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# SOUTH AFRICAN PSYCHIATRY

ABOUT the discipline FOR the discipline

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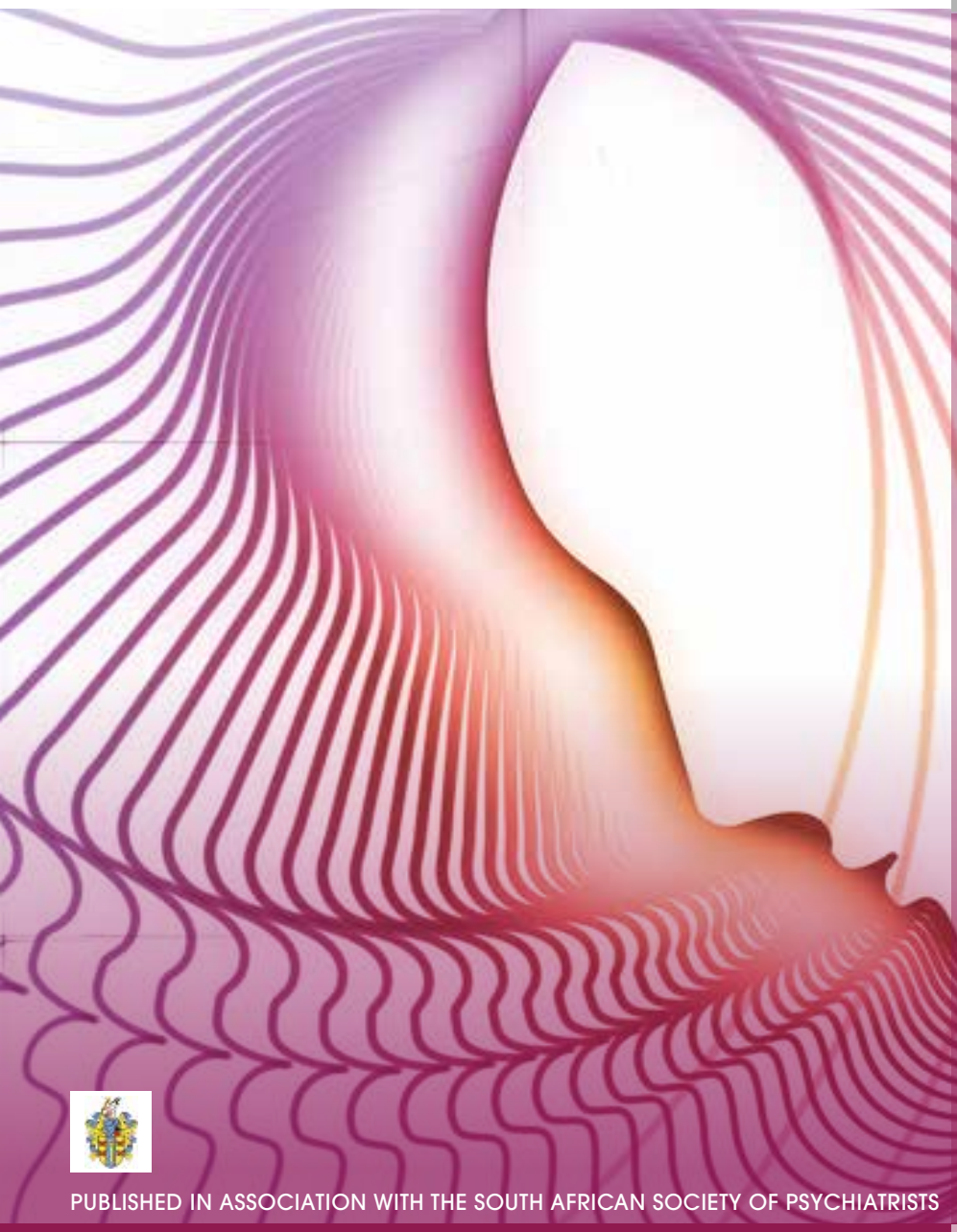

## TECHNOLOGY IN PSYCHIATRY

## THE RELEVANCE OF PARENT/CAREGIVER-INFANT INTERVENTIONS

## THE US/MRC UNIT ON ANXIETY & STRESS DISORDERS

## POSTGRADUATE PSYCHIATRIC EDUCATION IN SOUTH AFRICA

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**References: 1.** Clark BG, Jue SG, Dawson GW, Ward A. Loprazolam – A Preliminary Review of its Pharmacodynamic and Pharmacokinetic Properties and Therapeutic Efficacy in Insomnia. *Drugs.* 1986;31(6):500-516. **2.** Dormonoct® 2 mg Package Insert. **3.** Salkind MR, Silverstone T. The clinical and psychometric evaluation of a new hypnotic drug, loprazolam, in general practice. *Curr Med Res Opin.* 1983;8(5):368-374. **4.** McInnes GT, Bunting EA, Ings RMJ, Robinson J, Ankier SI. Pharmacokinetics and pharmacodynamics following single and repeated nightly administrations of loprazolam, a new benzodiazepine hypnotic. *Br J Clin Pharmac.* 1985;19:649-656. **5.** Botter PA. A Comparative Double-blind Study of Loprazolam, 1 mg and 2 mg, Versus Placebo in Anxiety-induced Insomnia. *Curr Med Res Opin.* 1983;8(9):626-630.

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# Features



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# FEBRUARY 2016





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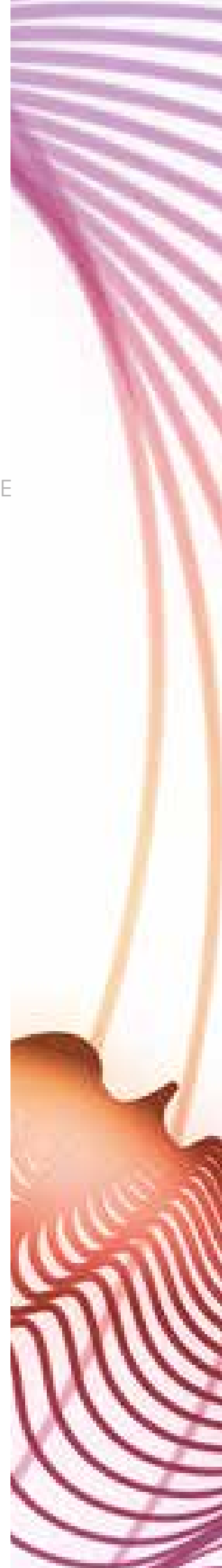

# Dear Reader,

Dear Reader,

With this the first issue for 2016, the year is well and truly underway. As usual we have a range of content with a number of themes, notably infant mental health with both a Feature article (Melanie Esterhuizen and Kgomotso Kwele) and a report on a conference (Katherine Bains).

Much of Psychiatry concerns itself with adults and to some extent children and adolescents, however the emerging importance and significance of infant mental health is emphasized in these related pieces. *South African Psychiatry* is most supportive of these individual and collective efforts in an area that warrants greater awareness.

Suvira Ramlall's part II piece on postgraduate education focuses on teaching and learning. Taken together with her part I Feature in the November 2015 issue it emphasizes the need for the discipline to pay careful attention to what we teach and how we both teach and assess as part of the training of future specialists, as well as develop as individuals within the discipline.

Shaquir Salduker provides some interesting reflections on the role of technology in Psychiatry, and Christine Lochner and Dan Stein highlight the significance of the Medical Research Council's unit on anxiety and stress disorders.

Aside from the Feature articles, there are numerous reports on events (both locally and beyond our borders in Africa) that serve to underline the vibrancy of the discipline and the range of endeavours contributing to both individual professional development and ultimately patient care. Each report also demonstrates the important role that industry plays in facilitating such events.

The Departmental News showcases achievements and notable developments nationally, with the College of Psychiatrists' report noting developments within the College as the national exit examining body. With the WPA IC 2016 taking place in Cape Town in November, a range of content relates to World Psychiatric Association (WPA) matters. The regular features, SASOP Headline and ECNP Message from the President, provide important insights and updates respectively whilst the movie and wine columns contribute their usual touch of culture…enjoy.

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# TECHNOLOGY IN PSYCHIATRY

When Freud sat behind his patient and listened to her free associate and presumably, in shorthand, tried to create as accurate a record as possible, he must have wished for an easier way to do things! Then again Sigmund saw only 1 or 2 patients a day! Modern psychiatry is a different animal completely.

*Shaquir Salduker*

As much as the understanding of the human brain has begun to explode, it was overtaken and lapped many times by the explosion in technology. This is the context in which we practice today. The Internet has been the single most influential event in modern history, a shared consciousness (quite Jungian) of behemoth proportions from which it is now almost impossible to hide. The machines and tools to access this new dimension has equally exploded and is advancing almost daily. There are inevitably the nay- sayers who claim we are losing our human communication skills, but that's an interesting debate for another forum.

In the average day of an average psychiatrist in practice one encounters technology at almost every turn. To enhance this experience is to know what is available and how to contextualize it to their requirements.

## Hardware:

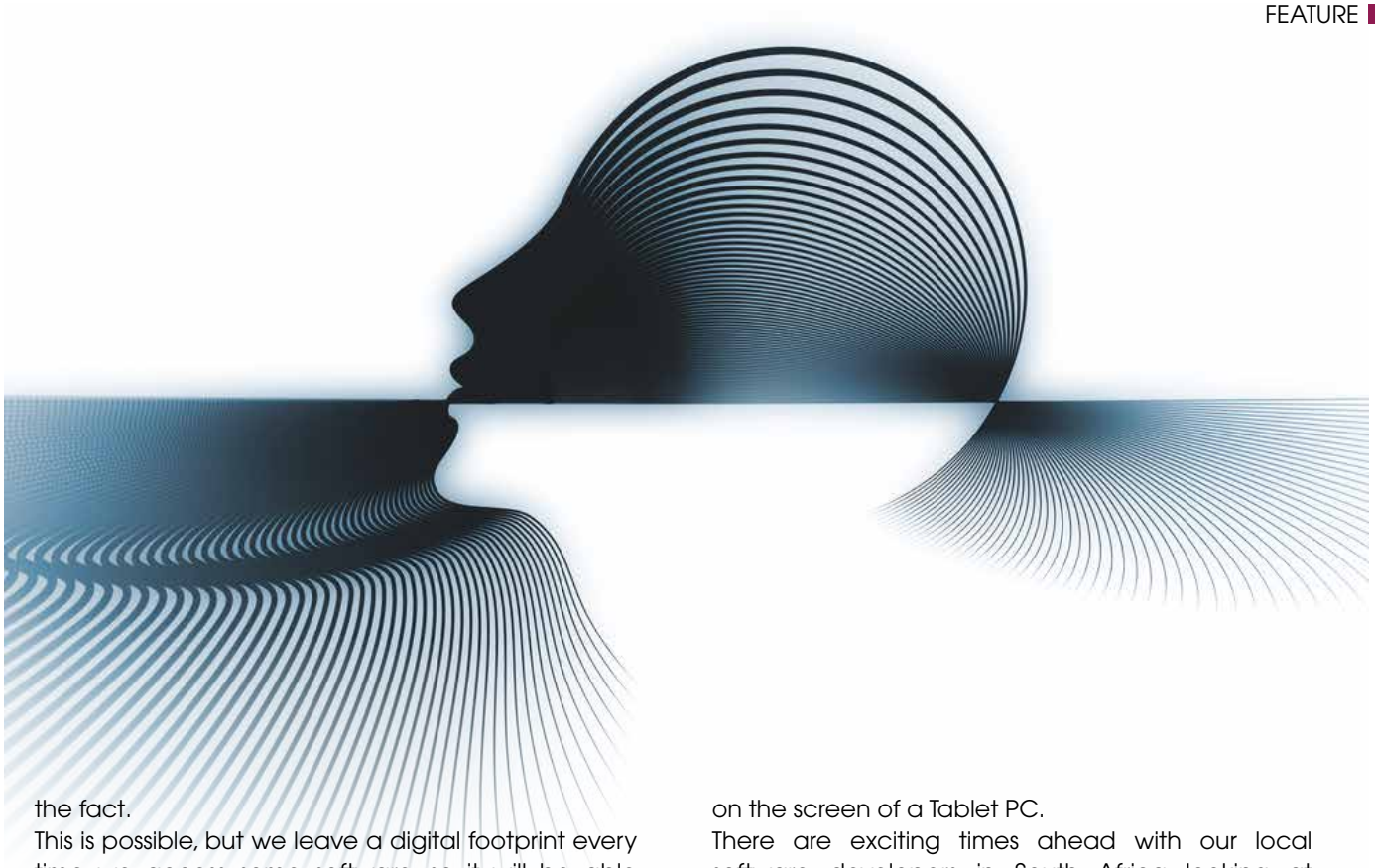
Computers, tablets, smart phones, remote storage devices, are some of the hardware we have to adapt to our needs. Our requirement is to be able to record data pertaining to our patient as accurately as possible and be able to keep this data in a safe place that's easily accessible in order to make our practice more efficient and most importantly give us maximum use of our most precious commodity, time. I have found the best way to keep notes has been through the use of a tablet PC (Microsoft surface pro 3) where one is able to write on to a screen and it is either converted to a type text or remains in freehand, and is stored on the device, which is entirely portable. I use simple software like Microsoft word or Microsoft Journal. Because the text files are so small, it is virtually impossible that you will run out of storage space. The downside is that you have to get used to the concept of writing on a screen whilst giving the patient the comfort of knowing they have your full attention. This takes some practice. Once that has been achieved, the upside is that you now have a device which is with you all the time- office, wards, home, different hospitals and clinics and the patients records go everywhere with you, so if you happen to see them in your office and then at a later date in hospital, the transition is seamless. It is also very handy if a colleague requires information on a patient. You can also do power point presentations, emails, store e- books all on the same device.

*Shaquir Salduker*

It becomes literally your office on the move. The next step is the safe storage of this data. There are various options available. I find it easiest at this stage to back up the data daily on to a hard drive which is then kept off site i.e. away from the office. You can also do a second backup less frequently and keep it in the office. The other option is cloud storage. This is now becoming derigeur in the IT industry and involves online storage where the physical data is kept at a remote (often other country) site and is accessible at any time and from any device as long as you are connected to the internet.

THIS IS DEFINITELY AN ADVANTAGE IN SETTINGS WHERE INTERNET ACCESS IS ALMOST GUARANTEED, HOWEVER WE ARE NOT ALWAYS ABLE TO BE ONLINE IN SOUTH AFRICA, SO THIS MAY TAKE A LITTLE MORE TIME TO BECOME MAINSTREAM.

The obvious concern is security and integrity of the stored data. These concerns have been extensively discussed and systems put into place to ensure this so that cloud computing is reasonably safe. The HPCSA has also had input into e-data and have made recommendations to ensure the confidentiality and integrity thereof. The other medico legal issue that arises is the ability to alter the electronic data after



the fact.
This is possible, but we leave a digital footprint every time we access some software, so it will be able to be traced back by the techno fundis. The other advantage to cloud computing is that you will be able to access a patient's record on your smart phone. Imagine the convenience! Being able to see a patient at the bedside, in your consulting room, in an emergency room- just about anywhere and be able to access their notes. The same applies to tablets and laptop computers of course. Once again the tablet PC seems to tick all the boxes here (Microsoft surface Pro 3).

## Software:

There is a virtual galaxy of stuff available! From customized individualized software to commercially available programs to Apps. Many startup companies especially in the USA have seen the need for niched software in medical practice and have come out with many different options each specialty specific. These commercial programs are often expensive and geared for the USA physician. there is also often a monthly maintenance fee involved. In the end it can become a costly exercise especially in a solo practice. I find it useful to adapt available commonplace software to suit your need. For example in most tablet PCs you will have Microsoft Word available with the device. If you practice your handwriting for a sufficiently long period of time so that the software can recognize letters, it will convert your handwriting into typed text in Microsoft Word. The more you use it the faster the computer will recognize your handwriting and the quicker you will be able to get through the note making process. Eventually you will reach a time when there will be no difference between writing on paper and writing on the screen of a Tablet PC.
There are exciting times ahead with our local software developers in South Africa looking at developing individualized software for each specialty and psychiatry is on that list. The intention with the software is to develop a standardized format of history taking, diagnostics, prescription databasesand report writing.

IF ALL GOES ACCORDING TO PLAN THE SOFTWARE WILL ALLOW YOU TO INTERVIEW AND EXAMINE A PSYCHIATRIC PATIENT AND INPUT ALL THEIR DATA INTO THE PROGRAM BY A MERE CLICK OF A TAB ON THE SCREEN.

This should reduce both the time it takes to input information as well as the accuracy and consistency of record taking. It should also theoretically generate a prescription and a report for the referring doctor or other colleagues. For those interested in research it will also form a perfect database of how your practices run, what type of patients you see, what medication you use most often, simple demographics like age, gender marital status.

There are a multitude of software changes on the horizon, but if we don't get on the bandwagon now, we will find these innovations too complex and difficult to adopt. The transition from paper to E media requires a comfort level; a comfort level which will only be there if one becomes less intimidated by the hardware. The key elements are simplicity and portability. Time is our commodity. We need to learn how best to control this.

*Shaquir Salduker* is a psychiatrist in private practice in Durban, Kwa Zulu Natal. He has a special interest in technology as well as pain management. **Correspondence: shaquir@shrink.co.za**

PART 2

# POSTGRADUATE PSYCHIATRIC EDUCATION IN SOUTH AFRICA
# IDEAS, IDEALS & IDEOLOGIES...(& PYRAMIDS!)

*Suvira Ramlall*

In order to aspire to the vision of the Lancet commission, we need to produce a new generation of critical thinkers so that quality can compensate for what we will never achieve in quantity: visionary leaders who can inform and transform the mental health landscape.

## TEACHING AND LEARNING PARADIGM

Our teaching methods need to stimulate critical, higher order thinking as opposed to the amassing of tons of ever increasing facts that are regurgitated in examination papers. In 1956 Bloom expounded his taxonomy (Figure 4) that saw an increase in thinking skills progressing from knowledge comprehension-application-analysis-synthesis-evaluation. The taxonomy divides learning into three intellectual domains: cognitive, affective, and psychomotor. Within each domain different intellectual skills and abilities are structured in a hierarchy that ranges from basic to more higher-order thinking skills (HOTS). The model, revised in 1910, places creativity at the pinnacle of learning. This is synchronous with the Lancet's vision for transformative learning and enlightened change agents. The somewhat passive didactic method of yesteryear will not serve the transformation of health services into the future nor does it lend itself to the transformed learning environment where access to information is no longer a challenge. If anything, excess characterises the learning challenge for millennium learners who should now be tasked with skills to manage, process and apply in creative ways the surfeit of information that exists.


*Figure 4: Bloom's Taxonomy of Higher Order Thinking Skills (1956)-revised (2010)*

Currently, our curricula are designed to clone existing practitioners and perpetuate past practices. They promote surface learning when the call of the millennium is for deeper learning (Figure 5) that can inform a much-needed renaissance.

*Suvira Ramlall*

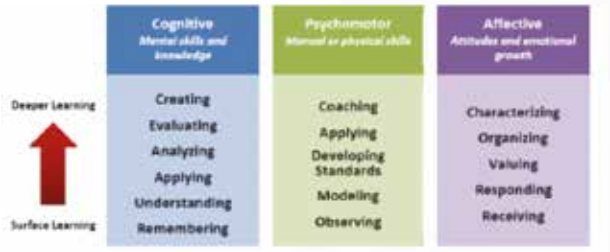



*Figure 5: Skill range from surface to deeper learning*

## CANMEDS COMPETENCIES

Apart from the burgeoning scientific literature that has to be accommodated into the curriculum, there has been a recent increase in the focus on the 'soft skills' of doctors. While these skills have always been implicit in varying degrees in training platforms, they did not enjoy formal emphasis or assessment.

In 1996 the CanMEDS physician competency framework *(Figure 6)* was launched which describes the abilities physicians require to effectively meet the needs of the people they serve. It is regularly updated by the Royal College of Physicians and Surgeons and is gaining acceptance around the world.

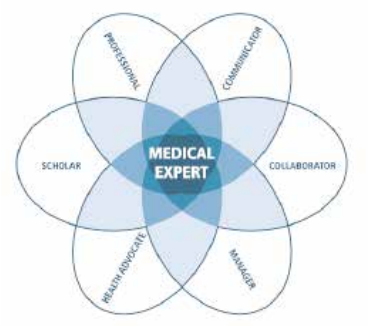



*Figure 6: CanMEDS Competency framework (2014)*

It focuses on seven core domains and related issues,

as listed below, for which core definitions, descriptions, key concepts, key and enabling competencies are described:

- Medical Expert
- Communicator
- Collaborator
- Manager
- Health Advocate
- Scholar
  - Lifelong learning
  - Critical appraisal
  - Teaching
  - Research
- Professional
  - Professionalism
  - Physician health
  - Patient safety and quality improvement
  - eHealth

Careful study of these competencies will confirm that they are aligned with the vision of the medical graduate of the future as defined in the Lancet. In light of the rise in litigation, largely driven by patient dissatisfaction with issues relating to professionalism and ethics, as opposed to technical competence of medical personnel, the HPCSA has formalised the teaching of CanMEDS competencies into undergraduate medical curricula. At the recent American Psychiatric Association conference, a meeting of 5 psychiatric colleges from around the world endorsed the need for these competencies to be formally incorporated into postgraduate psychiatric training. One of the greatest challenges this poses is determining how best to teach these competencies. The literature suggests that modelling would be the preferred method but therein lie greater challenges which are beyond the scope of this overview.

The greatest driver of learning is assessment. If we hope to transform our learning practices and outcomes, this needs to be done pari passu with our assessment methods.

## ASSESSMENT

Assessment is a key part of the education process and Holgrove (1997) noted that assessment is usually the most powerful factor in the entire curriculum; it determines the real curriculum which students follow and influences learner behaviour. Assessment influences learning through the curriculum content (blueprinting), format, feedback, the scheduling and the consequences of failure. To maximize the benefits of assessment, best practice suggests that multiple formats of assessment be used, each of which should be validated. Validity refers to the measure of how thoroughly, accurately and appropriately a test measures what it purports to measure (Brown 2006). It is also important that assessments not become burdensome for the trainee (or trainer) as this could then impair learning.

Assessments must relate directly to the curriculum and should validate the objectives and outcomes defined in the curriculum. The content of assessments should therefore be synchronized with the learning objectives-a process known as blueprinting. All outcomes to be measured are to be explicitly stated in a blueprint, allowing for a comprehensive assessment programme that utilizes appropriate assessment methods. This will also help to ensure that assessments are valid. The diverse aspects of clinical competence that need to be assessed require multiple forms of tests. The utility of assessments is a multiplicative function of reliability, validity, educational impact, acceptability and cost with different weights attached to each; trade-offs are inevitably required making perfect utility a utopian concept (van der Vleuten 1996).

AN ASSESSMENT PROGRAMME SHOULD PROVIDE FEEDBACK TO THE TRAINEE AND TRAINER TO IDENTIFY AREAS OF STRENGTH AND WEAKNESS I.E. FORMATIVE ASSESSMENTS. WORK-PLACE BASED ASSESSMENTS (WPBAS) SERVE A USEFUL FUNCTION IN GUIDING AND GROOMING A TRAINEE TO THE DESIRED LEVEL OF CLEARLY DEFINED CLINICAL AND PROFESSIONAL COMPETENCE HOW-EVER ITS RELIABILITY IS SUBJECT TO MANY CHALLENGES. ONE WAY TO OVERCOME THIS IS TO ENSURE WIDER SAMPLING ACROSS DIFFERENT SETTINGS. THE NATURE OF ASSESSMENT TOOLS TARGET DIFFERENT LEVELS OF COMPETENCE AND MILLER'S SCHEME (FIGURE 7) IS A USEFUL TOOL TO ASSESS THE 'SPREAD' AND APPROPRIATE-NESS OF A GRADUATE ASSESSMENT PROGRAMME.

Competency-based medical education (CBME) refers to a design of medical education that focuses on outcomes in the form of the abilities of graduates. Competency is defined as an observable ability of a health professional that develops through stages of expertise from novice to master clinician. Transformative learning requires the acquisition and demonstration of skills that can be applied in health settings. Similarly, the CanMEDS competencies are best practised and observed in the work arena as opposed to being reproduced in a written examination. This speaks to the methods of assessment and their appropriateness.

Miller's (1990) triangle (Figure 7) captures the progressive steps in levels of competence required. Special emphasis should be placed on the progression from showing how to actually doing; doing requires thorough analysis into how a skill

can be appropriately, creatively and effectively incorporated into local, daily practice and being able to reflect on it as a learning experience.

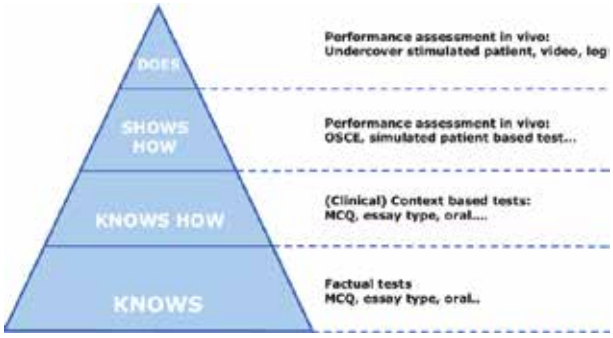



*Figure 7: Miller's Triangle with corresponding appropriate assessment methods*

Traditionally the CMSA summative examination comprised essay questions, an oral examination and a long-case presentation. This has gradually evolved to the inclusion of the objective structured clinical examination (OSCE) and the exclusion of the oral in an attempt to increase the reliability and validity of the examination. There is a move towards the replacement of essays with single-best answers (SBAs) which are not synonymous with multiple choice questions (MCQs). SBAs, if designed correctly, can assess not just knowledge but higher order cognitive skills as defined in Bloom's taxonomy. While the migration to SBAs will increase the validity and reliability of assessments, should this spell the demise of the traditional essay? Given the importance of language skills for the practice of psychiatry, I believe that the retention of the essay will add to the wider sampling of necessary skills for psychiatry graduates in particular. Daily, we analyse in minute detail the structure and content of patients' speech whereupon we make dire pronouncements on their mental wellness. In a culture reduced to minimalistic, grammar-impoverished text language, psychiatrists, more so than other medical specialists, need to demonstrate superior written and verbal communication skills in order to understand and communicate with their patients; these, in my opinion, are core clinical skills for a psychiatrist that should be a measure of a graduate's competence to practice.

