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Dear Reader,

Welcome to the May 2017 issue. This is our 11th and penultimate issue before applying for DoHET accreditation. This will follow publication of the August 2017 issue which will represent the significant milestone of 3 years of continuous publication. This is one of the criteria required for such an application. A successful application will be a further, major, milestone. To this end you will note that there has been change in terms of Feature articles being published with references and an open commentary as a form of peer review. Further, we have received several literature reviews comprising content from successfully examined research reports towards the MMEd degree. These have been submitted by final year registrars and early stage consultants. The examination process for research reports which requires 2 examiners constitutes peer review. This development will thus provide specialists in training and junior specialists with a “hassle free” first publication – a just reward for their efforts as well as providing important review pieces on locally relevant topics. It goes without saying that should the publication be DoHET accredited, such publications will also yield subsidy for the authors and Departments. A win-win-win situation. It is hoped that we will be receiving such content from Departments nationally and I will send out a further communication to all Heads of Departments reminding them of this development.

During the African Association of Psychiatrists and Allied Professionals (AAPAP) Congress in Mombasa (see content in this issue) I was approached regarding the possibility of exploring the relationship between *South African Psychiatry* and the AAPAP. I have no doubt that this discussion will unfold. The current issue sees the publication of a range of content related to African psychiatry. It is anticipated that this will be ongoing in future issues.

In essence, the publication is evolving, and we look forward to future developments and providing you the reader with an ongoing source of relevant content.

I hope you enjoy this issue.

Christopher P Szabo
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On my way home from the RK Khan Hospital I was confronted by an Ox in the middle of the freeway. With no space to manoeuvre, the ox and my Nissan made solid contact. The Ox – after destroying the front of the car – then proceeded to whip its hindquarters around to the driver’s side window and, after successfully smashing the window proceeded to deposit the content of its colon into my car. I was utterly gobsmacked!

The reason for my writing is the experience suffered 18 hours after the accident. Only in the morning after the accident did I begin to experience epigastric pain to the hypochondrium. My first thought was that this must be post-traumatic hypochondriasis. This was not to be! The next 12 hours were spent vomiting copious amounts of pure clear bile. Amount of clear bile is estimated to have been between 200 and 300 mls. No oral fluids could be kept down. I was admitted to Kingsway Hospital in the care of a Physician, Dr Abdool-Gaffar. Twelve hours later, IV fluids and symptomatic medication saw me discharged completely recovered. A discharge diagnosis of Toxic Hepatitis was made.

So what toxic substance could have been the cause? Concerned friends soon came up with the answer. Cow and ox dung is rich in the neuro and hepatotoxin, Auramine-O. Auramine-O is a “canary yellow” diaryl methane dye (C17H22ClN3) that crystallises as a yellow powder. It is very water soluble at room temperature. It is also alcohol soluble.

The molecule is hepatotoxic (centrilobular hepatic necrosis) and is also a mild neurotoxin (CNS depression) and GIT irritant. The combined effect of my liver being attacked by a hepatotoxin and the GIT irritation (epigastric pain) completes the reasons for the presenting clinical picture. So, in hindsight, I must have inadvertently swallowed a small amount of the ox faeces. In 2013 Hisham MD et al published, in the Indian Journal of Pharmacy Practice, an article on the toxic effects of cow dung.1 Cow dung has historically been used as a germicide. However, cow dung is no longer readily available. Synthetic cow dung, known as “Saani Powder” is now being used as a substitute. Although this powder is legally banned it is well known that “the powder can be cheaply purchased from grocery shops at Rs.5 per packet”. Further “cow dung powder is commonly used as a suicidal poison”.

I was fortunate to have consumed a “biologically manageable” amount of the toxin. “Auramine-O is a lethal poison with no antidote”.2 In the article describing the toxic effects of Auramine-O Khaja Mohideen Shertudeen et al report on two cases where Auramine-O was used in an attempt to commit suicide.2 Both reported cases, after a stormy passage in intensive care, survived. I am also delighted to have survived!

References

Lennart Eriksson, Psychiatrist, Pennington, South Africa Correspondence: lennarte@iafrica.com
Telepsychiatry belongs within the domain of telemedicine, which includes psychiatric and psychotherapeutic services via a video link. This is made possible with special software and secure data programmes. Telepsychiatry is different from internet treatment methods where treatment is shared by way of text material and exercises and with other contact taking place via email.

There is a shortage of psychiatrists in both the rural and urban setting. With respect to psychotherapists in Sweden, only 250 of the country’s 6000 psychotherapists practice CBT. The need therefore is hugely greater than resources. In order to meet a part of the public’s need, Telepsychiatry may be an alternative. The telepsychiatrist/therapist can link either from the home or from the local clinic or even from the holiday cottage. The patient can link from home, the local clinic or from a psychiatric clinic.

Or may even link from abroad. In rural areas a patient may no longer need to travel 120km for a repeat visit or an acute consultation. This can mean the difference being admitted to a ward or being neglected in the case of a movement impaired octogenarian, a working patient with her own children or for someone who for any reason is unable to leave the home or care facility.

IS TELEPSYCHIATRY ACCEPTED BY PATIENTS?

WHAT IS A TELEPSYCHOTHERAPIST?

The answer is YES. Since a few years ago Telepsychiatry has been established in Gällivare (Gällivare is a mining town in a very remote area of Lapland with enormous distances and a small population). Staff at the outpatient unit estimate that 9 out of 10 patients manage to communicate with the telepsychiatrist.

IS THERE A SHORTAGE OF PSYCHIATRISTS?

Could this be an alternative to locum psychiatry? Of course it is. Aside from improved continuity and less travel for the patients, the cost to the provincial authorities – payment for locum psychiatrists including travel and housing – will be contained. The psychiatrist can then rather work from home instead of staying in hotels far away from family, partners, pets or leisure time activities.

Telepsychiatry is eco-friendly, cost efficient and at the same time can improve compliance/continuity and the quality of the patient/therapist relationship. It improves equal access to care when rural people will get the same level of care as people living in the urban environment. The patient will be able to “return” to the same psychiatrist who will be able to monitor progress and any medication side effects. Family and the clinic staff can be present during the video consultation. A further benefit is that Telepsychiatry may contribute to reducing stigma.

Now wait a minute! Surely the therapeutic alliance cannot be as good as when the psychiatrist and the patient are together in one room? Actually YES – it can indeed be an advantage to meet the patient in a...
room during the first diagnostic interview. This permits forming a therapeutic alliance. There are, however, both advantages and disadvantages with distance created by the computer screen.

ARE THERE STUDIES COMPARING TRADITIONAL CONSULTATIONS WITH VIDEO CONSULTATIONS? YES – SUCH STUDIES EXIST. IN A USA STUDY 223 CHILDREN WITH ADHD WERE RANDOMLY SELECTED FOR TELEPSYCHIATRY & TRADITIONAL MANAGEMENT. THE CHILDREN ASSIGNED TO THE TELEPSYCHIATRY GROUP ALSO ATTENDED THE CLINIC BUT IN ADDITION HAD A VIDEO CONSULTATION. THE CHILDREN WHO HAD THE BENEFIT OF TELEPSYCHIATRY SIGNIFICANTLY IMPROVED AS COMPARED TO THE CONTROL GROUP.

In 2013, The American Telemedicine Association issued a guideline for video-based online mental health services. It added rules for the PC and mobile usage. It advocated that even patients with a psychotic disorder or paranoid delusions can be treated via video. It recommended that the patient give written consent and that the equipment used be of broadband quality and security stable. Further the room used for the purpose of Telepsychiatry must be suitably well-equipped – acoustics, microphone, speakers and a web camera with level eye contact. Support staff must have training in the use of the video equipment. There must also be emergency measures in place should contact be unexpectedly broken.

Telepsychiatry and international experiences was the topic of a symposium at the World Psychiatric Association International Conference held in Cape Town in November 2016.

In the WPA symposium, psychiatrist-in-chief Anna Svensson from the northern district of Hälsingland (pop.130 000, 19 psychiatrists including registrars) reported on the evaluations of about 500 patient consultations online as well as team meetings with a remote psychiatrist.

THE OVERALL EVALUATIONS WITH REGARD TO ACCEPTABILITY WERE HIGH; 4-5 ON A 5 POINT SCALE.

Malcolm Fisk of De Montfort University in Leicester U.K. reported on quality standards of tele-mental health, emphasizing the importance professional standards and codes of practice that are being developed and spread across Europe, such as The PROGRESSIVE project, and The International Code of Practice for Telehealth Services. Jennifer Chipps at the University of Western Cape, presented data from her thesis on 2012 on telepsychiatry in KwaZulu Natal. Her work was based on an extensive literature review, a protocol for services delivery, and experimental studies showing benefit with regard to patient consultations as well as remote education of psychiatry registrars. Fotis Papadopoulos from the Uppsala University, Sweden, had a futuristic presentation, comparing this technology to that of the iPhone, the exposure treatment of phobias with Virtual Reality, and the future of self-driving cars and machine learning. He envisioned that the future holds automatic emotion recognition, linguistic analysis and psychomotor activity analysis. The emerging hologram technology may put a 3-dimensional therapist in the room for you!

References
Dr. Albert Hertzog, Minister, for Posts and Telegraphs, commented in 1958 that television was “only a miniature bioscope which is being carried into the house and over which parents have no control.” The world has changed a great deal since then. The digital screen, in its many forms, has now become an integral part of our daily lives. Christer Allgulander’s report on a symposium “Telepsychiatry and international experiences” provided a perspective on this emerging option for service delivery.

**PSYCHIATRY AND PSYCHOTHERAPY HAS TRADITIONALLY BEEN, AND ESSENTIALLY REMAINS, AN EYEBALL TO EYEBALL ONE-TO-ONE ENCOUNTER. THE IDEA THAT THE ONE-TO-ONE ENCOUNTER CAN TAKE PLACE OVER A HUGE DISTANCE AND REMAIN A MEANINGFUL EXPERIENCE IS AN EXCITING NEW REALITY. THIS NEW REALITY – TELEPSYCHIATRY - PROVIDING BOTH CLINICAL PSYCHIATRY SERVICES IN ADDITION TO PSYCHOTHERAPY IS WELL DEMONSTRATED BY THE SWEDISH EXPERIENCE PRESENTED.**

Like all realities this new service modality needs to be assessed from different perspectives. Christer Allgulander speaks of Telepsychiatry now being accepted as a stand-alone branch of Telemedicine. South Africa has not been left out of the loop! So what is the African – and in particular the South African – experience? Telepsychiatry in South Africa has been described by Jennifer Chipps (Department of TeleHealth, University of KwaZulu Natal and one of the symposium presenters) and colleagues. With a participative team, which included seven psychiatrists and a registrar, the use of Telepsychiatry at Regional Hospitals was explored. In contrast to the Swedish experience there was a need for ground work. The technical requirements were a first basic starting point. This would all seem to have been in place in Sweden permitting the implementation of a “patient centred” telepsychotherapist encounter.

The rural South African need is not for individual “telepsychotherapist” interventions. The South African TeleHealth is rather focusing on the team members managing often difficult patients in a remote rural African setting. Education and clinical outreach sessions are the focus of South African Telepsychiatry. In the South African experience education proved to be beneficial. The clinical outreach, which would include individual clinical sessions is, to quote, “feasible, but will require administration and technical support for facilitation”.

**SOUTH AFRICA IS A LONG WAY FROM IMPLEMENTING A MEANINGFUL TELEPSYCHIATRY SERVICE. TECHNICAL TOOLS (MONITORS, SOFTWARE, MICROPHONES, WEBCAMS AND MORE) – THE CORRECT BANDWIDTH (128 KBPS VERSUS 384 KBPS) AND THE USE OF SUITABLE SOFTWARE WILL ALL NEED TO BE IN PLACE. FUNDING, SUITABLE INFRASTRUCTURE AND THE APPOINTMENT OF DEDICATED QUALIFIED STAFF – TECHNICAL, ACADEMIC – ARE MATTERS THAT ALL REQUIRE A NATIONAL COMMITMENT TO TELEMEDICINE.**

The Swedish experience is just so different from the urgent African need to bridge the treatment gap. But that should not allow us in Africa to lose momentum. Telepsychiatry has the means to improve the care of the mentally ill in our poorly serviced country where huge distances between specialist treatment centres and the rural communities is a geographic reality.

References:

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Janssen is currently providing financial support to the following Mental Health projects. The selection criteria for these 2 initiatives were based on value the aforesaid can add to the Mental Health continuum.

The above mentioned is a registered NPO, located and affiliated to Lentegeur Psychiatric Hospital in Mitchells Plain. Their primary function is on focussing a range of psycho-social rehabilitation and outreach projects to re-establish a sense of hope and recovery for Patients.

The Lentegeur Market Garden project provides a vocational training opportunity for patients at Lentegeur Hospital.
1. SPRING FOUNDATION

The scope of the project is:

- Psycho-social rehabilitation and recovery
- Mentoring and training of emerging farmers
- Challenging stigma
- Addressing food security
- Sustainability and Biodiversity
- Research

THE MANNER IN WHICH THE PROJECT IS STRUCTURED AFFORDS THE OPPORTUNITY FOR EVIDENCE BASED INNOVATIONS THAT ARE REPLICABLE.

2. ASSAF (ACADEMY OF SCIENCE IN SOUTH AFRICA)

ASSAF is being funded to conduct research pertaining to the skills required to implement the International competencies within the South African context.

The below is a brief summary with regards to the research initiative:

There is no clear strategy for ensuring that the different cadres of workers in the human resource mix envisaged to provide integrated care for Mental and Neurological Science (MNS) disorders are adequately equipped with the necessary competencies to implement the National Mental Health Policy Framework and Strategic Plan (2013-2020) plans.

To enable implementation, it is crucial that training programmes across the country ensure that service providers are equipped with the necessary competencies and skills to undertake these new roles and functions.

THIS RESEARCH INITIATIVE WILL AIM TO REVIEW THE EDUCATION AND THE TRAINING NEEDS OF HEALTH CARE WORKERS AND OTHER PROVIDERS IN SOUTH AFRICA IN MNS DISORDERS.

The above will be addressed utilizing a consensus study to:

- Provide baseline data on what is currently offered in South African training programmes of the different cadres of workers in the human resource mix for the delivery of integrated MNS disorder care;
- Adapt the Ugandan institute of Medicine core competencies framework for South Africa.
- Map baseline data against the agreed-upon core competencies for South Africa
- Make recommendations for core competencies required of training programmes to the Health Professions Council of South Africa (HPCSA), as well as other training and regulatory bodies.

The study scope will cover the WHO Mental Health Gap Action Programme (mhGAP) priorities: i.e. psychosis, depression, substance use disorders (including alcohol), child developmental disorders, child behavioural disorders, suicide, dementia and epilepsy.

Zeneida Claasen is an Occupational Therapist by profession that specialized in pediatrics and neuro developmental therapy. During her tenure as a clinical therapist she worked in the area of mental health for a number of years, however it was her appointment as the head of Occupational Therapy at Brooklyn Chest Hospital that really sparked her interest in TB and in particular Drug Resistant TB (DR TB). She then furthered her studies in public health and in 2009 she was appointed as the Provincial Programme Manager for DR TB in the Western Cape and in 2014 became the Provincial programme manager for Disability and Rehabilitation. In 2015 she relocated to Pretoria to join FHI 360 (Family Health International) as a Senior Technical Advisor seconded to the National Department of health to support the DR TB programme. At present she is employed at Janssen as the Medical Manager for MDR TB and Mental Health. Correspondence: zclaasen@its.jnj.com
A review of disciplinary proceedings against mental health professionals, principally psychiatrists and clinical psychologists, revealed that as recently as 2014 the most common complaints filed against such professionals are sexual misconduct with patients, which is second only to complaints of unprofessional conduct relating to biased reports regarding child custody disputes. (M Austen, April 2015 – Personal Communication).

While both categories of ethical contravention ultimately equate to the same result of ‘screwing one’s patient’ which can have severe consequences, they are qualitatively different in terms of intent as the latter infringement may often be quite unintentional in comparison to the former.

Given the alarming trend that most cases of unprofessional conduct may be the result of misunderstandings of the legal and ethical dilemmas germane to civil forensics, possessing a basic understanding of family law appears to be increasingly advantageous to South African psychiatrists and psychologists who attempt to navigate this kaleidoscope of conflict, as a safeguard in both the private and public health care sectors.

Family law, as delineated by Allan (2016), is a branch of civil law concerned with matters of divorce, separation, child custody and guardianship, adoption and surrogate motherhood. According to the Children’s Act no. 38 of 2005 (and its addendums), while it is the responsibility of a child’s parents (biological or otherwise) to uphold the best interests of a child, in the instance that there is a conflict of interest between the custodian parents regarding the child’s best interests, the court and appointed mental health professionals may be charged with making a determination as to how the child/ren’s best interests may be served by their parents.

Whether as the treating professional of the child or, alternatively, of one or both parents, the ethical position inherited by a psychiatrist is an extremely precarious one. The immediate ethical dilemma with which the treating professional is faced is adopting multiple roles with the same patient which may ultimately result in a conflict of interest (HPCSA, 1974). On some occasions, the treating professional may not enter this ethical minefield out of their own volition but may be unwittingly led down this route by the legal counsel (knowingly or unknowingly) of either party involved in the matter. While, of course, a psychiatrist will hope to uphold a duty of care to his or her patient while also facilitating a just legal outcome, these roles are occasionally misaligned and, if conflated, may result in damages to all parties— including the professional in question. The ethical question which inevitably arises from this concern is, therefore, where one draws the ethical line and to what extent one actively participates in this process.

The guiding principles that aid in answering such a question lie in distinguishing between the role of an expert witness and a fact witness in legal proceedings, specifically as this distinction applies in family law. Traditionally, South African psychiatrists fulfill the role of a fact witness in child custody matters as they are typically involved in the matter due to a pre-existing situation.
treatment relationship with one or more of the parties. The role of a fact witness implies that the professional in question is not unbiased and as an agent of his or her patient because of an ethical commitment to uphold a duty of care to that patient. As such, the burden of proof, a legal mandate or duty to prove a disputed fact (in this case the best interests of the child/ren), is not placed on a fact witness as they are inherently biased due to a professional responsibility to uphold the interests of their patient. Therefore, the role of a fact witness is to provide relevant information regarding their patient, including but not exclusive to a diagnosis, prognosis, treatment compliance and history, in the form of a report or interview to assist the court in making a decision, but is not required to offer an opinion regarding child custody or guardianship as that is the mandate of an expert witness.

In most cases in South Africa, the role of expert witness in child custody evaluations is assumed by clinical psychologists and occasionally by social workers. The heavy reliance on psychometrics and focus on formulating the dynamics of the family system are often cited as reasons why this role is commonly adopted by these professionals, although it should be noted that, while uncommon, psychiatrists are by no means proscribed from performing such a role (HPCSA, 1974). In such matters, it is important to note that the expert witness is typically appointed by the court or jointly appointed at the request of both parties. The expert witness, as an objective party with no previous relationship to either party and no vested interest in the matter, is in a position to focus on a just legal outcome unfettered by partiality or treatment commitments to anyone involved.

**THIS PROFESSIONAL IS CHARGED WITH A LEGAL MANDATE TO PROTECT AND UPHOLD THE BEST INTERESTS OF THE CHILD/REN AND BEARS THE BURDEN OF PROOF IN SUCH CASES.**

Typically, the expert witness will contact fact witnesses requesting collateral information (to supplement their own clinical interviews, home observations and psychometric data) about the parties and it remains a responsibility of the fact witness to ensure that they do not offer an opinion on child custody, but rather provides relevant information to aid the expert witness in making such a determination. A similar process is followed post-assessment as a case manager (usually a clinical psychologist, social worker or family advocate) assumes a decision-making capacity and may draw on fact witnesses to assist in their process of managing the family system. Whether before, during or after the assessment, the minimalist adage of “less is more” seems to be a useful axiom in considering the role of psychiatrists in child custody matters as illustrated by the diagram below:

**ALIENATION & THE FAMILY SYSTEM: AVOIDING CHARGES OF BIAS**

Not assuming the heavy mantle of the burden of proof in such cases is not only advantageous in its dissolution of ethical dilemmas, but also self-preservative in aiding a treating psychiatrist in avoiding charges of bias. Considerations of custodianship by one or either parent implicitly demands of a professional to have comprehensive knowledge of the family dynamics and the child/ren’s relationship with both parents. Seldom is a treating professional offered such an understanding beyond the subjective impressions offered by the child/ren and parents themselves, leaving any professional in a non-assessment role almost entirely dependent on hearsay evidence which could represent distorted impressions of family members for any number of reasons.

The most common family dynamic which has informed child custody evaluations to assist professionals in avoiding bias is the dynamic of parental alienation which has evolved since the original, and now expanded and improved upon, theory of Parental Alienation Syndrome espoused by Gardner in 1987. Gardner’s model emphasised that the most likely parent engaging in alienation behaviours would be the mother, with the father being the alienated parent. One of the extreme remedies he suggested was to force the child to visit with the alienated parent or to remove the child from the alienating parent’s custody. However, Gardner’s model has come under intense scrutiny as alienating behaviour by a parent is neither a sufficient nor a necessary condition for a child to become alienated. Fidler and Bala (2010) highlight the importance of understanding the complexity of family dynamics, situational factors, individual factors and even developmentally healthy factors in assessing a child’s resistance to one or other parent. Factors contributing to a resist/refuse dynamic (RRD) could include normal separation anxieties, resistance rooted in alignment with one parent in high-conflict divorce, resistance due to parenting style, resistance due to fears over an emotionally fragile parent, and resistance due to remarriage or other relationship concerns.
Irrespective of the aetiology or nature of the alienating dynamic, it can result in severe distortions in the perceptions and behaviours of the child/ren to one or both parents which may, in turn, be misleading to clinicians and result in a form of ‘splitting’ not unlike that noted in borderline personality dynamics. A professional not familiar with the alienated parent, may on the basis of the disclosures of the child/ren or the parent with whom he or she does have contact, unwittingly develop an unconscious bias leading to recommendations that would be unfavourable to the alienated parent without sufficient justification. In such cases, the burden of proof may be assumed by a fact witness with benevolent intentions but insufficient information to support the determination, resulting in considerable legal backlash from the alienated parent- extending and entrenching the acrimony already operative in the family system.

