abuse and a low score in reflective functioning 97% met criteria for BPD, whereas only 17% met criteria for BPD in those who had suffered abuse but scored high on reflective functioning.

THE "BIG THREE" PSYCHOTHERAPIES

Three major evidence-based psychotherapy treatments have emerged for BPD: dialectical behaviour therapy (DBT, developed by Linehan), and two therapies deriving from a psychoanalytic/psychodynamic approach, namely mentalization-based treatment (MBT, developed by Bateman and Fonagy) and transference-focused psychotherapy (TFP, developed by Kernberg).¹³

In DBT and MBT, patients are seen weekly in individual and group sessions; in TFP twice-weekly for individual sessions. Because of training needs, costs and time, these three therapies have, however, provided no meaningful response to public mental health needs. They also do not address family interventions, medication management, vocational needs and the often ambiguous role of the psychiatrist.¹³

A study comparing TFP vs. DBT vs. supportive therapy found some small advantages for TFP.¹⁴ Of interest is that supportive psychotherapy did nearly as well. A recent systematic review and meta-analysis showed that DBT and psychodynamic psychotherapy are effective for borderline symptoms.¹⁵ These two therapies, but not cognitive therapy, were found to be small to moderately more effective than non-specialised therapies.¹⁵ Other studies also indicate that treatments requiring less training and that are less intensive can be relatively efficacious.¹³ Research focussed thus on features shared by effective treatments, leading to the development of a generalist model of managing borderline patients.

THE EMERGENCE OF A GENERALIST MODEL

The generalist model of the management of patients with BPD centres on:^{6,13}

- Once weekly sessions with a case manager or psychotherapist who is supportive, directive and

pragmatic and who has previous experience with BPD.

- Unapologetically disclosing the diagnosis of BPD (in contrast to previous thinking where sharing this diagnosis with the patient was avoided).
- Psychoeducation, including discussing the handicaps imposed by the genetic makeup of the patient. This facilitates a process of mourning about the cards one has been dealt in life.
- The focus in the sessions is on problems in daily living, on managing present life situations.
- Family interventions, group therapy and medication are flexibly integrated.
- Interruptions are expected and additional sessions are arranged as needed.

Such a generalist model is advocated as a first line approach. Being in supervision is also suggested, especially for more inexperienced therapists.¹⁰ Furthermore, it is important to keep in mind that BPD presents with a spectrum of severity and patients should be referred for more specialized treatment if this approach has failed, or if they suffer from a more severe form of BPD. The reader is referred to the article by Gunderson¹³ for a very helpful discussion and vignette on the generalist model.

PRINCIPLES DERIVED FROM EFFECTIVE THERAPIES

Apart from learning about the generalist model, it is helpful to take note of principles of technique that, according to Gabbard, apply broadly to most patients with BPD.⁵

1. Establishing conditions that make psychotherapy possible. These patients need stability provided by external sources, since an internal stability is missing. In this context, the following needs to be clarified:
 - i. Appointment times, frequency and duration of appointments, fees and what to do if appointments are not kept.
 - ii. Hospitalization may be needed if there is a suicide risk.
 - iii. If the patient abuses substances the therapist might insist that the patient attends NA or AA.
 - iv. Medication might at times be necessary.
 - v. Lastly, the therapist needs to be available in between sessions for emergencies. Phone calls should be explored in the sessions and limits imposed if necessary.
2. Creating a holding environment. For patients with BPD relationships are absolutely necessary to stabilize their self-structure. Of importance are:
 - i. Empathic validation and acknowledgment of early trauma, if that has happened.
 - ii. The therapist allowing being transformed into a bad object; here the therapist acts as a container for the patient's intense feelings, such as anger, aggression and hate.
 - iii. Not allowing omnipotent control, for example through suicide threats.
 - iv. A supportive approach is needed; confrontation will lead to patients dropping out of therapy.

3. Maintaining flexibility in terms of approach; this refers to a disciplined spontaneity by the therapist vs. the keeping of boundaries. It also refers to flexibly move between a more supportive and a more interpretive stance according to the abilities of the patient.
4. Promoting mentalization (symbolic thinking) by, for example, connecting their underlying emotional state to their actions.
5. Helping patients re-own aspects of the self that have been disavowed, e.g. hatred. They have to learn that hatred is part of life, but that it must be tempered and integrated with love.
6. Setting limits or boundaries when necessary:
 - i. Misguided gratification may lead to them becoming more insatiable.
 - ii. Distinguish between "libidinal demands" or "wants" (e.g. hugs, extended sessions, round-the-clock availability) and "growth needs" (e.g. support and confirmation, but also the setting of limits) a distinction drawn by Casement.¹⁶ Growth needs require being attended to.¹⁶
7. Establishing and maintaining the therapeutic alliance:
 - i. Tolerate being seen as the rescuer and at times again as an adversary.
 - ii. Bringing the patient back to the goals of therapy might help.
8. Managing splitting between psychotherapy and pharmacotherapy, addressing the split of seeing the one as all good and the other as bad. If two different clinicians provide pharmacotherapy and psychotherapy the danger of splitting is even greater. Regular communication between the two clinicians is needed in such a situation.
9. Monitoring countertransference. It can be helpful to voice it in a controlled way, e.g.: "I get the feeling that you are trying to make me angry at you instead of letting me help you. Let's see if we can understand what's happening here" (p. 463).

SUICIDE THREATS AND RISK

Kernberg states that chronic suicide threats are unavoidable and a serious risk.¹⁷ According to him such threats are not a reflection of a depressive illness, but rather deeply rooted in a characterological predisposition. Suicide cannot be prevented nor predicted and long-term hospitalization provides an illusion of safety. He writes that psychotherapeutic help, which is preferable to long-term hospitalization, can only be provided if patient and relatives accept the risk that the patient may end up committing suicide. He thus considers it essential that a general contract is drawn up, a written record of full communication of risks and acceptance of these risks by the family, even a letter of understanding with patient and family may be necessary.¹⁷

According to Gabbard it is a mistake to try and demonstrate caring through heroic measures to save the patient.⁵ He mentions as an example a therapist who ended up seeing a patient seven times per week. Such action might result in the patient exercising omnipotent control over the therapist. Here the

PERSONALITY DISORDER

therapist takes full responsibility for the patient's survival instead of allowing the patient to accept most of the responsibility – which is an imperative. Gabbard states that it should be made clear what the limits of the therapist are, that the therapist is not an omnipotent rescuer, and that at times hospitalization might be needed.

McWilliams also gives valuable advice about suicide threats by borderlines.¹⁰ She writes that borderlines talk suicide not when they want to die, but when they feel “abandonment depression”, a term coined by Masterson.¹⁸ Borderlines want you to care about how bad they feel, having often learned that no-one pays attention unless you threaten mayhem.

Standard crisis intervention, in this situation, can be counter-therapeutic, since they want to talk about the context, not the content of the threat. Important is to respond to the painful affect behind the threat, rather than just doing a suicide risk assessment. Borderlines also flirt with suicide when there is in the therapy the real hope of change; this is done as a defence against the fear of again being devastatingly disappointed.¹⁰

HOSPITALIZATION

Hospitalization could either be long-term inpatient or day-patient treatment, or otherwise outpatient psychotherapy and only brief admissions during a crisis.⁵ The limits and boundaries provided by the hospital provide external substitutes for missing intrapsychic structures. A firm, consistent structure, a regular schedule, predictable pattern of meetings, clear consequences for impulsive acting-out and taking responsibility for self-control should all be part of the programme.⁵ Limit setting should be done in an empathic way and limits and boundaries should not be seen as punishments, but as cardinal features of providing a structure as already mentioned. Staff provide a secure base, they provide auxiliary ego functions, a holding environment and containment for intense affects.

It is interesting that lengthy on demand sessions with nursing staff leads to patients deteriorating in direct proportion to the amount of time spent in these one-to-one “therapy” sessions. Borderlines do better with brief meetings with nursing staff built into the regular structure.⁵

Borderline patients can disrupt units by externalizing their internal chaos.⁵ They recreate with staff members their inner conflicts and their old, established, conflicted patterns of relations. Countertransference reactions are thus a prominent phenomenon with these patients. If countertransference hatred and anger is denied, it will be communicated non-verbally.

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An accepting attitude towards staff is needed in which they can voice and discuss their emotional reactions to patients within the security provided by the treatment team. Furthermore, it can help staff to differentiate between having feelings and acting on them. Group processes have thus to be monitored on every psychiatric unit with frequent staff meetings.

FAMILY AND GROUP THERAPY

WORK WITH THE FAMILY IS OFTEN ESSENTIAL. IMPORTANT IS TO IDENTIFY THE ROLE OF THE FAMILY IN THE PATHOGENESIS AND MAINTENANCE OF THE PATIENT'S PATHOLOGY AND TO HELP THE FAMILY DEAL WITH CHANGE. PSYCHOEDUCATION AND SUPPORT OF THE FAMILY IS NEEDED, AS WELL AS AVOIDING SIDING WITH THE PATIENT'S VILIFICATION OF THE PARENTS.⁵

Group therapy may be a beneficial adjunct to individual therapy and forms part of DBT and MBT.

CONCLUSION

With the emergence of the generalist model the treatment of many patients suffering from BPD has moved out of the domain of the specialist psychotherapist into the domain of the general psychiatrist. The focus in this model is on a psychosocial approach in which medication and other interventions are flexibly integrated.

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COMMENTARY

Caroline Serebro

“People with BPD are like people with third degree burns over 90% of their bodies. Lacking emotional skin, they feel agony at the slightest touch or movement.” - Dr. Marsha Linehan

In the article Management of Borderline Personality Disorder by General Psychiatrists, Professor Manfred Böhmer provides a highly informative and practical approach to managing borderline patients. It is reassuring and affirming to hear from a senior colleague that interventions in this challenging and important group of patients can be thought of and managed with thoughtfulness and compassion.

As highlighted by McWilliams, most DSM personality disorders will most likely be in the borderline range of personality organization. A sizeable portion of these patients will not fulfill the DSM 5 diagnostic criteria fully hence their symptoms will easily be dismissed as part of another disorder such as major depressive disorder or bipolar disorder.

Professor Böhmer emphasises the infamous borderline pejorative and appeals to us as clinicians to move beyond the labeling and pervasive negative assumptions that hang like a dead weight around these patients' necks, where their behaviour is perceived as both deliberate and manipulative.



Caroline Serebro

Instead, there is a call for empathy and an emphasis on the need for keeping boundaries. There is also a reminder about the risk of over identifying with these patients and the pitfalls thereof. He describes the familiar sense of feeling quite overwhelmed by these patients and how we can act out in ways that are punishing towards them.

Of note is the discussion around use of psychotropic medication and its somewhat limited role in the treatment of BPD. A valuable point is the reminder to acknowledge previous trauma and genetic history.

This is an important paper especially for a junior clinician like myself who has a fervent interest in this group of patients and is often looking for an effective strategy to improve patients' quality of life.

burns over 90% of their bodies.
Lacking emotional skin, they
feel agony at the slightest
touch or movement.”

Caroline Serebro is a psychiatrist who trained at the University of the Witwatersrand. Having obtained her MBChB in 2001 she spent time working in general practice and in the pharmaceutical industry before returning to specialise in psychiatry. She obtained her FC Psych (SA) in 2017 and is currently working on her MMed that focuses on outpatient DBT at Tara Hospital.

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CONSULTATION LIAISON PSYCHIATRY

CONTRIBUTING TO HOLISTIC & COLLABORATIVE PRACTICE

Nazeema Ariefdien

Consultation Liaison Psychiatry (CLP), sometimes called psychosomatic medicine, is a sub-specialty of Psychiatry which incorporates clinical service, teaching and research at the point of integration of Psychiatry and Medicine.¹

While exploring the concept of psychosomatic relationships - i.e. the role of emotions and psychological stress in the genesis and maintenance of organic diseases, CLP has also become the interface of interaction and communication between Psychiatry and other medical specialties. The psychosomatic approach purports that health and disease is a result of the interaction of biological, psychological and social factors with a focus on individuals whose psychiatric illness stem from physical illness and disability or who communicate their distress in terms of somatic symptoms.¹

THE ROLE OF THE CL PSYCHIATRIST IS OFTEN TO INTEGRATE A COMPREHENSIVE HEALTHCARE APPROACH WHEN OTHER HEALTH CARE PROFESSIONALS ARE BECOMING INCREASINGLY SPECIALIZED AND WILLING TO ONLY DEAL WITH A CIRCUMSCRIBED SEGMENT OF A PATIENT'S HEALTH.



Nazeema Ariefdien

“Consultation” implies providing an expert diagnostic opinion and management approach to the referrer of a patient, while “liaison” suggests collaborative work, not just with the referring clinician but also with the patient, their family and other involved health care workers. However, relationships with other disciplines are often

marred by indifference, ambivalence and either covert or overt hostility. Advice by the CLP clinician may, for example, be acknowledged but not acted on, patients are often referred without notification or adequate work up, or are even prematurely discharged before completion of assessment or implementation of management. Building healthy, respectful and valued relationships with other disciplines is paramount to establishing an effective CLP team and producing the best outcomes for the patient.

DEVELOPMENT

Since the 1920's Psychiatry and CLP has increasingly become established in general hospitals as more hospitals opened psychiatric units. Historically, Weissman and Hackett's work in 1958 on the development of delirium following cataract surgery due to sensory deprivation and immobilization resulted in important changes in post-operative management.² The observation in 1965 by Kornfeld et al., of delirium occurring after open-heart surgery led to the term "intensive care unit (ICU) psychosis". This unfortunately resulted in most deliriums in the ICU being attributed to procedural and environmental causes, ignoring potential underlying medical conditions.³ Work was also focused on pre-operative evaluation, e.g. the prediction of adherence to post-operative immunosuppressive treatment.

Early work by Abrams,⁴ and Sayag et al.,⁵ amongst others, pioneered work in psycho-nephrology - the systemic study of the psychiatric effects of renal dialysis and kidney transplants. Schapiro et al., determined the following factors as negative predictors of non-adherence i.e. co morbid substance abuse, personality disorders, lower socio-economic status, "global psychosocial risk".⁶ Frasure Smith et al., concluded that patients who suffered a myocardial infarct and were depressed were 3-4 times more likely to demise within the first year.⁷ Morris et al., whose study determined higher mortality in post stroke patients with co-morbid depression resulted in prophylactic prescription of antidepressants in many rehabilitation centers.⁸

The psychiatric complications of many commonly used medications have been well documented. For example, interferon use in the treatment of Hepatitis C, multiple sclerosis and melanoma, is a common cause of depression. So too are some commonly prescribed anti-hypertensives.

Steroids are commonly associated with affective and psychotic disorders. Ongoing research into the psycho-physiological responses of the body to psychosocial stress has given further credibility to CLP, paving the road to improved collaborative work between different clinical departments.

AS CLP HAS BEEN PRACTICED IN SOUTH AFRICAN CLINICAL SETTINGS FOR DECADES AND HAS BEEN PART OF THE CLINICAL ROTATIONS OF MOST PSYCHIATRISTS TRAINED IN OUR ACUTE HOSPITALS, CLP HAS BEEN MOTIVATED AS A FORMAL SUBSPECIALTY BY THE SOUTH AFRICAN COLLEGE OF PSYCHIATRISTS, WHILE IT IS ALREADY OFFERED AS AN MPHIL COURSE BY THE UNIVERSITY OF CAPE TOWN.

Some delays, however, for its official approval as a sub-specialty by the Health Professions Council of South Africa, seems to be continuing. Its eventual approval will be lagging by at least a decade in comparison to the USA and some European countries, as the American Board of Specialties already approved psychosomatic medicine as the seventh sub-specialty in Psychiatry in 2003.⁹

REASONS FOR REFERRAL TO CLP

There does not seem to be one single source of referral and the reasons for referral for psychiatric consultations are manifold, including:

1. Evaluation of a patient with a suspected psychiatric disorder, a known psychiatric history or on psychotropic medication.
2. Evaluation of an acutely agitated patient.
3. Evaluation of risks and presence of psychiatric pathology in acutely suicidal or homicidal patients.
4. Evaluation of patients who may be at high risk of developing a psychiatric disorder due to either a serious medical condition or treatment thereof.
5. Evaluations of capacity or other medicolegal situations (e.g. genetic counselling and end-of-life decisions).
6. Evaluations of patients with known or suspected substance abuse issues.
7. Evaluation of patients who request to be seen.

In terms of capacity assessment, the question posed to the CLP clinician is often "does the patient have the mental capacity to sign out against hospital advice"? The expectation is usually for the psychiatrist to rubberstamp a "legal discharge" or hold the patient against their wishes.

QUITE OFTEN THE REFERRER HAS NOT ATTEMPTED TO ASCERTAIN THE REASON BEHIND THE PATIENT MAKING A POTENTIALLY SELF-DESTRUCTIVE DECISION THAT MAY SEEM HIGHLY IRRATIONAL.

It is up to the CL psychiatrist to determine the numerous possible reasons for such behavior, ranging from anger, anxiety, psychosis or cognitive impairment due to delirium or dementia.¹⁰

The Academy of Psychosomatic Medicine Practice has issued Guidelines for Psychiatric Consultation in the General Medical Setting, with noted problems that commonly lead to requests for psychiatric

consultation in the medical/surgical setting, while also listing a set of required skills (Table 1).¹¹

Required skills for the evaluation and treatment of patients with psychiatric disorders in the general medical setting.¹¹

1. Ability to take a medical-psychiatric history
2. Ability to recognize and categorize symptoms
3. Ability to assess neurological dysfunction
4. Ability to assess the risk of suicide
5. Ability to assess medication effects and drug-drug interactions
6. Ability to know when to order and how to interpret psychological testing
7. Ability to assess interpersonal and family issues
8. Ability to recognize and manage hospital stressors
9. Ability to place the course of hospitalization and treatment in perspective
10. Ability to formulate multiaxial diagnoses
11. Ability to perform psychotherapy
12. Ability to prescribe and manage psychopharmacological agents
13. Ability to assess and manage agitation
14. Ability to assess and manage pain
15. Ability to administer drug detoxification protocols
16. Ability to make medicolegal determinations
17. Ability to apply ethical decisions
18. Ability to apply systems theory and resolve conflicts
19. Ability to initiate transfers to a psychiatry service
20. Ability to assist with disposition planning

Table 1.

TRAINING, A PERSONAL REFLECTION

In the United Kingdom, the Advanced Course in Liaison Psychiatry, coordinated by Prof Elsie Guthrie, Professor of Psychological Medicine and Medical Psychotherapy at the Manchester Royal Infirmary, is an example of structured training offered to medical health professionals involved in the field.

The course content was aimed at providing an overview of common conditions faced by CLP staff, challenges they may experience, information on how to set up a CLP service and the cost effectiveness of such a team. An additional benefit was to provide a platform for international collaborative work amongst CL specialists. The author attended this course in 2016.

