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## AMPHETAMINE-RELATED SYMPTOMS: DESCRIPTIVE ANALYSIS AND REASONING

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In the last few years much data in the gulf region indicate that amphetamine psychosis has become more common and more prolonged.

**Aim.** This study was done to: 1) assess clinical features related to amphetamine withdrawal, 2) assess if there are changes in these features in comparison to other previous studies or not, 3) study the relation between amphetamine and chronicity of psychotic symptoms, 4) find a reason for such suspected changes if present.

**Methods.** A total of 150 male amphetamine dependent inpatients were selected according to ICD-10 research diagnostic criteria. Patients were subjected to the following procedures: 1) Oral informed consent. 2) Full psychiatric interview. 3) Urine test for common addictive substances on admission 4) Symptoms checklist which have been designed by the authors to assess Clinical features associated with amphetamine 5) Symptom Checklist-90-Revised (Derogates 1994).

**Results.** Generally the present study shows that the psychotic symptoms were very common with Amphetamine dependent patients and the severity of all symptoms decreased significantly during the different phases of treatment. Delusions and hallucinations were very common during 2nd week (54% and 51% respectively) and persisted for more than 8 weeks in 24% and 10% of patients respectively.

**Discussion.** Some of the results are similar to previous studies as Dalmau *et al.* 1999 and Koyama *et al.* 1991 but still the duration of psychosis is much longer.

**Conclusion.** There is increased risk of psychosis with use of amphetamine and a lot of reasons may play role as starting abuse at early age, sensitization process that may lead to chronic psychosis, and adulterating substances like ephedrine that may be dangerous and can lead to permanent damage of brain serotonin nerve endings.

## CHRONIC PAIN, IS IT A PSYCHIATRIC DISORDER?

**Eugene Allers**

*Psychiatrist in Private Practice, Benoni, Gauteng*

**Background.** Chronic pain is classified into functional (or dysfunctional) pain in 70% of patients, nociceptive pain in 25% of patients and neuropathic pain in 5% of patients.

66% of patients with psychiatric disorders complain of chronic pain symptoms, while as many as 50% are addicted to opiates at the time of admission to hospital. Most of these also then present with analgesic rebound pain.

As many patients with psychiatric disorders present with chronic pain, the management of these patients is essential to ensure a favourable outcome of the psychiatric disorder.

A review of the literature regarding pain, the classification and diagnosis of pain, the medical management and the psychotherapy in patients with chronic pain is discussed.

## THE 2007 COST STUDY RESULTS AND CODING STRUCTURE

**Eugene Allers**

*Psychiatrist in Private Practice, Benoni, Gauteng*

**Background.** For the past 3 years psychiatrists have presented the South African Society of Psychiatrists, P3 (Psychiatrists in Private Practice) with a cost study to

determine the costs of private practice. The cost study has been conducted in terms of the guidelines in circular 69 of 2005 of the Council for Medical Schemes.

The cost of running a private practice for psychiatrists is detailed.

Medical Schemes and psychiatrists use a standard coding structure for consultations and procedures. Medical Schemes use the codes for payment and cost management purposes, and psychiatrists for billing purposes.

The investigation into the new coding structure for 2008 is discussed in view of the Australian Classification of Health Interventions (ACHI) as the suggested coding structure for South Africa by the Board of Healthcare Funders, and the National Health Reference Price List (NHRPL) committee of the Department of Health (DOH).

## STRUCTURE AND LOSS OF SELFVIDENCE: THE 'MATRIX OF MENTAL FORMATION' AND ITS BREAKDOWN IN PSYCHOSIS AND SCHIZOPHRENIA

**Dr N. Andersch, UK**

For psychiatry in its demand to be acknowledged as a scientific discipline with universal recognition, one challenge still remains unresolved: How to describe and differentiate conditions of pathology without having a functioning model of mental formation in the first place; which leads to further questions:

1. Is there a system of 'invariable patterns' of human development with universal validity – independent from ethnological or regional/cultural variations?
2. Which are the rules to connect biological and social patterns within such a context?
3. What constitutes deformation or pathology within this proposed 'Matrix of Mental Formation'?

This paper investigates and tries to reconstruct discussions from the 'Weimar Republic', all of which focused on a new understanding of the structure of consciousness and psychopathology. In 1920 psychiatrist Arthur Kronfeld stressed the necessity to base all mental activity on ontologically irreducible patterns to safeguard the logic, theory and autonomy of psychiatry. Only later he came to recognize the studies of philosopher Ernst Cassirer, who – in his main oeuvre 'Philosophy of symbolic forms' – provides the theoretical framework to shift the focus on psycho-pathology from the brain and its localizations to the living interaction between man and his/her social environment. He values the liberation of mental properties during their emigration to the realm of symbolic interdependency, with a changed and more variable, constantly fluctuating relatedness to its organic basis. Cassirer postulates different forms of 'worldmaking' which all emerge in the creation of 'symbolic forms', as there are: magic, myth, religion, language, politics, science, the arts and others. Kurt Goldstein used Cassirer's theories to better understand the mental change in patients with braintrauma, aphasia and psychosis – and his clinical studies were again acknowledged by Kronfeld in his attempts to deconstruct schizophrenia. Those promising links came to a halt as all scientists involved in this concept were forced into exile.

This paper revisits psychopathological, philosophical and clinical attempts in the 'Weimar Republic' to contribute to a 'new concept' of psycho-pathology. It takes up the shared idea of all scientists involved, that 'natural selfevidence' is not a 'given', but a fragile construct of universal, symbolically-linked human patterns – a network of 'ways of worldmaking' – which comes to a breakdown in severe mental

illness. Based on these ideas this paper proposes a 'Matrix of Mental Formation' as transculturally valid model of consciousness, from which a universal concept of psycho-pathology subsequently can be deduced as a second step.

## THE SCIENTIFIC CHALLENGE OF SUBJECTIVITY

**Alex Antonites**

*Department of Philosophy, University of Pretoria*

My concept of subjectivity is more comprehensive than consciousness and avoids body mind dualism: my brain does not think, but me as subject.

Subjectivity integrates conscious multimodal experiences. First person experiences, ontologically distinct from other phenomena. The subject is *quo ens est*, not a thing amongst others. I thus argue for an ontology of an irreducible first person where my actions, belong to me and no one else. I have privileged access to it.

Realities of subjectivity are not replicable like uniform natural processes, but are a) more than discourse or metaphors; b) are testable; c) conforms to criteria of scientific objectivity. Complexity theory can be explored to make sense of the emergence and co-existence of consciousness/subjectivity with the physical/chemical brain.

I argue for a dialectical relationship between real persons and the world. This relationship is not causal or quantifiable. In this dialectics, persons are elicited by meanings in world. Persons and their bodies react not only upon physical-chemical impulses, but also the meaning it has, like simple sensations: attention arrest, irritation, glaring light, sudden cold, a very false note, pleasant beauty.

When mentally fatigued, we first do not notice our fatigue, but reduced meanings. Metabolism, blood circulation, the central nervous system blood sugar content, normal glycogen supplies in muscles and liver can cause fatigue e.g. in the Comrades Marathon. However this physically induced fatigue can change radically by a sudden experience of positive meaning.

In the case of illness, the dialectical capacity to let go and take up things, become rigid. Persons with troubled minds, like in neurotic, inauthentic existence, a loss of world and depersonalization loses the addressing character of meaning. Emptiness ensues.

My conclusion is that subjectivity in dialectical relationship to the world, makes explanatory sense of human actions and behaviour.

## HOW SHOULD WE UNDERSTAND SOMATISATION? OR, 'IF IT'S ALL IN MY HEAD THEN WHY DOES MY STOMACH HURT?'

**Rachel Bingham**

*Philosophy Department, King's College, London*

Difficulties understanding the nature of so-called psychosomatic disorders have been attributed to a faulty dualist ontology, resulting in an historical division in Western medicine between 'mental' and 'physical' disorders, with supposedly psychologically produced symptoms being treated with suspicion. This paper argues that no tenable metaphysical position justifies a view of mental causes as somehow less real than their physical counterparts. I further argue that neither side of the corresponding clinical division – between psychological and biological medicine – has provided an adequate account of somatisation.

1. Psychological theories are yet to explain somatisation. Empirical support for theories offering reductive accounts of these diverse manifestations is lacking. Moreover, such accounts are often rejected by people whose conditions they seek to describe as failing to capture the phenomenology of their experience.

2. While the 'biomedical model' is considered unable to account for somatisation, it is not clear that this model sufficiently describes any conditions. Even in bacterial infection – the model's supposed paradigm case – genetic, social/environmental and even psychological factors contribute to levels of predisposition and vulnerability. Many medical diagnoses have psychological manifestations and psychological interventions are of demonstrated benefit in many cases. I conclude by suggesting that an account of somatisation is possible within the emerging new

paradigm: a framework which accommodates causal factors from both sides of the old dichotomy, acknowledging that a combination of biological, psychological and social/environmental interventions is often required. It follows that somatisation disorders should be examined in the context of their similarity to other, better understood conditions, rather than as a separate, more mysterious category of disorder. Implications for classification systems are briefly discussed. The hope is that their stigmatising status as a particular, and particularly 'unexplained', group of conditions may be reinterpreted to benefit both theoretical understanding and people with such symptoms.

## MENTAL DISORDER AND CULTURE

**Prof. Derek Bolton (UK)**

The heated debates about psychiatry and its medical model in the 1960s presented many challenges including this: define 'mental illness' or 'mental disorder' to show that it is any different from social deviance, and that psychiatry is not just a mechanism of social control. One direction taken was the development of definitions in the ICD & DSM. Another was the naturalistic definitions of Boorse and Wakefield. Wakefield's evolutionary theoretic definition has dominated the field for the past decade or so. With the ICD-11 and DSM-V in preparation it is timely to review the position.

Both the 1960s debates and the naturalistic responses to them assumed a dichotomy in the domain of the psychological between the natural and the cultural. It will be argued here that this dichotomy is no longer viable in the current behavioural science including evolutionary psychology and genetics. This raises many issues regarding the relation between 'disorder' and culture, and the original questions regarding the proper domain of psychiatry and its relation to the social.

## VOLUNTARY CARE, NON-VOLUNTARY CARE AND THE MENTAL HEALTH CARE ACT

**Craig Bracken**

*Rivonia, Gauteng*

**Aim.** To show why the inability to make informed decisions due to mental illness according to the South African Mental Health Care Act, Act 17 of 2002 (the Act) may ethically permit, but does not require, formal legal procedures for non-voluntary treatment.

**Argument.** I examine the ethical principles justifying the current legal regulations according to the Act to access "voluntary, assisted and involuntary" treatment. Informed consent is not relevant unless the individual is competent to make decisions and I clarify why I regard "assisted" and "involuntary" care as non-voluntary care. Informed decision making ability, which is not defined in the Act, defines the distinction between voluntary from non-voluntary care. With respect to the ethical principles justifying the importance of informed consent I discuss the plausibility of arguments based *firstly* on the need to protect autonomy. *Secondly* I discuss ethical arguments for the value of informed consent not based on protecting autonomy, but rather given the language of rights and duties that the Act invokes, based on a Kantian conception of autonomy with respect to the work of Onora O'Neill.

**Conclusion.** I conclude that the ability to make informed decisions alone is a poor standard for statutory legal review requirements of treatment of mental illness.

## SCHIZOPHRENIA, STRUCTURAL VIOLENCE AND HUMAN RIGHTS

**Jonathan Burns**

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The core phenomenon 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 people's 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. I draw on new data from a South African first-episode cohort in drawing these links between poverty, income inequality and 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.

### **PROLONGED EXPOSURE THERAPY FOR PTSD**

**Franco Colin**

*Psychiatrist, Pretoria*

PTSD is one of the most important illnesses in a traumatized South Africa. The medication treatment has been established to a reasonable degree and is widely used in SA. The psychotherapy of PTSD is however severely neglected and often unproven, non-evidence based psychotherapies are used. This talk will present the work of Edna Foa, who developed PROLONGED EXPOSURE THERAPY FOR PTSD. This represents one of the psychotherapies with the most extensive evidence base known to psychiatrists and psychologists. The technique will be dealt with in detail and the evidence base will be presented briefly.

### **THE BIRTH OF THE PERSON: TOWARDS AN INTEGRATIVE PSYCHIATRY**

**Prof. John Cox**

*Secretary General, WPA*

This conceptual paper is based on international research and clinical experience in perinatal mental health, as well as my present preoccupation with values and where they come from.

Recent advances in knowledge of infant brain development and new genetic studies of perinatal mental disorder suggest that the causes and management of these conditions can only be grasped with reference to Pluralistic Explanatory Models (Engel, Kendler) and an interactive perspective (Buber, Tournier, Bowlby). It will be argued that this approach has also an evidence base for understanding the causes of most other mental disorders.

It is inadequate to consider only narrow monistic theories of mental disorder restricted to biological or social mechanisms alone but to develop further the research and clinical competencies to determine causal beliefs and sociocultural perspectives that hold together the left and right brain, and which make sense to the individual, the family and the health care worker.

I conclude with an account of initiatives within WPA relevant to these issues including the Medicine of the Person\*, and the Institutional programme 'Psychiatry of the Person', as well as the implications of these approaches for team working and the therapy of the community.

\*John Cox, Alastair V. Campbell, Bill (K.W.M) Fulford, eds. *Medicine of the Person: Faith, Science and Values in Health Care Provision*. London: Jessica Kingsley Publishers, 2006.

### **THE PHILOSOPHICAL CONCEPT (HYPOTHESIS) OF OCCUPATION BEING ESSENTIAL TO THE 'REAL PERSON', IS THE BASIS OF INTERVENTION BY OCCUPATIONAL THERAPY WITH PSYCHIATRIC DISORDERS**

**Rosemary B Crouch, Enos Romano**

*Occupational Therapy (MEDUNSA), Mellon Research Mentor, University of the Witwatersrand*

The aim of the presentation is to enlighten and inform participants as to the modern and ancient concept of the balance of "occupation" as being essential to mental health.

It is well documented that the control of a mental illness is by medication and also by promoting a balance of living in terms of occupation, the domain of occupational therapy. This is essential in maintaining a balance to control the illness. With a multidisciplinary approach the "real person" can be returned to as near as possible "normal life".

The presentation will commence with a brief overview of the philosophical concept of the Science of Occupation on which the profession of occupational therapy is based.

The modern intervention of occupational therapy with psychiatric and psychosocial disorders is based on this interesting concept. Coupled with this is the theory of "Creative Ability", a South African model by Vona du Toit, which is much revered in South Africa and internationally.