AS A MEANS OF UPHOLDING A DUTY OF CARE WHILE ALSO SAFEGUARDING ONE’S OWN PROFESSIONAL INTEGRITY, CONSIDERATION OF THE ROLE OF A POTENTIAL ALIENATING DYNAMIC IN ANY SITUATION OF FAMILY CONFLICT IS, THEREFORE, NECESSARY.

Failure to make such a consideration could not only be detrimental to the treating (or even assessing-) professional, but also to the child/ren in question as Fidler and Bala (2010) report that clinical observations and case reviews indicate that alienated children demonstrate higher rates of emotional immaturity, greater anxiety about interpersonal intimacy, poor reality testing, lower self-esteem, emotional dysregulation and dependency than their same age peers. Warshak (2010) adds that most alienated children express disappointment at authorities who do not intervene to facilitate reconstruction of relationships with both parents when they reach maturity. As such, bias against either parent is to be avoided by fact and expert witnesses alike as there is substantial evidence that children are more likely to attain their psychological potential when they are able to develop and maintain meaningful relationships with both of their parents, whether or not the two parents live together.

CONCLUSION

Family law, and child custody evaluations in particular, represent a kaleidoscope of conflict into which clinicians (both experienced and novice) can be drawn if they lack the necessary skills and knowledge to navigate it. A consideration of immense importance in this regard is that the adversarial nature of these matters inevitably extends to the health professionals involved in them, and this is evidenced by charges of misconduct in civil forensic matters representing the highest proportion of complaints against mental health professionals in South Africa as recently as 2014. In order to navigate these conflicts and avoid the ethical pitfalls endemic to the civil forensic enterprise, it is crucial that psychiatrists remain mindful that as fact witnesses in such matters they are not bound by a burden of proof and should, therefore, avoid issuing opinions on custody and contact and rather offer the required collateral information to the expert witness to uphold a duty of care, while also facilitating a just outcome without exposing oneself to ethical reprimand and legal action. The necessity of not assuming the mantle of a burden of proof remains all the more important when one considers that alienation can result in significant distortions in the subjective impressions of parents and children, which may result in well-intentioned but biased recommendations of psychiatrists underpinned by insufficient evidence.

IT APPEARS THAT BY REMAINING NEUTRAL IN THE FAMILY SYSTEM, EFFECTIVELY ACTING AS A FACT WITNESS AND FOCUSING ON TREATMENT WITH AN AIM TOWARDS THE RECONSTRUCTION OF RELATIONSHIPS WITH BOTH PARENTS, SOUTH AFRICAN PSYCHIATRISTS CAN FEEL PROTECTED AND EMPOWERED IN ASSISTING KALEIDOSCOPES OF CONFLICT TO MORPH INTO PRISMS OF HARMONY.

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Anthony Townsend is a clinical psychologist with special interests in forensic psychology and neuropsychology. In addition to running a busy private practice at the Sandton Psychology & Wellness Centre, Anthony is also a consultant psychologist at multiple hospitals in Johannesburg where he provides general services with a special interest in the treatment of anxiety disorders using cognitive-behavioural therapy. Anthony currently serves as a guest lecturer and researcher at the University of Pretoria where he teaches undergraduate and post-graduate courses in cognitive neuroscience, psychopathology and integrative psychotherapy. After being named one of South Africa’s 100 Brightest Young Minds, Anthony has been actively presenting his research on wide-ranging topics of parental fitness, the neuropsychology of depression and the dynamics of self-harm at international conferences such as the 31st ICP in Yokohama, Japan and the 10th AFCC Conference in Boston, USA.

Correspondence: anthony@sandtonpsychologists.co.za.
It is the psychologist’s duty to explain to the court that a diagnosis of mental illness does not necessarily make someone a bad parent.

The field of child custody evaluations by psychologists is characterized by several challenges currently. Some of these include the lack of opportunities for formal, academic and practical training in the field, despite the Health Professions Council of South Africa creation of a category for forensic psychology, which can be challenged with regards to its rigour and focus.

The varied kinds of psychologist involved in these kinds of assessments (educational, clinical, counselling) have elicited political contests regarding which kind possesses the necessary scope and training to conduct such evaluations and make recommendations thereon.

The field also relies primarily on internationally developed research and formulae with little development of the South African field to account for local idiosyncrasies such as multiple child-headed households, multi-cultural permutations and cultural specificities pertaining to the various ethnicities present in the South African community.

Despite these challenges, the psychologist’s role in child custody evaluations remains key and pivotal with regards to adding depth and breadth to the legal management of these cases by the psychologist’s area of expertise with regards to child development (cognitive, emotional, social), attachment and psychopathology.

It is the psychologist’s duty to explain to the court that a diagnosis of mental illness does not necessarily make someone a bad parent, to counter biases towards the primacy of caregiving by the biological mother in cases where the child’s stronger bond is to the paternal or non-biological caregiver, and to explain that the needs of children vary given their developmental stage and context and relationships.

To facilitate the above, there needs to be greater dialogue between legal and psychological professions as well as within the profession of psychology and psychiatry. This will enable the creation of mutually beneficial structures to better cater for the best interest of the child in such evaluations, and to overcome political and professional divides that have historically stood in the way of such progress.

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¹ Efegen XR 75/150. Reg No: 2012/042314. Each extended release capsule contains venlafaxine hydrochloride equivalent to venlafaxine 75 mg and 150 mg respectively. Pharmacological classification: A 10 Psychoanaleptics (antidepressants). Applicant Ranbaxy (SA) (Pty) Ltd.

References:
1. Efegen XR package insert, Ranbaxy (S.A.) (Pty) Ltd (July 2012)
Applicant: Ranbaxy (S.A.) (Pty) Ltd, a SUN PHARMA company; Ground Floor, Tugela House, Riverside Office Park,
1300 Haulwiel Avenue, Centurion, 0201. Tel: +27 12 643 2000, Fax: +27 12 643 2091. www.sunpharma.com
Recently, mental health promotion has been viewed as a cross-cutting health priority internationally, and has been included in the United Nation’s (UN) Sustainable Development Goals (SDG), albeit an add on after SDG 3.4: “By 2030, reduce by one third premature mortality due to non-communicable diseases through prevention and treatment and promote mental health and well-being.” 1 In support of this goal, the World Health Organisation (who is endorsing the concept of Psychological First Aid (PFA) As a means of promoting Mental health for all.

**PSYCHOLOGICAL FIRST AID**  
PFA is a critical source of first-line psychosocial support for people who are affected by crises, and is defined as a: “…Humane, supportive and practical response to people suffering exposure to serious stressors and who may need support. It is an approach to help people recover by responding to their basic needs and showing them concern and care, in a way that respects their wishes, culture, dignity & capabilities.” 2 A critical consideration of the definition begs the question as to whether or not this is simply describing the act of a decent human? Family, friends, neighbours, teachers, community members and first responders of various kinds (emergency medical teams, police, firefighters) are considered by the WHO to be those who are most likely to provide PFA. Anyone can be a mental health promoter using PFA, and in the process of equipping people to use this approach, the starting point should be to first do no harm.

Importantly in addition to teaching people what they should or can do when assisting someone in a crisis, people also need to be educated about what not to do in such situations. The application of PFA, relies on 4 principles, which are: prepare, look, listen and link. These are in turn underpinned by 4 basic assumptions: respect, safety, dignity and rights. According to the WHO, PFA can be used when there are large scale, or individual crises that result in traumatic experiences.3 But what about endemic continuous crises?

**JOHANNESBURG AS A PLACE OF ENDEMIC CONTINUOUS CRISSES**  
Based on crime statistics, Johannesburg Central was found to be the third worst crime precinct in Gauteng, and Hillbrow the tenth, particularly in relation to social contact crimes such as: murder, assault, robbery, sexual assault and concealment of birth. 4 These are crimes that are committed by people against other people and result in the loss of connection and trust within communities. According to studies, “children in inner-city communities experience the same number of stressful events in 1 year as other children experience over their entire lifetime.”5 Furthermore, people living in the inner city chaos of Johannesburg Central and Hillbrow are affected by poor nutrition, poor hygiene and health, and have limited access to education and social services. 6 When combined, these factors have a detrimental effect on children’s development, increasing the number of high risk behaviours that they are likely to exhibit as well as their risk of developing mental health problems. The result is a self-perpetuating cycle of violence and crime with limited professional mental health and social services to offer intervention. According to the WHO’s definition, Johannesburg is a crisis zone, and given the fact that young people are more likely to seek out assistance from friends and family rather than from health professionals when there is a crisis, there is a case for PFA to be used to expand the mental health safety and support net for children living in the inner city. The focus is then on how to apply the principles of PFA amongst children in the inner city with the primary aim of mental health promotion.

**CRISIS IS OPPORTUNITY**  
Whilst crisis is seemingly inevitable for children living in the inner city of Johannesburg, it can be seen as an opportunity to build resistance, as opposed to resilience. In developmental psychology, resilience
has developed into the idea that children can be subjected to anything and will somehow bounce back, because they are resilient. This should not be the default position. Children’s so-called ‘resilience’ should be seen as the active resistance against what has been imposed on them, so as to retain some sense of self worth and dignity, and develop adequate mental health. With this in mind, negative behaviour may be understood then as a form of protest. When children present with behaviours such as drug-taking, stealing, drinking and gang membership, they are actively protesting against the fact that we have not given them sufficient infrastructure, social security and networks to grow up as normal young people. The behaviour of our children is a protest that tells us that we are not doing enough. In the context of the inner city, we see children’s behaviour as an opportunity to build a community of care through which the principles of PFA can be applied.

BUILDING A COMMUNITY OF CARE: FIGHT WITH INSIGHT

In attempting to build the community of care for children in the inner city, we have developed a programme for mental health promotion, in the form of a boxing and life gym, which is situated in an area of high need, low resources and limited access to mental health services.

HOW ARE THE PRINCIPLES OF PFA APPLIED IN THIS CONTEXT?

PREPARATION: The setting up of the gym required an extensive amount of preparation, which included the need for a safe space, safe people and holistic programming. The gym is located in the Children’s Memorial Institute, along with over 30 other NGOs that address the needs of children. The space is seen as a safe haven by children in the local community. The coaches, staff and “psychological foot soldiers” are trained and supervised around child development, safeguarding and protection. A developmental approach, which considers life stage and life long needs, informs programming.

LOOK: Observation skills are key and are applied within the frame of lifespace intervention. This involves “doing with children” and is a way of connecting with them through interactions in their everyday life spaces.5

LISTEN: Communication and counselling skills training provide the foundation for the initial response to the child. Basic screening is applied to identify which children may be in need of more specialized intervention.

LINK: When a child is identified as in need of specialized services, then a referral is made. Although, we have a network of referral resources for the children, this has been the most difficult aspect of the work, because resources are limited, particularly with regards to children’s basic rights. Importantly, the gym is an open access facility. This allows for a consistently available space, where the children are able to participate to the extent that they choose. The opportunities that the gym provides for belonging to a positive peer group and mastering the art of boxing are significant factors that have contributed to mental health promotion amongst the children that participate in the programme.

DIGNITY IN MENTAL HEALTH PROMOTION

In our programming we ascribe to the International Classification of Functioning, which is based on the premise that participation in society should be encouraged regardless of ability, because participation is believed to promote functioning. As such, the boxing programme has been extended to include children with autism, children affected by HIV and children diagnosed with psychiatric disorders. These children participate in a mental health promotion programme, which recognizes the ability for agency in children, regardless of whether they are suffering from a mental health crisis or not. Children do not need to be defined by the label that brought them to care. In a human rights-based approach, we all have a duty to children which states “first do no harm.” However, those of us who have chosen to work with children also have a duty to do good for children when they present to us. The crisis and the fact that children present for services is our opportunity to do good things. In conclusion, it is not something we do with children that makes a difference, it is everything.

References

Luke Lamprecht is a Child Protection and Development Specialist completing his MSc in Neurodevelopment at Wits University. He has worked in the NPO field for 25 years and is currently a director at Fight With Insight: Hillbrow Boxing Re-Evolution Life Gym at the Children’s Memorial Institute. He is an amateur boxing and lifespace coach and fitness instructor. As part of his ongoing development he belongs to a variety of professional groups, and does talks and training with interests in health, mental health, disability, development and sexuality. Correspondence: luke.jca@gmail.com

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Change in appetite  Suicidal ideation  Decreased concentration
Irritability  Tearfulness
Lack of energy  Pain  Feelings of guilt
Brooding
Anxiety phobias  Change in sleep
Depressed mood  Obsessive rumination
Excessive worry over physical health
Change in psychomotor skills  Loss of interest

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5 Cymbalta 30 mg, 60 mg. Each capsule contains duloxetine HCl, equivalent to 30 mg or 60 mg duloxetine. Reg. No. 37/1/2018; 37/2/2018. 55 CymGen 10 mg, 64 mg. Each capsule contains duloxetine HCl, equivalent to 30 mg or 60 mg duloxetine. Regs. No. 41/1/2018; 41/1/2018. For full prescribing information refer to the latest package insert approved by the medicines regulatory authority.

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- Schizophrenic Psychoses¹,
- Affective symptoms associated with schizophrenia¹,
- Dementia related behavioural disturbances¹,
- Disruptive behaviour (Paediatrics aged 5-12 years)¹.

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Reference: Refer to package insert for more info.
Risperidone 0.5, 1, 2, 3 and 4 mg. Each tablet contains 0.5, 1, 2, 3 and 4 mg of Risperidone respectively.
Reg. No.: 42/2.5/15/105; 42/2.5/15/109; 42/6.5/15/157; 42/6.5/15/198 and 42/2.5/15/159.

For full prescribing information refer to the package insert approved by the Medicines Regulatory Authority.
In their paper Communities of Care: Psychological First Aid in Practice, Luke Lamprecht and Sheri Errington propose and discuss the important idea of Psychological First Aid (PFA) as a potentially valuable means of promoting access to mental health care for all South Africans. They cite the WHO as proposing that PFA is useful in contexts where there are large scale or individual crises, and go on to highlight the challenges faced by children growing up in a context (Johannesburg) where traumatic stress and crises are endemic and continuous.

THE IMPACT OF ADVERSE CHILDHOOD EXPERIENCES (ACES) ON THE DEVELOPMENT OF PSYCHOPATHOLOGY, AS WELL AS NUMEROUS OTHER PHYSICAL AND MENTAL HEALTH OUTCOMES HAS BEEN WELL DOCUMENTED INTERNATIONALLY.

There is clearly a great deal of merit in the proposal that in a society as unevenly and inadequately resourced as ours, skillling a wide range of people in PFA strategies will allow more people to get support and relief from distress, and potentially reduce the negative impact of the endemic and continuous crisis on developing children.

I must take issue with the author’s critique of developmental psychologists understanding of the notion of resilience. They argue that the assumption of developmental psychology is that children are intrinsically resilient and “can be subjected to anything and will somehow bounce back, because they are resilient”. This is certainly not the mainstream or accepted understanding of resilience in developmental psychology. Resilience is seen as a process, and a capacity to adapt to or cope positively with crisis or adversity and emerge with competent functioning. It is not understood to be an individual personality trait or an innate part of children’s functioning. Rather it is the outcome of multiple interacting factors including early attachment experiences, individual disposition, life circumstances and the presence of protective factors that potentially ameliorate negative life experiences.

Lamprecht and Errington prefer the term “resistance” and explain that the negative, acting out, self-harming and socially challenging behaviours of inner city youth are a form of protest against their adverse life circumstances and our failure, as a society, to provide adequate resources for them.

I believe that most developmental psychologists would endorse the authors’ proposal that PFA be applied within the context of a “community of care” (in this instance the very exciting and innovative gym and boxing programme at CMI) to assist inner city youth and to provide opportunities for engagement with potential protective factors that may build meaningful and lasting resilience (and positive resistance) in the face of adversity.

RECOMMENDED READING


Judith Ancer is a Clinical Psychologist who trained at the University of the Witwatersrand and the University of Natal (PMB). She is in private practice in Greenside, Johannesburg and has worked at Tara Hospital on the adult psychotherapy ward; at Crossroads Remedial School with children and parents; and as a supervisor and trainer of other mental health professionals. She is a director of Shrink Rap, a company that offers continuing professional education to healthcare and human resource professionals and provides training and counselling services to small companies. She often gives talks and runs workshops and used to write a weekly column called Letting Grow on parenting issues for the Sunday Times.

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CONCENTRIC CIRCLES OF CONCERN
WORKING WITH THE AFTERMATH OF COMPROMISED PARENTING - PART I

Edited by Melanie J Esterhuizen & Megan Jones
Contributors: Anna Schmidt-Ehmke, Mary-Ann Tandy, Nicki Dawson, Katherine Bain, Vossie Goosen, Bruce Laing, Anele Honono, Renilla Singh, Katharine Frost, Irene Chait, David Hadley, Jonathan Percale

Ububele Educational and Psychotherapy Trust, JPCCC (Johannesburg Parent and Child Counselling Centre), and Tara Hospital’s Psychology Department hosted the fourth annual conference on 14 October 2016, exploring therapeutic work with children in the aftermath of compromised parenting.

‘Concentric Circles of Concern’ was the theme for the fourth annual conference held at Ububele on psychodynamic/systemic interventions with children and families. The conference is organised by a group of clinicians who work across public health, NGOs and private practice settings, and is co-ordinated by David Hadley, a visiting UK based Child and Adolescent Psychotherapist.

The underlying goals of the annual conference have always been twofold: first, to bring together clinicians from across agencies and disciplines to learn from one another; second, to celebrate the effectiveness of individual child psychotherapeutic work, but also to highlight that clinical work with infants, children and young people, in particular, requires close attention to, and engagement with the family and social context. Over the years the presenters have been drawn exclusively from the professional community of Johannesburg and an extraordinarily high standard has been maintained, thanks to the links that the organising group have into that community. As a consequence the conference draws large audiences with a satisfying mix of age, ethnicity, professional discipline and context.

A model of three or four short papers, followed by a plenary has evolved and led to increasing engagement by the audience with the presenters and discussants. The 2016 conference event proved particularly successful in generating this engagement. In part, this may be a consequence of increasing experience and confidence on the part of the organisers and discussants, and a developing sense of engagement by a committed audience.

Themes covered in previous years have included an exploration of how mental health professionals who work with children conceptualise and manage their engagement with the children’s parents or caregivers (2013 and 2014). In these two conferences, we tried parsing out which aspects of current clinical approaches are determined primarily by our theoretical positions and which by practical, pragmatic and contextual constraints - and how the dynamic interplay between theory and context
can catalyse the development, adaptation and implementation of models of thinking. In the 2015 conference, we turned to thinking about family therapy interventions where children are the identified patients, and explored the contribution of psychoanalytic thinking in developing systemic work with families. In 2016 we focused on the impact that parental struggles (caregiver as parent and society as parent) have on children.

IT IS WELL ACCEPTED THAT ‘GOOD ENOUGH’ PARENTING HELPS SHAPE HOW CHILDREN PUT THEMSELVES TOGETHER AND IS MIRRORED IN SOME OF THE SUCCESSES AND STRUGGLES THEY ENCOUNTER LATER IN LIFE. HOWEVER, GRIEVOUS BLOWS ALONG THE WAY CAN COMPROMISE PARENTS AND THE PARENTING PROCESS. THESE BLOWS MAY ARISE FROM PARENTAL DEATH OR ABSENCE, PSYCHIATRIC OR MEDICAL ILLNESS, SOCIO-ECONOMIC AND RACIAL DISEMPOWERMENT, AND OTHER TRAUMA. ALL OF THESE CAN IMPACT ON A CHILD’S DEVELOPING PSYCHE & IMPAIR THEIR CAPACITY TO MAKE USE OF GOOD-ENOUGH PARENTING WHEN IT AGAIN BECOMES AVAILABLE.

Birth parents or surrogate caregivers can feel stuck in a repeating cycle of failure when the internal psyche and the external environment – past and present – conspire to disempower the parenting process. Relationships and development in the family as a whole may be compromised, as well as parents’ capacities to access and use external services in a way which enables rather than usurps the parental function.

The 2016 conference was thus an attempt to explore, through carefully selected clinical case presentations, how a therapist’s understanding of the interaction of parents’ and children’s internal worlds can inform and facilitate a capacity to support caregivers to move from compromised to good-enough parenting.

The first two papers presented in this article (Part I) track the progress of traumatised young infants and their significantly traumatised carers, and the clinical work being done with the dyads. The cases highlight the harrowing painfulness, complexity, but also sometimes hopefulness of working with shared trauma in this early and critical developmental phase.

The last two papers (Part II) examine work with adolescent children of domestic employees where the employing family had taken on, sometimes undermined, and often usurped parental responsibility. Two main dynamics emerged from this particularly South African phenomenon, with a cultural and political component that the presenters made explicit. These were of the enormous difficulty of finding words to articulate the trauma of loss and violence, in what is anticipated as a hostile environment. Also, to find ways of understanding, the rhetoric of racism with its polarities and oppressive hierarchies of the past which emerge inevitably in the present.

David Hadley, in his opening address asked us to think about trauma as an earthquake - the shock waves felt after the trauma, help us to determine something about the nature of the earthquake... the depth, the cause, the likelihood of it happening again. There is evidence in the shockwave. As mental health professionals, David suggested there is a danger that we can resort to only two ways in which we respond to trauma, we shut down, or feel overwhelmed emotionally and unable to think, with the risk of re-enactment. It was suggested then, and is now, to observe the emotional impact of the clinical material. By encouraging professionals to think and process subjective experiences together, even if just in the writing and reading about it, trauma can be thought about and represented in a more manageable form. Each person will find evidence regarding the trauma from their own personal countertransference responses and together we can make sense of what has happened, rather than re-enact.

A BEGINNING OF LIFE IN THE MIDST OF TRAUMA AND DEATH - A MOTHER & CHILD’S JOURNEY

Anna Schmidt-Ehmke

To contextualise the first paper presented by Anna Schmidt-Ehmke, we need to think about the global phenomenon of being an asylum seeker, a refugee, a stranger in a sometimes hostile land. As mental health professionals working in the public health sector, we encounter individuals who have experienced unspeakable trauma in their country of birth and have fled, sometimes alone, surviving long and treacherous journeys, in this case, to South Africa. Many of these refugees have lost their families in politically motivated killings and it is here where our first presentation begins.

