

# *Serenity*

Anxiety and Depression – A Positive Outlook

Vol. 5 • No2

Issue 16 June 2007

# Treatment of Depression

**D**epression is a serious psychiatric condition that needs the best treatment to prevent a bad outcome and chronicity.

In clinical trials, 50% - 70% of patients respond to antidepressant therapy. Up to 45% of patients treated with an antidepressant do not achieve remission with between 25% - 35% of patients experiencing full remission. One third of patients experience chronic symptoms with about half of those diagnosed with major depression needing ongoing treatment.

There are different remission rates between SSRI's (excluding Escitalopram), TCA's, Moclobemide and Venlafaxine.

- SSRI's remission rates 20% - 39%,
- TCAs remission rates 46% - 53%.
- Moclobemide remission rates 30% - 47%
- Venlafaxine remission rates 37% - 67%.

Patients had a 50% greater likelihood of achieving remission when treated with Venlafaxine than they did when treated with an SSRI.

The persistence of residual symptoms during treatment is a sign of a poor prognosis and is a primary risk factor for relapse. Residual symptoms are strong predictors of early relapse, which occurred in 76% of patients with residual symptoms and 25% of those without.

Escitalopram was also statistically superior to conventional SSRI's in a severely depressed subgroup of patients (Citalopram, Fluoxetine, Paroxetine or Sertraline) and in comparison with Venlafaxine not statistically significantly different. Escitalopram is also comparable with Venlafaxine with comparable rates of response and remission.

International treatment guidelines suggest the use of SSRI's as first line treatment, with a trial of a second SSRI if a poor response is evident on the first SSRI. SNRI's are only suggested as third line therapy with augmentation as the fourth line of treatment.

Evidence though suggests that the best treatment be offered to patients early in treatment which includes the SNRI's and Escitalopram. In an environment where short hospital admissions of patients with Major Depression is encouraged, augmentation of antidepressants early in treatment is often initiated to treat symptoms of depression and encourage early discharge.

Continuing antidepressant therapy for 4-9 months after the remission of acute symptoms has been demonstrated to reduce the likelihood of relapse or the recurrence of depression and the general consensus today



**Dr E Allers**  
Psychiatrist  
Benoni, Gauteng



recommends the use of anti-depressants for at least one year after full remission.

Psychotherapy should be encouraged in all patients with Major Depression and should be initiated as soon as patients are able to take part in therapy. ◆

[References on request](#)

# Psychiatry

---

## in Development



**Dr T. Rangaka**  
SASOP President

Sometimes medical practitioners lose contact with the bigger picture and arena of Public Health; it was a pleasure for me and more than twenty colleagues to have been exposed to what the World Psychiatry Association deals with. I attended the first regional meeting of the WPA held in Africa in Nairobi, Kenya during March 2007. The theme: "PSYCHIATRY IN DEVELOPMENT."

The conference was attended by psychiatrists, mostly from East Africa, medical officers dealing with psychiatric patients, psychologists, social workers, economists and health care service administrators and the attendees who all made valuable contributions.

What struck me on my first visit to Nairobi, and which I now see as a global issue, was the traffic tardiness and traffic jams all the way from the Jomo Kenyatta Airport to the Elephant Park Hotel on the opposite end of Nairobi city! The major road from the north east of Kenya to the coastal areas of Mombasa, runs through the centre of the city, the way it did when the city was still a one horse cart town! Traffic jams, journey delays, uncertain, unreliable, scarce, costly and unsafe public transportation systems affect citizens, especially the indigent in a catastrophic way. A democratic government should demonstrate its commitment to the health and wellness of the voters by providing them with a reliable, sustainable, regular, affordable, safe and state sponsored public transport, reticulation of trains, and safe pedestrian and cycle

paths. This would show that the government cares, and this applies to Kenya as well as to South Africa.

