SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS
SASOP NORTHERN GAUTENG MINI SYMPOSIUM:
TRAUMA AND MENTAL HEALTH

Carla Kotze

The SASOP Northern Gauteng Subgroup hosted their annual mini-symposium at the CSIR in Pretoria on the 18th June 2016.

Dr Pierre Malherbe chaired the event with the theme: Trauma and Mental Health. Londocor assisted with the event management and feedback has been overwhelmingly positive. The symposium was well attended with 14 industry sponsors. Presentations were of the highest standard, comprising a range of invited speakers.

PROF PIERRE JOUBERT:
POSTTRAUMATIC STRESS DISORDER (PTSD) AND ACUTE STRESS DISORDER (ASD): DSM-IV TO DSM 5

Prof Joubert expressed the opinion that the developments around PTSD / ASD present an example of psychiatrists trying to get a better understanding of a complex phenomenon. It is done to the exasperation of disciplines and individuals idealizing constancy. What we are seeing is the scientific process in action over relatively brief periods of time.

He highlighted the changes in diagnostic criteria from DSM-IV to DSM 5 in a very clear and concise manner and provided the following summary for PTSD changes:

Prof Joubert and Dr Pierre Malherbe (Chair)

The traumatic event(s) is better described; Re-experiencing symptoms are now called intrusion symptoms and there are small changes involving better definitions; Symptoms of avoidance have their own category; Symptoms of changes in cognition and mood have their own category and include changes from DSM IV-TR; Symptoms of arousal and reactivity include reckless or destructive behaviour. For ASD: The traumatic event(s) is better described; No immediate reaction of intense hopelessness etc., or dissociation is required; The traumatic event(s) involve the only criteria that must be met.

He concluded with the idea that psychiatrists should not get stuck on cherished opinions – if the facts, even just for a period of time, properly point in a different direction, we must go with the facts in the true spirit of science.

DR ANDROULA LADIKOS:
IMPACT OF CHILDHOOD TRAUMA

Dr Ladikos gave an in depth discussion about the way in which children's early social experiences shape their developing neurological and biological systems. Stressful and traumatic experiences undermine their health, social competence and their ability to succeed academically as well as in life.

Stable attachment bonds are essential for an infant's continuing neurobiological development and form the basis of a child's coping strategies and later adult mental health. It also affects the individual's style of engagement and seeking out of supportive relationships later in life. Attachment is a process that continues throughout the later stages of life and early trauma has immediate as well as long term consequences. It is not only trauma within the first two years of life that is psycho-pathogenic. Long term trauma such as having an abusive father can also have a very negative effect on the developing child.

On the positive side, positive environmental influences, such as social support can ameliorate genetic and environmental risk for psychopathology and promote resilience.There is evidence that effective psychotherapy interventions can be made in traumatized two year olds. In order to understand

and make sense of the effect of trauma in childhood, one has to understand the underlying mechanisms that have an effect on the developing brain. Early intervention and identification of the negative events of early childhood trauma is everyone working in mental health's business.

Androula Ladikos, Pierre Joubert, Ugasvaree Subramaney

PROF UGASVAREE SUBRAMANEY: *PTSD CONTROVERSIES AND DETECTION OF MALINGERING*

Prof Subramaney focused on 2 aspects of PTSD: Firstly, she discussed issues surrounding the clinical utility of the diagnosis. It is the only disorder for which the diagnostic criteria specify a clear cause/precipitant. Whereas PTSD was once conceptualized as a normal response to an abnormal event, it is now increasingly viewed as an abnormal response to events that turn out to be relatively common. Belief systems and how people make sense of what happens to them may impact on how trauma is experienced and PTSD is expressed. While controversy about PTSD is understandable given that it can be used for purposes of compensation, there is continuing evidence that PTSD is characterized by specific psychobiological disturbances, and that this condition deserves increased recognition and improved treatment.

The second half of the talk concentrated on the detection and management of malingering. People might malinger for financial reasons, to avoid criminal responsibility, in order to justify their level of functioning to others, or to gain the attention and respect of fellow comrades/veterans. Detection of malingering is typically a probabilistic judgement and one should ombine all available evidence and determine wether the bulk of the evidence points toward a particular conclusion. A recommended starting point is the Miller-Forensic Assessment of Symptoms (M-FAST; Miller 2001), combined with a diagnostic interview and collateral information. It is important to spend time studying the mind of the claimant and to remember that no single finding from a clinical assessment is sufficient to definitively identify malingering.

DR RICHARD SYKES: *PSYCHOPHARMACOLOGY FOR TRAUMA-RELATED DISORDERS*

Dr Sykes highlighted the neurobiological changes and discussed some of the psychopharmacological dilemmas in PTSD. These include the high rate of comorbidity, different responses based on the types of trauma, that no agent has been developed specifically for PTSD, with few double-blind trials and poor response and remission rates. There are many different treatment guidelines available and they all acknowledge pharmacological and psychotherapeutic approaches. It is recommended that psychotherapy should be used before pharmacotherapy when possible.

