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Oral Presentations

GENERICS – CURSE OR COST SAVER?

Eugene Allers
Psychiatrist in Private Practice

Background: Many doctors and patients complain that 'generic medication does not work'. Should generic medication be used as first-line medication or should there be switching from original product to generic at some stage?

The standards of generic medication in comparison with original medication are reviewed with emphasis on the registration process in South Africa and the standards set by the Medicines Control Council in South Africa.

The legislation pertaining to generic substitution and the pricing of medication is reviewed.

The literature is reviewed regarding the use of generic medication internationally and nationally to ascertain whether the above comments are relevant.

Indiscriminate switching from original to generic medication is problematic – where does the answer lie? Switching medication and switching strategies are reviewed from international studies.

MANAGING PATIENTS WITH PSYCHIATRIC DISORDERS APPROPRIATELY SAVES COSTS

Eugene Allers
Psychiatrist in Private Practice

Background: Data from Eternity Health, a managed health organisation from Chartered Accountant Medical Aid Fund, are analysed for the year 2003 and compared with the data from 2005.

Eternity Health is one of the only managed health care organisations that has a structured mental health programme in place that supports patients and does not utilise a restricted formulary. The programme was started in 2004 in partnership with SASOP P3.

The data are analysed in terms of the utilisation of psychiatric benefits for these two years and the data compared from 2003 and 2005 to monitor the cost.

Methods: The 'psychiatric population' is defined for 2003 and 2005 and the data for this population are compared with the rest of the beneficiary population regarding benefit utilisation.

The cost of medication, consultations, psychotherapy and hospitalisation is compared. Problems are identified regarding the utilisation of benefits for chronic analgesic and benzodiazepine use.

Results: The utilisation of psychiatric benefits decreased from 2003 to 2005. The overall utilisation of psychiatric benefits decreased from 2003 to 2005 from 3% to 2.38% of the total contribution income of the medical scheme, despite an increase in the level of care and benefits to patients.

The number of beneficiaries increased 8.95% from 2003 to 2005. The increase in psychiatric patients was 13.7%. If the chronic analgesic group was excluded the increase was only 2.85%, a real decrease in the number of these patients of 6.1%. The increase in the number of patients using analgesics chronically increased 25.23% from 2003 to 2005.

The overall cost to the medical scheme increased by 3.64% in total from 2003 to 2005 while the contribution income increased by 30.61%. The increase in the utilisation in the group, if chronic analgesic use was excluded, increased by 1.78% only, a real decrease of 28.83% from 2003 to 2005 in the utilisation cost of psychiatric patients. Even if the chronic analgesic group was included in this, the overall real increase in the utilisation cost for these patients was 26.97%.

Conclusion: Managing psychiatric patients appropriately and making treatment available to patients saves costs, contrary to the popular belief that capping benefits saves costs. This could only be achieved through the application of strict appropriate protocols, supported by evidence-based medicine and appropriate case management.

The relationship between the funder and the providers was strengthened to the benefit of the patient.

A PRELIMINARY REPORT ON ALCOHOL DRINKING PROBLEMS, OTHER DRUGS, SEXUAL AND PHYSICAL ABUSE AND UNIVERSITY POLICIES AT WALTER SISULU UNIVERSITY, MTHATHA

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Background: The use of alcohol and other drugs among university students is a matter of concern for mental health care providers and university authorities. The primary objective of the present study was to assess the use of alcohol and other drugs of abuse and their association with physical or sexual abuse. The secondary objective was to assess the students' knowledge about alcohol and drug-related policies at Walter Sisulu University in Mthatha.

The present paper is a preliminary study at the Faculty of Medicine only.

Material and methods: The (AUDIT) Alcohol Use Disorders Identification Test (cut off point of 8), embedded in a broader questionnaire was used as a screening tool to assess primary and secondary objectives, among the student population ($N = 96$) attending classes on a given day from 2nd-year and 5th-year groups at the Faculty of Medicine at Walter Sisulu University, Mthatha

Results: Only 4 (4.35%) male students tested AUDIT positive. 86 students (93.4%) believe that drugs should not be available on campus, but only 53 (57.6%) gave the same opinion about alcohol. Only 9 (9.3%) believe that campus is concerned about prevention of alcohol and drug use. 57 (61%) are ready to volunteer some of their time to help other students with drug- or alcohol-related problems. 60 (65.2%) of the students interviewed never drink alcohol, while 6 (6.5%) reported somebody injured last year related with the way they were drinking. There was no significant statistical association between sexual or physical abuse and alcohol or drug consumption.

Conclusions: Alcohol was the most commonly abused drug in the screened group. University policies about alcohol and drugs need to be reviewed and publicised.

'Facts & Values in Psychiatric Practice'
Selected abstracts

SCHIZOPHRENIA, STRUCTUAL VIOLENCE AND HUMAN RIGHTS

Jonathan Burns
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The core concept of schizophrenia is best conceived in terms of the Bleulerian concept of autistic alienation. The contributions of Heidegger, Merleau-Ponty and Wittgenstein allow us to arrive at a new 'philosophy of interpersonal relatedness', which better reflects the 'embodied mind' and signifies the end of Cartesian dualistic thinking. Patients with schizophrenia exhibit neurobiological and clinical evidence of social brain dysfunction. They find themselves seriously disadvantaged in the social arena and particularly vulnerable to the stresses of their complex social environments.

Farmer (2005) has used the term 'structural violence' (derived from Liberation Theology) to describe the social, economic and political forces such as poverty, inequality, racism and discrimination that influence peoples' health. These forces shape both the landscape of risk for developing illness and the context in which health care is provided. The concept of structural violence is relevant to schizophrenia since low socio-economic status, income inequality, urbanicity, homelessness and migration are factors that increase risk for the disorder. Furthermore, poverty and inequality are associated with earlier age of onset, longer duration of untreated psychosis, increased comorbidity and poorer access to services – all variables impacting negatively upon onset, course and outcome of schizophrenia.

Taken together, these observations call for a human rights perspective on schizophrenia in society. At-risk individuals suffer increased alienation, more severe psychosis and greater disability in response to toxic social forces such as deprivation and exclusion. I argue that modern, Western, neoliberal societies that are characterised by gross income inequality, urban poverty, low social cohesion, poor social welfare and high numbers of migrant, homeless and imprisoned subjects, are guilty of structural violence against individuals who are biologically vulnerable to psychosis. This constitutes a violation of the human rights of those predisposed to and suffering from serious mental disorders such as schizophrenia.

Farmer P. (2005) Pathologies of Power: health, human rights and the new war on the poor. Berkeley and Los Angeles, California: University of California Press.

HEAVY ALCOHOL USE IN ADOLESCENCE: EFFECTS ON BRAIN FUNCTION AND STRUCTURE – A PILOT STUDY

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Background: Alcohol use disorders (AUDs) are highly prevalent among adolescents and result in significant social and psychiatric morbidity. Yet surprisingly little is known about the specific effects of alcohol on the developing brain of adolescents. We examined frontal white matter integrity and grey matter volumes in adolescents with AUDs compared with healthy controls and hypothesised that white matter was likely to be more vulnerable to alcohol-induced damage given that brain development is particularly active during adolescence.

Methods: AUD adolescents (n=6, mean age 14.1 years, SD 1.47) without psychiatric and substance abuse comorbidity were compared with matched healthy controls (n=7, aged 12.4 years, SD 0.54). Structured and semi-structured interviews were followed by neuropsychological assessment and structural and diffusion weighted magnetic resonance imaging. We determined frontal fractional anisotropy (FA), an indicator of white matter tract integrity and regional grey matter volumes.

Results: Adolescents with AUDs had higher mean frontal deep white matter FA measures than the control group (0.79 [SD 0.008] vs 0.365 [SD 0.013]), F=4.251, p=0.049). Mean frontal grey matter volumes showed a trend to lower volumes in the AUD group (mean 158 195 mm^3 [SD=13 864]) vs controls (mean 159 365 mm^3 [SD=12 365], F=.082, p .875). Overall neuropsychological performance was at an average or below average level and we found no significant between-group differences based on mean scalar scores in any of the key neuropsychological domains tested.

Conclusion: The apparently paradoxical findings for grey and white matter in frontal regions may be a function of a different capacity of tissue types for repair following alcohol-induced injury. Lower frontal grey matter volumes may be irreversible with the result that the development of adequate brain reserve at this crucial phase of brain development is limited.

Resilience to future insults may be diminished and may translate to a higher risk for cognitive impairment and psychiatric morbidity later in life

BEHAVIOURAL INHIBITION AND SHYNESS IN HIV-POSITIVE PATIENTS

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Background: Psychosocial variables are known to influence disease progression in HIV. More recently social inhibition was identified as a risk factor for HIV progression, probably mediated by autonomic nervous system activity (ANS) (Cole et al., 2003). In contrast, temperamental constructs such as *behavioural inhibition* (BI) (a pattern of withdrawal and fearful behaviour in novelty situations) and *shyness*, both associated with anxiety disorders, have not been studied in HIV disease.

Methods: As part of a validation study of self-report screening instruments for depression, alcohol use and PTSD, 485 HIV+ adults were screened for cognitive impairment on the Mini Mental State Examination (MMSE) and the HIV Dementia Scale (HDS) to determine eligibility. 406 patients who scored >24 on the MMSE and >9 on the HDS were administered the MINI, Center for Epidemiological Studies Depression Scale (CES-D), Alcohol Use Disorders Identification Test (AUDIT), Life Event Checklist (LEC), Harvard Trauma Questionnaire (HTQ), Retrospective Self-Report of Behavioral Inhibition (RSRBI), and the Revised Cheek and Buss Shyness Scale, among others. The relationship between childhood BI and shyness, anxiety disorder, and HIV disease status was examined.