A most pleasant observation was that the overwhelming majority of scientific papers at the conference were presented by Black people. The scientists in East Africa actually challenged Black South African psychiatrists and other healthcare practitioners on the issue of Psychiatry in Development. It reminded me of a challenge often issued by President Thabo Mbeki where he asks, "Where are the Black intellectuals?" I remembered advice from the Black motivational speaker, preacher and writer, Myles Munroe who said you must just put pen to paper and write; ideas will pour forth. In Setswana we have a saying which goes, "Mmua-lebe o a bo a bua la gagwe." Loosely translated it means that someone talking what may be criticised by others is expressing his own views and must be respected.

Developmental issues as they affect and are affected by mental health were explored from varying perspectives. The most erudite approach was taken by Professor Norman Sartorius, who took everyone of the nine Millennium Developmental Objectives of the World Health Organisation and showed how they affect Mental Health and Wellness.

The take-away message from the conference was that psychiatrists and healthcare providers in general must get involved in developmental issues and interact with politicians, economists and other policy makers to ensure that mental health and psychiatry retain a high profile. A good mental health care programme ensures an effective developmental plan. ◆



# Post-traumatic Stress Disorder

## Facts & Fiction

**P**sychediatric illness has replaced physical illness worldwide as the most frequent cause of disability. The reasons for this are manifold. There may be a real increase in psychiatric morbidity, related to stressful life styles. On the other hand, certain psychiatric conditions are relatively easy to fake, and it is more difficult to disprove symptoms of depression and anxiety than physical symptoms like lower backache – modern imaging techniques make this possible.

In the South African context PTSD is a relatively popular ground for claiming occupational disability, as this syndrome often relates to trauma suffered in the course of employment which entitles the claimant to compensation. On the other hand, in a violent society as ours one would expect a higher incidence of this syndrome.

Great care should therefore be taken before such a diagnosis is established, as this can have far reaching consequences for the patient and the employer. Employers have become increasingly sceptical about this diagnosis, and frequently ask for one or more “independent” opinions before they consider long disability leave or medical boarding.

### Some points to consider before considering PTSD

1. Being exposed to a trauma does not automatically mean that a person will develop the disorder. This will depend on a number of predisposing factors (developmental, psychiatric and historical).
2. Even when the disorder is present, this does not automatically mean loss of occupational functioning. A South African study of working members of the police showed that up to 50 % met the criteria for PTSD, but continued to work and function.

### How to establish a firm diagnosis of PTSD

1. Adhere strictly to DSM criteria:
  - a. A trauma of considerable magnitude in the context of the individual (e.g. one would expect professional soldiers, members of the police, health care professionals etc. to have a higher threshold for traumatisation)
  - b. Persistent re-experiencing of the event (not mere mulling over incidents)
  - c. Persistent avoidance of stimuli associated with the trauma (not mere avoidance of the employer's offices)
  - d. Persistent symptoms of increased arousal (this may have numerous other causes which should be considered)
2. Compare the patient's report of symptoms to the presentation at the interview
3. If at all possible, get collateral information from reliable sources (spouses are not always objective)
4. Psychological tests may be helpful: the MMPI-2 is a widely used test for the detection of malingering; when used in conjunction with other tests (SIRS, M-

FAST and TSI) the chances of detecting malingering become much better. However, the latter tests are not widely available.

### Management of persons claiming PTSD

1. Persons suffering from PTSD:

The goal of treatment is always return to previous levels of functioning in the person's occupation. A combination of pharmacotherapy (usually SSRI's and other antidepressants) and psychotherapy (cognitive-behavioural therapy has the best outcome) should lead to a resolution of symptoms. Tranquilizers should be avoided, as PTSD sufferers (like other anxiety disorders) are at higher risk to develop dependence.
2. Persons not meeting the criteria for PTSD:

The fact that a person does not meet the criteria for PTSD does not mean that he or she does not have a condition that warrants psychiatric attention. Quite often these persons have serious problems at work for other reasons; they often present with depressive symptoms, be it a major depressive episode or an adjustment disorder. Personality disorders or traits thereof are often present, as is substance abuse, in particular abuse of alcohol.