First-line pharmacotherapy is SSRIs, with the best evidence for paroxetine, sertraline and fluoxetine. The SNRIs, especially venlafaxine, are also considered first-line options, but do not improve hyperarousal. Other medications with some evidence for improvement of certain symptoms include, phenelzine, meclobemide and mirtazapine. Trazodone and gabapentin may help for insomnia. Carbemazepine can help with flashbacks, insomnia, irritability and impulsivity, while valproate can improve hyperarousal and avoidance. Topiramate and lamotrigine can improve insomnia, re-experiencing and irritability. Lithium is helpful in reducing irritability and anger. Antipsychotics, including risperidone, olanzapine and quetiapine can also be used in severe, treatment-resistant PTSD. Benzodiazepines have limited value in treating the core symptoms of PTSD.

The take-home message was that PTSD is a complex, multi-dimensional neuropsychiatric illness, with a high probability of chronicity and comorbidity. SSRI's and SNRI's have the most evidence as first-line agents in

Fanie Bale, Carla Kotzé, Richard Sykes

combination with psychotherapeutic treatments. Current treatments fail to address all the dimensions of the illness. Adrenergic inhibiting agents, especially as early intervention treatments, provide promising results. There is an investigative drive underway and currently there are more than 30 randomized controlled clinical trials testing novel agents for the prevention and treatment of PTSD.

TRAUMA & MENTAL HEALTH

DR FANE BALE:
HYPNOTHERAPY FOR TRAUMA IN PSYCHIATRY

Dr Bale gave a brief history of hypnosis and highlighted some of the misconceptions. He briefly discussed the hypnotherapy process, which includes the pre-induction phase, trance induction and deepening phase, termination phase and post-hypnotic phase. The APA has said the following about hypnosis: 'Hypnosis is not in itself a therapy, but rather is a state of aroused, attentive, focal concentration with a relative reduction in peripheral awareness that can be utilized to facilitate a variety of psychotherapeutic interventions'.

During the hypnotherapy process a full psychiatric history, including the organic work up is important, before initiation of the hypnotherapy process. Afterwards a post-hypnotic interview is done and therapy is continued. Hypnotherapeutic and hypno-analytic techniques applicable in psychiatry after trauma exposure were discussed with the focus on regression hypnotherapy and ideomotor signals. The abreaction-therapeutic process of releasing intense emotions while recovering buried memories was also discusses. Abreaction is a highly emotional reliving of an experience, which frequently becomes a catharsis. The purpose is to transform unfinished stuck places/memories/suggestions/beliefs that have been continuing to negatively affect the patient's current life.

Dr Bale concluded with a case presentation that demonstrated one of these techniques used in a psychiatric patient. Hypnotherapy augmentation to pharmacotherapy in the management of some psychiatric conditions like PTSD has been reported to have some value in some studies.

DR CARLA KOTZÉ:
ELDER ABUSE:
ETHICAL AND LEGAL ASPECTS

Dr Kotzé discussed the increase in the older population and elder abuse as a global public health, criminal justice and human rights problem. The phenomenon of elder abuse is understudied and clear evidence of the prevalence and scope of the problem is unknown, partly due to problems with the exact definition of what constitutes abuse. Older people have reported that they perceive marginalization and exclusion as a result of structural deficits and social transformation as a violation of their human rights.

The Older Persons Act of 2006 was discussed in the context of the historical background, its main objectives and limitations with implimentation. Some ethical dillemmas, such as the duty to report, protection and safety vs. confidentiality, victim autonomy and right to self-determination were also addressed. There is a legal obligation to report suspected abuse, but the overriding concern must always be the safety of the patient and prevention of unnecessary suffering.

AS A CONCLUSION THE NEED FOR MORE RESEARCH INTO THE PHENOMENON OF ELDER ABUSE WAS HIGHLIGHTED. HEALTH PROFESSIONALS SHOULD CONSIDER ROUTINE SCREENING FOR ABUSE, ESPECIALLY IN HIGH-RISK POPULATIONS, AND PATIENT-CENTERED TREATMENT AND PREVENTION STRATEGIES SHOULD BE IMPLEMENTED. THERE SHOULD BE COORDINATED EFFORTS AT NATIONAL LEVEL TO PRESERVE AND PROTECT THE HUMAN RIGHTS OF VULNERABLE AGING POPULATIONS. THE PROBLEM OF ELDER ABUSE CANNOT BE PROPERLY SOLVED IF ESSENTIAL NEEDS ARE NOT MET. WE MUST CREATE AN ENVIRONMENT IN WHICH AGEING IS ACCEPTED AS A NATURAL PART OF THE LIFE CYCLE AND WHERE OLDER PEOPLE ARE GIVEN THE RIGHT TO LIVE IN DIGNITY – FREE OF ABUSE AND EXPLOITATION – WITH OPPORTUNITIES TO PARTICIPATE FULLY IN EDUCATIONAL, CULTURAL, SPIRITUAL AND ECONOMIC ACTIVITIES.

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