Apparent from the Manchester course is that not only does the CLP specialist require a solid foundation in all Psychiatric disciplines (Neuropsychiatry, Old-Age psychiatry, etc.), but also needs to be reasonably knowledgeable about most common general medical conditions.

A strong emphasis was, however, placed on the assessment and management of medically unexplained symptoms/somatisation and somatoform disorders. One of the driving forces behind this was to reduce the costs associated with the frequent use of emergency room and general practitioner consultations for purely functional conditions.

AS A RESULT, A LARGE COMPONENT OF AVAILABLE RESOURCES WERE ALLOCATED TO PROVIDING COUNSELLING AND PSYCHOTHERAPEUTIC INTERVENTIONS. THIS WAS AIMED AT ASSISTING PATIENTS IN REFRAMING AND REATTRIBUTING THEIR PRESENTING PHYSICAL HEALTH SYMPTOMS WITH A MORE PSYCHOLOGICALLY ACCEPTABLE MODEL.

Larger inner-city centers however provide a more comprehensive service akin to our own current models of CLP. The clinical focus of a training course in a South African setting may necessarily differ from those abroad, while the structuring of a CL service largely depends on the needs of the community being served.

These may vary from providing sessional input to a specialist unit (e.g. cardiology, oncology or stroke rehabilitation), or being based full-time in a general hospital, providing services for all units especially emergency medicine departments.

LI A I S O N

WHY SHOULD WE INVEST IN CLP SERVICES IN AN ALREADY RESOURCE RESTRAINED MILIEU?

The cost of inpatient care is the most expensive form of medical care. Wancata et al., in a prospective study of 993 patients admitted to two general hospitals, concluded that co-morbid psychiatric diagnosis increased these patients' hospital stay.¹²

THIS APPLIED MAINLY TO PATIENTS WITH DEMENTIA, SUBSTANCE ABUSE AND RELATED DISORDERS. OTHER STUDIES ALSO SHOWED AN INCREASE IN THE LENGTH OF STAY (LOS) ASSOCIATED WITH DEPRESSION AND ANXIETY. SARAVAY ET AL., CRITICALLY REVIEWED 26 OUTCOME STUDIES ON THE IMPACT OF PSYCHIATRIC CO-MORBIDITY ON LOS FOR MEDICAL AND SURGICAL PATIENTS.¹³

They concluded that impaired cognition due to either delirium or dementia, depression and personality factors - not only increased the LOS, but also resulted in greater use of hospital and other health services after discharge. Wancata et al., noted in their report that in general medical wards, approximately 30% of patients had a psychiatric disorder.¹²

Delirium was as common as 10% in all medical inpatients and as high as 30% in at risk groups.¹² They noted that frequent users of medical care facilities in their study have been shown to commonly have co-morbid psychiatric conditions as well: e.g. 23% with depression, 22% with anxiety and 20% with somatization.¹²

Many of these patients' co-morbidity was missed, resulting in a heavy burden on health care providers. CLP services can result in the improved early detection and intervention in these situation, with a reduction in financial costs and a better quality of care.

The article was peer reviewed with suggested changes incorporated into the final version rather than an accompanying commentary.

Nazeema Ariefdien is a consultant psychiatrist in the Department of Psychiatry at Charlotte Maxeke Johannesburg Academic Hospital where she is responsible for the Consultation Liaison services. She is jointly appointed in the Department of Psychiatry, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa. Dr Ariefdien obtained her MB BCh at the University of the Witwatersrand where she also completed her postgraduate Fellowship (FC Psych SA) in 2003. Following this she spent seven years in the UK, predominantly working in London, expanding her knowledge of the various sub disciplines in psychiatry and was actively involved in the training of junior doctors. On return to SA in 2011, she spent a year in forensic psychiatry at Sterkfontein hospital but is now mainly focused on Consultation Liaison psychiatry which she has been practicing at Charlotte Maxeke Johannesburg Hospital since 2012. She remains dedicated to the training of medical students and trainee doctors and more recently is actively involved in research, collaborating with other medical disciplines.

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CONCLUSION

THE RECENT MOTIVATION OF CLP AS A SUBSPECIALTY IN PSYCHIATRY HAS PROVIDED US WITH AN OPPORTUNITY TO FURTHER DISPEL THE MYTH THAT PSYCHIATRY IS A SEPARATE ENTITY FROM MEDICINE BY ALLOWING US TO MANAGE PATIENTS HOLISTICALLY IN COLLABORATION WITH OUR COLLEAGUES. WE ARE UNIQUELY PLACED TO RAISE AWARENESS OF THE INTERACTIONS OF THE MIND AND BODY IN THE PROMOTION OF OVERALL HEALTH & WELLBEING AND AS SUCH, PROVIDING BETTER QUALITY OF CARE FOR OUR PATIENTS WHILE AT THE SAME TIME REDUCING COSTS IN AN ALREADY RESOURCE CONSTRAINED ENVIRONMENT.

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CONCENTRIC CIRCLES OF CONCERN

WORKING WITH THE AFTERMATH OF COMPROMISED PARENTING - PART II

Edited by Melanie J Esterhuizen & Megan Jones

Contributors: Anna Schmidt-Ehmke, Mary-Ann Tandy, Nicki Dawson, Katherine Bain, Vossie Goosen, Bruce Laing, Anele Honono, Renilla Singh, Katharine Frost, Irene Chait, David Hadley, Jonathan Percalle

Ububele Educational and Psychotherapy Trust, JPCCC (Johannesburg Parent and Child Counselling Centre), and Tara Hospital's Psychology Department hosted the fourth annual conference on 14 October 2016, exploring therapeutic work with children in the aftermath of compromised parenting. Following on from Part I featured in *South African Psychiatry* - May 2017 issue - herewith the 3rd and 4th papers together with content from the closing plenary.

UNEXPECTEDLY BECOMING A PARENT

Vossie Goosen

An adolescent boy orphaned by AIDS, left to the care of two dads who became parents unexpectedly. The dads/guardians have to contend with difficult early histories which left this young person learning disordered and in need of a number of interventions. The therapist and presenter hoped to tease out how, in a context of compromised development and parenting, it is necessary to keep supporting the parental figures while keeping the adolescents' therapy space safe and confidential. This case describes the process of T's 5-year therapy with Vossie Goosen.

Vossie describes T's therapeutic process as 'quiet' ... 'a preserved but hidden, private self whose five year therapy took place mostly in silence.' It began in April 2011 when T was 13 years old. He was brought to therapy by his two dads (B & M). They are a gay couple. T's presenting problem was described as



Megan Jones



Melanie Esterhuizen

'anxiety affecting his school performance.' T's mother was B & M's domestic worker who died when T was 5 years old. T's father was a fitter and turner and died 2 years later when he was 7 years old.

T initially lived in B & M's outbuildings with his 15 year old brother. Eventually, B & M brought him in to the home. From 0 to 18 months T was with his mother. From 18 months to 3 years he lived with his grandmother. After 3 years he came back to his mother and was with her until she died. Not only did T lose his mother at the breast, but again later when she died.

B&M run their own business from home. M lost his mother at 5 years of age too. He came from a very conservative Afrikaans family. T has kicked B&M into looking at their own childhood. B has a close relationship with his older sister. In her paper, Vossie describes T's therapy as engaged and alive despite the silence like the effective silent protests of the

four young women for Kwezi when president Jacob Zuma announced the 2016 local election results, and like that of the so-called sign language interpreter at the memorial service of former president Nelson Mandela: these messages could not be missed (the sign language interpreter finally received help for his psychiatric illness after the whole world witnessed the gibberish he made of the translation).

She describes trauma as being jolting, ear shattering, staccato. Vossie juxtaposed the adolescent's silence with his guardian's insistence that he speaks in his therapy and their loud protests to what they regarded as infringements by myself and the adolescent. Vossie described how T would build with Lego in the sessions, his hands moving constantly, expressing his feelings, including his grief for his orphaned self and for his parents who both died of Aids-related diseases. It brought to mind not knowing what you are building, being able to freely associate, to trust the process to hold something from the early pre-verbal stage. She speculated that T was perhaps trained into silence being the child of a domestic worker in B&M's house. B&M remained suspicious of Vossie's idea of elective mutism, saying that 'he talks so easily at home.' She is aware that what is said could be felt as missiles or weapons. Vossie speculates that T's silence may also be about being afraid of his anger. T does not want to lose B&M, or Vossie. Vossie sometimes witnesses a tear in T's eyes... his grief is always silent and his tears single and somewhat imperceptible. Vossie shares a poem which she associates to T's tears and her own father and T's unconscious longing for his mother.

'OH TUNE WITH GRIEF LADEN,
ON THE EAST WIND'S DRONE,
LIKE THE SONG OF A MAIDEN,
IN HER LOVE MADE ALONE.
IN EACH GRASS BLADE'S FOLD,
A DROP OF DEW GLEAMS BOLD,
AND IT PALES QUICKLY TO FROST
IN THE COLD'
(EUGENE MARAIS 1871-1936)

In his play, Vossie describes how T constructs a wall between two parties, often this is used as a support for figures in his play, sometimes to balance themselves. Vossie talks about how she experiences T as saving his power inside himself. She shares an association and excerpt from 'Burning Memory' by Professor Njabulo Ndebele:

MY FEAR OF "WHITE" PEOPLE, NO MATTER HOW ECONOMICALLY OR MILITARILY POWERFUL THEY MAY HAVE BEEN WAS REPLACED BY AN ENORMOUS SENSE OF INNER POSSIBILITY AND POWER WHICH DID NOT IN ANY WAY MINIMISE THE BRUTAL REALITY OF WHAT COULD HAPPEN TO ME WERE I TO FALL INTO THE HANDS OF THE "WHITE" SYSTEM, AS STEVE BIKO

DID. DESPITE THE OVERT POWER OF THE RACIALLY OPPRESSIVE SYSTEM, THERE WAS SOMETHING IN ME BEYOND ITS REACH.

This alludes perhaps to T's parts of the self which are kept protected. It may also talk to parents and therapists who hide parts of themselves, suggesting that we were all also compromised as children. Vossie suggests that if the therapist and guardians can put themselves in the adolescent's shoes and consider how compromised he as a child is as a result, they might assist rather than hinder the emergence of the private self. She suggests after all the therapist and guardians were all compromised as children and hid their private selves – as a result of apartheid, with regards to their sexual orientation.

Vossie talks about the difficulty T has in having the confrontation about him leaving school work unattended. T appears to try hard to interpret what the adults want. Vossie in her therapeutic role tried to interpret and translate what she heard. She often felt unable to carry what she sees and this left her feeling useless and inadequate.

T APPEARS TO SEARCH FOR LANGUAGE FOR HIS EXPERIENCE. AFTER SOME TIME HE USES THE PHRASE 'I AM EXCAVATING.' VOSSIE DESCRIBES HOW SHE FEELS HE DOES NOT WANT TO TELL HER AND THAT SHE MUST BE VERY PATIENT. SHE SHARES AN ASSOCIATION TO THE IDEA OF RESISTANCE AND PROTEST REGARDING KINKY, CURLY HAIR WHICH CAN BE SEEN AS A TOOL OF RESISTANCE DESPITE SO CALLED 'POST RACIAL COLOUR BLIND THINKING.'

The idea that adopted children be able to express their anger towards their parents was emphasized. There is also, Vossie Goosen suggests, a South African custom of keeping adopted children in therapy as a form of surrogacy, that Psychologists are absorbed as volunteer parents. This may result in disempowering the parents. Vossie believes T was ready to end psychotherapy as he has 2 dads who care for him very deeply.

Bruce Laing, Clinical Psychologist in Private Practice was chair for Vossie Goosen's presentation and raised the following important issues:

Bruce raised the idea of the therapist's vulnerability when dealing with the pain of a lost parent, or an unwilling parent and their own experience of being a parent. He reflected on how T's loss was experienced through his play which had a profound impact on his individual subjectivity. Bruce reminded us of the quote by Eli Wiesel... 'I have many things to say then... I watched helplessly as language became an obstacle.' Within the idea of finding a language for pain is the issue of race which is present in this presentation as it is in all the cases presented. Are the parents adopting

out of altruism? Is it a liberalist response to a social problem? Is it unconscious guilt? Is it the psychic fallout of unconscious resentment acted out? We cannot generalise about the reasons individuals choose to adopt a child, but we do need to think about it. This case also raises the issues of gay parenthood and the history of homophobia in psychoanalytic thinking and theory. How does the heteronormative therapist manage the reality of not having an actual mother? Can the real breast become a symbolic breast and can paternal and maternal functions be performed by one individual?

QUESTIONS WERE RAISED BY THE AUDIENCE WANTING TO KNOW TO WHAT EXTENT T WAS GIVEN A CHOICE REGARDING HIS ADOPTION. ISSUES OF GUILT, COLONISATION AND OWNERSHIP WERE RAISED. T'S 'CHOICE' TO USE ENGLISH TO COMMUNICATE WITH HIS SIBLINGS WAS QUESTIONED. CONCERN ABOUT HOW HE WOULD KEEP CONTACT WITH HIS SEPEDI/TSONGO ROOTS WAS EXPRESSED. THE CONVERSATION GRADUALLY MOVED FROM THE 'CHILD IN THE FAMILY' TO THE POLITICAL AND BROADER ISSUES IN SOUTH AFRICAN SOCIETY.

Vossie Goosen is a clinical psychologist in private practice with an abiding interest in working with families. She is and has been a member of several psychology groups and trainings and is a past chairperson of the Johannesburg Association for Child Psychotherapy. Having been a journalist and editor of publications in NGOs before becoming a psychologist, she is currently involved also in writing up relevant therapy issues and cases.

MADAM AND EVE AND THE FORGOTTEN CHILDREN

Renilla Singh (Social Worker) & Anele Honolo (Clinical Psychologist)

This case presents a glimpse of a historic South African racial and socio-economic hierarchy and the influence of the madam-and-helper relationship on the lives of those involved. Renilla Singh (Social Worker) and Anele Honolo (Clinical Psychologist) presented the case of a 19-year-old boy who had been in the unfortunate position of growing up with a caring, but absent mother who was more involved in caring for her employer's family than for her own. Marked with a history of an abusive relationship between his parents, we find a young man who has not had enough care and attention from his mother and who has grown up with compromised ability to think and make sense of his experience. This has resulted in his resorting to big displays of emotional and behavioural dysregulation to gain any kind of involvement from others. This case also presents the complicated dynamic of an overinvolved

employer, who controls and on some level "blackmails" her employee with her ability to help her financially, and two mothers who on some level are both more involved with the other's child than with their own.

T was admitted to Tara Hospital's adolescent unit after multiple parasuicide attempts. His mother was seen by Social Worker, Renilla Singh for parental counselling, and clinical psychologist Anele Honolo saw T for individual therapy. T was 5 years old when his parents divorced. His father was physically and emotionally abusive and has made little financial contribution to T's upkeep over the years. T has no relationship with his father and did not want him to know that he had been hospitalized. Before becoming ill, T's was described by his mother as quiet, cooperative, withdrawn young man who was a good student and sportsman and well-liked by his teachers and peers. During his childhood, T's elder half-brother died. There appears to have been little consideration for T's feelings at the time. At the end of the previous year, T's elder half-sister committed suicide. He was not able to attend the funeral as he was writing exams. After his sister's suicide, he started to withdraw, had less energy and he would disappear overnight and threaten suicide. He said he wanted to keep walking and never return. He was eventually suspended from school because of multiple threatened suicide attempts, after which he attempted suicide for the first time.

In sessions, T's mom was thoughtful, soft and gentle, but also somewhat subservient and deferential. She provided the facts which she felt had led to T's deterioration in functioning which included his half-brother's death, his half-sister's suicide, T's breakup with his girlfriend of many years and the absence of T's father in his life.

WHAT SLOWLY BECAME CLEARER WAS T'S MOM'S COMPLICATED RELATIONSHIP WITH HER EMPLOYER. T'S MOM WAS A DOMESTIC WORKER AND HER EMPLOYERS RELIED HEAVILY ON HER TO TAKE CARE OF THEIR CHILDREN. HER LIFE CONSISTED OF VERY EARLY MORNINGS, OFTEN WORKING LATE INTO THE EVENING, AND WORKING ON PUBLIC HOLIDAYS – OVERTIME WAS SELDOM REMUNERATED. IT FELT LIKE HER WORK ENVIRONMENT WAS A BLATANT ABUSE OF HER HUMAN RIGHTS.

When Mom fell pregnant with T's younger sibling, her employer took her to hospital for a termination of pregnancy. Her employer stormed out when she finally stood up for herself and said 'no' to the termination.

The employer would pay T's mother's rent, her transport and school fees for the children. She reported feeling beholden to her employer. T's mother described her employers' marital relationship as being full of conflict and that their adolescent son had behavioural problems. She was often called on to babysit this son who was destructive, had fits of rage and once broke

T's mother's hand. T's family has paid a high price for his mother's commitment to her employers' family's welfare. T's mother said she had thought of looking for a new job, but her employer refuses to give her a reference.

T has had to take on a parenting role to his two younger half-siblings, both of whom have learning difficulties. T is aware of his mother's work difficulties and knows that her employer relies heavily on his mother. His mother's employers are a mixture of benevolent and malevolent. T has run away from home twice. His mother was terrified and her employers have twice accompanied his mother in search for T.

Communication between T and his mother is difficult and she finds it hard to understand him. She has supported his admission to Tara as she had started to recognize the pattern of his behaviour. T's mom has been diagnosed with Major Depressive Disorder and is on medication and has been placed on the waiting list for therapy. T's mother's employer has accompanied her to two sessions, where they were able to acknowledge that their family added extra pressure to T's mom.

In individual sessions, T was open to therapy which was initially supportive in nature. When exploring the events which lead to his admission, T admitted being fearful of losing his loved ones. He was depressed and angry and his acting out behaviours had become predictable. He would slash his forearms and on one occasion took a rope to the park. When he ran away he would walk for long distances and sleep overnight at garages.

HE SEEMED TO OPERATE FROM THE PREMISE THAT UNLESS HE DID SOMETHING BIG, HE WOULD NOT BE SEEN OR NOTICED. HIS PARASUICIDES APPEARED TO BE ANGRY GESTURES DRIVEN BY HIS SHAME AND HIS LACK OF AN INTERNAL SCAFFOLDING TO MAKE SENSE OF HIS TROUBLING EMOTIONAL EXPERIENCES. HIS EMOTIONS MOVED FROM DESPAIR TO OMNIPOTENT DEFENSE. HE FELT INACCESSIBLE.

During group sessions, T was passive aggressive, oscillating between raging and being withholding. He was very aware of race and socio-economic disparities - he had always experienced his white peers and his mother's employers' son as racist. He had a love/hate relationship with his mother's employers.

T's disadvantage was the absence of caregivers with accessible and available minds. He displayed a profound lack of insight into his emotional world and was very angry about many things.