### Psycho-legal aspects

1. The process of boarding and compensation:

While medical boarding can be a relatively swift process and, indeed, the employer may be eager to get rid of cumbersome employees – the compensation process is slow and can drag on for years. During this time, the claimants become fixated in their sick role, even when symptoms are minimal. This impacts on their ability to function in the labour market.
2. Future employment opportunities:

Most of the claimants are relatively young - in their 30's or 40's. Unless they become self-employed, their record of having been boarded for a mental disorder makes them almost unemployable.
3. If a mental health professional actively endorses medical boarding, this may lead to later claims against this practitioner, once the claimant realizes the financial predicament he or she finds himself/herself in.

### Summary

The diagnosis of Post-traumatic Stress Disorder relies largely on the patient's self-report of symptoms. This requires that the clinician adheres to the strict criteria for the diagnosis, that collateral information be obtained, and that clinical judgement be applied judiciously. Whenever possible, tests like the MMPI and other more specific tests should be applied to support or reject the diagnosis. ◆



**Dr H Erlacher**  
*Chief Psychiatrist and  
Clinical Head, Fort  
England Hospital,  
Grahamstown*

# The Trauma Trap:

---

## A Case Study



**Gerhard I Grundling**  
*Clinical Psychologist,  
Benoni, Gauteng*

**J**ohn 30 years of age came into my consulting room, well dressed and groomed. He appeared extremely anxious and when prompted to tell me about his problems had difficulty doing so, not knowing where to start.

It was evident from the start that he was a somewhat shy man and the present situation was difficult for him to deal with. He confirmed this by saying that he had never before spoken to a clinical psychologist and for that matter also had not spoken about his problems to any of his family or friends except to his wife during the past week. It was also his wife who insisted he needed to seek help as she had been complaining about him being very distant towards her, and even suspecting him of being unfaithful to her.

### Severe depressed mood

John also presented with a severe depressed mood revolving around the possibility that his wife might leave him as well as a long standing history of periodic alcohol abuse and analgesic dependence (since late adolescence). John had a pattern to increase his substance intake at night to try and avoid being able to be intimate with his wife. He explained

that he wanted to avoid sexual contact as far as possible. This resulted in conflict between them as his wife was very keen on falling pregnant.

John is married without any

children. His wife is also 30 years old and they got married at the age of 26. Both his parents are still alive but they were divorced when he was three years old.

John is the eldest of two children. His sister is his junior by one year. John recalls his parents having marital conflict. After the divorce of his parents his father kept contact with him for the first year and then disappeared. He only had contact with his father 3 times after this. He knows in which town his father stays but does not want to resume contact with him.

John's mother stays in the same town as he does and she remarried only after he left school. She has had no other children. It is clear that John and his mother tend to have an over-dependant relationship. John says that he has felt responsible for his mother since she divorced his father. They suffered great hardships during the first couple of years after the divorce. This led to John and his mother and sister being forced to give up their home and to move in with his aunt, the elder sister of his mother, also a divorcee. His aunt's youngest child a son of 15 years was still at home. John and his cousin had to share a room for the next 9 months after which they moved back into their own flat.

### Sexual abuse

John sees this as one of the most difficult times in his life. His cousin started to sexually abuse him in a very violent and aggressive manner. He was continuously threatened that if he told his mother they would be thrown out on the street and that his aunt would never believe him. He experienced extreme levels of



anxiety and fear due to the assaultive nature of the abuse, in a physical and emotional manner. John also didn't want to tell his mother or any other trustworthy adult about his traumatic experiences, as he thought that this would cause his mother harm

and he wanted to avoid that at all costs. By doing this John started to take responsibility for his mother's emotional well being.

John's reliving of his trauma disappeared at the age of 6 years when the family moved out until the age of 15 years when he had his first sexual



encounter with his girlfriend. This triggered a flash back of a particular situation that he experienced with his cousin that was very violent in nature. This memory, since then, reappeared every time John has been confronted by a situation of a sexual nature.