A practical presentation, incorporating the available research, on intervention by occupational therapy as part of a multidisciplinary approach, will be illustrated by case presentations. Emphasis will be based on the rehabilitation of the "real person" behind every psychiatric and psychosocial illness and the development of latent and previous creativity as regards the various spheres of occupation. The result of this intervention often addresses the maintenance of this "real person" within a normal or accommodated society.

### **SUBJECTIVITY AND NEUROIMAGING: BRIDGING AN EMPIRICAL AND PHILOSOPHICAL GAP**

**Leon de Bruin, Ewoud de Jong**

*University of Leiden, Netherlands*

A growing number of cognitive scientists have called for the need to make systematic use of introspective phenomenological reports in studying the brain basis of consciousness, in order to close the 'explanatory gap' in our understanding of how to relate neurobiological and phenomenological features of consciousness. However, the integration of such first-person data into neuroscientific experiments still faces a number of challenges. Firstly, it seems philosophically puzzling why first-person reports about subjective experiences, that are often biased and inaccurate, should contribute to neuroscientific research that is concerned with the third person domain of brain dynamics. This is often argued for on the basis of the Cartesian notion of 'privileged access': that subjects have a unique relationship to the contents of their conscious experience, a form of access that cannot be obtained from a scientific point of view. Secondly, the integration of first-person data into the experimental protocols of cognitive neuroscience faces epistemological and methodological difficulties, for example, how subjective states can be identified in terms of neurophysiological activation patterns, and whether subjects should be naïve or phenomenologically trained.

In this contribution, we present the (preliminary) results of an experiment in which phenomenological insights were front-loaded into the design of an neuroimaging experiment, and identified in terms of neurophysiological activation patterns (EEG), by using a visual delayed matching to sample task. The subjective states concerned feelings of attentional focus, distraction, inattention, feelings of certainty, and cognitive strategies. Usually, variations in these subjective states are considered as noise and experimentally controlled. In our approach, however, they were explicated instead, and used to constrain brain dynamics during the task. Besides the presentation of our results, we also offer a more philosophical account of how they might be interpreted, alongside with some guidelines for future research.

## THE MENTAL HEALTH CARE ACT, NO. 17 OF 2002 AFTER 10 YEARS OF PARTICIPATION: INTEGRATING VARIOUS SOURCES OF KNOWLEDGE

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**Background.** After 10 years of close participation with the development and roll-out of the new Act many unanswered questions; unresolved differences; procedural problems remain. The aim was to integrate practical knowledge, published reports and departmental feedback in order to define the present status situation to help with training of practitioners.

**Method.** This study focused on minutes of meetings, presentations and feedback at workshops, small group discussions, Imbisos, circulars, memos, guidelines, published reports in scientific journals and interviews with executive role-players, from the draft stages to the present time. The main problems were summarised.

**Results.** Reports in scientific journals were limited to a few editorial comments. A lack of statistics makes it impossible to evaluate service delivery in a meaningful way. The balance between Mental Health Care User demand and Mental Health Care Practitioner service delivery at the different health service points remains uncertain.

A spectrum of problems in terms of applying the Act and Regulations include ethical issues concerning the Discharge Report – MHCA 03; application of Emergency Admissions (Section 9.1)(c) versus Involuntary Admissions (Section 34); and the active role of other Mental Health Care Practitioners versus *Medical Practitioners*.

A spectrum of problems in terms of the workableness of procedures includes Application for Assisted/Involuntary Admission (Form MHCA 04); Transfer and Leave of Absence of Mental Health Care Users; and the role of the Head of the Health Establishment.

**Conclusions.** The implementation of the MHCA is still not at the place where the preamble places it at – if this is an opinion or fact remains a question. In particular, some procedures are not workable. Possible solutions would depend on the development of a functional, accessible database, statistics, and research protocols. Detail needs to be published, and regularly updated, and accessible to all levels' role-players.

## APATHIC ASYLUM SEEKERS IN SWEDEN INTERPRETED FROM A PHENOMENOLOGICAL PERSPECTIVE

Ingemar Engström

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**Background.** During the last five years, over two hundred children and adolescents in Sweden, who were all asylum seekers, have developed what has been called an "apathic syndrome". This epidemic has led to considerable interest, both in Sweden and abroad. The media debate about this epidemic has mostly centred on the possibilities of simulation or parental forcing of their children. The psychiatric debate has centred mostly on different diagnostic possibilities. There has also been an extensive ethical debate both among professionals and on the public arena. Not much interest has been paid to the syndrome from a phenomenological perspective.

**Method.** I will present the key case that I was summoned to examine from the Swedish government. This is the case of Makram, 11 years of age, who had been in an almost persistent apathic state since one and a half year.

**Results.** The life experience of Makram will be discussed in terms of a total withdrawal from the world, which is interpreted as a solution to lift off an all too heavy burden within the family. The process into apathy will be discussed in relation to psychiatric and philosophical concepts like dissociation and stupor. There is a professional agreement that this kind of syndrome cannot be explained neurophysiologically. I will instead centre on possible interpretations from a phenomenological perspective based on interviews with patients and relatives.

**Conclusion.** The key interpretation will be that this is a syndrome characterized by mental exhaustion leading to a wish, unconscious or not, to withdraw from being in the communal world and stay in a private world until circumstances have changed enough to elicit a longing for coming back to the real world.

## PSYCHIATRY, INVOLUNTARY TREATMENT AND THE CONSTITUTION IN SOUTH AFRICA

Dr Mike Ewart-Smith

After the introduction of the 1996 South African Constitution, it was recognised that there was a need for legislation to afford mental patients the rights enjoyed by other people. A new Mental Health Care Act came into effect in 2005, with the stated objective of clarifying the rights and obligations of mental health care users. However, although commentators have generally welcomed the Act's strong human rights focus, it does allow for certain mental health care users to be treated without their consent.

But, is involuntary admission and treatment not an unacceptable infringement of liberty, a form of detention without trial of persons who have not committed a criminal offence? Is this compatible with the Constitution and its Bill of rights?

Are psychiatrists (and other mental health care professionals) competent to exercise their appointed role of detecting those patients who, because of mental illness, may be detained and treated involuntarily?

In this paper it is argued that:

(a) involuntary treatment as provided for in the MHCA for certain patients who because of mental illness cannot give informed consent, is a valid process and is entirely compatible with the Constitution.

(b) the MHCA compares favourably in this regard with similar legislation in other countries, and with good medical practice.

(c) the procedures in the MHCA to give involuntary patients access to necessary treatment, and to prevent abuse of individual rights, are for the most part satisfactory.

## IS THE SOUTH AFRICAN SYSTEM FOR DEALING WITH POTENTIALLY DANGEROUS PERSONS SATISFACTORY?

Dr Mike Ewart Smith

Cho Seung-hui was known to be suffering from mental illness before his killing spree at Virginia Tech in April 2007. Several aspects of his behaviour were considered abnormal and also several of his lecturers recognised that his creative writing assignments revealed abnormal thinking.

This paper considers the South African situation with regard to individuals (with special reference to students) whom others suspect of being mentally ill.

The Mental Health Care Act specifies procedures to be followed when involuntary treatment is imposed in the absence of informed consent. But, how would South African psychiatrists react to concerns of the type expressed by Cho's lecturers and fellow students?

Would this type of scenario be considered an indication for involuntary treatment under terms of the Act?

Are the resources necessary for providing such treatment accessible and adequate?

Could a similar tragedy occur in South Africa?

## BIO-POWER AND PSYCHIATRY: THE GENEALOGY OF PSYCHIATRIC CATEGORIES

Grant Gillett

Professor of Medical Ethics, Dunedin Hospital and Otago Bioethics Centre, University of Otago Medical School, Dunedin, New Zealand

Psychiatric categories fall under the general typology of medical taxonomy which assumes that they are intrinsic disorders of the individual and therefore to be treated by the application of individual directed remedies. That means that their genealogy in terms of standard classifications, funded research, and perceived dynamics are

all configured according to a medical model. But this can be challenged in terms of the metaphysics (of which, for scientific realism at least, the aetiology is part), the detection and manifestation, and the structure of mental health care as a response to the situation that arises for a human subject. When we make use of post-structural, narrative, and recovery models of mental disorder the picture looks slightly different and therapy can slightly re-orient itself.

## REAL PERSONS AND THE NEUROPHILOSOPHY OF FREE WILL

Gerrit Glas

According to some cognitive neuroscientists free will is an illusion: all mental functioning is brought about by brain processes and these brain processes also produce the illusion of free will.

In this lecture I will examine the philosophical background of this position. I will show how the current debate is dominated by two points of view that were developed in early Enlightenment philosophy: (1) (Cartesian) separation between body and mind; and (2) (Humean) reluctance to view the will as a causally effective (mental) power.

We will see how these two viewpoints return in recent work of Daniel M. Wegner, a cognitive neuroscientist who wrote an influential book on the nature of free will. According to Wegner the 'causal' aspect of volition refers to an exclusively bodily phenomenon (a); whereas the awareness of willing is based on the attribution of causal agency to a subject (b). This attribution of agency, in its turn, is mixed with the stream of first person sensations that accompany one's doings (c).

I will criticize the hidden Cartesian and Humean presuppositions of Wegner's account. I proceed by suggesting that we are in need of a conceptual framework that overcomes brain – mind dualism and that does not associate willing with self-initiation (or: self-causation). To will means to respond to (normative) moments in the situation in which one lives. This normative appeal precedes all forms of self-initiation and structures the way people take action in response to the situation. This 'structuring' can go both ways: top-down and bottom-up.

From such an enriched and more refined conceptual framework we can reinterpret the results of the famous experiments of Benjamin Libet on the initiation of actions. Mental activity should not be seen as something distinct but as 'embodied' in motor behaviour and physiological responses that in their turn should be seen as intrinsically related to both the physical and the human world.

## PHYSICAL DEATH REVISITED

Johann Grobler

*Private Psychiatric Practice, Lydenburg*

*Death does not really exist – Elizabeth Kubler-Ross*

*Our perceived reality does not exhaust Reality – Pascal Kaplan*

*The human mind cannot conceive of its own non-existence – Karl Menninger*

Throughout the ages it has been one of man's deepest held hopes – that life does not end in the grave. Survival has been a central postulate in different belief systems attempting to address the inevitability of death and the dread of dying. Reportage from clinical resuscitation accounts, near death studies as well as out-of-body experiences over the past decades has recently been subjected to serious scientific scrutiny. Various explanations such as hypoxia, hypercarbia, temporal lobe epilepsy, the effects of anaesthetics and consciousness independent of the brain will be considered. Critical analysis will assess methodology, internal consistency and criteria validity.

The likelihood of an emerging paradigm with the integration of science and spirituality and the advent of a transcendental perspective with a new approach to death will be discussed and the following implications explored:

- the opening of a new avenue of consciousness research and re-examination of the concept that consciousness is a product of brain functioning and confined to it;
- a better understanding of the multidimensionality of our being;

a more intellectually satisfying and empowering dynamism in counselling;

the artificial prolongation of vegetative existence as an indefensible option, and the relegation to the past of the conventional myopic obsession with an exclusively physical perspective of life.

It appears to be a progressive, evolutionary development to contemplate looking beyond the brain – indeed, beyond physical biology toward the survival of the personality and continuation of consciousness in a higher dimension.

## EMOTIONAL INTELLIGENCE: POP-PSYCHOLOGY OR SCIENCE?

Gerhard I Grundling

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**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, enabled him to coherently define in layman's language, what emotional intelligence is and the importance of it 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 twentieth century to measure the so called 'soft skills' that enable people to be successful in life. Due 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.

## BOUNDARIES IN PSYCHOTHERAPY

Gerhard Grundling

Psychotherapy constitutes a specific relationship between a suitably qualified professional (e.g.: psychologist, psychiatrist) and a client or patient with the intent on utilising such a fiduciary relationship to enhance the process of change or healing. Within the therapeutic frame of the psychotherapeutic relationship it is possible to engage specific psychotherapeutic techniques to achieve the goals for the process of change or healing.

All relationships have specific boundaries. For the psychotherapeutic process to be successful it is necessary to set or impose specific boundaries. Boundaries are also helpful to ensure safety for both parties, confidentiality and a willingness from clients to expose themselves in the psychotherapeutic relationship.

A distinction will be drawn between boundary crossing and boundary violation. Boundary crossing can be beneficial, compared to boundary violation that would cause harm even if the intent to do harm was not present. It is therefore of great importance that psychotherapists should have the necessary skills and knowledge to distinguish between boundary crossings and boundary violations. It is also necessary for psychotherapists to be able to set the proper boundaries in place when they engage in the process of psychotherapy.

If boundaries are set too narrowly this could have a negative influence on the psychotherapeutic process and cause goals not to be achieved. Different psychotherapeutic techniques could also have different boundary settings. Furthermore; values, cultural factors, gender, diagnosis and personality type are some of the factors that would impact on the boundaries that a psychotherapist would set. It will be demonstrated that boundaries are complex and more often than not, in flux and thus most likely not rigid in nature.

The context of psychotherapy is thus crucial for understanding the meaning and appropriate application of boundaries. In the assessment of boundaries it is always necessary to take the context of the psychotherapeutic relationship into account.

### IDEAL TYPES: AN ALTERNATIVE METHODOLOGICAL APPROACH TO CLASSIFICATION?

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**Background.** Current Psychiatric classification is guided by a specific methodological approach, the use of operationally defined diagnostic concepts to ensure adequate reliability, the latter being an initial step towards establishing valid diagnostic categories. This approach reflects a particular methodology and philosophy of science: logical empiricism. An alternative approach is the use of diagnostic concepts based on ideal types. Ideal types were originally introduced by Max Weber in the social sciences. Karl Jaspers acknowledged their potential clinical usefulness. More recently, ideal types were proposed as an alternative approach to classification in psychiatry.

This paper attempts to evaluate two different methodological approaches to classification: one that is empirically derived, based on operationally defined concepts, and another which is phenomenologically derived, based on ideal type concepts.

To achieve this purpose, the classification of subtypes of schizophrenia was compared, using the Diagnostic and Statistical Manual of Mental Disorders (third edition revised) (DSM-III-R) and a classification specifically designed to be based on ideal types.

To achieve this purpose, we investigated the reliability and validity of ideal types. Then we investigated the differences between the two approaches in other areas pertinent to classification such as coverage and patterns of discrimination between different subtypes within and across both classifications.

**Method.** The sample consisted of 94 male subjects from the services at the department of psychiatry, Cairo University. The subjects selected had an equivocal diagnosis of schizophrenia and represented as much as possible the different DSM-III-R subtypes of schizophrenia.