Results: Of the 406 patients, 75% were female and 64% were Xhosa-speaking. Their mean age was 33.5 years (± 30.4) and the mean duration of HIV diagnosis was 33.9 months (± 30.4). About half (51%) were on antiretroviral medications. 14% met criteria for an anxiety disorder. The most prevalent anxiety disorder was PTSD (5.7%), followed by agoraphobia (5.2%) and generalised anxiety disorder (4.7%). Patients with an anxiety disorder had significantly higher scores of childhood BI ($p < 0.001$) and shyness ($p < 0.015$) than patients without an anxiety disorder. BI and shyness scores were highly correlated ($p < 0.001$) While women reported more shyness than men overall ($p < 0.02$), there were no gender differences on retrospective self-reports of BI. Neither CD4 cell counts nor viral loads showed significantly correlations with BI or shyness measures.

Conclusions: These data, in an HIV-positive sample, support previous findings of a relationship between BI and anxiety in non-HIV samples,

specifically social anxiety and panic disorder. Further work is needed to establish whether the robust relationship between BI and anxiety disorder in HIV is mediated by shyness and whether, like social inhibition, is also mediated by differential ANS activity.

Reference

Cole SW, Kemeny ME, Fahey JL, Zack JA, Naliboff BD. Psychological risk factors for HIV pathogenesis: mediation by the autonomic nervous system. *Biol Psychiatry* 2003; **54** (12): 1444-56

DEFICIENT TESTOSTERONE IN MEN ABOVE 45 YEARS WITH MAJOR DEPRESSIVE DISORDER – AN AGE-MATCHED CASE CONTROL STUDY

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Background: Symptoms of partial androgen deficiency in ageing men (PADAM) overlap considerably with those of major depressive disorder. The relationship between these conditions is complicated by the usual age-related decline in serum testosterone concentrations.

Aim: To test the hypothesis that depressed men above 45 years of age would have a lower serum testosterone concentration in comparison with an age-matched control group.

Method: Serum testosterone fractions of 20 men above the age of 45 years suffering from a major depressive disorder were compared with those of 20 healthy men. An age-matched controlled design was used to account for the usual age-related decline in serum testosterone concentrations.

Results: Testosterone concentrations of men who suffered from a major depressive disorder were statistically significantly lower than an age-matched control group without depression.

Conclusion: The role of testosterone deficiency in depressed men needs to be examined further in order to develop appropriate treatment options.

ASSESSMENT OF PROFESSIONAL ATTITUDE OF FINAL YEAR MEDICAL STUDENTS, UNIVERSITY OF PRETORIA

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Introduction: Society expects from physicians a standard of behaviour and ethical values of the highest order. Medical educators must ensure that the training environment strengthen the humanist qualities that are essential to medical professionalism. This has proven to be a formidable task worldwide but there have been little attempts to evaluate the impact of this training. Two different assessments have been proven to be Beneficial: peer evaluation and assessment of their medical educators. In this ongoing research project the final year medical students assess their own professionalism and that of their peers in comparison with the assessment of their supervisors.

Method: Final year medical students rotate at Weskoppies Hospital for their 7-week Psychiatry rotation. Each student receives an informed consent to decide if they want to participate in this project. They assess their own and two allocated peers' professionalism and complete a standardised questionnaire with a scoring rate from 1 to 9, 9 being the highest score in the following six aspects: respect, empathy, interpersonal relations, maturity, integrity and responsibility. The registrars also complete the questionnaire on the students who worked in their firm.

Results: Two groups have been tested so far and the data for both groups show similar results. They assess themselves in most cases exceptional (score of 8), and the supervisors also assess mostly exceptional (score of 8-9), but they assess their peers either unacceptable (4-5) or very high (score=9).

Discussion: Designing tools to assess professionalism proves to be a difficult task and if results are not discussed in format of feedback sessions nothing may be gained. A professional attitude workshop is suggested in the future to assess our assessment tool. Peer assessment can be of benefit if medical students learn the importance of peer interactions during their basic science years of medical education. Peer evaluation is an important factor for later professional success, e.g. referrals and teamwork. Assessment of professional attitude also involves a continuous process of self-evaluation of our professionalism as teachers.

NEUROIMAGING IN PSYCHIATRY – 'SEEING IS BELIEVING'

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Introduction: This is a colourful presentation of abnormal regional cerebral activity (RCA) in schizophrenia, depressive disorders and anxiety disorders. It became apparent through neuroimaging that usually not only one brain region is changed, but several of them, possibly at quite different places in the brain, and interacting in a complex manner. Neuroimaging also shows that symptoms have the predictive power in determining patterns of regional cerebral activity and is independent of diagnostic category. For instance psychomotor retardation is a symptom in both major depressive disorder and negative symptoms in schizophrenia and is associated with decreased regional cerebral activity on the left prefrontal cortex (PFC), and reduced spontaneous speech, also seen in schizophrenia and depression, showed decreased RCA of the left dorsolateral PFC, independent of the 'syndromal' diagnosis.

Method: Medline search and Google-image search with keywords: neuroimaging/schizophrenia/depression/bipolar/anxiety disorders/ SPECT/

Results: The overall impression is that the prefrontal cortex, anterior cingulated gyrus, thalamus, temporal lobe gyrus and amygdala are implied in all these conditions. In schizophrenia increased regional cerebral activity is found in the right dorsolateral prefrontal cortex, especially in cases with negative symptoms. The thalamus plays an important role in information processing capacity and abnormal anterior thalamus activity is found.

Major depressive disorders also show abnormal activity in PFC but a decrease in the dorsolateral and dorsomedial areas, which is reversible with antidepressant treatment. Where patients with schizophrenia showed decreased activity in the amygdala when viewing fearful faces and no change in activity when watching unpleasant images, depressive patients showed increased activity. Post-traumatic stress disorder also shows increased activity in the amygdala and increased activity in the orbitofrontal cortex.

Discussion: This study summarises all existing studies on abnormal regional cerebral activity in schizophrenia, depression and anxiety disorders and shows the region(s) of interest (ROI) in these conditions may be better predicted by symptom-profiles.

AIMING FOR A BETTER OUTCOME IN SCHIZOPHRENIA: IS REMISSION ATTAINABLE?

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Background: Identifying reliable predictors of treatment outcome in schizophrenia would enable clinicians to recognise patients requiring special interventions at an early stage of the illness. Previous attempts

to identify clinically useful predictors of outcome have been hampered by methodological inconsistencies, including a lack of standardised outcome measures. Recently proposed operationally defined criteria for remission provide an opportunity to re-investigate possible predictors of outcome. The development of operationally defined criteria for remission has focused attention on improving the overall outcome of schizophrenia. Studies to date suggest that oral antipsychotics, although very effective in the short term, do not lead sustained remission in the majority of cases. Non- and partial adherence appear to be major contributing factors, particularly in the early phases of the illness.

Method: Data will be presented indicating that defining remission according to sustained symptom reduction is a good way of identifying people with overall better outcome and quality of life. In another study, we examined the potential of various demographic, baseline clinical and early treatment response variables to predict remission and non-remission in schizophrenia. The remission criteria were applied to a sample of 57 subjects with first-episode psychosis who were treated according to a fixed protocol over 2 years. We employed discriminant analysis to assess their ability to predict remission or non-remission. We also assessed the symptom improvement patterns and compared endpoint psychopathology in the remitters and non-remitters.

Results: A model incorporating early treatment response, duration of untreated psychosis, neurological soft signs and depressive symptoms at baseline was able to correctly predict 82% of remitters and 85% of non-remitters.

Discussion: A major shortcoming of oral antipsychotics is their failure to provide sustained remission in the majority of patients. Alternative methods of antipsychotic delivery need to be urgently sought. A combination of demographic, baseline clinical and early treatment response variables may accurately predict treatment outcome.

WHO REMAINS IN INSTITUTIONAL CARE FOR MORE THAN 40 YEARS?

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South Africa has a long and tragic history of institutional care. Under the new dispensation an official policy of deinstitutionalisation has been adopted. To support this strategy the promulgation of the Mental Health Care Act (2002) (MHCA), and special attention to rehabilitation with a view to discharge are now in place. The Community-based Mental Health Project has given attention to preparing the community for the return of institutionalised mental health users.

Patients previously described as the 'chronic mentally ill' have been given renewed attention under the banner of persons with 'serious and persistent mental illness' (SPMI). These patients are also referred to as persons with a 'severe psychiatric condition'. But who are these persons with a severe or serious and persistent mental illness who remain institutionalised for more than 40 years?

Inspired by the requirements of the Periodical System promulgated in the MHCA a number of patients long resident in two institutions were reviewed for the purpose of a Periodical Report.

This paper will present, in sketch format, three patients institutionally resident for periods of 55 years, 47 years and 46 years.

An analysis of 12 persons who have remained, and continue to remain, in institutional care after more than 40 years will also be presented.

Implications for and recommendations regarding the future management of persons 'permanently' resident in institutions will be discussed.

'WORK PHOBIA' IN WOMEN APPLYING FOR MEDICAL BOARDING IN SOUTH AFRICA

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Background: The high prevalence of psychiatric conditions in the general population and the known association between these conditions and disability, inevitably leads to increasing claims for disability on psychiatric grounds. Indeed, psychiatric conditions have taken over from musculoskeletal disorders, in particular low backache, as the leading cause of disability in South Africa.