While some of the competencies can be assessed in the OSCE, it is not uncommon for trainees to rehearse well for an OSCAR performance in the OSCE for the benefit of the examiner (knows and shows how) yet fail to practice these skills in the workplace (?does). To produce graduates that will fulfil the Lancet vision, workplace based practice needs to be the golden yardstick that measures graduate competence. Inculcating a work-ethic that is not driven by the singular goal of 'passing an examination' should make registrar training a journey of joyful learning and personal and professional growth. An optimum graduate assessment programme should incorporate regular, valid work-place based formative assessments that monitor and nurture the development of clinical and professional skills applicable to both clinical and public health settings; these would pave the way to a summative assessment that utilizes SBAs and essay questions in the written section and an OSCE and part-observed long case presentation.

## PHYSICIAN KNOW THYSELF: PROFESSIONAL IDENTITY FORMATION

There has been increasing emphasis on professionalism in medical education over the past several decades, aimed at helping students internalize the value system of the medical profession. Professionalism is a means to an end i.e. professional identity formation (PIF) with the latter being recognized as the foundational process one experiences during the transformation from lay person to medical practitioner. Cruess et al (2014) proposed that a principal goal of medical education should be the development of a professional identity and that educational strategies should be developed to support this new objective and the Carnegie Foundation report recommended that identity formation constitute a "pillar" of medical education.

Cruess et al (2014) defined medical professional identity as 'a representation of self, achieved in stages over time during which the characteristics, values, and norms of the medical profession are internalized, resulting in an individual thinking, acting and feeling like a physician.'

Jarvis-Selinger et al (2012) define the process of identity formation as an adaptive developmental process that happens simultaneously at two levels: (1) at the level of the individual, which involves the psychological development of the person and (2) at the collective level, which involves the socialization of the person into appropriate roles and forms of participation in the community's work. This definition resonates with the Lancet vision for a curriculum that is informed by health systems' needs and applies equally to undergraduates and postgraduates. The integrative developmental process involves the establishment of core values, moral principles, and self-awareness. PIF can be approached from various paradigms-professionalism, psychological ego development, social interactions, and various learning theories.

'It is the function of undergraduate and postgraduate medical education to transmit the culture of medicine and …to shape the novice into an effective practitioner of medicine, to give him the best available knowledge and skills and to provide him with a professional identity so that he comes to think, act and feel like a physician' (Merton et al 1957). The formation of a professional

identity occurs through a process of socialization throughout medical education and practice and can be fostered by an understanding of the nature of identity formation, specific definition of the professional identity to be created and thereafter creating a curriculum and educational environment that facilitates the evolution to the desired identity. Richard and Sylvia Cruess (AMEE, 2015) believe that when the acquisition of a professional identity becomes an educational goal, it needs to be assessed and the ultimate level of assessment in Miller's triangle (Do) is no longer adequate as the implication is that what one is is defined by what one does. They therefore propose an evolution of Miller's triangle to accommodate another level termed 'Is' which they position at the apex. The student would be expected to consistently demonstrate expected values, attitudes and behaviours that define a physician. Likewise, they describe corresponding competencies for each of the tiers of Miller's triangle. The authors concede that 'is' may not be the ideal term nor the apex the ideal location: PIF is not a static endpoint, as the term 'is' implies, but rather a state one seeks to continuously grow or evolve towards; PIF could be situated at the base (or elsewhere) and inform the acquisition of knowledge and skills.

Given that issues of identity are central to psychiatric practice, supporting professional identity formation especially among psychiatry graduates is worthy of rumination and implementation. Establishing it formally as an educational objective will require institutional support, allocation of responsibility, and integration into current educational activities. Establishing membership in a community of practice should become an aspirational goal. The system required to assess professional identity (as distinct from professionalism) must accommodate different discourses, multiple purposes of assessment and utilizes multiple methods. It is an assessment that is mainly formative and should be sensitive to capturing change over time.

Importantly, the way doctors arrive at a professional identity may also influence whether they survive or thrive in the profession. A series of articles in Academic Medicine (June, 2015) highlights that doctors who lack a deep personal clarity and commitment of purpose are more vulnerable to job-related stress and burnout.

Currently boundaries between internal medicine, neurology, psychology and the neurosciences are becoming increasingly fluid, professional identities are constantly evolving and there is an exciting, exponential expansion of the brain sciences. While PIF may appear to be a distant ideal in the current 'meducation' climate it is perhaps an opportune time for us as psychiatrists to begin to define and develop our professional identity…and thereby more deftly steer the future generations of psychiatrists.

## CONCLUSION

In seeking to address a leaking roof (increasing burden of disease and treatment gap) we could easily solve the problem by continually placing a bucket under the leak i.e. training increasing numbers of graduates to treat the casualties. This will make little impact on the mental well-being of society as a whole. We could alternately aim to find a solution i.e. fix the hole in the roof. I believe that changing what we teach, how we teach and how we assess future graduates carries the only hope for us to match the giant strides we have made in understanding the neuroscientific basis of mental illness with improving the mental health of the nation.

*"As a valued outcome, transformative learning involves three fundamental shifts: from fact memorisation to searching, analysis, and synthesis of information for decision making; from seeking professional credentials to achieving core competencies for effective teamwork in health systems; and from non-critical adoption of educational models to creative adaptation of global resources to address local priorities"*
*(Lancet, 2010).*

WHAT IS
LEARNING…
A JOURNEY,
NOT A DESTINATION
WHAT IS DISCOVERY…
QUESTIONING THE ANSWERS,
NOT ANSWERING THE QUESTIONS
WHAT IS THE PROCESS…
DISCOVERING IDEAS,
NOT COVERING CONTENT
WHAT IS THE GOAL… OPEN MINDS,
NOT CLOSED ISSUES
WHAT IS THE TEST…
BEING AND BECOMING,
NOT REMEMBERING AND REVIEWING
*AA GLATTHORN*

*Suvira Ramlall* is Bio-clinical Head of Psychiatry-King Dinuzulu Hospital Complex; Lecturer-Department of Psychiatry, UKZN; Secretary- Council, College of Psychiatrists; Member of KZN mental health advisory committee. References are available from the author. **Correspondence: Ramlalls4@ukzn.ac.za**

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S4 Pramiola™ 0,125 ; 0,25. Each tablet contains 0,125; 0,25 mg pramipexole dihydrochloride monohydrate. Reg. No. 43/5.4.1/0856; 43/5.4.1/0855.
S5 Sandoz Mirtazapine 15; 30. Each film-coated tablet contains 15 mg; 30 mg mirtazapine. Reg. No. A40/1.2/0584; Reg. No. A40/1.2/0585.
S5 Sandoz Venlafaxine XL 75; XL 150. Each extended release capsule contains venlafaxine hydrochloride equivalent to 75 mg; 150 mg venlafaxine. Reg. No. A40/1.2/0494; Reg. No. A40/1.2/0492.
S5 Sandoz Amitriptyline HCl 25. Each tablet contains 25 mg amitriptyline hydrochloride. Reg. No. W/1.2/60.
S5 Sandoz Sulpiride 50. Each capsule contains 50 mg sulpiride. Reg. No. U/2.6.5/32.
S5 ProHexal™ 20; 20T; 40T. Each capsule contains 20 mg fluoxetine. Each tablet contains 20 mg; 40 mg fluoxetine. Reg. No. 31/1.2/0638; Reg. No. 32/1.2/0103; Reg. No. 32/1.2/0104.
S5 Lanazyp® 2,5; 5; 10. Each tablet contains 2,5 mg; 5 mg; 10 mg olanzapine. Reg. No. 44/2.6.5/0572; Reg. No. 44/2.6.5/0573; Reg. No. 44/2.6.5/0574. Applicant: Brimpharm SA (Pty) Ltd. Reg No. 1998/031236/07.
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**APPLICATIONS ARE OPEN FROM 1st JULY 2015 AND CLOSE ON 30th JUNE 2016.**

For further details contact: Greg Sinovich, 082 449 9844
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SANOFI

# THE US/UCT MRC UNIT ON ANXIETY & STRESS DISORDERS

The Medical Research Council (MRC) of South Africa aims to improve the health of the nation via research. The MRC has nearly 50 Units; some are intramural (based at the MRC) while others are extramural (based at Universities).

*Christine Lochner, Dan Stein*

Given that mental disorders contribute a large portion of the local burden of disease, there should be a number of Units devoted to these conditions. As it turns out, there are 2; i.e. an intramural Unit on substance use and related disorders, and an extramural unit on anxiety and stress disorders, based at Stellenbosch University (SU) and the University of Cape Town (UCT).

The MRC Unit on Anxiety and Stress Disorders was initiated in 1997 by Prof Dan Stein, then a young lecturer at Stellenbosch University. The anxiety disorders are the most prevalent of the psychiatric conditions, and the initial proposal also emphasized the importance of psychological trauma and post-traumatic stress disorder (PTSD) in the South African context.

> THE VISION WAS A TRANSLATIONAL ONE; MOVING FROM BENCH TO BEDSIDE, AND FROM BEDSIDE TO BUNDU – THUS THE PROPOSAL INCLUDED A FOCUS ON ANIMAL MODELS OF ANXIETY DISORDERS, ON CLINICAL RESEARCH, AND ON PUBLIC HEALTH ASPECTS OF PSYCHIATRY.

At the time the Unit was initiated, there were relatively few senior investigators locally in the area of psychiatry. Stein was fortunate to have had the mentorship of Prof Robin Emsley, who was Head of the Department at Psychiatry at SU for many years, and he was fortunate to attract a range of junior colleagues willing to take leadership in key areas. Over time, such colleagues became national and international leaders in a range of areas. For example, Prof Brian Harvey, who led the animal research program from the North-West University in Potchefstroom, is now an internationally recognized behavioural pharmacologist. Prof Soraya Seedat, who led the PTSD program, is now supported by the South Africa Research Chairs Initiative of the Department of Science and Technology and National Research Foundation and a major international figure in her field. Prof Christine Lochner, who has led the program on obsessive-compulsive and related disorders is now internationally recognized for her contributions.

*Christine Lochner*

*Dan Stein*

Radical changes have taken place in science over the years. It can be said that of all the medical specialties, psychiatry is one of the areas that have changed most over the last two decades as a result of basic and clinical research. New areas of inquiry, ranging from clinical, molecular biology and genetics research through neuroimaging to mental health services and advocacy research, have emerged as important influences on psychiatric practice. Dr Sian Hemmings was the first PhD student in neurogenetics on the Unit; she worked on 1 gene at a time. Nowadays, the Unit is involved in whole exome sequencing work. Sequencing of the exome, rather than the entire human genome, is considered a powerful and cost-effective new strategy to search for alleles underlying disorders that may be intractable to conventional gene-discovery strategies. A collaboration with Prof Ben van Heerden in Nuclear Medicine allowed some of the initial brain imaging work on the Unit, focusing on single-photon emission computed tomography (SPECT) perfusion methods; nowadays Prof James Warwick employs positron emission tomography (PET) and selective radioligands. Members of the Unit also played a key role in the acquisition of MRI scanners for brain research – most recently at the University of Cape Town, and the Unit continues to do a range of sophisticated structural and functional MRI work in multiple disorders.

# ANXIETY & STRESS

The Unit has always put significant effort into mentorship and into collaboration. Several dozen doctoral students and post-doctoral fellows have trained on the Unit, and many are now national and international leaders in their respective fields of interest. Stein and Lochner emphasize that such students are the driving force of science.

The Unit has also collaborated with researchers around South Africa, Africa, and the world. Both Stein and Lochner regard this as one of the real privileges of their job; they have close relationships with many leaders in the field. Stein is a psychiatrist, and Lochner a clinical psychologist, and they note how much their work has benefited by working with a broad range of basic and clinical scientists.

related disorders. They note that the Unit undertook some of the first genetic and brain imaging studies in key areas of neuropsychiatry locally, including work on HIV/AIDS and substance use disorders. Based on these and other projects, the Unit has published more than 800 papers in peer-reviewed journals.

Where next for the Unit? Stein and Lochner are working on 3 large projects which they hope will continue into the next several years. The first is the Drakenstein Child Health Study, an ambitious birth cohort study which has the potential to shed new light on the biology of early development. The second is ENIGMA, an international collaboration focused on combining brain scans from around the world; Unit members play a key role in the

THE UNIT'S MENTAL HEALTH INFORMATION CENTRE **(www.mentalhealthsa.org.za)** HAS COLLABORATED CLOSELY WITH CONSUMER ADVOCATES AND DECISION-MAKERS IN THE AREA OF MENTAL HEALTH, MAKING KEY CONTRIBUTIONS TO EFFORTS TO DESTIGMATIZE MENTAL DISORDERS AND TO OBTAIN PARITY IN RESOURCING.

The extent to which the landscape in this area has also changed over the years is remarkable. For example, the South African Depression and Anxiety Group (SADAG) is now one of the largest consumer-led health organizations on the continent, and mental health advocacy by many has resulted in a national mental health policy. The aim of good research, Stein and Lochner argue, is not only to understand the world, but also to transform it when necessary.

Looking back at nearly 20 years of work, it's hard to say what has been the most important achievement. Stein emphasizes the value of the South African Stress & Health Study (SASH), the first nationally representative study of mental disorders in the country. Lochner notes how the word of the Unit on OCD and related disorder played an important role in providing a rationale for the new chapters in DSM-5 and ICD-11 on obsessive-compulsive and

work on ENIGMA-OCD and ENIGMA-HIV. The third is NeuroGAP (i.e. the Neuropsychiatric Genetics in African Populations), a large-scale study across a number of African countries.

Stein also notes that there is much work to be done in terms of philosophy of psychiatry, now that the Unit has so much empirical data to reflect on. Lochner has expressed the hope of continuing to attract young psychiatrists and psychologists to the Unit; she enjoys mentoring the next generation of leaders. Both are grateful to the MRC for the resources that the Unit has provided them, and remain passionate about the possibilities for future work in psychiatry and clinical psychology. And they are always open to consulting with patients with OCD and related disorders; they have more than 800 patients on their books, but as they point out, even larger numbers are needed to fully understand the relevant neurogenetics.

*Christine Lochner,* Co-Director US/MRC Unit on Anxiety & Stress Disorders; Department of Psychiatry, Stellenbosch University. **Correspondence:cl2@sun.ac.za** *Dan Stein,* Director US/MRC Unit on Anxiety & Stress Disorders; Department of Psychiatry and Mental Health, University of Cape Town

# COLLEGE OF PSYCHIATRISTS
# 2015 SECOND SEMESTER REPORT

The second semester of 2015 has been a busy and exciting time. During this period, the new blue-printed curricula for the Diploma in Mental Health and the Fellowship Parts I & II were examined, in their respective new examination formats.

## Diploma in Mental Health

The clinical examination saw the introduction of an OSCE which was positively received by both examiners and candidates. Finer aspects of OSCE setting and mark schemes will be refined as we learn from the first experience. Seventeen candidates sat the August written examination and fifteen were invited to the clinical component in October which was passed by fourteen of the doctors. The overall pass rate was 82% with a smooth transition to the new clinical format.

## FC Psych Part I

This was the first sitting of the revised curriculum which introduced clinically applied and focused content for the applied clinical neurosciences paper (combined neuroanatomy and neurophysiology) as well as the introduction of a new paper, introduction to clinical psychiatry which focused on topics in clinical psychiatry appropriate for a junior registrar. Although the content has been better defined than in the past, this did not improve the historically poor pass rate in the Part I examination. Eleven candidates entered the FC Psych (SA) Part I examination and 1 candidate (9%) passed. Several potential contributory factors for the poor performance have been identified. A remediation action plan is being devised and will be implemented in 2016 to provide better support to future candidates.

## FC Psych Part II

Thirty two candidates entered the exam, one withdrew and one candidate was unable to attend the clinical examination due to illness; 13 out of 30 finally passed, giving an overall pass rate of 43%.

This was the first integrated Clinical OSCE examination which included neuropsychiatry and general psychiatry stations based on the revised curriculum blueprint. Prior to this, the Part II clinical examination comprised an OSCE that was wholly dedicated to neuropsychiatry. Despite the considerable logistical challenges associated with conducting an OSCE examination, the examination ran smoothly for both examiners and candidates. The

*Suvira Ramlall*

*Soraya Seedat*

format allowed for a wider sampling of clinical skills and content. The healthy spread of marks suggests that the examination was valid and reliable. Minor shortcomings that were identified will be progressively addressed as experience and confidence with the Clinical OSCE increases.

## Certificate in Child & Adolescent Psychiatry

One candidate sat the examination and was successful.

## Sub-specialties

The Council is pleased to announce that, in addition to the Certificate in Child & Adolescent Psychiatry, the following subspecialties are now offered for subspecialty training:

- **Certificate in the Subspecialty of Neuropsychiatry**
- **Certificate in the Subspecialty of Forensic Psychiatry**
- **Certificate in the Subspecialty of Addiction Psychiatry**
- **Certificate in the Subspecialty of Geriatric Psychiatry**
- **Certificate in the Subspecialty of Consultation-Liason Psychiatry**

Except for Consultation-Liason Psychiatry, regulations, blueprints and training logbooks for all the above-mentioned subspecialties may be viewed on the College website (www.collegemedsa.ac.za).

## Registrar Workshop

Our annual registrar examination workshop will be held in Durban on the 5th & 6th February 2016 and will be preceded by a Council workshop that will focus on revising and updating the FC Psych portfolio of learning. A report is anticipated in the May 2016 issue of *South African Psychiatry* We look forward to another successful and stimulating academic year and aim to host new sub-specialty examinations by 2017.

*Suvira Ramlall*
Secretary, **Correspondence: Ramlalls4@ukzn.ac.za**
*Soraya Seedat*
President, **Correspondence:sseedat@sun.ac.za**

S5

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## JOHANNESBURG'S FIRST INFANT MENTAL HEALTH CONFERENCE:

# "THE BODIES AND MINDS OF BABIES IN RELATIONSHIP: DIALOGUES IN A MULTIDISCIPLINARY CONTEXT"

*Katherine Bain*

As our understanding of the science of human development has grown, it has become clear that infant development unfolds within a relational context. Neurological development in infancy and later mental health is the outcome of the interactions between genetic potentialities and the quality of the rearing environment in infancy (Hall & Perona, 2012). Research in sub-Saharan Africa has shown that being born into deprived circumstances has negative effects on child development outcomes (see Lancet special edition on child development, 2007). Early intervention is recommended, when the likelihood of positive, long-lasting treatment effects is largest. However, as in many developing countries, funding in South Africa tends to focus on decreasing infant mortality rates, as opposed to the promotion of infant mental health (IMH).

The first IMH conference to be held in Johannesburg took place on the 30th and 31st of October 2015, co-hosted by the Gauteng Association for Infant Mental Health (GAIMH-SA), the University of Witwatersrand's School of Human and Community Development and the DST-NRF Centre of Excellence in Human Development.

THE CONFERENCE AIMED TO RAISE AWARENESS AROUND INFANCY AS A DEVELOPMENTAL PERIOD AND TO PROMOTE EARLY INTERVENTIONS TARGETING PERINATAL MENTAL HEALTH.

Represented professions included: paediatrics and neonatology, psychiatry, psychology, occupational therapy, physiotherapy, speech therapy and social work. The inclusion of the NGO sector was crucial, in order to acknowledge contributions made by these organisations in South African IMH, and to encourage greater cross-referral and research collaboration. Presentations by lay counsellors and mother-baby home visitors, who are working at the coal-face with our country's most at risk infants and parents, gave faces to the subjects of research in the more academic presentations. Due to student protests, the conference, originally due to be held at the University of the Witwatersrand, was moved to Ububele, a Johannesburg NGO. This seemed a fitting venue, as Ububele has been instrumental in raising awareness about infancy as a sensitive developmental period in the last 10 years.

*Katherine Bain*

Opening the proceedings, ***Ms Zanele Twala***, the Director and Sector Expert on Early Child Development in the Department of Planning, Monitoring and Evaluation in the Presidency, emphasized the importance of local research in order to direct and inform future policy in the departments of Health and Social Development. The presentations at the conference did not disappoint and while some exciting attention is being given to this stage of human development, the need for further research and collaboration was evident.

***Alessandra Piontelli's*** (Psychiatrist, Psychoanalyst and Obstetrician, University of Milan) opening plenary gave a thought-provoking account of 'foetal myths'.

SINCE THE PRENATAL PHASE IS THE DEVELOPMENTAL PERIOD IN WHICH WE HAVE THE LEAST ACCESS TO RESEARCHING THE EXPERIENCE OF THE INFANT, FOETAL EXPERIENCE IS PRONE TO IDEALISATION, PROJECTION AND MYTH. SHE CHALLENGED A NUMBER OF POPULAR NOTIONS ABOUT FOETAL LIFE AND PROVIDED AN OVERVIEW OF WHAT IS KNOWN ABOUT FOETAL COMPETENCIES.

Since foetal sensations are evinced by motor reactions or through heart rate accelerations and decelerations to a stimulus in the late stages of

pregnancy, researchers are still hypothesising infants' functioning according to the degree of maturational substrates presiding over them. Piontelli emphasised that this makes our knowledge of foetal experience at best very uncertain. The conference then turned to what we do know and other questions that require answers.

*Prof Peter Cooper Head Paediatrics and Neonatology University of the Witwatersrand*

High rates of HIV infection in sub-Saharan Africa pose a threat to the health and well-being of infants born to infected mothers. ***Peter Cooper*** (Academic Head: Paediatrics and Child Health, WITS, Charlotte Maxeke Hospital) gave an overview of the progress made in last 25 years with regards to infant HIV infection. Following the landmark Constitutional Court Ruling of 2002, that legislated the introduction of antiretroviral therapy to prevent mother to child transmission (MTCT), rates of MTCT have decreased from around 30% in the year 2000 to current rates of approximately 3%. Breastfeeding is currently encouraged as mothers are provided with ARVs for the duration of breastfeeding. The early commencement of ARVs for infected infants and related decrease in infant mortality and improved developmental outcomes was also noted. ***Joanne Potterton*** (Physiotherapy, WITS) presented findings from three studies on HIV encephalopathy. The studies compared the developmental levels of HIV-exposed and infected (HEI) and HIV-exposed uninfected (HEU) infants and found that the HEI infants showed a significant delay in all areas of development from as young as four months of age. Early commencement of ARVs was found to contribute to some developmental gains, but these infants remained delayed when compared to their uninfected counterparts.

THE DEVELOPMENTAL CHALLENGES OF INFANCY ASSOCIATED WITH HIV, DESPITE ACCESS TO ARVS AND ADEQUATE VIRAL SUPPRESSION WERE FOUND TO EXTEND INTO CHILDHOOD, WITH HEI PRE-SCHOOL AGE CHILDREN CONTINUING TO DEMONSTRATE INCREASED RATES OF DEVELOPMENTAL DELAY.

***Amina Abubakar*** (Psychology, Lancaster University, UK; Centre for Geographic Medicine Research, Kenya) presented research on executive function (EF) in the context of HIV exposure. Functional brain imaging and scans have found that EF-related brain regions (predominantly pre-frontal cortex) are especially susceptible to HIV-related damage. While little is known regarding the genesis of these deficits, EF regulatory control plays a significant role in cognitive, behavioural and social development, significantly influencing everyday functioning and academic achievement.
Abubakar highlighted the importance of the


*Dr Katherine Bain, WITS & Prof Cora Smith, Chief Clinical Psychologist Charlotte Maxeke Hospital*

early detection of executive dysfunction in at-risk paediatric populations in order to identify those children in need of early intervention. ***Tarryn Stevens*** (Speech Therapy, WITS) presented findings of a recent pilot study comparing the effects of Nevirapine and Efavirenz on the language development of HIV-exposed uninfected infants exposed to either Nevirapine or Efavirenz through MTCT. The mean language scores of infants exposed in utero to Nevirapine were significantly higher than those exposed to Efavirenz. No correlations between maternal factors and the child's language abilities were found. These presentations underlined that while laudable progress has been made in the past 25 years with regards to understandings and treatment of paediatric HIV, researchers are still working to fully understand the effects of HIV exposure and infection and ARVs on brain development.

Prematurity as a risk-factor for infant development and parenting was also addressed in a number of presentations. ***Lynn Preston*** (Psychology, NWU) presented a review of studies commonly citing post-traumatic stress reactions in parents of hospitalised parents. She presented evidence for the provision of support for parents with infants in NICUs, finding benefits for both parents and professionals in these settings. ***Kerry Brown and Carla Brown*** (Occupational Therapy, Red Cross War Memorial Children's Hospital, UCT) presented similar findings for a parent group established in the PICU at the Red Cross Hospital, which aims to provide psychosocial support for parents and education on the neurodevelopmental needs of their infants. Various techniques were used to achieve these aims in language and education diverse groups.

***Sian Green and Warwick Phipps*** (Psychologists) presented a comparative study that analysed interactional behaviours between mothers and infants receiving incubator care versus Kangaroo Mother Care (KMC) at George Mukhari Hospital. Their study found that the mothers in the KMC group, which encouraged skin-to-skin infant carrying, demonstrated significantly more effective interactional patterns with their infants than those in the incubator group.