Anele reflected on the importance of the mental health team as critical when trying to make sense of the case. One of the team members who had seen T briefly reported how he had said to her that 'If I get angry I would kill people, so I must rather kill myself.'

Katharine Frost, Educational Psychologist and CEO of Ububele was chair for the above presentation and raised the following issues:

HOW DO WE TRY TO STRIKE THE BALANCE WHICH DAVID MADE REFERENCE TO IN THE PREVIOUS PRESENTATION ABOUT KEEPING THE CHILD, KEEPING THE YOUNG PERSON AT THE CENTRE, WITHOUT BEING ABSORBED AND TAKEN AND FLOODED BY THE EXTERNAL EVENTS THAT WE ALL AS SOUTH AFRICANS FEEL SO VERY INTENSELY?

Katharine wondered if there was not something in both of the presenters' scripts that they mentioned over and over, referencing 'the team.' Katharine suggested that it sounded like 'the team' was and is, a critical part of trying to make sense of such a case, for all of us.

There were many thoughts offered by the audience after this final presentation. The expression of anger became a focus with reflections about T as an obedient, helpful young boy who after many unbearable losses began his attacks on himself. Where was his mother's anger? Did he carry it for her? The complexity of South African society was evident where interpersonal relationships have been damaged by racially defined power and opportunity differentials. With the anger and rage that burns in the country, therapists are exposed to enormous amounts of pain and anger, and we are called on to survive it, and not to retaliate, rationalize or intellectualize. There has been a perversion of attachment relationships and the victim-perpetrator dualism that exists in this case is recognized in the broader, macro societal system and within the micro family systems. Audience members suggested that unless we are able to hear the rage and survive it, we may not be able to prevent patients, like T, from escaping their unbearable and unmetabolized rage and pain, by killing themselves.

Renilla Singh is a social worker who graduated in 1989 with a BA Social Work (Hons) from the (then) University of Durban-Westville. She spent a few years working for NICRO (National Institute for Crime Prevention and the Rehabilitation of Offenders), then worked at Streetwise, an organisation working with street children. From 1993-1999 she worked at Johannesburg Child Welfare, in the adoptions department, first with birth parents considering adoption and then with prospective adoptive parents. After a break from working for a few years, she worked for four years at Impilo, an organization dealing with child protection and adoption services. She has now been at Tara Hospital for almost four years working in the child and adolescent teams.

Anele Honono is a Clinical Psychologist at Tara, the H. Moross Centre's Adolescent and Eating Disorders Units. She is family systems trained, and has a special interest in the impact of interpersonal relationships on mental health, especially among the adolescent population who are vulnerable to pathological family relationships because of their dependence on the family as their primary source of emotional and financial support. Anele is a member of the SAPI Intergenerational Transfer of Trauma Group.

CONCENTRIC CIRCLES OF CONCERN

FINAL PLENARY DISCUSSION

David Hadley requested that the discussion time be opened with a remembrance of the death of Bianca Warburton on this day 7 years ago. Bianca was a white Psychology intern working at Ububele in 2009. She was on her way to Alex Clinic to work when she was shot and killed by two young black men. During the court case, they confessed that it had been a mistake. David asked that the audience sit and reflect on how one expresses and finds a place for those things that have been perpetrated in the past, and find a way to think about managing those things that continue as an echo of the past. A quiet thought I had during this time was... what about the perpetrators? The two young black men and the trauma of their lives? Their rage? When thoughts were expressed after the period of remembrance, it was suggested that rage could be a gift... the rage that finds expression (not in killing) may give opportunities for dialogue.

David introduced an image from a paper on trauma work with asylum seekers in the UK. It was of a house with lots of doors and windows over which the patient had little control. Repeatedly, overwhelming experiences of traumatic events and losses are triggered and this is exacerbated by the uncertainties and fragility of the asylum seekers continuing existence. A multi-faceted intervention is needed to help regain a sense of agency and safety and David argued that a multidisciplinary team was often needed to take care of such a fractured and complex internal structure, in order to have control over what comes in and what is kept out. Layers of intervention, a range of people or approaches with different perspectives were needed to explore the system. One mode is not enough in order to engage issues with layers of meaning. One of the nurses in the audience commented on the rage and the pain that is embedded in layers of many complex things. He felt there was a need for continued and persistent cooperation in bringing different resources to help in moderation of that pain. He wished that it could be spread out to other team members, especially nurses. One of his colleagues supported this saying that there is a dire need for nurses to process their unbearable feelings as they sit with so much resentment, hatred, racial and many political issues that they need a space to process.

David commented saying that perhaps it is not just

Melanie Esterhuizen is a Clinical Psychologist and Baby Mat Practitioner working for the Department of Health in the Johannesburg Metro Community Clinics. Melanie worked for the Rahima Moosa Mother & Child Hospital for 5 years and then for the Ububele Educational and Psychotherapy Trust for 4 years where she managed the Mother-Baby Home Visiting Project in Alexander Township. She has trained and supervised professionals in Parent-Infant Psychotherapy. Her clinical work also focuses on adult, child and couple psychotherapy in the community clinics and in private practice. Her special interests also include psychoanalytically informed family and group psychotherapy. **Correspondence: mje.ububele@gmail.com**

Megan Jones is a clinical psychologist who works on the Adolescent and Eating Disorders Units at Tara Hospital. She runs a small, part-time private practice where she focuses on child psychotherapy and assessment.

about cooperating but also respect. People can be driven by the impact of work to disrespectful behaviour across disciplines, in the same way that nurses may not always be respected by colleagues in South Africa so, for example, psychiatry and a medical model can also be vilified or parodied. Though this is certainly something that occurs in the UK, there may be historical forces also at work here. Perhaps we need to think about ways in which teams can support one another.

One of the presenters reflected on the importance of surviving trauma, surviving something pre-verbal - not put into words. She reflected that containment often happens after the session with colleagues where things were talked about, cried about and digested so that the therapist could return to the patient intact.

A reflection was made regarding the heavy silences after the overwhelming material presented in the cases. Perhaps at times there was an anxiety that as South Africans we can each identify with both the victim and the perpetrator and how do we manage and process that.

A question was posed... How can we confront the employer inside each of us? It is so easy to see the vulnerable mother and child as victims, but if you identify so strongly with the vulnerable parts of your patients, you may miss the strong, resilient part of the story. We also often look for the bad outside of the family system. An important point was made about relational trauma and the history which goes with being a colonizer... we all have to hold something excruciating. The task is how do you bear unbearable pain and carry on thinking so that rage becomes productive and does not become despair or destructiveness?

And finally, it was suggested that these are all conversations which we need to have with each other and with ourselves. What it means to be white? What it means to be black? What it means to be a victim? What it means to be a perpetrator? These are difficult and painful questions, and even more difficult conversations to have. In the field of mental health, we have a responsibility to begin this process wherever we live and work? It is felt that this conference went some way toward beginning to think about the threats to effective, multidisciplinary teams working with a particular client base and the old hierarchies that can be imported if we do not remain vigilant.

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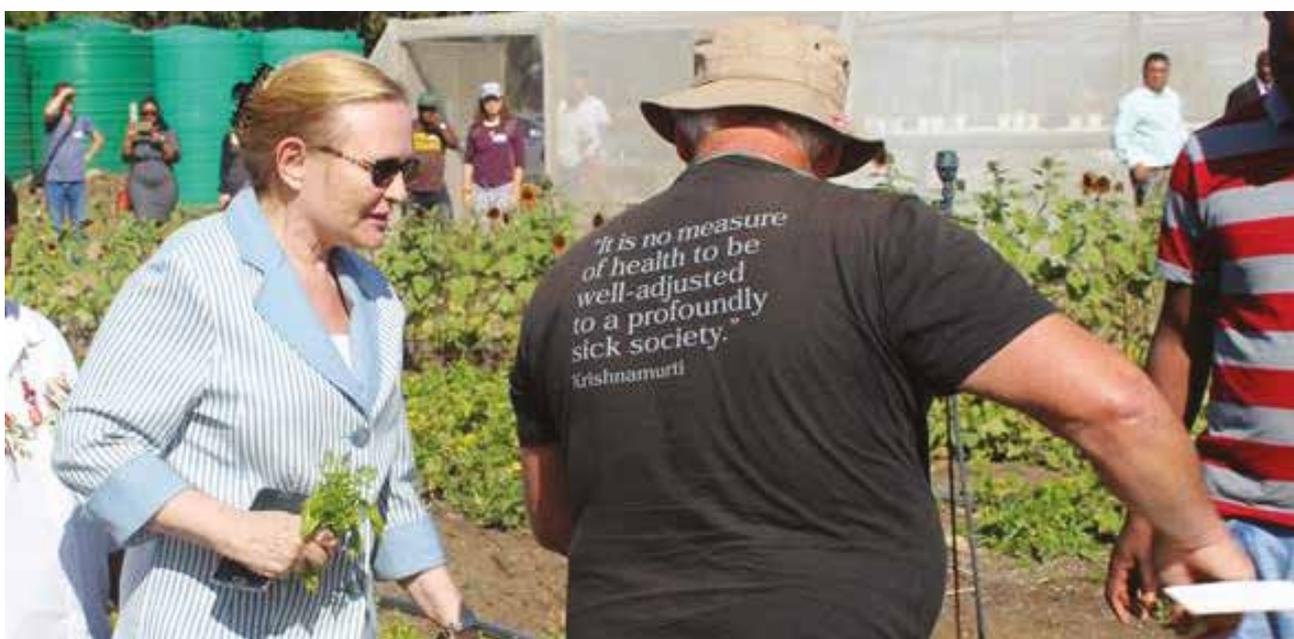
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JANSSEN CONTRIBUTION TO GARDENING INITIATIVE

HELPS REINTEGRATE PSYCHIATRIC PATIENTS INTO SOCIETY

Sheree van der Poll

On 25th April 2017, Janssen Pharmaceutica, together with the Spring Foundation and Lentegeur Hospital, celebrated the success of the Market Garden initiative, which aims to enable psychiatric patients to rediscover, reconnect and rebuild their mental and physical wellbeing through agricultural activities.



Western Cape Premier, Helen Zille

Being the first of its kind in the Western Cape, the Market Garden initiative uses organic farming techniques and borehole water for irrigation. The initiative is managed through a collaborative partnership with the Spring Foundation, a registered Non-profit Organisation (NPO) and Lentegeur Hospital.

Western Cape Premier Helen Zille delivered a keynote address at the event where she commended the initiative and reaffirmed the importance of reintegrating mental health patients into the community. In 2016 the Premier, through the South African Urban Food and Farming Trust, recognised the potential of the Market Garden and sponsored just under R745 000 to assist in developing the initiative.

“With the addition of other major sponsors, Janssen Pharmaceutica and The Rupert Foundation, the project has now expanded to a 1, 2ha organic vegetable and flower garden which provides hope and recovery to the patients and healthy food for the community,” explained Zille.

JANSSEN’S CONTRIBUTION TOWARDS THE INITIATIVE TOTALLED R600 000 IN 2016. THIS SUPPORT HAS HELPED TO EXPAND THE PSYCHOSOCIAL REHABILITATION INITIATIVES AT LENTEGEUR HOSPITAL, FOCUSED ON PROMOTING PERSONAL RECOVERY, SUCCESSFUL COMMUNITY INTEGRATION & SATISFACTORY QUALITY OF LIFE FOR PATIENTS AT THE FACILITY.

The Market Garden, which is part of psychosocial rehabilitation, is a form of ‘Green Therapy’, which aims to improve mental and physical wellbeing through voluntarily doing outdoor activities in nature.



Although a core group of 20 patients are involved on a regular basis, around 80 patients have benefited from being involved in the gardening activities since its inception in 2012. Patients receive practical, hands on training, and are actively involved in growing, harvesting, packaging, sustaining and marketing the garden's organic produce. This produce, which includes cauliflower, green beans and peas, beetroot, carrots, onions, tomatoes cabbage and potatoes, is sold via organic markets or directly to staff members and members of the public. Each patient is also paid a regulated stipend for their participation, and taught how to manage his/her money and to be financially responsible – necessary skills for reintegration.

Dr John Parker, Psychiatrist at Lentegeur Hospital and Director of the Spring Foundation, says that patients' participation in the garden has had a profound impact on their mental, physical and emotional wellbeing.

“OUR TEAM HAVE NOTICED THAT PATIENTS ARE MORE MOTIVATED, MORE EMOTIONALLY STABLE, AND HAVE SHOWN IMPROVED TEAMWORK AND INTERPERSONAL SKILLS. SOME OF THE OTHER KEY BENEFITS INCLUDE EDUCATIONAL DEVELOPMENT WHICH IMPROVES THE PROSPECTS OF FUTURE EMPLOYMENT AFTER DISCHARGE,” explains Parker.

Business Unit Director Diane Crossman says that as a multi-national pharma company, it has been rewarding and inspirational to be involved with the Spring Foundation Project. “It has been great to be able to partner with Lentegeur hospital, as well as with government; it's a good example of a public/private partnership,” says Diane. “This is a project where our involvement has enabled us to help the actual patient through participation in a programme, extending far beyond just our provision of medicines. To see how patients can reach their potential in this type of setting is just amazing. It makes working for J&J most meaningful.”

Diane goes on to thank Dr Parker for proactively reaching out for support:

“KUDOS TO DR JOHN PARKER FOR NEVER GIVING UP, AND STICKING WITH HIS DREAM!” says Diane.

“THROUGH OUR INVOLVEMENT IN THIS PROJECT WE HOPE TO ENCOURAGE OTHER BUSINESS AND THE COMMUNITY TO BECOME EVEN MORE INVOLVED.”

Should you be interested in partnering with the Spring Foundation you can contact Mariska Mabee on mariska@mitchellsplainlive.com or landline: 021 392 1747, Mobile: 073 669 1799.

Johnson & Johnson



Business Unit Director Diane Crossman

Sheree van der Poll, Senior Communications Specialist, Johnson & Johnson Sub-Saharan Africa.

Correspondence: svande46@its.jnj.com

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WPA NEWS

Official Quarterly News Bulletin of WPA

JULY 2017

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Message from the Secretary General



Dear Colleagues and Friends,

Happy to come back to you again! We had a very fruitful period of activities during the last three months. The major event during the period was the

WPA Inter Zonal Congress at Vilnius, Lithuania 3-6 May 2017. Theme: "Changing Society, Changing Psychiatry and Changing Self". Nearly 500 psychiatrists from 40 countries attended. WPA President Dinesh Bhugra presided. Part of the Congress was held in the Lithuanian Parliament. Minister of Health Aurelijus Veryga and EU Commissioner Vytenis Andriukaitis spoke at the Congress. Hearty congratulations to Alvydas Navickas and his committed team! The WPA Planning Committee met at Florence, Italy on March 31-April 1 chaired by WPA President-Elect Helen Herrman and discussed changes in WPA Statutes and By-Laws. My second visit to the WPA Secretariat, Geneva took place on April 8 and 9, 2017. We had useful planning on the arrangements for WPA Berlin Congress and discussions with Andrea and Steffi of CPO Hanser. Updates on our website and changing our old server to an offsite solution were also discussed.

The biggest event of the triennium is the World Congress of Psychiatry, October 8-12, 2017. Under the overall theme "Psychiatry of the 21st Century: Context, Controversies and Commitment". Visit www.wpaberlin2017.com. WPA has a strong presence in the social media now. Links to all social media accounts are incorporated in our website. Our Facebook page is <https://www.facebook.com/wpanet/>. Please visit our newly designed website www.wpanet.org and kindly send us your valuable comments.

Roy Abraham Kallivayalil
 Secretary General
 World Psychiatric Association

Message from the President

Dear Friends and Colleagues,

This is my penultimate message to you all as my term draws to a close.

Following the successful launch of **Bill of Rights** for Individuals with mental illness, a **Bill of Rights for children and young people** was also launched. I am delighted to report that it is being circulated. Please get your Association/Organisation to support both the Bills of Rights. These are available on WPA website. A Bill of Rights for individuals with intellectual disability is under preparation.

A survey of discrimination has been completed in Commonwealth countries and will be launched on the 3rd World Mind Matters Day on 4th September 2017. Details of the **international discrimination survey** were published in a special issue of *International Review of Psychiatry* volume 28(4). The contents are available online.

WPA-Lancet commission on Psychiatry report is complete. Copies of the report will be available in the World Congress in Berlin in October 2017.



Chapel Bridge: The Chapel Bridge is a 204 meter (670 foot) long bridge crossing the Reuss River in the city of Lucerne. It is the oldest wooden covered bridge in Europe, and one of main tourist attractions in Switzerland. The covered bridge, constructed in 1333, was designed to help protect the city of Lucerne from attacks. Inside the bridge are a series of paintings from the 17th century, depicting events from Lucerne's history. Much of the bridge, and the majority of these paintings, were destroyed in a fire in 1993, though it was quickly rebuilt.



Dinesh Bhugra

WPA Position Statements on *Homelessness and Mental Health* and *Mental Health in the Work Place* are ready and will be available shortly on the WPA website. Please look out for these on the WPA website.

Following two successful **round table meeting** on violent radicalisation (hosted by the WPA Collaborating Centre in London) and another one on early Interventions in Psychiatry (hosted by Hong Kong College of Psychiatrists) the papers from the former are being edited for a special edition of *International Review of Psychiatry*. A very successful Round Table on Migrant Mental Health in Europe was held in Oslo, Norway in March.

The work on setting up **Diploma in Psychological Medicine in collaboration with University of Melbourne** aimed at psychiatrists continues apace and we hope to launch it later this year. We are also working on the Diploma for non-psychiatrists.

We are continuing to look for examples of **good clinical practice** around the world so that we can learn from each other. Please keep them coming. Please check the website regularly and get involved. I look forward to seeing you all in the World Congress in Berlin.

I would like to take this opportunity to congratulate Prof Mario Maj for his stellar contribution to making World Psychiatry number 1 journal in the world

Best wishes,

Dinesh Bhugra, CBE
 President
 World Psychiatric Association

WPA NEWS

Official Quarterly News Bulletin of WPA



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JULY 2017

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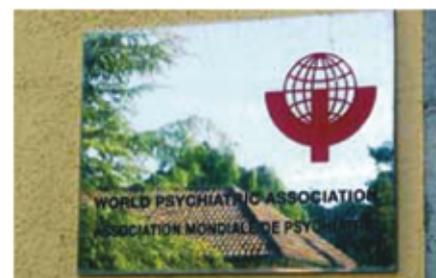
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The World Psychiatric Association (WPA)

The WPA is an association of national psychiatric societies, presently 140 (including two ad hoc associations), spanning 120 different countries and representing more than 200,000 psychiatrists.

The WPA organizes the World Congress of Psychiatry, International and Regional Congresses, and Thematic Conferences. With its 72 scientific sections, it promotes collaborative work in specific domains of psychiatry. It has developed ethical guidelines for psychiatric practice, including the Madrid Declaration.