During the last 12 years the author has conducted independent assessments on over 800 women applying for medical boarding on psychiatric grounds, supported by treating psychiatrists and psychologists and other professionals. The average age of these women was in the low 40s.

Emergence of 'work phobia' as a major psychiatric problem: Some variation of chronic mood disorder was the almost universal stated diagnosis. But common adverse life situations and experiences made significant contributions, although adjustment reaction was rarely diagnosed. In particular, common negative attitudes to aspects of work and the working environment became clearly discernible in this population.

The author concluded that, in large numbers of women, the final decision to apply for medical boarding may be best conceptualised as resulting from a 'work phobia'.

Resistance of 'work phobia' to current treatments: Symptom relief was the goal of most treatment regimens, usually based on the algorithms of standard guidelines for the management of mood and anxiety disorders. And some symptomatic improvement was fairly commonly achieved during periods of sick leave. But, unsurprisingly, this typically had little effect on overcoming the underlying 'work phobia'. Remarkably, few of the women had ever been exposed to any rehabilitation programme aimed at overcoming the specific resistance to returning to work.

Aim of the presentation: To encourage increased recognition of the impact of associated but poorly managed 'work phobia' on psychiatric conditions in women in South Africa.

VALUES-BASED AND EVIDENCE-BASED PSYCHIATRY: EITHER, BOTH OR NEITHER?

K W M (Bill) Fulford

Much of the debate around the very status of psychiatry as a medical discipline has focused on the significance of psychiatry's more value-laden diagnostic concepts compared with other areas of medicine. Anti-psychiatrists, working in the tradition of Thomas Szasz, have argued that these value judgements showed psychiatry to be a social rather than medical discipline, concerned with 'life problems' rather than genuine diseases. On the other side there have been authors, such as R E Kendell, who have argued that with future developments in the neurosciences, psychiatric diagnostic concepts will become no more value-laden than the concepts of general medicine. This paper will use case examples to illustrate the way in which values come into the very heart of psychiatric diagnosis. Recent developments in a branch of analytical philosophy, called philosophical value theory, will then be drawn on to show that these diagnostic values, contrary to the views of both antipsychiatrists and scientifically minded psychiatrists, are integral to the nature of psychiatry as a discipline that is both genuinely science-led but also genuinely patient-centred. Some of the practical implications of this conclusion will be briefly outlined.

VALUES-BASED PSYCHIATRY: NATIONAL INITIATIVES AND INTERNATIONAL PROSPECTS IN PHILOSOPHY, PSYCHIATRY AND NEUROSCIENCE

K W M (Bill) Fulford

The 1990s, although rightly celebrated as the 'decade of the brain', also turned out to be the 'decade of the mind'. Alongside dramatic developments in the neurosciences, there was an unprecedented growth in interdisciplinary work between philosophy and psychiatry. This paper will outline these developments, focusing particularly on the impact of the new philosophy of psychiatry on service development, policy training and neuroscience research in what has become known as 'values-based practice'. The paper will give examples of some of the ways in which values-based practice, working alongside evidence-based practice, is being used to support clinical decision-making in context, such as in cultural psychiatry, where complex and diverse values are in play. The paper will conclude with my briefly setting current developments in their historical context and indicating the likely future directions for future developments in the new field.

EMOTIONAL INTELLIGENCE: POP-PSYCHOLOGY OR SCIENCE?

Gerhard I Grundling

Background: The publication of Daniel Goleman's book *Emotional Intelligence: Why it can matter more than IQ* in 1995 generated unprecedented interest in the role emotional intelligence plays in our lives. Being both a journalist-writer and a PhD scholar in psychology from Harvard, he was able to coherently define in layman's language what emotional intelligence is and its importance for success.

Emotional intelligence did not first appear in 1995, but has a longstanding history as it appeared under various other terms in scientific psychology. Robert Thorndike referred to social intelligence in 1936. David Wechsler defined 'non-intellective' aspects of general intelligence in 1940.

It has been recognised that cognitive intelligence does not necessarily guarantee success in life. The drive has been established early on in the 20th century to measure the so-called 'soft skills' that enable people to be successful in life. Owing to the complexity and the difficulty to measure emotional intelligence efficiently, the interest subsided, and this sent it into a state of hibernation.

Method: The literature regarding emotional intelligence will be reviewed to show the development from cognitive intelligence measurement towards the development of scientific measurement of emotional intelligence. In this regard the work of Dr Reuben Baron will be of specific importance as it relates to the South African context. The composite scales of emotional intelligence as well as the factorial components thereof will be discussed.

Results: The applicability of emotional intelligence in clinical settings will be identified. The value of emotional intelligence in psycho-diagnostics will be shown as it relates to patient's psychological well-being and potential for emotional health. Emotional intelligence can help determine the need for therapy, and to establish clear therapeutic goals. This can be applied both in the psychiatric patient population as well as in settings where patients with severe medical conditions need to be assessed and helped.

Conclusion: It will be shown that emotional intelligence is not pop psychology, but has been scientifically developed into a measurement tool(s) that enables the identification of problem areas as well as identifying focus areas for development that would enhance the general emotional well being of patients and clients alike and increase their ability to achieve success in life.

INVESTIGATING THE ROLE OF THE GLUTAMATE-NITRIC OXIDE PATHWAY IN POST-TRAUMATIC STRESS DISORDER: STUDIES USING TIME-DEPENDENT SENSITISATION

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Pre-clinical studies have provided robust evidence that severe stress is damaging to the brain. While this observation has been difficult to reproduce in humans, brain-imaging studies in posttraumatic stress disorder (PTSD) have emphasised that severe stress does indeed induce pronounced changes in regions of the brain involved in regulating the response to stress, in particular shrinkage of the hippocampus. While controversy prevails as to whether these changes represent an adaptive process or are indeed pathological, they are associated with marked changes in memory and other cognitive functions. Moreover, the latter changes appear to be correlated with illness severity and are reversible following illness improvement after successful pharmacotherapy. Stress in various guises may alter synaptic connectivity in the brain by bolstering glutamatergic excitotoxic mechanisms, one of particular relevance being the release of the pleiotropic messenger molecule, nitric oxide (NO). Not only does NO have profound neuromodulatory actions on the release of serotonin, noradrenaline and dopamine, but it has prominent actions on cellular pathways that mediate neuronal plasticity, resilience and survival. These mechanisms may contribute in a significant manner to the neuropathology of PTSD, while a better understanding of their role may realise improved treatment stategies. This paper will present recent pre-clinical and clinical evidence supporting a role for the glutamate-NO pathway in PTSD. In particular, data based on studies using an animal model of repeated trauma known as time-dependent sensitisation will be presented.

METHAMPHETAMINE IN SOUTH AFRICA: QUO VADIS?

V H Hitzeroth, L Kramer
1 Solway Street, Bellville, W Cape

Background: The abuse of methamphetamine ('tik') in South Africa has increased dramatically over recent years. The South African Community Epidemiological Network on Drug Use (SACENDU) has reported that the initial wave of 'tik' abuse has already spread from Cape Town to the rest of the country. It thus seems likely that the 'tik' problem will remain with us for a considerable period of time. Unfortunately the medical, psychological and social costs of 'tik' abuse are high. In order to address this methamphetamine crisis, psychiatrists have to familiarise themselves with the physical and psychological complications, as well as the intervention options.

Method: This presentation will place 'tik' into the illicit drug-abusing context. It will highlight the pitfalls associated with the medical and psychological risks of methamphetamine use. The main body of the presentation will focus on the latest evidence-based research regarding the treatment options available to clinicians for amphetamine-based drug intoxication, withdrawal and dependence. This research includes a number of recent reputable international guidelines and publications. These will be presented and discussed in detail.

Results: Various pharmacological and psychological interventions for methamphetamine abuse have been studied. These interventions include a number of antidepressant medications, dopaminergic agents, mood stabilisers and substitute drugs, as well as various psychological treatments. Numerous studies have been conducted, but very few of these are of a sufficiently high scientific standard to be included in the evidence

base. This presentation will conclude by discussing practical and safe treatment options that are available to the practicing psychiatrist who is faced with such a case.

Conclusion: The search for an effective treatment for amphetamine-based drug abuse has produced many results, which have been grasped at with both hands by patients and practitioners alike. Unfortunately, the scientific evidence-base for such treatment interventions remains limited. While the scientific community continues their search for this particular 'holy grail', the clinicians, patients and affected families are continuing their struggle at the clinical coalface. In order to provide safe and effective care, knowledge of the evidence base is crucial. This can then be tailored to local treatment needs.

THE 'DISEASE CONCEPT' OF ADDICTION: FACTS AND VALUES

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Background: The contemporary view of addiction relates to the medical model. Our assessment and treatment of a patient who is addicted to a substance is based primarily on the disease concept of addiction. This model is well established and widely accepted. Yet it also has many critics. The criticism of the disease concept is often ignored and neglected to the disadvantage of our patients.

Method: This presentation will outline and explain the disease concept of addiction. The scientific facts and the cultural values that influenced this model, as well as the relevant academic studies that made a significant contribution throughout its development, will be highlighted. The influence that the disease concept has exerted on the formation of the DSM IV and ICD 10 Classifications systems will be pointed out. Common criticisms of the disease concept will be presented. Evidence for and against alternative addiction models will also be shown. These include the moral, sociological, political and psychological contributions.