This paper outlined the experiences of working with a mother and her 12-month-old infant on the background of ongoing severe trauma, dislocation, and uncertainty. It described the process of trying to offer a containing therapeutic space for the mother and child dyad which went beyond the traditional therapeutic frame. The therapy worked towards creating space for both the acknowledgement of a sense of an ‘internal death’ within the mother as well as the beginning of life and connection between a mother and her child.

Anna’s patient (J) presented with disorganized behaviour and psychotic like symptoms. Clutching on to her 12 month old daughter, staff reported that she viewed everyone around her as a potential
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perpetrator out to violate and kill her. When speaking with her, she tended to dissociate and turn away. Her mood was very low.

J – was in her early 20’s, a beautiful young woman from the Democratic Republic of Congo. Her father had been a high ranking official in the army in the DRC and her mother was a businesswoman. She was the oldest sibling among five children. J reported being very close to her mother and father. J’s family was attacked by the opposition in the DRC. Her family were raped and murdered in front of her. She recalled the screams and a vast amount of blood. The perpetrators used guns and machetes. Anna reported that hearing this history was extremely hard and she had to work to hold herself together. She shared her tears with her colleagues after the session. J had then been captured by the opposition, taken hostage in the DRC. For two weeks she was repeatedly gang raped, violated, beaten and humiliated. She eventually escaped, found a place of safety and after a while a male relative organized asylum for her in South Africa. On their way to South Africa they were involved in a car accident and her uncle was killed. J had to mourn another violent loss. When she finally arrived in South Africa, she was accommodated in a shelter and began to buy and sell clothes to survive. During this time, J met a man from the DRC and began a relationship. She fell pregnant with her daughter (D). Six months into the pregnancy, the father left to find work. J and he never got back together. J reported feeling very alone. She stated that her daughter was the only family she had left. D represented an ‘aliveness’ for J and carried the burden of J’s sadness and unmet needs.

When D was 8 months old, J left her in care at the shelter and went to the local clinic to have her eyes tested. On her way there, she was confronted by three men who were affronted when she was unable to greet them in their language. They pulled her behind a deserted building, robbed and gang raped her and cut her on her thighs and chest with a knife. J ran back to the shelter in a traumatized state. Shelter personnel brought her to the Hillbrow Clinic where she was seen by the Psychologist on duty.

Anna began therapy with J when she was an inpatient in the womens biological ward at Tara. Parent-Infant Psychotherapy seemed to be the intervention which held out the possibility of assisting J to keep herself alive internally and connected to her infant.

Anna described how in the sessions she was very aware of how D might be experiencing the separation. With her big, dark brown eyes watching her intently, she would not leave her mother’s side. Slowly, D’s silence formed a contrast to her behaviour. Through play, she found her voice. Gradually trust was built. The space & contact with Anna became familiar.

Overwhelming experiences were put into words. Anna observed that D had to work hard to get her mother’s attention. J seemed suspended in a state of unbearable despair and hopelessness. When D moved close to her mother’s body, J appeared to experience it as a violent intrusion. D tried to break through J’s psychological absence. Anna described how the mental space felt filled with death.

After some time in therapy, moments of connection where J could feel delight and even love and joy for her child started to occur. However, it was mostly obvious that J was struggling to hold D and herself in mind. J would sometimes choose to come to therapy alone and talk about her need to protect her child from herself. She would talk about survivor guilt, how she missed her family, how she was a bad person for being angry towards her father for moving the family to a dangerous place, she questioned whether he was a bad person and felt her anger towards, and her love for him.

J would sometimes talk about an internal deadness and question whether she would be able to love again. She also marked the anniversary of her family’s death in a therapy session. She expressed that she sometimes wished that she had died with her family and was ashamed that she was still alive. In between these moments, Anna was aware that J was beginning to access some good within herself.

It was at this point that disaster struck. Anna received a call over a weekend from the Social Worker to say that J had been kidnapped and gang raped again by the same 3 men. They had dropped her off in Soweto, naked in the early hours of the morning. The perpetrators had threatened to kill her. J was immediately moved to a different shelter for protection. Again J was overwhelmed by feelings of trauma, helplessness and rage. Anna wondered whether J’s mindlessness and tendency to dissociate may at times make her less aware of her environment and put her at risk.
IT WAS SO HARD TO MAKE SENSE OF THE CONTINUED SUFFERING WHICH J HAD TO SURVIVE.

J did not want to move shelter and was worried about xenophobia at the new shelter. D was also very unhappy in the new shelter which was more restrictive. J felt unsafe and unsettled and was having paranoid fantasies. When she awoke to fireworks one night, J was traumatized and thought they were gunshots. J was admitted to Tara. It was felt that a multidisciplinary team including a psychiatrist and the safety of the familiar ‘brick mother’ would assist J to remain present to reality.

During her time at Tara, an application was made for J and D to be relocated to a first world country. J was eventually placed in a shelter closer to Tara so that she and D could continue to attend Parent-Infant Psychotherapy with Anna until she left. J and D also attended Occupational Therapy at Tara. Finally, J and D were assisted to relocate to Sweden. J was fearful. Anna had 2 weeks to work with J and D before their departure and this continued with phone calls from Sweden for several months: daily at first, than at reducing frequency. A significant feature of the calls was the need to be reassured of the consistency of the physical space.

The above presentation was chaired by Katharine Bain. Her commentary highlights the importance of the ‘concentric circles of concern’ which assist mental health practitioners to hold onto a thinking mind in the face of unspeakable experiences.

Katharine Bain comments:
I believe that in much of our work the unspoken communications transmitted through affect are often the most helpful, so it was with interest that I noted my own countertransference responses to this paper when I first read it.

THERE WERE FEELINGS OF SHOCK, DESPERATE SADNESS, FEAR, ANGER AND AT TIMES, DISBELIEF. I FELT ANGRY WITH J FOR HAVING ALLOWED HERSELF TO BE ATTACKED FOR A SECOND TIME IN SA AND FEAR AROUND THE FACT THAT IF THIS WAS TRUE, THAT J SOMEHOW MUST BE ATTRACTING OR ALLOWING THESE MEN TO VICTIMISE HER.

This then elicited feelings of shame in myself about “blaming the victim”. These feelings I think give some insight into how trauma can temporarily overwhelm our capacities for integration, creating powerful and often opposing emotions, and how it can break down our capacities to stay connected and compassionate. However, by the end of the paper, I felt profound admiration for J’s bravery and her capacity to put herself back together and psychically survive, which again attests to Anna’s abilities, both as a therapist, but also in how she captured J’s story in such a sensitive and three-dimensional way.

Some of these countertransference feelings may give a glimpse into J’s experiences – her shame, her possible oscillating identifications with both victim and perpetrator, her need to be dead to her pain and her frequent disconnections from herself, her baby and from Anna. The way that Anna managed to stay connected to J’s pain, was likely a strong contributor to J’s ability to tolerate it herself in moments and reconnect with the parts of herself that had preceded and endured beyond these traumas. I thought the paper dealt sensitively with the vulnerability of victims of complex trauma to further traumatic victimisation – whether an unconscious compulsion to re-live and attempt to master her most feared experiences, to punish herself for having survived, or a result of a decreased vigilance due to dissociation – her vulnerability to further victimisation, given her living circumstances and the realities of the South African context was given thoughtful consideration by her treating team.

The paper captured most beautifully J’s strength and her psychic resilience – there is indeed a lot of research that confirms that the resilience of individuals who have good enough relational experiences in childhood. Heineke and Levine (2008) state that securely attached individuals who also score as unresolved or disorganised with respect to trauma or loss on the Adult Attachment Interview are more capable of overcoming the impact of trauma. Other researchers, such as: Schuengel, van Ijzendoorn and Bakermans-Kranenburg (1999) and Jacobvitz, Leon and Hazan (2006) have also found that these individuals, as mothers, also tend to exhibit less frightening behaviour in relation to their infants than traumatised mothers with underlying insecure attachments. The absence of overt aggression in J toward D was notable. Heineke and Levine (2008) hypothesize that linked to these individuals’ abilities to better overcome trauma, is their ability to use interventions to aid their resolution of trauma. This was clearly evident in the way that J came to internalise Anna and Anna’s office in a way that offered her anchoring and a powerful sense of comfort. J was able to use the therapeutic space to process her fear and anger and the fact that she was able to develop some insight into her difficulties remaining present for her child appeared invaluable.

I thought this paper exquisitely captured the painful disconnects between mother and child. D’s perseverance in her attempts to recapture her mother’s attention were hopeful. I realise that the time limits imposed on these papers make it so hard to include everything significant, but I wondered about how difficult it must have been to get a sense of D when her mother’s pain was so overwhelming and demanding of clinical attention.

My last thought was around the concept of loss in this case. While J’s losses were acknowledged I wondered if the horror of J’s violent rapes and the murder of her family perhaps hi-jacked attention away from...
the losses. Attachment research shows that loss can be as disorganising, if not more so, to mothers’ states of mind, especially in relation to their attachments to their infants. I wondered about D’s losses and her experiences of her mother’s absences, both physical and emotional.

While it is evident that D also found her voice in the therapy and used it to find her mother, I think her play at ‘falling’ captured the real traumatic impacts of the losses they had both suffered – it seemed to be less about testing out the trustworthiness of her objects and more about a manic, repetitive enactment of an ambivalence about being, ‘a playing with dying that felt dangerous in her mother’. This would create much anxiety in the object designated to catch. I wondered if this was not the dynamic behind Anna’s vigilance and need to be constantly available for J – a feeling that J may ‘fall’ at any time.

**WHILE I THINK THERE IS STILL MUCH WORK TO BE DONE AROUND LOSS, I THINK THAT ANNA WAS THE ANGEL IN D’S NURSERY, HAVING DONE THE INITIAL AND MUCH NEEDED TRAUMA WORK WITH J AND THE CRUCIAL, TIME-SENSITIVE PARENT-INFANT WORK, WITHOUT WHICH D MAY WELL HAVE LOST HER MOTHER TO CONTINUOUS FALLING.**

Anna Schmidt-Ehmcke is a clinical psychologist who has been working at Tara, the H. Moross Centre, a specialized psychiatric hospital, for the past seven years. She is currently working in the outpatient department as well as the female biochemical inpatient ward. Her special interests include working with complex developmental trauma, severe psychopathology, and attachment difficulties. Parent-infant psychotherapy as well as psychoanalytically informed group psychotherapy are further areas of interest.

**WHEN TWO SETS OF RELATIONAL TRAUMA MEET: THE CASE OF “C” AND “D”**

Nicki Dawson

This paper presented an ongoing caregiver-infant psychotherapy with two year old baby “C” and her step-grandmother (and primary caregiver) “D”. Referred by her OT after a diagnosis of autism was ruled out, “C” presented in psychotherapy with odd self-stimulating behaviours and delayed speech. This paper will outline the therapeutic process of unpacking and processing the intensely traumatic early relational experiences of both “C” and “D”. It also outlined the subsequent developmental gains, as “C’s” odd behaviours diminished and her words came. Poignant words, like “fall”, “sore”, “broken”, and “owie”. The case makes evident how common but separate experiences of pain both support and hinder attachment in the context of family foster placement.

Nicki presented the case of “C” (2yrs) who was referred by Occupational Therapy due to developmental concerns such as slow and delayed speech, odd autistic-like behaviours, walking tiptoe. “C” did not live with her parents. She was an unwanted pregnancy and her father was a violent alcoholic. At 6 months, “C” was removed by welfare. She was malnourished and delayed and extreme neglect was suspected. “C’s” father had been using drugs and there was extreme domestic violence.

“C” has been adopted by “D”, who is “C”’s step mother. “D” described “C”’s mother as selfish, irresponsible, always in debt and unable to care for herself. “D” described herself as ‘not mothered’ as her mother was also a violent alcoholic. “D” had concerns about “C” being like her mother.

Nicki described her approach to the case which was to observe and mentalise, to wonder about “C”’s mind and to observe her play. “C” would pull cushions off the couch, run around clumsily, falling over the cushions and couch. “D” was worried about her hurting herself, as was Nicki. “C” appeared delighted by her thrill seeking game. Nicki wondered if ‘danger is always imminent’ could be a description of “C”’s earliest moments of experience with her parents.

**NICKI’S PRESENTATION MADE THE IMPORTANT POINT THAT EXPERIENCES OF ABUSE AND NEGLECT HAVE LONG BEEN LINKED TO SOME OF THE HARSHEST IMPLICATIONS OF PSYCHOLOGICAL AND GLOBAL DEVELOPMENT.**

An experience of trauma perpetrated by something impersonal, such as a hurricane – shatters our sense of the world as safe. An experience of trauma perpetrated by a strange human shatters our trust...
in humanity, but trauma perpetrated by a primary object – our attachment figure, shatters our psychic structure. Lieberman, A states that ‘trauma shatters the protective shield which requires quick repair in order to restore trust.’ Lieberman in her book ‘Don’t hit my mommy’ goes on to say that there are 2 keys steps which are central to Child-Parent Psychotherapy:
1. Know and name the unspeakable trauma. As with all infant work the focus is on conveying content through accessible words, alongside appropriate tone, affect and facial expression. This allows for the co-creation of a narrative of what was previously unspeakable in the context of empathy and containment.

Nicki made additional efforts to explore the possible experiences of “C”’s first 2 months with her parents. She met “C”’s mother who was obese and childlike. “C”’s father continued to be an unemployed drug addict who would sell appliances for money. Nicki wondered what had “C” seen and heard and experienced with her biological parents? Violent fights where she feared for her life? Nicki felt she was able to piece together vivid images of the life-threatening war zone which was “C”’s early world. She attempted to convey this to “C” and organize them for her. Using simple affective descriptions like… ‘Mom and Dad were very angry’, ‘Dad made Mom very sore’, ‘“C” was scared’ gave “C” a narrative for her experience which was commonly understood and found to be reassuring.

After 4 months of therapy, “C” was making good progress in Occupational Therapy. A follow up assessment indicated that her development was now close to age appropriate, confirmed also by her Speech Therapist. There was no indiscriminate behaviour; all her autistic-like behaviours had ceased and she was talking extensively.

SHE COULD NAME COLOURS, OBJECTS, BODY PARTS AND SHE ALSO HAD AN UNEXPECTEDLY LARGE ABSTRACT VOCABULARY…. WORDS LIKE CAREFUL, SHAME, OWIE, SORE, SORRY “C”, BITE YOU, PINCH YOU… SHE HAD FOUND WORDS FOR THE UNSPEAKABLE H Horrors WHICH SHE HAD EXPERIENCED.

However, Nicki noted that her attachment style was still anxious and ambivalent. Her affect continued to zigzag. Nicki became aware that “D” was encumbered by her own ghosts. Her responses to “C” were inconsistent. In a session where “C” appeared to have dropped something and became upset and fearful, “D” started off being firm and stern and rationalizing. Nicki observed how it was only when she reflected to “C” that maybe she was scared that she had broken something, that “D” went to her, picked her up and cuddled her.

The second key concept in Child-Parent Psychotherapy according to Lieberman, is the idea that ‘Parents’ unresolved conflicts are re-enacted with the child. The work is then to resolve these conflicts in order to shift something in the relationship. Nicki was aware that “C” was making progress but “D” was not and each of their fates lay in the hands of the other. However, “D”’s own experience of being failed as a child was largely unspoken and out of bounds. Using the Video Feedback Model, Nicki was able to assist “D” to reflect on her own experience. Watching herself attempt to soothe “C”, “D” suddenly burst into tears.

This paper suggests that both infant and Step grandmother bring their own personal traumas to each other. It is in the shared trauma that they find connection and in the shared trauma that they struggle to connect. Nicki highlights Lieberman’s second step in Parent-Child Psychotherapy which is ‘to tolerate the inevitable rage.’ She states that rage and revenge are universal responses to trauma and that trauma leads to rage. As therapists, we need to respond to this rage with corrective experiences. Nicki postulated that rage may lie under “D”’s sweet identity as selfless rescuer and that “D”’s own childhood trauma drew her to “C”…. the vulnerable, motherless, abused little girl. This was hard for “D” to look at within herself and this is where the ongoing work would focus.

**Ann Tandy comments:**
This paper demonstrated the use of a parent-child psychotherapy model to address both the child’s developmental delay, and what appears to be an autistic presentation further complicated by the caregiver’s difficulties of her own. As Nicki Dawson described in her presentation “always the problem is understood by the practitioner as something inter-subjective, something shared, something relational, something that happens in between (Stern, 2005).” The patient is the relationship (Baradon & Joyce, 2016). Fraiberg et al. (1975) are renowned for vividly depicting how, if the baby represents the parent with unresolved hurts and disappointments from the past, the baby can unknowingly haunt a parent, in a ghostlike manner, of which the parent is unaware.

AN INTERVENTION IN INFANCY ALLOWS ONE TO WORK WITH, AND POSSIBLY TRANSFORM, A VERY REAL PROBLEM: NAMELY THE BABY’S REACTION, AND OFTEN IDENTIFICATION, WITH THE PARENT’S DEFENSIVE PROCESSES (BATEMAN AND FONAGY, 2004).

This dynamic between “C”, the child and her caregiver “D”, is illustrated in the presentation.

A striking feature in this presentation was the capacity to allow a very painful narrative to unfold and to try and piece it together rather than allow the ghosts in this nursery to continue their torment of both “C”
(the child) and “D”, her carer. Through the therapist’s sensitivity, “D”, the grandmother is able to begin to reflect on her own self and the impact it has on “C”.

The beginning of what Bion terms a capacity for “reverie” which enabled something to be worked out within the mother or carer rather than to get rid of it unprocessed or undigested usually into the child.

Through the therapist’s work with “D” she seems to have the potential for this, but one has a sense that it remains unconsolidated and would require further work.

One of the challenges of parent-infant work is to resist the pull to identify with one or other of the dyad. In this case the challenge seemed to be of finding a way of working without over-identifying with the child, but keeping “C”’s parents, who subjected her to such distress and cruelty, in mind.

This paper also illustrated the beginning of a developing capacity within “C” to be soothed; the beginning of emotional regulation. With the therapist’s help “D”, the carer, was able to begin to offer her some assistance with this.

Faced with such violence and neglect, essential developmental processes get corrupted and the child has to resort to primitive defenses in order to survive. In “C”’s case it seems she has developed autistic defenses as a way of becoming almost mindless in order to manage the violence and neglect.

Does she turn to self-generated sensations for reassurance that she exists? The reliance on sensation in children with ASD features can be excessive and can interfere with the articulation of emotion and verbalizable memory. It is hard to for such a small child to begin to articulate her body memories and piece together such a fragmented and traumatized early start.

The idea of enabling “C” to organize her narrative seemed an essential component in beginning to find a sense of identity, and helping “C” to establish and maintain a relatively stable sense of self.

Maria Rhode suggests that for children on the autistic spectrum, extreme anxieties concerning bodily survival and their reliance on bodily sensation in order to counter these anxieties can interfere with symbolic capacities involved in autobiographical memory.

At the end of the paper reference is made to Lieberman’s second idea; the ability to tolerate the child’s rage. Would “D” be able to contain and tolerate “C”’s rage? Can you as the therapist be in Winnicott’s words “used as an object,” able to survive the rage? This seems a key factor in the therapeutic process.

My impression overall was the way in which psychoanalytic ideas and understanding can be used in applied contexts to understand the complex lives of so many South Africans.

Also, that in order to do this work and survive the impact, the therapist needs a time and space to process this through supervision and peer support.

Nicki Dawson is a community-based counselling psychologist, and currently works at the Ububele Educational and Psychotherapy Trust, heading up their Parent-Infant Programmes. Her clinical work is largely focused on supporting infants and young children in institutional, foster, or adoptive care. She is also currently completing her PhD at the University of Witwatersrand on “Maternal Sensitivity, Culture and Context in Alexandra Township”.

Part II of the article featuring Papers 3 and 4 will be published in the August 2017 issue of South African Psychiatry.

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

Megan Jones is a clinical psychologist who works on the Adolescent and Eating Disorders Units at Tara Hospital. She runs a small, part-time private practice where she focuses on child psychotherapy and assessment.
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Sanofi South Africa is pleased to announce that Thibault Crosnier Leconte has been appointed, as Country Chair and General Manager RX Business for South Africa, Namibia & Botswana effective March 13, 2017.

With 15 years of industry experience, Mr. Crosnier Leconte has a long and successful track record overseeing the commercial operations both in Supply Chain and Vaccines business. His background includes leadership positions at Sanofi in the UK and in Russia, where he served as the General Manager for the vaccine business.

“Having spent 15 years at Sanofi, Thibault has built an impressive track record of strategic, operational and commercial accomplishments,” said Jon Fairest, Head of Sanofi Africa. “He has proven to be a successful and trusted leader and brings to this position a strong reputation for developing people and inspiring teams. His wealth of experience across our global system, particularly in Europe, will be a valuable asset as we continue to accelerate growth through our 2020 Vision and our previously announced five strategic actions. Thibault is emblematic of the deep bench strength we have developed at Sanofi, and I could not be more pleased about his appointment to this critical role at this important time” continues Fairest.

Thibault holds a master degree from ENSAM Paris, (France) and has a track record of strong leadership both in pharma and in the vaccine business. This combined with his deep industry knowledge and institutional tenure makes Thibault uniquely qualified to lead the South Africa affiliate successfully into the future.

“I’m honored, and grateful to Sanofi Management for the opportunity to lead this exceptional organization of innovative, dedicated and talented professionals,” said Crosnier Leconte.