**Tools.** Each subject was rated by at least two raters. Each rater was provided with a manual describing the ideal types, which were designated types A, B and C, as well as guidelines for rating. The outcome measure for reliability was inter-rater reliability. Discriminant validity was used as an outcome measure of validity for both classifications.

Discriminant validity was assessed using components derived by factor analysis of scores on Positive and Negative Syndrome Scale. It was administered to each subject by an independent rater.

Statistical procedures included: kappa statistic for inter-rater reliability and discriminant function analysis for discriminant validity. In addition, regression with a dummy dependent variable and analysis of variance were used to investigate further differences between the two classifications. Principle Component analysis was used

to identify components and their variance order in the whole sample.

**Results.** Ideal types demonstrated adequate levels of reliability and validity. Comparison between the two approaches showed differences in coverage and in the way in which corresponding types relate to the clinical profile of the whole sample.

### CONCEPTUAL AND ETHICAL DILEMMAS WITH THE EARLY DETECTION OF PSYCHOSIS PARADIGM

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**Background.** The prospect of early identification of psychotic development before the first overt psychotic break confronts us with novel problems, not encountered in clinical work with psychotic patients. The target of prevention, usually "psychosis", is a fuzzy concept with multiple definitions, indeterminate boundaries and unclear content. Consequently, the prospective setting of early detection and intervention is rife with problems both conceptual (What are the meanings inherent in the diagnostic concepts we use?) and ethical (What are the consequences thereof?). In this paper I will discuss the grammatical features of various conceptualizations of pre-stages of psychotic disorders, specifically their clinical, nosological and existential significance. This discussion has relevance for both diagnostic practices and ethical debate on the early intervention agenda.

**Methods.** Conceptual analysis. Material source for this analysis was representative literature and publications from the time period 1990-2007. Five different conceptualizations of pre-stages of psychotic disorders were investigated as to their clinical, nosological and existential significance.

**Results.** "At-risk-mental state" emerged as the most prudent and contextually relevant formulation of psychosis risk in preventive setting as it implies clinical significance, is nosologically a weak concept and does not directly imply mental disorder or psychoticism, thus retaining some degree of existential neutrality. The shortcomings of other available options were described and novel options suggested.

**Conclusion.** This conceptual analysis provides us with a meaningful tool for distinguishing the differential clinical, nosological and ethical implications of available (and future) conceptualizations of early stages of psychosis.

### CONSTRUCTIVE DECONSTRUCTION

**Volker Hitzeroth**

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Psychiatry, psychology and philosophy are disciplines that rely on accurate communication. The work we do, and the interactions we engage in, rely on effective information exchange. Continuous effort is required to ensure adequate understanding of various viewpoints. In our training we have learnt to listen to the words our patients speak, as well as to look beyond their language, in search of the deeper meaning.

In the 1960s Jacques Derrida developed his philosophical theory on deconstruction. His views have proven a controversy to many and a challenge to most. Derrida's deconstruction is an attempt to critically analyze the very manner of our communication. He would want us to re-look at the words we speak and the language we use. By deconstructing our communication within the modern world, we can expose existing inaccuracies. Derrida suggests that we search for the true meaning beyond the superficial inaccuracies of our daily communications. It is within the realm of the "Beyond" where truth, meaning and insight can be realized.

I shall argue that, in order to work and interact constructively within the fields of psychiatry, psychology and philosophy, we have to be able to deconstruct the supposed reality we see and hear every day. This implies having to remain open to possible alternative and deeper meanings. In short, we have to be able to move into the realm of Derrida's "Beyond". I shall suggest that in order to work constructively, we have to become deconstructionists.

## PHILOSOPHY AND PSYCHOANALYSIS: THREE PASSIONS: LOVE, SEX AND DESIRE

A Hurst

Many novels and films raise complex questions concerning the passions that drive us (love, sex, and desire), because they deal with the common, but curious, phenomenon of a "fatal attraction" whereby precisely what individuals find powerfully attractive in each other simultaneously draws them towards mutual destruction. For intrinsic reasons, then, that have to do with who a person "is", rather than contingent, external or pragmatic constraints, such relationships are ill-fated from the start, and, across all the myriad and various forms and events that describe them, their shared narrative structure is one of a path traced towards an inevitable tragic destination. The media offer so many manifestations of this pattern of fatal attraction, that one cannot help suspecting a certain fascination with it; a collective repetition compulsion, which suggests that we remain in search of adequate means to make sense of it.

In this paper, I propose to investigate the fecundity of the Lacanian hypothesis that the figure of the "Borromean knot," offers a productive heuristic for interpreting the complex alloy of three driving passions that constitutes healthy individuals. By extension, this investigation should shed light on the persistence of ill-fated relationships, despite the extensive wealth of psychological insight available to ordinary people. While Lacan has plenty to say about love, sex, and desire, his statements are often frustratingly enigmatic and perplexing. The resources of the philosophical tradition, therefore, will be explored to amplify the Lacanian conceptions of these three passions. In the interchange between psychoanalytic theory and philosophy, Lacanian concepts will hopefully find their elucidation, and provide insight into the surprising complexity of what at face value seem to be simple love affairs.

## INTEGRATION OF A SPIRITUAL DIMENSION INTO SOUTH AFRICAN PSYCHIATRIC PRACTICE

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**Aim.** Review of SA literature as control data for a qualitative, descriptive, model-generating single case study on how to integrate a spiritual dimension to current specialist psychiatric practice and training in the greater Johannesburg/Gauteng area.

**Argument.** Recently proposed legislation (Traditional Health Practitioner's Act, No. 35 of 2004) confirms that the western "scientific" model of health is increasingly regarded as only one approach next to others e.g. traditional African healing practices, with much greater emphasis on integrated mind-body-spirit outlook. SA figures may be difficult to confirm, but it has been estimated that about 80% of black South Africans will concurrently with a biomedical practitioner also consult a traditional healer. Studies on the pathways to mental health care confirmed this trend.<sup>1,2</sup> The use of alternative health practices is encouraged by many and be proxy often incorporated into formal health services, especially in under-resourced rural areas with few available facilities. In an overview of psychiatric services in Africa by Odejide *et al.*,<sup>3</sup> the practice of African traditional medicine and syncretic churches is discussed. Okasha in his review of psychiatric services in Egypt,<sup>4</sup> states that traditional and religious healers have a major role to play in primary psychiatric care. However, with regard to the incorporation of a spiritual dimension to the current bio-psychosocial dimensions of specialist psychiatric care, many questions remain unanswered. Such integration will probably have a significant impact on the practice and teaching of psychiatry as a biomedical discipline and on service infrastructure and delivery systems, while it may probably contribute to an increase in costs and in demands on human resources for formal mental health services in SA.

**Conclusions.** Concepts and criteria for concepts to be included in a conceptual framework/model for the integrating of a spiritual dimension into South African specialist psychiatric practice and training will be identified.

1. Obiodun OA. Pathways to mental health care in Nigeria. *Psychiatric Services* 1995; 46: 823-826.
2. Mkize LP, Uys, IR. Pathways to mental health care in Kwazulu-Natal. *Curationis* August 2004. pp. 62-71.
3. Odejide AO, Oyewunmi LK, Ohaeri, JO. Psychiatry in Africa: An overview. *Am J Psychiatry* 1989; 146: 708-716.
4. Okasha A. Focus on psychiatry in Egypt. *Br J Psychiatry* 2004; 185: 266-272.

## THE EXPERIENCES OF WOMAN AFTER A SPONTANEOUS ABORTION

E S Janse van Rensburg, M Poggenpoel, C P H Myburgh

*University of Johannesburg*

**Background.** The story of loss, after the experience of spontaneous abortion affects the women's being as a whole. It impacts her emotional, physical, intellectual, social and spiritual dimensions. The woman finds herself robbed of her voice by her social network. She stands isolated in her new reality of loss and bereavement. In the reality of loss and bereavement, the participants identified hope givers and hope stealers.

Hope givers include:

- a strong connection with women who experienced spontaneous abortion themselves,
- strengthening their relationship with God,
- time as a healing factor,
- the value of sharing their stories,
- the ability to find meaning after spontaneous abortion and
- the need for emotional growth.

Hope stealers include:

- the response from people in her social network with regard to the spontaneous abortion,
- experience of loss of control,
- insufficient support in their interpersonal relationships and social network,
- confronting the finality of the loss and
- being confronted with pregnant women and babies.

**Method.** A qualitative, descriptive, exploratory and contextual design was used. In-depth, semi-structured, phenomenological interviews were held with seven women who fitted the sample criteria. Recorded interviews were transcribed and analyzed using Tesch's data analysis techniques. A central storyline was identified and themes highlighted. A literature control was undertaken to highlight similarities and differences between this and other research.

**Results.** Results included the content as well as the processes of the women's emotional experiences after the experience of spontaneous abortion. The impact of loss affected her social dimension in terms of emotional processes as well as emotional expression. The spontaneous abortion had an impact on her physical, spiritual and social dimensions. Participants experienced a strong need for acknowledgement of their loss and understanding of their reality of loss and bereavement.

**Conclusion.** The results stress the emotional support needed by women after they experience a spontaneous abortion. Guidelines for the advanced psychiatric practitioner were described to provide support and assist the women in mobilizing their resources to facilitate the promotion of their mental health.

## ADHD THROUGH THE MOVIES

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<sup>2</sup>Director, ADHD Clinic, Training and Research Institute, Scarborough Hospital and Professor, University of Toronto, Canada

There is a growing awareness in educational literature that visual strategies work best for ADHD patients. The art of film-making can effectively utilized as a tool to

help us navigate the emerging science of ADHD. Showing patients charts, graphs and electronic information has more appeal than auditory strategies (like an office based educational strategy). During this session I will present movies that have a clear connection to both diagnosis and treatment of ADHD:

1. Symptoms of impulsivity will be illustrated using clips from: *Home Alone*, *Dennis the Menace* and other key choices.
2. Treatment strategies that illustrate the immature personality and growth will be illustrated using *Mrs Doubtfire* and *The Lion King*.

Understanding the personality profile is a major component of long term therapy, if one believes that a genetic disorder is likely to alter personality development if it affects the individual from early childhood. Therefore, the patient must deal with attachment and trust. Fostering the therapeutic alliance with the physician can be illustrated:

1. Showing the movie *Officer and a Gentleman* – attacking the vulnerability of Anti-Social Personality Disorder
2. Pushing buttons with *Good Will Hunting*.

The participant will have a keener sense of what ails ADHD adults and the treatment strategies that will benefit them.

## ANXIETY AND DEPRESSION IN ADULT ADHD

**S A Jeeva<sup>1</sup>, A Turgay<sup>2</sup>**

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<sup>2</sup> Director, ADHD Clinic, Training and Research Institute, Scarborough Hospital and Professor, University of Toronto, Canada

As Turgay *et al.* (Turgay *et al.*, APA 2005, 2006) comorbidity studies with over 3000 children and adolescents established, about one in five children and adolescents with ADHD meet the criteria for anxiety disorder or depression or both. One in three to one in four adolescents with ADHD have mood or anxiety disorders. Turgay *et al.* studies (APA, 2005, 2006; Turgay and Ansari 2006) with over 300 adults with ADHD, one in two adults with ADHD suffer from comorbid Mood Disorders or Anxiety Disorders or both.

This presentation will provide focus on a practical evaluation of adult ADHD and a rating scale providing a reliable differential diagnosis and useful tool for establishing comorbid disorders. The presentation will also cover the medical treatment of the adults with ADHD, anxiety and depression. The first line of medical treatment of patients with ADHD and comorbid depression or dysthymia should include those medications that interfere as little as possible with cognitive functioning and already compromised attention and concentration and executive functions of the patients with ADHD.

For the patients with ADHD and Depression, an effective antidepressant treatment is essential. SSRI's and tricyclic antidepressants can be safely combined with psychostimulants. Among antidepressants, bupropion, imipramine and desipramine have been found effective in controlling ADHD, anxiety and depression symptoms. Their anti-ADHD effects are not as significant as psychostimulants or atomoxetine. Some patients will benefit the most with the combination of the most effective ADHD medication and most effective anti-depressant. For the suicidal patients the most effective antidepressant with the least wait time for the desired effect should be chosen. In patients with sleep problems, tics, anxiety and ADHD atomoxetine can be more effective.

In patients who do not experience improvements in their depression and anxiety with those medications, a drug from the class of selective serotonin reuptake inhibitors (SSRIs) should be considered. Fluoxetine is a stimulating antidepressant that does not interfere much with attention and should be considered first. Two clinical studies found fluoxetine and psychostimulant combination safe and effective.

## ACHIEVING IMPROVED MENTAL HEALTH THROUGH HOLISTIC THERAPY: A PATIENT'S VIEW

**Susan Catherine Keter**

*Cool Waters Publishing, Nairobi, Kenya*

**Aim.** To bring out the plight of psychiatric patients in society and hindrances to their recovery. The stigma they face from family, medical health providers, medical practitioners and society as a whole.

**Argument.** Mental disorders affect 1 in 4 people at some time in their lives, causing a heavy burden not only on families but also economies of many countries. I am a survivor of a mood disorder and several members of my close family have been diagnosed with some psychiatric disorder or other. What have we gone through as patients? What hindrances did we face in the course of treatment? What did we feel could have been handled better?

**Conclusion.** There is need for general practitioners, psychiatrists and behavioral therapists to work hand in hand with the patients and their close family members not only for the correct diagnosis to be made but also for the correct treatment regime to be achieved. Holistic treatment is necessary for healing to be achieved.

## WORKSHOP: 'DOCTOR PATIENT RELATIONSHIP: ETHICAL ISSUES'

### Organizers:

**Professor Afaf Hamed Khalil**, *Professor of Psychiatry*

**Dr Yasser Abdel Razek**, *Asst Professor of Psychiatry*

**Dr Ghada Refaat**, *Lecturer in Psychiatry*

*Institute of Psychiatry (WHO Collaborator Center for Training and Research), Ain Shams University, Egypt*

**Introduction.** It is well known that doctor-patient relationship is the most important issue in medical practice. Although this importance it was under discussed in the past. Nowadays doctor patient relationship is a very important topic in the curriculum of training and examination of all medical specialties all over developed countries. Doctor patient relationship is the main guide of management process with patients and their families. While classifications, diagnoses and current drugs may be changed, Doctor patient relationship and clinical skills will persist along time. During this relationship is going on a lot of problems occur and immediate intervention is required to keep the management process healthy.

**Objectives.** This workshop will have the following objectives

1. To discuss the main principles of Doctor patient relationship
2. To discuss the most common problems of this relationship and how to deal with.

Target population. Psychiatrists, psychologists, physicians.