Results: The listener will be presented with a history and definition of the disease concept of addiction. This will be critically analysed. Alternative models will be presented, their evidence explored and their usefulness explained.

Conclusion: Although our own background and training relates to medicine and psychiatry, we have to become aware of the reasonable (and unreasonable) criticisms aimed at our way of working. We have to be knowledgeable enough about the facts and values of alternative addiction theories, and flexible enough to use these concepts and practices when our patients require or demand it.

This is the only way to ensure the best possible outcome for a patient struggling with a substance-related disorder.

CENTRAL REGULATION OF APPETITE

Leigh Janet

Obesity is rapidly emerging as one of the major health problems confronting humankind. For the first time in history the number of overweight people on earth is tending to exceed the number of underweight people. Overweight and obesity is increasing in all population groups, with concomitant increases in related medical illness. Among the numerous causes of increased weight are psychotropic medications. The interaction between psychiatric morbidity, psychiatric treatments and overweight/obesity creates additional management issues for the clinician. Some mechanisms by which psychotropic drugs interact with appetite and weight regulation are discussed. Amid an evolving propaganda, elegant advances in neuroscience have received little attention. The regulation of eating behaviour both at rest and under stress is yielding exciting new data. Numerous pharmacological agents with diverse and novel mechanisms of action are being evaluated as a means to combat overweight and obesity.

COMORBIDITY IN BIOPOLAR DISORDER

Leigh Janet

The management of bipolar disorders is influenced by two complex factors: mixed states and comorbidity. Comorbidity – that is, the presence of comorbid psychiatric and medical conditions – is the rule with bipolar type II mood disorders, and is frequent in bipolar I mood disorder. Psychiatry continues to grapple with the psychopathological and aetiological implications of comorbid states. Recent opinions on these matters will be highlighted, including the novel proposal of Akiskal and Lara. Pertinent developments in genetics will be highlighted. The presence of comorbid conditions in the majority of bipolar II patients increases the difficulty of assessment and management of these patients. The review deals with the types of comorbid conditions commonly found in bipolar spectrum mood disorders, how these conditions influence the clinical presentation and how they are managed.

PUBLIC SECTOR MENTAL HEALTH PRACTICE ACCORDING TO THE NEW MENTAL HEALTH CARE ACT

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Background: One of the main aims of the new Mental Health Care Act, Act No. 17 of 2002 (MHCA), is to promote the human rights of people with mental disabilities. However, upholding these rights seems to be subject to the availability of resources. Chapters 5, 6 and 7 of the Act define and regulate the different categories of mental health care users, clarify the procedures around these categories and spell out mental health practitioners' roles and responsibilities in this regard. Chapter 2 of the MHCA clarifies the responsibility of the State to provide infrastructure and systems. Owing to 'limited resources' practitioners often work in an environment where staff ratios may be a fraction of of what could be expected and in units with totally inadequate physical structure and security systems. This interface between individual professional responsibility versus the impairment on clinical decisions resulting from inadequate infrastructure and staffing needs to be dissected out.

Method: A review was undertaken of current relevant legislation in order to clarify the legal, ethical and labor position of public sector mental health practitioners as employees of the role player responsible for adequate mental health resources according to the MHCA.

Results: Legislation reviewed includes the Mental Health Care Act, No. 17 of 2002; the Bill of Rights included in the Constitution of the Republic of South Africa, Act No. 108 of 1996; the National Health Act, No. 61 of 2003; the Medical, Dental and Supplementary Health Services Professions Amendment Acts No. 18 of 1995 and No 89 of 1997; the Medicines and Related Substances Control Amendment Act, No. 90 of 1997; the Medical Schemes Act, No. 131 of 1998; the Labor Relations Act, No. 66 of 1995; and the Promotion of Access to Information Act, No. 2 of 2000.

Conclusion: Formal legal advice on the legal, ethical and labor position of public sector mental health practitioners as state employees is necessary and should form the basis of the principles endorsed by SASOP and other organised mental health care practitioner groups.

CT SCANS IN PSYCHIATRIC PATIENTS AT CHRIS HANI BARAGWANATH HOSPITAL

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Aim: The aim of this study was an exploratory one to determine the yield of abnormal X-ray computed axial tomography (CT) in mentally ill patients at Chris Hani Baragwanath Hospital, Johannesburg.

Method: All mentally ill in-patients, aged 18 years and older, who presented during the period March to August 2005 were screened and those who underwent an X-ray CT of the head were included in the study. The investigators recorded the patients' demographic data, clinical details, special investigations and the results of the X-ray CT.

Results: A total of 55 X-ray CTs were conducted during the study period. 20 (36.4%) of these patients showed some abnormal finding. The mean age of the study population was 38.3 years (SD: 16.3) and 7 (35%) patients with abnormal X-ray CTs were over the age of 60 years. There was a significant correlation between abnormal X-ray CTs and advancing age (r= 0.5; $p < 0.001$). In the group with abnormal X-ray CTs: the gender distribution was similar; 15 (75%) presented with a first episode of psychosis; 5 (25%) had a concurrent abnormal physical examination; and 7 (35%) had abnormal special investigations. There was no significant difference between this group and the group with normal X-ray CT scans with regard to these variables respectively (χ^2=0.75; p=0.385); (χ^2=2.76; p=0.096); (χ^2=0.51; p=0.473); (χ^2=0.13; p=0.714).

Conclusion: X ray CT in the psychiatric population provides a significant yield of abnormalities especially in patients with first episode psychosis. This study also suggests that clinical abnormalities (physical and laboratory) are unreliable predictors of abnormal CTs.

MEDICATION CHOICE IN ADULT ADHD

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This presentation will review the most common core and associated symptoms of ADHD in adults and frequent comorbid disorders. A practical use of a recently validated Adult ADHD Rating Scale will also be introduced (Turgay *et al.*, APA, 2004). Ritalin has been the hallmark drug for the treatment of ADHD for many years. During the last few years, long-acting psychostimulants (i.e. Adderal XR, Concerta, and Ritalin LA) and a non-stimulant, Strattera, became available.

Psychostimulants and Strattera are considered first-line medications in the treatment of adult ADHD (Canadian ADHD Practice Guidelines, 2006). In the determination of 'first choice' for each patient and 'second, third or fourth' choices, the following factors are considered: 1. Subtype of the ADHD, 2. Presence or absence of high blood pressure, 3. The nature and severity of comorbid disorders. 4. Earlier history of medication use, desired effects and side effects experienced. 5. The impact of ADHD during the day and evening. The duration of effect for ADHD medications are different: Ritalin: 4 hrs, Dexedrine: 6 hrs, Adderal XR, Concerta, Ritalin LA: 12 hrs, Strattera and Imipramine: 24 hrs. For the adults with ADHD only, psychostimulants and Strattera will the considered as the first-line medications. For the patients with tic or Tourette disorder and/or anxiety disorders Strattera can be the first choice because of its positive effects on ADHD and these other disorders. For cases where aggressive behaviour is associated with ADHD, where there is an urgent need for immediate efficacy, psychostimulants will be the drug of choice. Among the ADHD medications with strong antidepressant effect, Bupropion and imipramine can be considered. Both have strong antidepressant and antianxiety effects but some patients may still need additional psychostimulants to enhance the anti-ADHD effect. Studies by Turgay *et al.* (APA, 2005, Turgay *et al.*, *Psychiatry* 2006 April issue) indicated that half of the adults with ADHD also suffer from mood disorders and/or anxiety disorders. SSRIs and psychostimulants can be combined to improve the chances of complete remission for depression and normalisation for ADHD symptoms. This presentation will outline starting, maintenance and maximum dosing for the commonly used ADHD medications, their side-effects and the most effective strategies in controlling the adverse reactions.

MENTAL ILLNESS AS A DEFENCE AGAINST MURDER IN A SOUTH AFRICAN SETTING

P M Joubert, W van Staden

Aim: To establish the forensic psychiatric findings in terms of Section 78 (2) of the Criminal Procedures Act, No. 51 of 1977, as amended in observation cases charged with murder who were admitted to Weskoppies Hospital for assessment from 1987 - 2000.

Method: South African courts refer people who are accused of murder for a psychiatric assessment if they suspect that, due to mental illness, the accused persons are not accountable or able to stand trial. We researched such referrals specifically with regard to psychiatrists' reports indicating whether the accused persons were accountable or not accountable due to mental illness.We searched for all forensic psychiatric observation cases with a charge of murder who were referred to Weskoppies Hospital in terms of Section 78 (2), read together with Section 79, of the Criminal Procedures Act, No. 51 of 1977, as amended, over the period 1987 - 2000. Data were collected from hospital registers and clinical files. Where it was needed and indeed possible, diagnoses were converted to the nearest appropriate DSM-IV-TR diagnoses. All available cases where a charge of murder was confirmed ('murder observations') were included. Charges of attempted murder or culpable homicide were not included, except if there was also a charge of murder. Demographic information, diagnoses, and the outcomes regarding accountability were collected.