THE IMPORTANCE OF EARLY SKIN-TO-SKIN CONTACT FOR NEW-BORN INFANTS WAS ALSO HIGHLIGHTED BY KAREN POTGIETER (OCCUPATIONAL THERAPY, WITS). EARLY SKIN-TO-SKIN CONTACT IS ASSOCIATED WITH THE PROMOTION OF BREAST-FEEDING, THE STABILISATION OF INFANT RESPIRATION, TEMPERATURE AND BLOOD PRESSURE REGULATION, REDUCTION OF STRESS HORMONE RELEASE, REDUCTION IN HYPOGLYCAEMIA, REDUCTION IN CRYING, AND PROMOTION OF QUIET ALERT AND DEEP SLEEP STATES.

*Judy Davies - Clinical Social Worker & Prof Tessa Baradon - Head Infancy and Early Years Anna Freud Centre & Adjuct Professor School of Human and Community Development, WITS*

Benefits of KMC were also noted in a presentation by ***Tahiyya Hassim*** (Founder/Director of New Beginningz Baby Haven) where this method is used to promote bonding and development in high-risk infants in care. ***Miemie du Preez*** (Neonatology, Stellenbosh University, Tygerberg Hospital) presented a convincing argument for the need to encourage maternal verbal engagement with premature infants, citing numerous studies that demonstrate shared reading (parents to infants) as a highly

efficient way of safeguarding children from school failure in developed countries. She presented a touching account of the development of a reading programme in the Tygerberg Hospital NICU, using local languages and rhymes to create books for mothers to read to their infants. ***Mark Tomlinson*** (Psychologist & Professor, University of Stellenbosch) also presented on a book-sharing clinical trial running in tandem with the Thula Sana Mother-Baby Home Visiting Programme in Cape Town.

WHEN INTERVENING THERAPEUTICALLY IN AT-RISK PARENT-INFANT RELATIONSHIPS, THE INCLUSION OF THE INFANT IN THE THERAPY SPACE AS AN INDIVIDUAL IN THEIR OWN RIGHT IS CRUCIAL, IN ADDITION TO FACILITATION OF PARENTAL ABILITIES TO HOLD THE INFANT IN MIND, TO ATTUNE TO THE INFANT'S NEEDS, AND TO REGULATE THE INFANT'S AFFECT.

*Prof Astrid Berg - Emeritas Professor Stellenbosch and UCT and Dr Makgabo Manamela - Director Mental Health Services Gauteng*

Psychology contributions to the conference ventured beyond the practice of parent-infant psychotherapy to topics such as nannies' caregiving influences (***Judy Davies***, Tavistock Clinic, London; ***Nicola Dugmore***, psychologist) and the subjectivities of mothers with disabled infants (***Clare Harvey***, Psychology, WITS; ***Lisa Saville-Young***, Psychology, Rhodes University). The use of the Brazelton Neonatal Behavioural Observation (NBO) to highlight the infant's capabilities in the parents' minds was presented by ***Katharine Frost*** (Head of Ububele's Parent-Infant Programme) and ***Zanele Vilakazi*** (Lay Counsellor, Ububele).

In line with the South African context, with high numbers of children in care, the promotion of attunement and reflective function in Child Care workers in shelters (***Nicky Dawson and Jade Richards***, Psychologists, Ububele) and in adoptive parents was also covered (***Marietjie Strydom***, Social Worker). Lay counsellor case study presentations from Ububele home visitors and the Family Counselling Centre in Zimbabwe contained painful, yet poignant descriptions of mothers and infants struggling with the effects of poverty and trauma. The important roles that lay counsellors and their respective organisations play were highlighted.

***Mireille Landman*** (Psychologist, Consultant to the Parent Centre) presented a hopeful, yet realistic account of the successes, challenges and lessons learned from 20 years of running a community-based parent-infant home visiting attachment intervention (Thula Sana). Her presentation gave a sobering account of essential, yet emotionally taxing work with mothers and infants living in contexts of poverty, substance abuse and trauma, being done by underpaid lay counsellors, supported by organisations with funding uncertainties. The concerning fact that much of the early intervention (0-3) in South Africa is carried by NGOs who

*Ms Thandiwe Khumalo - Ububele Mother-Baby Home Visitor*

function under tenuous financial circumstances was highlighted.
However, there were presentations by public hospital staff that seemed to signify a growing recognition of the need for infant mental health services in this sector. ***Helen Clarke's*** (Head: Child and Adolescent Psychiatry, Baragwanath Hospital, WITS) presentation emphasised the 0-3 age period in the formation of neurodevelopmental trajectories. She highlighted epigenetic risk factors that surround children from third world settings and the effects of deprivation on parenting. The tendency toward an external caregiver locus of control tends to place the focus on the child, as opposed to the child-caregiver relationship, increasing the demand for a child based intervention.

She emphasized the need for interventions that focus on the parent-infant relationship and announced the establishment of a 0-3 clinic at Baragwanath Child Psychiatry Unit from 2016. Due to the complexity of the confluence of biopsychosocial influences on development, the importance of transdisciplinary treatment was emphasised throughout the conference.

***Janice Cowley*** (Occupational Therapist), ***Bianca Veira*** (Speech and Hearing Therapist) and ***Melanie Esterhuizen*** (Psychologist) provided an inspiring description of the development of an early intervention multidisciplinary team at South Rand Hospital.

The team comprises Speech Therapy and Audiology, Occupational Therapy, Psychology, Physiotherapy and Dietetics. Monthly clinics allow for infants and caregivers to receive a number of treatments in the same visit, and the shared space and effective communication between disciplines allows for easy cross-referrals. The service minimises travel costs for patients, improves service delivery and outcomes, empowers parents, and provides cross-discipline learning for professionals. The conference itself was a source of cross-discipline learning.

***Meg Faure's*** (Occupational Therapist, co-author of Baby Sense books) presentation served to highlight the importance of understanding toddler behaviour in the context of sensory temperament, serving as a reminder to include the child's unique contributions to interactions when these are assessed.

***Belinda Spalding-Jones'*** (Psychologist) case study high-lighted the role of psychic factors in an infant's delayed development toward muscularity and motion. The infant's journey from dependency to independence relies on a complex interplay of both physiological and emotional factors. The parent-infant relationship plays a critical role in this journey and in the interplay of these factors over time. These presentations emphasized the utility of multidisciplinary understandings of pathology.
Concerns in the early child development literature have noted the increasing homogenisation of the field of infant development, with lip service paid to cultural and contextual differences (Pence & Nsamaneng, 2008). Taking a critical approach to sources of knowledge, ***Gillian Mooney*** (Psychologist, WITS) conducted an analysis of articles published from 2000-present in the journal Developmental Psychology, finding that the focus in the developmental psychology literature remains on the experiences of white, middle-class American children and their mothers, with very little on fathers noted.

This conference, however, offered a number of presentations that prioritised local understandings and practices around infancy and child-rearing. Creative interventions that accommodate cultural and contextual factors were presented, such as Ububele's Baby Mat service, which is a mat on the floor of Baby Wellness clinics (in Alexandra and Hillbrow) staffed by psychologists and trained counsellor/translators.

MOTHERS IN THE WAITING ROOM ARE INVITED TO BRING THEIR INFANTS TO SIT ON THE MAT TO DISCUSS ANY CONCERNS THEY MAY HAVE. THE SERVICE AIDS MOTHERS TO REFLECT AROUND THEIR EXPERIENCES AND THOSE OF THEIR INFANTS AND ACTS AS AN EFFECTIVE SHORT-TERM INTERVENTION, SCREENING AND REFERRAL SERVICE

***Nicola Dawson and Jade Richards***, (Psychologists, Ububele). ***Astrid Berg*** (Child and Adolescent Psychiatrist, psychoanalyst, Emeritas Professor: UCT and Stellenbosch) highlighted the importance of reflective practice in clinical work, especially in multicultural contexts which carry "multiple potential barriers, such as language, different world cosmologies, as well as hardships of daily living" (Berg, 2015). She advocated for a stance of inner and outer reflectiveness and detailed observation, in order to allow the dynamics of the case to be uncovered and understood.

***Cora Smith*** (Adjunct Professor, Psychiatry, WITS; Chief Clinical Psychologist, Charlotte Maxeke Hospital) presented on the ethical dilemmas of attachment and custodial rights in baby swop cases. In addition to a thoughtful consideration of the balancing of the best interests of the children and their respective parents, the important role of culture was highlighted. Cultural beliefs in these instances

serving purposes by invested parties was addressed. Trends in the assimilation of knowledge regarding the relational needs of infants amongst mothers from Alexandra Township were also presented (***Katherine Bain***, Psychology, WITS and ***Jade Richards***, Psychologist, Ububele).

Strong culturally-linked inclinations towards the denial of negative maternal affect post-birth were found, highlighting the need for further research in order to determine possible associations to rates of maternal depression found in higher-risk South African populations (36%), that are three times those found in developed countries (10-12%) (Hartley et al., 2011). This study also found that one in three mothers living in Alexandra does not feel that the father's involvement in infant care is important. The roles of fathers emerged strongly as a theme throughout the conference.

***Tessa Baradon's*** (Head: Infancy and Early Years, Anna Freud Centre, London) paper asked some interesting questions around the marginalisation of fathers, both in the practice of parent-infant psychotherapy and in the theory, where fathers are positioned as a support to the mother and infant, rather than as subject, with a relationship with their infants in their own right.

SHE STRESSED THE NEED FOR A PARADIGM SHIFT THAT ENGAGES FATHERS AND INVITES THEM BACK INTO THE CAREGIVING SPACE. THIS TOPIC PROVOKED MUCH DISCUSSION AROUND CULTURAL PRESCRIPTIONS AROUND FATHERHOOD. THE FACT THAT THE TENDENCY TO EXCLUDE MEN FROM NURTURING SPACES IS ALSO REFLECTED IN THE GENDER COMPOSITION OF THE HELPING PROFESSIONS WAS ALSO RAISED.

***Mark Tomlinson's*** closing plenary presentation concluded that neuroscientific, biological, genetic and social science research has unequivocally demonstrated that the period up until the third year of life is foundational in terms of brain development. He proposed that the challenge for future research is to determine more clearly who benefits from what kind of early intervention, and why, in order to streamline types and costs of interventions. The conference closed with a thought-provoking discussion. A call for more collaboration between private, public and NGO sectors was made. The need for continued advocacy for infant mental health in South Africa was stressed in order for the critical significance of infancy to be acknowledged by policy makers, and the care of our infants and their parents within our health system to be prioritised.

*GAIMH-SA is an affiliate of the World Association for Infant Mental Health (WAIMH). WAIMH promotes education, research and study of the effects of mental, emotional and social development during infancy on later normal and psychopathological development through international and interdisciplinary co-operation, publications, affiliate associations, and through regional and biennial congresses devoted to scientific, educational and clinical work with infants and their caregivers.*

*For more information, please visit our website at www.gaimh.co.za*

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# THE RELEVANCE OF PARENT/ CAREGIVER-INFANT INTERVENTIONS FOR PSYCHIATRY

**As a Clinical Psychologist working on the Johannesburg Metro Community Circuit one is acutely aware of the challenges faced - most especially the volume of patients in the communities that need to be seen on a daily basis. With this come feelings of helplessness when faced with individuals who are mostly responding appropriately to the extreme psychosocial hardships of their lives.**

*Melanie Esterhuizen, Kgomotso Kwele*

There is no medication for poverty, for broken attachments, for lack of family support, loss and bereavement. When an individual experiences loss through death or divorce, time is needed for the process of grieving, for slowly letting go of the person around which one's life is built. Psychotherapy is very often the treatment of choice. However, there are long waiting lists due to a desperate shortage of psychologists providing this service in community clinics - very often patients have to wait for more than 4 months to be seen. In the meantime, Psychiatry registrars sit with their patients, feeling the pressure and the responsibility to provide them with some relief.

According to research, a multidisciplinary approach to mental and emotional suffering is most effective. Ideally, Psychiatrists should have adequate consultation time to take a thorough history and assess the impact of the patient's life circumstances on his/her state of mind.

PSYCHIATRISTS SHOULD HAVE THE OPTION TO REFER THE PATIENT FOR PSYCHOTHERAPY FOR APPROXIMATELY 16 SESSIONS (WEEKLY SESSIONS OVER 4 MONTHS) BEFORE PRESCRIBING PSYCHIATRIC MEDICATION.

If the patient's state of mind does not improve during this relatively brief psychotherapeutic intervention, a course of medication is then indicated and could then be commenced alongside the psychological work for maximum benefit to the patient's healing. This is however, an ideal.

While the social ills of our country are perpetuated in the main by broken attachments, relational trauma, lack of education, poverty and unemployment, the situation is mitigated by a dire shortage of

*Melanie Esterhuizen*

*Kgomotso Kwele*

Psychiatrists, Psychologists and Psychiatric Nurses. With a multidisciplinary approach to the treatment of mental illness largely out of reach, professionals are often left with feelings of hopelessness and despair, which we all manage differently.

Given my training (ME) and background in psychodynamic psychotherapy and exposure to child and adult psychotherapy for 10 years in state hospitals and in the community, I have developed what I think is a necessary interest in early attachment relationships and in the neuroscience of attachment. Working within an NGO on the outskirts of Alexandra township for 4 years, I was privileged to run a Mother-baby Home Visiting research project which aimed to support the attachment relationship, and to provide evidence that pre-birth and post-birth home visits, by trained community mental health workers, could shift the relational trajectory of high-risk mother-baby dyads. The work and the research is showing positive results, and is ongoing.

Like many before me, I have arrived at a point in my work where I have no doubt in my mind that early care and intervention has a decisive, lifelong influence on how children learn, form relationships, experience and regulate their emotions and their behaviour (Belsky,2001; Melhuish, 2004).

In line with one of the Department of Health's 2020 guidelines, I have also become more and more convinced that our resource emphasis should be given to a broad primary, preventative mental health care philosophy which is crucial to disrupting the intergenerational transfer of relational trauma in South Africa.

International focus on parent-infant interventions started in 1980 at the first World Association of Mental Health Conference held in CasCais in Portugal, and the more recent global '1000 days' campaign introduced at the 2014 Infant Mental Health Conference in Edinburgh continues to lead the way. In South Africa over the past 10 years, there has been a rapid increase of parent-infant therapeutic interventions born out of psychosocial conditions which highlight the alarming prevalence of disturbance in the early parenting period. Also, within the mental health professions there has been a growing realisation that primary relationships are not only systemic and intersubjective, but also sub-cortical and non-symbolised. In other words, they consist of highly emotional exchanges between two or more reciprocally influential beings i.e. mother/caregiver and infant – who intuitively register and react to each other's feelings (Raphael-Leff, 2005).

In the neuroscience literature, Ziabreva and colleagues (2003) conclude that:
***"The mother (caregiver) functions as a regulator of the socio-emotional environment during early stages of postnatal development... subtle emotional regulatory interactions, which obviously can transiently or permanently alter brain activity levels... may play a critical role during the establishment of maintenance of limbic system circuits."***

Baradon (2010) states:
***"Because the human limbic system myelinates in the first year and a half (Kinney et al., 1988) and the early maturing right hemisphere (Geschwind & Galaburda, 1987; Schore, 1994) which is deeply connected into the limbic system (Tucker, 1992; Gainotti, 2000) – is undergoing a growth spurt at this time, attachment communications specifically impact limbic and cortical areas of the developing right cerebral brain (Cozolino, 2002; Henry, 1993; Schore, 1994, 2000, 2005; Siegel, 1999)."***

According to Schore (2002) the developmental neurobiological model has significant implications for psychiatry and other mental health professions. The organisation of the brain's essential coping mechanisms occurs in critical periods of infancy. This construct of 'critical periods' implies that certain detrimental early influences lead to particular irreversible or only partially reversible enduring effects. The flip side of this critical period concept emphasizes the extraordinary sensitivity of developing systems to their environment, and asserts that these systems are most plastic and open to intervention in these periods. The experience of the right brain is experience-dependent, and this experience is embedded in the attachment relationship between caregiver and infant.

PATIENT'S HISTORIES ARE FREQUENTLY LITTERED WITH MULTIPLE CARETAKERS, EARLY SEPARATION/ABANDONMENT BY A PRIMARY CAREGIVER, NEGLECT, TRAUMA, HOSTILITY AND ABUSE. NEUROSCIENTIFIC RESEARCH HAS SHOWN THAT BRAIN DEVELOPMENT IS AFFECTED AS NEURONAL PATHWAYS 'FIRE' IN RESPONSE TO THE BABY'S EXPERIENCES OF BEING CARED FOR. FOR INSTANCE, BABIES AND YOUNG CHILDREN WHO ARE REPEATEDLY EXPOSED TO VIOLENCE AND OTHER TRAUMA, SUCH THAT THEY EXPERIENCE SEVERE AND UNMITIGATED DISTRESS OVER SUSTAINED PERIODS, TEND TO BECOME CHRONICALLY ANXIOUS. THIS RESULTS FROM EMOTIONAL EXPERIENCES BEING 'HARD WIRED' IN THE DEVELOPING BRAIN SO THAT STATES OF DISTRESS BECOME CHARACTERISTIC FEATURES OF THE PERSON'S DISPOSITION OR WAYS OF BEING (PERRY ET AL., 1995).

Given what we know now about infant brain development, it is important to ask: Does psychiatry consider infants as patients? Are regulatory problems in infancy related to sleep, feeding and soothing recognized as signs of possible attachment difficulties between mother and baby? Do we see beyond the presenting relational difficulties to unconscious conflicts, or triggers of a caregivers' deeply unconscious re-enactments of their traumatic history played out with their baby? If a mother presents with post natal depression, do we recognise the primary patient as 'the relationship' between mother and infant?

This article hopes to draw mental health professionals, and especially Psychiatrists, deeper into the internal world of the infant, the infant's caregiver and the extraordinary potential of early relational interventions for improved mental health trajectories.

## CAREGIVER–INFANT PSYCHOTHERAPY EMERGING OUT OF A PSYCHODYNAMIC MATRIX

For the purposes of this article, it is useful to be reminded of the basic underpinnings of the psychodynamic theoretical paradigm within which parent-infant psychotherapy is situated:

- We have an inner world… some of which is unconscious and which we are only partly aware of… feelings, memories, beliefs , instincts and fantasies.
- Practitioners work to assist patients to become aware of their inner world… to make it more conscious
- This inner world… or unconscious, is dynamic and therefore purposeful (it directs our motivations, behaviours and choices)
- We all experience inner conflict which leads to emotional pain
- This leads us to develop defenses against pain and conflict – these can be functional or dysfunctional defenses
- The way we manage pain is set up in early childhood, and our relational experiences during this time influences our adult personality
- The relationship between the patient and psychologist/psychiatrist is central to change
- We are all resistant to change

## EARLY CHILDHOOD EXPERIENCES INFLUENCE ADULT PERSONALITY

Most present day psychoanalytic theory starts with a symptom or clinical syndrome such as stealing, depression, schizophrenia – and makes hypotheses about events and processes which are thought to have contributed to its development. This article focuses on events in early infancy/childhood, and attempts to work within this primary relational experience in order to nudge the attachment relationship away from a possible trajectory of psychopathology.

Freud described the child's relationship to the mother as `unique, without parallel, established unalterably for a whole lifetime as the first and strongest love-object and as the prototype of all later love relations' (1940). Our earliest relationships set up `internal working models' (Bowlby, 1969) or template for relating, which affects physical, emotional, cognitive and social development.

IF WE REFLECT ON OUR CASES IN THE CLINICS, IT IS CLEAR THAT MOST PSYCHOLOGICAL SUFFERING IS RELATIONSHIP BASED… OUR PARENT'S FAILINGS/ABSENCE, OUR PARTNER'S CRUELTY, OUR CHILD'S ANGRY FEELINGS AND BEHAVIOUR, OUR COLLEAGUES` CRITICISM, INSENSITIVE ORGANISATIONAL AND POLITICAL LEADERSHIP, BRUTALITY OF LAW ENFORCEMENT PERSONNEL, THE INTERPERSONAL TRAUMA OF SEXUAL ABUSE, TO MENTION ONLY A FEW. MOST MEANINGFUL AND LASTING PSYCHOLOGICAL WORK WITH ADULTS IS ABOUT EXPLORING THEIR CURRENT AND EARLIEST RELATIONSHIPS IN ORDER TO UNDERSTAND THEIR CONTRIBUTION TO THEIR CURRENT WAY OF RELATING, AND HOW IT MIGHT BE CAUSING THEM SUFFERING AND CREATING PSYCHOLOGICAL DISTURBANCE.

## THE IMPACT OF EARLY TRAUMA IN INFANCY AND CHILDHOOD… THE NEUROSCIENCE OF ATTACHMENT

For over a century, clinicians and scholars have been concerned about the enduring impact of early trauma in infancy and childhood. With the emergence of attachment theory (late nineteenth/early 20th Century) a considered awareness emerged on how the quality of an infant's early care and parental attachment left an indelible mark on an individual child's psychology, capacity for love, and ability to care for others as an adult. There has been an explosion of research in neurobiology and neuropsychology which is investigating the establishment of `internal working models,' and how therapy works to modify these later in life. Much research and work is taking place worldwide in the field of parent-infant psychotherapy… where evidence for the establishment of `internal working models' is being observed within the first 3 years of life. Out of this has emerged a worldwide initiative around `the first 1000 days' as the optimum window for intervention and PREVENTION of the development of psychopathology.

But what of genes? Fortunately, according to Perry (2002), 'we now know more about our genes and more about the influence of experience on shaping biological systems than ever before. These advances tell us that humans are a product of nature and nurture… genes and experience are interdependent. Genes are merely chemicals and without 'experience' – with no context, microenvironmental signals to guide their activation or deactivation – create nothing. And 'experiences' without a genomic matrix cannot create, regulate or replicate life of any form… we require both. '

## WHY INFANT MENTAL HEALTH?

Perry (2002) reminds us that the time in life when the brain is most sensitive to experience – and therefore most easy to influence in both positive and negative ways, is in infancy and childhood. This is a time of great opportunity – and great vulnerability – for expressing the genetic potentials of a child. This is well supported by Schore (2001) who states that early relational experiences impact brain development. By the time a child is 3 years old, 90% of their brain has developed (Perry, 2000). It has been proposed recently that the impact of early experience may have a greater influence on development than heredity (Schore, 2001). Early experiences either enhance or diminish innate potential. "The child's capacity to learn when she enters school is strongly influenced by the neural wiring that takes place in the early years of life...and brain and biological pathways in the prenatal period and in the early years affects physical and mental health in adult life" (McCain et al., 2007, p. 33).

## BRAIN CIRCUITRY LINKED TO RESILIENCE OR VULNERABILITY

Children's Emotional Development is built into the architecture of their brains. The timing and quality of early experiences combine to shape brain architecture

SECURE ATTACHMENT HAS A RANGE OF BENEFITS ."CHILDREN WHO FALL VICTIM OF INSECURE ATTACHMENT RELATIONSHIPS ARE SIX TIMES MORE LIKELY TO DEVELOP PSYCHOLOGICAL PROBLEMS. THIS HAS A MUTATING EFFECT AND GETS PASSED ON FROM GENERATION TO GENERATION" (VAN RENSBURG, 2013)

## THE IMPORTANCE OF INFANT MENTAL HEALTH IN SOUTH AFRICA?

South Africa is a country that urgently requires primary preventative interventions, given the scale of our Mental Health crisis. The violence of poverty and the apartheid system of governance that reinforced separate development and the especially disempowering Group Areas Act – set up the conditions for ongoing psychosocial and economic hardship, and relational trauma – both within families and between different race groups. Infant Mental Health is influenced by:

- Lack of knowledge… due to inferior educational opportunities
- Poverty… the despair of having no work or work far from home
- Mental illness/Post natal depression
- Substance abuse
- The high percentage of HIV infected parents and children in our society
- Political and Institutional failures… both past and present
- Changing family structures… lack of community support
- Intergenerational transmission of disorganised attachment… caregivers are often overwhelmed and preoccupied with trauma e.g. Loss, violent crime, domestic violence
- Role of fathers…their central place in attachment and child development

## POST NATAL DEPRESSION

Post Natal Depression may contribute to a large number of adverse child outcomes such as stunted growth, impairments in cognitive functioning, and emotional development such as infant social withdrawal, compromised early mother-child interactions, and failure to thrive (Cooper et al., 1999; Field, 1995; Murray & Cooper, Stein, Swartz, & Molteno, 20016).

In several studies conducted in Khayalitsha, a high-risk, peri-urban setting near Cape Town, the prevalence of women meeting screening criteria for clinically significant depressive symptoms has ranged from 32 – 47% in the antenatal period, and 16-35% in the postnatal period. This is an unusually high prevalence of post-partum depression. The Khayelitsha study found at 2 months depression to be 34.7% (Cooper et al., 1999), a rate almost 3 times the rate in Western samples. Tomlinson, Cooper & Murray (2005) also found a strong correlation between the presence of post-partum depression in the mother, and insecure or disorganised attachment patterns in the infant. To complicate matters, even higher rates of Post Natal Depression are being found amongst HIV-positive women (Pelzer & Shikwane, 2011).

## DISORGANISED ATTACHMENT

Disorganised attachment is characterised by trauma in attachment relationships. The infant feels afraid, terrified, overwhelmed and out of control. Alone, abandoned, neglected and invisible, without the

needed comfort & understanding, the caregiver is producing the stress, inflicting pain and is not available to soothe the infant. The infant dissociates and his/her ability to regulate his/her emotional state is compromised. The infant/child becomes angry and can't calm down, acts impulsively, is extremely reactive to other's emotions and misinterprets relational signals. The child is constantly vigilant, reactive and unreceptive and resorts to a combination of freeze (dissociation), flight (keeps moving and avoiding contact), fight (excessive expression of hostility and aggression).

From a developmental psychology viewpoint, the profoundly negative psychological effect of relational trauma (early abuse and neglect) creates the context for this disorganized-disorientated attachment that begins in infancy and endures through childhood, adolescence and adulthood, and 'acts as a risk factor for later psychiatric disorders' (Schore, 2001, 2002, 2003a).