**Plan.** A lecture will be presented to summarize the main principles of the doctor-patient relationship. A specially prepared questionnaire about the common problems with psychiatric patients will be distributed and recollected. All persons who are interested will be classified into 5 groups. Each group ranges from 5 to 10 persons. Each group will select 5 problems concerned with Doctor patient relationship. Each group will discuss the problems and put a summary for their proper solutions within 60 minutes. Each group will select a member to present the summary to the other groups within 15 minutes. A summary and recommendations will be presented at the end.

## A PSYCHIATRIC BRAIN: BEYOND DUALISM AND DETERMINISM

**Jakob Korff**

*UCP/ UMCP, Groningen, The Netherlands*

**Aim.** Kendler advocates a philosophical structure for psychiatry. Briefly, his positions are: psychiatry is grounded in first-person experiences; dualism and epiphenomenalism are false; both brain-mind and mind-brain causality; psychiatric disorders are etiologically complex; explanatory pluralism and pragmatic reductionism are

acceptable, shift "preconcepts" to scientifically confirmed complexity explanations. I discuss these issues in the context of conceptions of brain physiology. Our recent depression results are used to illustrate my viewpoint.

**Argument.** Depression has 3 major aetiologies: molecular dysfunction (including genetic, neurotransmitter and hormonal), life-events and social interactions. The impact of life-events depends on previous experiences. Retrieval processes occur in milliseconds up to a few seconds. Mood changes occur in minutes. We determined time-to-recovery (cross-sectional, NEMESIS, Van der Werf *et al.*, 2006; longitudinal, INSTEL, De Jonge *et al.* 2007) and following somatic disorder (myocardial infarction; MIND-IT, Kaptein *et al.*, 2006). Recovery is random and intra-individually variable; somatic conditions impair mood transitions. Rapid brain-state transitions become possible in a self-organizing iso-energetic brain.

**Conclusion.** An iso-energetic brain allows fast and complete access to memory. It is also the "interface" between genes and behaviour. I propose that the concept of the iso-energetic brain enabling fast state-transitions could serve refining Kendler's positions.

Kendler KS. Towards a philosophical structure for psychiatry. *Am J Psychiatry* 2005; 162: 433-440.

Van der Werf S Y, Kaptein K I, De Jonge P, Spijker J, De Graaf R, Korf J. Major depressive episodes and random mood. *Arch Gen Psychiatry* 2006; 63: 509-518.

Kaptein K I, de Jonge P, Korf J. Course of depressive symptoms following myocardial infarction and cardiac prognosis: a latent class analysis. *Psychosomatic Medicine* 2006; 68: 662-668.

## DEPENDENCY VERSUS ADDICTION, ACCOUNTABILITY VERSUS RESPONSIBILITY – MEANINGS AND IMPLICATIONS B Latecki

The paper will discuss the meaning of words and concepts used in psychiatry:

- Accountability versus responsibility
- Dependency versus addition.

A large body of evidence has been gathered that emotional disturbances stem not only from functional but also anatomical changes in human brain. The existence of this evidence challenges the present opinion, all too often prevailing, that depression, anxiety, and predisposition to addiction or dependency could be managed by the person just with adequate attitude, and the affected person is somehow responsible for "getting himself out" of it.

The attitude towards one's suffering and illness is discussed, based on selected philosophical schools. Finding a golden means between determinism and considering a human free is attempted. Consideration is given to the consequences of the assumption that biological dysfunction by definition renders the person less capable of adequate functioning and only partially accountable for possible failure of that functioning – no matter whether physical or emotional condition is in question.

Accountability involves an "account" or payment or, in other words, meeting requirements and obligations. Responsibility involves "res" as the issue related to the given individual, in terms of the existing causal link. But the existing causal link does not necessarily imply the obligation to prevent negative developments or consequences resulting from such a causal link, even if they can be predicted.

## PATTERN APPROACH IN PSYCHOLOGY AND THE OTHER FUNDAMENTAL DISCIPLINES – PHYLOGENETIC PATTERNS OF WORLD 1, 2 AND 3

**Lyudmila Lozanova**

*Thracian University, Medical Faculty, Department of Neurology and Psychiatry, Zagora, Bulgaria*

Contemporary science is faced with a new challenge – the introduction of the biocybernetic paradigm and its system approach (L. f. Bertalanffy, N. Wiener) In this context, the reactivity of the mechanical self-organising systems (organisms, societies, global ecosphere) is organised by their inner reflective systems (programme networks

and information noospheres). The most developed systems are the human (CNS, psychic noosphere), the postindustrial state (institute network, science noosphere) and the global system (satellite network, programme noosphere). The global phylogenetic pattern is the potential of common origin and functional differentiation of all global forms – systems, products and spheres (fields).

**The aim** of the research is a model projection of the phylogenetic patterns of the real and ideal spheres (Worlds 1, 2 and 3 according to K. Popper). **The hypothesis** is that natural forms have cross-dialectical profiles: "material-energy", "programme-information", "mechanical-reflective", "reactive-modelling", "system-sphere", etc. **The methods** include the fundamental high-methodological approach for the recognition of the programme-information forms. The fundamentalists "shrink" the theoretical insight horizon down to the technical principle schemes (formulas, graphs, etc.). **The results** are four-stage block-schemes of the existential spheres, their levels and forms - the real objects in global ecosphere (World 1), the reflective models in psychic sphere (World 2) and the extrapolated ideal models in global noosphere (World 3). **The conclusion** is that the cross-dialectical forms "self-organising systems – self-developing spheres" have mutually limiting "core-tectorial" programmes and possibilities for impact. In this context, the programmes of the human are "genetic-neural" while the cumulative possibilities of psychic and global spheres are "chaotic-selective". The system has inner spheres and the sphere has inner systems. **The application** is for a new problem orientation, introduction of the global existential paradigm and its pattern approach in science, organisation of the psychological fundament, etc.

## THE SELF-ORGANISING PATTERN OF HUMAN BEHAVIOUR AND HIGH-METHODOLOGICAL CLASSIFICATION OF THE PERSONALITY DISORDERS

**Lyudmila Lozanova**

*Thracian University, Medical Faculty, Department of Neurology and Psychiatry, Zagora, Bulgaria*

The introduction of the system paradigm in biology, psychology and sociology led to the organisation of the system biopsychosocial model in medicine. The new problem orientation covers the autonomous behavior of the individual as an organism (biological system) and a person (social element).

**The aim** of the research is a model projection of the self-regulative mechanisms of human behaviour and their paracomensation (personality disorders). **The hypothesis** is based on E. Haeckel's law that ontogenesis repeats phylogenesis – the self-organised pattern of all systems is analogous to the phylogenetic pattern of the global system (four-stage pattern of self-organisation – geosphere, biosphere, sociosphere and global cybersphere). The individual, as a key system of the bio-social transition, has two upgraded reflective programmes to satisfy the biological and social system needs. Reflective programme networks are the signal-associative systems with universal four-stage pattern of programmed system reactivity. Therefore, the human has altogether 8 functional levels of system behaviour. **The main task** is to coordinate the neuro-regulative mechanisms of behaviour – levels of system needs, reflection mechanisms of stimulation and blockage, relevant emotional feedbacks, instinctive automatisms of compensation and paracomensation (personality disorders), etc. **The material of the research** is the psychological concepts of the needs, emotions and instincts and the psychiatric diagnostic models of the personality disorders. **The methods** include the high-methodological approach which upgrades the fundamental modelling approaches (analogous, contextual, system, etc). **The results** are cybernetic eight-stage block-schemes of the behavioural self-regulation, with 16 polarized mechanisms of stimulation and blockage. **The conclusion** is that the penetrating potential of all mechanisms outlines the personality profile and the automatic paracomensations determine 16 types of personality disorders. **The application** is for new fundamental psychodiagnostics and psychotherapy, correction of the classifications of personality disorders in ICD-10R and DSM-IVR, etc.

## FACING THE EXISTENTIAL ISSUES OF LIFE

**Marilyn D Lucas**

*Monash South Africa, Roodepoort, South Africa*

**Background.** The identification of a marker for Huntington's disease (HD) in 1993 paved the way for predictive testing. For the first time, persons at risk for this cruel genetic disorder with onset in mid-life, a slow inexorable decline into mutism, rigidity and dementia, could find out their risk status prior to symptom onset.

What is it like to find out your fate? What impact does it have on you?

The aim of this research project was to investigate the psychological profiles of those who request testing before and after testing, including their preferred coping mechanisms and psychiatric status, within an existential theoretical framework of: Awareness of concern – Anxiety – Defense Mechanisms.

**Method.** Participants who had requested predictive testing (N=69) were asked to participate in the study prior to testing and at least a year after their results were to hand. A variety of assessment tools were used including the MCMI-II and III, Purpose in Life Questionnaire and the Brief Coping Scale.

**Results.** A predominant psychological style is seen in those who request testing. Overt reasons to request testing are orientated towards practical explanations. Differences in psychological status after receiving the test results were found.

**Conclusion.** Few of those at risk for HD request predictive testing and generally only those with sufficient ego strength do so. The preferred defence mechanisms utilised are varied but include denial. When the defence mechanisms are no longer adequate to keep the reality of being at risk at bay, testing is requested. Once status is established, anxiety is persistently higher in those found positive. Coping mechanisms include distraction, use of religion and increased substance abuse.

## USING THE RORSCHACH INKBLOT METHOD TO EXPLORE CHANGE IN GROUP PSYCHOTHERAPY: A CASE STUDY OF SEVEN LONG-TERM PSYCHIATRIC PATIENTS

**Daleen Macklin, Christa Kruger**

**Background.** On 1 January 2006 a new multi-disciplinary team started rendering services dedicated to the long-term patients at Weskoppies Hospital, aiming at evaluating and improving rehabilitation. As group psychotherapy was introduced as therapeutic intervention, it is necessary to explore the effectiveness, as well as suitability, of such an intervention.

Weiner and Exner (1991) suggest that certain Rorschach variables may provide a meaningful measure of progress in therapeutic interventions. The expectation that it is possible to measure change in therapeutic interventions is based on research evidence that psychotherapy generally contributes to improve coping capacities and an enhanced sense of well-being. Specific indices on the Rorschach of adjustment difficulty may then have the potential for measuring progress in therapeutic interventions, as the frequency should diminish over time among patients who engage in therapeutic relationships.

**Method.** The Rorschach Inkblot Method was administered in February 2006 on seven long-term psychiatric patients as part of selection criteria for group psychotherapy. The group consisted of patients with a variety of diagnoses from a higher functioning long-term ward. The Rorschach was re-administered in February 2007, after a year of sustained group psychotherapy grounded in the principles of Yalom (1995). In analyzing the Rorschach data descriptive and inferential methods of analysis were used.

**Results.** The results demonstrate significant improvement in stress management (D and Adj D), a conventional and consistent manner of dealing with experiences (EB), modulating affect (FC: CF + C), more effective ideation (FQ-), being less preoccupied with themselves (Ego Ind), and having and desiring better interpersonal relationships (COP).

**Conclusion.** According to the findings on the Rorschach, it seems that group psychotherapy may contribute to the rehabilitation process of long-term psychiatric

patients. Future studies may incorporate other assessment methods and feedback from other disciplines in the team.

## PHILOSOPHY AND FAMILY THERAPY: A FORCED OR NECESSARY UNION?

**M.C. Marchetti-Mercer**

*Department of Psychology, University of Pretoria*

Postgraduate Psychology students encountering the reading material required in any family therapy course for the first time will probably believe that in order to become a successful family therapist they may also need a qualification in philosophy. The theoretical works on which the practice of family therapy is based, are often very abstract and also closely linked to existing theories in the discipline of philosophy. One only has to look at the postmodern movement in philosophy and the impact it has had on the practice of family therapy. Family therapists-in-training keen to focus on practical interventions may become frustrated with the amount of philosophical groundwork that seems to be needed in order to access the psychological knowledge necessary for therapeutic work. In this paper the author who is a family therapist and has had post-graduate exposure to both disciplines will explore the implications of the union between these two disciplines especially with regard to the impact it may have on students-in training. It will be argued that a study of both disciplines as part of psychotherapeutic training should be seen as a way of deepening the quality of therapeutic work. The author will also look at how creating a training context, which manages to bring the two disciplines together can only enrich the professional development of students.

## THE ROLE OF THE BRAIN IN MENTAL DISORDER

**Eric Matthews**

*Emeritus Professor of Philosophy and Honorary Research Professor of Medical and Psychiatric Ethics, University of Aberdeen, Scotland, UK*

The aim of this paper is to question a philosophical assumption underlying the view that the various forms of mental illness should in principle be diagnosable by reference to their causation by a biological dysfunction in the brain. The philosophical assumption derives from the doctrine of 'eliminative materialism', and the method used to question it is that of phenomenological analysis.

'Eliminative materialism' is the view that the only scientifically respectable alternative to Cartesian dualism and the 'folk psychology' which describes and explains mental life and human behaviour in terms of concepts like 'thoughts', 'reasons', etc. is to reject all such entalistic language and to describe and explain human behaviour in terms of a 'complete neuroscience'. This is explicitly meant to apply to the description and explanation of so-called 'mental disorder'. It is argued, however, from a phenomenological point of view, that both eliminativism and dualism are misguided in very similar ways. Mental life, it is contended, is not to be equated with either the inner life of the soul or the electro-chemical activity of the brain: it is rather the response of the whole embodied human subject to his or her surrounding environment, in which that environment takes on meaning for the human being. 'Mental disorder' is then naturally seen as a disturbance in that response, as judged, not by biological, but by human criteria. Brain functioning may, but need not, provide the background necessary conditions for the disturbance in response, but the primary mode of explanation for the disturbance, by its very nature, must be that of empathetic understanding of its meaning for the patient, using the concepts of 'folk psychology'. It is argued that folk psychology is capable of being as scientifically respectable, in its appropriate field, as neuroscience is in its.

## THERAPEUTIC RELATIONSHIP: THE POWER OF HEALING

**Azemina Miftaroska**

*5 Park Gate, London*

This conference intends to address a specific mode of psychotherapeutic relationship as a base for therapeutic healing and client's reconnection with the world. Rather than encouraging and employing therapeutic techniques in working with PTSD sufferers, this paper aims to explore an *authentic, unscientific, and non-assumptive*

state of mind of a therapist in his/her approach to working with PTSD clients and initiating communication which not only reaches traumatic memories but spreads far beyond client's traumatic awareness.