He experienced extreme levels of anxiety and fear due to the assaultive nature of the abuse, in a physical and emotional manner.

### Cognitive schemas

John's psychopathology can be described in cognitive behavioural theory as cognitive behavioural maladaptive modes that reoccur with regularity.

Modes consist of cognitive systems, affective systems, motivational systems and behavioural systems. For psychopathology to be formed, a stimulus is needed. This could be in the shape of particular situations or internal factors such as sexual arousal that prompt the individual to construct a cognitive schema. These cognitive schemas will then lead to the motivation of a set of emotions and behaviour to be formed.

Two very prominent cognitive schemas were formed during John's period of sexual abuse:

1. The trauma of sexual abuse forced him to identify any situation with sexual content as potentially dangerous. It has to be feared and leads to high levels of anxiety followed by a strong motivation to avoid such situations. This has been consistently repeated in John's life, and has become entrenched as an automatic maladaptive mode. It is maladaptive because it has become dysfunctional in his marriage causing further emotional distress for both John and his wife.
2. The over-dependant relationship with his mother has contributed to John constructing a cognitive schema that he should not look after his own well being but has to protect his mother at all costs, even to his own detriment. "I am not as important", is a thought that repeats itself with regularity. This has disempowered John not only during his traumatic experiences but has become part of his life in general. He does not feel good enough and avoids situations where he needs to be assertive and confrontational and has also

become an automatic maladaptive mode.

The literature suggests that assaultive violence (physically harmed by someone) comparative to other traumatic events has a life time prevalence of 37.7%. If assaultive violence is linked to violence of a sexual nature it can lead to sexual numbness.

The case of John illustrates how someone can become trapped through trauma. This trauma trap causes the person harm in most of his or her life. John's symptoms include re-experiencing of the traumatic event with emotional arousal when confronted with a situation related to the traumatic event (fear, anxiety and hopelessness) an emotional maladaptive schema.

The context in which such symptoms present itself is of importance to understand the patient and will be of help in treatment planning to resolve not only the symptoms but also to remove the obstacles that have prevented the patient from being healed.

It is important to note that the over-dependant relationship with his mother underpinned the construction of the trauma trap as an ongoing process as John was not able to resist the trauma because he wanted to protect his mother. An interactional style of over-dependence and avoidance has become part of John's life and has caused John to start abusing substances. This illustrates the behavioural maladaptive schema. This has worsened his dependency and avoidance behaviour.

It is important to identify those maladaptive modes (all the integrated maladaptive schemas) that are present in the patient that keep the trauma "alive". If these maladaptive modes can be resolved through cognitive behaviour therapy, it will assist in the process of recovery.

**Author's note:** John is a fictional name of a patient who gave permission that his personal information may be used for this article. ◆

References on request

If assaultive violence is linked to violence of a sexual nature it can lead to sexual numbness

# ADHD Signs & Symptoms

## changes throughout the life cycle

**R**ates of ADHD persistence through adulthood vary widely, and range from 5%-75% (Am J Psych 1993;150:1792-1798) it has been well recognised that as many as 75% of children with attention deficit/hyperactivity disorder (ADHD) experience persistent ADHD into their adolescent years and 60% into their adult years. There is a dearth of research on the clinical diagnosis and management of adults with ADHD with a high response rate to available treatments with psychostimulants and atomoxetine. Adults with ADHD have more inattentive symptoms than hyperactivity and impulsivity and many associated features. Therefore, effective diagnosis and management of these patients requires recognising how the core ADHD symptoms of hyperactivity, inattention and impulsivity transform from their childhood manifestations to their adult signs and symptoms.

Self-reporting tends to under-recognise prevalence for every age, while external informants such as parents or spouses are more likely to recognise symptoms of ADHD. Using either reporting method will likewise yield different rates of persistence.