Its website is currently visited from almost all countries across the world and the WPA News is widely disseminated. Various educational programmes and series of books had been produced including an E-Learning long distance programme. World Psychiatry, the WPA official journal, could be freely downloaded from PubMed Central and the WPA website (www.wpanet.org).



What are its Aims?

The core missions of the WPA include the following:

- To encourage the highest possible standards of clinical practice
- To increase knowledge and skills about mental disorders and how they can be prevented and treated
- To promote mental health
- To promote the highest possible ethical standards in psychiatric work
- To disseminate knowledge about evidence-based therapy and values based practice
- To be a voice for the dignity and human rights of the patients and their families, and to uphold the rights of psychiatrists
- To facilitate communication and assistance especially to societies who are isolated or whose members work in impoverished circumstances

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DEPARTMENTS OF PSYCHIATRY UNIVERSITY OF THE WITWATERSRAND



**MENTAL HEALTH FUN WALK FOR MANDELA DAY AT TARA
“6,7 KM IN 67 MINUTES”**



About 150 people gathered at Tara the H. Moross Centre on the 18th July 2017 to be part of the 6.7km fun walk for the International Mandela Day, an annual event celebrated globally.

In keeping with the values Mandela stood for, Tara, a public psychiatric hospital affiliated to the Department of Psychiatry, University of the Witwatersrand, brought together staff members, the local community, mental health organizations and colleagues from the Gauteng Department of Health to raise funds by walking 6.7km within 67 minutes. It is through registration that each participant made their donation which would be passed on to Ububele and the Talisman Foundation, mental health organisations which work within our community.

Celebrating Mandela Day is a tradition for Tara. The aim for this year was not only to engage the community but it was also to marry the concept

of physical health playing a role in mental health, as Madiba demonstrated through his boxing and general exercise regimes.

The Tara team would not have made it without the support and contributions from Old Mutual, SanlamSky, Liberty, Fruit & Veg Randburg, EDWIN CONSTRUCTION COMPANY and Hospersa. At the end of the walk many participants successfully completed the 6.7km walking distance.

“TAKE ACTION, INSPIRE CHANGE, MAKE EVERY DAY A MANDELA DAY” – NELSON MANDELA.

Ms Vuledzani Munzhelele is the Communications Officer, Department Of Health:Tara The H.Moross Hospital.
Correspondence: Munzhelele.vuledzani@gauteng.gov.za
Nondumiso Bikitsha and Dr Thebe Madigoe edited and provided comments.





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UNIVERSITY OF CAPE TOWN



DR EUGENE L DAVIDS POST-DOC



Post-doc included in Mail & Guardian 200 Young South Africans 2017. Dr Eugene L Davids, a post-doctoral research fellow from the Adolescent Health Research Unit (AHRU) in the Division of Child & Adolescent Psychiatry has been selected for inclusion in the 2017 Mail & Guardian list of top 200 Young South Africans. The list is announced

Dr Eugene L Davids

annually in June/July to celebrate highly talented young people across Arts & Entertainment, Business, Civil Society, Education, Environment, Film & Media, Health, Justice & Law, Politics & Government, Science & Technology, and Sport.

Kadija Patel, Editor-in-Chief of The Mail & Guardian writes: "We have chosen these 200 young South Africans for their feats of brilliance as individuals, yes, but we have also chosen these wonderfully talented, resourceful, caring people because they remind us that all is not lost. They remind us that the pursuit of a better world is never in vain. Mostly, these young people remind us that we are not so alone in the world."

CAROLINE KUO

Caroline Kuo, Honorary Lecturer in the department's Liaison division, won a poster award on her local research at the American Public Health Association annual meeting. This points to the high quality of the work that she and Prof Jackie Hoare are doing locally in the adolescent HIV space.

DR CATHY ABBO

Dr Cathy Abbo, a psychiatrist from Uganda worked in the division of Child and Adolescent psychiatry to complete her M.Phil in Child and Adolescent Psychiatry. Her research explored the psychometric properties of the Wessex Behavioural Schedule to determine its suitability for use in child and adolescents in a South African setting and to generate clinical cut-offs to define ID. She was awarded the dissertation with distinction.

AUBREY KUMM & EUGENE DAVIDS

Aubrey Kumm and Eugene Davids were awarded the inaugural Cultural Diversity Poster Award at the annual International Meeting for Autism Research in San Francisco. This award recognises "innovative research focused on issues of racial, ethnic, cultural and socioeconomic diversity in autism with the potential to have a significant impact on traditionally underserved communities." Their research focused on the of smart phone application as a feasible to screen for ASD in low resourced African communities.



Aubrey Kumm and Dr Eugene Davids conducting research.



DR MARC ROFFEY

Dr Marc Roffey of the Forensic psychiatry division undertook a study on group music therapy as an intervention for negative symptoms of Schizophrenia with forensic outpatients. This was a collaborative study with music therapy intern, Bruce Muirhead from the University of Pretoria Department of Music Therapy. The study is unique in being the first to have taken place in a forensic setting in South Africa. The department would like to acknowledge and congratulate Drs Kerry Armstrong, Kirsten Reid, Robyn Akhurst, and Marise Bruwer for passing their Part II examinations.



Bruce Muirhead facilitating a music therapy session.

PROF KATHERINE SORSDAHL & DR CLAIRE VAN DER WESTHUIZEN

Prof Katherine Sorsdahl and Dr Claire van der Westhuizen (below) from the Division of Public Mental Health travelled to Greece in April 2017 to find out more about Global Burden of Disease statistics. Participants from over 20 countries attended the ten-day intensive training, where topics ranged from global health policy, to data collection methods, to the technical details of complex modelling approaches.



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EDUCATIONAL SEMINAR ON PSYCHIATRIC TRAINING

AMERICAN PSYCHIATRIC ASSOCIATION CONGRESS 2017

Soraya Seedat

The aim of the seminar was to share good practice in psychiatric training across English speaking nations internationally.

Following previous successful meetings at the American Psychiatric Association Congress (APA) in 2015 and 2016 a further educational seminar was organised for 2017. Previous topics have included differential attainment, differences in training structures in psychiatry across countries and assessment and regulation. The 2017 seminar took place on Tuesday 23rd May at the APA Congress held in San Diego, California, USA.

There were 2 sessions with the morning session devoted to "Developing Training - challenges and successes" with presentations as follows: "Challenges and developments in psychiatric training in Hong Kong" by Professor Eric Chen, President, Hong Kong College of Psychiatrists; "RANZCP competency based training program - updates and evaluation" by Dr Kym Jenkins, President, RANZCP; Working with Actors with Learning Disability as simulated patients in the UK CASC exam by Dr Ian Hall, Associate Dean, RCPsych. The session concluded with a roundtable discussion on challenges and opportunities in psychiatric training.

The afternoon session related to "Keeping Up to Date in Developments in Neuroscience" with presentations as follows: "Neuroscience for US Psychiatric Trainees" by Dr Melissa Arbuckle, Co-Chair, National Neuroscience Curriculum Initiative; "South African experiences in the Neuroscience and Neuropsychiatry curricula" by Professor Soraya Seedat, College of Psychiatrists of South Africa; "The UK Neuroscience Project" by Dr Wendy Burn, RCPsych President Elect & Co-Chair Gatsby Wellcome Neuroscience Project



Soraya Seedat

and Dr Gareth Cuttle, Project Lead, Neuroscience Project, Royal College of Psychiatrists. The session closed with round table discussions regarding challenges, experiences and opportunities relating to neuroscience and the psychiatric curriculum.

ATTENDEES WERE AS FOLLOWS:

Dr Melissa Arbuckle

(National Neuroscience Curriculum Initiative),

Mr Glenn Brimacombe

(CEO, Canadian Psychiatric Association),

Dr Wendy Burn

(RCPsych President Elect, Co-Chair Gatsby Wellcome Neuroscience Project),

Professor Eric Chen

(President, Hong Kong College of Psychiatrists),

Dr Gareth Cuttle

(Project Lead, Neuroscience Project, Royal College of Psychiatrists),

Dr Anita Everett

(President Elect, American Psychiatric Association),

Dr Ian Hall

(Associate Dean, Royal College of Psychiatrists),

Professor Helen Herman

(President Elect, World Psychiatric Association),

Dr Kym Jenkins

(President, Royal Australian and New Zealand College of Psychiatrists),

Dr Saul Levin

(CEO, American Psychiatric Association),

Dr Kate Lovett

(Dean, Royal College of Psychiatrists),

Dr Maria Oquendo

(President, American Psychiatric Association),

Mr Paul Rees

(Chief Executive, Royal College of Psychiatrists),

Professor Soraya Seedat

(President, College of Psychiatrists of South Africa).

Soraya Seedat is a psychiatrist and Professor/Head of the Department of Psychiatry at the University of Stellenbosch. She is the current President of the College of Psychiatrists in the Colleges of Medicine of South Africa. **Correspondence: sseedat@sun.ac.za**

LEAVING NO ONE BEHIND

5TH GLOBAL MENTAL HEALTH SUMMIT

ABOUT THE MGMH

The Movement for Global Mental Health

The Movement for Global Mental Health (www.globalmentalhealth.org) is a network of individuals and organisations that aim to improve services for people living with mental health problems and psychosocial disabilities worldwide, especially in low- and middle-income countries (LMIC) where effective services are often scarce. Two principles are fundamental to the Movement: scientific evidence and human rights. The history of the Movement began in 2007 with a Call for Action published in the first Lancet series on global mental health. Through volunteerism and collaboration, the Movement has gradually grown to a stage where members are able to share ideas, initiate activities and seek resources, often in partnership with other members.

The Movement has grown to a membership of approximately 200 institutions and 15,000 individuals, many of who are actively involved. An average of 30 new membership applications are received daily that indicates a continuous growth.

MEMBERS OF THE MOVEMENT INCLUDE INDIVIDUALS AND FAMILIES AFFECTED BY MENTAL HEALTH PROBLEMS, HEALTH CARE PROVIDERS, ACTIVISTS, DECISION MAKERS AND RESEARCHERS WORLDWIDE.

The Secretariat is based at the SA Federation for Mental Health (www.safmh.org). ■



"Leaving no one behind"



5th Global Mental Health Summit

8-9 February 2018, Johannesburg, South Africa

REGISTRATION : 15 JUNE 2017 - 31 OCTOBER 2017

For more information/ registration for the 5th Global Mental Health Summit:

<http://www.globalmentalhealth.org/5th-global-mental-health-summit>

REPORT OF THE SPECIAL RAPPORTEUR ON THE RIGHT OF EVERYONE TO THE ENJOYMENT OF THE HIGHEST ATTAINABLE STANDARD OF PHYSICAL AND MENTAL HEALTH

June 2017

Pursuant to Human Rights Council resolution 24/6, the secretariat has the honour to transmit to the Council the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

Pursuant to Human Rights Council resolution 24/6, the secretariat has the honour to transmit to the Council the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. In an attempt to contribute to the discussion around mental health as a global health priority, the Special Rapporteur focuses on the right of everyone to mental health and some of the core challenges and opportunities, urging that the promotion of mental health be addressed for all ages in all settings. He calls for a shift in the paradigm, based on the recurrence of human rights violations in mental health settings, all too often affecting persons with intellectual, cognitive and psychosocial disabilities.

The Special Rapporteur makes a number of recommendations for States and all stakeholders to move towards mental health systems that are based on and compliant with human rights.

I. INTRODUCTION

1. Mental health and emotional well-being are priority areas of focus for the Special Rapporteur (see A/HRC/29/33). In each thematic report, he has attempted to bring mental health into focus as a human rights and development priority in the context of early childhood development (see A/70/213), adolescence (see A/HRC/32/32) and the Sustainable Development Goals (see A/71/304).

2. In the present report, the Special Rapporteur expands on this issue and provides a basic introduction to some of the core challenges and opportunities for advancing the realization of the right to mental health of everyone. In the light of the scope and complexity of the issue and of the evolving human rights framework and evidence base, in his report the Special Rapporteur seeks to make a contribution to the important discussions under way as mental health emerges from the shadows as a global health priority.

3. The present report is the result of extensive consultations among a wide range of stakeholders,

including representatives of the disability community, users and former users of mental health services, civil society representatives, mental health practitioners, including representatives of the psychiatric community and the World Health Organization (WHO), academic experts, members of United Nations human rights mechanisms and representatives of Member States.

A note on terminology¹

4. Everyone, throughout their lifetime, requires an environment that supports their mental health and well-being; in that connection, we are all potential users of mental health services. Many will experience occasional and short-lived psychosocial difficulties or distress that require additional support. Some have cognitive, intellectual and psychosocial disabilities, or are persons with autism who, regardless of self-identification or diagnosis, face barriers in the exercise of their rights on the basis of a real or perceived impairment and are therefore disproportionately exposed to human rights violations in mental health settings. Many may have a diagnosis related to mental health or identify with the term, while others may choose to identify themselves in other ways, including as survivors.

5. The present report distinguishes between users of services and persons with disabilities, based on the barriers faced by the latter, considering in an inclusive manner that everyone is a rights holder.

II. CONTEXT

6. Despite clear evidence that there can be no health without mental health, nowhere in the world does mental health enjoy parity with physical health in national policies and budgets or in medical education and practice. Globally, it is estimated that less than 7 per cent of health budgets is allocated to address mental health. In lower-income countries, less than \$2 per person is spent annually on it.² Most investment is focused on long-term institutional care and psychiatric hospitals, resulting in a near total

policy failure to promote mental health holistically for all.³ The arbitrary division of physical and mental health and the subsequent isolation and abandonment of mental health has contributed to an untenable situation of unmet needs and human rights violations (see A/HRC/34/32, paras. 11-21), including of the right to the highest attainable standard of mental and physical health.⁴

7. Forgotten issues beget forgotten people. The history of psychiatry and mental health care is marked by egregious rights violations, such as lobotomy, performed in the name of medicine. Since the Second World War and the adoption of the Universal Declaration of Human Rights, together with other international conventions, increasing attention has been paid to human rights in global mental health and psychiatry. However, whether the global community has actually learned from the painful past remains an open question.

8. For decades, mental health services have been governed by a reductionist biomedical paradigm that has contributed to the exclusion, neglect, coercion and abuse of people with intellectual, cognitive and psychosocial disabilities, persons with autism and those who deviate from prevailing cultural, social and political norms. Notably, the political abuse of psychiatry remains an issue of serious concern. While mental health services are starved of resources, any scaled-up investment must be shaped by the experiences of the past to ensure that history does not repeat itself.

9. The modern understanding of mental health is shaped by paradigm shifts often marked by a combination of improvements and failures in evidence-based and ethical care. This began 200 years ago with the desire to unchain the “mad” in prison dungeons and moved to the introduction of psychotherapies, shock treatments, and psychotropic medications in the 20th century. The pendulum of how individual pathology is explained has swung between the extremes of a “brainless mind” and a “mindless brain”. Recently, through the disability framework, the limitations of focusing on individual pathology alone have been acknowledged, locating disability and well-being in the broader terrain of personal, social, political, and economic lives.

10. Finding an equilibrium between the aforesaid extremes of the twentieth century has created a momentum for deinstitutionalization and the identification of a balanced, biopsychosocial model of care. Those efforts were reinforced by WHO in a report in 2001, in which it called for a modern public health framework and the liberation of mental health and those using mental health services from isolation, stigma and discrimination.⁵ A growing research base has produced evidence indicating that the status quo, preoccupied with biomedical interventions, including psychotropic medications and non-consensual measures, is no longer defensible in the context of improving mental health. Most important have been the organized efforts of civil society, particularly movements led by users and former users of mental health services and organizations of persons with disabilities, in calling attention to the failures of traditional mental health services to

meet their needs and secure their rights. They have challenged the drivers of human rights violations, developed alternative treatments and recrafted a new narrative for mental health.

11. The momentum sustained by civil society towards a paradigm shift has contributed to an evolving human rights framework in the area of mental health. The adoption of the Convention on the Rights of Persons with Disabilities in 2006 laid the foundation for that paradigm shift, with the aim of leaving behind the legacy of human rights violations in mental health services. The right to the highest attainable standard of health has much to contribute to advancing that shift and provides a framework for the full realization of the right of everyone to mental health.

12. One decade later, progress is slow. Effective, acceptable and scalable treatment alternatives remain on the periphery of health-care systems, deinstitutionalization has stalled, mental health investment continues to be predominantly focused on a biomedical model and mental health legislative reform has proliferated, undermining legal capacity and equal protection under the law for people with cognitive, intellectual and psychosocial disabilities. In some countries, the abandonment of asylums has created an insidious pipeline to homelessness, hospital and prison. When international assistance is available, it often supports the renovation of large residential institutions and psychiatric hospitals, undermining progress.

13. Public policies continue to neglect the importance of the preconditions of poor mental health, such as violence, disempowerment, social exclusion and isolation and the breakdown of communities, systemic socioeconomic disadvantage and harmful conditions at work and in schools. Approaches to mental health that ignore the social, economic and cultural environment are not just failing people with disabilities, they are failing to promote the mental health of many others at different stages of their lives.

14. With the adoption of the 2030 Agenda for Sustainable Development and recent efforts by influential global actors such as WHO, the Movement for Global Mental Health and the World Bank, mental health is emerging at the international level as a human development imperative. The 2030 Agenda and most of its sustainable development goals implicate mental health: Goal 3 seeks to ensure healthy lives and promote well-being at all ages and target 3.4 includes the promotion of mental health and well-being in reducing mortality from non-communicable diseases. How national efforts harness the momentum of the 2030 Agenda to address mental health has important implications for the effective realization of the right to health.

15. The current momentum and opportunity to advance are unique. It is from this juncture in history, within a confluence of international processes, that the Special Rapporteur seeks to make a contribution with the present report.

TO ACCESS FULL TEXT:
<http://undocs.org/A/HRC/35/21>

PERINATAL MENTAL HEALTH PROJECT

The Perinatal Mental Health Project (PMHP) is an independent initiative based at the University of Cape Town.

ABOUT THE PMHP

The Perinatal Mental Health Project (PMHP) is an independent initiative based at the University of Cape Town. It is located within the Alan J Flisher Centre for Public Mental Health, in the Department of Psychiatry and Mental Health.

We are a non-profit entity and have been operating since 2002. We partner with the Departments of Health and Social Development.

We provide mental health services for pregnant and postnatal women, train those who work with mothers to improve the quality of their care, form partnerships to promote the scale-up of services and inform global interventions through robust research and advocacy.

We support state agencies and partner with non-profit organisations to achieve health and social development objectives.

WE ENVISION MENTAL HEALTH SUPPORT FOR ALL MOTHERS TO PROMOTE THEIR WELL-BEING, AND THAT OF THEIR CHILDREN AND COMMUNITIES.