## CAREGIVER-INFANT INTERVENTIONS INTRODUCED ON THE JOHANNESBURG METRO COMMUNITY CIRCUIT

In response to the critical window of opportunity offered by infancy, it has become imperative that preventative parent-infant interventions within the primary healthcare clinics on the Johannesburg Metro Community Circuit be offered. The service was begun in November 2014 with the introduction of the 'Baby Mat' at the Hillbrow Community Clinic on Monday and Thursday mornings.

## THE BABY MAT

- A community- based PRIMARY PREVENTATIVE parent-infant mental health intervention initiated by Ububele Educational & Psychotherapy Trust and replicated at Hillbrow Clinic
- Aim: To promote healthly caregiver-infant attachment (Frost, 2012).
- Compliments or works alongside the ongoing utilization of medical care and/or consultation with traditional healers
- Use of a culturally-diverse therapeutic couple… co-therapist as language translator AND cultural translator

*The Baby Mat*

- A psychodynamic intervention… all mental health symptoms, behaviours and somatic and physiological difficulties have meaning
- Respectful curiosity and engaged neutrality… non-elevation of any one meaning system
- Can be seen as a first line or safety net… identifying high-risk dyads for in-the-moment intervention OR… for referrals to appropriate allied professionals for ongoing assistance

Once high-risk dyads are identified on the Baby Mat, these dyads can be referred for parent-infant psychotherapy.

## PARENT-INFANT PSYCHOTHERAPY (PIP)

Parent or Caregiver – Infant Psychotherapy is essentially a psychoanalytic model drawing on attachment theory, neuroscience and is built on object relations concepts, intersubjectivity (Bowlby, Winnicott, Freud, Anna Freud, Klein, Kohut, Stolarow, Stern). Recent work in the field has been described as 'the decade of the brain' (1990's) and has provided hard science evidence for our clinical findings. Neuronal pathways 'fire' in response to the baby's experiences of being cared for. Emotional experiences are 'hard wired' into the developing brain so that states of distress become characteristic features of the person's disposition or ways of being (Perry et al, 1995).

Where an infant is at risk, early intervention can prevent later disturbance… it is important to intervene before maladaptive patterns of relating become too rigid. Parent-Infant Psychotherapy addresses a range of conscious and unconscious factors that shape the individual parent's and infant's specific modes of 'being' with each other. The intervention can be brief term or longer term therapy. The work is done within a psychoanalytic frame, where containment of the mother and infant are promoted through exploration, reflective functioning, interpretations, making previously learned implicit ways of relating more conscious and available for modification. The patient is the RELATIONSHIP between the mother/ caregiver and the infant.

## APPROPRIATE REFERRALS FOR PARENT-INFANT PSYCHOTHERAPY

Traditionally mothers with Post Natal Depression are prescribed anti-depressant medication and referred for individual psychotherapy. However, by referring for parent-infant psychotherapy, psychiatrists would be selecting an intervention which simultaneously addresses the mother's depression, as well as the attachment relationship with her baby.

### Further examples of appropriate referrals:

- Pregnant mothers with unplanned babies
- Pregnancies as a result of rape
- Supporting adoptive mothers

- Supporting adoptive mothers
- Supporting Grannies who are given custody
- Supporting mothers and their babies who learn of their HIV status when testing for pregnancy
- Supporting single mothers with little familial support
- Teenage pregnancy (high risk)
- Supporting fathers increased involvement

## CAREGIVER-INFANT PSYCHOTHERAPY GROUPS

In February 2015, Caregiver-Infant Psychotherapy groups were initiated at South Rand Hospital on the first Wednesday of every month

- Mothers and their Cerebral Palsied babies (medium and high risk mothers) were invited to attend
- All the mothers/fathers/caregivers are seen by a Multidisciplinary team… Occupational Therapists, Physiotherapists, Speech and Hearing Therapists and the Psychologist
- Attendance has varied between 4 and 2 dyads at each group
- Cross-referrals are made between professionals
- The predominant theme which underlies the daily care of infants with disabilities is the Caregiver/Mother/Father's shock in relation to their infant's condition. The future becomes unimaginable, they are grappling with the loss of the 'ideal baby'. It is very often felt as a trauma which stops time, where the past is obliterated and parents are held prisoner in an enduring present.

## FINAL THOUGHTS

This article presents various models of parent/caregiver – infant psychotherapy. These models see the baby as an active and initiating partner in the therapy. This article proposes the importance of replicating a more public, primary, preventative intervention of the 'Baby Mat' which provides an effective perinatal service within the day-to-day clinic spaces. It also highlights the option for a more in-depth therapeutic intervention for high-risk dyads in the form of parent-infant psychotherapy. And finally, the supportive and more resource-effective intervention of group caregiver-infant psychotherapy is presented. The psychoanalytically based model of parent-infant psychotherapy presented in this article to the psychiatric community is a remarkably effective form of treatment. Research outcomes in terms of improved reflective functioning in the parent and of infant development, suggest that this psychodynamic and attachment-based model is helpful even for very high-risk populations (Fonagy et al., 2002; Baradon et al., 2008; James et al., 2009).

IN SOUTH AFRICA, AS IN MANY OTHER COUNTRIES, MOST OF THE CLINICAL WORK THAT IS BEING DONE IS WITH SEVERELY TRAUMATISED PARENTS: PARENTS WITH MENTAL HEALTH PROBLEMS, HISTORIES OF ABUSE, VIOLENCE, LACK OF SOCIAL CARE AND ECONOMIC AND POLITICAL REFUGEES. THE MINDS OF THESE PARENTS ARE OFTEN COLONISED BY UNPROCESSED FEELING STATES AND HAVE LITTLE CAPACITY FOR PRIMARY PREOCCUPATION WITH THEIR BABY.

As Raphael-Leff (2005) describes, "parent/caregiver – infant interventions (such as the ones presented here,) capitalise on rapidity of change due to the plasticity of development of the baby within primary relationships. The therapy enables primary relationships to run a healthier course by enhancing the carer/s' capacity for reflectiveness and by creating faith in interactive repair, based on their own internal resources and the baby's resilience."

*Melanie Esterhuizen* is a Clinical Psychologist and Baby Mat Practitioner working for the Department of Health in the Johannesburg Metro Community Clinics. Melanie has presented papers at the World Association of Mental Health Conferences in Cape Town (2012) and Edinburgh (2014) on the Ububele Baby Mat and the Ububele Mother-Baby Home Visiting Research Project. Melanie has trained and supervised professionals in Parent-Infant Psychotherapy. Her clinical work focuses on the parent-infant field, as well as offering adult, child and couple psychotherapy in the community clinics and in private practice. References are available from the author. **Correspondence: mje.ububele@gmail.com**

*Kgomotso Boitumelo Kwele* is an Intern Clinical Psychologist. She completed her BA Honours degree in psychology (2013) at the University of the Witwatersrand and is currently completing her Masters in Clinical Psychology (2015). Her special interests include working with trauma victims, neurological and cognitive assessments, couples counselling and parent Infant psychotherapy.

# FORENSIC PSYCHIATRY
## AT THE UNIVERSITY OF THE WITWATERSRAND

*Ugash Subramaney*

The Subspecialty of Forensic Psychiatry has been registered with the Health Professions Council of South Africa (HPCSA), and was gazetted on 15 April 2011 (refer Government Notice No. R. 341, Regulations Gazette No. 34205, Government Gazette, 15 April 2011, Regulation 3). Soon, South Africa will have a host of specialised forensic psychiatrists, specialists that work at the interface of mental illness and the law. With this, begins a new era of training and teaching in this branch of Psychiatry. Academic departments around the country are in the process of developing a training programme in keeping with the blueprint /curriculum as set out by the College of Psychiatrists within the Colleges of Medicine of South Africa (CMSA), available on the College's website.

WITHIN THE DEPARTMENT OF PSYCHIATRY AT WITS UNIVERSITY, STERKFONTEIN HOSPITAL IS THE OFFICIAL SITE THAT OFFERS FORENSIC SERVICES, AND HENCE IS THE SITE FOR SUBSPECIALTY TRAINING IN FORENSIC PSYCHIATRY. THE SITE RECEIVED HPCSA APPROVAL FOR SUB SPECIALIST TRAINING IN 2015. A 2 YEAR TRAINING PROGRAMME IS IN PLACE, SUPPLEMENTING THE ALREADY WELL ENTRENCHED "PSYNAPSE" PROGRAMME RUN ON A FRIDAY MORNING PRIOR TO THE OBSERVATION WARD ROUND. THIS HAS HISTORICALLY SERVED AS CORE TRAINING FOR REGISTRARS IN PSYCHIATRY AT WITS.

The subspecialty-training programme in Forensic Psychiatry at Wits University began in earnest at Sterkfontein hospital in February 2015. The specialised hospital serves all Southern Gauteng courts for observation of awaiting trial detainees, and is the largest specialised hospital in Southern Gauteng that trains Wits university specialists, as well as medical students (in addition to training intern psychologists, OT students and other mental health practitioners).
In 2014 psychiatrists interested in a career in forensic psychiatry have also undergone training in civil aspects of forensic psychiatry with Dr. Merryll Vorster. Part of the 2-year training programme includes 2 Saturday seminars in forensic psychiatry focusing on both civil and criminal forensic psychiatric matters. Experts in the field will be invited for a full morning's session.

*Ugash Subramaney*

The inaugural seminar, which was open to all interested parties and was CPD accredited, took place on the 19th September 2015. Associate Professor Gerard Labuschagne, a brigadier within the South African Police services (SAPS), working in the investigative crimes unit and a national and international expert in the field of forensic psychological investigations and psychological profiling was the guest speaker. Professor Gerard Labuschagne recently completed his LLB, and has many special interests, including threat assessment, and psychological profiling. He has been involved in many landmark cases in South African forensic and criminal investigations.

*Professor Gerard Labuschagne*

The inaugural seminar proved to be very successful; Prof Labuschagne educated and entertained the audience on expert testimony, as well as on threat assessment and management. The seminar was generously sponsored by Janssen Pharmaceutica.

*Ugash Subramaney* is an Adjunct Professor in the Department of Psychiatry, University of the Witwatersrand and a subspecialist Forensic Psychiatrist at Sterkfontein hospital **Correspondence: Ugasvaree.subramaney@wits.ac.za**

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**References:** 1. Boyer P, Montgomery S, Lepola U, Germain J-M, Brisard C, Ganguly R, et al. Efficacy, safety, and tolerability of fixed-dose desvenlafaxine 50 and 100 mg/day for major depressive disorder in a placebo-controlled trial. Int Clin Psychopharmacol. 2008;23(5):243-253. 2. Nichols AI, Tourian KA, Tse SY, Paul J. Desvenlafaxine for major depressive disorder: incremental clinical benefits from a second-generation serotonin-norepinephrine reuptake inhibitor. Expert Opin Drug Metab Toxicol. 2010;6(12):1585-1574. 3. Pae C-U. Desvenlafaxine in the treatment of major depressive disorder. Expert Opin Pharmacother. 2011;12(18):2923-2928.

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# THE LUNDBECK REGISTRAR FINISHING SCHOOL 2015

*Elaine Milne*

The transition from registrar to consultant/ private practitioner in psychiatry can be difficult. As well as the huge differences between private and public sector patient profiles, the responsibility of running a private business and managing new relationships with various stakeholders such as funders, hospitals and the pharmaceutical industry, are added challenges.

MOST YOUNG PSYCHIATRISTS IN SOUTH AFRICA END UP IN SOLO PRACTICES WITH FEW WORK-RELATED SUPPORT SYSTEMS AND HIGH SERVICE DEMANDS. THOSE WHO CHOOSE TO REMAIN IN THE PUBLIC SECTOR NEED TO LEARN TO NEGOTIATE THE INTRICATE PATHWAYS OF THE PUBLIC HEALTH SYSTEM.

Lundbeck presented the inaugural and highly appreciated 'Registrar finishing school (RFS)' seminar in July 2013. The 2-day seminar focuses on the skills and competencies needed for a successful transition to private practice. This year, the third annual RFS, was attended by 25 young psychiatrists and final year residents in psychiatry.

*Elaine Milne*

The programme was developed, co-ordinated and facilitated by The Lundbeck Institute with the help of South African psychiatrists as guest speakers. The speakers donated their services and time free of charge to this venture.

The venue, strategic and logistic support was provided by Lundbeck. In keeping with The Lundbeck Institute tradition, the programme was strictly non-product-related.

During the seminar, registrars had the opportunity to establish support networks with colleagues from across the country and also network with possible mentors who had been practicing psychiatry for over 5 years. Feedback from the participants was highly positive. Lundbeck intends to continue these seminars annually.

*Elaine Milne,* Marketing Manager, Marketing, Lundbeck South Africa (Pty) Limited,North Riding, South Africa.
**Correspondence: EEJ@Lundbeck.com**


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# TARA H MOROSS
# MENTAL HEALTH DAY 2015

*Ronelle Price Hughes*

This year the World Mental Health Day theme is "Dignity in Mental Health". To use the words of Dr. Patt Franciosi, chair of World Mental Health Day it is "a topic that is relevant everywhere, and can be defined according to local circumstances and needs. Dignity in the mental health context can have many meanings and can be applied to every aspect of care. Further, a concern for dignity counters the discrimination and bias that are all too often encountered by people with mental illness. " World Federation for Mental Health (2015). World Mental Health Day Dignity in Mental Health Report. Available at http://wfmh.com/wp content/uploads/2015/09/WMHD_report_2015_ FINAL.pdf (Accessed on 28 November 2015)

The annual Tara Hospital Mental Health Day was held on the 23rd of October 2015 and the theme was aligned to the World Mental Health Day theme. While discussing the topic with colleagues in preparation for the event, I realized the truth of Dr Franciosi's words. "Dignity in Mental Health" triggers different thoughts in different people depending on our context and our experiences at the time. To me that is the beauty of an event like the annual Tara Mental Health Day. It allows a safe space for mental health care practitioners from different contexts to share their perspectives and have an opportunity to think and grow together as clinicians.

DUHAIME'S LAW DICTIONARY DEFINES HUMAN DIGNITY AS "AN INDIVIDUAL OR GROUP'S SENSE OF SELF-RESPECT AND SELF-WORTH, PHYSICAL AND PSYCHOLOGICAL INTEGRITY AND EMPOWERMENT".

Initially when I heard the theme I thought about the dignity of our patients and the manner in which we engage with them and their families. Thinking back on the event I realize what I took away from this inspiring theme, which is the importance of dignity within the multi-disciplinary team. To me "multi-disciplinary team" refers to a more formal team within a ward or clinic setting, but also a more informal team when we think together about challenging or interesting cases. I am hoping that in our every day lives dignity can also extend to the way we think about ourselves as well as anyone else with whom we come in contact. As per tradition the Mental Health Day planning committee consisted of representatives from all departments within the hospital. It was such a privilege to be part of the committee this year and to really experience how powerful a team can be if we are able to treat each other with dignity, are open to feedback and allow each individual team member an opportunity to contribute according to his or her strengths.

*Ronelle Price Hughes*

*Beaded pins with ribbons for registration.*

I would like to use this opportunity to share some of the Tara Mental Health Day 2015 with you.

The main event was in the recreation hall at Tara Hospital and the chosen colour scheme was orange and black. The orange theme was picked up in the flower arrangements, tiebacks and beaded pins with ribbons given to attendees at registration. The committee members with more obsessive compulsive tendencies ensured that the chair covers and tie backs were perfect for the event. During registration the attendees could mingle and enjoy a delicious

homemade poppy seed rusk made by the Tara Mental Health Care Users under the guidance of the Tara Occupational Therapy (OT) team. In true OT fashion the rusks were beautifully packaged and labelled.

AFTER REGISTRATION THE PROGRAMME DIRECTOR, ZAMO MBELE, A SENIOR CLINICAL PSYCHOLOGIST BASED AT TARA HOSPITAL WELCOMED THE AUDIENCE AND INTRODUCED THE TARA CHOIR. THEY LOOKED BEAUTIFUL IN THEIR ORANGE DRESSES. AFTER A VERY UPLIFTING PERFORMANCE BY THE TARA CHOIR IT WAS TIME FOR THE PRESENTATIONS.

*Zamo Mbele*

In the first presentation Professor Thaddeus Metz gave a more philosophical perspective in his talk titled "Mental Health in light of African Views of Dignity: A defense relative to Western Theories". He is a Professor of Philosophy at the University of Johannesburg and it was a privilege to have him at Tara Hospital.

The next speaker, Luke Lamprecht gave us a glimpse into his very inspiring boxing programme with inner city Johannesburg children. Luke is the Director of

*Jacqueline Moodley & Thaddeus Metz*

Fight with Insight and Child Advocacy Forum. He is also involved in the Johannesburg Parent Child Counselling Centre and Art Therapy Centre. Fight With Insight's Hillbrow Re-Evolution Boxing and Life Gym is a holistic model for teaching life skills as well as promoting mental health through exercise, nutrition, and mindfulness to youth that present with behavioural difficulties.

The first two talks were followed by tea, which was sponsored by Sanofi. The tea break allowed an opportunity for attendees to support Tetelo Creations. Tetelo Creations is an income generation programme

*Luke Lamprecht, Judith Ancer, Yvette Esprey and Pierre Brouard*

for clients attending Lufuno Neuropsychiatry clinic. The clients use it as a stepping-stone to become independent and decrease the burden of care on their families by selling beautifully made bracelets. Attendees also had an opportunity to engage with representatives from South African Depression and Anxiety Group (SADAG), pharmaceutical companies, speakers as well as other clinicians.

After tea Pierre Brouard discussed health and dignity issues involving the lesbian, gay, bisexual, transgender and intersex (LGBTI) community. He looked at contemporary approaches to LGBTI and at the importance of considering social and political wellness. He also looked at how human rights work could inform the way health care practitioners respond to the broader health care needs and wellness of sexual and gender minorities in a respectful, thoughtful and appropriate manner. Pierre Brouard is a clinical psychologist and Co-Director of the Centre for Sexualities, AIDS and Gender at the University of Pretoria.

The next speaker was Judith Ancer, who looked at the history of the international and local mental health profession in relation to ethical aspects of working within the context of political and social repression and oppression. Judith Ancer is a clinical psychologist in private practice. She is also a director of Shrink Rap, a company that offers continuing education to healthcare and human resource professionals and provides training and counseling services to small companies.

YVETTE ESPREY CONCLUDED THE ACADEMIC PROGRAMME WITH HER TALK TITLED " 'WHO DO YOU SEE WHEN YOU LOOK AT ME?' FOREGROUNDING DIGNITY WHEN WORKING WITH BORDERLINE PERSONALITY DISORDER." YVETTE LOOKED AT THE STIGMA ATTACHED TO PATIENTS DIAGNOSED WITH BORDERLINE PERSONALITY DISORDER, THE CHALLENGES IN WORKING WITH THEM AS WELL AS THE IMPORTANCE OF FINDING A COMMON HUMANITY AND WORKING WITH DIGNITY.

The event ended with a raffle draw and a lunch sponsored by Adcock-Ingram. Market Caterers prepared beef and vegetarian lasagna as well as salad. The food was delicious and the staff members were very friendly and professional. Dessert was a scrumptious cupcake prepared by the Occupational Therapy Department.

The day would never have been possible without the assistance, patience and guidance of Pharmapreneurs. They really went out of their way to assist the committee in all possible ways. Another big thank you to all our sponsors; Adcock Ingram, Aspen Pharmacare, Lilly, Lundbeck, Novartis, Sandoz and Sanofi, whose generous support gave us the opportunity to make the day special for everyone. I would also like to thank The Source Event Management Company as well at the organising committee and all Tara staff members that worked really hard to make the day a sucess.

*Jonathan Percale & Cora Smith*

I would like to end off with words by Prof George Christodolou, President of the World Federation for Mental Health. "Incorporating dignity into an approach to mental health issues is fundamental to dealing with stigma and discrimination" and "As we seek to change outlooks, the importance of recovery is a central part of the message. Dignity is inherent in recovery".

I am looking forward to the next Mental Health Day and I am hoping that the next theme is as inspiring and thought provoking as this year.

*Ronelle Price-Hughes* is a sub specialist Child and Adolescent Psychiatrist at Tara Hospital, jointly appointed in the Department of Psychiatry at the University of the Witwatersrand. **Correspondence: Ronelle.Price-Hughes@gauteng.gov.za**

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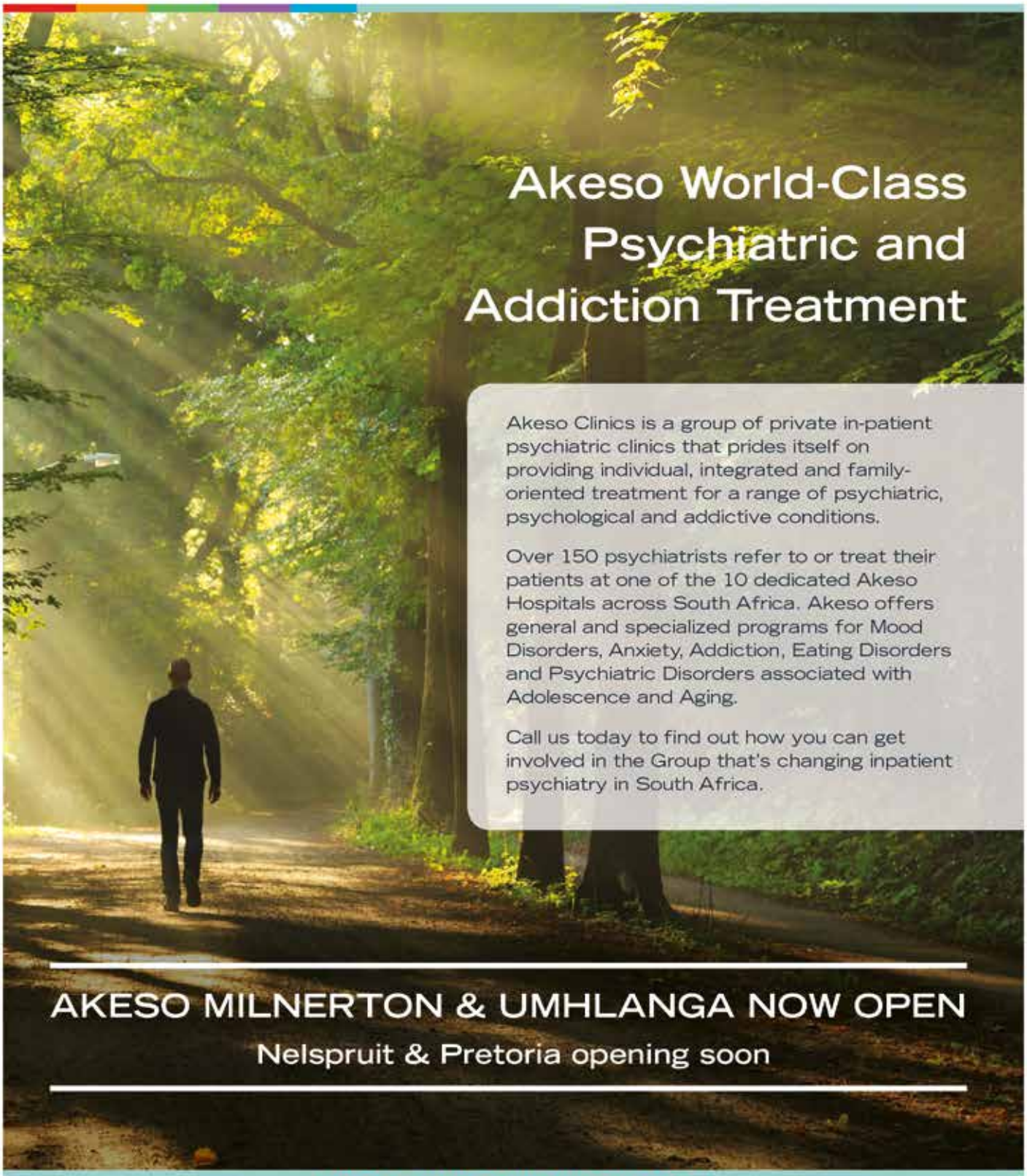

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# DEPARTMENTS OF PSYCHIATRY

## UNIVERSITY OF THE WITWATERSRAND

### MMED GRADUATIONS:

*Eleanor Holzapfel*

" PHARMACOTHERAPY PRESCRIBING PATTERNS IN THE TREATMENT OF BIPOLAR DISORDER IN AN OUTPATIENT POPULATION AT TARA HOSPITAL"

*Nompumelelo Sotobe Mose*

"OVERVIEW OF GERIATRIC INPATIENTS IN THE ACUTE PSYCHIATRY UNIT OF HELEN JOSEPH HOSPITAL"

*Reyanta Ramouthar*

"A COMPARISON BETWEEN FORENSIC OBSERVATION PATIENTS ADMITTED WITH FIRST EPISODE MENTAL ILLNESS AND THOSE WITH AN EXISTING MENTAL ILLNESS"

*Joanna Taylor*

"APPEALS AGAINST ASSISTED AND INVOLUNTARY ADMISSION UNDER THE MENTAL HEALTH CARE ACT NO 17 OF 2002 IN REGION A, GAUTENG PROVINCE, SOUTH AFRICA, BETWEEN DECEMBER 2004 AND DECEMBER 2011"

*Taryn Sutherland*

"A RETROSPECTIVE REVIEW OF LIFETIME PREVALENCE OF TRADITIONAL HEALER CONSULTATION BY AN OUT PATIENT SAMPLE OF XHOSA SCHIZOPHRENIA SUFFERERS"

### HPCSA SUBSPECIALIST REGISTRATION

*Anersha Pillay - Neuropsychiatry*

*Gregory Jonsson - Neuropsychiatry*

*Bernard Janse van Rensburg,*

### NRF rating - C2

*Ugash Subramaney - Forensic Psychiatry*

*HPCSA APPROVED SUB SPECIALIST TRAINING SITE – FORENSIC PSYCHIATRY*

- Sterkfontein Hospital

# UNIVERSITY OF STELLENBOSCH

## NRF RATINGS - 2015

*Prof Christine Lochner*

**Prof Christine Lochner** completed a MA in Clinical Psychology and a PhD in Psychiatry at Stellenbosch University. She now is an Associate Professor at the Department of Psychiatry (Stellenbosch University) and Co-Director of the MRC Unit on Anxiety & Stress Disorders, at the same institution. This unit is known as a centre of international excellence in psychiatric genetics, psychiatric brain imaging, basic neuroscience, and mental health promotion.