### Difficulties in Diagnosis

Apart from the different symptomatology that should be looked for, diagnosing the adult ADHD patient differs from childhood diagnosis in other ways. For example, adults with ADHD tend to have a greater level of self-awareness and insight into their own behavior than children. This lessens the need for external sources in the diagnostic process. Since a history of childhood ADHD is a significant risk factor for adult ADHD, the first step in diagnosing the adult patient involves obtaining their developmental history. Once a history of ADHD is established, there is the need to meet Diagnostic and Statistical Manual - IV (DSM-IV) criteria for ADHD. However, this is often difficult because many of the items and criteria in the DSM -IV do not likely apply to adults. For example, "often runs about or climbs excessively; often has difficulty playing or engaging in leisure activities quietly; often avoids or strongly dislikes tasks that require sustained mental effort, such as schoolwork or homework," are usually not applicable to adults. Because the diagnostic criteria do not always describe the behaviour of adult ADHD patients, a diagnosis of ADHD: not otherwise specified (NOS), is often required. Supplementing the DSM criteria with scales such as the Brown Attention Deficit Disorder Scale and the Conners' ADHD rating scales can be helpful in diagnosing cases of persistent ADHD. Similarly, asking the right questions can help elucidate the extent of functional impairment in the suspected adult ADHD patient.

### Different Comorbidities

Importantly, the paediatric and adult ADHD populations differ in the prevalence of comorbid disorders. In

children, comorbid psychiatric disorders include oppositional defiant disorder (approximately 60%), conduct disorder (15%), mood disorders (25%), anxiety disorders (27%) and learning disorders (25%) are the most common. In contrast, the most prevalent comorbidities among adults are anxiety disorders (50%), mood disorders (32%), antisocial disorders (28%) and substance abuse (26%) (Biol Psych 2005; 57:1215-1220) Adults with ADHD are also more likely than children to initially present with these other comorbidities, while children who spend their days in the classroom are more likely to be referred for ADHD as the treatment focus. In children, therefore, comorbidities may be left untreated, while adults may leave ADHD untreated. A careful medical and personal history in these patients often reveals both ADHD and the comorbid disorder, both of which may require treatment.

### Children Jump while Adults Speed

While the core ADHD symptoms of hyperactivity, inattention, and impulsivity are present in both adults and children, they manifest differently. Since children are limited mainly to the school setting, manifestations such as excessive jumping, running and climbing are quite visible. In contrast, adults are involved in a number of environments during their days. In the workplace they fidget and pace, excessively shake their legs, play with rubber bands, rustle papers, talk out of turn, blurt out inappropriate comments, miss appointments and deadlines, and repeatedly fail to file taxes. All of these manifestations can make it difficult for adult ADHD patients to keep a job down. Outside of work, adult hyperactivity and impulsivity can lead to stimulus-seeking behaviour, consequent poor health, vehicle speeding and accidents, unwillingness to wait in queues, emotional overreaction and a low tolerance to stress. All of these symptoms can impair a patient's ability to learn social skills and to adapt to social norms, leading to a high rate of divorce and multiple marriages.

Clearly, the up to 3/4 of children who grow into adults with ADHD can experience significant functional impairment if their ADHD is left untreated and assumed to be a disorder of childhood. In light of the possibility of such severe functional impairment in adults with ADHD, clinicians must consider all aspects of a suspected ADHD patient's functioning in determining the presence and severity of adult ADHD. ◆



**Dr Shabeer Jeeva**  
*Specialist Psychiatrist,*  
*Melrose Arch,*  
*Johannesburg*  
[www.adhdclinicjeeva.com](http://www.adhdclinicjeeva.com)