OUR MISSION IS TO DEVELOP AND ADVOCATE FOR ACCESSIBLE MATERNAL MENTAL HEALTH-CARE THAT CAN BE DELIVERED EFFECTIVELY AT SCALE IN LOW RESOURCE SETTINGS.



Simone Honikman

MESSAGE FROM THE DIRECTOR

SETTING NEW RECORDS WHILE EMBEDDING PROVEN PRACTICES

I am delighted to report that the PMHP has had a highly productive year. Our team continues to work with unwavering dedication towards our goal. We began 2016 by refining our vision. This helped us to work smarter and more collaboratively among ourselves and with our partners.

IN 2016, MANY OF OUR PROJECTS CAME TO FRUITION AFTER SEVERAL YEARS IN GESTATION. THERE WAS PLENTY OF CAUSE FOR CELEBRATION!

While our clients continue to face extreme poverty, traumatic past histories and highly dysfunctional relationships, we were pleased to increase our service outputs. More vulnerable women were seen by our counsellors, for a greater number of sessions each.

The evaluation of our services showed that with the simple techniques of problem solving, affirming and psycho-education, the mothers were able to draw on their resilience and capabilities to improve their symptoms and functioning. We trained far more individual care providers than in any previous year in our history.

Furthermore, our Respectful Maternity Care Practical Skills Module, which includes our 'Secret History' method, was rolled out by master trainers of the National Department of Health.

This took place in all provinces, as part of the Essential Steps for the Management of Obstetric Emergencies (ESMOE) in-service training programme for maternity staff.

The research programme saw the dissemination of our findings through a record number of journal publications. In addition, we presented and gave workshops at several national and international conferences.

Another highlight was our contribution to several key policy and programme changes at provincial level, including the Postnatal Care Policy, the Birth Companion Policy, as well as many elements of the First One Thousand Days initiative.

Our brief mental health screening tool was incorporated in the Practical Approach to Care Kit (PACK) primary health-care guide, which has been adopted province-wide.

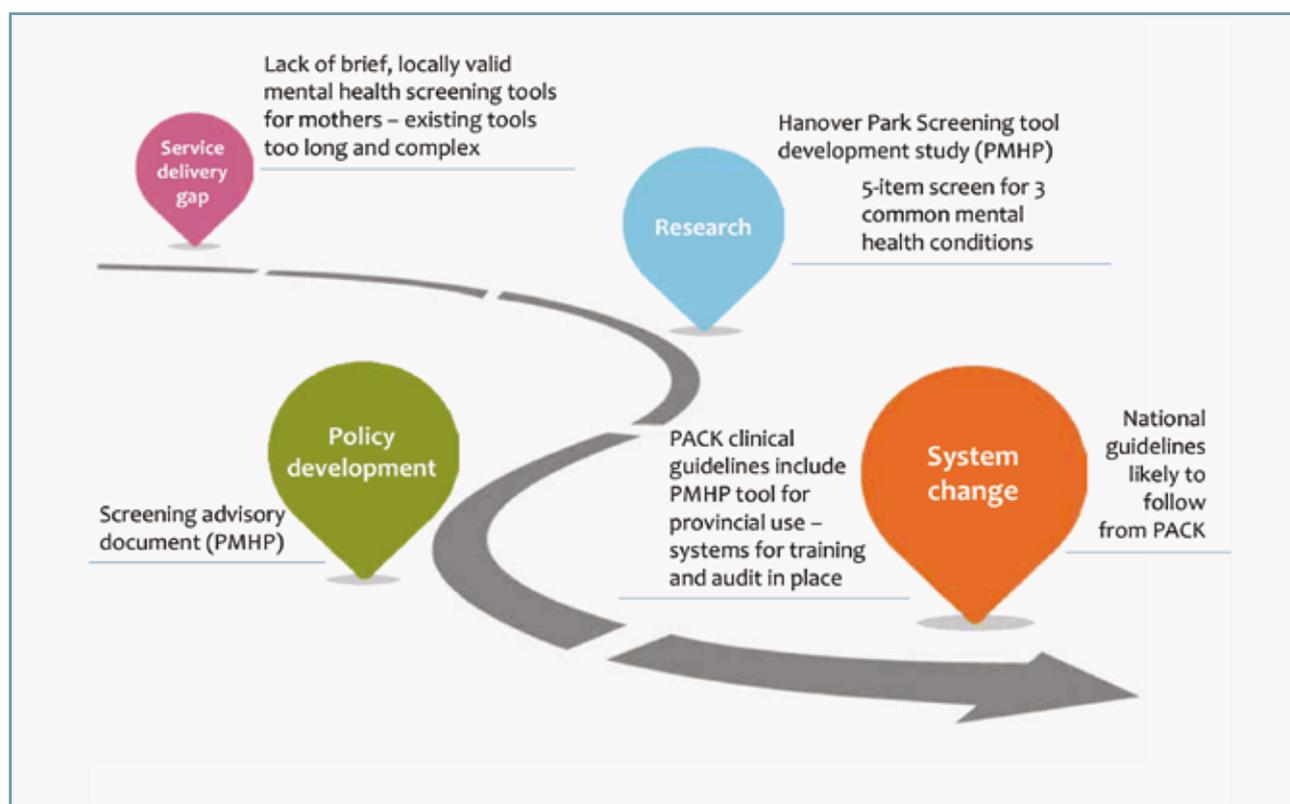
We were able to augment the standard maternity stationery used by health staff, with fields for staff to indicate specific types of care support provided to mothers.

THE PATHWAY IMAGE ILLUSTRATES HOW WE WORK FROM REAL-WORLD SERVICE DELIVERY PROBLEMS THROUGH TO ENSURING EVIDENCE-BASED INTERVENTIONS ARE PROVIDED FOR MOTHERS AT SCALE. BY EMBEDDING OUR TRIED-AND-TESTED PRACTICES INTO OUR PARTNERS' LARGER SERVICE DELIVERY PROCESSES, WE ARE MUCH CLOSER TO ACHIEVING OUR VISION. THIS INTEGRATION IS LIKELY TO HAVE LONG-TERM AND WIDESPREAD IMPACTS FOR THE MENTAL AND OVERALL HEALTH OF MOTHERS AND THEIR FAMILIES.

Your support has been vital for us on this path. We still have a way to go, but are looking forward to accomplishing more of our vision each year.

PATHWAYS TO SCALE-UP:

THE EXAMPLE OF THE PMHP MATERNAL MENTAL HEALTH SCREENING TOOL



You can 'Make a Difference' by donating to the PMHP

For online donations and donations from countries other than South Africa,
please visit our website: www.pmhp.za.org/donate/

Simone Honikman: Director Perinatal Mental Health Project Correspondence: Simone.Honikman@uct.ac.za

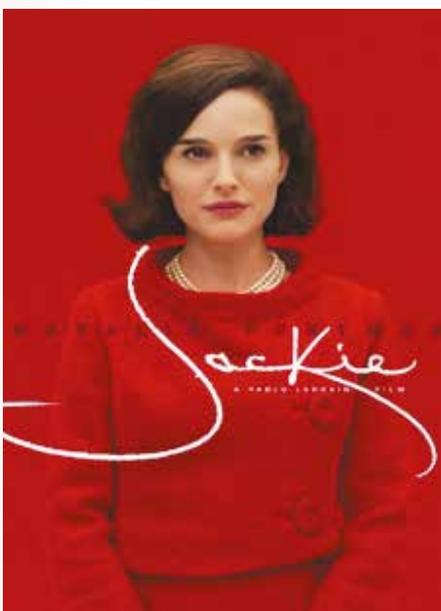
JACKIE

A film review by Franco P. Visser

A Pablo Larrain Film
Written by Noah Oppenheim
A 2016 Fox Searchlight Pictures Release

There are several events in modern history that will live on in human memory for many, many more years to come. One of them is the assassination of the 35th president of the United States of America, John F. Kennedy. Whether it be as a result of never-ending conspiracy theories that are perpetually 'investigated' by all and sundry, or whether it is due to the powerful dynastic image of the Kennedy family, the tragic end of a young husband and father-of-two's life in a motorcade travelling lazily through a down-town plaza complex on a sunny Dallas early afternoon continues to fascinate Americans and people the world over. It is thus not difficult to understand that numerous documentaries and films have seen the light of day over the decades since Kennedy's brutal assassination at the hands of an inept communist on the 22nd of November 1963.

The film that I chose for this edition's review is yet another movie with the topic of the Kennedys as content, yet I would like to say from the start that from everything I have viewed thus far, no other piece of cinematography even comes close to this biographical drama simply titled as 'Jackie'. Set in the period just following Kennedy's assassination and funeral, the film centres on an interview that Jackie Kennedy (played by Natalie Portman) gave to Time Magazine in early 1964. This is one of three interviews, although it remained a secret for years following Kennedy's death. Jackie invites a journalist to the Hyannis Port Kennedy compound and proceeds to tell him about her life as First Lady, her relationship with her husband and the famous television tour of the just-renovated White House that she made with CBS in 1962. Her relationship with various staff members are also reflected in the



film, and as the story unfolds, the interview naturally drifts towards the assassination of her husband John, or 'Jack' as he was known in the family, his very grand and imposing state funeral and Jackie's severe emotional difficulties in coming to terms with her husband's traumatic demise.



Franco P. Visser

Whilst Jackie is relaying information to the journalist (played by Billy Crudup), flash-back sequences are shown in the film of key moments in the lives of Jackie and Jack including his funeral and the reburial of the two children that Jackie had lost next to their father's grave at Arlington National Cemetery. It is a little known fact that Jackie suffered the loss of a stillborn daughter in 1956, a miscarriage in 1957 and the loss of an infant son Patrick in 1963. The film culminates in the events of that fateful November day in 1963 and the barrage of bullets that were sent her husband's way, ending in a massive head wound that Jack sustained that was infamously evident in frame 313 of a home-movie made by a bystander on the day, Abraham Zapruder.

The film Jackie not only takes the viewer to the day and the assassination of Kennedy, but it goes deeper in taking one into the limousine in which they were travelling, portraying the events from Jackie's perspective as it unfolded. Naturally, there are scenes of a graphic nature, but the film succeeds in reflecting the absolute horror and trauma that Jackie went through during the day of her husband's assassination. Through the manner in which the film was put together one has an insider's perspective into events that have captured the world's fascination for

decades, and I think that this is one of the reasons why this is such a captivating film to view. The aftermath at Parkland Memorial Hospital and Lyndon B. Johnson's troublesome insistence to be sworn in as 36th president of the United States of America before Air Force One could depart from Dallas are also portrayed in the film, as is Jackie's statement arrival in Washington alongside her husband's coffin whilst still wearing the blood and brain matter-stained pink Chanel wool bouclé suit in which she arrived in Dallas.

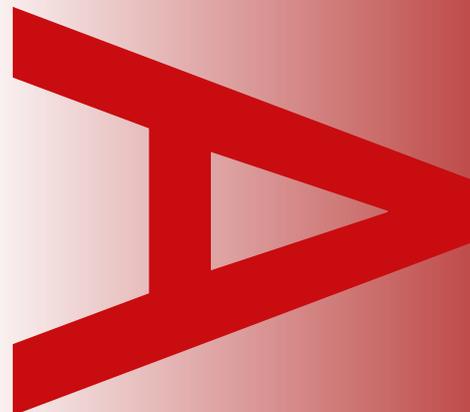
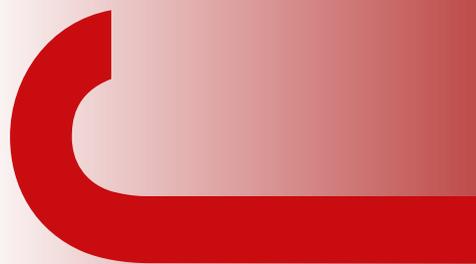
Throughout all of the events, Jackie's reactions, her emotional turmoil, the debilitating shock that she sustained and her intense loneliness and isolation in the White House in the days immediately following Jack's death were also brilliantly portrayed. The fragile side of Jackie was very evident, albeit a side of herself that she only showed behind closed doors, and so too was her other persona who managed her husband's posthumous image to the outside world with steely and calculated determination.

SHE WAS ALSO VERY ABLE TO CENSOR AND CONTROL ANY INTERVIEW CONTENT WHICH SHE GAVE PERMISSION FOR TO BE PUBLISHED, FAMOUSLY ENDING THE TIME MAGAZINE INTERVIEW WITH A QUOTE FROM THE MAIN THEME SONG OF THE MOVIE CAMELOT - 'DON'T LET IT BE FORGOT, THAT ONCE THERE WAS A SPOT, FOR ONE BRIEF SHINING MOMENT, THAT WAS KNOWN AS CAMELOT'.

Whilst viewing the film it was very interesting to note how Jackie was able to switch between her debutant persona and an image of a woman who was able to hold her own in a tough and demanding political and family environment. Jackie's precise control over her environment and the people in it belies her soft-spoken debutant manner that she showed in front of others. Jackie is a film that I most certainly would recommend for those of you who have an interest in history and in the tragedy that marked the lives of the Kennedys throughout the decades. This is a film that has been carefully researched and put together in order to provide insight into the life of a very private and complex individual.

Jackie Kennedy Onassis remained an American icon and enigma until her death in May of 1994 due to cancer, and the mystique of Camelot - that storybook Utopia of love and peace - remains to characterise the golden days of the Kennedy presidency up to the present day. Until next time, happy viewing.

Franco Visser is a psychologist and lecturer in the Department of Psychology at UNISA, Pretoria, South Africa. He has a special interest in Forensic Psychology.
Correspondence: Vissefp@unisa.ac.za ■



YOUNG GUNS, OR SAME OLD, SAME OLD?

The millennials have captured the wine front.

David Swingler

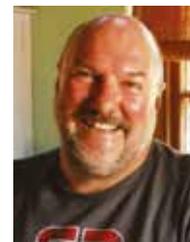
While industry monoliths like Distell appear to have decided the future (for which read, 'profit') is in cider and spirits and are flogging their wine interests – witness the Lusan sell-off – a new wave of progressive winemakers has emerged. Or, so believes Roland Peens, Director of Wine Cellar who conceived and hosts 'Young Guns', a showcase of these hip, hop, and happening oenological newbies.

And hip, hop and happening it certainly was at The Church @ Roodebloem Studios in trendy Woodstock – a Cape Town suburb that seems to have been (like Muizenberg) forever 'happening', but never quite 'happens' – when 'Young Guns Seven' took the stage in June. That the new lick of paint to freshen up the deconsecrated place of worship gave a pinotage-acetone edge to several wines was immaterial. Hordes of young wine luvvies were out on the night to taste the wares of their winemaking peers with names like 'Garajeest' (a play on the garagiste movement, small-scale entrepreneurial wine-making that originated in the Bordeaux region of France in the mid-Nineties; one which does not adhere to the traditions of wine-making), 'Geronimo' (the leap of going it alone), 'Thistle & Weed' (Mumford & Sons?) and 'Maanschijn'.

Maanschijn? Most Young Gunners have day-jobs with indulgent bosses who allow them to make a few barrels of their own label, or are making the transition

to a fully-fledged solo business. They have other defining characteristic too: 25-35 years old, trendy with attitude, they give their wines silly names, market it with old music, and don't ever undercharge.

So it was @ The Church. Lights were low as social media feeds flooded the screen – various favourites



David Swingler

trended on Twitter, Instagram was aglow and, considering there were some of my generation in the audience, even Facebook got a look-in. Gunners with fabulous (real) names like Lukas van Loggerenberg, Stephanie Wiid, Paul Hoogwerf and – wait for it – Jessica Saurwein (A winemaker called Saurwein? And tremendous women she is too!), poured oddly-named elixirs to the sounds of ... the Eighties! Simon's Graceland, Dylan's Property of Jesus, Springsteen's Born in The USA an even Fleetwood Mac reverberated around good ol' Woodstock.

Grape varieties were as expected of the trendies – eschewing mainstream cabernet sauvignon and chardonnay and embracing 'rediscovered' old Cape classics like chenin blanc, semillon, grenache gris, cinsaut and cabernet franc. Winemaking is all natural; native yeasts, no additives such as acids, enzymes or tannin treatments, cold soaks and skin contact, only old oak or concrete egg vessels, and bottling without fining or filtration.

Peens launched Young Guns in 2011. After a run of





four years, it seemed the stream of potential Gunners was drying up and Roland hosted a 'Reloaded' version in 2015 – father and son winemaker combos with wine from then, and now. It's back on form with 2017 being the 7th rendition. But where are previous Gunners now? Did they all make it? Some have not just entered the mainstream, they are in the vanguard. Chris Alheit (Alheit) sells everything on allocation and is setting new Cape benchmarks. Peter-Allan Finlayson now commands global pricing with his 'Crystallum' pinot noirs. David Sadie who makes 'David & Nadia' with viticulturalist wife Nadia is considered new Cape top-drawer. John Seccombe's 'Thorne & Daughters' bottlings are not far behind. (Oh, the ampersand '&' is another YG trademark...)

Then there's a clutch of left-field vintners who will never be big but have an adherent band of support – Craig Hawkins' 'Testalonga', Jurgen Gouws (Intellego) and Stompie Meyer (JH Meyer). And sadly, some have fallen by the way and have either resorted to cellar employment, or moved on to other things. The father-&-son combo 'Young Guns Reloaded'

raised the interesting question about generations in wine. Are the Young Gunners any different to their fathers when they started their careers? Neil Ellis, Etienne le Riche, Jacques Bornman (Boschkloof), Danie Steytler (Kaapzicht), Peter Finlayson (Bouchard Finlayson) and Braam van Velden (Overgauw) were likely hardly less energetic, passionate and innovative than their sons at the outset of their careers, albeit in different social-political and economic contexts. And the 'discoveries' of the next generation – semillon gris, grenache blanc, co-fermenting cinsaut with cabernet – are hardly new. They were, perhaps, put aside in the pursuit of what was then new, like new small French oak barrels.

After a relaxing glass and a snack @ The Church, the Gunners and their acolytes headed off to The After-Party. It was held at Tjing Tjing Torii, known for its 'indie, electronic vibe'. 'Same building,' says its website, 'better wine, easier dining, still no dress code...' Sort of fits the bill, doesn't it?

(Young Guns is held in Cape Town and Johannesburg in June each year. Visit <http://www.winecellar.co.za/> for further information.)



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

Young Guns

Back to Basics

In June 2017, Wine Cellar is hosting the 7th edition of Young Guns – SA’s hottest wine tasting event that showcases the young winemakers breaking the rules and pushing the limits. With the memories of last year’s battle against the industry-shaping Old Bullets still fresh in our minds, this new generation of Young Guns is going ‘Back to Basics’. Equipped with interesting grape varieties and their bare hands and feet, this club of hunter-gatherers has produced a killer set of new wave classics.