Although she is a clinical psychologist by training, research is her priority. Her interests include the phenomenology, psychobiology and neuroimaging of obsessive-compulsive (OCD) and OCD related disorders. These disorders are associated with significant distress, functional impairment and costs – to the individual and his/her family, as well as society.

*Dr Sharain Suliman*

**Dr Sharain Suliman**
Completed a MA in Psychological Research at the University of Cape Town and a PhD in Psychiatry at Stellenbosch University. Active researcher and currently a postdoctoral fellow in the Department of Psychiatry, Faculty of Health Sciences, Stellenbosch University, since 2003. Focus has largely been on posttraumatic stress disorder, with an interest in neurocognition, early predictors and brief prevention and intervention for PTSD.

*Prof Charles Parry*

**Prof Parry** is currently the director of the MRC's Alcohol, Tobacco & Other Drug Research Unit. He is a former acting vice-president of the South African Medical Research Council and is an extraordinary professor in psychiatry at Stellenbosch University.

He undertook post graduate studies in mathematical statistics and psychology in South Africa and the USA and completed a postdoctoral fellowship in clinical services research at Western Psychiatric Institute & Clinic in Pittsburgh. He is registered with the HPCSA as a clinical and research psychologist.

He has authored more than 180 journal articles and co-authored three books. He is a member of the editorial/advisory boards of five journals including Addiction. He is a member of the WHO Expert Panel on Drug Dependence and Alcohol Problems; the WHO Technical Advisory Group on Alcohol & Drug Epidemiology (chair 2015/16); the Technical Advisory Group of the UNODC/WHO Joint Programme on Drug Dependence, Treatment and Care; the UNODC World Drug Report Scientific Advisory Committee; and the board of the Global Alcohol Policy Alliance.

THE DEPARTMENT HAS SEVERAL EXISTING NRF RATED STAFF I.E. PROF ROBIN EMSLEY (B) SINCE 2011, PROF DANA NIEHAUS (C) SINCE 2013, PROF SORAYA SEEDAT ( B) SINCE 2011.

# UNIVERSITY OF PRETORIA

*Dr Gerhard Grobler*

## APPOINTMENT

**Dr Gerhard Grobler** was appointed by the Local Organising Committee of the 2016 World Psychiatric Association International Congress 2016 as the Deputy Chairperson of the Scientific Committee.

# UNIVERSITY OF THE FREE STATE

## SENIOR SPECIALIST POST

**Requirements include:**

Registration as a specialist with the HPCSA,

FCPSYCH/MMED(PSYCH) or equivalent qualification.

**Recommendations:**

Evidence of competence in research, Experience in

post- and undergraduate student training.

**Contact details:**

Prof PJ Pretorius, pretorpj@fshealth.gov.za

# UNIVERSITY OF CAPE TOWN

## NRF RATINGS – 2015: MARGIE SCHNEIDER & ASTRID BERG WERE RATED C1 AND C2 RESPECTIVELY

*Marguerite Schneider*

**Marguerite Schneider** is a senior lecturer and project manager at the Alan J Flisher Centre for Public Mental Health, University of Cape Town. Marguerite's early career was in Speech-Language Pathology and Audiology before moving into broader social science research focusing on disability studies and mental health.

She obtained her PhD at the School of Public Health, University of the Witwatersrand with a thesis entitled: 'The social life of questionnaires: Exploring respondents' understanding and interpretation of disability measures'. She has published on disability measurement, the intersection of disability, poverty and social protection, and in mental health.

*Astrid Berg*

**Astrid Berg** is a Psychiatrist, Child & Adolescent Psychiatrist as well as a Jungian Analyst. She is an Emerita Professor at the University of Cape Town and a Professor Extraordinary at the University of Stellenbosch. She consults to and teaches at the Parent-Infant Mental Health Services and Child Psychiatry Divisions at both Universities.

The Department has a number of existing NRF rated staff i.e. 2 A rated staff, Dan Stein and Jack van Honk, 2 B rated staff, Crick Lund and Petrus de Vries and 2 Y rated staff, Katherine Sorsdahl and Fleur Howells.

## NIH FUNDING

*Dr Samantha Brooks*

**Dr Samantha Brooks**, won NIHfunding to work with Prof Steve Shoptaw of UCLA, on anintervention for methamphetamine dependence, which will be including brain imaging before and after.

## EXCELLENCE FUND GRANT

**Dr Dickens Akena** has been awarded a prestigious African Research Excellence Fund grant, which will cover costs of spending time at UCT, and furthering his ongoing investigations of visual symptom scales in psychiatry (very important in places where illiteracy is high). Dr Akena is a lecturer in psychiatry at Makerere University in Uganda, and is doing a post-doctoral Fellowship in our Department.

# ALAN J FLISHER CENTRE FOR PUBLIC MENTAL HEALTH DESIGNATED AS A WHO COLLABORATING CENTRE

*By Crick Lund*


The World Health Organization (WHO) recently designated the Alan Flisher Centre for Public Mental Health (CPMH), in the Department of Psychiatry and Mental Health at the University of Cape Town, as the only mental health and psychiatry Collaborating Centre (WHO CC) in South Africa.

The CPMH is one of only two mental health and psychiatry collaborating centres in Africa. Being appointed as a WHO CC takes a lot of time and effort and the recent announcement marks the end of a lengthy process. "This ends a process that I initiated on Dr Shekhar Saxena's(1) suggestion 4 years ago, and we are very pleased that it has come through," says CPMH director, Prof Crick Lund.

"The CPMH applied for WHO CC status to formalise collaborations that have been ongoing since 2001. At that time some of us in the Department of Psychiatry and Mental Health at UCT were invited by WHO to collaborate on the development of mental health policy and service guidelines, mainly targeting low and middle-income countries.

We subsequently collaborated with WHO on the Mental Health and Poverty Project, a DFID funded consortium working in 4 African countries (2005-2010) and then in the Programme for Improving Mental Health care (PRIME) (2011-2017), a research consortium working in 5 countries in sub-Saharan Africa and south Asia," Lund explains.

This collaboration allows the CPMH to work with WHO in the implementation and evaluation of the mhGAP Intervention Guide in 5 low and middle-income countries, namely Ethiopia, India, Nepal, South Africa and Uganda. It will also serve to develop a costing tool for calculating the resources required to implement this intervention in these countries. Furthermore this collaboration also serves to enhance the uptake of mental health research into policy and practice in low and middle-income countries.

"IT IS IMPORTANT FOR THE CPMH BECAUSE IT FORMALISES OUR TIES WITH WHO, AND ALLOWS US TO WORK MORE CLOSELY WITH WHO ON PROJECTS TO STRENGTHEN MENTAL HEALTH POLICY AND SERVICES, ESPECIALLY IN SUB-SAHARAN AFRICA. THE NEW WHO COLLABORATING CENTRE STATUS IS ALSO AN ACKNOWLEDGEMENT OF THE VALUE OF OUR WORK TO WHO AND UN MEMBER STATES. FURTHERMORE IT ALLOWS US TO WORK MORE CLOSELY WITH MINISTRIES OF HEALTH IN LOW AND MIDDLE-INCOME COUNTRIES, INCLUDING SOUTH AFRICA.

Hopefully this will allow us to ensure that the research results we generate are taken up in policy and practice, in a manner that improves the lives of people living with mental illness, particularly those living in poverty." CPMH will continue to work closely with the WHO and Ministries of Health in various countries to scale up mental health care. "This also strengthens our resolve to get mental health on international health and development policy agendas, and provide evidence to scale up mental health care across the continent," says Lund.

*(1) Dr Shekhar Saxena* is the Director of WHO's Department of Mental Health and Substance Abuse.

# WALTER SISULU UNIVERSITY

## APPOINTMENT OF HEAD OF DEPARTMENT

*Zukiswa Zingela*

**Zukiswa Zingela** is the new Head of Psychiatry at Walter Sisulu University since June 2015.

Prior to this she was Head of Psychiatry at Dora Nginza Hospital, where she lead a multidisciplinary team responsible for psychiatric services in the 3 general hospitals in Port Elizabeth.

She also supervised the training of WSU Psychiatry Registrars and undergraduate students within the general hospital setting, since January 2011.

Between 2008 and 2010 she ran a private practice in Port Elizabeth and was also involved in training and supervision of medical students and psychiatry registrars. Prior to this Zuki had worked in the UK as a consultant Psychiatrist where she lead the Blackpool North Community Mental Health Team from early 2003 to early 2008.

She gained significant experience in community psychiatry, including the assessment and management of severe personality disorders.

**Brief Background**

Zuki was born and bred in Port Elizabeth and trained as a doctor at the University of Natal where she qualified in 1995. She did her registrar training at Weskoppies Hospital, University of Pretoria, where she passed her FCPsych in May 2002 and her MMed end of 2002. She was granted the Denmar Registrar of the Year Award in 2002. Her areas of interest include Public Mental Health and Service Delivery, Cultural Psychiatry and Catatonia.

RESEARCH HAS INCLUDED PREVALENCE OF HIV IN PSYCHIATRIC INPATIENTS, CATATONIA CASE SERIES, INVESTIGATOR FOR THE BALANCE TRIAL, ANALYSIS OF THE EASTERN CAPE MENTAL HEALTH SERVICES, USE OF TRADITIONAL AND ALTERNATIVE HEALERS IN MENTAL HEALTH AND BEING AN EXPERT REFERENCE GROUP MEMBER EXPLORING THE ESTABLISHMENT OF A MEDICAL SCHOOL IN NELSON MANDELA METROPOLITAN UNIVERSITY.

Zuki is the current chairperson of the SASOP Eastern Cape Subgroup.

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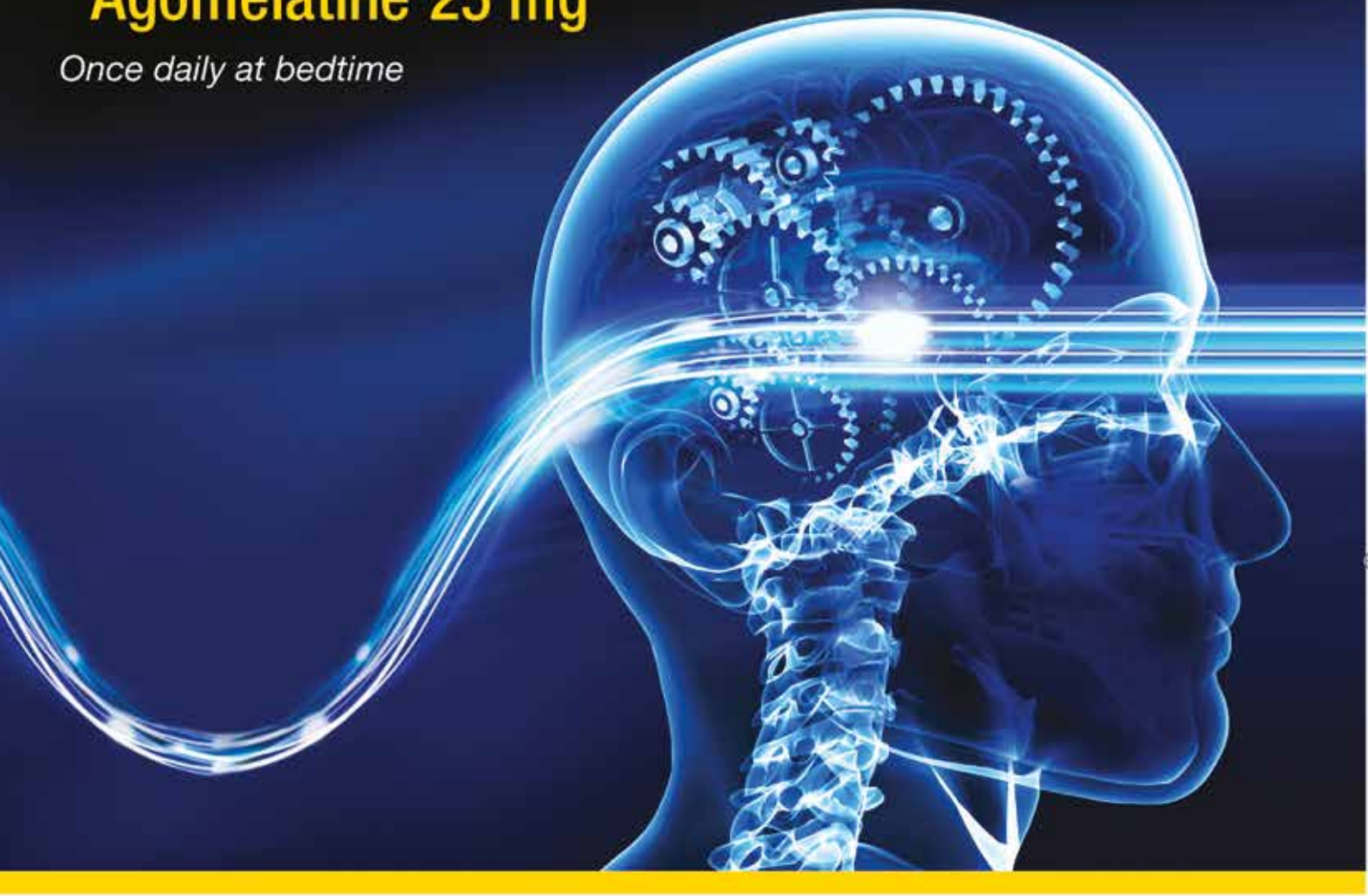

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References: **1.** De Bodinat C, et al. *Nature reviews* 2010;9(8): 628-642. **2.** Goldwood P. *J Clin Pharmacol* 2010;24(Suppl 8): 15-19. **3.** Laux G. *Psychopharmacotherapie*. 2011;18: 18-26. **4.** Cumble E, et al. *Journal of the EPA*. 2011. **5.** Oral presentation, Goodwin. *ECNP 12th - 16th September 2009, Istanbul, Turkey*. **6.** Lemoine P, et al. *J. Clin Psychiatry*. 2007;68: 1723-1732. **7.** Package Insert Valdoxane®. **8.** Kennedy SH, Rizvi SJ. *CNS Drugs*. 2010;24: 429-493.


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# NO NEED TO PANIC OVER NEW RETIREMENT SAVINGS RULES

Mixed emotions greeted the signing into law of the Tax Laws Amendment Act, which proposes to introduce changes to the way retirement savings are treated.

Earlier in January 2016, President Jacob Zuma signed the law that will compel all members of provident funds to use a portion of their savings to buy a pension instead of cashing out everything as a lump sum.

Karin Muller, Head of Growth Market Solutions at Sanlam, says misperceptions about what these changes entail are what is causing panic. These regulatory changes, she says, are intended to help people provide for an income in their retirement, and to prevent a situation where elderly people are not able to meet their basic needs.

"MOST PEOPLE RUN OUT OF MONEY IN RETIREMENT BECAUSE OF A NUMBER OF REASONS, INCLUDING NOT SAVING ENOUGH TO BEGIN WITH, AND CASHING OUT THEIR SAVINGS WHEN THEY CHANGE JOBS.

Research we conduct annually at Sanlam shows that most people are not able to retire comfortably. The majority of pensioners in the country find themselves having to rely on government support grants of only R1 420 a month," says Muller.

She says the new law will harmonise the manner in which different types of retirement funds are treated, whether one is invested in a pension, provident or retirement annuity (RA) fund. In the past, members of provident funds could take all their retirement savings as a lump sum when they reach retirement. But now they can only receive a maximum of one-third as a lump sum and will need to invest at least two-thirds to receive a pension.

This means someone with R1.5 million in retirement savings can take only R500 000 as a lump sum and then use the remaining R1 million to buy a pension in order to receive a monthly income during retirement.

"Many people may have the misconception that they will not have access to their retirement savings any more or that Government is taking control of their money. But that's not the case. All the money you've saved for retirement during your working years is still yours. The only difference now is that you will get a portion of it as a monthly income and not everything as a lump sum."

She says it's important for people to remember that regulatory changes are intended to help them provide for an income in their retirement, and not to harm them in any way.

"IN A COUNTRY WHERE ONLY 3 IN 10 PEOPLE (30%) ARE ABLE TO MAINTAIN THEIR STANDARD OF LIVING IN RETIREMENT, YOU HAVE TO ENSURE THAT YOU SAVE ENOUGH FOR YOUR RETIREMENT SAVINGS TO LAST YOUR LIFETIME IF YOU DON'T WANT TO END UP HAVING TO LOWER YOUR STANDARD OF LIVING OR LIVE IN POVERTY WHEN YOU ARE OLDER."

Last year reports surfaced that civil servants, especially teachers, were resigning to cash out their retirement savings. Muller says with the latest developments, there are once again concerns that some people might see this as the last opportunity to access their retirement savings in cash lump sums.

She points out that the new rules will, however, only apply to money invested after the date on which the changes are implemented. The old rules will apply to money invested before 1 March 2016.

IN OTHER WORDS, RETIREMENT SAVINGS ACCUMULATED IN A PROVIDENT FUND BEFORE 1 MARCH 2016 CAN STILL BE TAKEN AS A LUMP SUM ON RETIREMENT. MULLER REMINDS PEOPLE THAT IF THEY CASHED OUT THEIR RETIREMENT SAVINGS NOW, THEY WILL PAY HIGHER TAXES THAN THEY WOULD PAY AFTER RETIREMENT.

*Sanlam is a Licensed Financial Services Provider.*

# PAYING ATTENTION TO ADULT ADHD!

*Renata Schoeman*

On Saturday, 21st November 2015, the first Adult Attention-Deficit/Hyperactivity Disorder (ADHD) Workshop took place at the Oxford Health Care Centre in Saxonwold. This exciting day saw some psychiatrists and psychologists pay close attention to some very interesting presentations. The workshop was hosted by the SASOP Southern Gauteng Subgroup in collaboration with the ADHD Special Interest Group. Adj Prof Rita Thom opened the day, while Dr Wendy Duncan presented an overview on the beautiful facilities and services rendered at Oxford Healthcare Centre.

*Rita Thom*

The first speaker was Mr Anthony Townsend (clinical psychologist in private practice; guest lecturer, University of Pretoria) who presented "Executive (dysfunction in Adult ADHD: trapped in the revolving door of consciousness". Anthony explained how all too often attention and concentration, the adjacent doors of the cognitive gateway to consciousness, are misrepresented as a single, undifferentiated construct (Goldstein, 2014). While in childhood, the ability to maintain concentration on even short, simple tasks is compromised, most adults with ADHD are, for the most part, capable of sustaining attention for basic instructions and tasks.

*Anthony Townsend*

THIS IS NOT TO SUGGEST THAT THEY HAVE 'GROWN OUT' OF THEIR ADHD, BUT RATHER THAT WHILE THEIR CAPACITY FOR SIMPLE ATTENTION IS INTACT, THESE INDIVIDUALS INSTEAD EXPERIENCE IMPAIRMENT IN THE COMPLEX PROCESSES OF ATTENTION (SCHOENBERG, 2012) MANIFESTING AS PSEUDO-FORGETFULNESS AND DIFFICULTY MANAGING A DAILY ROUTINE WHICH INDICATES IMPAIRMENTS IN THEIR EXECUTIVE FUNCTIONING RATHER THAN IN SIMPLE PROCESSES OF ATTENTION.

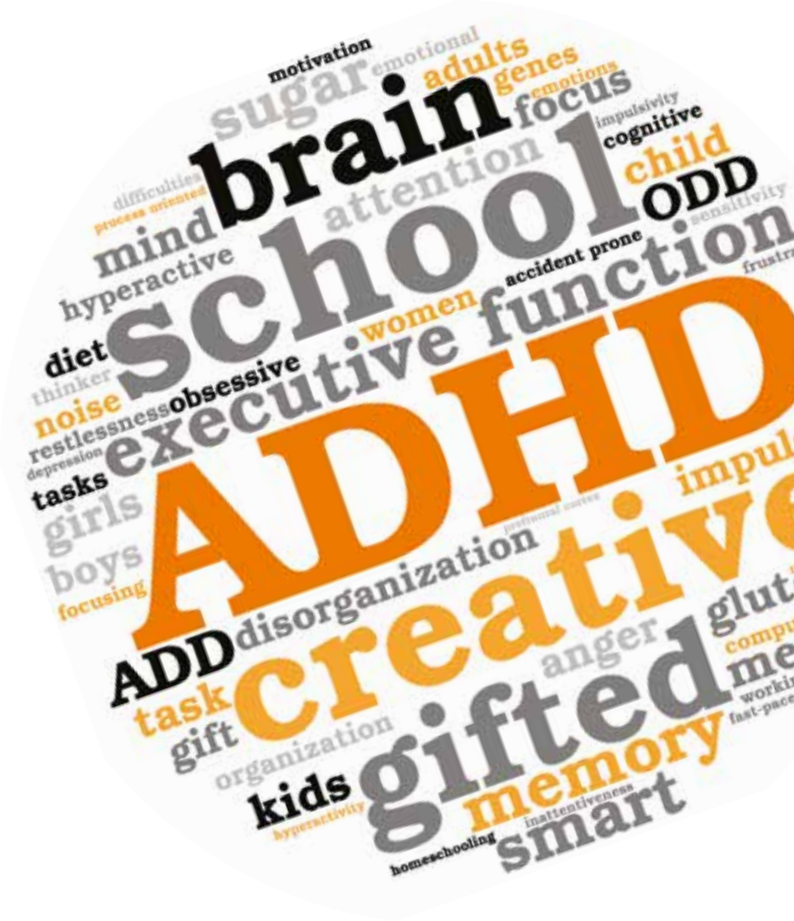
This indicates impairments in working memory (the ability to manipulate information held in memory) and set-shifting (the ability to hold two sets of instructions in mind and alternate one's responses between them). These complex attentional processes, mediated by the frontal lobe, require attentional resources to not only be activated but also delegated, and coordinated in multiple simultaneous activities.

The uncoordinated chaos and forgetfulness emblematic of the self-report of adults with ADHD may therefore be better understood as difficulty coordinating multiple attentional resources and task demands leading some to be lost in the shuffle (pseudo-forgetting) while others remain incomplete or attended to in a frantic manner. Anthony gave an interesting and practical overview of different neuropsychological assessments, as well as the specific impairments experienced by adults with ADHD. He then concluded with an emphasis on the need for Cognitive-rehabilitation therapy (CRT), in addition to pharmacological intervention, to adjust a patient's task responses and improve cognitive performance and self-esteem, and ultimately their occupational and social functioning (Wilson, 2010). Through optimal interventions, the revolving door of executive dysfunction in adult ADHD may give way to the steady, coherent traffic of a gateway by compensating for a lack of internal attentional direction with a structured external environment.

*Renata Schoeman*

Dr Renata Schoeman (psychiatrist in private practice; senior lecturer: Leadership, USB; co -convenor of the ADHD SIG) followed with "Adult ADHD in the

workplace". On the basis of reconceptualising the cognitive profile of someone diagnosed with adult ADHD (as discussed in the previous presentation), the rationale behind interventions of structured tasks and environments, visual reminders and avoiding multi-tasking becomes much clearer. With a prevalence rate of 2.5-4.3%, adult ADHD affects roughly 1 million South Africans. However, a recent study (Schoeman, 2015) indicated a prevalence rate of up to 52.5% in clinical psychiatric settings. Dr Schoeman emphasised how the manifestation of the core symptoms of ADHD (inattention, hyperactivity and impulsivity) change over the lifespan, and how the associated symptoms (behavioural, cognitive, emotional and social problems) contribute to work-related and interpersonal impairment. Although symptoms often appear to decrease over time, adults are often more adept at managing symptoms, and compensate for ADHD-related impairment through lifestyle and career choices. ADHD is a costly, chronic disorder, with significant impact on the quality of life of patients and their families. Adults with ADHD often lead a life of perpetual failure: poor work records, interpersonal conflict and marital discord, financial difficulties, and even forensic problems are often present. The costs (direct, indirect, and intangible) of adult ADHD are substantial, with disability adjusted life years calculated at 424/100 000 (Murray, 2012), a substantial decrease in work performance (Kessler, 2009).




There is a legal obligation on employers to accommodate adults with ADHD in the workplace (Employment Equity Act, 1998). Affirmative action legislation emphasizes that reasonable accommodation for people with disabilities should be provided to make the workplace more accessible according to the person's needs. **The following questions can be considered (Whetzel, 2014):**

- What limitations does the employee with ADHD experience?
- How do these limitations affect the employee's job performance?
- What specific job tasks are problematic as a result of these limitations?
- What accommodations are available to reduce or eliminate these problems?
- Can the employee provide information on possible accommodation solutions?

It is advisable to focus on an individual's strengths and developmental opportunities and not focus on "weaknesses". Adults with ADHD can be highly intelligent, creative, and out-of-the box thinkers. They have high energy levels, can hyper-focus, and take risks. They are good starters, but bad finishers. They often lack attention to detail and procrastination, inconsistent performance, and organizational impairment are problematic. Specific tips are to avoid multi-tasking, be flexible in terms of schedules, "buddy up" with a more organised colleague, give feedback, use flowcharts, diaries, and visual aids (paper-and-pen being more effective than electronic versions), schedule interruptions and "movement breaks", and provide a private workspace. Coaching and social skills training is highly recommended. A useful motto: "write it, time it, check it". Frequent review meetings are important and corporate mental health awareness, training and education are crucial.