Results: Out of the available files at Weskoppies Hospital, we found 579 observation cases who were charged with murder. Twelve of these were excluded: 4 because the files could not be revisited later and 8 because the observations were not completed. The remaining 567 cases were used. The group was comprised of 482 males (85.01%) and 85 (14.99%) females. Of these cases the final psychiatric reports to the courts indicated the following: 24.34 % lacked criminal responsibility, 6.35% had reduced criminal responsibility, and 62.61% had full criminal responsibility. In 6.53% of cases the outcome was unsure and in 0.18% the outcome was in dispute. A psychotic disorder was the most common finding among those considered lacking criminal responsibility; for those deemed to have reduced criminal responsibility most had a combination of diagnoses (33.33%) followed by an adjustment disorder (16.67); for those deemed to have full criminal responsibility by far the most had no diagnosis (66.76%) followed by a combination of diagnoses (7.61%). By far the majority of those considered to lack criminal responsibility (63.39%) had a diagnosis of schizophrenia, followed by psychotic disorder not otherwise specified (12.5%). The mean ages were as follows: of all the subjects – 32.32 (± 10.06) years; of those deemed to have lacked criminal responsibility –32.58 (± 8.51) years; for those deemed to have reduced criminal responsibility – 33.36 (± 11.11) years; for those considered fully criminal responsible – 31.99 (± 10.55) years; for those with an unsure outcome – 33.57 (± 9.8) years. The four most common overall diagnostic categories were: no diagnosis (43.56%), a psychotic disorder (20.99%), alcohol abuse or dependency (6.35%), and epilepsy uncomplicated by a psychiatric disorder (5.64%).

Conclusion: Nearly two-thirds of these observations were considered to be accountable on psychiatric grounds, even though about one-third of these cases had a psychiatric diagnosis. A psychotic disorder was the most common finding in cases considered not accountable due to mental illness.

UTILISATION OF CONSULTATION-LIAISON PSYCHIATRIC SERVICES FOR KNOWN HIV-POSITIVE INPATIENTS AT A GENERAL HOSPITAL

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Background: With the current HIV epidemic in South Africa, consultation-liaison psychiatric services are encountering increasing numbers of HIV-positive referrals. Many local studies on HIV and psychiatry have focused on outpatient populations, in contrast to the inpatients frequently encountered by consultation-liaison services. The study aimed to examine the profile of known HIV-positive inpatients at a general hospital who were referred for psychiatric evaluation, and to explore the reasons for such referral.

Method: A retrospective chart review was conducted of all psychiatric consultation requests received for HIV-positive inpatients at King Edward VIII Hospital during a 12-month period.

Results: Most consultations were for females (83.3%), median age 30, with no previous psychiatric history (95.8%) and symptom duration of less than 1 week (54.2%). Medical (70.8%) and Obstetrics and Gynaecology wards (25.0%) provided the bulk of the consultations.

Patients were referred mainly for behavioral disturbances (57.9%), psychotic features in the form of hallucinations (57.9%) and delusions (47.4%). Anxiety and depressive symptoms did not feature as reasons for referral.

The commonest psychiatric diagnoses made included delirium (50.0%), dementia due to HIV (16.7%), and psychotic disorder due to HIV (16.7%). All patients with delirium had multiple aetiological risk factors for the development of the disorder. All patients with dementia had evidence of a co-morbid delirium on initial assessment. One patient was diagnosed as having mood disorder due to HIV, with manic symptoms, but no depressive or anxiety disorder diagnoses were made.

Most (83.3%) patients were co-managed in the referring ward, with only those diagnosed with psychotic disorder due to HIV requiring admission to a psychiatric ward.

Conclusions: In contrast to outpatients, HIV-positive inpatients present mostly with 'organic' mental syndromes, in particular with delirium. The condition is frequently missed, and thus there is a need for greater training of health professionals in the detection and management of delirium. The study also highlights a likely problem of under-recognition and under-referral of HIV-positive inpatients, with anxiety and depressive disorders.

DOMESTIC VIOLENCE AND THE SOUTH AFRICAN POLICE SERVICE

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Background: It is generally accepted that members of the SAPS are exposed to extremely high levels of stress. The stress that police have to endure has been implicated in, among other things, police suicides, psychiatric morbidity, domestic abuse and family murders. This study aims to explore the correlates of domestic abuse among members of the SAPS, and their intimate partners.

Method: A retrospective chart review was conducted of all adult members of the police medical aid scheme who presented to a private practice psychiatrist in the period 01/01/2005 to 31/12/2005. Patients who self-reported abuse as defined by the Domestic Violence Act of 1998 were identified.

Results: 149 subjects, 84 (56.4%) male and 65 (43,6%) female, were identified. 99 (66.4%) were employed by the SAPS, while 65 (33.6%) identified their intimate partners as being employed by the SAPS. Most were in their 5th decade (49.0%), were married (81.2%) and denied previous psychiatric history (58.0%). 45.0% of the total sample admitted to abusing substances, mainly alcohol. Among males, 65.5% reported abusing alcohol. Only 4% of all patients had utilised the police services Employee Assistance Programme. 47 (31.5%) of the total claimed to have experienced domestic abuse at the hands of their intimate partner. Of these 42 (89.4%) were female and 5 (10.6%) male. Among female patients the rate of reported domestic abuse was 64.6%. Emotional (95.7%) and physical abuse (72.3%) were most common, with economic (36.2%) and sexual (21.3%) abuse less frequently reported. Male patients reported emotional abuse alone. The abuse continued for over 4 years in 68.1%. 72.3%of those abused had required hospitalisation for the psychiatric consequences of abuse, and 12.8% had required hospitalisation for physical injuries related to abuse. Only 25.8% had sought assistance for abuse from the police or legal profession. All the abused patients were diagnosed as having depression; some had comorbid substance abuse and anxiety disorders. 70.2% implicated substance abuse by their intimate partner as a causative factor for the domestic abuse.

Conclusions:

1. High rates of domestic abuse.
2. Low utilisation of help resources.
3. Possible association between substance abuse and domestic abuse.

ADDICTION AS VIRTUAL SEEKING – EVOLUTIONARY INSIGHTS INTO ADDICTION

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The ability to adapt to changing levels of stress or threat (allostasis) derives from an earlier homeostatic ability to maintain intact bodily systems. Emotions (as well as the stress response system and pain perception) are allostatic because unlike homeostasis, they have no set point and reflect an exquisite link to our social milieu (e.g. success, failure, defeat) – allowing us to adapt to a constantly changing world. Stress responses, therefore, can continue to escalate predisposing to depression with consequent negative effects on the body. Prenatal stress, maternal stress and early life stress predispose to long-lasting or chronic arousal of CRF and increased salience of environmental stimuli (adaptive), vulnerability to later anxiety and substance abuse.

The seeking system (dopamine mediated) is an ancient emotional system, which allows us to find and anticipate survival needs by exploration (from nuts to knowledge, mates to fear responses). The seeking system responds to stressors and anticipation of pleasant and aversive events i.e. animals must seek solutions. It is adaptive because one must seek when one is under stress. Cocaine and amphetamines provide a direct porthole into the feelings evoked by this system. Opiates provide such a porthole into the attachment system of social bonding (recruited by the seeking system).

The cognitive apparatus and ultimately consciousness provides humans with vastly wider behavioural choice and adaptive flexibility (partially via emotional control, metacognitive or re-representational capacity, working memory, placticity, modelling).

The cognitive choices we make are an intimate refection of our current allostatic state. I will argue that with the evolution of executive function and language in combination with our capacity for shared pretend play and self-deception, has arisen the ability to act out *virtual seeking behaviour*. This offers a *forme frustes* or frustrated refection of the allostatic problem, as well an immediate solution. Like denial and fantasy if sustained, these become addictions and very soon a behavioural trap de-linked from better alternatives and eventually, from life itself. The addiction very soon adds to stress biochemically, as well as via damages and losses.

The Alcoholic Anonymous adage that *sobriety equals abstinence* plus change has far-reaching implications for this model.

MORPHOLOGICAL FEATURES IN A XHOSA SCHIZOPHRENIA POPULATION

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Various minor physical anomalies have been described in schizophrenia and suggest a neuro-developmental underpinning to the aetiology of this illness. It is of interest to identify the critical prenatal phase in which these specific physical anomalies develop. The aim of the study was therefore to investigate the relationship between minor physical anomalies and schizophrenia in a Xhosa schizophrenia population.

One hundred and forty participants (21 affected sibling pairs,1 affected sibship of four, a group of affected probands with an affected non-participating sibling (n=17), 20 non-affected sibling pairs and 37 non-affected singletons) of Xhosa ethnic origin were recruited for a larger genetic study. Each participant was examined (standardised digital images) by a clinical geneticist blinded to the diagnostic status of the participants using a modified Waldrop scale. A univariate and multivariate analysis, with allowance for the correlation between the sib pairs, was done.

Adherent earlobes were significantly more common in the non-affected sibling pair group (p=0.003), asymmetrical ears more common in the non-affected singletons (p=0.005) and a gap between the 1st and 2nd toe significantly more common in the affected sibling pair (p=0.013) and affected proband group (p=0.019). This relationship was not confounded by gender in the multivariate analysis.

The overrepresentation of specific minor physical anomalies in affected sib pairs may be indicative of specific developmental abnormalities linked to shared familial factors.

VALUES, MORE THAN FACTS, DETERMINE DRUGS TERMINOLOGY

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Background: Globally and throughout history, people have used drugs for their mind-altering properties. Yet precisely what is meant by the term 'drug' has varied across societies and the ages. Today, it is still not easy to find a commonly agreed-upon definition of the term 'drug'. The literature displays various complexities and inconsistencies. The view of whether a given substance is, or is not, considered to be a 'drug' bears little correlation with the scientific properties of the substances in question and has more to do with prevailing social values and norms.