Price: R 500 (includes a selection of canapés)

Johannesburg: Wednesday, 14 June,
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Time: 18:00 for 18:30



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A MEANINGFUL MEAL OF PSYCHIATRIC AND PSYCHOLOGICAL INFORMATION

Chef: Ethelwyn Rebelo

Below is a meal of dishes put together after I went shopping for delicious case studies and tasty tidbits of research.



Ethelwyn Rebelo

For starters, I found a case study on a genetic disorder known as Williams Syndrome as well as a description of a person with Pseudobulbar Affect.

This is followed by a main course consisting of the reliability and validity of children's accounts in clinical interviews; maternal epigenetic programming of rat pups; attachment and depression; attachment and interpersonal competence; the health benefits of intimate relationships and difficulty in overcoming the loss of a spouse.

A refresher consists of the summary of an article on managing the cognitive deficits that may accompany Bipolar Mood Disorder.

Dessert is a pilot study on the benefits of yoga for Depression, a note on the development of advanced genetic sequencing technology and one on evidence for the influence of the gut microbiome on human behaviour.

We end with a warm cup of consideration that there is still much we need to know about how the gut microbiome and brain communicate with each other.

STARTERS

WILLIAMS SYNDROME

In the *New Scientist*, Clare Wilson reviews a book written by Jennifer Latson, titled 'The boy who loved too much: A true story of pathological friendliness'. It is an account of a child who suffered from Williams Syndrome. This is a genetic disorder which causes those affected to be over-affectionate, talkative and gregarious. It affects 1 in 1000 people and is caused by an absence of 26 genes. One of the difficulties faced by such individuals is that they are unable to identify danger or exploitation in others. However, the syndrome is also associated with reduced intelligence, physical dexterity and heart problems. Hence few with the disorder are able to live independently.

The boy discussed in the book hugs bus drivers, waiters and strangers, tells them he loves them - and means it. Everyone is his new best friend. Wilson notes that the degree of pathology perceived in the syndrome varies across cultures. In Greece, for example, where people are publicly demonstrative, it is not viewed as a problem. On the other hand, in a different culture, such as that of the socially-reserved Japanese, it presents as a clear disturbance.

PSEUDOBULBAR AFFECT (PBA)

Daniel Shalev (2017), writes about a case study involving a woman who could not stop crying, despite not feeling sad. She had suffered a stroke which caused a left hemiplegia. Her constant bursts of uncontrollable weeping were therefore initially understood to be an expectable response to her disabilities. However her crying persisted through days of therapy, rehabilitation and antidepressant medication. She was eventually diagnosed as suffering from a Pseudobulbar Affect which had arisen as a result of brain damage caused by the stroke.

This disorder emerges when the emotional circuit from cortical regions to the pons is disrupted and it is expressed in involuntary bursts of emotional expression. These emotional expressions occur independently of an experience, on the part of the sufferer, with the affect we associate with them. Normally, cortical structures such as the frontal lobe

identify emotional contexts and send the information to the brain stem via the cerebellum. The latter acts as a gatekeeper, inhibiting or allowing impulses to pass to the pons which then executes them as laughter or tears. In the case of Shalev's patient, the pons was injured in the stroke. Pseudobulbar Affect can occur in many neurological disorders, including amyotrophic lateral sclerosis (Lou Gehrig's disease), multiple sclerosis, Parkinson's Disease and stroke. It is treated usually by Nuedexta, a combination of dextromethorphan and quinidine. These substances act to block glutamate, one of the major excitatory neurotransmitters in the brain, regulating the deviant signaling in the affected pathway. In the case of Shalev's patient, Nuedexta could not have been administered on account of drug interactions. He accordingly prescribed an SSRI which she took in addition to her usual antidepressant (which worked through norepinephrine) and her symptoms reduced significantly.



MAIN COURSE

FROM THE MOUTHS OF CHILDREN

Macleod et al (2017) carried out a study to find out whether the information provided by children in interviews during mental health assessments was reliable and valid. They assessed the responses of 31 children aged between 5 and 12 years old, coding their answers in terms of whether they were clinically relevant; and whether they could be used to diagnose their problems and to formulate treatment plans. They found that most of the material obtained was clinically relevant, including information about behaviour, affect, temporal details, thoughts, people, the environment and the child's physical experiences. It was also clinically valid: congruent with the problem discussed (84%) and with the eventual diagnosis that the child received on completion of the assessment (74%). They concluded that children can provide both relevant and clinically useful information in interviews conducted with them during psychological assessments.

EPIGENETIC PROGRAMMING THROUGH MATERNAL BEHAVIOR

Weaver and others have carried out research on the epigenetic programming that takes place through maternal behavior. They found that levels of pup licking, grooming and nursing by rat mothers altered their offspring's epigenome at a glucocorticoid receptor gene promoter in the hippocampus. The implications of varying rat maternal responses to their pups had both health and behavioral consequences. Work on the epigenetic mechanisms of transgenerational care has also been explored by Champagne in 2008. The question remains: is insecure attachment associated with epigenetic consequences in humans, as it is in other animals?

ATTACHMENT AND DEPRESSION

A study investigating the interaction between attachment style and interpersonal psychotherapy for depressed adolescents, Gunlicks-Stoessel (2017) found that attachment anxiety and avoidance were amenable to intervention during adolescence.

Interpersonal psychotherapy was found to be an effective intervention for addressing problems in attachment style and in decreasing attachment anxiety and avoidance. These decreases were, in turn, also associated with a significant reduction in depressive symptoms. Forty adolescents aged between 12 and 17 participated in a 16-week randomized clinical trial of 4 adaptive treatment strategies for adolescents including combinations of interpersonal psychotherapy with and without fluoxetine. Measures of attachment and depression were administered at baseline and at weeks 8 and 16. It was found that attachment anxiety and avoidance decreased significantly from baseline to week 16. Lowered baseline avoidance positively predicted a greater reduction in depression, controlling for fluoxetine. Reductions in anxiety and avoidance levels were also significantly associated with reductions in depression, again controlling for fluoxetine.

This provides support for selecting interpersonal psychotherapy as an option for adolescents who are depressed and who describe experiencing difficulty with attachment security. Interpersonal psychotherapy appears to be particularly effective for adolescents with an avoidant attachment style, who suffer discomfort with and have a tendency to avoid intimacy.

ADULT ATTACHMENT AND INTERPERSONAL COMPETENCE

In a systematic review of research on the association between adult attachment and interpersonal difficulties, Hayden et al (2017) found a strong association between interpersonal distress and anxiety and avoidance. The studies revealed a trend between attachment anxiety and friendly-submissive behavior in relation to others. An association was also found to exist between attachment avoidance and hostile-dismissive interpersonal problems.

HEALTH BENEFITS OF GOOD QUALITY INTIMATE RELATIONSHIPS

Waldinger and Schulz (2016), reporting on the results of two long-term research investigations spanning 75 years at Harvard (Grant and Glueck studies), have noted that the most important message gleaned from the results obtained are the following: having a close relationship in which individuals feel able to be vulnerable with each other, experience emotional safety and believe themselves to be understood benevolently - has positive effects for the health of the nervous system and reduces both emotional and physical pain. This builds on Vaillant's (2002) work. He directed the study from 1972 to 2004 and noted that there are two basic psychological factors associated with this:

1. The first is being able to love; and
2. The second is possessing coping skills that do not push love away.

LOSING A SPOUSE

Infurna and Luthar (2017) address a growing controversy in the field of resilience regarding the commonality of resilience to major life stressors. Investigating resilience in response to the death of a spouse, they applied growth mixture modelling to data from 421 participants. The researchers examined the extent to which individuals appeared to be resilient across three indicators of subjective well-being, namely life satisfaction, negative affect and positive affect and two indicators of health: perception of general health and physical functioning. They also explored factors that might promote resilience. They found that only 8% of their sample exhibited multidimensional resilience. Hence resilience in the face of spousal bereavement is less common than previously thought. They conclude that researchers should move away from debating rates of resilience based on single-adjustment indicators. Strength in any one domain may coexist with weakness in others.



REFRESHER

DEALING WITH COGNITIVE DEFICITS ASSOCIATED WITH BIPOLAR MOOD DISORDER

The remission of Bipolar symptoms does not result in complete functional recovery for all patients with this diagnosis. Aiken (2017) advises that, in addition to choosing mood stabilizers with a favourable cognitive profile (if possible); educating patients with regard to possible cognitive difficulties; and adjusting medication carefully, the following practices should be encouraged:

1. Exercise for 30 to 60 minutes a day;
2. Sufficient sleep;
3. Augmentation with Ashwagandha, an Indian form of Ginseng which research has revealed to have neuroprotective effects on the hippocampus;
4. Following a diet consisting of flavanols (for example tea, berries and dark chocolate) and omega 3 fatty acids. Saturated fats and simple sugars are to be avoided; and
5. Behavioural therapy providing social skills training and techniques to assist with the compensation of cognitive deficits.



DESSERT

DEPRESSION AND YOGA

In a prospective, randomized controlled pilot trial, Prathikanti et al (2017) have found evidence that yoga can assist with the treatment of depression. The experimental group were taught active yoga twice a week, while the control group were taught about the history of yoga. The researchers found that yoga practice helped those with depression to improve their mood after eight weeks. A problem with this study is the small sample size of 38 people. However it sets a foundation for future exploration.

TAPEWORMS WATCH OUT

In a recent article in the Scientific American, Kat McGowan (2017) reported, among other matters, on the development of a test able to detect the origins of brain infections. This test has been created by neurologist, Michael Wilson; biochemist, Joseph De Risi; and Charles Chiu, an infectious diseases expert. It makes use of genetic-sequencing technology, analyzing all the DNA and RNA identified in a sample of cerebrospinal fluid. DNA and RNA that does not belong to the patient shows up in the results and assists doctors to determine the source of an infection more speedily.

GUT FEELINGS

Dinan et al (2015), in their review article have found a significant degree of evidence for the influence of the gut microbiome on human behavior. Within the human gut is a dynamic and complex microbial ecosystem. The average adult possesses approximately 1kg of bacteria, which is approximately the weight of the brain. Genes within the microbiome outnumber human genes in the body and produce a myriad of neuroactive compounds which have been found to play a role in regulating behavior. Research has shown that they influence cognitive function, social interaction and stress management.

They are described as part of an unconscious system of influencing behaviour. In the absence of these microbes, our neurochemistry is altered.

Ethelwyn Rebelo is a clinical psychologist working in private practice and completing a PhD through the Department of Psychiatry, Faculty of Health Sciences, University of the Witwatersrand. She has spent a good part of her professional life based in psychiatric wards and psychiatric clinics. A full reference list is available from the author **Correspondence: ethelwyn@live.co.za** ■

They suggest that psychobiotics consisting of probiotics and prebiotics may exert a potential mental health benefit. Probiotics, when ingested, confer mental health benefits through commensurate gut bacteria. Prebiotics enhance the growth of beneficial gut bacteria.



HOT DRINK

MORE NEEDS TO BE UNDERSTOOD

In a later article, Sarkar et al (2016) suggest that the definition of psychobiotics may need to be expanded beyond probiotics and prebiotics to include other means of influencing the microbiome. They stress that a great deal remains to be revealed. For example the mechanism through which psychobiotics exert their effects have yet to be clearly defined and comprehended. A crucial step still to be undertaken is to understand in greater detail how the microbiome and the brain communicate with each other. This is just one gap in our knowledge, a multitude of other questions still remain.



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DR. REDDY'S ACADEMIC WEEKEND

Christopher Paul Szabo

The 2017 Academic Weekend was held on the 9th -11th June at the Mount Nelson Hotel in Cape Town – representing the 7th such weekend to date.

The event was attended by 169 psychiatrists from around the country representing both the public and private sectors. The involvement and efforts of Drs Robertson, Talatala and Seape in contributing to the success of the weekend is acknowledged. Aside from lectures related to specific topics the weekend afforded an opportunity for the South African Society of Psychiatrist's (SASOP) Public Sector Group (Pubsec) to host a workshop on the Friday afternoon. The workshop commenced with addresses by various speakers (Prof. Janse van Rensburg - SASOP President, Dr Robertson – Pubsec Chair and Prof. Chiliza) highlighting current challenges within the discipline – with a specific emphasis on public sector psychiatry. Thereafter each subgroup Eastern Cape, Western Cape, Northern Gauteng, Southern Gauteng, Free State, KwaZulu – Natal and Limpopo had an opportunity to present regional feedback in terms of challenges and activities. A number of themes emerged related to resources (staffing/physical), demand for services and the relationship between clinicians and employers as well as those between psychiatry and other disciplines and sectors, notwithstanding regional variation. The Life Esidimeni tragedy was frequently cited.

The workshop closed with a discussion related to the National Essential Medicines List which was followed by the SASOP Pubsec AGM. The AGM yielded a lively discussion with the emergence of a number of key issues that should be pursued. Critically it was understood that whilst the Life Esidimeni tragedy has captured centre stage it potentially represents the tip of the iceberg and speaks to significant systemic problems that might see further such tragedies. Some of the systemic problems highlighted included the National – Provincial divide in terms of Provincial implementation of National policy, as well as the



Christopher Paul Szabo

inclination of politicians to ignore clinicians at a cost to patients, based potentially on political rather than clinical agendas. Strategies proposed included more effective media engagement and community mobilization. A suggestion was that the forthcoming 2018 National Congress consider allocation of time to facilitating the development of a clinician driven mental health agenda for presentation to Government.

The AGM served as a perfect segue to the opening session of the following day (Saturday 10th June) which was dedicated to the topic of human rights and the mentally ill (Adv. Bongani Majola – Chair, South African Human Rights Commission) as well as a presentation on the thorny issue of the patient advocacy role of the clinician within the context of a system that is neither receptive nor responsive (Dr Talatala – former SASOP President; Cassey Chambers – SADAG; Tendai Mafuma – Section 27). Subsequent sessions (Saturday 10th June/Sunday 11th June) included a range of presentations related to both clinical issues (Dementia; ADHD; Depression; Pain; Schizophrenia; Addiction) as well as issues impacting on clinical practice (Bigotry; the health of private practice). A SASOP Consultative Forum with Southern African psychiatrists from Botswana, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe was held with a specific intention of establishing networks for a sustained research agenda. The weekend closed with a Pubsec strategic planning session aimed at charting a way forward for Pubsec.

Christopher Paul Szabo is Professor of Psychiatry and Academic Head, Department of Psychiatry, University of the Witwatersrand and Head of Clinical Department, Department of Psychiatry, Charlotte Maxeke Johannesburg Academic Hospital, Johannesburg, South Africa. **Correspondence:** Christopher.szabo@wits.ac.za

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SASOP SPECIAL INTEREST GROUP FOR ADULT ADHD

Renata Schoeman

On 6th and 7th May 2017, the Adult ADHD SIG hosted a Train-the-trainer workshop at the Southern Sun hotel, OR Tambo International Airport.



The purpose of the Train-the-trainer workshop was to provide training to members of the SASOP adult ADHD SIG to ensure alignment in diagnostic and management aspects of adult ADHD. Attendance and participation in this workshop provided endorsement to individual SIG members to act as trainers. This enables the SIG to decentralise training of other health care providers (psychiatrists, registrars, general practitioners, and other health care professionals).

TRAIN THE TRAINER

PRESENTATIONS INCLUDED:

Dr Renata Schoeman (co-convenor of the SIG): the neurobiology of ADHD, the diagnosis of adult ADHD, pharmacological and non-pharmacological interventions for ADHD, workplace interventions for ADHD.

Dr Eleanor Holzapfel: neuropsychology of ADHD, adult ADHD and substance use disorders, and psychotherapeutic interventions for adult ADHD

Dr Rykie Liebenberg (convenor of the SIG): comorbidity in adult ADHD, lifestyle intervention for adult ADHD and ethical considerations in adult ADHD

The venue and refreshments were kindly provided by Dr Reddy's.



Photo (from left to right): Drs Pieter Pienaar, Chris van den Berg, Carina le Roux, Kobus Roux, Theonie du Plessis, Gerhard Grobler, Frans Korb, Rykie Liebenberg, Anita Gangaram, Renata Schoeman, Janus Steyn, Ingrid Williamson, Kim Ragsdale, Christian Schuler, and Eleanor Holzapfel.

Congratulations to the newly endorsed adult ADHD trainers!

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ACHIEVEMENTS HITHERTO & A NEW EDITORIAL TEAM FOR THE SOUTH AFRICAN JOURNAL OF PSYCHIATRY

South African Journal of Psychiatry
ISSN: (Online) 2078-6786, (Print) 1608-9685

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The South African Journal of Psychiatry (SAJP) is in its 24th year of publishing scholarly work in psychiatry. This is no small achievement. The archives of all the articles that have been published (all from 2002 are available open access at www.sajp.org.za) is evidence of this as well as the various milestones that have been achieved over the years in the face of various daunting challenges along the way.

I remember clearly the discussion led by Prof. Robin Emsley in the early 1990s on a SASOP national executive meeting (I was an observer as a psychiatry registrar at the time) where he was pioneering the route for establishing the SAJP. Prof. Cliff Allwood and Prof. Robin Emsley took the reign consecutively for the first 12 years, and I have been carrying the editor-in-chief baton for the past 11 years, supported from 2013 by three deputy editors, namely, Prof. Liezl Koen, Prof. Soraya Seedat and Prof. Bernard Janse van Rensburg.

Over the past decade, SAJP has achieved a gradual increase in the quality and number of articles published, featuring work by researchers from South Africa, the rest of Africa and increasingly from other continents. From processing half a dozen articles at a given time 10 years ago, the editorial task has reached recently about 70 submissions at a given time, for which each requires back and forth correspondence with its authors, reviewers and the copy editors.

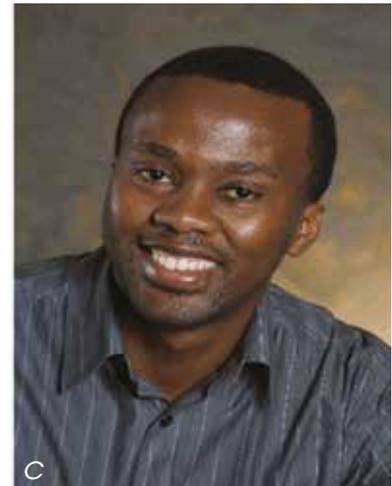
MUCH HAPPENS BEHIND THE SCENES, INCLUDING GUIDANCE AND FINDING WAYS IN WHICH A POTENTIALLY WORTHY ARTICLE CAN BE RESCUED WHEN, FOR EXAMPLE, IT IS POORLY WRITTEN, DEALING WITH (EMINENT) AUTHORS WHO FEEL AFFRONTED, ETC.

Emerging from these efforts, 30% - 40% of all submissions during the past 3 years have resulted in published articles. All this has been paying off. The expectations set in 2006,^{1,2} I believe, have been met owing to excellence in research and publishing afforded by all the role-players.