An authentic human relationship, which is seen as a powerful source of healing when working therapeutically, is extensively informed by the existential philosophy of Martin Buber (1937). According to this philosopher, human encounters fall into two relational categories:

- a) "I-It", which is described as Subject-Object relational mode, one of conformity, necessity, based on assumptive thinking, and inspired by scientific analysis, and
- b) "I-Thou", which is experienced as a meeting, a place of a dialogue where measure and comparison disappear and "immeasurable becomes a reality". (M. Buber, 1937). This relational mode is not classifiable, "cannot be surveyed", has no fixed qualities, but can only be experienced.

This conference will explore the power of the 'I-Thou' therapeutic relation through the presentation of a case study; it will address its risks and initiate discussion about its creative possibilities and limitations.

### **A THEORETICAL APPROACH TO AGGRESSION – THE ROLE OF COGNITIVE AND SOCIAL MATURITY**

**Anelia Mitkova**

*Center of Military Psychology, Sofia, Bulgaria*

The present paper has the aim not only to account for Bjorkqvist and colleagues' developmental hypothesis for aggression (Bjorkqvist, Osterman & Kaukiainen, 1992), but also to suggest further the integration of different directions in the research field.

Exhibited different forms of overt and covert aggression are a matter of major concern in modern societies due to the negative outcome they have on the individual as well as on the entire society. We suggest the position that aggression, as a fundamental construct, could be understood as means for dealing with the external world depending on the cognitive development and social experience of the individual during lifespan. Some of the recent studies have shown that aggressive behavior is not linked with age- and maturity-related changes in the form of aggression used (Vaillancourt, Brendgen, Boivin & Tremblay, 2003) while others confirm the use of indirect aggression more often by older than by younger children (Bjorkqvist, Lagerspetz & Kaukiainen, 1992). An overview on the conducted research and theories in the field will account for proposing a *Stage hypothesis* concerning individual development concentrated around the idea that aggressive behavior has to be studied also as outcome of the individual's complex maturity predominating the way one could answer environmental requirements and challenges.

In the present, the *stage hypothesis* proposes an integrating view, including developmental stages, emotional competencies, cognitive resources, and social maturity, as mainly influencing the utilization of aggression as means for facing external world and dealing with challenges.

### **REEL PSYCHIATRY: THE THEORY AND PRACTICE OF PSYCHIATRY IN THE CINEMA**

**Dr Leverne Mountany**

Filmmakers appear to be just as fascinated by psychiatry as psychiatrists are by the movies. Cinematic art and modern psychodynamic psychiatry grew up together. The relationship may be seen as both complementary and hostile. As cooperative endeavours, both psychiatry and the cinema strive to cut through the seemingly random content of everyday life and reveal the secrets of the human character. Since curing and entertaining are often related in our culture, movies as well as psychiatry have been regarded as therapeutic.

The aim of this workshop is to explore the portrayal of the psychiatrist as well as that of psychiatric illness in modern day film. Furthermore the application and usage of films in everyday practice is highlighted.

See you at the movies!

### **PSYCHOPATHS AND MORAL PSYCHOLOGY**

**Dominic Murphy**

*Division of Humanities and Social Sciences, California Institute of Technology, Pasadena CA, USA*

The aim of this paper is to assess the moral psychology of psychopaths and explore its significance for theories of moral psychology. I begin by laying out an argument, made by several contemporary philosophers and psychologists, that the appalling behavior and lack of empathy in psychopathy coexists with intact rational capacities and that psychopaths understand the nature and content of moral rules. But this knowledge has no effect on the behavior of psychopaths. The conclusion drawn is that psychopaths act out of emotional, but not rational, deficits, and therefore show that rational immorality is a real phenomenon and that moral conduct has emotional rather than rational sources, which supports Humean rather than Kantian theories of moral psychology. To assess this argument, I look at the empirical literature on psychopathy and some related conditions in which similar symptoms emerge after frontal lobe damage. I argue that the evidence suggests that psychopaths do in fact display rational shortcomings. But I will further argue that there is good evidence that the moral deficiencies in psychopathy do depend on causally prior deficits in various moral emotions as well as reasoning deficits. This does support a form of sentimentalism, on which the ability to rationally respond to moral considerations rests on underlying emotional capacities. But I will argue that the full picture shows that reason and emotion are both involved.

I conclude that psychopathy is a threat to the idea that moral judgment is either an exclusively rational process or an exclusively emotional one. I use this finding to assess some recent work in both philosophical and empirical moral psychology that does not accord with this.

### **ERWIN STRAUS'S CONTRIBUTION TO PSYCHOPATHOLOGY**

**Prof. C Muscelli (Italy)**

Erwin Straus developed a keen reflection on the relationship between psychiatry and philosophy. His governing premise is that the psychiatrist tacitly takes a stance on specific philosophical problems such as identity, norm and relation to others. Any philosophical theory that underlies the clinical work always includes some issues of which psychiatrists are not always aware. In fact, philosophy has contributed to an understanding of man as a pure essence and to neglect all that has to do with materiality and corporeality. According to Straus, man's relation to the world is primarily an 'opposition': Straus sees how man constantly works to keep a distance from the ground, to stand physically in the 'upright posture', to modulate the distance between the body and objects in a way that makes the world utilizable by man. In order to make the relation possible, man has to be able to oppose the world physically: it is the fight against gravity that lets man walk and enter into communications with other men. More than other phenomenologists, Straus attributes a significance to materiality, to the physical aspect of the world, to the bodily relation: any psychopathological description must pay attention to these corporeal characters.

### **ESTABLISHING PSYCHIATRY REGISTRARS' COMPETENCE IN PSYCHOTHERAPY: A PORTFOLIO-BASED MODEL FOR TRAINING**

**T Naidu, S Ramlall**

*King George V Hospital, Nelson R Mandela School of Medicine, University of KwaZulu-Natal*

**Aim.** To explore psychotherapy training programmes for psychiatric registrars internationally in terms of their applicability within a South African program and to propose a program for training South African registrars.

**Argument.** South Africa has followed international trends in the training of psychiatrists during most of the latter part of the last century. Training programs have become increasingly focused on the neurobiological aspects of psychiatric disorders with less attention being paid to psychotherapy. This is consistent with

developments in psychiatric research. In the clinical arena this manifests as a focus on pharmacological and medically based interventions and a resulting relative inattention to non-pharmacological interventions, most especially psychotherapy. In an effort to address what is seen as an imbalance there has been an international initiative, over the past two decades, to establish an acceptable level of competence in psychotherapy in the training of psychiatrists. In order to produce a programme for establishing competence in psychotherapy for registrars at the Nelson R Mandela School of Medicine the authors examine the psychotherapy component of several international programs. Programmes are examined in terms of their applicability to the context within which registrars in the department of psychiatry function. Defining and setting preliminary standards for competence is emphasized. Finally a programme based on five core psychotherapy components using a portfolio-based model to facilitate learning and assessment of competence in psychotherapy is proposed.

**Conclusion.** A South African programme needs to take account of international trends and adapt them for the local context. A portfolio-based model is a possible solution.

### ABUSIVE PATIENTS IN PSYCHIATRY

**Prof. Margaret G Nair**

While psychiatric training prepares us adequately to manage violent and aggressive patients there is little training or preparation to help psychiatrists cope with verbally abusive or threatening patients who are not psychotic or intoxicated. The literature on this subject matter is sparse with very little data on how psychiatrists should handle these patients. Interestingly, GPs, physicians, surgeons and nurses have documented abuse and formulated strategies or guidelines for dealing with abusive patients. Yet psychiatrists and trainee psychiatrists deal with the most dysfunctional patients and are exposed to abuse regularly. Possible reasons why psychiatrists have high tolerance levels to abuse, don't document or discuss their exposure to abuse, or don't have adequate policies in place (especially those in private practice) will be discussed. The therapist as the victim is an interesting concept to explore.

### PSYCHIATRY AND SPIRITUALITY IN CONTEMPORARY TIMES

**David M Ndeti**

*Professor of Psychiatry, University of Nairobi, and Director, Africa Mental Health Foundation (AMHF)*

That there is a renewed and highly vibrant interest in the relationship between Psychiatry, Spirituality and Philosophy is well evidenced by the high profile this triad is given in professional bodies and emerging literature. For example the Royal College of Psychiatrists (UK) has a website dedicated to this: [www.rcpsych.ac.uk/spirit](http://www.rcpsych.ac.uk/spirit). The interest in this subject varies from: Spirituality and Psychopathology; The meeting point of spirituality and psychiatry in management of and coping with stress; The meeting point of spirituality, psychiatry and immunology, thus providing a scientific basis for spirituality in clinical medicine. The theme of this conference is yet another illustration of this fast emerging interest.

The relevance of spirituality to medical practice – indeed psychiatry, is to be found among other areas such as in transformation of attitudes, facing death and life stresses and personal development. This paper will examine the evidence for the relevance of spirituality in contemporary practice of psychiatry and will draw from research based evidence in Kenya on the role of spirituality in mental health practice.

### HUMAN KNOWLEDGE AS PARANOID: FOWLES'S THE MAGUS AND LACAN

**Bert Olivier**

*Philosophy, NMMU*

In this paper, a reading is offered of John Fowles's novel, *The Magus*, in an attempt to show that the conception of human 'knowledge' put forward in the narrative

is an instantiation and development of Lacan's claim, that human knowledge is 'paranoiac' or delusional. Far from amounting to the claim that humans can and should do without it, though, Fowles, like Lacan, demonstrates in the unfolding story of his main character, Nicholas Urfe, that there is a veritable exigency for (or what Foucault has called a 'will to') 'truth' on the part of the human subject, even to the point of clinging to a presumed residual 'layer' of 'truth' when everything around one has been systematically discredited as far as its veracity is concerned. In this way, I would like to show, one can learn a great deal from Fowles's insights concerning the epistemic demands of 'healthy' people, about the structure of psychosis (which is perhaps not all that different from the indispensable illusions, if not delusions of 'sanity').

### YORUBA WORLD VIEW AND THE NATURE OF PSYCHOTIC ILLNESS

**Olufemi Olugbile, M P Zachariah**

**Background.** The Yoruba are an ethnic group in southern Nigeria. Although they are put under one umbrella in popular perception, they are mini-nationalities clustered in locations such as Ibadan, Ijebu, Oyo, Ile Ife, and in pockets in places like Benin Republic and Brazil. They speak a common language, Yoruba, with local dialects, and are said to originate from a mythical ancestor – Oduduwa. The major religions are Islam, Christianity and traditional religions. The adherents of 'modern' religions often weave elements traditional practice into their rituals. It is said that the world view centres around a continuous battle between forces of good and evil. There are several deities under a supreme being. Adverse events such as illness are due to the malevolence of enemies, using metaphysical means. Remedy often involves corrective metaphysical intervention, either exclusively or in addition to other methods, such as 'western Medicine'. This 'rule' is said to fit mental illness more than any other type of illness, although there is a lack of published material on the subject.

**Method.** The study is focused on identifying elements of a Yoruba world view in the Lagos area, and factors relevant to the perception and treatment of psychotic illness.

500 Yorubas in Lagos were randomly sampled with a questionnaire, as were 100 'home video' films.

Data were analysed for:

- i) elements of world view in general
- ii) elements that pertain to illness in general
- iii) elements that pertain to psychotic illness.

**Result.** The world view has a significant influence on perception of psychotic illness.

**Conclusion.** It is necessary to understand a people's world view in order to understand (and influence) attitudes towards psychotic illness in themselves or others.

### THE EMBODIED MIND: A CONCEPTUAL EXPLORATION OF MOVEMENT THERAPY AND NEUROSCIENTIFIC PRINCIPLES OF THERAPEUTIC CHANGE

**Annalie Pauw, Annelies Cramer**

*Department of Psychology, University of Pretoria*

**Aim.** The aim of this paper is to explore the complex relationship between mind and brain, emotion and reason or even body and soul through the discipline of movement therapy as therapeutic modality. The authors furthermore aim to draw on the field of neuroscience and in particular, knowledge and understanding of the embodied mind and the neurobiological principles of therapeutic change.

**Argument.** Movement therapy in its various forms relies on non-verbal experiences through the medium of dance and offers intrapsychic, interpersonal and transcendental benefits and offers the possibility of an alternative avenue for

integration of the apparent dualisms of mind/brain; emotion/reason; and body/soul. Movement therapy therefore aims to integrate the physical, emotional and cognitive levels of the individual through the stimulation and release of feelings and catharsis through movement and gesture; communication and contact through non-verbal activity; reduction of anxiety through non-critical therapeutic setting, experiencing physical and emotional joy through rhythm and the use of innate human response to rhythm. Movement therapy is also discussed as a means of becoming aware of the content of our own and the minds of others in a metacognitive way. The discussion will be facilitated through the use of Biodanza as an example of a distinct form of movement therapy.

**Conclusion.** In conclusion the authors make conceptual links between the fundamental principles of movement therapy and recent developments in the field of neuroscience and focus on the complexities of personal and social domains of functioning and the biological explanations linked to these.

### VICTORY OVER THE DARKNESS: A SPIRITUAL BATTLE

**Lilian Marteh Pieljtes**

*PO Box 4707, Nairobi, Kenya*

**Aim.** To demonstrate the efficacy of faith-based practices in providing holistic treatment for depressed patients.

**Argument.** At a recent conference entitled 'Spirituality and Healing in Medicine', Associate Professor of Medicine at Duke University, Dr. Harold G. Koeing asserted that the link between religion, medicine and faith stretches back to ancient times. He noted that at that time, little distinction was made between the healing of the body, mind or the spirit. Today, he recognizes that, "because so many people use religion as a way of coping it makes it extremely relevant to doctors and medicine".

I certainly concur because in my 17-year history with bi-polar depression, my Christian faith has been a great source of strength in helping me to endure this most agonizing journey. I attribute my resilience and even restraint from taking my life to two profound principal beliefs: the fear of God and the love of God.

The faith pillars of prayer, praise, Bible reading and even fellowship with believers literally 'saves' my life. What puts me on higher ground and helps me win the battle, is the hope and love I get from the word of God and by people inspired by him. When my inner self is validated and I get the focus off myself and onto God and others, positive change occurs and I get true and sustained victory over the gulf of darkness.

**Conclusion.** I would like to call upon your team of highly respected experts, to examine the significance of faith and the major role it could play in patient therapy. This is due to the evident impact it has in generating positive and uplifting thoughts during times of tremendous suffering. I believe this approach could help countless others in fighting the challenging and debilitating illness of depression as it does for me.

### THE EFFECT OF GENDER REASSIGNMENT SURGERY IN GENDER IDENTITY DISORDER PATIENTS

**J P M Pienaar, P F Coetzee, G B F Lindeque, P F Colin**

Patients with Gender Identity Disorder (GID) often seek Gender Reassignment Surgery (GRS). It is imperative that this type of pathology be managed by an experienced multidisciplinary team. The road to GRS must be paved with proper diagnosis, supportive psychotherapy, well timed hormonal therapy and excellent patient compliance.