Methods: This presentation will explain why the term 'drug' does not signify a clear-cut category. It will critically review the literature and explore the different aspects that need to be considered when determining drugs terminology. It will firstly challenge and then ultimately enhance the listener's understanding of the social construction of the term 'drug'.

Results: The presentation will shed light on why it is difficult to determine precisely what is meant by the term 'drug'. It will discuss Claridge's Total Drug Effect Model and provide insight into the processes of changing drug definitions that occur as a drug permeates throughout society. The social construction of the term 'drug' and how drug definitions can be manipulated to serve political and economic interests will be explored. The presentation will discuss why we should avoid value-laden terms and suggest terminology based on facts.

Conclusion: 'Drugs' are given attributes that are largely socially fabricated. Practitioners in the substance misuse field need to clarify what is meant by the term 'drug', so as to develop a balanced and objective view of the various perspectives. Informed debate on drug-related issues will benefit drug users, their families and practitioners alike.

THE VALUE OF ART AND CREATIVITY IN A SEX THERAPY SETTING

Bernard Levinson

Placing a blank sheet of paper in front of a patient with the soft urging 'draw whatever you wish …' can be extremely daunting. With gentleness and care art becomes a hot, immediate, all-revealing journey.

I will demonstrate how paintings can be used as a springboard for therapy; how they become a valid diagnostic tool; and how accurately they can portray the changes taking place in the patient.

In sex therapy I use art to provide a unique 'dialogue' between the couples.

Art reveals everything.

PERSISTENCE OF ATTENTION DEFICIT HYPERACTIVITY DISORDER INTO ADULTHOOD: A STUDY CONDUCTED ON PARENTS OF CHILDREN DIAGNOSED WITH ATTENTION DEFICIT/HYPERACTIVITY DISORDER

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Childhood ADHD was first recognised in the early 1900s but recognition of the disorder's persistence into adulthood did not occur until the 1970s. The pioneers who first identified ADHD in young children assumed that they would outgrow the condition in adulthood. Recent literature including follow-up studies have however found that the persistence of ADHD into adulthood is higher than previously thought with as many as 50% to two-thirds of children with ADHD continuing to have the disorder as adults. No figures are available for South Africa.

Objective: To determine the persistence of ADHD into adulthood in parents of children currently attending the child and adolescent clinics at Weskoppies Hospital and Eersterus Community Clinic.

Method: A structured questionnaire was completed by 58 parents of ADHD children. Those parents identified as having childhood ADHD were further required to complete a screening questionnaire for adult ADHD.

Results: 37.9% (22) of the 58 participants were found to have childhood ADHD. Of these 22 participants 36.4% (8) were still found to have symptoms suggestive of ADHD.

Conclusion: Childhood ADHD has been reconceptualised as a lifespan disorder. Our study was in keeping with other studies showing a persistence of ADHD into adulthood.

HUMAN RIGHTS ABUSES AT A MENTAL HOSPITAL IN KWAZULU-NATAL

D L Mkize

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Introduction: Following allegations of human rights abuses at Townhill Hospital in Pietermaritzburg, KwaZulu-Natal that were reported in the local newspaper, the national Minister of Health and the provincial Minister of Health visited the hospital. Because of the seriousness of the allegations, the Minister of Health established a committee of enquiry to investigate the allegations.

Commission of enquiry: Eight members including experts in mental health care services, legal services, public service oversight, hospital board and a representative of the community formed the commission. A committed secretarial service with the responsibility of audio recording of the proceedings was assigned to the commission.

Objectives: The terms of reference of the Committee of Enquiry were to investigate allegations of human rights abuses of psychiatric patients at the hospital and report their findings to the Minister in line with the media reports.

Methodology: The public was invited through notices in the print and electronic media to make submissions relating to the allegations. Interviews and site inspections were conducted. Written submissions were received. Legislative and regulatory frameworks were studied. Reports of previous commissions as well as hospital records were analysed.

Findings: The findings of the committee confirm media allegations of human rights abuses at the hospital. In addition the committee identified the following systemic defects:

- Weak management over a long period of time.
- Absence of a hospital board.
- Inadequacies in the physical layout and quality of facilities.
- Abuse of staff by patients.
- Staff reporting on duty under the influence of alcohol.
- High rate of absenteeism.
- Shortage of staff.
- Lack of discipline.
- Evidence of racism, nepotism and favouritism.
- Strained relations between the management and unions.

Recommendations: The committee recommends that remedial and preventative measures be undertaken as a matter of urgency to combat human rights abuses and address deficiencies in the system.

THE PATTERN OF CRIMINAL OFFENCES ALLEGEDLY COMMITTED BY PATIENTS WITH MENTAL RETARDATION ADMITTED FOR PSYCHIATRIC OBSERVATION AT WESKOPPIES HOSPITAL FROM JANUARY 2003 TO DECEMBER 2004

A A Motojesi, S T Rataemane

The socio-demographic characteristics and the types of criminal offences committed by individuals with mental retardation have remained largely under-studied. The aim of this study was to determine the type of criminal offences allegedly committed by patients with mental retardation admitted for psychiatric observation at Weskoppies Hospital, Pretoria, during the period January 2003 to December 2004.

Of a total of 649 patients were admitted for observation during the period of study, only 60 were diagnosed with mental retardation and included in the study. The diagnosis and categorisation were made on clinical grounds by the psychiatrist in conjunction with the multidisciplinary team. Thirty-five (58.34%) were mildly mentally retarded, 8 (13.33%) had mental retardation with unspecified severity while another 8 (13.33%) had moderate mental retardation. Seven (11.67%) were of borderline intelligence and the remaining 2 (3.33%) had severe mental retardation.

This retrospective study showed that the majority of patients in the sample were male, single, unemployed, from rural areas, and economically disadvantaged. The most common crimes allegedly committed were sexually related 55% (rape, indecent assault), whilst assault with intent to do grievous bodily harm accounted for only 12%, followed by house breaking 10%, theft 8% and murder 8%. The age range at the time the crime was allegedly committed was mostly 15 - 24 years.

In conclusion, this study indicated that socio-demographic factors and the severity of mental retardation had an impact on the nature of crime allegedly committed by individuals with mental retardation.

PSYCHIATRIC GENETICS: WHAT DO I TELL MY PATIENT?

D J H Niehaus, L Koen, W Pienaar, G de Jongh

Research supports a genetic contribution to the development of psychiatric illness. The mental health worker is therefore increasingly confronted with questions on the genetic risk to family, and especially children, of affected individuals. The aim of this workshop is therefore to give the mental health worker user-friendly guidelines to follow when dealing with family or patients' questions on the genetic risks associated with psychiatric illness. The content of the workshop will focus on a pragmatic approach for clinical practice, and no prior knowledge of genetics is required.

MENTAL HEALTH AND POLITICAL FREEDOM: 'A STUDY OF THE MENTAL HEALTH OF THE AFRICAN, A GENERATION AFTER ATTAINING POLITICAL FREEDOM'

F G Njenga

When the wind of change blew across Africa in the late fifties and early sixties, the African landscape was gripped by a state of euphoria that defied description. Year by year, country by country the African attained political freedom with the promise of health and prosperity for all under the wise new leaders.

In 1994, South Africa entered the long list of African democracies and again the promise of health and prosperity was made.

This paper traces mental health practices and attitudes before and after political independence, argues that in some cases the deals cut at independence with the colonial powers were designed to fail leading to the current state of social, political and economic turmoil in many parts of Africa, setting up the stage for widespread poverty and disease. It also argues that because of wars, internal and external displacement, increasing poverty and violence, as well as HIV/AIDS, the 'Free African' is worse off in his mental health status than he was a generation ago.

Possible approaches to this mental health challenge are discussed.

WHISTLEBLOWING IN PSYCHIATRIC PRACTICE – THE NEED, THE PAIN, THE PITFALLS AND THE COURAGE

Willie Pienaar
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In the discipline of psychiatry we serve a vulnerable patient community. At times, because of patient illness, the psychiatrist must make treatment decisions without fully informed patient consent. Patients trust their therapists and mostly do not ask questions about the boundaries of good clinical practice. Patient care can be compromised if the therapist suffers from an illness, has a lack of clinical knowledge or is guilty of unethical practice. If the patient would not report the impaired physician to his/her professional body (HPCSA), it would leave only peer review to secure good clinical practice at the workplace. The presentation would answer questions as to the difference between reporting and whistleblowing, when to report, how to report, the challenges, the pitfalls and possible negative consequences for the reporter and the need to report. The ethical and moral dilemmas and obligations of peer review will form the essence of the presentation.

MEDICAL BOARDINGS ON PSYCHIATRIC GROUNDS IN KWAZULU-NATAL

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Background: Psychiatric causes of disability now comprise an increasing proportion of disability claims admitted in the South African insurance industry. Depression is a major cause of lost work days worldwide and will emerge as the leading cause of disability by the year 2020. Psychiatric assessments for disability have been described as a 'subjective, controversial and at best difficult task'. What, if any, impact have the SASOP guidelines of 1997/2002 had on boarding applications and assessments in KwaZulu-Natal?

Methods: 170 applications for boarding on psychiatric grounds received from civil servants from 1997 to 2004 were analysed for demographic, treatment and outcome measures. All assessments were based on the SASOP guidelines for disability assessment – 2nd edition.