Other than the contents of SAJP, the most striking milestones during the past decade are the various international listings or indexing that have been awarded, including some of the most prestigious in the world. These listings are on Web of Science Core Collection, Science Citation Index Expanded, SCIE (previously known as ISI); Web of Science Core Collection, Social Sciences Citation Index, SSCI (previously known as ISI); SCOPUS; GALE; CENGAGE Learning; SciELO SA; African Journals Online (AJOL); African Index Medicus; Google Scholar; Norwegian Register for Scientific Journals, Series and Publishers, Level 1.

Other milestones during the past decade include the transition from a manual submission and communication process to a web-based software platform, having new and past issues available gratis on the web and open access to all interested readers, and the transition to the current publishing house (AOSIS). A major challenge arose during 2014, when the previous publishing house had unilaterally enforced a number of changes including the

THE NEW EDITORIAL TEAM



Source: (a) Photo provided by Prof. Werdie van Staden; (b) Photo provided by Prof. Jonathan Burns; (c) Photo provided by Prof. Bonga Chiliza
 FIGURE 1: (a) Prof. Werdie van Staden Outgoing Editor-in-Chief (b) Prof. Jonathan Burns New Editor-in-Chief (c) Prof. Bonga Chiliza New Deputy Editor.

defiance of contractual arrangements for publishing SAJP, terminating the website and editorial software platform dedicated exclusively for SAJP and replacing this infrastructure with a website shared with other journals. Adding insult to injury, the new website crashed irreversibly, without the publisher having secured adequate backup of content. Consequently, several submissions and communiques were lost, which then had to be recovered through external means insofar as possible. As the relationship with the publisher had become untenable, the SASOP Board of Directors then decided to contract with another.

THE RESULTING TRANSITION IN THE BEGINNING OF 2015 WAS SUCCESSFUL BUT SOME DAMAGE WAS INEVITABLE AS SEEN, FOR EXAMPLE, IN THE SUBSEQUENT DROP IN THE JOURNAL'S IMPACT FACTOR. FORTUNATELY, PRELIMINARY INDICATIONS ARE THAT THE IMPACT FACTOR IS ON THE RISE AGAIN. MOREOVER, DOWNLOADS OF FULL ARTICLES CURRENTLY REACH CLOSE TO 3000 PER MONTH.

SAJP has survived these trying times and is flourishing in quality and quantity more so than ever before. Its growth and the rapidly changing world of scientific publications bring about higher demands editorially and for its sustenance. The SASOP Board

of Directors has recognised these challenges, by which henceforth the contracted editor-in-chief will be receiving a stipend for services and will no longer be tasked with the Achievements hitherto and a new editorial team for the South African Journal of Psychiatry financial and funding matters of the journal. These developments should provide for gearing up to a next level of accomplishments.

The SASOP Board of Directors, furthermore, upon my request almost a year ago, has secured a new editorial team as from July 2017: Prof. Jonathan Burns from the University of Exeter as editor-in-chief, Prof. Bonga Chiliza (University of KwaZulu-Natal) as deputy editor and Prof. Bernard Janse van Rensburg (University of the Witwatersrand), Soraya Seedat (Stellenbosch University), Christopher Szabo (University of the Witwatersrand) and myself (University of Pretoria) as associate editors.

I attest that editorship of SAJP has taken a lot of courage (and work, of course). I sincerely congratulate our colleagues on being assigned to their new roles and wish them abundant success with meeting the ever-increasing demands and seeking out creatively further 'gear changes' for SAJP. I implore all psychiatrists in their various roles as well as other stakeholders to support actively the new editorial team in every sensible way.

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MEDIA STATEMENT

APALLING STATE OF MENTAL HEALTH SERVICES IN SOUTH AFRICA

The critical situation found in state mental health hospitals and the as yet unaddressed issues raised in the Health Ombudsperson's report of February this year, has led to the provincial subgroup members of the South African Society for Psychiatrists (SASOP) Public-Sector Psychiatrists' forum reporting on the state of care in their respective regions.

The result is appalling and acts as a second call from SASOP for an overhaul of the mental health care system in all the provinces.

Limpopo province and the Eastern Cape suffer the most severe lack of resources, says Prof Bernard Janse van Rensburg, president of SASOP.

"ONLY SIX PUBLIC SECTOR PSYCHIATRISTS SERVE THE WHOLE OF LIMPOPO, MAINLY FROM GENERAL HOSPITALS. HAYANI HOSPITAL, A 390-BED MENTAL HEALTH SPECIALIST HOSPITAL, WHERE IN 2016, A PSYCHIATRIC NURSE WAS KILLED BY AN INPATIENT, HAS CURRENTLY NO PSYCHIATRIST."

"CHILD AND ADOLESCENT PSYCHIATRIC CARE IS NON-EXISTENT IN THE EASTERN CAPE AND LIMPOPO PROVINCE, AND IN ALL PROVINCES, PSYCHIATRISTS HAVE TO ADMIT CHILDREN AND ADOLESCENTS UNLAWFULLY INTO ADULT PSYCHIATRY WARDS. NO PROVINCE CURRENTLY HAS AN ORGANISED COMMUNITY-BASED PSYCHIATRIC SERVICE."

The report found Mpumalanga and the Northern Cape has no public-sector psychiatry representation whilst in KwaZulu-Natal a massive specialist staffing crisis exists whereby only 20 of the 45 specialist posts are filled.

"WITH PHYSICAL BEDS MISSING, OTHERS NOT IN USE DUE TO FLOODING OF WARDS CAUSED BY THE NON-REPAIR OF DAMAGED ROOFS POST A STORM IN 2015, AND NO WATER OR FOOD AT SOME HOSPITALS SUCH AS UMZIMKHULU IN KWAZULU-NATAL AS FOUND AT SO MANY OTHERS ACROSS THE COUNTRY, THE MOST FUNDAMENTAL BASIC HUMAN RIGHTS OF PATIENTS ARE UNDER THREAT."

Prof Janse van Rensburg says the Eastern Cape is struggling with a dearth of general hospital beds to accommodate acute psychiatric admissions and in most regions the inability to deal with aggressive behaviour by severely mentally ill people has resulted in long waiting lists for forensic psychiatric services.

Other common themes that emerged were an absence of mental health directorates in five of the nine provinces and that Mental Health Review Boards are generally dysfunctional in all provinces.

“MENTAL HEALTH REVIEW BOARDS ARE KEY STRUCTURES PROVIDED FOR BY THE MENTAL HEALTH CARE ACT OF 2002, TO PROTECT THE HUMAN RIGHTS OF THOSE PATIENTS WHOSE DISABILITY OR ACUTE ILLNESS RENDERS THEM UNABLE TO STAND UP FOR THEMSELVES. HOWEVER, THERE IS A GAP IN THIS ROLE, IN THAT SUCH PATIENTS LIVING IN THE COMMUNITY MAY NOT BE PERCEIVED TO REQUIRE SUCH PROTECTION.”

“When living in the community, whether with family or at a residential facility, the severely mentally ill need to access physical and psychiatric care at district health services, with timeous hospital admissions when required.

The report revealed a significant lack of communication and planning regarding the provision of psychiatric care at all levels of the mental health care system, particularly at district services and in general hospitals.”

SASOP called for a complete overhaul of the mental health care system in February following the release of the report by the Health Ombudsperson.

“THE HEALTH OMBUD’S REPORT RECOMMENDED SOME ACTION TO BE COMPLETED WITHIN 45 DAYS, YET 150 DAYS LATER, IT IS GLARINGLY APPARENT THAT THE GENERAL POOR ACCESS TO BOTH PHYSICAL AND MENTAL HEALTH CARE AT COMMUNITY LEVEL REMAINS UNADDRESSED, AND NO COMPREHENSIVE REMEDIAL STRATEGY HAS YET BEEN TABLED IN GAUTENG, OR ELSEWHERE. OUR OWN REPORT NOW SERVES AS A SECOND CALL FOR ACTION TO BE TAKEN.”

“While almost all the previous Life Esidimeni patients have been transferred from the NGOs in Gauteng back into hospital, we are still awaiting positive action on other important recommendations made by the health ombud. Notably recommendation 16, referring to the whole mental health system which should include resourced, developed community-based primary and specialist multidisciplinary teams. The reality however is that the health system still does not cater adequately for the thousands of people who continue to live with mental illness within the community.”

PROF JANSE VAN RENSBURG SAYS, “THE SPECIFIC NEEDS AND HIGHEST PRIORITIES OF EACH PROVINCE MUST BE ADDRESSED. THE FAILURE TO PROVIDE ACCESSIBLE MENTAL HEALTH CARE WILL ONLY ENTRENCH THE PERVASIVE STIGMA AND DISCRIMINATION OF THE MENTALLY ILL IN SOUTH AFRICA.”

SASOP Board

Johannesburg, 23 June 2017

Date issued: 28 June 2017

Enquiries: Linda Christensen, linda@jigsawpr.co.za, 0846669972

UPDATE SINCE THE MEDIA STATEMENT:

TO DATE THE SASOP BOARD HAS BEEN NOTIFIED OF CONFIRMED APPOINTMENTS WITH THE MINISTERIAL ADVISORY COMMITTEE ON THE 22ND AUGUST 2017, AND WITH THE MPUMALANGA MEC FOR HEALTH, MR GP MASHEGO ON THE 8TH SEPTEMBER 2017, AS WELL AS WITH THE KWAZULU-NATAL DEPARTMENT OF HEALTH. RESPONSES ARE BEING AWAITED FROM THE OFFICES OF THE MECs OF HEALTH OF LIMPOPO, FREE STATE AND EASTERN CAPE. THE SASOP BOARD WILL CONTINUE TO REPORT BACK TO ITS MEMBERS ON THE PROGRESS WITH THESE COMMUNICATIONS.

AUGUST 2017

headline



OFFICIAL NEWSLETTER OF THE SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS (SASOP)

SASOP: THE ALTERNATIVE SOLUTION

1. FROM THE EDITOR

The SASOP Headline was "resurrected" after an absence of about four years in November 2015, and has been distributed quarterly ever since as part of South African Psychiatry in both hardcopy and digital format. Being primarily a newsletter, it has been a vehicle for the distribution of news pertaining to SASOP and its members, so that members of the Society can remain informed of work being done from Board of Directors (BOD) and National Council level, down to the Divisions, Special Interest Groups and Subgroups, and even that of individual psychiatrists.



Ian Westmore

The intention of Headline has been to keep SASOP members informed, so that the Society can operate as a cohesive whole. It would be the perfect place to refer anyone who asks the question, "What does SASOP do for me?" to, and its content has also been intended to generate debate amongst members about the work of SASOP.

It has become apparent that, after almost two years, we need to look at whether Headline in its current format is in fact delivering on its mandate effectively. We have been in discussion with a PRO company who will be assisting us in looking at how we deliver news to our members, and how we could possibly improve. In due course, we will be sending out an electronic survey to members, to assist us in re-thinking the newsletter – so please participate and let us have your views!

Dr. Ian Westmore (Editor)
May 2017

Ian Westmore is psychiatrist in private practice in Bloemfontein and is a Past President of SASOP (2010-2012). He is the current convenor of the SASOP Mentorship, Young Psychiatrists and Registrars Division and a member of the Local Organising Committee of the WPA International Congress to be held in Cape Town in November 2016. He has served on the SASOP Executive and National Council in various capacities since 2002. **Correspondence:** westmore@axxess.co.za

2. FROM THE PRESIDENT

The SASOP PubSec Group met in June 2017 during the Dr Reddy's weekend in Cape Town and reported on the state of care in their different regions. This led to a decision by the SASOP Board to release another media statement, which was a second call for an overhaul of the mental health care system. This statement focused on other areas and provinces such as Limpopo, Eastern Cape, KZN and the Free State. It was, however, heavily criticized for its content and timing from the view that SASOP should first have consulted again with decision-makers in the different regions and that SASOP should stick to professional matters and not engage in advocacy.

It is therefore of importance to note here that one of SASOP's objectives is to be an advocate and to promote patients' rights and interests, in addition to that of psychiatrists. Subsequently, letters to the National Minister, the Chair of the Ministerial Advisory Committee and to several MECs have been sent requesting interviews. Responses are being awaited and follow-up communication will be released following these requested meetings.

Prof Werdie van Staden recently completed a period of more than 10 years as Editor-in-Chief of the SAJP. He served the publication selflessly and with distinction over this whole period to ensure a local South African academic publication of high standing and quality. As SASOP Board and on behalf of the whole membership, we want to thank and acknowledge Prof van Staden for this, in particular during the past two years, for negotiating the changing financial model for the journal and the change of publishers. We also want to thank Prof Jonathan Burns - currently from Exeter University, for taking over this position as from July 2017.

Prof Bernard Janse van Rensburg

SASOP President 2016-2018

3. SASOP PUBLIC SECTOR PSYCHIATRISTS (PUBSEC) REPORT DR LESLEY ROBERTSON (NATIONAL CONVENOR)

DR REDDY'S/SASOP WEEKEND

Dr Reddy's sponsored 50 public sector psychiatrists to attend the congress in early June this year. The public-sector meetings took place on the Friday afternoon and Sunday morning.

At the meeting, dire reports were given by the subgroup representatives. With variations between provinces, common challenges included a severe shortage of psychiatrists, poor access/shortage of medication, no child and adolescent services, inadequate numbers of acute beds, no substance rehabilitation units and grossly inadequate forensic services. Mental health review boards were reported as dysfunctional or absent, as were the Provincial Mental Health Directorates. Whilst feedback from the Eastern Cape, Limpopo province and the Free State were particularly disturbing, there was no representative at all from Mpumalanga. Specialist psychiatric hospitals with no psychiatrists included Umzimkhulu and Madadeni hospitals in KZN, and Evuxakeni and Thabamooopo in Limpopo province. District level psychiatric care was problematic in all provinces with inadequate resources for 72-hour observations throughout. Community psychiatry was not evident anywhere, although the Western Cape had some psychiatric services in district hospitals and Gauteng had extremely limited district psychiatric clinics.

The Sunday morning was devoted to strategic planning. Most of the discussion revolved around a proposal for Community Psychiatry staffing that had been submitted on request to the National Director of Mental Health previously. Inputs were provided by representatives of each province; these will be combined to form a SASOP proposal which may be submitted in the public domain.

MEDIA STATEMENT

The central themes of the subgroup reports were all placed in the public domain in a SASOP media statement on the 28th of June. This was done with the knowledge and agreement of all present at the Friday afternoon meeting. The statement elicited an immediate strong negative reaction by the Minister of Health and some criticism by the Health Ombud, particularly with respect to the timing of the statement and perceived contradictions regarding the numerous hats we wear as SASOP members. Despite

the reaction, Prof Bernard Janse van Rensburg continued to represent SASOP in interviews regarding the contents of our statement. He has also made further attempts to communicate with government and a meeting request has been sent by SASOP to each Provincial MEC of Health.

Issuing media statements is new territory for us as public-sector employees. It differs from issuing a response to a public sector matter in that, with a statement, we initiate the media conversation. Whilst there may be some debate to be had as to how and when we do this, the sense of futility with discussion through official channels is overwhelming.

UPCOMING EVENTS

- The South African Human Rights Commission (SAHRC) is to hold a national hearing into the status of mental health care in August this year. Prof Janse van Rensburg and I have both been appointed to the Section 11 Committee, which assists the SAHRC in its preparation for the hearing.
- A brief PubSec meeting will be held at the Biological Psychiatry Congress, very likely on the Friday afternoon immediately after the Pre-Congress workshops. Please could all members attend.
- A second "Step up for Mental Health" advocacy walk is being planned in KZN. Could we this become a national event? ... to be discussed at our meeting in September.
- Dr Roux will continue as convenor of the SIG.

4. FROM THE SUBGROUPS: SOUTHERN GAUTENG SUBGROUP DR PEVASHNEE NAICKER

ACTIVITIES (SINCE START OF THE TERM)

- The subgroup committee aims to meet once every quarter alternating with the core committee and then the extended committee. The core committee met on 12 May 2017 and the Extended committee on 20 January 2017 (Next meeting is planned for 2 August 2017).
- The subgroup hosts a "meet and greet tea" with the newly appointed WITS registrars every 6 months. We explain SASOP's role as a professional body and this personalised meeting has been successful in encouraging registrar membership. This took place on the 11th January 2017 and again on 7th July 2017.
- Academic activities: we generally aim for 2-3 mini symposia per annum. We hosted the Psychotherapy Workshop on "Mindfulness" which took place on 27 May 2017. Dr Simon Whitesman, an expert in mindfulness therapy was flown up from Cape Town to share his valuable insights on the therapy. His mentee, Dr Gaveeta Chiba delivered a stimulating talk

on the practical aspects of practicing Mindfulness with psychiatric patients. Thanks to sponsorship by Novartis & Zentiva-Sanofi, SASOP members attended at no cost and were treated to scrumptious tea. The workshop was very well attended by over 40 delegates, and included clinical psychologists and allied mental health practitioners. It also provided a nice forum for collaboration and networking between the multiple disciplines. The next CPD accredited seminar will be on "Psychiatric Aspects of Pain Syndromes and MUS" and is planned for 4 November 2017.

SOUTHERN GAUTENG PUBSEC

- The subgroup has been engaging with the Gauteng Mental Health Department (MHD) for the last 3 years in an attempt to foster relationships, lend assistance to various psychiatric programs and play a supportive role in facilitating solutions to the never-ending mental health care issues in the province. The last meeting with the Gauteng MHD and other stake holders was held on 24/04/2017 at the MHD offices. The Northern subgroup is also included in these meetings.

Although the Life Esidimeni issue dominated the last 2 meetings, various aspects of the relocation project were clarified. The important aspect of the District psychiatry program (or lack thereof) was discussed at length. It was suggested that if any progress was to be made regarding the improvement of a community psychiatry program, a strategic workshop that included all possible stakeholders needed to take place to possibly come up with an integrated solution that can best use the limited resources.

A PubSec SIG meeting was held on 27/05/2017 and chaired by Dr Tando Melapi. We are looking into the possibility of having a psychotherapeutics group that can critique peer-reviewed data on the various psychotropic meds available to assist with motivations for psychiatric medications on the EML.

- The subgroup sponsored the prize for the best research presentation at the WITS research day event on the 21 June 2017. The subgroup feels that is important to support research initiatives and promote excellence in the registrar-training program.
- The subgroup also actively participated in the Dr Reddy's academic weekend and had many of its members, both public and private, attending the conference.
- The subgroup will part-sponsor 5 delegates' registration fees for the upcoming Biological Psychiatry conference - we are currently requesting applications from subgroup members for the sponsorship.

5. SPECIAL INTEREST GROUPS (SIGS) BIOLOGICAL SPECIAL INTEREST GROUP:

THE BIOLOGICAL PSYCHIATRY CONGRESS 2017 UPDATE
ANUSHA LACHMAN,
CHRISTINE LOCHNER

CONGRESS THEME: RISK AND RESILIENCE IN MENTAL HEALTH: IMPROVING LIFE THROUGH SCIENCE

"Mental health is a fundamental element of the resilience, health assets, capabilities and positive adaptation that enable people both to cope with adversity and to reach their full potential and humanity" (WHO Statement on Mental Health, Resilience and Inequality, 2009).