Sanofi is committed to protecting patients’ health, answering public healthcare needs and acting responsibly in all aspects of its business. A major element of our commitment is ensuring the quality and safety of our products. “The company has been highly successful in the past few years under the leadership of John Fagan, which has resulted in our ability to invest in further growth and new business opportunities. The challenge is to continually to evolve the business, to develop and bring to market pharmaceutical products, to meet the ever growing healthcare demands of our patients” concludes Jon Fairest. Thibault Crosnier Leconte will be based in South Africa.
The 3rd Sanofi/Zentiva 2017 Psychiatry-in-Focus Meeting was held on the 24th - 26th February 2017 at the Mount Grace in the Magaliesberg. The event was attended by 120 psychiatrists from around the country and featured a range of speakers covering a variety of topics:

Value Based Care - Ms L Grace (Discovery); Telepsychiatry - Dr S Salduker (Psychiatrist in Private Practice, Durban); Assessment and Management of Traumatic Brain Injury - Dr A Pillay (Psychiatrist - Charlotte Maxeke JHB Academic Hospital); So much information, so little wisdom. So much haste, so little time - Dr R Liebenberg & Dr E Holzapfel (both Psychiatrists in Private Practice, Gauteng); Approach to Anxiety Disorders and Management in Children - Dr A Lachman; Fibromyalgia - Dr E Allers (Psychiatrist in Private Practice, Gauteng); Role of the Psychiatrist in Custody Battles - Mr A Townsend (Clinical Psychologist Specialising in Neuropsychology & Forensic Psychology, Gauteng); Business of Medical Schemes from a Psychiatrist MBA Perspective - Dr R Schoeman (Psychiatrist in Private Practice, Western Cape); Roles and Responsibilities of the Funder, Council of Medical Schemes, Patients and Psychiatrists - Ms E Klinck (Specializes in health law, policy and other services to health sector and other role players).
Exsira significantly improves work impairment in major depressive disorder, by reducing absenteeism and increasing productivity* ¹,²

* As measured by the WPAI (Work Productivity and Activity Impairment) scale.


Exsira desvenlafaxine
efficacy made simple ¹,²
The World Health Organisation (WHO) estimates that 350 million people of all ages suffer from depression, making it the leading cause of disability worldwide. Suicidè, the most severe outcome of a depressive episode, is the second leading cause of death among young adults between the ages of 15 and 29 years and the fifth leading cause of death among 30-49 year olds. Depression is a complex disease with variable and diverse presentations. These may be seemingly unrelated conditions, such as accident proneness or erectile dysfunction, such that the depression itself is ‘masked’ and remains undiagnosed. Even in those who are diagnosed, treatment is difficult. At least 30% of patients do not respond to pharmacotherapy and more than three quarters are at risk of relapse or chronic symptoms. Furthermore, depression is frequently comorbid, co-occurring with a vast array of pathologies, including anxiety, panic attacks, alcohol and substance abuse, and somatic illnesses such as cancer, diabetes and chronic pain. In recent years, socioeconomic pressures have contributed significantly to increases in the prevalence of depression. People of all ages are subjected to unrelenting psychosocial stress, which may severely impact on both physical and psychological health. Clearly, pharmacotherapy and the traditional aims of treatment, namely symptom reduction and improved functionality, do not go far enough to effectively manage the causes, symptoms and course of depression. Recently, a third goal of treatment has been described that may improve health, not only in people with depression and other mental health issues, but in society in general. The concept of ‘wellness’ recognises the need to address the profound detrimental impact of modern lifestyle on physical and mental health, in terms of unhealthy changes and neglect in approaches to nutrition, physical activity, social engagement, thinking and coping skills. Past president of the American Psychiatric Association, Dilip Jeste, points out that the aim of psychiatric treatment should not only be to reduce symptoms, but rather to help patients ‘grow and flourish’. This entails nurturing positive psychological traits, including resilience, optimism, wisdom, self-efficacy (belief in one’s own ability to manage and influence one’s own life) and social engagement. These positive traits are tightly linked to human biology and associated with significant positive health outcomes. Indeed, studies have indicated that these attitudes are associated with healthy behaviours, longevity, better functioning and reduced susceptibility to mental and physical disorders, including depression, cancer and cardiometabolic diseases. In depression, resilience in particular is important, being a significant determinant in the ability to manage life stressors and risk of relapse after an initial depressive episode.
THE WILD 5 WELLNESS INTERVENTION PROGRAM

The Wellness Interventions for Life’s Demands (WILD) 5 program was designed to meet the needs of a practical and achievable, trackable, accountable, self-directed wellness program for patients with depression.

IT ENCOURAGES AND GUIDES PATIENTS TO DEVELOP AND INCORPORATE FIVE ELEMENTS OF WELLNESS INTO THEIR DAILY ROUTINE, NAMELY PHYSICAL EXERCISE, MINDFULNESS, OPTIMISED SLEEP AND NUTRITION, AND IMPROVEMENT IN SOCIAL CONNECTEDNESS.

These elements were selected because each one of them has been previously demonstrated to improve mental wellness scores with sustainable benefits. WILD 5 is supported by online resources that are available to both the treating clinicians and participating patients.

Patients are introduced to the program during a 30-day induction phase, which is individualised according to their capabilities and modified (e.g. for pain, limitations of movement) if necessary. Thereafter, the behaviours should be continued for life. Program expectations for the initial induction period are listed in Table I. Daily program activities are documented using a Participant Tracking Form.

It is helpful to remind patients that perfection is not the goal, but that sustained participation to the best of one’s ability in all of the five elements is essential if one is to benefit from the program. There is no wear-off effect associated with wellness behaviours, which may be started at any age, and the benefit improves with time and practice. Tracking daily progress motivates patients to adhere to the program, whereas without tracking the drop-out rate is likely to be high.

In a small pilot study, including 36 patients, WILD 5 was shown to significantly improve mental wellness in terms of mood, anxiety, sleep, mindfulness and social connectivity, both in those taking and not taking psychotropic drugs.

Patients generally found the program easy to implement into daily life. Compliance with the 30-day program was similar regardless of medication, being highest for social connectedness (28 days) and sleep (25 days), and lowest for mindfulness (18 days).

WILD 5 IN DIFFICULT TO TREAT POPULATIONS

Positive results using a WILD 5 induction program have also been obtained in two separate populations of patients, one with severe anxiety and one with chronic pain, both of which are frequently difficult to manage.

TO CONTROL FOR THE INFLUENCE OF PERCEIVED SPECIAL CARE, GUIDANCE THROUGH THE PROGRAM WAS CONDUCTED TELEPHONICALLY AND PATIENTS WERE ASKED TO DOWNLOAD A FREE WELLNESS SOFTWARE APPLICATION ON TO THEIR MOBILE DEVICE. A WORKBOOK AND EDUCATIONAL BOOKLETS FOR EACH OF THE FIVE COMPONENTS WAS AVAILABLE TO DOWNLOAD FROM THE WEBSITE.

In patients with severe anxiety (N=50; GAD-7 score ≥10) in addition to depression or bipolar depression, a 30 day induction program was associated with improvements in emotional eating, sleep, depression and anxiety, and markers of wellness, including happiness, optimism, enthusiasm and resilience (Table II).

Table I. WILD 5 program expectations

<table>
<thead>
<tr>
<th>Exercise</th>
<th>Exercise for 30 minutes every day for 30 days, at least moderate intensity. Patient capabilities need to be taken into account. Start with low intensity activity and increase intensity according to developing capability.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mindfulness</td>
<td>Practice mindfulness at least 8 minutes each day for 30 days.</td>
</tr>
<tr>
<td>Sleep</td>
<td>Implement at least 4 of 6 pro-sleep hygiene practices each day for 30 days:</td>
</tr>
<tr>
<td></td>
<td>• If you are unable to sleep, get up and go to another room.</td>
</tr>
<tr>
<td></td>
<td>• Do something quiet, calm and relaxing in dim light.</td>
</tr>
<tr>
<td></td>
<td>• Do not fall asleep anywhere other than your bed.</td>
</tr>
<tr>
<td></td>
<td>• Do not watch the clock.</td>
</tr>
<tr>
<td></td>
<td>• Go back to bed when sleepy.</td>
</tr>
<tr>
<td></td>
<td>• Always use the alarm in the morning set for the same time.</td>
</tr>
<tr>
<td>Social connectedness</td>
<td>Text or call family members or friends each day for 30 days.</td>
</tr>
</tbody>
</table>

Protocols for these expectations and a workbook for tracking the activities may be downloaded from www.wildresources.com (password: wellnessmatters).
These latter wellness characteristics were measured using an 11-point numeric rating scale (NRS) from 0 to 10, in which a higher score denotes greater wellbeing. Similar results were obtained in a group of 39 patients with chronic pain, 36 of whom had a comorbid mental disorder. Patients were included if they had experienced pain for at least 4 days per week for 6 months or longer, with or without chronic opioid therapy. After 30 days, there was a 46% improvement in depression score (PHQ-9) and 40% improvement in anxiety score (GAD-7). Total sleep time was increased by 36 minutes. Improvements were also observed in measures of functionality, productivity and performance at work, resilience and optimism (Table III). The mean overall improvement in wellness was 42.8% (standard deviation 22.2%). Individual components of the Brief Pain Inventory (BPI) improved by 21% to 31%, with the exception of pain interference with sleep. Nevertheless, all changes in the BPI were statistically significant. Although WILD 5 should not be seen as a stand-alone management program for chronic pain, this small pilot study suggests that it may be an effective and safe strategy to augment usual treatment.

### Table II. Results before and after participation in the WILD 5 30-day program in patients with GAD

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Pre-study score (mean)</th>
<th>Post-study score (mean)</th>
<th>Percentage change (mean)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional eating (DEBQ)</td>
<td>37.5</td>
<td>33.2</td>
<td>11%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Insomnia (PSQI)</td>
<td>12.4</td>
<td>8.5</td>
<td>31%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Anxiety (GAD-7)</td>
<td>15.2</td>
<td>8.3</td>
<td>45%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Depression (PHQ-9)</td>
<td>15.1</td>
<td>8.4</td>
<td>44%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Happiness (NRS)</td>
<td>3.3</td>
<td>4.6</td>
<td>39%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Enthusiasm (NRS)</td>
<td>2.5</td>
<td>4.4</td>
<td>76%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Optimism (NRS)</td>
<td>3.1</td>
<td>4.6</td>
<td>48%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Resilience (NRS)</td>
<td>2.7</td>
<td>4.8</td>
<td>77%</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

DEBQ: Dutch Eating Behaviour Questionnaire; PSQI: Pittsburgh Sleep Quality index; GAD-7: Generalised Anxiety Disorder 7-item scale; PHQ-9: Patient Health Questionnaire 9 item version.

### Table III. Results before and after participation in the WILD 5 30-day program in patients with chronic pain

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Rating Scale</th>
<th>Pre-study score (mean)</th>
<th>Post-study score (mean)</th>
<th>Percentage change (mean)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>PHQ-9</td>
<td>12.1</td>
<td>6.5</td>
<td>46%</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Anxiety</td>
<td>GAD-7</td>
<td>9.8</td>
<td>5.8</td>
<td>40%</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Wellness</td>
<td>WHO-5</td>
<td>8.3</td>
<td>13.1</td>
<td>57%</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Sleep</td>
<td>PSQI</td>
<td>11.5</td>
<td>7.7</td>
<td>33%</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Total hours slept</td>
<td>PSQI</td>
<td>6.4</td>
<td>7.0</td>
<td>9%</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Mindfulness</td>
<td>MAAS</td>
<td>53.6</td>
<td>64.1</td>
<td>19%</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Social connectedness</td>
<td>SCS</td>
<td>28.5</td>
<td>36.8</td>
<td>29%</td>
<td></td>
</tr>
<tr>
<td>Emotional (binge) eating</td>
<td>DEBQ</td>
<td>33.9</td>
<td>29.1</td>
<td>14%</td>
<td>0.003</td>
</tr>
<tr>
<td>Disability</td>
<td>SDS</td>
<td>12.2</td>
<td>8.1</td>
<td>33%</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Work productivity</td>
<td>EWPS</td>
<td>38.1</td>
<td>28.9</td>
<td>24%</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Happiness</td>
<td>NRS (0-10)</td>
<td>3.8</td>
<td>4.9</td>
<td>28%</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Mental wellness</td>
<td>NRS (0-10)</td>
<td>3.7</td>
<td>5.4</td>
<td>45%</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Optimism</td>
<td>NRS (0-10)</td>
<td>3.4</td>
<td>5.2</td>
<td>52%</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Enthusiasm</td>
<td>NRS (0-10)</td>
<td>3.0</td>
<td>4.6</td>
<td>53%</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Resilience</td>
<td>NRS (0-10)</td>
<td>3.3</td>
<td>5.3</td>
<td>60%</td>
<td>&lt;0.0001</td>
</tr>
</tbody>
</table>

PHQ-9: Patient Health Questionnaire 9 item version; GAD-7: Generalised Anxiety Disorder 7-item scale; WHO-5: World Health Organisation (Five) Well-Being Index; PSQI: Pittsburgh Sleep Quality index; MAAS: Mindful Attention Awareness Scale; SCS: Social Connectedness Scale; DEBQ: Dutch Eating Behaviour Questionnaire; SDS: Sheehan Disability Scale; EWPS: Endicott Work productivity Scale; NRS (0-10): 11-point numeric rating scale.
BACKGROUND AND RATIONALE FOR THE INDIVIDUAL COMPONENTS OF WILD 5

1. Exercise

There is a large body of evidence confirming that exercise improves mood and energy levels in patients with depression, which itself is associated with tiredness and fatigue, and reduced motivation and drive. A large Cochrane meta-analysis of 39 studies concluded that exercise improves symptoms of depression, but needs to be continued in the longer term for the benefits to be maintained.14 Benefits of sustained exercise were greater than control intervention and comparable to those achieved with psychological and antidepressant pharmacological treatments.14,15

The mechanisms behind the effects of exercise on mood and wellbeing are multifactorial. Fatigue and impaired executive function, which in turn reduces the motivation to be physically active, in depressed people is linked to disturbed cerebral dopaminergic and noradrenergic transmission.

THERE IS A BIDIRECTIONAL RELATIONSHIP BETWEEN PHYSICAL ACTIVITY AND MONOAMINE NEUROTRANSMISSION IN THAT EXERCISE MODULATES DOPAMINE AND NORADRENALINE ACTIVITY IN BRAIN REGIONS LINKED TO COGNITIVE AND MOTOR FUNCTION, WHICH IN TURN MAY INCREASE THE ABILITY AND MOTIVATION TO EXERCISE.

It important to note that the individual monoamines do not work in isolation, and dopamine, noradrenaline and serotonin receive reciprocal regulation from each other. This interrelationship is complex. For example, whereas under physiological conditions, serotonin induces dopamine secretion, by selectively increasing serotonin concentrations, selective serotonin re-uptake inhibitors (SSRIs) may worsen deficiencies in dopaminergic activity in areas of the brain associated with movement control and motivation (e.g., prefrontal cortex, striatum and cerebellum) and contribute to fatigue.16-18

The synthesis and secretion of serotonin (5-hydroxytryptamine; 5-HT) in the brain and expression of serotonin receptors are also modulated by exercise. These effects depend on the intensity of exercise and vary in different regions of the brain, where 5-HT levels have a significant influence on mood, cognition, fatigue and motor performance.18

Changes in tryptophan metabolism during stress and exercise are fundamental to regulation of mood. Tryptophan is an essential amino acid precursor required for the synthesis of proteins, 5-HT and niacin. In peripheral body tissues, including skeletal muscle, liver and white blood cells, the primary pathway by which it is metabolised, accounting for approximately 95% of its metabolism, is the kynurenine pathway.

STRESS HORMONES, SUCH AS CORTISOL, OR INFLAMMATORY MEDIATORS, SUCH AS INTERFERON-γ, INDUCE THE LIVER AND MONOCYTES TO INCREASE EXPRESSION OF ENZYMES THAT DRIVE THIS PATHWAY, RESULTING IN THE FORMATION OF, AND EXCESSIVE INCREASES IN CIRCULATING KYNURENINE. KYNURENINE CROSSES THE BLOOD BRAIN BARRIER, WHEREAFTER IT IS CONVERTED TO A NUMBER OF NEUROACTIVE AND NEUROTOXIC METABOLITES.

In the brain, these metabolites increase inflammation and alter neurotransmission, effects which have been implicated in the pathophysiology of a number of brain disorders, including depression. Animal studies have shown that moderate intensity exercise induces the expression in skeletal muscle of PGC-1α transcriptional cofactors, and importantly PGC-1α1. In turn, these transcriptional cofactors activate the PGC-1α1-PPARα/β pathway causing increased expression of kynurenine aminotransferases (KATs), which convert kynurenine into kynurenic acid. Because kynurenic acid is incapable of crossing the blood-brain barrier, this additional exercise-associated pathway increases resilience to stress by limiting the amount of kynurenine that reaches the brain and thereby reducing the generation of metabolites associated with these pathophysiological states.19-21

Importantly, studies have shown that PGC-1α1 expression is reduced in older people and in those with type 2 diabetes. Lower levels of PGC-1α1 may be associated with increased accumulation of kynurenine in the brain, contributing to co-existing depression.19 By increasing the activity of the PGC-1α1-PPARα/βKAT-kynurenine pathway, exercise may increase resilience to stress and be a helpful adjunct in the management of patients with depression.20

STRESS-INDUCED PRO-INFLAMMATORY MEDIATORS MAY ALSO MODULATE DEPRESSION BY A DIRECT EFFECT ON SEROTONIN ITSELF.

Under normal circumstances tryptophan is transported from the periphery across the blood-brain barrier where it is converted to 5-HT in the brain. Increased expression of the kynurenine pathway increases the rate of tryptophan degradation, resulting in a peripheral deficit of the amino acid. This may lead to an insufficient availability of tryptophan to cross into the central nervous system and contribute to a deficiency in 5-HT. Furthermore, in the brain, pro-inflammatory mediators, such as IFN-γ, IFN-α, IL-1β and TNF-α directly upregulate serotonin transporter proteins, leading to increased re-uptake of 5HT, thereby reducing extracellular concentrations of the neurotransmitter.21
Neurotoxicity associated with these pathways (and specifically overstimulation of NMDA receptors) may also contribute to neurodegeneration associated with depression and the hippocampal atrophy that has been demonstrated with brain imaging in studies of people with major depression. The associated deficiency in the normal regulatory role of the hippocampus on the activity of the hypothalamic-pituitary-adrenal (HPA) axis may result in HPA axis overactivity, setting up a vicious cycle of stress, chronic inflammation, neurotoxicity and psychopathology. It is interesting that physical exercise has been shown to induce rapid changes in angiogenesis and neuronal cell proliferation in the hippocampus, leading to a significant increase in hippocampal volume within 10 days.

**POSITIVE PSYCHOLOGICAL EFFECTS OF EXERCISE ARE WELL DESCRIBED AND CAN ALSO BE DEMONSTRATED OBJECTIVELY BY MEASURING ENDОGENOUS CANNABINOID (CB) OR OPIOID SIGNALLING ACTIVITY.**

In animal studies, in comparison to sedentary controls, 8 days of voluntary exercise significantly increased CB1 receptor site binding density. In human athletes, visual analogue scale (VAS) scores taken before and after exercise indicated significant increases in happiness and euphoria after running, which were associated with reductions in opioid receptor availability in prefrontal and limbic/paralimbic brain structures.

Taking both neurophysiological and clinical studies into account, the following is recommended in terms of exercise as part of a management program for patients with depression:

1. Exercise should include both aerobic and resistance training.
2. The optimal number of exercise session per week is no less than 5.
3. Exercise should be of at least moderate intensity.
4. Duration of each individual exercise session may be 20-30 minutes, but it may be acceptable to break this up into several shorter intervals during the day.
5. There appears to be no plateau of the benefits achieved with exercise over time and a daily exercise routine needs to become a life-long practice.
6. Taking into consideration capabilities, available resources and achievable goals, a sustainable exercise plan will need to be individually tailored to each patient.
7. Keeping a diary of mood before and after exercise can help to illustrate the benefit to patients and motivate them to continue.
8. Motivational interviewing is helpful to assist patient in finding solutions to barriers that might prevent them for beginning and sustaining a lifestyle that includes regular exercise.

**2. MINDFULNESS**

Mindfulness may be defined as “the awareness that emerges through paying attention on purpose, in the present moment, and non-judgmentally, to the unfolding of experience moment by moment.” It involves a consciousness of sensations, perceptions, emotions and thoughts and is the attentional state that underlies all forms of meditation.

**MINDFULNESS-BASED COGNITIVE THERAPY (MBCT) IS BELIEVED TO WORK BY REDUCING COGNITIVE AND EMOTIONAL REACTIVITY TO STRESSFUL EVENTS AND PROMOTING RESILIENCE.**

It has been shown to assist in recovery from a variety of painful and psychological conditions, especially depression and anxiety. In unstable patients with major depressive disorder who had achieved remission, MBCT was as effective as medication in preventing relapse over a two-year period, reducing the risk of relapse by more than one half in comparison to placebo.

Magnetic resonance imaging studies have demonstrated that regular mindfulness mediation has neuroplastic effects that influence brain structure. In comparison to nonmeditating matched control subjects, meditators had volumetric changes in numerous areas of the brain involved in learning and memory processes, emotion regulation, self-referential processing and perspective, including cortical gray matter, cerebellum, amygdala and hippocampus.

The stress response and inflammatory activity is also affected by mindfulness. In comparison to novices, expert yoga practitioners had a markedly attenuated stress response, indicated by lower interleukin-6 (IL6) plasma levels and lower heart rate at baseline and after being exposed to stressful stimuli. Both returned to baseline levels faster in the expert group.

**YOGA SESSIONS WERE ASSOCIATED WITH INCREASES IN POSITIVE AFFECT SCORES.**

These data suggest that regular yoga practice may reduce inflammation below levels predicted by such key risk factors as age, abdominal adiposity, cardiorespiratory fitness, and depressive symptoms.

**3. SLEEP**

Insomnia is a common problem that is under-recognised and undertreated. In a large telephone survey of more than 10 000 adults in America, Europe and Japan, more than one third reported difficulty falling asleep, maintaining sleep and/or poor quality of sleep that significantly affected quality of life. It is estimated that up to one half of adults suffer from at least subthreshold insomnia problems and up to
one in six has chronic insomnia. More than two thirds of patients consulting their general practitioner complain of insomnia. Parts of the brain that manage memory, concentration, decision-making, emotional regulation and alertness are significantly impaired by insomnia. Obesity, depression, anxiety, drug and alcohol abuse all share a bidirectional relationship with sleep disorders. In addition to psychiatric illnesses, many other health problems are associated with insomnia, including cardiovascular disease, gastrointestinal disorders, neurologic diseases and cancer.