## Symptoms of Hyperactivity often manifest differently in adults

Hyperactivity often changes to inner restlessness

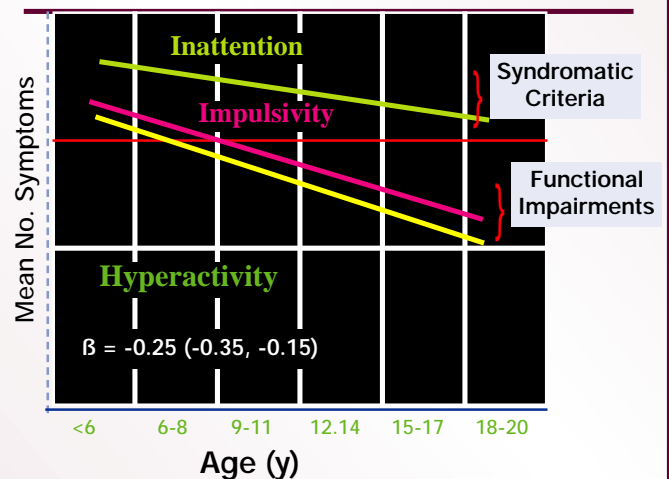
### DSM-IV Symptom Domain

- Squirms and fidgets
- Can't stay seated
- Runs/climbs excessively
- Can't play/work quietly
- "On the go"/driven by motor
- Talks excessively

### Common Adult Manifestation

- Workaholic
- Overscheduled/overwhelmed
- Self-selects a very active job
- Constant activity leading to family tension
- Talks excessively

## Age-dependent decline of ADHD Symptoms



## Symptoms of Impulsivity often manifest differently in adults

Impulsivity in adulthood often carries more serious consequences

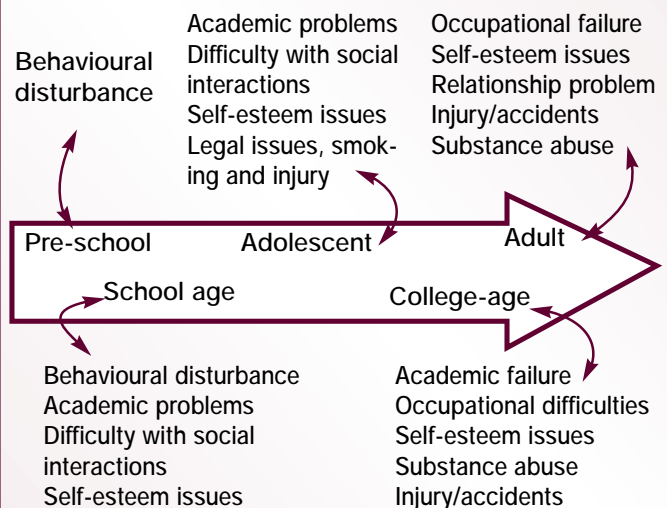
### DSM-IV Symptom Domain

- Blurts out answers
- Can't wait turn
- Intrudes / interrupts others

### Common Adult Manifestation

- Low frustration tolerance
- Losing temper
- Quitting jobs
- Ending relationships
- Driving too fast
- Addictive personality

## Developmental Impact of ADHD



## Symptoms of Inattention often manifest differently in adults

### DSM-IV Symptom Domain

- Difficulty sustaining attention
- Doesn't listen
- No follow-through
- Can't organise
- Loses important things
- Easily distractible, forgetful

### Common Adult Manifestation

- Difficulty sustaining attention
- Meetings, reading, paperwork
- Paralyzing procrastination
- Slow, inefficient
- Poor time management
- Disorganised
- Poor financial management

## ADHD in childhood: as adults

- Many adults who had ADHD in childhood continued to have:<sup>1-6</sup>
  - Stuttering, speech and language disorders
  - Anxiety disorders
  - Restlessness
  - High impulsivity (e.g. more car accidents, move house more often)
  - Interpersonal problems and sexual problems (many divorced or separated)
  - Higher rates of antisocial personality disorders (e.g. contact disorder)
  - Substance abuse (particularly with co-existing conduct and antisocial disorders)