*Rykie Liebenberg*

Dr Rykie Liebenberg (psychiatrist in private practice; convenor of the SASOP ADHD SIG) gave an overview of current research on adult ADHD in South Africa (Schoeman, 2015) and lead an interactive and very vocal discussion on the need for guidelines for the management of adult ADHD in the country. In SA, psychiatrists see 9.25±18.21 adults with ADHD between 18 and 40 years/week, of which 1.65±1.07 are newly diagnosed, while in the age group 40 to 60 years, 6.79±13.13 (1.41±1.06 newly diagnosed) are seen. Comorbidity is common – adding to the complexity of diagnosis and treatment. The most common comorbid disorders in adults with ADHD (in the South African context) are anxiety disorders (40.33%), substance use disorders (SUDs) (33.81%), Major depressive

disorder (33.28%) and personality disorders (28.26%). South African psychiatrists prefer the following as first line treatment for adults with ADHD: Controlled release (OROS) methylphenidate (MPH), followed by long-acting MPH, immediate release MPH, atomoxetine, and bupropion. **Reimbursement in SA is problematic with payment as follow:**

- Consultations: out-of-pocket expense to the patient (34.98%), followed by reimbursement from medical scheme savings accounts (34.65%
- Medication: out-of-pocket expense to the patient (41.17%), followed by reimbursement from medical scheme savings accounts (34.60%), acute benefits (33.73%), and chronic benefits (16.21%)
- Supportive and alternative therapies: predominantly from patient resources (62.26%)

Dr Liebenberg then presented a high-level overview of current international guidelines (BAP, 2007; CADDRA, 2011; ENAA, 2010; Maudsley, 2009; NICE, 2013). Although SASOP guidelines (2013) exist for the treatment of child- and adolescent ADHD, it is clear that SA guidelines for the diagnosis and treatment of adult ADHD is needed. **Specific topics suggested for inclusion in the guidelines are:**

- Acknowledgement of adult ADHD as a disorder
- Access to care: medication and therapy
- Not funding adult ADHD can be considered discrimination
- Who should diagnose ADHD
- How should ADHD be diagnosed (clinical interviews, rating scales, and the(limited) role of computerised assessments)
- How should ADHD be treated (no "diagnostic trials")
- The ethics of diagnostic accuracy versus access to cognitive enhancement

The high rates of comorbidity contributes to the complexity in the diagnosis and management of ADHD. Dr Frans Korb (psychiatrist in private practice) presented "Comorbidity in adult ADHD: diagnosis and management". He emphasised the importance of a comprehensive clinical assessment (Haavik et al, 2010; Kooij, 2010) with leaders in the field spending up to 3 hours on a first interview with a patient! Dr.Korb stated that "adults do not outgrow the disease – they outgrow the criteria". It is also important to note that ADHD seldom occurs alone: 75% of patients have at least one other disorder, while 33% has two or more disorders (e.g. Kooij, 2004; Kessler, 2006). ADHD is also comorbid in 20% of other disorders (e.g. Fayyad, 2006; Van Dijk, 2010)!

*Frans Korb*

IT IS THEREFORE DEBATABLE WHETHER GENERAL PRACTITIONERS ARE EQUIPPED TO DIAGNOSE ADULT ADHD AND INITIATE TREATMENT.

Dr Korb then discussed key articles by Searight (2000) and Weiss (2004) which explained the shared and differential features between ADHD and Major depressive disorder, Bipolar mood disorder, Generalised anxiety disorder, and Borderline personality disorder. The rules for treatment in ADHD with comorbidity is as follow: First treat depression, anxiety, bipolar disorder, SUDs, then add stimulant for ADHD; In case of a personality disorder, first treat ADHD. Although no randomised controlled clinical trials are available, clinical experience suggests that MPH can be safely and effectively combined with Selective Serotonin Reuptake Inhibitors, lithium, sodium valproate and anti-psychotics. MPH can increase the plasma levels of tricyclic antidepressants and should be used with caution. Atomoxetine is preferred over MPH in patients with comorbid psychotic disorders. Frans concluded his presentation with an emphasis on the importance of psychoeducation, psychotherapy, and coaching interventions in the holistic management of adult ADHD.

*Richard Sykes*

The final presentation was by Dr Richard Sykes (psychiatrist in private practice; part-time consultant, Weskoppies hospital) on "Adult ADHD and sleep" which had everyone wide awake and alert!

Sleep debt affects the prefrontal cortex with a negative effect on mood (irritability), cognition (impaired attention, alertness, difficulty initiating and planning, decreased mental endurance, and learning and memory consolidation). After 22 hours of sleep deprivation, behaviour mimics alcohol intoxication with disinhibited behaviour and increased impulsivity! The prevalence of sleep disorders in ADHD is 25 to 55%, with a multidirectional and multifactorial relationship.

COMMON PROBLEMS ARE DIFFICULTY GOING TO BED ON TIME (78%), FALLING ASLEEP (70%), SLEEPING THROUGH (50%), GETTING UP IN THE MORNING (70%) AND DAYTIME SLEEPINESS (62%).

This lifetime pattern, present in 60% of adults with ADHD, is suggestive of delayed sleep phase syndrome (DSPS). ADHD can be considered a deficit in alertness, where motor hyperactivity may

be a counter behaviour for staying awake. DLMO (Dim light melatonin onset) is a good indicator of circadian rhythm. Usually melatonin peaks 14 hours after lights on (e.g. awake at 7am, then DLMO at 9pm) and sleepiness occurs two hours later. In ADHD, the circadian clock malfunctions.

Adults with ADHD therefore seem to lack any sense of time, as well as any rhythm in day/night patterns. Their habitually lateness is regarded as a planning problem, but it may in fact reflect a fundamental problem of the biological clock! It is postulated that "eveningness" (night owls) ma be an endophenotype for the inattentive subtype of ADHD. ADHD may not only be associated with circadian rhythm disturbances, but also interfere with cyclical and seasonal, leading to problems with impulsiveness, eating, sleeping and mood (e.g. Barkley, 1997; Kooij, 2003; Davis, 2009).

*Oxford Health Centre*

ADHD is associated with a higher prevalence of Seasonal affective disorder and Premenstrual dysphoric disorder. It is also linked with an increase in obesity, insulin resistance and diabetes – skipping breakfast, binge eating and sleep deprivation (through leptin dysregulation) play a role (e.g. Lauderdale, 2006; Shea, 2005). Sobranski (2008) demonstrated the beneficial effect on MPH on sleep through improved sleep efficiency, reduced sleep latency, and an improved subjective and objective restorativeness of sleep – most likely due to better daytime adjustment having a beneficial effect on sleep. Richard concluded with an overview of sleep hygiene and the role of melatonin.

The workshop was a big success and paved the way for workshops during 2016 – scheduled for the Western Cape and KwaZulu-Natal. For more information on our activities and to join the ADHD SIG please contact Dr Renata Schoeman at renata@renataschoeman.co.za.

The overall objective of the ADHD SIG is to improve the basket of care available to our patients with ADHD. This is only possible through a combined and concerted effort of individuals with a special interest in and passion for ADHD to improve knowledge about and funding for the care of individuals with the disorder.


*Renata Schoeman* is a psychiatrist in private practice; senior lecturer: Leadership, USB; co-convenor of the SASOP ADHD SIG.
References available on request. **Correspondence: renata@renataschoeman.co.za**


REFERENCES: 1. Janssen Data on file. 2. IMS, March 2013 TPM Data.

For full prescribing information, refer to the latest package insert (April 2013). JANSSEN PHARMACEUTICA (PTY) LTD. (Reg. No. 1969/011232/07). Building 6, Country Club Estate, 21 Woodlands Drive, Woodmead, 2191. www.janssen.co.za. Medical Info Line: 0860 11 11 13.
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# PSYCHOPHARMACOLOGY UPDATE 2015, KENYA

*Mike West*

The first African "Update on Psychopharmacology", a collaboration and co-hosted by the University of Cape Town, Moi University School of Medicine (Kenya) and University of Nairobi (Kenya) and organized by the International College of Neuropsychopharmacology (CINP) and Londocor Event Management, was held recently over 8-9 October 2015 at the Boma Hotel in Nairobi, Kenya. This event was made possible by an unrestricted educational grant from the Lundbeck International Neuroscience Foundation. 71 delegates were in attendance, many of whom had travelled great distances from within Kenya, from other African countries (including Tanzania, Uganda, Ethiopia and Namibia) and overseas (United Kingdom, Australia). Also in attendance were several South African psychiatrists, who participated on the organizing committee and gave oral presentations.

**These included:**

*Frank Njenga & Dan Stein*

Professor Dan Stein (Chair and Head of Department of Psychiatry and Mental Health, University of Cape Town and director of the Medical Research Council unit on anxiety and stress disorders), Professor Solomon Rateamane (Head of Department of Psychiatry, Sefako Makgatho Health Sciences University and President of the African Psychiatric Association and Allied Professionals 2014-2016), Dr Bonga Chiliza (senior lecturer and researcher, University of Stellenbosch) and Dr Mike West (senior lecturer, University of Cape Town).

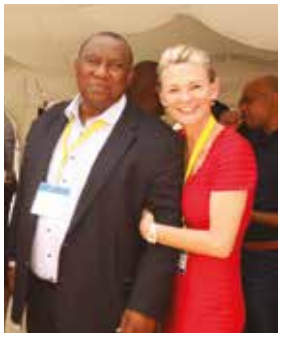
**Other notable faculty included:**

Professor Lukoye Atwoli (Dean of Moi University School of Medicine and Associate Professor of Psychiatry), Professor David Baldwin (University of Southampton), Professor David Castle (University of Melbourne), Professor David Ndetei (University of Nairobi), Dr Frank Njenga (University of Nairobi), Dr Susan Hinga (University of Kenyatta, Kenya) and Dr Cathy Abbo (Makerere University, Uganda).

The conference was held over two days, and began with an introductory review of the theoretical essentials of psychopharmacology, including classification of psychiatric medications. A series of algorithm-based approaches to common and serious mental disorders were presented, with speakers highlighting real-world experiences with patients, emphasizing the often nuanced art of prescribing.

Day 1 was dedicated to major depression, the anxiety disorders, obsessive-compulsive and related disorders and post-traumatic stress disorder. Day 2 covered bipolar mood disorder, schizophrenia, substance use disorders, sleep disorders and an overview of prescribing in children and adolescents.

Discussions between delegates during breaks were rich, and revealed similar provider, patient and health-system related challenges in effective and efficient psychopharmacology prescribing in Africa. In some instances, notable successes were mentioned – for example, Tanzania has the largest state-funded opioid substitution program in the region; South Africa, in comparison, has next to none. It is clear that fostering links between countries and encouraging collaboration between clinicians and academic centres across the continent is going to be a critical tool in addressing a significant mental health burden.



*Solly Rataemane and Sonja du Plessis (Londocor)*

Prompted by this, and the success of this meeting, the CINP has been encouraging psychiatrists in the public and private sector across the continent to form an African College of the organizers of this conference are looking forwards to drawing up a constitution and arranging a second conference in either 2016 or 2017.

*Dr Mike West* is a consultant psychiatrist employed at Groote Schuur Hospital, where he co-managed the acute services. He also operates a private practice from Akeso Clinic, Milnerton, where he has developed a special interest in the pharmacological management of substance use disorders. **Correspondence: info@drmikewest.co.za**


# Research Award for Established Researchers

**The Biological Psychiatry Special Interest Group (South African Society of Psychiatrists) is supporting more established researchers. Grant valued at R150,000 - R300,000**

**Applicants should be:**

- Psychiatrists, clinical psychologists, clinical researchers and basic neuroscientists.
- Working full-time in research or clinical activities relevant to biological aspects of psychiatry or neuropsychopharmacology.

**To apply, please forward one original set of the following documentation:**

- Research proposal of 10 pages including a budget.
- Up-to-date curriculum vitae.
- Half-page personal statement outlining your most significant career accomplishments in the past 5 years.
- List of publication outputs in the past 5 years.

**Application Deadline:**

- **Friday, March 11, 2016**

**Submit applications via email to:**


- **Vanessa Jones**
- **Ph: (021) 938 784**
- **vanessaj@sun.ac.za**

Biological Psychiatry Congress 2015
Trends & Treatments: The Changing Landscape

# Early Career Research Development Awards

## The Biological Psychiatry Special Interest Group (South African Society of Psychiatrists) is awarding two Early Research Career Awards valued at R100,000 each

**Applicants should be:**

- Psychiatrists, clinical psychologists, senior registrars or medical officers in psychiatry, clinical researchers or basic neuroscientists.
- Ability to conduct an innovative and feasible project in any area relevant to biological psychiatry or neuropsychopharmacology.
- Holder of a post for the full duration of the project.
- Under 45 years of age.

**To apply, please forward one original set of the following documentation:**

- Research proposal of 10 pages including a budget.
- Up-to-date curriculum vitae.
- Half-page personal statement outlining your most significant career accomplishments.
- Statement explaining how this research award would particularly benefit you at this time in your career.

Successful awardees should be willing to (i) join up as members of the Biological Psychiatry Special Interest Group (membership is free) and (ii) be co-mentored by a member of the Biological Psychiatry Executive Committee.

**Application Deadline:**

- **Friday, March 11, 2016**

**Submit applications via email to:**


- **Vanessa Jones**
- **Ph: (021) 938 9784**
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**Speaker** • Internationally acknowledged Clinician and Author, **Robert Weiss**, LCSW, CSAT-S
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# ONE DAY AT A TIME

## Identifying addiction triggers

*By Robert Weiss LCSW, CSAT-S*


Robert Weiss

Jonathan is a 45-year-old structural engineer. He has been in recovery for both sex addiction and meth/cocaine addiction for just under a year. Jonathan is serious about his recovery and about saving his marriage. Unfortunately, his office is located in a part of town that forces him to drive through a seedy neighbourhood littered with strip clubs, drug dealers, and prostitutes. On his good days, he doesn't even think about these temptations when he drives past. However, if he and his wife have been arguing, or he's had a tough day at work, or he simply woke up on the wrong side of the bed, he finds that he can think of nothing else. On two occasions he has "slipped" on his way home from work – once finding himself high on cocaine in a strip club, another time ending up in the back seat of his car with a meth-addicted prostitute. He was truthful with his wife about both slips, and whilst she was grateful for his honesty, her patience is wearing thin. Meanwhile, Jonathan can't understand why he's had these moments of weakness when he's working so hard to heal from his addictions and to rebuild relationship trust with his wife.

From an addiction perspective, Jonathan's slips have occurred primarily because he has failed to recognize the potency of certain "triggers" for his addictions. He has not acknowledged the thoughts, feelings, and external influences (people, places, and things) that precipitate his desire to get high and act out sexually. A few of these triggers include fighting with his wife, work-related frustrations, and visual reminders of his active addiction. When Jonathan doesn't remain aware of these triggers and actively work to avoid or counteract them, or when he is slammed by multiple triggers at once, his ability to make sound, recovery-based choices decreases. The perception of powerlessness is apparent in the language he uses to describe his slips – "finding himself" in a strip club, "ending up" with a prostitute. That is very different than "choosing" or "making a conscious decision" to do something.

Regrettably, anything (internal or external) that triggers an addict to remember the long-lost pleasure of active addiction is a potential precursor for relapse. **Internal triggers** typically involve emotional (or sometimes physical) discomfort like depression, shame, anxiety, anger, fear, guilt, remorse, boredom, etc. For instance, if/when a married sex addict's spouse is away for a few days, he or she might feel lonely and abandoned. This emotional discomfort might trigger a desire to act out sexually. **External triggers** can be people, places, things, and/or events. For instance, when a sex addict sees an old acting out partner, he or she might be triggered to act out sexually.

Addicts must also deal with **intertwined triggers** (triggers that are both external and internal). For instance, when a sex and stimulant addict argues with his or her spouse or has a bad day at work (an external trigger) he or she is likely to experience emotional discomfort (an internal trigger), with both triggers causing a desire to act out. And this desire may be exacerbated by visual triggers that remind the addict of his or her addiction (such as driving past strip clubs, prostitutes, and drug dealers).

Interestingly, not all triggers are negative in nature. Sometimes material successes and positive emotions will evoke a desire to celebrate and thus a desire to drink, use drugs, act out sexually, gamble, spend, etc. For sex addicts, a few of the more **common internal triggers** are:

- Unresolved resentments and anger
- Loneliness, fear, boredom, anxiety, shame, stress, frustration
- An unmet need for validation and/or affection
- Low self-esteem
- Feeling unappreciated
- Sadness and/or grief

For sex addicts, a few of the more **common external triggers** are:

- Unstructured time alone
- Unexpected losses or tragedies
- Drug and/or alcohol abuse
- Conflict or relationship breakups
- Travel (especially alone)
- Unexpected life changes (job, home situation, transportation, etc.)
- Highly stimulating positive experiences
- Unexpected exposure to sexual stimuli (driving past a prostitute, seeing a sexy billboard, encountering an attractive person, etc.)
- Trouble within the family (like a child struggling at school)
- Financial insecurity
- An emotionally or physically unavailable spouse

Both of the above lists could be extended indefinitely. Unfortunately, triggers cannot easily be avoided. Think about alcoholics driving past billboard ads for beer, scotch, and vodka. Think about drug addicts watching television crime dramas where the "perps" are selling or using drugs. Think about all of the attractive people (i.e., potential sexual partners) that a sex addict sees on a daily basis. Then think about any addict at all dealing with the rollercoaster of life and the emotions it induces. Triggers are everywhere, and there is nothing that addicts can do about that fact beyond learning to recognize them and deal with them in healthy ways such as thought stopping, diversion, self-nurturance and using support systems. One day at a time.

Robert Weiss LCSW, CSAT-S is Senior Vice President of National Clinical Development for Elements Behavioral Health. He is also an internationally acknowledged clinician and author of several highly regarded books. For more information please visit his website at robertweissmsw.com

Hear Robert speak on "sexual evolution, the effect of digital and social media on relationship intimacy and addiction" - at the launch of the new face of Elim Clinic on the 15th March 2016.

# CINP WORKSHOP-2015

*Christopher Paul Szabo*

The 2015 CINP workshop was held at the Vineyard Hotel in Cape Town on the 24th/25th October 2015 with delegates from across the country participating. The workshop was opened by Dr Shaquir Salduker, followed by a few words from Steve Speller (CEO – Servier, South Africa). This was the 6th year of Servier support and the 8th such meeting. It has become increasingly popular, with growth over the years. Servier currently supports two meetings within the discipline – the CINP workshop and the Registrar's exam workshop held under the auspices of the College of Psychiatrists – as part of their commitment to adding value.

*Steve Speller & Robin Emsley*

Beyond Psychiatry Servier has a range of products including for diabetes and cardiovascular disease. Non communicable diseases are increasingly burdensome and Steve Speller noted the changing world of healthcare.

HE SPECIFICALLY CITED INCREASING COSTS, THE NEED FOR MORE EFFICIENT DISEASE MANAGEMENT , THE EXTENT OF GENERIC DRUGS WITH A REDUCTION IN R & D, AND A SHIFT FROM CURATIVE CARE TO PRIMARY CARE.

He further noted that aside from Valdoxane, Servier would shortly be launching Psyquet (quetiapine).

Prof. Robin Emsley followed and explained what CINP (the international college of neuropsychopharmacology) was about – with a strong emphasis on research and a specific focus on teaching. The emphasis has traditionally related to psychopharmacology, but this meeting was different in terms of the content. The need for knowledge related to general medical conditions was emphasized, in relation to psychiatry. ) In this regard he acknowledged the contribution of Judith Herald (Servier – Group Product Manager) in assisting with determining the programme. Speakers were almost exclusively from outside of the discipline of Psychiatry, but with content related to topics of relevance which emphasized the increasingly inter disciplinary nature of our work and thus the need to inform ourselves and engage with fellow professionals outside of the discipline.

*Christopher Paul Szabo*

A brief synopsis of presentations follows, noting that each presentation comprised a significant amount of content , not all of which is included:

**Dr Marshall Heradien (Cardiology)** emphasized the brain – heart connection and covered a range of topics related to some of the latest trends within cardiology i e. obesity/sleep apnoea; hypertension; hyper cholesterolaemia, as well as ischemic heart disease, heart failure, valvular heart disease,

*Marshall Hearadien*

pericardial diseases, Wellens Syndrome & QT interval prolongation. The latter being of specific interest and relevance to psychiatrists given the impact of a range of psychiatric drugs on cardiac functioning **www.crediblemeds.org .**

**Prof Helgard Meyer (Pain)** noted that pain management was an independent sub specialty within the Colleges of Medicine of South Africa. The area had seen significant growth but with such management often sub optimal. Patients are seen too late so earlier identification is required. Chronic pain is a disease in its own right – 20% of individuals worldwide.

*Helgard Meyer*

Acute pain becomes chronic pain and acute treatment is critical. Genetic susceptibility, whereby inadequate acute management sensitizes predisposed individuals to chronicity, was highlighted. Further, training is inadequate at an undergraduate level and veterinary students were more likely to be educated in pain management than medical graduates. The importance of teaching pain to psychiatrists is that emotional pain activates classic pain circuitry with links to MDD, Borderline PD, Addictions and PTSD. Psychosocial factors also contribute. The therapeutic relationship is a critical component of pain management. Context is critical i.e. the unique circumstances of the sufferer.

DISTRACTION MAY BE HELPFUL AS MAY CBT. MAGNIFICATION, RUMINATION AND HELPLESSNESS ARE COMMONLY EXPERIENCED AS WELL AS CATASTROPHIZING AND PERCEIVED INJUSTICE I.E. 'MY PAIN AS A CONSEQUENCE OF SOMEONE ELSE'S NEGLIGENCE' WHICH THE LITIGATION PROCESS EXACERBATES!

Hence one sees that Psychiatry is a necessary discipline in the management. Concerns regarding overuse of opioids was emphasized and the role of agents such as amitriptyline (especially in combination with fluoxetine) was noted. Specific mention was made of Fibromyalgia and the overlap between Fibromyalgia and psychiatric disorders, especially bipolar disorder.

**Prof. Tess van der Merwe (Endocrinology)** covered the topics of obesity and appetite regulation. 46% of 600 million obese live in the developing world with the projected figure for SA being 3.4 million severely obese (BMI > 45), with exponential growth of overweight and obese too.

Genetics and epigenetics are crucial components. The environment is obesity promoting with factors such as sleep, gut microbes, exposure to radiation and age of mothers at first birth associated.

GESTATIONAL ENVIRONMENT/MATERNAL EATING BEHAVIOR CAN INFLUENCE DEVELOPMENT OF OBESITY IN OFFSPRING. OTHER FACTORS INCLUDE SOFT DRINK CONSUMPTION WHICH HAS INCREASED BY 42% IN THE PAST 10 YEARS AND URBANIZATION (WILL BE 64% BY 2025) AS WELL AS PHYSICAL ACTIVITY WITH ALMOST 50% OF ADULTS PHYSICALLY INACTIVE. OBESITY IS COMPLEX AND NOT SIMPLY ABOUT "EATING LESS".

The physiology of Appetite regulation was discussed noting the complex interactions between peripheral and central mechanisms modulating energy requirements and food intake. Regarding a drug to curb obesity, a magic bullet was unlikely notwithstanding advances in knowledge related to endogenous substances controlling/influencing appetite and satiety.

*Zubeida mahomedy & Tessa van der Merwe*

**Dr Zubeida Mahomedy (Psychiatry),** discussed psychiatric considerations for patients seeking bariatric surgery for the treatment of obesity, with Psychiatry as part of a multidisciplinary team. The consequences of obesity include cognitive deficits and depressive episodes. Bariatric surgery is basically gastric bypass, with metabolic consequences. Criteria for such surgery include age between 18-60; BMI > 40, no psychosis, no substance abuse, no borderline PD. Post surgery there are lifestyle changes required e.g. small meals, eat slowly, chew well, stop when full. But why the need for psychiatric evaluation? High rates of psychiatric disorders are reported among candidates for surgery i.e. 38% current, 66% lifetime (axis I) conditions. Mood/Anxiety/Binge Eating are

the most common. Psychopathology impacts on 1 year weight change maintenance. Local data are similar.

HOWEVER, PSYCHIATRISTS ARE NOT GATEKEEPERS. PSYCHIATRIC ILLNESS IS NOT AN EXCLUSION CRITERION – BUT IT MIGHT DELAY SURGERY. BASED ON INABILITY TO PROVIDE INFORMED CONSENT, ONE MIGHT DENY PSYCHOTIC PATIENTS OR SUBSTANCE ABUSERS. ESSENTIALLY THERE IS A PROCESS LEADING TOWARDS THE EVENT. THE SURGERY IS THE NEXT STEP, NOT THE FINAL STEP.

Motivation/expectations need to be established. Family education is an important component. Screening for cognitive deficits and substance use will determine related interventions to facilitate appropriateness. Following bariatric surgery one generally sees improvements in mood, binge eating, Quality of Life and cognitive ability.

However, improvements may not be maintained and weight regained with increased suicide rates have been reported (may be overstated). The surgery does seem to alter alcohol tolerance as opposed to contributing to the emergence of alcohol misuse. Medication adjustments are required – lithium is a specific problem and contra indicated; immediate release rather than sustained release medications should be considered.

**Dr Brent Tipping (Geriatrician)** provided a comprehensive overview of screening, prevention and management of older adult patients. A specific message was that one should not medicate normal. Common presentations include sleep problems and cognitive impairment.

Whilst changes to sleep are normal one should exclude conditions that could impact e.g. pain/ urinary problems/lack of activity noting that the use of benzodiazepines has been linked to Alzheimer's disease/cognitive decline with use of anti- cholinergic drugs increasing risk too e.g. antihistamines/antispasmodics and a range of agents for medical conditions.

Beyond the decision to treat, how should one treat? With regard to hypertension, there is an increased risk of hip fracture when commenced on anti-hypertensives i.e. unintended consequences with potentially unnecessary or overly aggressive intervention. But, hypertension control is "brain protective", hence a need for careful consideration of risks/benefits as a general principle.