Recently, the discovery of the ‘glymphatic system’ has helped to explain, at least in part, why sleep is so important to health. The glymphatic system is a network of perivascular tunnels formed by astroglial cells in the brain that promotes efficient elimination of soluble proteins, metabolites and potentially neurotoxic waste products, including β-amyloid and tau, from the central nervous system. In addition, it facilitates brain-wide distribution of various compounds including glucose, lipids, amino acids, growth factors and neuromodulators. The glymphatic system functions almost exclusively during sleep and is switched off during wakefulness. Glymphatic dysfunction may provide the link between impaired sleep, disturbed cognition, psychiatric and neurodegenerative diseases.

Benzodiazepines and other treatments for insomnia
Use of medication to manage sleep complaints generally tends to compound the problem and should be avoided. Concerns associated with short and long-term benzodiazepine use are listed in Table IV. Depressed patients already taking benzodiazepines should be slowly weaned (over approximately a month) until the medication can be discontinued altogether.

Table IV Concerns associated with short- and long-term use of benzodiazepines
- Over-sedation
- Drug interactions
- Cognitive difficulties
- Neurodegeneration
- Falls and associated trauma
- Reduced mobility and driving skills
- Poor sleep quality
- Depression & emotional blunting
- Adverse effects (elderly; pregnancy)
- Drug abuse/dependence
- Socio-economic costs with long-term use

Nonpharmacological treatment options to manage insomnia include sleep restriction, cognitive therapy, paradoxical intention and sleep hygiene education. General sleep health recommendations, and those used in WILD 5 are listed in Table V.

Table V Sleep health recommendations
- The bed is only for sleep & sex.
- Avoid daytime napping.
- Avoid caffeinated drinks from 14h00.
- Electronic devices should be avoided within 90 minutes before bed time.
- Enjoy a warm bath or shower before bed
- Eliminate ambient light in the bedroom.
- If you are unable to sleep, get up & go to another room.
- Do something quiet, calm & relaxing in dim light.*
- Do not fall asleep anywhere other than your bed.*
- Do not watch the clock.*
- Go back to bed when sleepy.*
- Always use the alarm in the morning set for the same time.*
- Ensure adequate sleep on weekends to compensate for the sleep debt accumulated during the working week.
- Patients participating in WILD 5 were asked to observe at least 4 of these 6 recommendations.

4. SOCIAL CONNECTEDNESS

Although large studies suggest that conversation is one of the activities that people associate with the greatest degree of happiness, technological progress seems to be distancing people from each other and reducing face-to-face interaction. On the other hand, people with depression tend to prefer to isolate themselves from others and do so on purpose.

A wealth of evidence indicates that social isolation and lack of meaningful relationships are risk factors, not only for psychological disorders, but for poor health in general.

Life events involving social rejection are associated with activation of brain areas involved in processing negative affect and distress, and upregulation of the HPA-axis, sympathetic-adrenal-medullary axis and inflammatory response. These neurophysiological events are, in turn, associated with clinical depression. Similarly, social isolation has been linked to increased incidences of psychological stress, depression and coronary artery disease, independent of other cardiovascular risk factors.

Community-based studies suggest that positive health benefits of social integration may extend to increased longevity, and lower levels of cancer, fatal cardiovascular events, depression and anxiety; less severe cognitive decline with aging; improved
Social integration helps to promote emotional wellbeing and positive feelings of identity, purpose, self-worth and security independently. In doing so, it induces physiological responses that are beneficial to both mental and overall health. Furthermore, being part of society motivates one to care for oneself. Both quality and quantity of social interactions are important to health. Quality in terms of positivity and happiness of the individuals involved, strength of the bond between individuals, level of conversation and enjoyability of the interaction; and quantity in terms of regularity, where daily contact should be encouraged.

5. NUTRITION

Obesity is a common, multifactorial condition associated with significant health risks, including, among others, cardiovascular disease, type 2 diabetes mellitus, sleep apnoea, other respiratory conditions and cancer.49 For most people, diet is the primary determinant of whether or not they maintain a healthy body weight as they age.

Obesity also has a significant impact on mental health, and is associated with increased risk of mood and bipolar disorders, generalised anxiety, panic disorder and agoraphobia in both men and women.50 The relationship between obesity and depression is bidirectional. In comparison to those with normal BMI, obese women were almost 4 times as likely to suffer from depression; whereas depression is significantly associated with reduced physical activity and increased caloric intake.51 Depression and obesity share common pathophysiologicals and both are influenced by gene-environment interactions. Shared neuropeptidergic and neurotransmitter systems include corticotrophin releasing hormone (CRH), neuropeptide Y, serotonin and noradrenaline, insulin-like growth factor-1, and leptin. Both depression and obesity are proinflammatory states. Depression is characterised by overactivation of the HPA axis. Adipose tissue is metabolically active and associated with activation of the immune system and the production of inflammatory cytokines. These cytokines cross the blood-brain barrier and increase the risk of depression through their interaction with virtually every pathophysiologic domain relevant to it, including effects on the serotonergic, dopaminergic, glutaminergic and monoaminergic systems, neuroendocrine function and synaptic plasticity.52,53

Modern diets consist of an overabundance of macronutrients, calories, fats, and carbohydrates, but insufficient micronutrients, such as vitamins and minerals. In order to improve mental health and overall wellness, a balanced diet is required that consists of healthy combinations of proteins, healthy fats and carbohydrates, and sufficient intake of micronutrients. However, people with psychiatric symptoms frequently do not consume a balanced, nutrient-rich diet. Deficiency of micronutrients plays a significant causative role in mental illness, exacerbates symptoms and interferes with recovery. In particular, B vitamins (B2, B6, B9 and B12) are required for proper functioning of the methylation cycle, which controls monoamine production (including serotonin, dopamine and noradrenaline), DNA synthesis and maintenance of phospholipids, such as myelin. Fat-soluble vitamins A, D, and E play important roles in genetic transcription, antioxidant recycling and inflammatory regulation in the brain.54 Deficiencies can therefore directly influence brain function.

The MIND diet

Both the Mediterranean and DASH (Dietary Approaches to Stop Hypertension) diets, which emphasise the importance of micronutrient-rich foods, omega-3 fatty acids and fibre-rich foods, and discourage consumption of saturated fats and refined carbohydrates, have been shown to slow cognitive decline or reduce the risk of dementia.55-58 Moderate adherence to the Mediterranean diet was also associated with reduced risk of depression.55

The MIND (Mediterranean-DASH Intervention for Neurodegenerative Delay) diet was developed by combining these two diets, with emphasis on antioxidants, omega-3 fatty acids (in particular DHA) and B vitamins - the dietary components linked to neuroprotection and prevention of cognitive decline (Table VI).59,60 Like the Mediterranean and DASH diets, the MIND diet emphasises natural plant-based foods, but goes further in specifying frequent consumption of berries and green leafy vegetables. Whereas high adherence to the Mediterranean and DASH diets was associated with 54% and 39% reduction in risk of dementia, respectively, even moderate adherence to the MIND diet was associated with reduced risk (35% risk reduction for high adherence).60

Table VI MIND diet

<table>
<thead>
<tr>
<th>Recommended foods (brain healthy foods)</th>
<th>Unhealthy foods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green leafy vegetables</td>
<td>Red meats</td>
</tr>
<tr>
<td>Other vegetables</td>
<td>Butter and stick margarine</td>
</tr>
<tr>
<td>Nuts</td>
<td>Cheese</td>
</tr>
<tr>
<td>Berries</td>
<td>Pastries and sweets</td>
</tr>
<tr>
<td>Beans</td>
<td>Fried/fast foods</td>
</tr>
<tr>
<td>Whole grains</td>
<td></td>
</tr>
<tr>
<td>Fish</td>
<td></td>
</tr>
<tr>
<td>Poultry</td>
<td></td>
</tr>
<tr>
<td>Olive oil</td>
<td></td>
</tr>
<tr>
<td>Wine</td>
<td></td>
</tr>
</tbody>
</table>
MINDFUL EATING

Mindful eating is a learned mindfulness activity that relates to paying special attention to the experience of eating from moment to moment, nonjudgmentally. It begins with making conscious food choices, being aware of physical vs. psychological hunger and satiety cues, and eating healthily in response to those cues.

During eating, the mindful individual would pay attention to seeing what is on the plate, experiencing the aromas, and being aware of the movements and sensations associated with eating, tasting and swallowing.

Mindfulness shifts attention to the environment to attention to the thoughts, actions and sensations associated with the eating experience, and appreciation of those.\textsuperscript{61,62}

Mindful eating has been shown to have numerous benefits, including positive health effects in obese subjects and those with type 2 diabetes. Benefits include healthier food selection, greater cognitive control over eating behaviour, lower calorie intake, reduced binge and emotional eating, weight reduction, reduced fasting glucose and improved overall glycaemic control (HbA1c), and a reduction of depressive symptoms.\textsuperscript{63-65}

Wellness behaviour change among subjects participating in WILD 5

Telephonic guidance and provision of detailed written information, combined with online resources and smartphone applications, motivated and empowered patients to positively change their behaviours in each of the five wellness elements. Some of the behaviour changes over one month of study are summarised in Table VII.

### Table VII. Positive behaviour change over 30 days in WILD 5 (n=79)

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Pre-study score (mean)</th>
<th>Post-study score (mean)</th>
<th>Percentage change (mean)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exercise</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days with exercise during 30 day study period</td>
<td>18</td>
<td>(range 3-300)</td>
<td></td>
</tr>
<tr>
<td>Days with exercise per week</td>
<td>2.0</td>
<td>4.3</td>
<td>100% increase</td>
</tr>
<tr>
<td>Mean exercise intensity</td>
<td></td>
<td></td>
<td>48% increase</td>
</tr>
<tr>
<td>Mean exercise duration</td>
<td></td>
<td></td>
<td>29% increase</td>
</tr>
<tr>
<td><strong>Mindfulness</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of days with mindfulness practice during 30 day study period</td>
<td>21.4</td>
<td>(range 6-30)</td>
<td></td>
</tr>
<tr>
<td>Number of days with 8 minutes of mindful practice per week</td>
<td>1</td>
<td>5</td>
<td>36% increase</td>
</tr>
<tr>
<td>Ability to stay in present moment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative and/or judgemental feelings in response to thoughts (NRS; 0-10)</td>
<td>5.5</td>
<td>3.4</td>
<td></td>
</tr>
<tr>
<td><strong>Sleep</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total sleep time</td>
<td>6.9</td>
<td>7.3 (additional 24 minutes)</td>
<td></td>
</tr>
<tr>
<td>Quality of sleep (NRS; 0-10)</td>
<td>3.8</td>
<td>5.6</td>
<td>47% improvement</td>
</tr>
<tr>
<td><strong>Social connectedness</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feelings of isolation (NRS; 0-10)</td>
<td>4.5</td>
<td>2.8</td>
<td>37% improvement</td>
</tr>
<tr>
<td>How connected do you feel to family and friends in the last 7 days? (NRS; 0-10)</td>
<td>4.7</td>
<td>6.5</td>
<td>38% improvement</td>
</tr>
<tr>
<td>How connected do you feel to social life and community in the last 7 days? (NRS; 0-10)</td>
<td>3.4</td>
<td>6.1</td>
<td>79% improvement</td>
</tr>
<tr>
<td><strong>Nutrition</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often have you practiced mindful eating in the last 7 days?</td>
<td>3.2 days</td>
<td>6.1 days</td>
<td>90% increase</td>
</tr>
</tbody>
</table>

NRS; 0-10: 11-point numeric rating scale
More information about WILD 5 can be obtained from www.wild5resources.com (password: wellnessmatters).

References

10. Jain S, Jain R, Mittal Kumar L. WILD 5 Wellness: impact of a five-pronged (exercise, mindfulness, sleep, social connectedness, & nutrition) 30-day wellness routine can significantly improve clinical outcomes in patients with mood disorders and chronic pain. It is important to note that the benefits of WILD 5 are dependent on participation in all five of the wellness components and as an adjunct to usual therapy. Of course, mindfulness, exercise, sleep, healthy nutrition and socialisation are not new. They are normal life skills. Unfortunately, they are skills that society seems to be losing as it becomes more sedentary, and dependent on technology and the conveniences of modern living.

As such, the WILD 5 program will not only be of benefit to patients. It is a lifestyle of behaviours that would benefit all in the pursuit of living a happy, meaningful, and healthy life. It will help all of us to grow and flourish.

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CONCLUSIONS

WILD 5 is the first complete wellness program available to clinicians with ready-to-use support materials that can be downloaded free of charge from the internet. Although the WILD 5 pilot study was small and of short duration, the results are extremely encouraging. We believe that five wellness interventions that are relatively easy for patients to incorporate into their daily routine can significantly improve clinical outcomes in patients with mood disorders and chronic pain. It is important to note that the benefits of WILD 5 are dependent on participation in all five of the wellness components and as an adjunct to usual therapy. Of course, mindfulness, exercise, sleep, healthy nutrition and socialisation are not new. They are normal life skills. Unfortunately, they are skills that society seems to be losing as it becomes more sedentary, and dependent on technology and the conveniences of modern living.

More information about WILD 5 can be obtained from www.wild5resources.com (password: wellnessmatters).
Dr Carina Marsay attended the 2016 International Marcé Society Conference. The Marcé Society aims to promote, facilitate and communicate about research into all aspects of the mental health of women, their infants and partners around the time of childbirth. The theme of this year’s conference, held in Melbourne, Australia was ‘Frontiers in Perinatal Mental Health – looking to the future’. Dr Carina Marsay, PhD student and honorary joint appointee at the Department of Psychiatry at Wits University, presented a paper entitled “Validation of the Whooley questions for antenatal depression and anxiety among low-income women in urban South Africa”.

FELLOWSHIP AWARD

Dr Nirvana Morgan was awarded a Cassandra Miller-Butterworth Wits Clinician Scientist PhD Fellowship 2017-2020. For the duration of the Fellowship she will remain an honorary appointment in the Department of Psychiatry.
UNIVERSITY OF CAPE TOWN

PROF COLLEEN ADNAMS

Head of the Division of Intellectual Disability in the Department, was voted as President-Elect of the International Association for the Study of Intellectual and Developmental Disabilities (IASSIDD). The association is the first and only world-wide group dedicated to the scientific study of intellectual disability.

PROF PETRUS DE VRIES

Chair of Child & Adolescent Psychiatry, has won a bid to hold the first regional IMFAR (International Meeting for Autism Research) in Africa.

DR NASTASSJA KOEN

Dr Nastassja Koen, a Lecturer in Neurogenetics, and co-head of the Psychiatric Neurogenetics Group in the Department, was awarded SAMA’s “Young Leader Award: Research” for 2016. This is a highly prestigious award, made to a young doctor who is making a difference to his or her community or healthcare environment.

DR SIMONE HONIKMAN

Dr. Simone Honikman, Director of the Perinatal Mental Health Project (PMHP), in the Division of Public Mental Health in the Department, was elected to the Marcé Society board – the first board member from Africa in the 36-year history of this international society. Marcé (https://marcesociety.com/) is dedicated to supporting research and services surrounding prenatal and postpartum mental health for mothers, fathers and their babies.

DR SHAUN SHELLY

A MPhil (Addictions) student and PGDip Lecturer in the Department, received SASOP Western Cape’s “Award of Special Recognition”, based on his notable contribution in advocating for positive change in the field of addictions.

PROF CRICK LUND

Head of the Division of Public Mental Health in the Department, has been offered a position as Chair of Global Mental Health at King’s College London. He will divide his time between KCL and the University of Cape Town 50:50.
HEADS OF DEPARTMENTS MEETING

The annual Heads of Departments meeting was held on the 17th February 2017 with financial support from Lundbeck. A range of issues were discussed, including: duration of registrar training, registrar evaluations and workplace based assessments, the HPCSA accreditation of the University of Limpopo’s Department of Psychiatry, the Portfolio of Learning, the MMed research report, harmonization of registrar

WORLD PSYCHIATRIC ASSOCIATION
ELECTION OF OFFICE BEARERS / 2017 -2020

At its meeting on 2nd May 2017, the Nominations Committee of the World Psychiatric Association (WPA) approved the nominations of:

PROF. CHRISTOPHER PAUL SZABO
to stand for the post of Secretary for Scientific Publications.

PROF. SOLOMON RATAEMANE
to stand for the post of Secretary for Scientific Sections

DR MVUYISO TALATALA
to stand for Zonal Representative – Zone 14 (Eastern and Southern Africa)

The elections will take place at the WPA General Assembly on the 10th October 2017 during the forthcoming World Psychiatric Association Congress in Berlin, Germany.
The 7th annual College of Psychiatrists registrar workshop was held on the 3rd and 4th February 2017 at The Capital Moloko Hotel in Johannesburg.

The event was funded and arranged by Servier, through an unrestricted educational grant, in collaboration with the College of Psychiatrists. The event also included an examiner workshop on the 2nd February, attended by examiners from around the country, related to both the Part II and DMH exams.

THESE WORKSHOPS SPECIFICALLY AIMED TO REVIEW AND DISCUSS CURRENT AND FUTURE TRAINING AND EXAMINATION APPROACHES WITHIN THE COLLEGE.

These workshops specifically aimed to review and discuss current and future training and examination approaches within the college.

The registrar workshop, which was preceded by a College Council meeting, was formally opened by the current President of the College, Prof. Soraya Seedat, followed by a brief address outlining Servier’s commitment to and support of both clinical services and educational activities related to Psychiatry in South Africa by Mr Steve Speller (Servier South Africa’s CEO).

The registrar workshop comprised content related to examination technique as well as didactic lectures covering a range of relevant topics over the two days, which included sleeping disorders, psychosexual disorders, child & adolescent psychiatry, OCD Spectrum disorders and forensic psychiatry including examination technique that assisted the registrars in preparation towards their Part 2 examinations.

There were a total of 91 attendees, over the 2 days, which included 50 registrars from academic Departments nationally, 8 speakers together with 33 attendees who were part of the examiner workshop / Council meeting.

ANONYMOUS FEEDBACK COLLECTED FROM THE REGISTRARS WAS POSITIVE AND GENERALLY NOTED HOW HELPFUL THE EXPERIENCE HAD BEEN WITH SPECIFIC MENTION OF THE EVENT BEING WELL ORGANIZED. SERVIER ARE COMMITTED TO ONGOING SUPPORT OF THE EVENT AND PLANNING WILL SHORTLY COMMENCE FOR 2018.

Thanks to Judith Herald, Elma du Plessis and Siyanda Ngidi (Servier Laboratories South Africa (Phy) Ltd) for specific information and photos provided towards compiling the Report.
YOU AND SERVIER AT THE HEART OF SOUTH AFRICA’S HEALTHCARE.

TOGETHER WE ADD YEARS TO LIFE AND LIFE TO YEARS.
PHOTO COLLAGE

SERVIER COLLEGE REGISTRAR WORKSHOP

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In the past century, neuroscience has made significant progress, however, it has been argued that advances specific to southern Africa have been limited due to a lack of access to techniques and skill development as well as to stunted research innovation (Spottiswoode & Carey, 2008).

The recent colloquium on ‘Why the Brain Matters’, hosted by the Johannesburg Institute for Advanced Studies (JIAS), opened a unique space for discussions among local and international neuroscience experts on historic, current and future research in the neurosciences. In doing so, it helped establish a precedent for the necessity for advances in both clinical and laboratory-based neuroscience research in southern Africa.

The purpose of the colloquium was to initiate academic thought around pertinent neuroscience topics. The natural step in trying to expand the scope and practice of neuroscience in the region is to gather experts from various disciplines to learn, discuss and evaluate how to advance the field.

A seminar series, as a follow-up from the colloquium, creates this opportunity to develop a network of researchers dedicated to advancing the field. In trying to foster collaborations across institutions, these seminars will be a joint initiative between JIAS and the DST-NRF Centre of Excellence in Human Development at the University of the Witwatersrand. The initiative is additionally supported by the Southern African Neuroscience Society and the Wits Cortex Club and is being organised by two of the colloquium participants, Dr Sahba Besharati and Dr Tanya Calvey from the University of the Witwatersrand.

This joint initiative will be an interdisciplinary seminar series that explores the past, present and future of neuroscience in southern Africa. It will cover topics that are locally relevant and internationally significant. A primary focus of the seminar series is to stimulate interest and build capacity in neuroscience research among both young and established scientists and to attract enthusiastic students who are interested in pursuing postgraduate studies in the neurosciences. This will offer an excellent platform for students to explore research interests, meet potential supervisors and enquire about funding opportunities. Another focus of the series is to bring together clinicians, neuroscientists, radiologists, computational neuroscientists and biomedical engineers with the aim of establishing a neuroimaging research unit in Gauteng.

The launch of the Brain Matters Series took place at the University of the Witwatersrand School of Public Health on Thursday 23rd March 2017. It was well attended by neuropsychologists, neuroscientists, psychiatrists, philosophers, radiologists, biomedical engineers, epidemiologists, neurosurgeons, neurologists as well as faculty and students from The University of the Witwatersrand, the University of Johannesburg and the University of Pretoria. Prof Linda Richter (Director CoE Human Development) chaired the event, with Prof Peter Vale (Director JIAS) providing the report on the JIAS Why the Brain Matters Colloquium. Prof Willem Hendrik Gispen (Utrecht University; Director of Why the Brain Matters Colloquium) delivered the keynote address, putting neuroscience research into historical and contemporary context. The event concluded
BRAIN MATTERS

Tanya Calvey completed a science undergraduate majoring in anatomy and physiology following which, she completed
an honour’s in human biology and evolution. Her PhD thesis, completed in 2015, was on mammalian brain evolution where
she analysed the cholinergic, catecholaminergic, serotonergic and orexinergic neural systems in 13 mammalian species. This
research was published in the Journal of Chemical Neuroanatomy. All of her formal training took place at the University of the
Witwatersrand where she is now a lecturer in the School of Anatomical Sciences. Tanya now conducts clinical research on
addiction, the comorbid psychiatric disorders and neuropsychopharmacology. This research is funded by the Medical Research
Council of South Africa and she is developing a research group. Tanya is also actively involved in developing neuroscience
research in Africa. Last year she organised the African Advanced School on Neuroimaging at the University of Cape Town that
was sponsored by the International Brain Research Organisation. She is the Secretary for the Southern African Neuroscience
Society, the co-founder of the Wits Cortex Club and has recently been nominated as the southern African representative for
the Society of Neuroscientists of Africa. Correspondence: Tanya.Calvey@wits.ac.za

Sahba Besharati is a Postdoctoral Researcher at the University of the Witwatersrand (Wits). She completed a collaborative PhD
in neuropsychology from Kings College London and the University of Cape Town (UCT), having previously trained in psychological
research and clinical neuropsychology during her MA at UCT. She has published in several leading international journals such as
Brain and Cortex. Dr Besharati’s research integrates neuroimaging, neuropsychological and experimental methods to investigate
She is particularly interested in the recent interdisciplinary approach of a social, cognitive and affective neuroscience.