1. Seidman LJ et al. Biol Psychiatry 1998;44:260-268.
2. Biederman J et al. Am J Psychiatry 1993;150:1792-1793.
3. Gittelman R et al. Arch Gen Psychiatry 1985;42:937-947.
4. Weiss G et al. J Am Acad Child Psychiatry 1983;24(2):211-220.
5. Elya J et al. N Engl J Med 1999;340(10):780-788;
6. Reviewed in Mannuzza S & Klein RG. Child Adolesc Psychiatr Clinics N Am 2000;9(3):711-726

# Mental Health of Prisoners



**Dr J. Chabalala**  
Psychiatrist in  
Private Practice  
Polokwane

Very little is being said about mental health challenges faced by prisoners and awaiting trial persons. This is understandable, considering the crime epidemic that has besieged our country. People focus on the plight of victims, particularly in our society, where there is a perception that criminals enjoy more human rights while in jail. While it may be true that criminals get treated well by the justice system, there are signs that this is changing. Jail sentences are getting stiffer and conviction rates are getting higher.

Prison life is not good for anyone. This is contrary to commonly held beliefs that the prisoners lounge in a lap of comfort at the tax payers' expense. The food is better, inmates are not routinely assaulted and murdered, and their rights are upheld in many cases. The authorities are set to eliminate prison gangsterism and other possible hazards. The only thing that prisoners are deprived of is their freedom, and this is what this article will focus on. Being deprived of one's freedom has a lot of mental health implications.

Inmates go through stages of mental health difficulties, and in some cases develop frank mental illnesses which need urgent intervention. The problems and disorders will be discussed below:

## 1. Anxiety

Anxiety is very common among awaiting trial inmates, who don't know what their fate will be. Some people have been awaiting trial for

more than two years. Prisoners who have been recently sentenced to lengthy prison terms have a lot of anxiety and feel overwhelmed by the nature of their sentences.

The presence of gangsters in jail adds to many woes for the new inmate and can lead to a lot of anxiety. Some more experienced inmates extort money and favours from the unwitting. The fear of being sodomized and infected with dread disease is very real and frightens many an inmate. This often leads to many requests to the custodial officers to move prisoners around. It should be remembered that the brutal criminal who committed extremely aggressive acts outside becomes a meek lamb when inside.

## 2. Depression

Prisoners are very prone to depression, and for a variety of reasons.

- Some have a genetic predisposition to depression, which then becomes exacerbated by the prison

environment.

- Once the reality of their prison sentence sinks in, the result is usually severe depression and sometimes suicide attempt. Successful suicides have been reported.
- Depression can also occur as a result of the changes in one's life as a direct result of imprisonment, such as loss of property, getting divorced while in jail, being denied the right to see their children, loss of contact with their family, being viewed through a thick glass window by the family, being exposed to strife within the prison and a variety of other reasons.
- Depression can occur as part of Bipolar illness which may not have been diagnosed at that time.
- Some inmate could be experiencing feelings of shame and guilt over their deeds, for the first time in their lives.

## 3. Post Traumatic Stress Disorder

This disorder is very common in prisoners who have murdered their victims. They have vivid dreams of their victims, either fighting back, staring at, or questioning their motives for murdering them. It is amazing to learn that even serial killers have post traumatic stress. They have vivid and frightening nightmares, and are often referred to the doctor by fellow inmates for their nocturnal restlessness and screaming. Prison has an effect of bringing a human out of many a beast.

Even murderers who have not been caught or sentenced for their deeds experience a private hell due to PTSD. Hired assassins and "political rivalry" killers are particularly prone to this problem.

## 4. Development of Mental Disorders

Some inmates develop frank psychosis once inside the prison. These can either be Schizophrenia, Bipolar Disorder or other psychotic illness. Interestingly, they are feared by fellow inmates. Nobody wants to get close to them or to be grouped with them. One then wonders what happened to a one time gun-wielding and brave villain who traumatised people so much in the recent past.

The inmates who become psychotic may or may not have a history of psychotic behaviour in the past. Some are epileptic patients who had defaulted their medication as they got involved in criminal activities.