The Pretoria Academic Hospital Gender Reassignment Clinic has consulted 54 patients from March 1998 until October 2005. The objective of this study was to do a follow up study of their physical and mental progress after GRS. Thirty one patients could be located and 29 agreed to partake in the study.

It was found that all patients experienced positive changes in their lives since the start of the gender reassignment process until completion of GRS. The greater majority was functioning well on emotional, social, sexual and occupational levels and there

were no post-operative regrets. Suicide thoughts and attempts reduced to almost nothing and the patients could contribute to society and lead full lives. It is therefore believed that GRS played a valuable and positive role in the lives these patients and that the multidisciplinary approach at this hospital was successful.

### 'WHAT BEST INTEREST?' MORAL DILEMMAS IN DECIDING 'PATIENT BEST INTEREST' BY CASE PRESENTATIONS

**Willie Pienaar**

*Department of Psychiatry, Stellenbosch University, and Stikland Hospital, Associated Psychiatric Hospitals, Western Cape*

Caring for severely disordered patients in at times, overcrowded psychiatric hospitals therapists are confronted with conflicting patient best interest, patient rights, respecting patient autonomy and what is fair or reasonable. Therapists are forced in practice to make judgement calls in this imperfect hospital environment and our imperfect science of healing. By presenting clinical cases, conflicting arguments on 'best results', human rights, the action of good intent, respect for autonomy, beneficence, non-maleficence, justice and duty to care are going to be discussed. The presentation task is to ask the questions, to listen to arguments, to weigh and balance ideas and possible actions, to strive towards virtue despite the fact that we do not know!

### CHAOS AND ORDER OR THE PRINCIPLE OF DOSED INSTABILITY: AN INTERDISCIPLINARY ANALYSIS AND ITS PSYCHOLOGICAL AND PSYCHOPATHOLOGICAL DIMENSIONS

**Georgi Popov**

*Chr. Smirnenski str. 1, St. Marina University Hospital Second Clinic of Psychiatry, Varna, Bulgaria*

The aim of this paper is to make an attempt for step-by-step multidisciplinary analysis of the categories chaos and order using phenomena from physics (e.g. quantum mechanics), the information theory, strategic management, group and individual psychology as well as psychopathology.

At all levels the notional constructs are introduced of complementarity, entropy and negentropy together with the principles of dosed instability and minimum necessary change.

**In conclusion** chaos and order are defined as co-existent, mutually complementary categories than alternatives. The main result of the analysis is the manifestation of this definition in micro- and macro-groups as well as within the personality.

### THE PSYCHOLOGICAL EXPERIENCES OF HIV/AIDS BY INFECTED PERSONS IN THE VHEMBE DISTRICT OF LIMPOPO PROVINCE OF SOUTH AFRICA

**Ramovha Muvhango Rachel**

*Box 269, Thohoyandou*

**Introduction.** HIV/AIDS is a major health and social problem facing South Africa. Media reports show the ever increasing rates of this disease. People informed of their HIV positive status become depressed because of the horror caused by "the big disease with the little name".

**Aim.** To explore and describe the psychological experiences of HIV/AIDS by infected persons in the Vhembe district of Limpopo Province of South Africa.

**Methodology.** The research design was qualitative, explorative, and descriptive, using the phenomenological approach.

**Results.** The following psychological experiences of HIV/AIDS experienced by the participants: depression, hopelessness, self-destructive behaviour, rejection and stigmatisation, anxiety and fear. Contributory to psychological imbalances identified, participants reported that their low socio economic status, and the lack of support system also affected their psychological behaviour. Some participants reported rejection and lack of support by family members, health professionals and loved ones.

The expression of participants' level of fear and intense anxiety dominated the discussion. Males who participated in this study looked more incapacitated than females. They also had more serious physical problems than their female counterparts.

**Conclusion.** There is a need for more health education campaigns directed mostly at the youth and at elderly people as they are likely to have to care for the infected, abandoned youth in the families. The campaign should focus on how HIV is spread, its prevention, and the care of the infected persons.

### COGNITIVE BEHAVIOR THERAPY TRAINING PROJECT IN THE REPUBLIC OF SOUTH AFRICA

**S Rataemane**

*Department of Psychiatry, University of Limpopo (MEDUNSA)*

The goal of this project is to assess the efficacy of three training approaches on Republic of South Africa (RSA) clinicians' ability to adhere to the core elements of a research based model for individual Cognitive Behavioral Therapy (CBT) that is adapted for use in RSA. These methods include: 1) An in-vivo (IV) CBT training and supervision program in which clinicians receive training and supervision from an expert trainer; 2) A distance learning only (DLO) training and supervision approach via a teleconferenced and interactive broadcast with the same expert trainer; and 3) A self instructional manual only approach (MO). The first cohort has been completed and included of 31 clinicians from South African National Council on Alcoholism and Drug Dependence (SANCA) treatment centers in Johannesburg and Pretoria (Gauteng Province). –Baseline data were collected as well as subsequent audiotapes and therapist checklists at 4, 8, and 12 weeks post training. Audiotapes are sent to the United States for standardized ratings. The aggregate total of tapes collected from baseline through week 12 was 88 tapes out of a projected 124 tapes for an overall collection rate of 70.9%. Successes and challenges of this highly regarded international project are discussed.

### STIGMA AND MENTAL HEALTH: A SOUTH AFRICAN PERSPECTIVE

**Solomon Rataemane**

*University of Limpopo*

**Lusanda Rataemane**

*MEHADIC, South Africa*

Stigma often implies shame, disgrace or disapproval and usually results in an individual being shunned or rejected by others. Rejection by friends, relatives, neighbors and the community as a whole can increase the family's sense of isolation, resulting in restricted social activities, and the denial of equal participation in normal social networks. The stigma associated with mental illness is strong but generally increases the more an individual's behavior differs from that of the 'norm'. Although recent advances in psychiatry have increased the understanding of psychiatric disorders, many people with chronic or severe psychiatric disorders may be unaware that effective treatment is available. Ignorance and stigma may prevent mentally ill persons or their families from seeking appropriate help. Help seeking behavior is determined to a large extent by community attitudes and beliefs about the illness. Blame for the illness may sometimes be placed on the patient or their families. Mental health problems are also sometimes "understood" as character weakness than real illness that requires proper health care - the mentally ill are thought to be dangerous and likely to have a criminal record. In addition to the obvious distress of seeing a loved one disabled by the consequences of a mental disorder, family members are also exposed to further stigma and discrimination. Medical insurances seem unwilling to pay for some forms of mental illness, thus creating more financial burden to individuals who are mentally ill and their families.

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### PERSONALITY DIMENSIONS IN PATIENTS WITH MAJOR DEPRESSIVE DISORDER AND GENERALIZED ANXIETY DISORDER: A COMPARATIVE STUDY AND RELATION TO QUALITY OF LIFE

**Ghada Refaat**

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**Objectives.** The current study was designed to compare personality characteristics between patients with generalized anxiety disorder and unipolar non-psychotic major depression and evaluate their impact on clinical and quality of life aspects.

**Methods.** 60 Saudi outpatients (32 patients with major depression and 28 with generalized anxiety disorder) were subjected to DSM-IV Structured Clinical Interview, Tridimensional Personality Questionnaire, Beck scale for depression, Taylor scale for anxiety and Rating scale for psychopathology and Quality of Life.

**Results.** Both GAD and MDD showed significantly high harm avoidance scores that were positively associated with Beck and Taylor scores. Two lower-order traits of harm avoidance (worry and pessimism, shyness) showed statistical difference between both disorders. Other positive associations were found between the lower-order traits, clinical symptoms, and different quality of life aspects.

**Discussion and conclusion.** Patients with MDD and GAD had similar personality characteristics; however, there appears to be substantial difference between both patients groups. Evaluation of personality characteristics in depression or anxiety is recommended as a fundamental part of effective treatment strategies.

### DETECTION OF MENTAL HEALTH PROBLEMS IN AN EGYPTIAN PEDIATRIC OUTPATIENT CLINIC

**Ghada Refaat Amin, Ghada Ibrahim Gad**

*Departments of Neuropsychiatry and Pediatrics, Ain-Shams University, Cairo*

**Objectives.** To evaluate and screen children attending an Egyptian pediatric outpatient clinic for behavioral and emotional problems using simple screening questionnaire, identify risk factors related to positive scores on screening and explore the relationship between medical and psychiatric disorders in positively screened children.

**Methods.** A cross-sectional hospital-based study was conducted at the pediatric outpatient clinic in Ain Shams University. Children aged from 4 to 15 years were recruited. The final sample included 262 out of 300 randomly selected children. They underwent assessment for medical health. Parents were asked to complete a screening questionnaire (Pediatric Symptom Checklist; PSC) in addition to taking socio-demographic information. Children scored positive on PSC were evaluated in another session by a psychiatrist to detect mental health problems.

**Results.** The rate of positive PSC screening was 55 (21 %) of the final sample. Specifically, 11 out of 70 (15.7 %) preschool aged children (< 6 years) were PSC positive and 44 out of 192 (22.9 %) school-aged children (6 years or older) were PSC positive. Factors related to positive scores on PSC included male sex, parental non-education, low income, single parent family and history of mental health use.

**Conclusion.** Mental health screening can be effectively implemented in pediatric practice. Short screening questionnaire as PSC is useful for the early detection of psychosocial problems in preventive child healthcare.

**PSYCHIATRIC MASQUERADES****Gail Riccitelli**

*MHS, Taranaki District Health Board, New Plymouth, New Zealand*

The aim of this symposium is to highlight the diagnostic challenges presenting to psychiatrists in the setting of a public Mental Health Service. The presentation will demonstrate the importance of neuropsychiatry skills to prevent the pitfall of misdiagnosis. Four clinical scenarios (actual cases) will be presented including the rare but increasingly recognized psychiatric presentation.

**THE ROLE OF DISSOCIATION AND NARCISSISM IN A PSYCHOLOGICAL UNDERSTANDING OF RAGE-TYPE MURDER****Jonathan G. Scholtz<sup>1,2</sup>, Christa Kruger<sup>1,2</sup>, Giada A. Del Fabbro<sup>2</sup>**

<sup>1</sup> *Department of Psychiatry, University of Pretoria,* <sup>2</sup> *Weskoppies Hospital, Gauteng Department of Health*

**Background.** This study aims to develop a model to explain how narcissism and dissociation with amnesia might combine in a rage-type murder. In rage-type murder, non-pathological incapacity is often used as a defence, where dissociation with amnesia becomes the focal question. Although the role of personality in these cases is not a priority for the court, research acknowledges its importance in a psychological understanding of the perpetrator. Whilst previous research examines the roles of both antisocial personality disorder and narcissism in such murders, the contribution of the former is accentuated at the expense of the latter.

**Method.** In order to develop an ideal type, various theoretical approaches, viz. object relations theory, a model of dissociation, attachment theory, rational choice theory and moral developmental theory were applied to four cases of rage-type murder, as set out in official court documents. In these cases, dissociation with amnesia figured prominently in the defence and the defendants were diagnosed with narcissistic personality, according to the Minnesota Multiphasic Personality Inventory II.

**Results.** The perpetrator is predisposed to securing narcissistic supply to compensate for compromised attachment relationships. An escalation phase is triggered when narcissistic supply is withheld and/or replaced by narcissistic injuries which compromise ego defences and increase dependence on the ideal/mirroring self (the victim). On a rational level the costs begin to outweigh the benefits. A precipitant event finally compromises the ego's ability to process conflicting self/other representations resulting in an outburst of primitive unconscious rage and concomitant dissociation.

**Conclusions.** This ideal type model informs and enhances a psychological understanding of rage-type murder. This study also raises a number of questions with regards to the ways in which dissociation and personality should influence court findings. Its potential as a legal tool, with practical implications for court proceedings warrants further investigation.

**GENDER IDENTITY DISORDER IN ADOLESCENCE: A CASE STUDY****Lindi Scribante**

*Weskoppies Hospital, Pretoria, RSA*

**Introduction.** Gender identity is defined as "a fundamental sense of belonging to one sex". Key developments in gender identity formation start between 18 and 36 months of age. By age 3 children usually have a clear identity as either a boy or a girl. Gender role refers to a collection of attitudes and behaviours that are typically male or female. This is usually established at age 3 years, but may still be malleable up to age 5. This third confounding factor which must be taken into account is sexual orientation, which may be hetero- or homosexual in patients with gender identity disorder.

**Case study.** The case of a 14 year old boy (LH), who presented at age 12 with a dysthymic disorder and the provisional diagnosis of Gender Identity Disorder, will be discussed.

The following will be considered based on the case of LH:

The theories regarding the development of gender identity disorder in children

The diagnostic problems and pitfalls regarding diagnosis of gender identity disorder in children

The use of psychometry and other tests to assist in the diagnosis

The differential diagnosis of gender identity disorder

The management of gender identity disorder in childhood and adolescence with specific mention of the place for gender reassignment surgery.

**CROSS-CULTURAL ISSUES IN PSYCHOMETRIC RESEARCH: A PARADIGM SHIFT FOR SOUTH AFRICA****Narropi Sewpershad, Isabelle Swanepoel, Christa Krüger**

*Department of Psychiatry, University of Pretoria and Weskoppies Hospital, Gauteng Health Department*

**Aim.** Given the limited utility of cross-cultural psychometric testing in the multicultural South African clinical context, the aim of this study was to evaluate how cross-cultural issues are addressed in psychometric research.

**Argument.** A literature survey using various databases was conducted with specific focus on the methods used to address cross-cultural issues in psychometric testing worldwide. Traditionally, publicised research was biased towards a Western approach, focusing on translation, collection of norms for different cultural groups on existing tests, adaptation of test content or test administration and new test development. Our findings point towards inadequate research and methodological flaws, indicating several ethical concerns inherent in the traditional methods. Previous research failed to examine the clinical utility and validity of a test battery for a specific cultural group before collecting data, yielding results that are content based, linear and reductionistic. Traditional studies thus did not validate tests but validated interpretations derived from test data, thereby jeopardising generalisability. Moreover, respondents' cultural contexts and an understanding of their ethnicity were not clearly described in these studies, and several questions regarding the examiner-examinee relationship remain unanswered. Furthermore, constructs were not clearly operationalised and research findings failed to account for the effects of confounding variables, including gender, sexual orientation and religion.