THE LAUNCH CAME TO A CLOSE WITH AN EXCITING ANNOUNCEMENT
BY PROF LINDA RICHTER OF A THREE-YEAR PHD STUDENTSHP AS AN
OUTCOME OF THE BRAIN MATTERS SERIES.
Trazodone is a Serotonin Antagonist and Reuptake Inhibitor (SARI) indicated for treatment of MDD* with or without anxiety.

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

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

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

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

Trazodone has minimal anticholinergic side effects.

* MDD: Major Depressive Disorder

**REFERENCES:**

**PHARMACOLOGICAL CLASSIFICATION:**
A 1.2 Psychoanaleptics (antidepressants)

Name and business address of license holder: Biotech Laboratories (Pty) Ltd
Block W West, Central Park, 400 16th Road, Randjespark, Midrand, 1685
Suite 150, Private Bag X65, Halfway House, 1665, South Africa
Tel: +27 (0) 11 848 3050  info@biotechlabs.co.za  www.biotechlabs.co.za

Date of publication of promotional item: August 2016
Promotional material reference number: BL0331/08/16
The recent Kenya Psychiatric Congress held in Mombasa was attended by a number of South African delegates – see photo below. Of significance was the appointment of the African Association of Psychiatrists Executive Board. The members are:

- Dr Abdalla Abdelrahman (Sudan) - President
- Prof Solly Rataemane (South Africa) - Immediate Past President
- Dr Juliet Nakku (Uganda) - President-Elect
- Prof Lukoye Atwoli (Kenya) - Secretary General
- Dr Mvuyiso Talatala (South Africa) - Treasurer
- Dr Mvuyiso Talatala (Sudan) - Treasurer
- Dr Mvuyiso Talatala (South Africa) - Treasurer
- Dr Solomon Teferra (Ethiopia) - Northern Africa Representative
- Prof Dan Stein (South Africa) - Eastern Africa Representative
- Dr Sammy Ohene (Ghana) - Southern Africa Representative
- Prof Christopher Szabo (South Africa) - Western Africa Representative
- Prof Christopher Szabo (South Africa) - Research and Publications member

Photo (L-R): Sue Hawkridge, Solly Rataemane, Bernard Janse van Rensburg, Bonga Chiliza, Dan Stein, Mvuyiso Talatala, Lydia Maodi, Lesley Robertson
The History of Psychiatry and Mental Health Services in Kenya

The First 100 years of Despair, Challenges, Opportunities, Hope and a Future

PROF. DAVID MUSYIMI NDETEI

Dr. Ghulam Mustafa Mughal
Dr. John Mburu
Dr. Dammas Kathuku
Dear Mentors, Teachers and Colleagues,

It is a new year and we hope it ushers in many successes and positive strides for child and adolescent mental health services on the African continent.

The AACAMH Executive Committee is happy to share the good news of our website (www.aacamh.org) which should provide more visibility for activities on the continent. Please share this information and interact with us via the website.

However, the website only provides the platform; it is our sincere hope that we would all contribute exciting information and news about CAMH in our respective regions and countries so we can disseminate same. We are also on facebook (http://www.facebook.com/aacamh).

Lastly, the latest AACAMH Newsletter is available for download from the website.

With best regards.

Jibril Abdulmalik
AACAMH Secretary
Launch of our Official Web site
www.aacamh.org

Please visit our website and interact with us.

Submissions -
for June/July 2017 Edition

Do you have
News or important
announcements about
child and adolescent
mental health
issues in Africa?

Send letters, comments,
news items, commentaries,
reports of CAMH services e.t.c. for the
June/July 2017 edition of the AACAMH Newsletter
to aacamh@gmail.com

Please remember to visit and like our
facebook page:

https://www.facebook.com/aacamh)
Dear Health Professional,

On behalf of the organizing committee of the third African College of Neuro-psychopharmacology (AfCNP) and Uganda Psychiatric Association (UPA), I take this opportunity to invite you to the joint AfCNP Congress and annual UPA meeting that will take place at the Silver Springs Hotel in Kampala, Uganda from 18 to 19 July 2017.

This conference will draw local, regional and international delegates with a wide variety of expertise in the fields of neuro-genetics, neuro-psychopharmacology, psycho-trauma, capacity building and implementation science. The intersection between these diverse fields in mental health is critical for taking the field of psychiatry forwards.

I look forwards to seeing you in Uganda!

Dickens H Akena,
Convener
Uganda

This conference is supported in part by the Stanley Center for Psychiatric Research at the Broad Institute of MIT and Harvard
Message from the Secretary General

Dear Colleagues and Friends,

It is a pleasure to keep in touch with you! We had a very active period of WPA activities during the last three months. My first visit to the WPA Secretariat as SG, in the third year of this triennium took place from January 23-25, 2017. WPA Berlin timetable was discussed and we had a conference call with the Berlin Congress Secretariat. This was very useful and preliminary logistics were worked out. We were holding WPA elections through electronic software during the last two elections and we are working out a similar process for 2017 as well. We will also hold the triennial WPA General Survey in 2017 and we request your active participation in it. We had a useful meeting with Prof. Jean-Michel Aubry, Head of the Department of Psychiatry at BUP (where the WPA Secretariat is located). On January 24th, SG had a meeting at the International Organization for Migration HQ Geneva and had discussion with Maurizio Busatti, Head, Multilateral Process Division and his team which was very fruitful.

WPA International Conference on Education in Latin America held at Cuenca, Ecuador, February 8-11, 2017 was a big success. The WPA EC also met on the occasion and had much fruitful discussions. We are now looking forward to the WPA Inter Zonal Congress at Vilnius, Lithuania, 3-6 May 2017 and above all to the World Congress of Psychiatry, October 8-12, 2017. Please visit our newly designed website www.wpanet.org and kindly send us your valuable comments.

Roy Abraham Kalivarayil
Secretary General
World Psychiatric Association

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Message from the President

Dear Friends and Colleagues,

Welcome to the first newsletter of 2017.

Following the successful launch of Bill of Rights for Individuals with mental illness, an Early Day Motion was placed in the House of Commons at Westminster Parliament supporting it. 61 organisations from around the globe have signed up to this. The Bill of Rights for Children is also available and please get your Association/Organisation to support both the Bills of Rights. These are available on the WPA website.

As mentioned previously, complete details of the discrimination survey were published in a special issue of International Review of Psychiatry volume 28(4). The contents are available online.

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

WPA Position Statements on Perinatal and Maternal Mental Health and a separate one on Prisoner Mental Healthcare will be launched shortly. Please look out for these on the WPA website.

After two successful round table meetings on violent radicalisation (hosted by the WPA Collaborating Centre in London) and another one on early Interventions in Psychiatry (hosted by Hong Kong College of Psychiatrists) the next Round Table on Migrant Mental Health will be held in Oslo, Norway later this month. Report from Africa Forum (held in Cape Town in November 2016) is being prepared and will be available soon.

The work on setting up Diploma in Psychological Medicine aimed at psychiatrists continues apace and we hope to launch it in June this year.

We are continuing to look for examples of good clinical practice around the world so that we can learn from each other. Please keep them coming.

Please check the website regularly and get involved.

Best wishes,

Dinesh Bhugra, CBE
President
World Psychiatric Association

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The Rhine Falls (German: Rheinfalls) near Schaffhausen, in Switzerland, is Europe’s largest plain waterfall. This amazing sight can be reached via a boat tour, which will also show visitors to Switzerland the lovely basin, riverside castles, and spectacular boulder perched in the middle of the river at the top of the falls. There are viewing platforms that reach out over the falls and allow guests to feel like they’re hovering directly above. A children’s playground, historical museum region and adventure trail make the visitor’s center a wonderful way to cap off the trip.
The World Psychiatric Association (WPA)

The WPA is an association of national psychiatric societies, presently 138, spanning 118 different countries and representing more than 200,000 psychiatrists.

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

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

What is its Aims?

The core missions of the WPA include the following:

• To encourage the highest possible standards of clinical practice
• To increase knowledge and skills about mental disorders and how they can be prevented and treated
• To promote mental health
• To promote the highest possible ethical standards in psychiatric work
• To disseminate knowledge about evidence-based therapy and values based practice
• To be a voice for the dignity and human rights of the patients and their families, and to uphold the rights of psychiatrists
• To facilitate communication and assistance especially to societies who are isolated or whose members work in impoverished circumstances
With the fiasco, to top all fiascos, of Oscar night 2017 just over two months behind us I thought it to be a good idea if I reviewed a film for this issue that is a bit removed from the Hollywood scene and set on the other side of the world. ‘Lion’, is a film based on the true life story of Saroo Brierly as captured in the book ‘Long Way Home’ written by him with the assistance of Larry Buttrose.

In 1986 the young Saroo was living with his mother Kamla (played by Priyanka Bose) and his older brother Guddu in north-west India. The family lived in impoverished circumstances and Saroo would steal coal from freight trains as a means of surviving. Saroo’s mother worked at an open stone pit in rather filthy and desperate circumstances. Saroo’s brother finds work away from home and their brotherly bond causes Guddu to take Saroo with him as Saroo refuses to stay behind.

One night at an empty and deserted train station Guddu asks his brother to stay at the train station whilst he went to find the place where he had to go and work. Guddu stays away quite some time, and Saroo falls asleep on one of the benches on the station platform. Guddu returns to find his brother sound asleep and struggling to wake him up he leaves Saroo to sleep a bit more. When Saroo wakes up his brother is nowhere to be found. The five-year-old Saroo then gets onto a freight train standing nearby thinking that his brother will be on the same train. Saroo then falls asleep again whilst on the train. Upon waking the train has travelled some distance and Saroo, unable to open the door of the cart travels south to Calcutta. Upon arrival he finds himself in very different circumstances, surrounded by hordes of people. He manages to find the ticket office where he tries to get a train ticket to a place that he called ‘Ginestlay’. Of course no one understands him and Saroo quickly finds himself down and out in Calcutta. The evening of his arrival Saroo tries to sleep with other street children at the station where later that night several men came to abduct the children - together with the help of a police official. Saroo manages to escape and he takes to the streets of the city where a police official takes Saroo into police custody leading to his placement in an orphanage.

At the orphanage Saroo sees boys being taken late at night from the dormitory, and the viewer can only speculate as to the dubious reasons therefor. After a stay of about three months in the Calcutta orphanage Saroo is introduced to a friendly lady called Mrs. Sood. She informed Saroo about the possibility of his adoption by a family living in Tasmania.
Australia. She takes it upon herself to teach Saroo some English and table manners. Eventually Saroo is placed on an aeroplane bound for Sydney and his new life and family.

Upon his arrival in Australia Saroo is met by his new father and mother, John and Sue Brierley (played by David Wenham and Nicole Kidman respectively). The Brierleys eventually also adopt another Indian boy called Mantosh (played by Divian Ladwa), and it soon becomes apparent that Mantosh is emotionally disturbed and prone to rage and self-harm as a result of his experiences in the orphanage where he came from. Many years go by and the Brierly family is quite content and happy except for some tension surrounding the now adult Mantosh whose emotional disturbance led him to a path of alcohol bingeing and self-destruction.

Saroo eventually goes off to university, and while having a dinner party with friends he sees the famous Indian sweet delicacy called ‘jalebi’ and this brings back a flood of memories for him. Saroo becomes consumed with finding his biological mother and amongst other methods uses Google Earth in his search. Saroo’s all-consuming search causes him to become isolated from his girlfriend and family which in turn leads to great emotional turmoil within him.

One night while sitting on his sofa saroo scrolls over google earth images of India on his laptop computer when he suddenly recognises the open stone pits where his mother used to work in a place called ‘ganesh talai’. He had thus been mispronouncing the name of the town from which he came from for many years. This was not the only mispronunciation that the little saroo managed to make, and when the viewer sees the link of what he believed his name was and the title of the film, it is truly a moment to treasure.

What happens next in the film, and how things develop towards the end of it I will leave up to you to discover and enjoy. I must also confess that I am rather fond of the sweet delicacy ‘jalebi’, and together with another Indian fudge-like confection called ‘burfee’, I am in the seventh heaven! As an adopted child myself I resonated very strongly with Saroo’s story and his search for answers and his biological family. This search can sometimes be a very difficult path to walk although with the help and support of others one can manage to bear the emotional ups and downs associated with finding the answers to your questions. I can highly recommend this film, not only for the storyline and Saroo’s amazing life-path, but also because it is a brilliant piece of cinematography.

Until next time, enjoy!

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: Visselp@unisa.ac.za
HOW BROAD IS MY VALLEY

David Swingler

‘And that, now that was a deal! I bought it on auction for a tenth of the price of a new one!’

With silver locks flowing as we bounce around the upper reaches of David and Leigh Kretzmar’s olive and wine farm in his sturdy 4x4, he points out his wood chipper with pride.

The chips from alien trees are piled next to a load of post-harvest grape pomace collected from a friendly neighbour (at no charge) with a pile of manure – also no doubt the result of some deal – waiting to be blended into an organic, moisture-sparing mulch fertilizer for the crops. There’s a taut edginess to Mr Kretzmar, and being with him has you on the edge of your seat; you never quite know what he may buy, sell, or barter, next…

David started out as a cattle and sheep farmer in the Northern Cape and came by way of property and other interests to this spot in the secluded Klein Rivier valley, up the top end of the ever-more illustrious Hemel-en-Aarde valley near Hermanus, home to luminaries such as Hamilton Russell, Bouchard Finlayson, Newton Johnson and others. At the foot of the Shaw Pass that crosses over to Caledon, it’s vineyards are not technically H&A Valley, rather ‘Overberg’, but the same road runs through it. Indeed, the new viticultural ward has been proclaimed: it just needs the farmers to agree on a name. With variations of Shaw’s Pass doing the rounds, don’t hold your breath…

David and Leigh were in search of a country getaway for family and friends when they came upon Breë Vlei, a derelict 105ha spread that had been, in untranslatable Afrikaans, agteruit-geboer (farmed without success; backward, into the ground). They bought it in 2009 and set about restoring the land and infrastructure, planting pinot noir in 2010; a 4.5ha olive grove and exciting new chardonnay vineyards have followed. The latter will bear its first potable crop in 2018, while the vagaries of olive harvest continue to frustrate even this most patient duo.

After a decent yield of olives in 2016, volumes were severely limited in 2017, so get your 500ml bottle or convenient 2L ‘boxed-tube-with-a-tap’ of extra virgin oil at one of the Cape’s better delis now.

The Kretzmars are nothing if not team people and, in a game that was new to them, they needed to gather a pretty decent one, quickly. Which they did through personal recommendations; local farmers Barry and
Catherine Anderson – involved with the establishment of Gabrielskloof in Bot Rivier – being at the epicentre. Veteran viticulturalist Kevin Watt advises on the grape growing. Ataraxia’s thoughtful Kevin Grant helps retain the expression of the place in the wine, and Ross Sleet gets it into glasses around the world while Stefan Rust keeps the home fires burning on the farm.

Breë Vlei is not likely to get your product jumping off retail shelves so ‘Broad Valley’ – unbelievably not already trademarked as a wine brand anywhere on the globe – was selected as the moniker.

For the anoraks, the 5.6 hectare of pinot noir at approximately 260m above sea level is planted to three Burgundian clones 115, 777 and 113.

Harvest is dictated by pip-ripeness rather than sugar levels and bunches are hand-picked in cool conditions with triage – discarding any unripe or unsuitable fruit – in the vineyard. A range of ripeness (220 – 260 Balling) is achieved by mid-February.

After destalking, the fruit is ‘cold-soaked’ at 120 C – for gentle extraction without fermentation, which is then allowed to proceed in small 5-ton stainless steel fermenters at 280 C. When bone dry, the settled wine is moved to 225 L French oak barrels where the ‘second fermentation’ (of malic acid to lactic acid) occurs, with rounding for the rest of the harvest year in wood. Between a quarter and one third of casks are new; the aim is to capture the character of the soil, a savoury texture rather than overt berry fruit or obvious oaky vanilla. Alcohol is a moderate 13% by volume.

The maiden 2013 was all exported to China, but 2014 and 2015 – there’re only 400 six-packs of each – will launch the BV brand. Ross shows it at the Juliette Cullinan Standard Bank Wine Festival at Summer Place on the 16th and 17th of May, and then at Wines Unearthed at the London Wine Fair 22-24 May 2017.
Join us at the Biological Psychiatry Congress 2017

14 - 17 September 2017
Lord Charles Hotel, Somerset West, South Africa

Following the success of the Biological Psychiatry Congress in 2015, the Organising Committee is very pleased to announce this year’s meeting, to be hosted in the fairest Cape, with the theme of “Risk and Resilience in Mental Health: Improving Life Through Science”.

We believe that the Lord Charles Somerset Hotel is the ideal setting to converge local and international clinical, research and teaching expertise, relating to neurobiological, genomic, cognitive and social science advances in the risk and resilience fields. For delegates from afar, you will be spoilt for choice in this city with its beautiful geographical and cultural landscape that boasts stunning beaches, mountains, vineyards, and much more.

The multidimensional nature of both risk and resilience and the heterogeneous way in which these concepts are conceptualized, assessed, and interpreted have hampered the translation of research findings into improving clinical outcomes. It is clear that what we need are newer and more robust ways of understanding psychopathology, protection of risk, and prevention of the range of psychiatric disorders that form the bread-and-butter of clinical practice. Risk and resilience models, in the context of adversity, may offer a more direct and novel approach to drug discovery, psychotherapy interventions, and preventive public health strategies for mood and anxiety disorders, and schizophrenia, among others.

This year’s high level scientific offering will comprise a mix of plenary lectures, symposia, interactive workshops, debates and posters against the backdrop of an outstanding social programme. We really look forward to your participation and encourage you to submit your scientific contributions to make this congress an especially memorable and meaningful one.

Prof Soraya Seedat
On behalf of the Organising Committee:
Biological Psychiatry 2017
GOLDILOCKS & THE BEAR - ADHD PROJECT

Renata Schoeman, Nic de Beer

I am sure you know the story of Goldilocks and the three bears from your childhood...But have you ever considered why Goldilocks got herself in such a lot of (potential) trouble?

Just perhaps she struggled with inattentiveness, absentmindedly wandered off into the woods, and then impulsively entered a strange house, and with her usual hyperactive way started climbing on furniture...

SHE WAS LUCKY, BUT THOUSANDS OF OTHER KIDS AREN’T...

At least one in 20 children in South Africa suffers from Attention Deficit/Hyperactivity Disorder (ADHD) – a disorder marked by symptoms of inattentiveness, hyperactivity and impulsivity. Although mental health clinics exist in the public sector, children with ADHD often never reach this point of diagnosis and treatment due to a lack of awareness and knowledge in their communities. They are never screened for ADHD, and may be labelled as naughty, or “stupid”, or just silently fall out of the educational system and only come to our attention when absorbed in the criminal justice system. These children never have the opportunity to flourish...

RUNNING FOR ADHD

We have therefore decided to give ADHD a run for its money: we run for awareness and to raise funds for the Goldilocks and The Bear Foundation.

THE FOUNDATION IS THE FIRST TO OFFER NON-PROFIT ADHD SCREENING AND EARLY INTERVENTION IN UNDERSERVED COMMUNITIES AT SCHOOLS.

This will ensure early referral, diagnosis and treatment, and improve the quality of life of these children. The initiative aims to initially screen 500 children per month (of the estimated 200,000 in the Western Cape who currently have no access to such services) and aim to broaden the reach nationally. See attached document and biosketches for more information on the project.

We have recently completed the CellC African X Trailrun (91km in gruelling heat – and in our special Goldilocks and The Bear outfits) where we have managed to secure a podium position AND was chosen as the best dressed team! However, this was not the objective: our objective is to raise awareness for the plight of these children, and to raise funds for the Goldilocks and The Bear Foundation to be able to roll-out the program!

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

Nic De Beer is a Cape Town based entrepreneur. His focus over the last few years has been in the hospitality industry - specifically identifying investment opportunities, structuring business relationships, starting up businesses and consulting business owners. Nic obtained a BProc Degree at the University of Pretoria and practised law for 10 years. As such, he understands the ins and out of running a business, the legal aspects involved in starting and running a business. Nic has excellent negotiation and contractual skills which is of a great benefit in decision making in any project. Nic is a passionate road and trail runner. He is a member of the Elite KPMG Running Club and a Salomon Brand Ambassador. He currently boasts 11 silver medals in Comrades marathon, 8 silver medals in Two Oceans marathon, and has achieved numerous trail running victories and podium finishes. He is highly respected in the running fraternity and is frequently invites as speaker at running seminars. Nic is passionate about the environment. He has taken part in charity events like the Rhino Peak challenge (in aid of the rhino and bearded vulture). He is also actively giving back to the community; as a coach, but also as a role model for the youth. He currently coaches many runners - from beginners to elite - sharing his knowledge, advising on training and encouraging them to be the best they can be.

You can support us through “Back-a-buddy”, via our splash page http://www.gb4adhd.co.za/, or on Facebook https://www.facebook.com/gb4adhd/. Please support #GB4ADHD!
“How beautifully leaves grow old. How full of light and colour are their last days.”

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INDICATIONS'
For moderately severe to severe Alzheimer’s disease.
Efficacy has not been established beyond 6 months.

Harmony in Mental Health

Dr. Reddy’s
HELPLINE
0800 21 22 23 www.sadag.co.za

ZA/08/2016/Cog/252.
For full prescribing information refer to the package inserts approved by the medicines regulatory authority.
The commission remains concerned with the possibility that citizens are being manipulated by religious leaders. This could cause the important role that religion has in society to be distorted. The commission has a mandate to "conduct investigations on any matter related to the violation and abuse of cultural, religious and linguistic right of communities".

With this mandate in mind the commission convened a "Meeting with Experts". The March 2017 meeting, held at the CRL offices in Braamfontein, had arranged for a wide range of presenters.