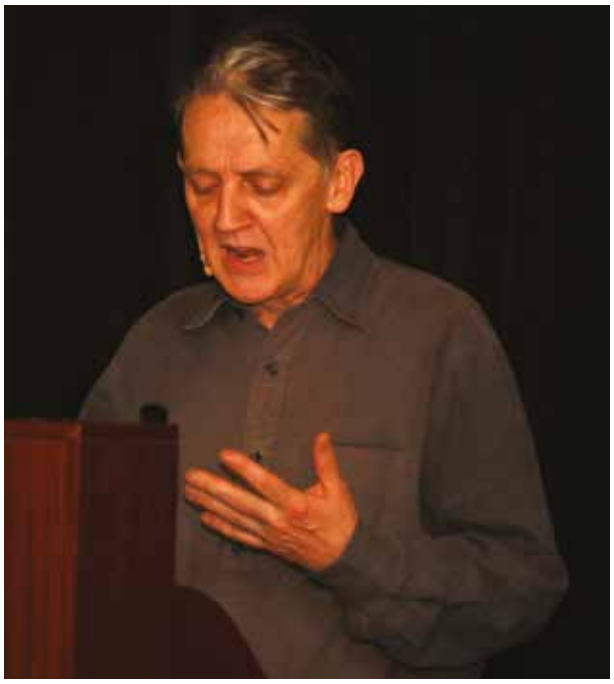
AGE RELATED DECLINE VERSUS DISEASE IDENTIFICATION IS AN IMPORTANT DISTINCTION WHICH IMPACTS ON MANAGEMENT. A CLEAR DISTINCTION IS IMPORTANT SO AS NOT TO OVER TREAT BUT NOT TO UNDERTREAT. AS APPROPRIATE DISEASE MANAGEMENT CAN IMPROVE QUALITY OF LIFE. THE ETHICS OF END OF LIFE WAS DISCUSSED SPECIFICALLY THE RIGHT TO REFUSE TREATMENT / LIFE MAINTAINING INTERVENTIONS IN THE FACE OF NO PROSPECT OF LIFE OR ONE WORTH LIVING.

The living will (an advance directive) was explained as a requirement to terminate life under such circumstances with no need for a lawyer. It should be readily available. The principle of autonomy underlies the process of such a will with the person needing to be ready to complete a living will.

The consequence is that an Incapacitated, terminally ill, person unable to make decisions removes the decision making burden from the care giver and can state what they want, not only what they don't want. The person can nominate a trusted person to make decisions. This allows for planning and is generally experienced positively in terms of outcome. Medical indication, patient preferences, quality of life and contextual features should each be considered in reviewing a decision to intervene.

THE HPCSA DEFINES THE CONCEPT OF "FUTILE CARE" WHEREBY A PRACTITIONER CAN WITHHOLD CARE IF DEEMED FUTILE. REGARDING "DEATH WITH DIGNITY" – CAN A PATIENT REQUEST TERMINATION BASED ON PAIN/UNLIKELY RECOVERY? THE LAW DEFINES THIS AS MURDER, ALBEIT THAT RECENT CASE LAW UPHELD SUCH A REQUEST BY A PATIENT. THERE IS A POTENTIAL SLIPPERY SLOPE ASSOCIATED WITH EUTHANASIA WHEREBY JUSTIFICATION FOR KILLING BASED ON PREJUDICE MIGHT EXIST. PALLIATIVE CARE RATHER THAN TERMINATION OF LIFE WOULD BE THE APPROACH BASED ON SUCH A REQUEST.

**Prof. Jonathan Carr (Neurology)** presented on the topic of functional disorders of the brain i.e. medically unexplained symptoms. This is a very common, with up to 30% of patients seen at a neurology out-patient department at a site in Scotland manifesting such a presentation. This figure can go up to 50%. Such presentations are not only unexplained but tend to persist and are disabling.



*Jonathan Carr*

THE DIAGNOSTIC ENTITY OF "SOMATIC SYMPTOM DISORDER" EXISTS IN DSM 5 TOGETHER WITH A RANGE OF SOMATIC ENTITIES. THE DIFFERENTIAL DIAGNOSIS WOULD INCLUDE MALINGERING WHICH MIGHT BE SUSPECTED BY DISCREPANT ACCOUNTS / PRESENTATIONS OR DIAGNOSED THROUGH CONFESSION OR CLEAR EVIDENCE E.G. VIDEO.

Malingering should also be distinguished from conversion disorder but the distinction can be tricky.

LABELLING THINGS AS PSYCHIATRIC WHEN THEY ARE NOT IS A PROBLEM E.G. TYPES OF DYSTONIAS, WITH A 4% MISDIAGNOSIS RATE. NOT WITH STANDING ISSUES NOTED, FUNCTIONAL DISORDERS CAN BE CONFIDENTLY MADE AND ARE NOT A DIAGNOSIS OF EXCLUSION I.E. THERE CAN BE A POSITIVE DIAGNOSIS BASED ON PRESENTATION.

Aside from the presentations related to physical aspects of patient care and their relevance to Psychiatry, the presentation by Tessa Dowling (SCHOOL OF LANGUAGES AND LITERATURES UNIVERSITY OF CAPE TOWN) entitled "Transplanting Tongues: language, understanding and health practices in South Africa" provided critical content related to a fundamental component of the discipline – communication.

Overall, the presentations were highly informative, well presented and certainly provided for an intense exposure to inter disciplinary areas that are relevant to Psychiatry.

*Tessa Dowling*

*Christopher Paul Szabo* is a psychiatrist and the current Head of the Department of Psychiatry at the University of the Witwatersrand and Head of Clinical Department, Department of Psychiatry, Charlotte Maxeke Johannesburg Hospital, Johannesburg. **Correspondence: Christopher.Szabo@wits.ac.za**

# THE LUNATIC FRINGE

The 2016 harvest got off to a hot start in January; in more ways than one, sadly.

*David Swingler*

The earliest crop for some years started in a heatwave, which intensified when runaway fires ravaged first the Elgin Valley and then the prime Simonsberg slopes of Stellenbosch. Thelema Mountain Vineyards atop the Helshoogte lost nearly 15 hectare of vines laden with ripe grapes awaiting picking. Apart from approximately 13 000 12-bottle cases of wine lost, it costs around R200 000 to replant a hectare, and then you have to wait several years before the vines mature and their grapes can be made into potable wine. Losses the big producers may be able to absorb, but that can easily wipe out the small guys.

Which is ironic, as 'small' is the 'new black' in Cape wine. A fresh wave of young winemakers has emerged recently, often rediscovering old-fashioned 'forgotten' varieties and seemingly antiquated winemaking processes. Minimalist intervention is core: natural acidities and wild yeasts with nothing added – no commercial yeasts, enzymes or acids; there's little active oak involved and the wines are bottled unfiltered and unfined.


They first emerged as 'Young Guns' (http://www.winecellar.co.za/youngguns): 'Winemakers who are pushing the boundaries, breaking the rules and creating cutting-edge wines with personality and energy…' As the ranks of oenologists making a few hundred cases under their own name swelled, an endearing band formed a loose collective dubbed 'The Zoo Biscuits'. Since famously called 'The lunatic fringe' by Michael Fridjohn in Business Day, this Group of Ten had no real admission criteria other than embracing the back-to-basics natural approach: 'It helps to be a lekker guy or girl, with lekker wines,' quipped sort-of-founder Peter-Allan Finlayson. 'It's an added bonus if you own the brand, and can choose the outfits you wear to public tastings without fear of what the boss might say.' Irreverence is taken as read…

Finlayson's Crystallum has already graduated to sought-after mainstream status, as have Chris & Suzanne Alheit (Cartology) and Duncan Savage (Savage) – whose day job is at Cape Point Vineyards. 'Stompie' Meyer (JH Meyer) also has formal employ at Antebellum in the Swartland, but his own brand is dedicated to a different set: the Burgundian varieties Chardonnay and Pinot Noir.


*David Swingler*

Mick & Jeanine Craven (Craven) took moonlighting a step further; both are winemakers, he at Mulderbosch and she – until very recently leaving to look after the Craven business – at Dornier. But what they do under their own name is something completely different, as the 2014 Clairette Blanche shows. It's from a seriously unsexy wallflower variety, fermented on its skins a la red wine in the 'orange wine' genre, has a refreshingly low 11% alcohol, and may even be cloudy as it's unfined. But it turns heads! As it did John Platter's; he show-cased it in his latest (deliciously enjoyable) book My Kind of Wine. It's so very Zoo…

Then there's a cluster – or should I say a packet? – of Biscuits who started building their own label while in a corporate cellar before (bravely) going it alone. Trizanne Barnard (Trizanne Signature Wines) did the salaried thing at Klein Constantia and its sister-brand Anwilka before decamping to the hippy side of the Peninsula, living in Kommetjie and producing TSW in nearby Noordhoek. Thinus Kruger (FRAM) – whose slightly bewildered country-bumpkin persona is, I suspect, somewhat cultured – saw much of the inside of Fleur du Cap and Boschendal cellars before embarking on his personal voyage of exploration – Fram being the 19th-century wooden Norwegian ship used for polar expeditions.

'Been there done that,' says Francois Haasbroek (Blackwater) of the company culture. While he had everything he could wish for as Waterford winemaker, he yearned for creative control of the

The Zoo Biscuits ready their stand at Cape Wine 2015

Trizanne Barnard with her TSW range

Thorne, and daughter

Suzanne & Chris Alheit and customer

Duncan Savage in full flight

Stompie Meyer and Francois Haasbroek having a beer break

Peter-Allan Finlayson engaging with a client

Marelise Niemann and fan

Alheits' best

Thinus Kruger

Mick Craven

whole spectrum of the product: from growing the grapes to applying the label. His 'Underdog Chenin Blanc' is a metaphor for both the grape that grows in the shadow of sauvignon blanc, and the solo independent winemaker… The last cracker in this pack is Marelise Niemann, who was Mej Janse van Rensburg making wine with Sebastian Beaumont on the latter's family farm in Bot Rivier when I first met her. Her own Momento Grenache wowed me with its remarkable finesse. She's since followed it up with Tinta Barocca and a sumptuous Chenin Blanc-Verdelho blend, and has gone solo

.

Thorne and Daughters is not quite out of the Zoo mould, but its philosophy, quality and sheer likeability put it in the vanguard. John Seccombe (family second name 'Thorne') trained in oenology in the UK and has made wine in England, France, California and Australia. He returned to South Africa to set up T&D and his 'Rocking Horse Cape White' and 'Tin Soldier Semillon' have set new standards: in the words of wine critic Christian Eedes, '(these) should bring tears to the eyes of most wine geeks'. In spite of such applause, wife Tasha (a professional photographer responsible for the images on these pages) is still on the wedding photographer circuit to balance the books. 'Pricing is consumer friendly,' said Fridjohn of the Biscuits in general, '(so) you have to assume they have alternative sources of income … to get through the year without collapsing under debt.'

As you would have gathered, the Seccombes have young daughters…

*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**

# WOMAN IN GOLD

*A film review by Franco P.Visser*

**A Weinstein Company & BBC Films Presentation**
**An Origin Picture Production**
**David M. Thompson & Kris Thyker Producers**

In my years as film reviewer I was struck by how many films were linked in some manner with the Second World War – films like the action-adventure *Indian Jones and the Raiders of the Lost Ark* (with Harrison Ford, 1981), *Schindler's List* (with Liam Neeson & Ralph Fiennes, 1993) *Life is Beautiful* (with Roberto Benigni, 1997), *Saving Private Ryan* (with Tom Hanks, 1998), *The Pianist* (with Andrien Brody, 2002), *The Boy in the Striped Pajamas* (with Asa Butterfield, 2008) and *The Imitation Game* (with Benedict Cumberbatch, 2014) to name but a few. This made me wonder if we would ever be able to rid ourselves of the horrors and atrocities, the memories and scars of not only the Second World War, but also the First World War and all the historical and subsequent violent clashes and killings occurring to the present day.

Referring to World War II one immediately thinks about Nazism and the incredibly disastrous effects that it had for the world, ands especially the Jewish population that bore the brunt of the Nazi's hatred and murderous proclivities. Not only were the Jewish citizens of the countries that Adolf Hitler invaded systematically removed from society and exterminated, their livelihoods crushed, being forced to face humiliation, starvation and the prospect of death on a daily basis. They were also robbed of their valuables and possessions at the whim of vulgar and perverted Nazi officers and high-ranking officials. For the Nazis it was especially precious metals, precious stones, furniture, money and artwork that were important commodities. And this is where we get to the film *Woman in Gold*.


Maria Altmann (played by Helen Mirren), an eighty-something year-old Jewish-American lady with Austrian roots, attends her sister's funeral following which she discovers letters and papers dated towards the end on the 1940's relating to the reclamation of art stolen from her family by the Nazis shortly before the outbreak of World War II. The film proceeds with Maria having flashbacks of her family life in Austria when she was younger and newly-wed.

Maria's family were wealthy Jewish citizens of Austria who resided in Vienna at the time of the German annexation in 1938, and the Altmanns and the Bloch-Bauers, shared a very close family relationship. Maria was particularly close to her Aunt, Adele Bloch-Bauer, the subject of a well-known painting by the Austrian painter Gustav Klimt. Forced to flee the country from the Nazis and forced to leave her mother and sickly father behind in Vienna, Maria eventually settles in America.


*Franco P.Visser*

Returning to present day events in the film. Following Maria's discovery of her sister's letters and papers - in which she sees her sister's struggle and an unsuccessful attempt to reclaim artwork owned by the family - she hires a young and inexperienced lawyer, Randy Schoenberg (played by Ryan Reynolds) to assist her to institute a claim to the Austrian arts restitution board.

Their specific interest is the painting of Maria's Aunt Adele by Klimt, now known as the 'Woman in Gold' in the Republic of Austria. A reluctant Maria along with her lawyer Randy travels to Austria for the claim proceedings only to be turned down as the country's Minister and Art Director believes the painting to be an important part of Austrian culture and identity. The Austrian officials also inform Maria and Randy that her Aunt Adele had in fact bequeathed the painting to the Austrian National Gallery. With the help of a local journalist Hubertus Czernin (played by Daniel Brühl) they discover that this was not the case. Maria's Aunt Adele did not own her own painting, and Gustav Klimt's fee was paid by Maria's uncle – he was thus the owner of the painting.

This is where I leave you to discover the rest of the story, as I do not want to divulge all of the interesting twists and turns of Maria's journey. I am also doing so as a means of encouraging you to get hold of the film and view it. The film *Woman in Gold* comes highly recommended and I list it as one of my all-time favourites. It is a superbly made piece of cinematography and of exceptional quality with a riveting plot. I so do enjoy a good story and justice is priceless.

*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**

# WPA ZONE 14

NOVEMBER/2015

**MONTHLY BULLETIN**

To all Psychiatrists in WPA, Zone 14,

Dear Colleagues,

Greetings and warm regards,
I hope this finds you well. It is my great honour and pleasure to send out this first edition of the monthly bulletin. The decision to create this bulletin came as a result of the need for a means of communication with members across the zone and a forum where members can share news and information from across the zone and the WPA Secretariat. In addition to this email version, we have created a space on the Africa Mental Health Foundation website where we will upload all issues of this bulletin for reference. It is my hope that this will be a vibrant avenue to share our experiences for growth in our independent practice and for Psychiatry as a profession. It is also my wish that this serves to strengthen the zone and the Association.

## REGISTRATION OF ASSOCIATIONS

In a recent WPA Board Meeting held in Taipei, Taiwan it was strongly recommended that every country in every zone across the World have an association of psychiatrists. The countries in Zone 14 include all countries in Eastern and Southern Africa. Ethiopia applied to join this zone and the final decision from the WPA Executive Committee will soon be communicated. I am making special arrangements to reach out to Angola, Mozambique and other Portuguese speaking countries to have an association registered with WPA as well as all the French speaking countries in the Zone. Mauritius is already on board.

For those with existing WPA registered associations, well done. I still encourage all of you who have not yet done so to register. Every country, even with one psychiatrist, should have a say in the affairs of WPA. If you have any problem whatsoever with the registration process, including remission of payments to the WPA secretariat for purposes of registration, please feel free to let me know and we will see together how best to assist. Note that registration requires annual renewal to remain active. Whenever possible I also encourage you to invite a WPA official to your annual country and regional meetings

PROF. DAVID M. NDETEI
WPA ZONE 14 REPRESENTATIVE

## ACTIVITIES AND NEWS FROM THE ZONE

We are interested in what you are doing. Of special interest to us are the regular CME meetings, your annual country and regional meetings and any other activities such as engaging with policy makers and development of services. I encourage all of you to share your annual schedule for planned meetings with my office and any other relevant news and information for dissemination through this forum to members of the zone and the WPA Secretariat.

## WPA INTERNATIONAL CONGRESS 2016

The WPA International Congress 2016 will take place in Cape Town, South Africa on 18th – 22nd November 2016. I encourage all of us to make arrangements to attend and give our colleagues in South Africa who are organizing this conference all the support they need for maximum success. Pass on the message to your colleagues and encourage young and upcoming mental health workers and researchers to attend and participate.

http://www.wpacapetown2016.org.za/

**I wish you a wonderful Christmas season and a most productive and rewarding 2016!**

WPA Zone 14 Representative - Africa Mental Health Foundation | Matumbato Road, Upperhill, Nairobi, Kenya |
P.O. Box: 48423 - 00100| phone: +254 202651360

WORLD PSYCHIATRIC ASSOCIATION
الجمعية العالمية للطب النفسي
世界精神病学协会
ASSOCIATION MONDIALE DE PSYCHIATRIE
WELTVERBAND FÜR PSYCHIATRIE
ASSOCIAÇÃO MUNDIAL DE PSIQUIATRIA
ВСЕМИРНАЯ ПСИХИАТРИЧЕСКАЯ АССОЦИАЦИЯ
ASOCIACIÓN MUNDIAL DE PSIQUIATRÍA

# WPA NEWS

*Official Quarterly News Bulletin of WPA*

DECEMBER 2015

WWW.WPANET.ORG

## *Message from the Secretary General*

*Roy Abraham Kallivayalil*

*Dear Colleagues and Friends,*

*Hearty greetings to you! Since publication of our last issue, we had WPA Regional Congress, Kochi, India: September 25-27, 2015. It was a grand event attended by more than 1,200 delegates. The 'WPA Kochi Statement' was also adopted at the Congress. Hearty congratulations to Kuruvilla Thomas and his team. This was followed by the WPA International Congress, Taipei November 18-22, 2015 which was a grand success. 2,149 participants from more than 55 countries attended this congress. The excellent scientific program consisted of Lectures, Symposia, workshops and poster presentations. Hearty Congratulations to Frank Chou and his team.*

*Our newly designed website www.wpanet.org has gone live on October 25, 2015. Some of the highlights and state-of-the-art features of our new newly designed website are: Functional Features like WPA GroupThink! (an Interactive WPA Discussion Forum with restricted access to all member countries), Meetings Calendar with Opt-in Reminder facility, Responsive design (device compatible), Digital Gallery, Upgraded CMS, Hyperlinks and Archiving besides many other technology features. Kindly do visit the website and send us your valuable comments.*

*We are looking forward to WPA Regional Congress at Manila February 4-6, 2016. Kindly do attend. We thank WPA President Dinesh Bhugra and the EC for their support and guidance. We are sorry, this will be the last edition in print of the WPA News, due to financial constraints. But the WPA News will continue in the electronic format for providing information and up-to-date news.*

*Thanking you,*

***Roy Abraham Kallivayalil***
***Secretary General***
***World Psychiatric Association***

## *Message from the President*

**Dinesh Bhugra**

Dear Friends,

You may recall that WPA has set up a **WPA-Lancet Commission on Psychiatry** to ascertain the future of our profession in early part of the 21st century. Separately I have sent you the link for the survey. Please respond and also encourage your members, colleagues and other stakeholders to respond too. We would like a global and wide response. The qualitative aspects were completed at the WPA International Congress in Bucharest and the quantitative survey has already been piloted. The revised deadline is for publication of the results and recommendations is summer 2016.

Needs of psychiatrists and their roles do vary across various countries due to resources and public expectations and therefore we need as full a picture as possible. Hopefully, this project will enable us to identify skills and competencies required of a psychiatrist in modern clinical practice. Following this we will be in a better position to develop suitable and appropriate curricula and training for future psychiatrists.

We celebrated **World Mind Matters Day on 4th September** with the launch of WPA Position Statement on Social Justice for those with Mental illness and also statement on migrants and asylum seekers. We hope that this will become an annual event. We aim to draw attention of policy makers to focus on outcomes based parity between physical and mental illness and funding for research and service development.

Various **task forces** are working hard to help develop curricula and policy statements which will be launched during the course of next year. A series of **round table discussions** will be starting early next year on a range of topics.

This is the last print edition of the newsletter. This painful decision was taken in order to save money. From next year the newsletter will continue to be available on the website on a regular basis. Season's Greetings to you, your members and families.

Yours faithfully,

**Dinesh Bhugra**
**President, World Psychiatric Association**

**L'Escalade,** ***or Fête de l'Escalade*** is an annual festival held in December in Geneva, Switzerland, celebrating the defeat of the surprise attack by troops sent by Charles Emmanuel I, Duke of Savoy during the night of 11–12 December 1602. The celebrations are usually held on 12 December or the closest weekend. The festivities start with a 5 mile race through the Old Town and culminate the following weekend with a torchlight procession of over 1000 marchers.

# Congress 2nd Announcement

PSYCHIATRY: INTEGRATIVE CARE FOR THE COMMUNITY

**World Psychiatric Association INTERNATIONAL CONGRESS**

**Cape Town**

**2016**

**18-22 Nov**

On behalf of the South African Society of Psychiatrists, it is our greatest honour to invite you to the **World Psychiatry Association International Congress** that is to be held in **Cape Town, South Africa, from 18 to 22 November 2016.**

**Dinesh Bhugra CBE, WPA President**

The congress theme is
***"Psychiatry: integrative care for the community"***
we invite you to submit your abstracts

**Call for Abstracts**

**www.wpacapetown2016.org.za**

**Mvuyiso Talatala, SASOP President**

## Confirmed Speakers


1. Helen Herrman (Australia). 2. Maria Oquendo (USA). 3. Vikram Patel (India and UK). 4. Francis Nyamnjoh (South Africa). 5. John Peteet (USA). 6. Olayinka Omigbodun (Nigeria). 7. Linda Lam (Hong Kong). 8. Graham Thornicroft (UK). 9. Dan Stein (South Africa). 10. Michael Robertson (Australia). 11. Jair Mari (Brazil). 12. Robin Emsley (South Africa). 13. Peter Tyrer (UK). 14. Ahmed Okasha (Egypt). 15. Andreas Meyer-Lindenberg (Germany). 16. Icro Maremmani (Italy)

SCATTERLINGS
CONFERENCE & EVENTS

Carina Du Plessis – **Registration Coordinator:** +27(0)11 463 5085 • carina@soafrica.com;
Carolyn Melnick – **Exhibition and Sponsorship Manager:** +27(0)21 422 2402 • caro@saoafrica.com
Lauren Gleeson – **Abstracts/Speaker Management:** +27(0)21 422 2402 • lauren@soafrica.com
Charlene Jansen – **Project Manager:** +27(0)11 463 5085 • charlene@soafrica.com

**www.wpacapetown2016.org.za**

WORLD PSYCHIATRIC ASSOCIATION
الجمعية العالمية للطب النفسي
世界精神病学协会
ASSOCIATION MONDIALE DE PSYCHIATRIE

WELTVERBAND FÜR PSYCHIATRIE
ASSOCIAÇÃO MUNDIAL DE PSIQUIATRIA
ВСЕМИРНАЯ ПСИХИАТРИЧЕСКАЯ АССОЦИАЦИЯ
ASOCIACIÓN MUNDIAL DE PSIQUIATRÍA

**WPA President**

**Prof. Dinesh Bhugra**
Professor of Mental Health and Cultural Diversity
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E-mail: dinesh.bhugra@kcl.ac.uk



16 December 2015

Dear Colleagues,

It gives me great pleasure to let you know of the work that has been done on your behalf by the WPA. This is the right time for reflection but also for looking forward.

You may recall that on 4th September 2015, WPA launched its First World Mind Matters Day with the launch of Position Statement on Social Justice for those with mental illness in which we call upon countries and the United Nations to urgently deal with discrimination. We also launched the WPA document on the mental health of migrants, refugees and asylum seekers which was produced by Dr. Meryam Schouler-Ocak, Dr. Marianne Kastrup, and their colleagues.

We are working on several major areas:

WPA-Lancet Commission on Psychiatry survey is live. I had separately sent you the details. Please let your membership know and spread the word as we need as wide a consultation as possible.

A further series of documents on mental health needs of migrants, refugees and asylum seekers and their children and families.

A global survey of social discrimination against those with mental illness which will cover areas of economic, social, political and civil rights is under way and I will come back to you for your help.

A major document on Mental Health for Nations is being developed and should be ready in the first quarter of next year.

We propose to carry on with campaigning, lobbying and advocating for our patients. I will keep you informed of next steps.

Following our discussions with various universities for the introduction of Diploma in Mental Health we have very nearly reached agreement on the curriculum. I am hopeful that we should be able to launch this programme in 2016.

Meanwhile please do let me have your suggestions and thoughts about disseminating these documents and policies.

You may recall that WPA has set up a series of round table meetings on specific topics in close co-operation with national associations. I will keep you informed.

Season's Greetings to you, your families, and members.