**Conclusions.** We propose a paradigm shift to address neglected cross-cultural issues in psychometric research. Future research might benefit from a greater emphasis on process rather than content issues. Such research should involve a multi-disciplinary team representing expertise in mental health, linguistics, psychometry, and an insider view from the relevant cultural group. A circular process of communication would allow multiple layers of meaning to emerge from conflicting perspectives and values. Research in such a new paradigm would contribute towards broadening the scope and utility of cross-cultural psychometric testing in South Africa while adhering to ethical practice.

**ETHICAL IMPLICATIONS FOR PSYCHOTHERAPY TRAINING AND PRACTICE: THEORETICAL PURISTS VS. ECLECTIC PRACTICE****C. Smith**

*Adjunct Professor and Principal Clinical Psychologist, Division of Psychiatry, Department of Neurosciences, University of the Witwatersrand*

The present paper aims to address the ethical implications of adopting a theoretically purist stance as a psychotherapist vs. an eclectic, atheoretical approach to psychotherapy.

The argument is based on several tenets. The difficulty in choosing the right form of psychotherapy for a particular patient has its roots in the theoretical foundations

of psychology. The debate entails the extent to which psychotherapists should ideologically position themselves as theoretical purists or adopt a position of technical eclecticism. Because psychology and therefore its clinical practice of psychotherapy is essentially still in the pre-paradigmatic period according to Thomas Kuhn's analysis of scientific revolutions, there is no single dominant theory to guide psychotherapists. It is argued that the basic assumptions embedded in the theoretical framework adopted by the psychotherapist will not only determine the nature and quality of the psychotherapy that will take place but also the diagnostic formulation of the case. It will be argued that the choice of theoretical orientation will also determine the nature of the ethical dilemmas that will arise. Clinical examples based on different theoretical schools viz., psychoanalytic, cognitive behavioural, systemic and humanistic approaches will be used to demonstrate clinical dilemmas. The impact of post modernism on the clinical practice of psychotherapy and resultant theoretical pluralism will be discussed. Finally, the potential ethical pitfalls of a post modernist approach within a clinically applied field will be addressed.

The conclusion will weigh up the value of adopting a single theoretical framework when training psychotherapists and paradoxically the importance of encouraging an appropriate theoretical integration that addresses both patient need and the particular psychotherapist's personal assumptions about human nature.

#### PHILOSOPHY OF COSMETIC PSYCHOPHARMACOLOGY

**Dan J. Stein**

Peter Kramer's volume "Listening to Prozac" introduced the reading public to the notion of cosmetic psychopharmacology. At the same time, a good deal of philosophical work has been taking place in the related areas of genetic engineering and enhancement therapies in general. A consideration of the use of enhancement therapies in psychiatry raises a range of conceptual questions (what are medical and psychiatry disorders?), explanatory questions (how do we explain and understand psychiatric symptoms?), and ethical questions (who and when should we treat with psychiatric interventions?). This lecture will attempt to outline a conceptual framework for considering the issues at hand. This framework emerges from a perspective which adopts a realist approach to scientific knowledge, which emphasizes the brain-mind as embodied, and which attempts to integrate arguments emphasizing the objectivity versus the subjectivity of medical practice.

#### VALIDATION THEORY – FROM BASIC NEUROSCIENCE TO PHARMACOPSYCHOLOGY

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The aim of the Validation theory (VT) as metaempirical construct is to rearrange the research in neuroscience as unified science for Mind-and-Brain.

VT is driven from the **fundamental arguments**, exposed in the *General Theory of Neuroscience* (1999). The contradiction between the methods of basic neurosciences and the psychological methods, discussed in other studies (Crick, 1979, Bechtel, 2001, Machamer, 2001) is in the focus. According to our analysis this discrepancy consists in the high **penetration** into the biological processes of the traditional neuroscience methods, coupled with low **extrapolation** (experimenting with animal models) and vice versa for the psychological and psychopathological methods. Herewith, the introduction of criteria for significance of the method defines the *difference between evidence and proof*.

A novel epistemological model for integrating psychological and neuroscientific knowledge is proposed. It is represented as *simultaneous investigation of the brain activity with penetrating high resolution functional Magnetic Resonance Imaging and in extenso application of set of psychological tests for exploring the correspondence (crossvalidation) between their compounds*. This can result in the revision of both neuroscientific and psychological terms, methods and data, respectively their relative **equability and interplayability**. It makes possible the practical exchange of the expensive but objective fMRI with the lower costing but irrelevant to neuroscience psychological instruments, that underlies the effect of

**"minimization"**. The approaches proceeding from VT will infiltrate diagnostics and prevention in psychiatry predominantly. Concerning therapy, on a further stage the **pharmacopsychological monitoring** will uncover new opportunities before the proofs-based treatment of mental disorders. The proofs-based research and practice are an integral counterpart of the values-based mental health care (Fulford, 2004, 2006).

**In conclusion** VT is a historical programme for replacing the Brain-Brain with Mind-Brain paradigm in neuroscience.

#### CORTISOL SECRETION AND TRAUMATIC STRESS IN A COHORT OF SOUTH AFRICAN METRO POLICEMEN: A LONGITUDINAL STUDY

**Ugash Subramaney**

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**Objectives.** The objectives of this study were to assess whether Metro policemen exposed to traumatic stress show alterations of HPA activity as measured by cortisol secretion and to assess whether correlations exist between cortisol secretion and depressive and traumatic stress symptoms.

**Method.** Demographic information was obtained by means of a questionnaire. A 24 hour urine sample for cortisol was obtained every 3 months. At 3 monthly intervals, for 1 year, subjects were assessed for Post Traumatic Stress Disorder (PTSD) using the clinician administered scale for PTSD (CAPS). For depressive symptoms the 17 item Hamilton Rating scale (HAM-D) was administered.

**Results.** Of the 28 subjects who volunteered, 63% were male. Ages ranged from 19 to 35. 7.1% had a history of suicide in the family. 23% had a history of alcohol abuse. At baseline, 1 subject was depressed. A diagnosis of current PTSD was present in 1 subject at baseline, with 10% showing lifetime prevalence. A repeated measures analysis of variance for all demographic variables compared over 5 visits with respect to current and lifetime PTSD revealed that the alcohol history category visits differed significantly ( $p < 0.0001$ ) with respect to total CAPS scores (current).

**Conclusions.** Cortisol secretion showed a tendency to slightly higher levels with increased exposure to traumatic stress, although this was not significant. The variable significantly associated with raised CAPS scores was a history of alcohol abuse.

#### ON THE INTERFACE BETWEEN PHILOSOPHY AND PSYCHIATRY

**Prof. T Thornton (UK)**

Much recent philosophy of psychiatry combines qualitative conceptual analysis with natural scientific findings. But two distinctions raise a fundamental dilemma: the epistemological distinction between a priori and a posteriori methods and the distinction of subject matter between accounts couched at the level of the person and sub-personal findings. The dilemma is prompted by the question: how can philosophy make a distinct contribution to understanding, or interface with, empirical findings? Either it is a distinct method usually based on a characteristic way of interpreting the whole person, placing them in the 'space of reasons', but if so how can it contribute to or learn from psychiatric findings which are usually couched in the terms of the 'realm of law'? Or it is not distinct in either method or subject matter but if so how can it add anything to psychiatry? I will address the first horn through an interpretation of the later Wittgenstein that allows empirical findings to play a role in transcendental arguments.

#### ETHICAL ISSUES IN SOUTH ASIAN COUNTRIES

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Ethics is derived from the Greek word "ethicos" which means "Rules of conduct that govern natural disposition in human beings". It is the body of moral principles or values governing a particular culture or group.

Ethics in psychiatry is always in a state of flux adapting to changes in the specialty & its place in the world at large.

The ethical issues that are relevant to the developing or low resource countries are in contrast to the industrialized countries. The issues such as euthanasia, surrogate motherhood, organ transplantation and gene therapy, which are on the forefront in the industrialized countries, are, for the moment, irrelevant in most developing countries. Here the ethics of scarcity, cross-cultural research, as well as the activities of multinational companies, are more relevant. The majority population in these areas is illiterate and unaware of their rights and is vulnerable to all sorts of mistreatments. There is a lack of consensus on the ethical issues and well defined ethical guidelines are needed.

Lack of resources and weak infrastructure mean that researchers in developing countries are often unable to conduct their own research. As they increasingly establish partnerships with groups from developed countries, a sound ethical framework is a crucial safeguard to avoid possible exploitation of research participants in these circumstances. Local needs should be taken into account when conducting research in developing countries and the role of research ethics committees in this respect needs to be emphasized. Early discussion of the issues with national authorities as well as the local communities concerned can help researchers to overcome the difficulties of adhering to conflicting international guidance.

All these ethical issues are pertinent to the South Asian countries and will be discussed in the presentation.

#### **A PROFILE OF STATE PATIENTS ADMITTED AT STERKFORTEIN HOSPITAL**

**Ahmed Valli**

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The association between crime and mental illness has long been of interest to clinicians, social scientists and the legal fraternity. Why do persons with mental illness get involved in crime? Some studies on the subject have been conducted in the developed world but little information is present from less developed countries. These countries are often in a stage of rapid social change, with high levels of crime, such as the case in South Africa. What is the relationship between crime and mental illness in this context and in particular between violent crime and mental illness?

The purpose of this study is to identify such relationships and investigate possible relationships between aspects such as demographic data, previous history of crime or violent crime, substance abuse, type of crime and type of mental illness.

Retrospective record reviews of a random sample of all state patients admitted to Sterkfontein Hospital for the years 1999, 2000 and 2002 are examined. Demographic data such as age, sex, area of residence, educational and employment status, as well as other variables such as type of crime and type of mental illness recorded and analysed. A qualitative arm of the study includes in-depth interviews of 10 state patients and explores circumstances surrounding specific crimes.

Findings of the study are presented. Data are summarised with descriptive statistics and possible associations are explored in contingency tables with the use of statistical tests of association where appropriate. Qualitative data are explored through thematic content analysis. Implications of the data are briefly explored.

#### **FAMILY-CENTRED INTERVENTIONS TO IMPROVE COMMUNICATION BETWEEN PSYCHIATRIC DISORDERED CHILDREN, THEIR FAMILIES AND THE MULTI-PROFESSIONAL TEAM**

**D van der Westhuizen**

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##### **Aim of family-centred intervention:**

- Early detection of poor family relationships followed by swift intervention to prevent the development of a psychiatric disorder

- Prevention of a known psychiatric disorder from getting worse by stabilizing the family environment

- Focusing on the child in the family context implies that entire family strengths and needs are considered, involving family members in assessment, planning of treatment. This in turn empowers the family system to support and maximize the process of intervention; improving parent-child communication-interaction.

**Argument.** The success rate of the service delivery depends on family members that continuously play their roles and maintain a perfect balance in the family system; an open communication channel and trusting relationship regarding the multi-professional team. Parents are seen as the leaders and experts in this partnership. Disrupted family systems suffer from severe impairment in communication growth and strained parent-child interactions.

The therapeutic process requires some special skills:

1. Screening/identification: the role that family plays as a medium for communication.
2. Assessment: strengths and needs of family system, bio-psychosocial assessment of the child, the parents school; and after-care.
3. Bio-psychosocial treatment of mental disorders of the child and parents to stabilize the family system: parent- and sibling-interaction.
4. Improve dialogue and relational problems in the family system using the multi-professional team: psycho-education, behaviour therapy, parent management skills training, problem resolution skills, cognitive behaviour therapy, family therapy, supportive therapy, life skills, marital therapy.
4. Ongoing evaluation: Users rate the family-centered program's effectiveness to allow information on what works for both a specific child and family to ensure ongoing patient tailored program development.
5. Co-ordination and networking with other departments, health care, education, justice department and social welfare and support groups.

**Conclusion.** Family members maintain their family roles but also facilitate interactions for the special needs of the psychiatric disordered child within the day-to-day activities without becoming overburdened.

#### **THE DRAMA OF PSYCHOLOGICAL THEORY**

**Vasi van Deventer**

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Every second year the world's theoretical psychologists come together to present and discuss the newest theories in psychology. Each conference produces a book of selected papers, which provides a contemporary overview of the status of psychological theory. These papers are normally categorised in terms of their content. But the most recent proceedings deviates from this practice by slotting papers in terms of a meta-perspective of psychological theorising. What emerges is a dramatic story, containing episodes such 'The play', 'The quest of norm', 'The siege', 'A secret agent', and 'A new practice'. Basically it is the story of a city and its citizens, of normative violence, the rise of the agent and the demise of the norm that leads to new practice. The current paper provides an overview of contemporary theorising in psychology against the background of this story. Three issues are highlighted: (a) the devalued currency of psychology in third world contexts, (b) the problem of the ultimate foundation of psychological personhood, and (c) the impact of contemporary theory on psychological practice.

#### **STRATEGIES FOR THE FACILITATION OF THE MENTAL HEALTH OF MARRIED COUPLES THROUGHOUT THE ANTE- AND POSTNATAL PERIOD**

**Vasti van Niekerk, Marie Poggenpoel, Anna Nolte**

*University of Johannesburg*

Having a baby is a life-changing event in a couple's life and it is normal to experience positive and negative feelings about this change. To have a baby is

often a celebratory experience for couples, but it can also be a strenuous time. A new child alters/changes the dynamics of a couple's relationship, which can lead to stress, pressure and negative patterns if not handled properly. Expectant parents spend months preparing for the arrival of the new baby. But even with all the preparation, the reality of caring for a new baby can be overwhelming.

The overall goal of the study is to develop and describe strategies in order to facilitate the mental health of married couples after the birth of their baby.

The researcher will utilize a qualitative, explorative, descriptive and contextual study design. The research will be carried out in three phases. The first phase will be to explore and describe the story of new parents after the birth of their baby. During this phase the researcher will collect data through interviews and naïve sketches (diaries) and the interpretation of drawings about new parents' stories. Different methods will be used to triangulate the data. Data analysis will be done by means of open coding. Results will be re-contextualized within the literature.

Trends in the results will be utilized as basis for the description of a conceptual framework (phase 2).

The third phase will be the formulation and description of strategies to facilitate the mental health of a married couple after the birth of their baby. Measures to ensure trustworthiness will be utilized and ethical principles will be adhered to right through the research process.

The uniqueness of this study will be to promote the mental health of married couples after the birth of their baby. This will enrich the new parents' relationship and also their relationship with their child.

## DEPRESSION, BURNOUT AND THE IMPACT OF EVENTS ON VOLUNTARY COUNSELLORS

**Naseema Vawda**

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**Background.** Volunteers working at nongovernmental organizations crisis centres often experience psychological distress. As this area is under-researched, this pilot study aims to assess depression, burnout and the impact of events using psychometric instruments in this group.