Results: Mean age of applicants was 42.69 years. The ratios of female applicants have steadily increased to exceed those of males. The mean duration of illness was 51 months and the average duration of continuous absence from work at the time of assessment was 407.03 days. On average, applicants were treated for 10.42 months and hospitalised for 4.7 days. Of those referred with a diagnosis of depression, 11.8% had been treated with maximum/optimum doses of antidepressants, 8.8% had had augmentation strategies instituted, 27.1% had psychotherapy and 3.5% had ECT. 78% of applicants were found to be psychiatrically impaired and 38% were recommended for boarding.

Conclusion: Despite the existence of clear guidelines from SASOP treatment guidelines are not being adhered to resulting in a high percentage of premature and unsuccessful applications for boarding.

SUICIDAL IDEATION AMONG MEDICAL STUDENTS AT THE UNIVERSITY OF PRETORIA

L Scribante, L van Niekerk, W van Vuuren, A J Viljoen

Background: In June 2005 a fourth-year medical student at the University of Pretoria committed suicide.

Suicide is one of the leading causes of death in the age group 13 - 25 years.[1] Studies published in the literature also show a high incidence of suicidal ideation among medical students[2] and higher rates of suicide among medical professionals than in the general population.[3]

Against this background a group of medical students, with assistance from the department of psychiatry, undertook a study to determine the incidence of suicidal thoughts and knowledge about help structures available at the University of Pretoria among medical and other students at the university.

Method: A questionnaire based survey was done. The questionnaires were distributed to all students in 4 of the medical classes and questionnaires were also distributed on main campus in the library study area. Participation was voluntary and anonymous.

Questions covered, among other things, previous and current suicidal ideation, previous suicide attempts, diagnosis of depression, knowledge about available help structures at the university and willingness to utilise such help structures.

Results: A total of 404 medical students and 244 other students completed and returned the questionnaires.17.3% of medical and 19.6% of other students reported having a diagnosis of major depression. 13.7% of medical students had sometimes or often thought about committing suicide and 3.4% reported having previously made a serious attempt. 11.1% of non-medical students had thought about committing suicide and 3.7% reported having previously made a serious attempt.

Knowledge about help structures varied greatly, with only 5% of medical students opposed to 76% of other students knowing what help the university offered to students. In both groups however, willingness to use these structures were limited with 30% of medical and 25% of non-medical students willing to seek university help.

Conclusion: Although training to be in a helping profession, medical students seem to be in need of care themselves. The incidence of suicidal thoughts and depression seems to be higher in this group of medical (and other) students than in the general population. Their unwillingness to use the available resources is worrying and merits further study.

PREVALENCE AND CLINICAL CHARACTERICS OF OBSESSIVE-COMPULSIVE SYMPTOMS IN AFRIKANER SCHIZOPHRENIA AND SCHIZOAFFECTIVE DISORDER PATIENTS

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Objective: Epidemiological and clinical studies estimate the rate of obsessive-compulsive phenomena in schizophrenia between 3% and 59%. This is considerably higher than the 2 - 3% rate of obsessive-compulsive disorder (OCD)/obsessive-compulsive symptoms (OCS) in the general population. There is also evidence of variation in the prevalence of co-morbid OCD among ethnic groups. This study evaluated the prevalence and clinical characteristics of OCD/OCS in Afrikaner schizophrenia and schizoaffective disorder patients.

Method: The Diagnostic Interview for Genetic Studies (DIGS) was used in an ongoing genetic study conducted on the genetically isolated Afrikaner population and diagnoses were assigned according to the DSM-IV. Relevant clinical characteristics were identified from narrative chronological summary reports and a questionnaire. From the original genetic group of 400, subjects with schizophrenia or schizoaffective disorder coupled with OCD/OCS were identified and matched for gender and age of onset of illness with a control group from the original group who do not have OCD/OCS.

Results: The prevalence of co-morbid OCD/OCS among 400 subjects was 13.25% [n=53], of which 40 were male and 13 female. Mean age of onset of OCD/OCS was earlier at 18.5 years than age of onset

of schizophrenia and schizoaffective disorder at 22 years ($p<0.0001$). 78.72% of the study group met the criteria for OCD and 21.28% for OCS. Contamination obsessions [n=17] were the most common type of obsession reported followed by religious obsessions [n=8]. The most prevalent compulsions were checking behaviour [n=22]. There was no family history of OCD/OCS in either group.

Onset of psychotic and OC symptoms were found to be insidious in 86.79% of the study group compared with 24.56% of the control group ($p<0.0001$). Second generation antipsychotic use was found to be statistically more prevalent in the study group (77.55%) than in the control group (45.76%) ($p=0.0008$). 73% of the study group experienced depressive symptoms compared with 50.85% of the control group. Both groups were found to have a similar incidence of suicidal thoughts and suicide attempts. Substance abuse amongst the control group was significantly higher (35.59%) than in the study group (19.23%) ($p<0.05$), with cannabis being the most common substance of abuse followed by alcohol abuse.

Both groups displayed a similar incidence of early non-psychotic deviant behaviour, with a significantly higher incidence of learning disabilities under the age of 10 years being experienced by the control group (54.24%) compared with the study group (32.08%) ($p<0.01$).

Conclusions: The prevalence rate of 13.25% of co-morbid OCD/OCS in Afrikaner schizophrenia and schizoaffective disorder patients is in contrast to the significantly low prevalence of OCD in a study of Xhosa-speaking schizophrenia patients (0.5%), suggesting further the possible role of genetic and cultural factors in the prevalence of co-morbid OCD/OCS.

The higher incidence of second-generation antipsychotic use suggests the possibility of treatment-induced OCD/OCS or aggravating pre-existing OCD/OCS.

IS PHARMACOLOGICAL PROPHYLAXIS OF PTSD A GOOD IDEA?

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While, on the one hand, it is likely that some early traumatic responses, such as intrusive memories and flashbacks, may facilitate the processing of trauma, on the other hand failing to intervene in recently traumatised individuals may increase the risk of development of posttraumatic stress disorder (PTSD).

Secondary prevention involves intervening in the aftermath of a traumatic event to hinder the development of PTSD. One model of pathogenesis implicates stress hormones (epinephrine, norepinephrine, cortisol, adrenocorticotropin [ACTH]) in the overconsolidation of emotionally distressing memories. This suggests that pharmacological disruption of neuronal mechanisms underlying fear conditioning and reconsolidation could prevent progression to PTSD in vulnerable individuals. To date, there have been very few empirically-driven studies on effective pharmacological interventions in the immediate aftermath of severe trauma. Propranolol, when given as a 2-3 week course within 2-20 hours following a traumatic event, has been shown in two preliminary controlled studies of trauma survivors presenting to emergency rooms to be effective in reducing subsequent PTSD. This presentation will highlight potential pharmacological preventive approaches (including the anti-adrenergic agents, selective serotonin re-uptake inhibitors or serotonin-norepinephrine reuptake inhibitors, benzodiazepines, cortisol, anti-kindling agents [e.g., phenytoin], cortocotrophin releasing factor receptor antagonists), rationale for their use, and ethical considerations in this setting.

Reference

Pitman RK, Delahanty DL. Conceptually driven pharmacologic approaches to acute trauma. CNS Spectrums 2005;10(2): 99-106.

HIV/AIDS-RELATED STIGMA AMONGST CAREGIVERS OF PLWA IN KWAZULU-NATAL, SOUTH AFRICA

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Issues: HIV/AIDS stigma is a major barrier for HIV testing, access to care, and adherence to ARVs. AIDS-related stigma in the caregivers of PLWA has not been assessed. This despite the importance of caregivers: patients disclose their status to caregivers; caregivers are the link to services, provide emotional support and assist in adherence. Caregivers assume an even greater role in the move to manage PLWA in the community. Stigma is difficult to assess.

Description: Data were collected as part of a province wide evaluation of the integrated community-based care (ICBC) model during November - December 2005. This was a cross-sectional survey of a stratified random sample of 5 of the 12 hospices. The response rate across the sites was 86 - 99 %. A community-care worker administered the AIDS-related Stigma Scale to a random sample of caregivers of PLWA enrolled in the ICBC program ($N=534$). The validated AIDS-related Stigma Scale records categorical responses to 9 items.

Lessons learned: The mean age of caregivers was 38.1 years (range 21 - 70 years) and 83% were female. Level of education ranged from no formal education to grade 12. 66.7 % felt it is NOT safe for people who have HIV to work with children. 15.6 % did not want to be with someone who has HIV despite them being caregivers of PLWA. 84.9 % thought people who have HIV should NOT be allowed to work. 9.9 % felt people with HIV must expect some restrictions on their freedom including being isolated.

Recommendations: Despite being caregivers of PLWA, the subjects exhibited high levels of stigma to PLWA or HIV-related issues. HIV/AIDS-related stigma might be a significant barrier in scaling up ARV rollout and people accessing care in resource-constrained settings. Strategies to reduce stigma must incorporate caregivers. Community health workers in resource-constrained settings could use this simple tool to assess stigma.

DEPRESSION AND CAREGIVER 'BURN-OUT' AMONG CAREGIVERS OF PLWA IN KWAZULU-NATAL, SOUTH AFRICA

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Background: Multiple strategies are being perused to maximise successful scale up of ARVs and care for PLWA in resource-constrained settings. The WHO '3 by 5' Initiative supports the integration of mental health research and services to positively impact on HIV/AIDS treatment and adherence. Caregivers are cost effective and often the only source of support and care for PLWA, especially in resource-constrained settings. Untreated mental disorders and caregiver 'burn out' will erode this important resource in delivering treatment and care to PLWA. KwaZulu-Natal is at the epicentre of this pandemic, and currently embarking on a large ART rollout. We assessed the mental state of caregivers of PLWA and their level of distress in caring for PLWA.