The world has always been changing, but we are having to accommodate rapidly escalating challenges within the context of globalization. There is an increasing number of displaced persons and refugees around the world – bringing with this social disruption, hunger poverty, and alienation – experienced by the most vulnerable. Countries trying to develop in the face of adversity (natural disasters, terrorist attacks, and unprecedented exposure to trauma) face impediments not just in infrastructure development but also in human development. Establishing a physically and a mentally healthy populace is a crucial component for promoting development in low-resource countries.

It is with this narrative in mind, that the Biological Psychiatry Congress for 2017 will be focused on "Risk and Resilience in Mental Health: Improving Life through Science".

This event, hosted by the Biological Psychiatry Special Interest Group, is an official meeting of the South African Society of Psychiatrists and will run from **14 to 18 September 2017** at the **Lord Charles Hotel in Somerset West, Cape Town.**

Building resilience through nurturing diversity, adaptive learning, and constructive positive feedback loops is consistent with calls for a shift in thinking from identifying what is missing and vulnerabilities, to identifying the strengths, skills, and resources that are already in place within communities. Many mental health problems among African populations have been tied to poverty, warfare and natural disasters — problems that

have displaced 10.5 million sub-Saharan Africans. The multidimensional nature of both risk and resilience and the heterogeneous way in which these concepts are conceptualized, assessed, and interpreted have hampered their translation to the improvement of clinical outcomes. Newer and more robust ways of understanding psychopathology, protection of risk, and prevention of the range of psychiatric disorders that form the bread-and-butter of clinical practice are clearly needed. In this regard, risk and resilience models, in the context of adversity, may offer a more direct and novel approach to drug discovery, psychotherapy interventions, and preventive public health strategies in schizophrenia, mood and anxiety disorders, amongst others.

The congress theme for this year is of particular relevance, as the recent surge in related neuro-scientific and genetic research has necessitated a translational approach. Currently, there is a great need to integrate empirical findings into effective diagnostic and treatment interventions. To this end, a number of renowned local and international speakers have been invited to present their latest findings. The program has been structured to include not only high calibre international experts on neuroscience and research, but also will include local and clinically relevant contributions, with specific focus on young up and coming researchers from the African Continent.

In addition to a range of expert plenary lectures, attendees will also have the opportunity to attend and participate in pre-congress workshops, of interest to researchers and clinicians alike, focusing on amongst others, molecular and cellular pathways involved in novel treatment agents and strategies, cannabis use and mental health, mindfulness, updates on psychopharmacology/pharmacotherapy, and chronic pain. There will also be sponsored breakfast sessions, poster presentations, and a parallel neuroscience symposium focusing on basic sciences.

As has become the tradition, this year's congress will offer not only a stimulating academic programme, but will also afford attendees the ideal space and setting to reconnect with colleagues, and to form new networks and working relationships.

As such, the weekend will provide an enviable opportunity for collaboration and information sharing between psychiatrists, neuroscientists and other professionals with an interest in promoting mental health and wellbeing by blending scientific advancements with clinically relevant and translatable research. Delegates visiting the fairest Cape will be spoilt for choice in this vibrant city with its beautiful geographical and cultural landscape that boasts stunning beaches, mountains, vineyards and much more.

The organizing committee looks forward to welcoming delegates to what promises to be a thought provoking and innovative congress on the African Continent.

Webpage:

<http://www.biopsychsa.co.za/>
Congress Organizers: Londocor

For further information or registration queries, please contact:

Sonja du Plessis:

Email: sonja@londocor.co.za

To book your stand or sponsorship opportunity, please contact:

Kea Poulton:

Email: kea@londocor.co.za;

Contact Number: 011 954 5753

6. GENERAL NEWS

6.1 EARLY CAREER PSYCHIATRISTS ATTEND INTERNATIONAL MEETINGS

6.1.1 THE AIN SHAMS UNIVERSITY INSTITUTE OF PSYCHIATRY CONGRESS DR TANDO MELAPI

The Ain Shams University Institute of Psychiatry, in Egypt, hosted its 13th International congress from 2-4 May 2017. Five international Early Career Psychiatrists (ECP) fellowships were awarded by the congress organizers to ECPs from across the globe. ECPs that received fellowships and presented at this congress were Sidharth Arya (India), Brihastami Sawitri (Indonesia) Yugesh Rai (Nepal), Ellen Minkenberg (Netherlands) and Tando Melapi (South Africa). Topics presented by these ECPs ranged from metabolic disorders among psychiatric patients, religious coping, leadership and professional development to migration related topics. Tando Melapi also did another presentation on the practice of psychiatry in South Africa. (This was a brief overview of how psychiatric services are structured in the country, what challenges we face and how we are learning to deal with them).

These international ECPs were joined by local Egyptian ECPs who also presented on various topics of relevance to psychiatric practice in Egypt.

As part of Egyptian hospitality, the international guests were hosted very kindly by the local ECPs under the leadership and guidance of Dr. Hussien Elkholy. Entertainment included visits to the Nile, exposure to some night life of busy Cairo and a formal dinner on the closing night of the congress. International ECPs also had time to visit historical sights and learn about Egyptian culture.

All invited ECPs would like to thank the congress organisers for this opportunity to learn and grow. We look forward to many more collaborations and cooperation that will result from the forged



Dr Tando Melapi (left) with the WPA ECP Section chair, Dr Hussien Elkholy (second from left) and other international ECP delegates at the Cairo congress.

professional relationships.

6.1.2 WHO FORUM ON ALCOHOL, DRUGS AND ADDICTIVE BEHAVIOURS DR NIRVANA MORGAN

The World Health Organization (WHO) Department of Mental Health and Substance Abuse held the first ever global forum on alcohol, drugs and addictive behaviours from 26 to 28 June 2017. I was honoured to be a part of this event at the WHO headquarters in Geneva. The aim of the forum was to enhance public health actions through strengthening international partnerships and collaboration. It was an important platform to highlight the outcomes of the 2016 United Nations General Assembly Special Session on the world drug problem. Both WHO and United Nations collaborators emphasized the need for member states to address the burden of alcohol, drugs and addictive behaviours from a public health perspective. The forum also saw the launch of an international Network of Early Career Professionals in the field of Addiction Medicine (NECPAM). This newly-formed network already has members from 15 countries around

the world. As elected co-chair, I look forward to growing the network, trusting that we will fulfil our goals to strengthen leadership, build capacity and empower early career professionals in the field.

I would like to thank the convenor of the SASOP Early Career Psychiatrists division, Dr Tando Melapi, for offering me the opportunity to attend the forum. My gratitude also goes to the Cassandra Miller-Butterworth Fellowship that made this trip possible.

7. IN MEMORIAM: DR MIKE EWART-SMITH

The following statement was issued on July 7th, 2017 by the SASOP President following the news of the passing of Dr Mike Ewart-Smith:

As a society, we were very sad to hear the news this week of the passing of Dr Mike Ewart-Smith. The Board of SASOP, on behalf of all the members, but in particular the Southern Gauteng Subgroup of which Mike was a long-standing member, would herewith like to extend our heartfelt condolences to his wife Jo and family, wishing them much strength and peace during this difficult time of loss and transition. Mike was a much-respected senior colleague in our group for many years and was, for many of us, a trusted mentor and advisor. He played a seminal role as consultant on forensic and disability assessment matters, and as such, for many years advised on SASOP's Advisory Committee in this regard.

We will really miss him, but will continue to think of him with fondness and appreciation.

**Prof Bernard Janse van Rensburg,
SASOP President**

8. IMPORTANT SASOP DATES FOR THE REMAINDER OF 2017

11 AUG 2017 11-13 AUG 2017	PSYCHMG BOARD MEETING PSYCHMG WEEKEND (ZIMBALI)
7-9 SEP 2017	SAACAPAP (CAPE TOWN)
14-17 SEP 2017	BIOLOGICAL PSYCHIATRY CONGRESS (SOMERSET WEST)
14 SEP 2017	BOD MEETING
22 JUL 2017	BOD & SIGS MEETING
16 SEP 2017	AGM
14 SEP 2017	BOD MEETING
16 SEP 2017	AGM
8-12 OCT 2017	WORLD PSYCHIATRY CONGRESS, BERLIN
21-22 OCT 2017	SERVIER CINP WEEKEND
11 NOV 2017	BOD & NATIONAL COUNCIL MEETING

PRESIDENT'S REPORT

Bernard Janse van Rensburg

Dear SASOP Member,

The provincial members of SASOP's Public Sector Group have met in June 2017 during the Dr Reddy's weekend in Cape Town and reported on the state of care in their respective regions.

THIS LED TO A DECISION BY THE BOARD OF SASOP TO RELEASE ANOTHER MEDIA STATEMENT ON THE STATE OF MENTAL HEALTH SERVICES IN SOUTH AFRICA. THIS WAS SASOP'S SECOND CALL FOR AN OVERHAUL OF THE MENTAL HEALTH CARE SYSTEM AND ACCESS TO APPROPRIATE MENTAL HEALTH CARE FOR ALL IN THE COMMUNITY, IN THE CONTEXT OF RECOMMENDATION 16 OF THE HEALTH OMBUD'S REPORT IN FEBRUARY 2017 ON THE DEATHS OF PSYCHIATRIC PATIENTS IN GAUTENG.

This second SASOP statement served in particular to highlight scenarios in other provinces and not to only focus on Gauteng and was deemed necessary by our regional representatives when reporting on the conditions in their areas and therefore, as it focused on the conditions in provinces with the least resources, such as Limpopo, Eastern Cape and Free State.

Our statement was, however, heavily criticized, both for its content and timing from the view that the SASOP should first have "consulted first with decision-makers" in these provinces, as well as that SASOP should stick to professional matters and not engage in advocacy. It should therefore be pointed out here though that one of SASOP's main objectives is to act as an advocate for patients and patients' rights.

BUT IN ORDER TO ADDRESS THIS CRITICISM, AS WELL AS TO CONFIRM THE TRUTHFULNESS OF THE STATEMENT'S CONTENT, WE SUBSEQUENTLY SENT LETTERS REQUESTING INTERVIEWS TO THE MINISTER OF HEALTH, DR AARON MOTSOLEDI, THE CHAIR OF THE MINISTERIAL ADVISORY COMMITTEE, PROF SOLLY RATAEMANE AND TO MECs IN MOST OF THE NINE PROVINCES.



Bernard Janse van Rensburg

We are awaiting responses and will report back in follow-up communication on the outcome of these requests and proposed engagements.

I also wanted to note again that Prof Werdie van Staden recently concluded a period of more than 10 years as the Editor-in-Chief of the South African Journal of Psychiatry (SAJP). Werdie took this position over from Prof Robin Emsley at the time and served the publication with distinction during this whole period. In particular during the last two years, where we have seen a change in the financing model for the journal, as well as a change in publishers.

As the SASOP Board and on behalf of the whole SASOP membership, we want to thank and acknowledge Prof van Staden for his continuous and selfless input over these many years to ensure a local South African academic journal of high standing and quality.

Prof Jonathan Burns, known to all of us, currently from Exeter University in the UK has agreed to take over the position of Editor-in-Chief of the SAJP as from July 2017, with Prof. Bonga Chiliza, academic head of department at UKZN, as deputy-editor. For both of you, thank you too and best wishes for taking charge of the new chapter for SAJP.

Bernard
2017

Prof Bernard Janse van Rensburg
President (2016-2018)



South African Society of Psychiatrists

Bernard Janse van Rensburg

Correspondence: bernard.sasop@mweb.co.za

INSTRUCTIONS TO AUTHORS

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

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

LETTERS TO THE EDITOR

- * Novel experiences
- * Response to published content
- * Issues

FEATURES

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

Feature articles will, as of the February 2017 issue, be sent for commentary to be published with the article. This will constitute a form of open peer review.

REPORTS

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

NEWS

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

ANNOUNCEMENTS

- * Congresses, symposia, workshops
- * Publications, especially books

The format of the abovementioned contributions does not conform to typical scientific papers. Contributors are encouraged to write in a style that is best suited to the content. There is no required word count and authors are not restricted, but content will be subject to editing for publication. Referencing should conform to the Vancouver style i.e. superscript numeral in text (outside the full stop with the following illustration for the reference section: *Other AN, Person CD. Title of article. Name of Journal, Year of publication; Volume (Issue); page number/s. doi number (if available)*). All content should be accompanied by a relevant photo (preferably high resolution – to ensure quality reproduction) of the author/authors as well as the event or with the necessary graphic content. A brief biography of the author/authors should accompany content, including discipline, current position, notable/relevant interests and an email address. Contributions are encouraged and welcome from the broader mental health professional community i.e. all related professionals, including industry. All submitted content will be subject to review by the editor-in-chief, and where necessary the advisory board.

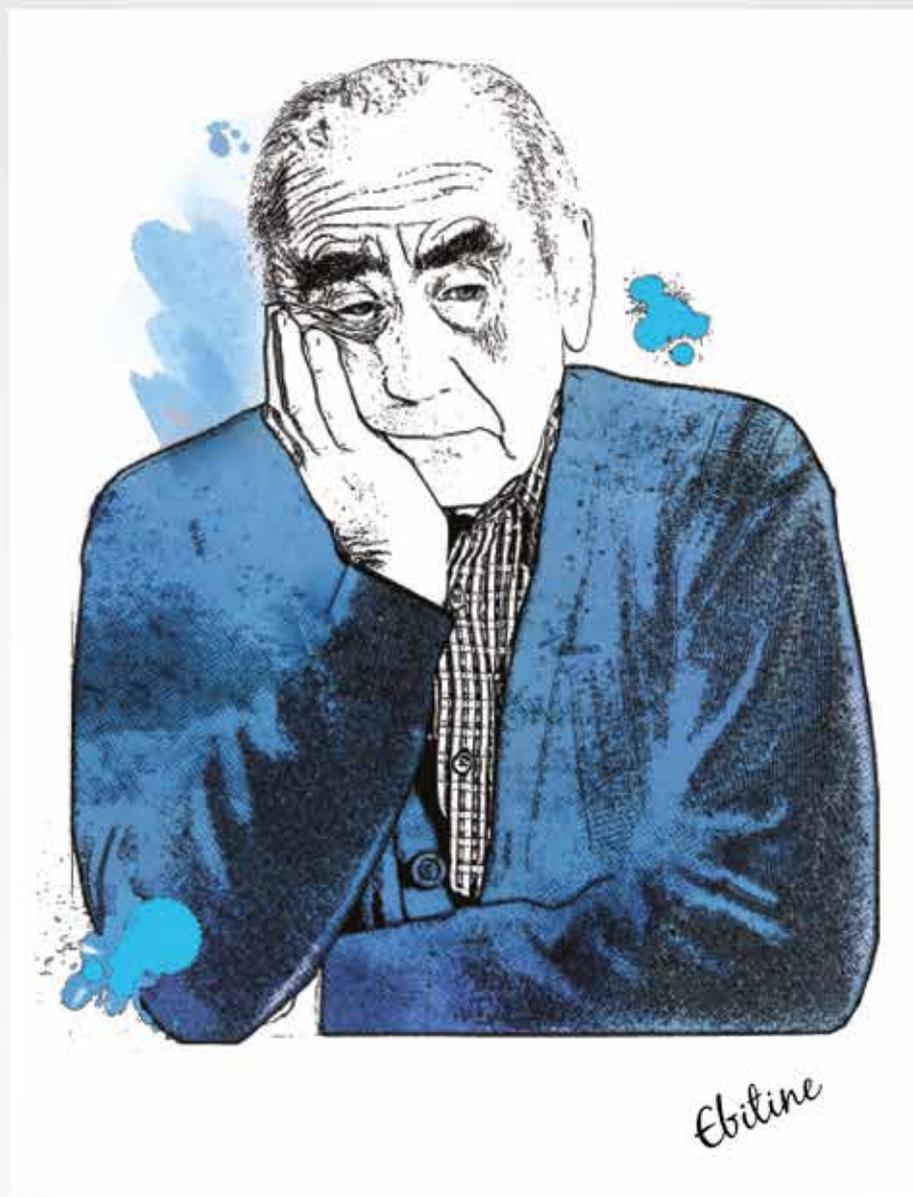
REVIEW ARTICLES

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

- * A 300 word abstract that succinctly summarizes the content will be required.
- * Referencing should conform to the Vancouver style i.e. superscript numeral in text (outside the full stop with the following illustration for the reference section : *Other AN, Person CD. Title of article. Name of Journal, Year of publication; Volume (Issue); page number/s. doi number (if available)*)
- * The submission should be accompanied by the University/Faculty letter noting successful completion of the research report.
 - * This will constitute peer review given that the examination process involves 2 independent examiners, with any revisions generally having been undertaken to the satisfaction of both your supervisor and Head of Department.

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

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- Improved Daily Functioning⁴ and Work Performance⁵

References: 1. Meen MD, Plosker GL. Zolpidem Extended-Release. *CNS Drugs*. 2006;20(5):419-426. 2. Weining E, McDougall S, Andre F, Blanchette G, Dubruc C. Pharmacokinetic profile of a new modified release formulation of zolpidem designed to improve sleep maintenance. *Fundam Clin Pharmacol*. 2006;20(4):397-403. 3. Monti JM, Spence DW, Pandi-Perumal SR, Langer SZ, Hardeland R. Pharmacotherapy of Insomnia: Focus on Zolpidem Extended Release. *Clinical Medicine: Therapeutics*. 2009;1:123-140. 4. Krystal AD, Erman M, Zammit GK, Soubrani C, Roth T. Long-Term Efficacy and Safety of Zolpidem Extended-Release 12.5 mg, Administered 3 to 7 Nights Per Week for 24 Weeks, in Patients With Chronic Primary Insomnia: A 6-Month, Randomized, Double-Blind, Placebo-Controlled, Parallel-Group, Multicenter Study. *Sleep*. 2005;31(1):79-90. 5. Erman M, Guiraud A, Jolish VN, Lerner D. Zolpidem extended-release 12.5 mg associated with improvements in work performance in a 6-month randomized, placebo-controlled trial. *Sleep*. 2008;31(10):1371-1376.

For full prescribing information refer to the package insert approved by the medicines regulatory authority.

SCHEDULING STATUS: [S5] PROPRIETARY NAME (AND DOSAGE FORM): STILNOX® MR 12.5 (Modified Release Tablet). COMPOSITION: STILNOX® MR 12.5: Each tablet contains zolpidem tartrate 12.5 mg. PHARMACOLOGICAL CLASSIFICATION: A 2.2. Sedatives, hypnotics. REGISTRATION NUMBERS: STILNOX® MR 12.5: A40/2.2/0441.

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