THE THRUST OF THE MEETING WAS SUMMARISED IN THE TITLE - "THE STATE OF THE NATIONAL PSYCHE AND HOW IT AFFECTS THE RELIGIOUS SECTOR".

The presenters were chosen in an effort to assist the committee of 12 CRL Commissioners to reach an understanding of the current phenomenon where some religious institutions are seemingly abusing members of the South Africa religious community.

Speakers were chosen from such diverse areas as Sociology, Psychology, Hypnotherapy, Atheism and Psychiatry. In my presentation - "A biological understanding of the spiritual experience" – I discussed the role of the brain being the organ that produces the spiritual experience. A spiritual experience may be produced by various stimuli – whether elicited chemically (Psilocybin, Cannabis and many more), by electrical phenomena such as in persons with Partial Complex seizures or the effect of discreet kindling or even life events such as a near death experiences or prolonged fasting. The psycho-social challenge created by individual expectations (interpersonal, financial, health, political etc.) in a forever changing socio-cultural environment was also emphasised.

The invited Sociologist, Dr Alex Asakitikpi, gave an excellent presentation examining the phenomenon from the perspective of the congregants (poverty, social exclusion, anomie, social disability, rapid social change) to the perspective of pastors and prophets (demonstrating power over the congregants in order “to keep them glued to the church” and also the role of performing bizarre rituals “forms a cheap form of advertising”).

Mr Thomas Budge, Hypnotherapist, explored the relationship between hypnosis and the trance phenomenon. He highlighted the persuasive power of hypnosis in a vulnerable and suggestable population who will then interpret the trance experience as “the work of the holy spirit".
Psychologist, Professor Kobus Maree, highlighted man’s psychological beliefs in magic – “Belief in magic lies at the heart of the Christian faith. Without the miracle of the resurrection, Christianity would long since passed from the scene”. He made a call for an African Theology.

The Atheist perspective was presented, with unambiguous clarity, by Mr Rick Raubenheimer from the South African Secular Society (SASC). He highlighted the atheist opinion that the probability of God – as envisaged in monotheistic dogma – is unlikely to exist.

The videotaped presentations will be reviewed by the CRL Commissioners before compiling a final report with recommendations.

**THE CULTURE, RELIGION & LANGUAGE RIGHTS COMMISSION IS THE GOVERNMENT “WATCHDOG” EMPOWERED TO INVESTIGATE THE STATE OF MATTERS TO DO WITH LANGUAGE, CULTURAL & RELIGION.**

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**Lennart Eriksson** is a psychiatrist and former Director of Psychiatric Services, Life Esidimeni. Historically he has a Pathology background – morbid anatomy and chemical pathology. He therefore has always had a special interest in Neuropsychiatry. To this end he remains actively involved with Dementia issues. As Director of Psychiatric Services, Life Esidimeni, he gained insight and experience working in a corporate world in a company responsible for the care of 12 000 patients in 14 institutions. Insight into the needs of any person with a serious and persistent mental illness (SPMI) remains. He is the convenor of the SASOP Spirituality and Religion Special Interest Group (S&R SIG). His contribution to the Commission on Culture, Religion and Language Rights was driven by a wish to assist the Government to manage religious groups who were abusing citizens in the name of religion. Psychiatry and the workplace, has been an area of special interest. He worked for 14 years in a psychiatric unit funded, in part, by the Office of the Compensation Commissioner. He is currently a sessional appointment as a lecturer in The Department of Psychiatry, Nelson Mandela Medical School, Durban. **Correspondence:** lennarte@iafrica.com

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Dr Lennart Eriksson (Right) in discussion at CRL Rights Commission meeting with CRL Chairlady, Mrs Thoko Mkhwanazi -Xaluva and Deputy Chairperson of the CRL Commission, Professor David Masoma.
Dopaquel is indicated for the treatment of schizophrenia and manic episodes associated with bipolar disorder.
The Life Esidimeni Tragedy

A UKZN Department of Psychiatry Symposium

Lennart Eriksson

Can anything good come from the Esidimeni tragedy?

We have hopefully learnt a great deal from the Marikana massacre when 44 people were tragically massacred. The Human Rights Commission sees a link between the Marikana tragedy and the death of the 100 involuntary institutionalised mental health care users. The Department of Psychiatry, under the leadership of Professor Chiliza, arranged a timeous symposium around the theme of the Esidimeni tragedy.

Dr Lennart Eriksson, past Life Esidimeni Director of Psychiatric Services, gave a personal and detailed presentation of what is required to care for the, in the past, nearly 12 000, patients who are diagnosed with a Serious and Persistent Mental Illness (SPMI).

Dr Eriksson emphasised the infrastructure, staffing and the legal management required to care for this huge group of patients.

Since the promulgation of the Mental Health Care Act, 2002, every involuntary patient in a Life Esidimeni facility must, by law, have a yearly periodical report. The cost, in time, effort and money to write the yearly periodical report versus the ability / desire by the various Mental Health Review Boards (MHRB) to read and comment on the reports was questioned. The ability, or non-ability, of NGO’s to meet the needs of this population of mentally ill citizens was highlighted.

Dr Mvuyiso Talatala, past President of SASOP, gave a spell bounding presentation on what the Department of Health managed to achieve when confronted with the illegal and inhumane decision to summarily discharge patients from Life Esidimeni facilities.

The courts, lawyers, managers of the Gauteng DOH sought every means possible to circumvent and undermine attempts by our elected President to protect this group of vulnerable group of patients.

As the title of his presentation confirms – “The Psychiatrist Who Took the Government to Court and Lost” – spells out, in no uncertain terms, the outcome of all his brave efforts!

The findings of the National Health Ombudsman, Professor Malegapuru Makgoba, in his statement (4th February, 2017) vindicated the efforts made by Dr Talatala and SASOP.

Dr Suvira Ramlall, senior psychiatrist in the Department of Psychiatry, changed the direction of the symposium from the tragic past. Dr Ramlall discussed what needs to be in place as we prepare to manage both the present and the future. In
her presentation – “Teaching implications – post graduate health professionals” Dr Ramiall sketched past models of teaching and how the current “crop” of young psychiatrists may be better skilled to meet the challenges of their profession in our ever changing clinical setting.

Dr Lebo Phahladira, from Stellenbosch University, explored the – “Research implications – Quality of Life (QoL) of long-term inpatients”. His presentation focused on research opportunities for young psychiatrists and registrars in this population of patients. He wants us to closely study long-term patients, what predicts patients with mental illnesses to be hospitalised for so long and how the patients are being managed. His preliminary findings from Cape Town are that some of the patients are not optimally treated with medications like clozapine.

Professor Bonga Chiliza, HOD UKZN Psychiatry, explored the clinical demands of identifying patients presenting with a first time psychotic episode. Patients who, over the long term, will benefit from well-co-ordinated and case managed clinical care was detailed.

THE ROLE OF CASE MANAGEMENT WAS ENTHUSIASTICALLY DISCUSSED AFTER PROFESSOR CHILIZA POINTED TO THE FACT THAT PERSONS TREATED ADEQUATELY IN THE FIRST OR EARLY PHASE OF A PSYCHOTIC ILLNESS WILL BE MORE ABLE TO FUNCTION INDEPENDENTLY IN THE COMMUNITY.

This area of research looks to supporting persons with a diagnosed Serious and Persistent Mental Illness (SPMI) will be able to remain in the community. Costly institutionalisation could then be avoided.

The symposium was well attended by a broad spectrum of mental health care professionals, members of the review boards, as well as managers. The active question and answer session bore witness to the interest – and concern – for the topics presented.
SASOP MEDIA STATEMENT − 6 February 2017 on:
HEALTH OMBUD REPORT ON THE CIRCUMSTANCES SURROUNDING THE
DEATHS OF MENTALLY ILL PATIENTS IN GAUTENG PROVINCE

The South African Society of Psychiatrists (SASOP) took specific note of the much anticipated report by the Health Ombud, Professor Malegapuru Makgoba, on the circumstances surrounding the deaths of mentally ill patients in Gauteng Province, which was released on Wednesday 1st February 2017.

The report was released with intense media coverage and has been awaited by concerned role players, including the families of the documented 94 patients who died during 2015 following their transfer from Life Health Esidimeni (LE) facilities to, amongst other, 27 NGOs across Gauteng.

Where, as a body of health care professionals, the SASOP and its individual members are e.g. familiar with the role and functions of the Health Professional Council of South Africa’s (HPCSA), to oversee and regulate the professional conduct of individual professionals, it was also the SASOP’s first experience of the outcome of an investigation by the relatively recently established Office of the Health Ombud (OHO), as part of the Office of Health Standards Compliance (OHSC). Where the HPCSA has the responsibility and mandate to protect the public by setting standards, through registering, regulating and when necessary, disciplining individual health care professionals, the OHO for the first time publicly released the far-reaching findings of its first major investigation into a reported breach of norms and standards expected from public and private healthcare establishments, its responsible managers and politically responsible officials.

It is of great significance that the Health Ombud’s first major report has put such emphasis on the need to prioritize mental health care services in South Africa and on the importance of preserving the human rights of mental health care users, who are often of the most vulnerable population groups. The OHO and the OHSC, through the Health Ombud’s extensive report and far-reaching recommendations, have indeed set a particular precedent in protecting and promoting the well-being of all patients by fulfilling its mandate towards this most vulnerable group, by enforcing compliance with prescribed norms and standards for public and private healthcare services and facilities, with implications for state hospitals and private clinics alike, extending to primary care clinics, emergency services, hospices, and community-based health care services and institutions, such as NGOs who offer rehabilitative, or frail care.

While the SASOP is still very disturbed about the unnecessary loss of life of members of a group of mental health care users who are indeed some of the most vulnerable individuals, the SASOP has already re-committed itself to further support and where possible to facilitate the recommendations made by the Health Ombud. This includes continuing to work closely with the groups (Section 17, SADAG and the SAMHP) who, with SASOP, were the other respondents in the original legal action taken in an attempt to prevent the transfer of LE patients in a poorly planned and manner. It also includes supporting the efforts of the National Department of Health and the Gauteng Department of Health’s implementation of the Health Ombud’s recommendations - in

SASOP Board of Directors: Prof. ABR Janse van Rensburg (President), Dr. B Chiliza (President-Elect), Dr. M Talatala (Past-President), Dr. Anusha Lachman (Hon. Secretary), Dr. I Chetty (Hon. Treasurer), Dr. S Seape (National Convener Private Sector Group), Dr. I Robertson (National Convener Public Sector Group)
MEDiA STATEMENT

particular, Recommendations 11 and 13, regarding the urgent assessment of the ex-LE patients remaining in
the implicated NGO’s, as well as the identified unlawful NGOs itself.

We believe that the remaining ex-LE patients, currently still in unlawful NGOs, should in the interim actually be
transferred back again to and accommodated in facilities operated by LE, as a safe temporary “holding space”,
until the detail and logistics of the implementation of a proper deinstitutionalization process could be
established.

The SASOP at this stage calls for the urgent review and overhaul of the entire mental health care system in
Gauteng, according to the principles of the existing policy such as the National Mental Health Policy
Framework and Strategic Plan 2013-2020. This will include the identification and costing of the required facility
and staffing interventions that must be in place to ensure capacity and integration on different levels, namely:

- residential and day-care community-based facilities and programs – providing a range of care-
treatment-and-rehabilitation services with a full-time MDT available
- primary mental health care services in districts
- acute psychiatric units in secondary, tertiary and central general hospitals – back-to-back with
  specialist community psychiatry service
- specialised psychiatric beds (Sterkfontein, Tara and Weskoppies hospitals)

The SASOP is, however, convinced, that unless there is a particular and significant commitment by the political
principals of the National and Gauteng Departments of Health to make such necessary resources and funds
now available for this purpose, that it will not be possible to address the extent of the current crisis which
resulted from accumulating years of neglect, delay and failure to prioritize mental health care services in this
and other provinces.

Of particular importance will be to ensure the correct and differential licencing of NGOs who are able to
provide safe residential care only, those who can provide psycho-social rehabilitative and nursing care services
in addition, as well as those who can provide day-care service with users e.g. residing with family members, or
independently. Of equal importance will be to capacitate all district hospitals, such as South Rand, Bertha
Gqowela and other hospitals in the different districts in Gauteng, to provide appropriate primary psychiatric
services, including initial 72-hour assessment services. Such community and district-based facilities must be
supported by multi-disciplinary specialist community psychiatry teams, consisting of psychiatrists,
psychologists, psychiatric nursing professionals, social workers and occupational therapists. Such specialist
teams must work closely with the specialist acute inpatient units in general referral hospitals, while all current
specialist acute units on secondary or tertiary levels, must be equipped to provide at least 40 acute beds
allowing for voluntary and involuntary mental health care. Here it is of note that at least three of the acute
psychiatric inpatient units in Gauteng (Charlotte Maxeke Johannesburg Academic Hospital, Helen Joseph
Hospital and Chris Hani Baragwanath Academic Hospital) are currently operating under significant pressure due
to the incomplete and delayed renovations at these different sites. In these units, numbers of patients are
currently nursed in areas intended for half such numbers, as a result of all the respective construction projects
now already being disproportionately delayed for several years because of poor and ineffectual managerial
processes.

The SASOP will continue its monitoring of the mental health service delivery environment in Gauteng, while it
will also continue attempts to participate in constructive action to effectively ensure an improved and
integrated provincial and national mental health care referral system.

SASOP Board
Johannesburg, 6 February 2017
Yelate is indicated for the treatment of:
- Depression as defined by DSM-IV Criteria
- Diabetic peripheral neuropathic pain (DPNP)
1. FROM THE EDITOR

With the first quarter of 2017 already over, the term of office of the newly elected Board of Directors and other officials of the Society is well underway. SASOP and its members continue to work at the coalface, not only providing much needed care for those suffering from mental disorders, but also engaging the government and policy makers. The latter groups who still have a long way to go in understanding the full implications of psychiatric disease, not only for individuals, but also whole communities.

This was particularly evident in the events that unfolded as the horrors of the Life Esidimeni crisis came to light. SASOP’s leaders, together with clinicians, were involved not only in warning of the disaster that would ensue should the plans to move the vulnerable patients go ahead as planned but have been giving the necessary guidance and support to various groups, including government, in dealing with this disaster.

It is, perhaps, a good time for us all to reflect on our “social contract with society” (the theme of the recent 2016 WPA congress) and SASOP’s aim: “to promote, maintain and protect the honour and interests of members, the discipline of Psychiatry as a medical specialty, and to serve the community”.

I am sure that as you read this offering of Headline, you will see for yourself ample evidence of SASOP members being active in all the above.

Dr. Ian Westmore (Editor)
May 2017

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

2. FROM THE PRESIDENT

3. THE SASOP BOARD OF DIRECTORS (BOD), AND NATIONAL COUNCIL MEETINGS

3-4TH MARCH 2017, JOHANNESBURG.

3.1 PUBSEC REPORT

DR LESLEY ROBERTSON (CONVENOR)

AGM
The next AGM is due to be held at the Dr Reddy’s meeting on the 9th of June 2017.

MENTAL HEALTH LOBBYING & ADVOCACY
In the past year, there has been unprecedented mental health lobbying and advocacy by the Southern Gauteng and Eastern Cape subgroups:

GAUTENG
Lobbying and advocacy was extensive around the Life Esidimeni issue, thanks largely to the intense work put into developing a mental health alliance by Bernard Janse van Rensburg and Mvuyiso Talatala, and the responsiveness of the alliance partners.

EASTERN CAPE
There have been serious issues in the Eastern Cape around service planning and staffing, with enormous challenges at all institutional, service and management levels regarding mental health care. Letters detailing the deficits and outlining the needs have been sent to Sifiso Phakathi, National Director of Mental Health, and Prof Melvyn Freeman, Head of NCDs at NDOH. A collaborative approach involving
the Eastern Cape PubSec members together with the SASOP Board has been adopted.

Two important meetings have been held. At the first, on the 15th February with the Eastern Cape HOD, Dr Mbengashe, central principles were discussed. At the second, on the 27th February with the Eastern Cape Director of Mental Health, Dr Nogela, a way forward regarding forensic beds, acute beds, a child and adolescent unit and District Specialist Mental Health Teams was tabled.

SIMULTANEOUSLY, A MENTAL HEALTH ALLIANCE BETWEEN SASOP, SAFMH, SADAG, THE RURAL MENTAL HEALTH GROUP, OCCUPATIONAL THERAPISTS AND SECTION 27 HAS BEEN FORMED.

The lobbying and advocacy from such an alliance should hopefully assist in obtaining concrete positive outcomes from the meetings with the DOH.

In KZN, PubSec efforts have been focussed on preventing service cuts and maintaining current levels of care, working through UKZN and the HOUs. Although there is an intention to meet with the DOH, no meeting has been secured yet.

A non-SASOP mental health awareness march took place on World Mental Health day in October 2016. However, a mental health alliance between SASOP, advocacy and legal groups has not yet been formed.

Feedback from other subgroups will be obtained at the Dr Reddy’s conference.

Funds
No proposals have been submitted for use of the funds of R75 000, made available in 2015 to PubSec by PsychMG. The only pending usage is for the College / SASOP Public Mental Health Forum for the 3rd year registrars to be held in September 2017.

Going Forward
The next national PubSec meeting will be at the Dr Reddy’s Conference from 9th – 11th June, 2017. PubSec will convene on the Friday afternoon of the 9th and Sunday morning of the 11th for a strategic planning session. The focus of this session will be to establish what we actually want in terms of mental health services.

The discussion will draw on the experiences of the past few years, the MHCA, the Mental Health Policy and the precepts of the Convention for the Rights of Persons with Disabilities. Hopefully, some consensus will be reached which will inform future lobbying and advocacy.

3.2 FROM THE SUBGROUPS
3.2.1 SOUTHERN GAUTENG
DR P NAICKER

- The subgroup held an Extended Committee Meeting on Friday, 20th January 2017. The new committee is as follows:
  - Pevashnee Naicker - Chairperson
  - Anusha Rama - Treasurer
  - N Govender - Secretary
  - Thando Melapi - PubSec
  - Sanushka Moodley - Reg/Early Career Rep
  - Sebo Seape - Private Sec
  - N Caximjee - Forensic SIG Rep
  - Joanna Taylor - Psychotherapy SIG rep
  - Laila Paruk - Substances and Pain SIG
  - Helen Clark - Child & Adolescent SIG rep
  - Anersha Pillay - Biological/Neuropsychiatry SIG Rep

Activities of the subgroup include,

I. 6-monthly meetings with newly appointed registrars to encourage membership, as happened on 11 January 2017.

II. Two to three CPD activities are planned for 2017
   a. Psychotherapy Workshop planned for 6 May 2017 (Mindfulness based therapy workshop)
   b. Possible Neuropsychiatry workshop around August, and
   c. A Forensic CPD meeting on impairment and disability.

III. PubSec
   i. Meetings were held with the Gauteng Mental Health Department late last year. No further meetings were planned until after the release of the Ombudsman’s report.
   ii. Active involvement in the Life Esidimeni issue as per the Ombudsman report.

3.2.2 FREE STATE
DR F BRINK
ACTIVITIES OF THE SUBGROUP:

- Monthly Journal Club Meetings: 11 are planned for 2017. These are normally well attended by registrars and psychiatrists, with an average of 20 doctors attending per meeting. These are CPD accredited and sponsored by pharmaceutical companies.
- Academic updates/symposia will be held on 12-05-2017 and 18-08-2017, where speakers from outside Bloemfontein are invited to present.
- The subgroup comprises of 27 private psychiatrists, 4 consultants in the state sector, 2 consultants in the SANDF and 15 registrars. In the Northern Cape there are two consultants and two in private practice.
PLANNED ACTIVITIES OF THE SUBGROUP

This year’s CME meeting took place on 30 March 2017. Prof Manfred Böhmer did a presentation entitled: “Management of personality disorders by the general psychiatrist, with the focus on borderline personality disorder”. The annual mini-symposium will take place during July and the theme for this year will be neuropsychiatry. Further information will be made available as soon as the venue is confirmed.

FINANCES

The subgroup is currently financially quite strong and is planning to sponsor two registrars for the Biological Psychiatry Congress in September 2017. We are also looking into the possibility of offering research grants. The amounts that will be offered for sponsorship and research grants are still to be finalized.

The financial management remains a challenge and Dr van Schoor has been struggling with access to the bank accounts, because of outstanding documentation (e.g. business rules / a written constitution from SASOP). Monthly statements are sent to Healthman, but the subgroup would still prefer to relinquish control of the finances to the central governance of SASOP.

3.4 Special Interest Groups (SiGs)

3.4.1 ADHD SIG

• This SIG held their AGM during the WPA/SASOP Congress in Cape Town on 19th November 2016. The group presented symposia at the Congress that were very well attended, and a write-up will follow in the South African Psychiatry journal. Topics presented included the “Ethics of cognitive enhancement” (Chris Verster & Willie Pienaar), “SA Guidelines” (Rykie Liebenberg), “CAMEs and other approaches” (Renata Schoeman), “CBT and mindfulness for ADHD” (Anton Kruger), “Emotional dysregulation” (Jack Krystofik), “Epigenetics” (Kobus Roux), and “Executive dysfunction” (Eleanor Holzapfel).

• SA Guidelines for adult ADHD have been approved by the SASOP and PsychMG boards. (under review for publication in South African Journal of Psychiatry).

• Projects for 2017

• The group are looking at holding training opportunities, starting with their own members (“Training the trainer”), and then broader training. This will possibly include registrars. They are also looking at translating the guidelines into policy documents/SOP’s.

• Those working in the Public Sector report that they are working under challenging conditions. These include the Free State Department of Health (DoH) currently being under administration by the Treasury; a shortage of consultants in the department with an ever-increasing list of people awaiting the 30 day forensic evaluation period. In 2015 a fire in the acute psychosis ward for males destroyed the ward, meaning that male MCUs are currently being managed in a long-term ward not geared to accommodate acutely psychotic patients. There is still no separate Child and Adolescent ward with in-patient facilities. ECT facilities are not available and the department has threatened to stop the outreach programme.

• The subgroup arranges a “family weekend” with sponsorship from Aspen annually, where there is a combined academic and recreational program.

• A separate Congress 2018 committee has started work on organizing the next National SASOP Congress for 2018.

3.3 LIMPOPO

DR MM KEWANA

• We still have one Private Facility that is not accredited to admit adolescents and involuntary patients, but there are some promises of a new Private Hospital coming up.