Methods: A cross-sectional survey of a stratified random sample of 5 of the 12 hospices that have adopted the integrated community-based care model (ICBC), funded by the GFATM. The response rate was 86 - 99 %. A community care worker administered the PRIME-MD Patient Health Questionnaire Brief and the Burden interview during November - December 2005 to a random sample of caregivers (N=522) of PLWA enrolled in the ICBC programme. Data from the Highway and Escourt hospices will be presented.

Results: The mean age of caregivers was 38.1 years (range 21 - 70 years) of whom 83 % were females. The level of education varied from no formal education to grade 12.

A depressive syndrome was diagnosable in 21 % of caregivers and anxiety symptoms occurred in 38.9 %. The mean Burden interview score was 23. This correlates to a high caregiver burden. Depressive symptoms were correlated with high BI scores (p=0.03).

Conclusion: There is an unrecognised high burden of depression and caregiver stress among caregivers of PLWA. Mental health needs of caregivers need to be addressed in ARV rollout programmes in resource-constrained settings to protect this resource and offer optimal care of PLWA.

THE TREATMENT OF EATING DISORDERS

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Eating disorders are among the most prevalent and fatal of psychiatric conditions. While the diagnostic criteria for these conditions, which include anorexia nervosa and bulimia nervosa, appear to make diagnosing these conditions a reasonably straightforward matter, this is not necessarily so. Eating disturbances are common to a number of both psychiatric and non-psychiatric conditions. Clinicians need to have an awareness of the phenomenology of eating disorders, related to specific fears and concerns, as well as sensitivity to the emergence and existence of these conditions in all population groups. Diagnosis is where treatment starts, but how to get started is not a straightforward matter. Issues of insight and denial complicate most cases. Whilst therapeutic nihilism is not an uncommon sentiment, the question of whether it is warranted probably has more to do with the clinician than the patient. While manual based approaches seek to justifiably standardise treatment delivered, technical skill is but one aspect of successful treatment.

THE MENTAL HEALTH CARE ACT 2002 – A REVIEW OF IMPLEMENTATION

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Introduction: The Mental Health Care Act, No. 17 of 2002 commenced operation from 15 December 2004. Almost two years later, it is an opportune time to review implementation. Anecdotal reports of difficulties in implementation abound. But there has not been a systematic attempt to review the course of events countrywide since implementation. The author was invited to hold a workshop at the SASOP Congress in September 2006 on the Mental Health Care Act. This will be an ideal opportunity to pool information and experiences from all the provinces in South Africa.

Methodology: The author will identify suitable representatives in all the provinces who would be able to contribute a meaningful report to the workshop prior to the congress. In addition, experts on the legislation will be identified and invited to attend the workshop. Contributions from mental health care practitioners in all provinces will be presented at the workshop. Areas that can be clarified in terms of a common interpretation of the legislation will be highlighted and consensus will be recorded. In addition, common themes/challenges will be identified and a list of issues requiring attention will be identified.

Outcome of the workshop: It is anticipated that there will be an improved common understanding of the legislation and its procedures and that challenges that require further intervention will be identified, as well as a plan to address these challenges as an organisation (SASOP).

MANAGING SEXUAL AGGRESSION IN ADOLESCENTS

D van der Westhuizen

General knowledge about adolescent sexual aggression has significantly increased over the past 20 years. However, despite significant public and professional concern, a lot of questions are still unanswered.

Violence and sexual aggression are multi-factorial in aetiology, involving individual (genetic, brain, developmental level) as well as environmental and societal factors. Evidence of the heterogeneity of this group is reflected in studies confirming personality characteristics, cognitive impairment and psychopathology.

The treatment of violence and sexual aggression in adolescents requires a multi-systems approach: individual psychiatric assessment, as well as the development of effective communication to policy makers, practitioners, the media, the public, and health and justice departments.

Most treatment programmes for sexual aggression use models of treatment borrowed from adult sex offender programmes and modified to fit the developmental level of the adolescent patient. Components of an effective treatment programme are dependent on a variety of factors.

Appropriate assessment and treatment facilities for adolescents and their families should be provided. A proper referral system should be in place. Adolescents are either referred through the criminal justice system or brought into psychiatric treatment by parents or guardians.

A bio-psycho-social approach should be followed in both evaluation and treatment. A psychiatric assessment should be done to identify co-morbid psychiatric conditions. Programmes sequentially target deviant sexual arousal, cognitive distortions and lack of empathy for the victim. Sex education and social skills training should be provided. Prevention of relapse is based on learning to identify situations that increase the risk of relapse or reduce social risks. Parents or guardians should be involved throughout the process of discussion of treatment alternatives and risk of offence or re-offence.

Biological treatments have been used to assist adult offenders to manage compulsive sexual behaviour. Anti-androgens such as medroxyprogesterone and cyproterone acetate have been found to be effective in reducing sexual thoughts, fantasies and arousal. Luteinizing-hormone releasing hormone (LHRH) analogues have been used with success in youths under 16 who have uncontrollable sex drives. Serotonin-reuptake inhibitors (SSRIs) are promising adjunctive agents in the management of sexual aggression.

Although the use of anti-androgen medication in this age group is controversial, raising ethical questions, the youth's decision to use medication should be voluntary and not involve coercion.

Researchers and experts in this field can play a valuable role in helping to sub-classify sexual aggression and ensure rational effective medical and public policy relating to sex offending. Finally, early identification and treatment might prevent entrance into medico-legal system, thus also ensuring the safety of the community.

CLINICAL TRIAL VCT COUNSELLOR'S SKILLS: POTENTIAL STRATERGY TO INCREASE MENTAL SERVICES IN RESOURCE-CONSTRAINED SETTING

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Issues: VCT with regard to HIV may be seen as an important individual-level strategy aimed at behaviour change as part of the multilevel response

to the HIV/AIDS epidemic. In KwaZulu-Natal, counsellors working in HIV prevention clinical trials are faced with the burden of disclosing HIV-positive results to 35 - 45% of participants who are screened out of these trials. Furthermore, counsellors provide ongoing counselling to HIV-negative women enrolled in the study. This study aimed to gain an understanding of the challenges faced and the needs of HIV/AIDS counsellors at the Medical Research Council's HIV Research Prevention Unit, Durban.

Description: Data were collected using 3 focus group discussions. Focus group sessions were conducted where 21 counsellors were interviewed on their experiences, challenges faced and training needs. Data were coded using content analysis and themes developed.

Lessons learned:

1. Counsellors had on average 2 - 5 years counselling experience working in the public and research sector.

2. Counsellors experienced few emotional problems and no one admitted to accessing professional mental health services.

3. Counsellors develop long-term relationships with enrolled trial participants and their sessions go beyond just HIV counselling and include issues like domestic violence, rape and grief.

4. HIV/AIDS counsellors felt inadequately trained to deliver services outside the scope of VCT.

5. Counsellors drew on the skills of their peer counsellors and senior counsellors for supervision and mentoring.

Recommendations:

1. HIV/AIDS counsellors in clinical trial settings provide services beyond VCT, and their training should be expanded to deal with a wide range of emotional problems.

2. Counselling in the context of VCT may be a developed into a cheap and effective strategy to deliver psychological services to the community in resource-constrained settings.

ECONOMICS AND HEALTH CARE

Casper Venter
Healthman (Pty) Ltd, PO Box 2127, Cresta, 2118

The presentation from a leading expert in the field of health economics will focus on the past, present and future of health care in South Africa.

Casper Venter and Healthman has been at the forefront in advising the South African Society of Psychiatrists, the South African Medical Association, the Council for Medical Schemes, Department of Health and other prominent organisations and bodies in strategies for the future regarding health care in South Africa. Healthman was also contracted to perform the cost studies for SASOP P3 for 2005 for NHRPL 2006 and 2006 for NHRPL 2007.

Policies for the future, the politics of health care and plans from government and the private sector will be discussed.

The presentation will also contain the latest news in terms of the private health sector and trends that will influence practice and health in the RSA.

Practitioners, pharmaceutical companies, funders and other providers of services would be able to formulate strategies and plans for the future from this presentation.

DUKUM: CULTURE-SPECIFIC SYNDROME, OR PSYCHOSIS? THREE CASE STUDIES AND AN EXPLORATION OF THE UNDERLYING CONCEPTUAL QUESTIONS

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Background: Dukum is a description of events that seems to be common in the Western Cape. Some of the symptoms can be seen as psychiatric, such as visual and auditory hallucinations. Whether the associated ideas are seen as delusional or as cultural is probably more of a philosophical question than a scientific question. Sometimes there are also supernatural/paranormal events such as spontaneous combustion.

Sometimes people who are affected by dukum present to the health system for help. Two questions are raised:

- What understanding of these events is most useful?
- What help (if any) should a psychiatrist provide?

Methods:

1. Three very different case studies will be presented that attempt to phenomenologically describe a range of dukum events.
2. A variety of opinions about these dukum events will be presented, possibly including:

- A Muslim scholar
- A traditional healer, called 'slim-man'
- A Freudian psycho-analyst
- A Jungian analyst

3. A review of the concept of culture-specific syndrome
4. An exploration of the underlying conceptual concepts

Results: There is no scientific answer to the question which of the different interpretations is valid. Psychiatric help may be useful in a number of ways.

Conclusion: Mental health practitioners in the Western Cape need to be aware of dukum.