**Method.** A sample consisting of 16 subjects was asked to anonymously complete a demographic questionnaire (e.g. age, marital status, etc.) and standardized self-report psychometric instruments. These consisted of the Beck's Depression Inventory (BDI), Maslach's Burnout Inventory (MBI) and the Impact of Events Scale (IES).

**Results.** Descriptive data (e.g. mean age, etc.) are presented. Twenty five percent of the sample reported moderate or severe depression on the BDI. On the MBI, 18.75% had high levels and 43.75% had moderate levels of Depersonalization. Furthermore, 43.75% reported a low sense of Personal Accomplishment on the MBI, while 12.5% reported high levels and 18.75% reported moderate levels of Emotional Exhaustion on the MBI. Correlational analyses indicated a positive correlation between the BDI and Emotional Exhaustion on the MBI ( $p < 0.05$ ). Both the avoidance and Intrusion subscales of the IES correlated positively ( $p < 0.05$ ) with the Personal Accomplishment scale of the MBI.

**Conclusion.** There are significant levels of depression and burnout among volunteers and the personal and organizational implications are discussed.

## TRANSLATION: THEORY AND PRACTICE

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The aim of this paper is to elucidate the ways in which translation affects our worldview, both in a theoretical sense with regard to philosophical theory, and in the practical context of psychiatry. Firstly, several philosophical theories concerning translation and the nature of meaning will be discussed, as well as the interconnectedness of language and culture. Secondly, to illustrate the differences

outlined above, the author will discuss her experiences working with mentally ill immigrants as a forensic psychiatrist.

Quine's indeterminacy thesis, grounded in behaviourist methodology, states that as a result of the public nature of language and the relative paucity of evidence, translation cannot be anchored on a concept of meaning and is thus hopelessly slippery. Rival theories of meaning – e.g. Gricean and Whorfian – seek to remedy this by rejecting behaviourism in favour of audience-centred or native-speaker centred approaches. The question then arises whether these theories provide satisfactory models of translation, or whether some languages still fail to be intertranslatable due to incommensurable conceptual schemes. It seems that conceptual scheme theory is no impediment to translation in philosophical and scientific contexts, but since the subtle emotional connotations of words are relative to a culture or community, a different strategy might be better suited to other contexts.

These differences are highlighted by the examples concerning a forensic psychiatrist's contact with mentally ill immigrants. Facing the possible additional problem of linguistic confusion due to mental disorder, the psychiatrist's work must take place in both discourses, as it is important to understand emotional and cultural dimensions of language in order to empathise with one's patients, yet one must not lose track of theory and the analytic mindset.

In conclusion, translation is properly thought of as relative to a context, whether scientific and transcending cultural differences, or taking emotional and cultural connotations into account.

## THE REAL PERSON BEHIND PAPYRUS, BERLIN 3024, WAS IT THE MAN, HIS BA OR BOTH?

**F Versonnen, S Tuinier**

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**Background.** In 1896 Adolf Erman, a famous Egyptologist, published the translation of Papyrus 3024 from the Egyptian Middle Empire. He considered the manuscript as an inner dialogue of a man, tired of life, with his soul. The following translations throughout the 20th century gave contradictory results, but agreed always on one topic: the text is a dispute between a man and his *ba*.

**Method.** Occasionally historians make modern psychiatric diagnoses in historical figures. Sometimes this is done with the expectation that doing this will add new information. However, modern diagnostic concepts are themselves historical narratives and social constructs and do not especially convey new information. Viewed from the perspective of the Lacanian discourse analysis, this is an example of 'the master' or 'scientific' discourse. In this contribution the internal dialogue of the man will be described from the Lacanian perspective.

**Results.** Analytical reading, in which the attention is focused on the speaking subject and his relationships, does not generate post hoc diagnoses in the usual sense, but may be helpful to understand more of the writer of the papyrus and his interpreters. The old manuscript focuses on a 'dichotomy' in man, somehow reflecting modern psychoanalytic insights in human personality development.

**Conclusions.** The Lacanian discourse analysis may be a suitable instrument to highlight the essential aspects of this old manuscript. Moreover, the aim to understand this manuscript and its translations reveals also some underpinnings of the dynamics in clinical psychodiagnosis.

## MANAGERIAL GUIDELINES TO SUPPORT PARENTS WITH THE HOSPITALISATION OF THEIR CHILD IN A PRIVATE PAEDIATRIC UNIT

**Michelle Verwey, Karien Jooste, Eben Arries**

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The admission of a child to a hospital is a very stressful period for both the child and parents. Whilst a growing number of hospitals have become more "child friendly" over the past decade, there are very few hospitals where family centered care is

facilitated. Parents often feel anxious and stressed when their child is admitted to a private paediatric unit and this may result in parents becoming negative towards the hospitalization process as well as nursing staff.

The overall aim of this study was to develop managerial guidelines that will support parents with the hospitalization of their child in a private paediatric unit.

The researcher utilised an interpretative, phenomenological, qualitative, explorative, descriptive and contextual study design. The researcher explored and described parent's experiences of their child's hospitalization in a private paediatric unit. During this phase the researcher collected data through interviews and naïve sketches (diaries) as well as the researchers own observations and field notes. Different methods were used to triangulate the data. Data analysis was done by means of open coding. Results were re-contextualized within the existing literature literature.

The findings of the research indicated that parents had various experiences within the following areas of the paediatric unit: namely the interactive processes within, and the environment of, the paediatric unit. Guidelines were then written that will address areas of concern in parental participation, communication, management of information and planning and organizing of the paediatric unit as well as the environment of the paediatric unit and facilities available to parents.

The uniqueness of this study is that there are very few guidelines to support parents with the hospitalisation of their child in South Africa, as well as providing practical managerial guidelines that could be implemented to minimize stress and anxiety during this period.

### **A MERGER AND ACQUISITION TEAM COACHING PROGRAMME TO FACILITATE THE MENTAL HEALTH OF MANAGERS FOR SUSTAINABLE PERFORMANCE**

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Merger and Acquisition (M&A) change impacts on job-related performance levels globally. Literature indicates that about 75% of change initiatives fail. This poses a threat to the mental health of those involved. In the hospitality industry, representing the context of this research, M&A activities are an integral part of growth initiatives and economic survival. Hotels strive to improve efficiency in an environment with shrinking budgets due to a softening global economy.

The core premise of this research is that collective processes of lifelong learning and growth underpin sustainable organisational transformation. Team coaching is increasingly recognised as a process that enables learning and development to occur and hence performance to improve. A relevant research question that developed against the backdrop of existing M&A realities is: How can the implementation and evaluation of an M&A team-coaching programme facilitate the mental health of hotel managers for sustainable performance?

**Method.** A qualitative, programme evaluative and theory validating design guided the research process. The purpose of the research, namely to implement and evaluate a team coaching programme in order to refine and validate the programme, was realised through three interconnected phases with specific methods directing each phase. Strategies to enhance trustworthiness included prolonged engagement with the participant team, as well as multiple data collection methods such as focus group interviews, naïve sketches, qualitative individual interviews and field notes. Data analysis entailed Tech's descriptive method of open coding. A literature control re-contextualised data in phase two.

**Results.** Findings indicate that M&A change poses a challenge to the mental health of managers. They experienced the M&A team-coaching programme as a tool facilitating personal, environmental and collective mastery.

**Conclusion.** The findings stress that companies facing M&A deals will benefit from investing in an M&A team coaching programme that is scientifically grounded and skilfully facilitated. Mentally healthy employees are productive employees!

### **USING AN INTERACTIVE VIDEO TO PROMOTE MENTAL HEALTH**

**John Weinkove**

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**Aim.** Mental health service utilisation in a rural community in South Africa was recently studied by the author (*SA Journal of Neuroscience* Aug 06). This study showed very low utilisation of the psychiatry ward despite the large population served. This finding is similar to that found in studies carried out in developed countries but far more marked. The reason for this is unclear. This phenomenon does not appear to be limited to psychiatric care but occurs in a wide variety of medical conditions. The present study attempts to place the question of lack of service utilisation within the total ambit of general medical care and puts forward a particular method for reversing the observation.

**Argument.** A preliminary review of service utilisation in hypertension is used as a model for the general problem. The issues that apply to under utilisation in this area are arguably applicable to a mental health setting. Methods of spreading the message of good health in the community are reviewed. A proposal is presented to use an interactive video for health education in Mpumalanga especially investigating audience participation. Methods of evaluation of such a tool are debated.

**Conclusion.** An interactive video may be a useful approach to increase awareness of mental illness and hopefully improve service utilisation and hence effect secondary prevention. The result of an awareness campaign should be to bring more people to care and at the same time go some way to identify the true extent of mental illness in the community.

### **USE OF LOGOTHERAPY IN A RURAL SOUTH AFRICAN SETTING**

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The aim of this presentation is to propose that Logotherapy could be an appropriate psychotherapeutic technique to be used in a rural South African setting.

The presentation will outline a definition of logotherapy and its basic tenets and principles. Logotherapy is presented as a possible intervention to help the bio-psycho-social rehabilitation of psychiatric clients subscribing to a belief system which is not easily accessible to eurocentric psychotherapeutic approaches. The presentation describes challenges emanating from the practice of psychiatry in a context of a rural South African setting, the meeting of different world views and the need for finding a therapeutic approach acceptable and understood by both the therapist and client who either already has tried the available traditional interventions or no longer believes in such interventions. Psychiatric disorders can be viewed as socio-cultural events lived by the affected people in their environment or context. The intervention will be demonstrated through three case presentations as well as a report on logotherapy with a family support group of mental health care users. These illustrations tend to suggest that logotherapeutic techniques can be effectively used in a rural South African setting despite the challenges imposed by the multicultural situation in the practice of psychiatry and medicine in general. Logotherapy seems to have some characteristics which allow its effective use in a multicultural situation. The author's experience of the application of logotherapy in a rural South African setting calls for further research in the area and possible inclusion of this approach in the training of mental health care workers.

### **WOMENS' MENTAL HEALTH: MOOD AND MEMORY IN MID-LIFE AND BEYOND**

**Denise White**

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**Aim.** To analyse the role of oestrogen on mood and memory during the transition to menopause and in the post-menopause.

**Argument.** Recent literature indicates that the diminishing levels of oestrogen that occur in women during the transition to menopause are an aetiological factor for both depression and cognitive difficulties in this phase of the lifecycle. Studies suggest that depression occurs not only in those women who have had a previous history of depression, but also in a percentage of women who have had no previous history and who experience a first episode of depression during the perimenopause. There is evidence that oestrogen replacement is an effective antidepressant for depression with onset during the perimenopause.

Recent studies also suggest that the timely administration of oestrogen during the perimenopause may have a protective function on the ageing brain and possibly delay the onset of degenerative changes associated with Alzheimer's disease.

However, the risks versus benefits of treating menopause-related symptoms with hormone replacement therapy (HRT) are unresolved following the adverse outcomes of HRT on women's health made evident by the major Womens' Health Initiative (WHI) study.

Recent critical re-evaluation of the outcomes of the WHI study indicate that there is evidence that HRT may benefit certain symptomatic perimenopausal women, including those presenting with mood disturbance and those at risk of cognitive decline.

**Conclusion.** The evaluation and management of mood and cognitive disorders throughout the life cycle falls within the scope of the psychiatrist. It is therefore necessary for psychiatrists to evaluate the benefits versus the risks, not only of psychotropic medication, but also hormonal therapy in the management of women experiencing psychological and cognitive symptoms associated with the hormonal changes of menopause.

## THE RELEVANCE OF THE CHANGEUX-RICOEUR DIALOGUE ON NEUROSCIENCE AND PHILOSOPHY TO THE FORMULATION OF HYPOTHESES ABOUT HUMAN EXPERIENCE

**Michael T H Wong**

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**Background.** Recent advances in neuroscience and increased interest in the philosophy of mind and consciousness provide an opportunity for new attempts of synthesis of knowledge and insights on the issue of what the best way is to describe the human experience.

**Method.** The published dialogue between Jean-Pierre Changeux and Paul Ricoeur<sup>1</sup> was reviewed and critiqued from the perspective of neuroimaging and related research<sup>2</sup> to identify key ideas that are relevant to the formulation of hypotheses about human experience.

**Results.** Informed by the findings from molecular biology, evolutionary biology and connectionist modelling and insights from reflective philosophy, phenomenology and hermeneutics the Changeux-Ricoeur Dialogue acknowledges the presence of two distinct discourses of neuroscience (objective) and phenomenology (subjective) and recognizes the challenge of formulating a "third discourse" that is different from that of substance dualism or eliminative reductionism. Drawing on neuroimaging research findings that highlight the interpretive problems of specificity, causality and

complexity in the neuroscience discourse it is demonstrated that the perspective of semantic dualism and methodological reductionism provides an alternative to the extreme positions of "brainlessness" or "mindlessness" as have been witnessed in the history of clinical and research psychiatry.

**Conclusion.** It is argued that a multi-layered personal narrative informed by neuroscience and philosophy and mediated by a hermeneutics that does justice to the richness of human experience through accepting the need to address the complexity, hierarchy and spontaneity of our nervous system provides an attractive alternative to describe human experience.

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## CAN HEALTH LEGISLATION ASSURE HUMAN RIGHTS AND CLINICAL STANDARDS WITHIN LIMITED RESOURCES?

**Emeritus Professor Tuviah Zabow**

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The Constitution of the Republic of South Africa (Act No. 108 of 1996), prohibits against unfair discrimination and recognises the socio-economic injustices, imbalances and inequities of health services of the past. Section 27(1) of the Constitution provides for the right of everyone of access to health services. The State is required to take legislative and other measures to achieve the progressive realisation of each of these rights. The State must, respect, protect, promote and fulfil the rights in the Bill of Rights which is the cornerstone of democracy in South Africa.. Important revisions of health laws and related legislation has been introduced in keeping with the new Constitution. These include in particular the National Health Act (2001) and the Mental Health Care Act (2002). An emphasis on human rights in both legislations is evident in relation to various areas including research and other ethical issues.

Various international and national organisations have issued documents in form of guidelines and principles. Amendments and review of legislation has increasingly focused on promotion of health and access to health services. The formulation of comprehensive legislation within limited resources does not automatically assure the provision of health services or the adherence to human rights principles.

The low priority accorded to health issues in developing countries frequently results in health service receiving inadequate financial and personnel resources. The access and quality of care in both physical and mental disorder must be provided for. The prevention of discrimination in providing treatment for those with adequate health insurance and the indigent populations have been addressed in legislation.

The recently introduced laws will be addressed as examples of the extensive review of legislation undertaken. Particular reference is made to the Mental Health Care Act and related laws affecting the service delivery to psychiatric patients. Discussion as to whether these introductions in law will assure the maintenance of quality standards of care and human rights.