• The Public Sector is still struggling to appoint Private Practitioners on a part time basis due to a lack of funds. They have invited private practitioners to join the public sector, and those who were interested applied for part time posts in September last year, but they have not yet received any response.

• Our meetings are held once a month, and our first meeting for 2017 was held on the 23rd of February. (These meetings are usually sponsored by Dr Reddy’s Pharmaceuticals). At these meetings we attend to SASOP business, PsychMG issues, and there is normally some teaching.

• We hosted our very first SASOP organised symposium on 17th September 2016 and it went very well; our keynote presenter was Prof B Chiliza. We will be hosting our 2nd Symposium in the 2nd half of 2017.

• There are still problems in the Public Sector with forensic assessments since the retirement of Dr Weiss.

• Our new PubSec representative is Dr Monica Ndala. (Dr Puleng Mokoena-Molepo has left Limpopo and is now working at George Mukhari hospital).

3.3.4 NORTHERN GAUTENG

DR C KOTZÉ

The current executive committee: Dr C Kotze (Chairperson); Dr P Malherbe (Secretary); Dr RA van Schoor (Treasurer); Dr M Rademeyer (Private Practice representative); Dr H Eksteen (UP registrar representative); Dr Muluvhu (SMU registrar representative).

A new committee is to be elected in September 2017.
3.4.2 BIOLOGICAL PSYCHIATRY SIG
PROF S SEEDAT
- Three new members joined the committee during 2016. They are: Prof. Jackie Hoare and Drs. Leigh van den Heuvel and Mari Retief.
- Profits from the 2015 congress were utilized to secure international speakers for pre-WPA congress presentations. Professor Andreas Meyer-Lindenberg and Professor Wolfgang Gaebel gave presentations at Stellenbosch University, Faculty of Medicine and Health Sciences on 17 November 2016. Profits were also utilized to sponsor the attendance of medical students at the WPA 2016 congress.
- Congress 2017: The Biological Psychiatry Congress 2017 will take place from 14 to 17 September 2017 at the Lord Charles Hotel in Somerset West. The theme is “Risk and resilience in mental health: Improving life through science”. International speakers that have already accepted the invitation to present are Helen Fisher, Paola Dazzan, Joan Kaufman and Scott Letendre. Registration fees have been increased at 10% across the board. The congress has its own website for the first time which makes registration and direct payments possible. The registration form also clarifies the SASOP discount. We would like to print abstracts in the South African Journal of Psychiatry. The call for workshops and early presentations at Stellenbosch University, Faculty of Medicine and Health Sciences on 17 November 2016. Profits were also utilized to sponsor the attendance of medical students at the WPA 2016 congress.
- The Biological Psychiatry Awards 2018: Criteria for the allocation of these awards will be re-evaluated during the course of this year with transformational criteria in terms of gender, race and HEI being seen as of high importance for inclusion. These new criteria will be finalized prior to the awards being adjudicated next year.
- Membership of World Federation of the Societies of Biological Psychiatry Payment of subscriptions (for both public sector and private psychiatrists) will be made soon.

3.4.3 CHILD AND ADOLESCENT PSYCHIATRY SIG (CAPSIG)
DR SUE HAWKRIDGE
- This SIG met during the WPA Congress in November on 20th November 2016. Items that were discussed included the following:
  - Access to paediatric psychotropic medication at all levels: Ritalin LA has again become unavailable except at tertiary level and excluded from the EML. This is because of a sudden and extreme increase in price by Novartis. It was suggested that alternative cheaper formulations are sought and suggested to the national department of health.
  - Private sector funding of psychotropic medication for children and adolescents: It was noted that conditions such as ADHD and depressive illness are not accepted as chronic disorders and medication is not covered. Admissions to hospital will only be covered for bipolar disorder, PTSD and schizophrenia. Action was advised through the Private Psychiatry group.
  - Admission facilities for children and adolescents: Information was sought concerning admission facilities across the country. Western Cape platform has 47 beds, Weskoppies about 18, and Tara has now approved a secure unit for adolescents. The Zebra ward for vulnerable patients at Baragwanath is available for adolescents. There is no facility in the Free State and the planned adolescent unit at Fort England has been postponed. There has been no progress on the adolescent inpatient unit that was planned and built in Kimberly.
  - 6 month mandatory training in child and adolescent psychiatry for general psychiatry registrars: It was reported that the College is supportive of the need for a six month rotation in child psychiatry but is not willing to make it mandatory. Suggestions as to how to move the matter forward were offered, including ensuring that more child psychiatrists stand for the College Council, pursuing the option of classification as a small speciality rather than a sub-speciality, and approaching the National Health minister directly.
  - The SAACAPAP conference 2017 will be held at Spier, Western Cape, 7-9 September. Prof Petrus de Vries is heading the organizing committee.
  - Court-ordered psychiatric admissions. There was some discussion, with the Western Cape members stating that they challenge attempts to order children into psychiatric hospitals when there is no psychiatric indication. It was agreed that concerted action needs to be taken at National level to attempt to stop this practice that is time consuming and leads to blocking of psychiatric beds with children who have behavioural issues.
  - The next meeting of the SIG will be at the SAACAPAP Conference in September 2017.

3.4.4 CELLULAR AND MOLECULAR SIG
DR KOBUS ROUX
Dr Roux reported that this SIG also met during the WPA Congress on 20th November 2016.

The SIG has already presented five workshops at different meetings, with good attendance, but plans to look at increasing membership of the group, as numbers are still very low. They are considering a name change, as it seems that whilst clinicians are interested in the topics presented, they are reluctant to become involved in “molecular genetics”.

Projects for 2017 include:
- A workshop at the Biological Psychiatry Congress in September regarding molecular pathways in novel treatments.
To facilitate a naturalistic trial to measure the utility and pharmaco-economics of a Pharmacogene chip for psychiatric treatments.

Dr Roux will continue as convenor of the SIG.

**3.4.5 SPIRITUALITY AND PSYCHIATRY SIG**

**DR LENNART ERIKSSON**

- Dr Eriksson reported to the National Council on some of the activities of the SIG:
  - Communication: the SIG has been sending out letters to interested persons but there has been a poor response – they would like to distribute their letters more widely using the SASOP database at Healthman.
  - The group is proposing that they resort in future under a so-called “Humanistic” cluster, as opposed to the current “psycho-social, philosophy, social psychiatry, psychotherapy and spirituality cluster”.
  - There was a proposal from the group that, to conform with international organisations, the name of the SIG be changed to “SPIRITUALITY AND RELIGION SPECIAL INTEREST GROUP”.
  - Regarding teaching, Prof van Rensburg introduced the issue of teaching Spirituality and Religion to undergraduate students. At UKZN a program is now in place for teaching Spirituality and Religion in Psychiatry, there seems to be a huge interest in the topic. (The current PowerPoint presentation is available to other centres on request. The College of Medicine have a section for examination purposes on Spirituality and Religion in the course content).
  - The SIG was active during the recent WPA Congress and presented a symposium entitled: “Incorporation Of Spirituality In Assessment And Training By South African Mental Health Professionals”. This was one of four symposia on Spirituality, Religion and Psychiatry and was jointly chaired by Prof. B van Rensburg and Dr BL Eriksson.

**5. GENERAL NEWS**

**5.1 SASOP BOARD & INDUSTRY DINNER**

The SASOP President, Prof B Janse van Rensburg and members of the SASOP BOD had their annual meeting with members of the pharmaceutical industry on 9th March 2017 at the Benvenuto Hotel and Conference Centre. This was an opportunity for the management of SASOP to give feedback on the use of sponsorships over the past year, as well as to give the industry the plans and vision regarding SASOP over the coming year.

Prof van Rensburg specifically alluded to the Presidential theme and eight strategic objectives for the term 2016-2018:

“Professional Psychiatric Practice in Medical, Socio-economic and Cultural contexts”

- SASOP members
- Service provider environment
- Advocacy groups
- Medical and academic institution
- Media and public relations
- Pharmaceutical Industry
- Creative Arts Program
- African Psychiatry

**4. IMPORTANT SASOP DATES FOR THE REMAINDER OF 2017**

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<td>20-24 MAY 2017</td>
<td>APA SAN DIEGO</td>
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<td>10-11 JUN 2017</td>
<td>DR REDDY’S WEEKEND (CAPE TOWN)</td>
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<td>26-29 JUN 2017</td>
<td>RCPSYCH, EDINBURGH</td>
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<td>22 JUL 2017</td>
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<td>BOD &amp; NATIONAL COUNCIL MEETING</td>
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The untimely passing of Professor Denise White earlier this year, shortly after her term as President of the South African Medical Association (SAMA) ended, has left the South African medical fraternity bereft of an outstanding and visionary leader. Whilst doctors from across the country mourn the loss of a colleague and friend, the South African Society of Psychiatrists (SASOP) is particularly keen to mark the life of a respected clinician. She will be remembered for her outstanding contributions to not only psychiatry in the country and abroad, but also for her leadership roles, particularly in SAMA.

Professor White worked in the public sector for most of her career as a psychiatrist, with some involvement in private practice towards the end. It was in the former that she, together with a colleague at UCT, identified a link between patients admitted to Groote Schuur’s psychiatric wards with catatonic illness and neuroleptic malignant syndrome (NMS) where they identified the administration of neuroleptic drugs to patients with a catatonic illness as the main contributing factor.

*IT IS AGREED THAT DENISE EARNED THE RESPECT OF HER COLLEAGUES AND ENEMIES IN DIFFICULT SITUATIONS.*

Most will remember the pivotal roles that she played in the June 2009 doctor strike (while acting as SAMA chairperson) as well as being a pivotal negotiator for huge improvements in doctors’ salary packages via changes to commuted overtime a decade earlier (as Chairperson of SAMA’s public sector committee). She will be remembered for her calm, yet assertive management of these potentially explosive situations, a skill which she no doubt naturally employed as a psychiatrist. It is, therefore, no surprise, that her peers in the Western Cape subgroup of SASOP when awarding her the SASOP Distinguished Service Award, described her as an inspirational negotiator, a quiet and dedicated leader and clinician of immense skill and intuition.

She was a person who left her mark in several areas of medicine and psychiatry throughout her career, fearlessly taking on issues of the day and showing her unique brand of insight, wisdom, and determination in especially the leadership roles that she took on. This is evident in the pieces she penned for the SAMA Insider whilst President of the organization – I had the opportunity of reflecting on these as I reviewed the themes that she chose to highlight during her term.

Professor White started off the year in 2016 reflecting on what lay ahead for the country as a whole, and the medical profession in particular. Against the backdrop of a severe drought that most of the country was experiencing, and the shockwaves that the sudden sacking of the Minister of Finance had in December 2015, she was aware of prominent challenges in the year ahead.

*DENISE ENCOURAGED DOCTORS TO LEAD THE WAY BY MAKING THEIR WORKING ENVIRONMENTS MORE “GREEN” AND CITED THE EXAMPLE OF A PUBLIC SECTOR HOSPITAL’S COMMITMENT TO “GREENING” IN THE INITIATIVE TAKEN BY THE LENTEGEUR PSYCHIATRIC HOSPITAL IN MITCHELLS PLAIN, WESTERN CAPE.*

She made it clear too, that doctors would need to work with all the other stakeholders in working out how the “marriage” between the public and private sectors would develop with the envisaged NHI, following the publication of the white paper on NHI in December 2015.

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Having worked in the public sector for most of her life, and then also in private towards the end, Prof White was acutely aware of the challenges facing the country in the delivery of healthcare to its citizens. In March 2016 she wrote:

"THERE IS NO DOUBT THAT THE STATUS QUO IS UNTENABLE. WE ARE ON A PATH TO NOWHERE WITH HEALTH UNLESS REFORM COMMENCES WITH URGENCY. AND IN MOVING FORWARDS, MUCH ‘GOLD AND SILVER’ WILL BE REQUIRED TO BRING ABOUT MEANINGFUL CHANGE”.

SHE CLOSED BY REFERRING TO GANDHI, SAYING: “AS A PROFESSION OUR COMMITMENT AND GOAL MUST BE TO ENSURE THAT ALL OUR CITIZENS ARE AFFORDED THE "WEALTH OF GOOD HEALTH"."

As the deadline for submissions on the NHI white paper loomed, Professor White, being an eminent psychiatrist herself, warned that there was a “critical omission of mental health from the district health services in the White Paper” and urged that this be “addressed with urgency”. She was quick to reference the contribution of mental illness to the growing global burden of disease, and the implications that this would have for service delivery in the future.

One of the changes that Denise was concerned about during her term as President of SAMA, was that which faced the South African Medical Journal (SAMJ) when there was a hierarchical restructuring of the Health and Medical Publishing Group (HMPG), heralding significant changes for the 118-year-old publication. In her wisdom, she warned that “Change and reform in systems must not only be embraced but also interrogated in a democratic society. It is, therefore, important that the readership gives voice to its satisfaction or concerns about the proposed changes to the SAMJ.”

Upon her return from the bi-annual World Medical Association (WMA) meeting in Buenos Aires where she represented SAMA, Professor White reported on the working of this world body, established in 1947. Whilst it was clear that urgent issues such as the Zika virus had been very much a focal point of discussion at the meeting, she made it clear that there were ongoing issues that needed to be discussed in future e.g. cannabis for medical use (proposed by SAMA), health databases and bio-banks, quality assurance in medical education and physician-assisted dying/euthanasia.

As President of SAMA, she was particularly concerned about the plight of junior doctors, especially so following the tragic death of an intern after working a long shift at Paarl Hospital. Professor White was worried that, once the media attention had dissipated, and authorities had responded with statements, nothing further would be done to improve the working conditions and hours of interns and junior doctors. The activist in her warned that “My experience tells me that meaningful change is not going to happen any time soon! Tragic events evoke outrage and lip service promises of remedial action, but once media headlines fade, action dissipates and nothing changes”.

SHE CONTINUED: “WORKING OUR PRICELESS YOUNG COLLEAGUES TO THE POINT OF UTTER EXHAUSTION AND IMPAIRMENT POSES NOT ONLY RISKS OF SERIOUS ERRORS OF CLINICAL JUDGMENT, BUT ALSO RISKS OF MALPRACTICE LITIGATION.

That is to say nothing of the danger it poses to them. It is therefore a no brainer that these irresponsible demands must not be allowed to continue.” It would, perhaps, be a fitting tribute to her, if the SAMA membership could continue to pursue this issue until a satisfactory guideline for the working hours of junior doctors could be finalized.

In September 2016, Denise highlighted the predicament that doctors, and in particular GPs find themselves in, with a rapidly changing and challenging healthcare environment in South Africa. Whilst general practitioners are called upon to be the “heartbeat” of primary healthcare, they are under constant threat from various sources. She showed particular insight when she reflected that “The essence of the issue is that practitioners in the private
sector have lost authority and leadership within their profession on multiple fronts” and “The health system is poised on the edge of what undoubtedly will be a painful abyss of change for many of its hitherto pivotal role-players and stakeholders”. An experienced leader herself, she advised that “balanced and assertive leadership from the profession is critical for the NHI principles to succeed and become the hoped-for lifeline for our GP constituency.”

Denise White will also be remembered for the significant role that she played whilst serving on the Medical and Dental Professions Board (MDB) of the Health Professions Council of South Africa (HPCSA) where she served two five-year terms. She also served on the health committee of the council (assessing and ruling on ‘impaired’ practitioners). It was whilst serving on the latter (something that she noted was ‘very worthwhile’) that she became particularly aware of the stresses that physicians and junior doctors, in particular, are subjected to, and this informed her call for physicians to take care of themselves.

It therefore comes as no surprise that in her contribution to SAMA’s Insider in October 2016 that she warned against the phenomenon of “burnout” in physicians. Her work as President of SAMA exposed her to many physicians and physician groups all over the country, and whilst noting their enthusiasm on many fronts, she was also keen to point to the obvious danger of physician burnout, in both the public and private sectors of South African Healthcare. Again she was keen to point out that our junior colleagues are especially at risk. Pointing out specific factors that contributed to burnout amongst doctors in the developing world, she mentioned, “long working hours, often under trying circumstances, uncaring bureaucracies and limited resources. Those working in the private sector are dealing with severe financial constraints: spiraling practice costs, inequalities in medical scheme funding and exorbitant medicolegal fees.”

POIGNANTLY, SHE REFERENCED A FACTOR THAT IS INCREASINGLY CONTRIBUTING TO BURNOUT AMONGST SOUTH AFRICAN DOCTORS – “EXPOSURE TO THE BEWILDERING SCENARIO OF SERIOUS POLITICO-SOCIOECONOMIC INSECURITIES IN THE COUNTRY”, THAT, AS SHE WROTE, “DOES NOT ENGENDER FEELINGS OF OPTIMISM AND WELLBEING.”

PROFESSOR WHITE LEFT US AT A TIME WHEN SOUTH AFRICAN DOCTORS CONTINUE TO STRUGGLE WITH THE LEGACIES OF THE PAST AND THE CHALLENGES OF THE FUTURE WHILST TREADING UNCERTAINLY IN THE PRESENT. WE WOULD DO WELL TO TAKE OUR CUE FROM HER EXAMPLE IN LEADERSHIP AND HONOUR HER MEMORY BY BRAVELY FACING THESE UNUSUAL CIRCUMSTANCES WITH HER WORDS OF WISDOM, WARNING, AND INSIGHT AS A SOURCE OF MOTIVATION AND INSPIRATION.

She closed by saying, “Self-care should be seen not as an option for physicians, but as an obligation. The obligation to care for patients necessitates care for the self, for when the health of the physician is compromised, so also is the quality of patient care.”

In the past, South African doctors have been known worldwide as pioneers in medicine. Denise White was one of them, not only because of her clinical skills and leadership roles but also because she was a brave human being.

MAY SHE REST IN PEACE.

Dr Ian Westmore

References
2. SAMA INSIDER, February 2016 (From the President’s Desk)
3. SAMA INSIDER, March 2016 (From the President’s Desk)
4. SAMA INSIDER, April 2016 (From the President’s Desk)
Dear SASOP Member,

I trust that all is still well, despite challenging political times and uncertain outcomes in terms of national communication and economic survival.

On the Public Sector front, since my last letter to you in February, the 45 days allowed by the Health Ombud for certain recommendations to be implemented has been extended to the end of April. But it seems already as if the issues of the “Life Esidimeni” (LE) psychiatric patients in Gauteng is slipping from public awareness and despite ample evidence of clinicians’ attempts to communicate their concern about this, as well as active steps to try to prevent it, the question to South African doctors of “what have you been doing?”, have also been raised in this time by some role players - including by the SASOP’s own members, by the WPA, as well as possibly by the public and others.

It seems though that the notion of a “submerged clinicians’ narrative” must be considered with regard to this extended experience, especially when considering the facts about: (1) the actual involvement of individual clinicians and professional societies collectively; (2) individual doctors’ responsibility as clinical decision makers in the case of the LE transfers; (3) other examples of clinicians’ ongoing and repeating narrative; and (4) possible conflict of interest between clinicians’ relationship with their patients, and their relationship as employees with a third party, such as a state or private employer.

Considering the evidence in this regard, as well as the institutional mechanisms to promote human rights in health practice that national professional organizations should implement - as listed in 2002 by the “Physicians for Human Rights and School of Public Health and Primary Health Care at the University of Cape Town”, at least several of these have been pursued by different individual clinicians and professional groups about the LE issue. Despite an unprecedented and sustained level of communication and action by clinicians, in particular psychiatrists, on this matter, it seems however that clinicians’ communication and activism did largely remain submerged and as such, remained outside of the public awareness and acknowledgement of the politicians and managers, who were in all instances the final decision-makers on the pertaining clinical matters with regard to these patients.

On the Private Sector front, the PsychMG Board members and Healthman continued to meet with role players, including on PMB, Discovery’s auditing of private practices as well as other pressing matters. Since February Shaquir Salduker has engaged the media on the legalization of cannabis and Mvuyiso Talatala on depression, in view of this year’s World Health Day’s on the 7th April, which focused for the first time on a mental health theme.

A few SASOP members and Board members, including Mvuyiso Talatala, Bonga Chiliza, Lesley Robertson and myself, as well as Sue Hawridge, Dan Stein and Solly Rataemane attended the 2017 Annual Conference of the Kenyan Psychiatric Association in Mombasa, Kenya from 30th March to 1st April 2017. Mvuyiso presented on Psychiatry’s Social Contract while Lesley and Bonga presented respectively on the substance abuse policy in South Africa and on long acting injectable antipsychotics in schizophrenia. The meeting was also hosting an African Association of Psychiatrists and Allied Professions (AAPAP) Annual General Meeting, at which Mvuyiso was elected as Treasurer - Congratulations!

With best wishes, until the next quarter.

Bernard

2017


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INSTRUCTIONS TO AUTHORS

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

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

LETTERS TO THE EDITOR
- Novel experiences
- Response to published content
- Issues

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

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

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

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

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

The format of the abovementioned contributions does not conform to typical scientific papers. Contributors are encouraged to write in a style that is best suited to the content. There is no required word count and authors are not restricted, but content will be subject to editing for publication. Whilst references may be noted in text, they will not be published with content but noted as available from the author/designated author where there are multiple authors. All content should be accompanied by a relevant photo (preferably high resolution – to ensure quality reproduction) of the author/authors as well as the event or with the necessary graphic content. A brief biography of the author/authors should accompany content, including discipline, current position, notable/relevant interests and an email address. Contributions are encouraged and welcome from the broader mental health professional community i.e. all related professionals, including industry. All submitted content will be subject to review by the editor-in-chief, and where necessary the advisory board.

REVIEW ARTICLES
Such content will specifically comprise the literature review of the final version of a research report towards the MMed - or equivalent degree - as a 5000 word review article
- A 300 word abstract that succinctly summarizes the content will be required.
- Referencing should conform to the Vancouver style i.e. superscript numeral in text (outside the full stop with the following illustration for the reference section: Other AN, Person CD. Title of article. Name of Journal, Year of publication; Volume (Issue): page number/s. doi number (if available)
- The submission should be accompanied by the University/Faculty letter noting successful completion of the research report.
  - This will constitute peer review given that the examination process involves 2 independent examiners, with any revisions generally having been undertaken to the satisfaction of both your supervisor and Head of Department.

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