Yours faithfully,

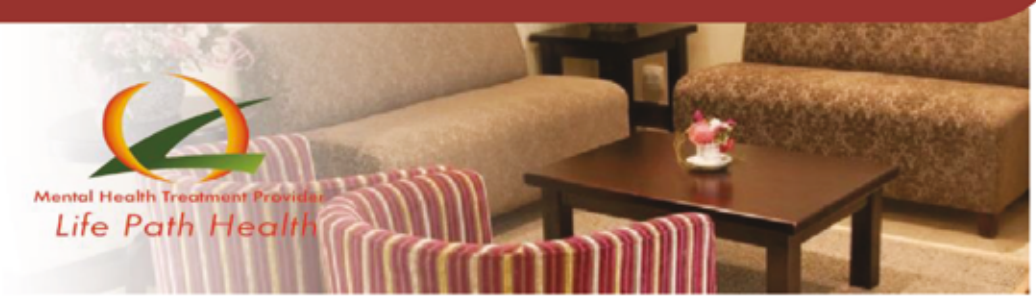
Dinesh Bhugra

Dinesh Bhugra, CBE
President, World Psychiatric Association

New exciting opportunity for a:

# PSYCHIATRIC PRIVATE PRACTICE

## PAARL, WESTERN CAPE




**If you as a PSYCHIATRIST are contemplating relocating, you might want to consider a PRIVATE PRACTICE in the lovely town of Paarl in the Western Cape.**

Sereno Clinic

Part of

**Life Path Health Group**

**This opportunity includes:**

- A **supportive network** of colleagues (psychiatrists as well as other mental health professionals in private practice).
- Admissions & treatment available for patients in **Sereno Clinic,** the local **Private Psychiatric Hospital**.
- Comorbidities could be treated at **Paarl MediClinic,** the local General Private Hospital.
- **The town and its surroundings** have magnificent Cape Dutch buildings (17-19th Century), scenic drives, hiking and cycling trails, excellent restaurants and the Paarl, Stellenbosch and Franschoek wine route, with its many wine tasting opportunities.
- The town boasts some of **the best academic high schools** in the country including Paarl Gimnasium High School (est. 1858), La Rochelle Girls' High School (est.1860), Paarl Boys' High School (est.1868), Paarl Girls' High, New Orleans Secondary School and Paulus Joubert High School (est. 1965).
- Less than **one hour from Cape Town**.

For more information contact:

karen@lifepathgroup.co.za
Cell 082 773 1379
www.lifepathgroup.co.za


Sereno Clinic


Sereno Clinic


Paarl Mall


Paarl Winelands


Paarl MediClinic

# WORLD ASOCIATION OF CULTURAL PSYCHIATRY

## POSITION STATEMENT ON THE MIGRANT CRISIS AROUND THE WORLD

*Puerto Vallarta, Jalisco, Mexico.*
October 29th., 2015 – November 2nd., 2015.

WORLD ASOCIATION OF CULTURAL PSYCHIATRY

GRUPO LATINO AMERICANO DE ESTUDIOS TRANSCULTURALES

WORLD ASOCIATION OF CULTURAL PSYCHIATRY

O.P.D. HOSPITAL CIVIL DE GUADALAJARA

CENTRO UNIVERSITARIO DE LA COSTA, UDG

CENTRO UNIVERSITARIO DE CIENCIAS DE LA SALUD, UDG

CENTRO UNIVERSITARIO DE LOS LAGOS, UDG

## PREAMBLE

The World Association of Cultural Psychiatry (WACP) was founded to encourage international collaboration, friendship, scholarship, research and compassionate mental health care around the world. Sharing and exchanging best practices, and improving the safety and quality of mental health care as a priority, emphasizing an objective focus on the diversity of cultures, legal systems, commissioning processes and wider political and social issues such as stigma, discrimination and prejudice against the mentally ill and their families, our organization has contributed to improvements in these areas, even though problems persist and our work will continue. Human resources and consistent support and funding from public and private agencies are required in order to make sure that the quality of care provided everywhere responds to expectations compatible with a profound respect for the dignity of all human groups and communities affected by mental illness or emotional ailments.

During the past several decades, there has been a steadily increasing recognition of the importance of cultural influences on life, general health care and mental health, in particular. Culture impacts practically all aspects of mental illness and, thus, culturally relevant care is needed for patients of diverse ethnic, racial, social and cultural backgrounds. From a social perspective, the world has witnessed rapid and significant changes magnified by political crises and information disseminated through a world media nourished by sophisticated technological advances.

One of the realities resulting from these facts is that countries, regions and societies all over the world are becoming multi-ethnic and poly-cultural in nature. An undisputed evidence of this process is the massive presence of migration phenomena both within and between nations worldwide.

THE MANY IMPLICATIONS (AND CONSEQUENCES) OF MIGRATIONS IN STATISTICAL, HUMAN AND CLINICAL TERMS URGENTLY REQUIRE IN-DEPTH EXAMINATION OF THEIR PRECIPITATING FACTORS, AND MULTIPLE ACTIONS ORIENTED TO IMPROVING THE CULTURAL COMPETENCE OF HEALTH AND MENTAL HEALTH PROFESSIONALS. A RESULTING COMPREHENSIVE MEDICAL AND PSYCHIATRIC CARE WOULD RESPECT IDENTITIES AND BELIEFS, AND WHOLLY CONSIDER THE ETHNIC, RACIAL AND CULTURAL BACKGROUND OF EACH AND EVERY IMMIGRANT PATIENT.

The theme of the 4th WACP Congress is appropriately titled Global Challenges & Cultural Psychiatry: Natural Disasters, Conflict, Insecurity, Migration and Spirituality.

*The full statement is available electronically at: http://4wacpcongress.org/wp-content/uploads/2013/10/WACP-Declaration-2015-F-Final.pdf*

# MESSAGE FROM THE PRESIDENT

ECNP neuroscience applied

## December 2015

The basis of clinical practice is evidence that drugs are effective and safe. That is a binary justification for the choice to prescribe or not to prescribe. How do we reach such a black and white position from the evidence we actually have? In other words how do we weigh the evidence and tip the scales one way or the other to reach a decision? Are such decisions simply rational or are they, as neuroscience suggests, intrinsically emotional and maybe subjective?

A desire for evidence based practice has been the big idea in medicine for my working life time. Indeed the idea has proved contagious; politicians now solemnly advocate evidence based policing, for example. The spiritual home of evidence based practice is the Cochrane collaboration. It came into existence in 1993. It is named after a relatively obscure British epidemiologist called Archie Cochrane. Its brand fast acquired an iconic status. This surprised me personally because data synthesis (meta-analysis) was the preferred methodology and it was in no way new. But Cochranites multiplied fast, developed a rule book of do's and don'ts and a slightly them and us mentality. The conclusions of a Cochrane review soon carried surprising status. In the case of Cochrane's psychiatry wing, this was always somewhat at odds, for me, with its scruffy offices in Oxford. The scruffiness was largely imposed by uncertain funding but it also fitted the ethos of the 1990s. Cochranites had radical ideals to de-construct the medical hierarchy (eminence based medicine?) and replace it with a more democratic evidence base.

The Cochrane collaboration still supports good work, and no one can dispute the premise that evidence should underpin medical practice. But, the problem with evidence based medicine is that sometimes, actually pretty often, there isn't much really good evidence. Practice cannot stop until there is. Worse, you can include in your Cochrane review stuff that really should not be included. If you insist on including dose finding trials when the doses were too low you can undermine evidence for efficacy, and if you include doses that were too high you magnify the burden of adverse effects. Finally if you insist on unrealizable trial standards for certainty, you end up doubting all the evidence you have. So Cochrane reviews can become orgies of uncertainty - deflated effects, inflated side effects, all evidence debunked as being of a low standard. You may need to be quite expert to know what is worth considering and what isn't and expertise was something Cochrane set out to debunk as opposed to 'the evidence'.

*Guy Goodwin*

In my opinion, there have been times when Cochrane zealots have tarnished the idealistic image of 'the collaboration'. I am tempted to say that it has become a bit like a failing political party - leaderless, easy to join and harbouring bewilderingly strong irrational opinions. The strongest opinions have inevitably been against the comic villain of schoolboy socialism, the drug companies. This has led to a number of 'controversial' reviews of the literature on antidepressants, Tamiflu, treatment for ADHD. Along with an intellectually challenged ally, the British Medical Journal, these 'Cochrane reviews' have helped to stoke uncertainty and controversy, at least where I live.

But let's get back to decision making. Criticism of the Cochrane approach is ultimately respectful. What should be particularly applauded is its latest GRADE system *(http://tech.cochrane.org/gradepro<http://www.ecnp.eu/sitecore/RedirectUrlPage.aspx?ec_camp=3CB6F7D586EF42F89D83B2486020AF12&ec_as=D42D920EAD924614955DA3A86395D8D8&ec_url=http%3a%2f%2ftech.cochrane.org%2fgradepro>)*. Cochrane rules on the evidence hierarchy traditionally revered the RCT and the summary of RCTs that could form a meta-analysis. Observational studies were treated as lower down the food chain. This approach has now been modified by the introduction of a way for us to describe how we rank evidence. In the words of my wise colleague Andrea Cipriani: ''the positive value of GRADE is that it allows people to do recommendations in a structured and transparent subjectivity". I love that because it actually models how we really make decisions.

May I end by wishing my friends around the world a very happy Christmas and a prosperous New Year. Long may subjectivity be transparent.

Guy Goodwin
ECNP President

headline
DECEMBER 2015
OFFICIAL NEWSLETTER OF THE SOCIETY OF PSYCHIATRISTS OF SOUTH AFRICA (SASOP)

# SASOP: THE ALTERNATIVE SOLUTION

## FROM THE EDITOR


*Ian Westmore*

May I wish all our readers, and SASOP members in particular, a belated Happy New Year. 2016 promises to be a "big year" for South African Psychiatry, culminating in the WPA International Congress in Cape Town in November. You can therefore expect to see substantial coverage of the build up to this meeting in the issues to come.

Organizing a congress of this magnitude is unprecedented in South Africa, and requires much preparation, hard work and sacrifice. At the same time, we all will continue with what we are called to do – seeing patients across the public and private sectors, doing research and preparing the psychiatrists of tomorrow for the task at hand. In this issue we report specifically on the third successful Registrar Finishing School held by SASOP and Lundbeck in November 2015.

The SASOP Board has met twice since the first issue of Headline appeared in November 2015, and as 2016 gets under way, subgroups, special interest groups (SIG's) and divisions will no doubt get busier. There are also CPD linked activities planned for 2016 – these provide an opportunity not only to learn, but also to network. I trust that this issue will fill the gap as far as networking is concerned in the meantime.

***Ian Westmore***

## FROM THE PRESIDENT,

I would like to wish all members of the South African Society of Psychiatrists (SASOP) a prosperous 2016.

The year has already begun with lots of activities for SASOP. In this year, the focus will remain on the key goals of our term of office, which are, unity within SASOP, African Psychiatry and the 2016 World Psychiatry Association (WPA) International Congress. In addition to these key goals there are on-going activities and engagements with stakeholders. The Minister of Health released the White Paper on National Health Insurance (NHI) on the 10th of December 2015. SASOP is busy studying this document and we will, in time, make comments pertinent to psychiatry. SASOP will also contribute to the comments that the South African Private Practice Forum (SAPPF) is busy drafting.

The issue of admission of children to psychiatric hospitals in South Africa remains unresolved. In the public sector there remains a lack of availability of beds for admission of children for involuntary care. This results in difficult situations where ill children requiring involuntary care end up being admitted in wards with adults. In the private sector, in some provinces, and especially in Gauteng, psychiatric facilities are required to have a special licence in order to admit children under the age of 16 years. Under this special licensing, children are admitted as assisted mental health care users, even if their mental status allows for voluntary admission. We have engaged with the Gauteng Mental Health Directorate and the National Mental Health Directorate on this issue for the past 2 years with no success.

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**

The National Mental Health Care Policy Framework and Strategic Plan (2013-2020) of the Department of Health that was produced through a process of consultations and a Summit in 2012 is the document that should be implemented and which SASOP supports. This document guides the process of deinstitutionalisation and the establishment of community mental health services.

Each province is expected to have a Mental Health Directorate. The government has been slow to implement this policy framework and in some provinces there is still no Mental Health Directorate. The Minister of Health, Dr Aaron Motsoaledi, inaugurated the Ministerial Advisory Committee on Mental Health in October 2015. We commend the Minister for this progressive step. We hope the Advisory Committee will be able to assist the Minister in implementing the policy framework.

IN ADDITION, WE HOPE THAT THE ISSUES OF DISCRIMINATION AGAINST PSYCHIATRY AND MENTALLY ILL PATIENTS WILL BE ATTENDED TO. SUCH DISCRIMINATION IS EXTENSIVE. IT IS HIGHLIGHTED BY THE TIME SPENT IN PSYCHIATRY BY DOCTORS DOING INTERNSHIP, WHICH REMAINS ONLY ONE MONTH IN SPITE OF THE INCREASING BURDEN OF MENTAL ILLNESS AND DISABILITY.

Patients suffering from schizophrenia and bipolar disorder are still discriminated against by the Prescribed Minimum Benefits (PMB) regulations and are expected to pay for themselves if they attend a public facility. This is not the treatment given to patients with diabetes, hypertension and the other PMB conditions.

However, the Minister of Health is quick to use Bipolar Disorder as an example when complaining about abuse of PMBs. We are hoping that the Ministerial Advisory Committee will engage with SASOP on these issues, establish the real facts and advise the Minister accordingly.

THERE IS A LOT OF WORK AHEAD AND I AM LOOKING FORWARD TO INTERACTING WITH SASOP MEMBERS IN THE MANY MEETINGS THAT ARE PLANNED FOR THE YEAR. THE ULTIMATE EVENT OF THE YEAR WILL BE THE WPA INTERNATIONAL CONGRESS IN NOVEMBER.

***Dr Mvuyiso Talatala***
*President*

# EXTRACTS FROM THE SASOP BOARD OF DIRECTORS (BOD) MEETING, HELD ON 14TH NOVEMBER 2015.

This was the first meeting of the BOD to be held following the AGM and National Council meetings held in September at the time of the Biological Congress.

***Ideally, some of these issues should be discussed at subgroup level too, hence their inclusion here:***

- Adult ADHD Treatment Guidelines: the newly established Adult ADHD Special Interest Group (SIG) is looking at writing guidelines for the treatment of Adult ADHD specific to South Africa. The existing SASOP Treatment Guidelines currently only cover Childhood and Adolescent ADHD.

- Scope of Practice of Educational Psychologists: the BOD made an initial decision to keep the Position Statement in this regard on the website, acknowledging a letter received from the Educational Psychologists Association of South Africa (EPASSA). However, at the meeting of the BOD held on 23.01.2016, further discussion followed, and a decision was made, in the light of legal processes in place, to provisionally remove the position statement.

- Emergency Psychiatric Care Project: SASOP has been approached by the "EMERGENCY CARE SOCIETY OF SOUTH AFRICA (ECSSA)" to determine how SASOP and ECSSA can work together. Specifically, an area of concern is the involvement of emergency care personnel and the SAPS when potentially involuntary mental health care users need to be transferred to hospital. Issues surrounding training of those involved were discussed and possible liaison will still be determined.

- Constitution of Health Committee – HPCSA: SASOP received a request to nominate two Psychiatrists per province to constitute a Health Committee. Only one Psychiatrist will be elected. It was agreed that each Sub-group should nominate 2 members, and subgroups were informed.

- Complaints regarding unprofessional conduct: from time to time, SASOP receives complaints regarding unprofessional conduct of psychiatrists. It was affirmed that these should be dealt with by the HPCSA, but that SASOP does have guidelines for local subgroups to deal with cases internally, possibly before complaints reach the HPCSA These were previously circulated to subgroups, in the form of a letter to subgroup chairpersons, but will be added here for reference:

**From time to time, it may happen that concern arises regarding the behaviour or conduct of a member of the subgroup. This may pertain to matters of a personal nature, interactions with colleagues or the broader medical fraternity, ethical dilemmas, disability related issues or matters related to treatment of patients. There may be concerns that a physician is impaired and that the treatment offered by him/her is compromised.**

**It is important that these issues be treated with the necessary sensitivity, caution, confidentiality and professionalism. You may find yourself having to deal with a difficult and sensitive situation, with far reaching consequences.**

***For this reason, the SASOP Board of Directors would encourage you to, when confronting such a situation, to take the following steps:***

1. ***Try and ascertain the facts related to the complaint as best possible. It would be helpful if these were recorded in writing.***
2. ***Put together a committee consisting of yourself (the subgroup chairperson), another senior member of the subgroup, and the local Head of Department of Psychiatry and enter into discussion with the colleague concerned. Monitor the situation and follow up if necessary.***
3. ***Should the outcome be undesirable, it may be necessary to report the colleague to the HPCSA (when impairment is suspected). SASOP can assist you in this regard.***
4. ***Should the issue at a subgroup level not be resolved, discuss this with the SASOP Board of Directors who can then assist you regarding the way forward.***

- **SASOP SOCIAL CONTRACT:** Professor Bernard Janse van Rensburg, President Elect and Convenor of the WPA 2016 Congress, reported that the "Social Contract" (theme for 2016 congress, and beyond) is on course and the last meeting was held on the 31st of October 2015 with multiple Societies. A detailed report of the meeting and joint statement as result of the meeting will be circulated. Another meeting is planned for 2016 with the DoH, CMS, HPCSA and other stakeholders of a similar nature. It was added that SASOP is in the progress of forming a Mental Health Alliance in South Africa. Documentation will be updated as the process is finalized to inform members.
- **FUNDING FOR SASOP PUBLICATIONS:** following on from the change of publishing house for the SAJP, it was decided that a funding strategy (including sponsorships) needs to be developed for the SAJP to ensure its long-term survival. Similar efforts need to be made for other SASOP publications, including the Headline.The Publications division is working on this.
- **TRAFFIC ACT S5 + S6 MEDICATION REPORTING:** Certain insurance companies requested that S5 and S6 medicine users be prevented from driving. It was proposed that an external consultant be approached for advice. At the BOD meeting on 23.01.2016 further discussion ensued, and it was agreed that Drs Seape and Talatala would research the issue further and report back.
- **APA MEMBERSHIP BENEFIT FOR SASOP MEMBERS:** following the AGM in September, a survey was conducted to determine whether SASOP members would be interested in joining the APA at a discounted rate. The survey was completed and results were then discussed at the January BOD meeting. It was decided that APA discounted membership will be available for those who are interested, and that the SASOP contribution will at least match the APA discount. Fees that are due will be collected by SASOP. PsychMG members will receive a further subsidy as agreed with the PsychMG board.

## BENEFITS OF JOINING THE APA WERE PRESENTED IN SEPTEMBER AS:

- Strong advocacy on the international level.
- 2015 Annual Meeting Registration was approximately US$ 1,150
  - Equals R15 500 (at the exchange rate at the time)
  - APA Members paid approximately R 8 500
  - **SAVING R 7 000**
- Free online Publications
  - American Journal of Psychiatry
  - Psychiatric News
  - Integrated Care Newsletter
- e-Learning
  - Access to FREE online educational modules to advance clinical and professional competencies.

*Members should note that not only is it possible to join the APA, but that other societies such as the Royal College in the UK also offer international membership packages. (The Royal College offers the opportunity of becoming an "International Associate" at a rate of GBP 120 per year).*

- **BROADER STRATEGIC FOCUS:** Dr Motlana presented her vision for a more effective communications division, starting with a broader strategic focus. She suggested that SASOP needed a "broader communications governance structure". It has been clear for some time now that members need to be more informed, and that the public perception should be noted. A decision was taken to employ an outside company to assist with this task.

- **SIG DIVISION:** At the meeting, Prof Liezl Koen was appointed as the new division convener with the support of Prof Bernard Janse van Rensburg. It was also noted that Dr Hawkridge is the new Child and Adolescent Psychiatry SIG (CAPSIG) convener.

  It should be noted that these are probably the best collection rates ever, and moving this function to Healthman has certainly paid off.

| MEMBERSHIP CATEGORY | MEMBERS LISTED | PAID UP MEMBERS | UNPAID MEMBERS |
|---|---|---|---|
| PsychMG | 219 | 219 | - |
| Full - Private | 152 | 134 | 18 |
| Full - State | 139 | 121 | 18 |
| Honorary | 8 | 8 | - |
| Life | 23 | 23 | - |
| International | 1 | - | 1 |
| Pensioner | 13 | 13 | - |
| Associate | 7 | 7 | - |
| Registrar | 105 | 90 | 15 |
| Medical Officer | 7 | 4 | 3 |
| | | | |
| | 674 | 619 | 55 |
| | | | |
| Psychiatrists | 555 | 518 | |
| Paid-up Member % | | 91.8% | |

- **MEMBERSHIP FEES:**
  A reminder to members that membership fees for 2016 were increased at the SASOP AGM in September 2015.

  **Fees for 2016 are as follows:**

  Full members: R3 100 per annum

  Associate members: R 1550 per annum

  Registrars: R 780 per annum

  Pensioners: R 780 per annum

*Remember that PsychMG members have their SASOP fees included in their annual membership fee.*

- **WPA INTERNATIONAL CONGRESS 2016**
  - Subsidy for SASOP members: the BOD has decided to subsidise SASOP members who have been paid up for two consecutive years prior to the congress, by an amount of 50% of the "early bird" registration fee. Details to follow – watch this space!
  - Registration and call for abstracts have opened. See www.wpacapetown2016.org.za for more details.
  - The Scientific Committee has started receiving abstracts for the congress. Dr Gerhard Grobler is the new deputy head of the Scientific Committee.
  - A SASOP Congresses Company has formally been established. This company will be the arm of SASOP that organises all future congresses.

## 5. MEETINGS TO TAKE NOTE OF FOR THE SASOP 2016 CALENDAR:

| DATE | EVENT |
|---|---|
| 18-FEB-16 | CIPLA WEEKEND, ARABELLA |
| 11-MAR-16 | PSYCHMG - SANOFI WEEKEND |
| 15-APR-16 | DR REDDY'S WEEKEND |
| 8-MAY-16 | WPA - INTERNATIONAL CONGRESS OF PSYCHIATRY |
| 14-MAY-15 | APA |
| 2-JUN-16 | WPA 112TH JSPN - JAPAN - MAKUHARI |
| 27-JUN-16 | ROYAL COLLEGE OF PSYCHIATRISTS MEETING, LONDON, UK |
| 29-JUL-16 | PSYCHMG WEEKEND (MAY CHANGE, TO BE CONFIRMED) |
| **14-OCT-16** | **POSSIBLE DATE - CINP - SA** |
| **21-Oct-16** | **POSSIBLE DATE- CINP - SA** |
| 18-22 Nov-16 | WPA 2016 Intl Congress in Cape Town |

## THE LUNDBECK/SASOP REGISTRAR FINISHING SCHOOL 2015.

The third Registrar Finishing School was held at the Quatermain Hotel in Sandton on 06 and 07 November 2015. This event was attended by registrars who have already completed their final exams, or who are close to qualifying. The aim of this two-day event is to prepare colleagues for the transition from registrar to either private practice, or for the consultant role in the state sector. Speakers included psychiatrists from both sectors, who offered up the two days to assist in mentoring our junior colleagues.

Dr Hoepie Howell acted as facilitator, and the event was made possible through generous sponsorship

*Drs Howell and Grobler assist a group in their presentation.*

and support of Lundbeck. In her introduction she alluded to the core competencies identified for psychiatrists which include: patient care; medical knowledge; interpersonal and communication skills; practice-based learning and systems-based knowledge. The five top hazards for junior doctors were presented as being: issues regarding consent, prescribing, confidentiality, record keeping and probity. This set the stage for lively debate and interaction over the next two days.

DR GERHARD GROBLER GAVE A COMPREHENSIVE OVERVIEW OF THE "SOUTH AFRICAN HEALTHCARE ENVIRONMENT". THIS GAVE REGISTRARS A GOOD IDEA OF THE SORT OF "MARKET" THAT THEY WOULD BE ENTERING SOON. HE ALSO GAVE AN OVERVIEW OF THE ACTS THAT ARE RELATED TO HEALTHCARE AND SPECIFICALLY TO THE MENTAL HEALTHCARE ACT, THE MEDICAL SCHEMES ACT, PMB LEGISLATION AND THE NATIONAL HEALTH ACT.

Registrars were encouraged to avail themselves of the concept of "Risk Management" by Dr Rob Allen – he pointed out that it was important that such a plan should be in place in hospitals and that communication of such a plan was vitally important. Dr Sebo Seape gave a practical presentation on the setting up of a practice. She specifically referred to the important topic of "record keeping" and the statutory requirements regarding the keeping of records of minors, those suffering from mental retardation and records following occupational health and safety assessments.

There were very practical sessions on financial management, tax issues and business administration in practice. These sessions were led by Drs Eugene Allers and Katinka Botha. Dr Pieter Cilliers spoke on Ethics in Practice and Dr Duncan Rodseth on the relationship between Psychiatrists and the Pharmaceutical Industry. The SASOP President, Dr Mvuyiso Talatala and Dr Ian Westmore prepared the registrars for engagement in the professional society.
The workshop style worked well, allowing all the participants to engage fully and be "mentored"

*Presenters and participants pose for a group photo at the conclusion of the workshop.*

for their future roles.

LUNDBECK HAVE INDICATED THAT THIS WOULD BE THE LAST TIME THAT THEY ARE ABLE TO SPONSOR THIS EVENT AND THE SASOP MENTORSHIP DIVISION WILL BE SEEKING ALTERNATIVE SPONSORSHIP FOR FUTURE EVENTS. IN 2016, AT THE TIME OF THE WPA INTERNATIONAL CONGRESS, THERE WILL BE MULTIPLE EVENTS FOR EARLY CAREER PSYCHIATRISTS. WE HOPE THAT SOME OF THE MATERIAL COVERED DURING THE REGISTRAR FINISHING SCHOOL WILL BE INCLUDED IN THESE SYMPOSIA.DRS HOWELL AND GROBLER ASSIST A GROUP IN THEIR PRESENTATION.

# INSTRUCTIONS TO AUTHORS

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

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

## LETTERS TO THE EDITOR

* Novel experiences
* Response to published content
* Issues

## FEATURES

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

## REPORTS

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

## NEWS

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

## ANNOUNCEMENTS

* Congresses, symposia, workshops
* Publications, especially books

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**Christopher P. Szabo - Christopher.szabo@wits.ac.za**

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