## 5. The "Magpie Syndrome"

I have coined this term to describe the recurrent and persistent complaints raised by inmates. They tend to know their right well and use the knowledge to annoy all and sundry. They have all sorts of requests, needs, complaints and demands. They could even embark on temporary hunger strikes.

The magpie makes a lot of noise when its wings have been clipped, and it can no longer fly. ◆

Being deprived  
of one's freedom  
has a lot of  
mental health  
implications.



26 - 30 August 2007, Sun City, South Africa

"Hypotheses, Neuro Science & Real Persons"



**W**e are delighted to invite your participation at the 10th International Conference on Philosophy, Psychiatry and Psychology, which will be held at South Africa's Sun City, known as Africa's Kingdom of Pleasure, on the verge of a 55 000 hectare game reserve.

The theme of the conference is "Hypotheses, Neuroscience and Real Persons". Philosophers, psychiatrists, psychologists and other healthcare practitioners all use hypotheses in research and in practice. Through hypotheses, cutting edge work opens new horizons for the neurosciences and for the real persons afflicted by psychiatric and psychological difficulties. Conversely, the thoughts, emotions, experiences and behaviour of real persons are subject matter for new hypotheses in philosophy and in the research and practice endeavours of psychiatry and psychology.

#### Host

- The South African Society of Psychiatrists (SASOP)
- International Network for Philosophy and Psychiatry (INPP)

#### Endorsements

- World Psychiatric Association (WPA)
- African Association of Psychiatrists and Allied Professionals (AAPAP)
- Psychological Society of South Africa (PsySSA)



#### Plenary Speakers

- Prof Derek Bolton (UK)
- Prof John Cox (UK)
- Prof Bill Fulford (UK)
- Prof Grant Gillett (New Zealand)
- Prof Gerrit Glas (Netherlands)
- Prof Martin Heinze (Germany)
- Prof Paul Hoff (Switzerland)
- Prof Eric Matthews (UK)
- Prof Juan Mezzich (President of WPA) (USA)
- Dr Cristian Muscelli (Italy)
- Dr Frank Njenga (Kenya)
- Prof Lord Kamlesh Patel (UK)
- Prof Nancy Potter (USA)
- Prof Tim Thornton (UK)
- Dr Dan Stein (South Africa)

#### Organising Committee

- Dr Eugene Allers
- Dr Gerhard Grobler
- Dr Leandre Gauche
- Prof Pierre Joubert
- Dr Shadi Motlana
- Dr Funeka Sokudela
- Prof Vasi Van Deventer
- Prof Werdie van Staden (Convenor)

#### Conference Secretariat

Londocor Public Relations & Event Management, South Africa

Sonja du Plessis / Dinie Bayley

Tel: +27 11 768 4355 • Fax: +27 11 768 1174

sonja@londocor.co.za / dinie@londocor.co.za

www.ppp2007.co.za

#### Accreditation

All issues of *Serenity* will be published on the website: [www.sasop.co.za](http://www.sasop.co.za)

Doctors whose articles are published in *Serenity* are entitled to accreditation points. Authors need to complete the relevant form and submit it together with a copy of the published article to CPD Services. Once submitted, the article will be reviewed. First authors could earn ± 15 points and co-authors ± 5 points per article. Authors will then be sent a confirmation together with an invoice for R100 per article accredited.

For further information or submission, please contact: Wits CPD Office, Postnet Suite 189, Private Bag X2600, Houghton 2041. Tel: 011 274-9273/4/5/6; Fax: 011 274-9277. Email: [gdavis@witshealth.co.za](mailto:gdavis@witshealth.co.za), web: [www.cpdservices.co.za](http://www.cpdservices.co.za).

The closing dates for application for 2007 are 27 July, 24 August, 21 September and 2 November. Authors who would like assistance with their submission are invited to contact their Wyeth representative.

#### Editorial Board

<b>Editor:</b>	Dr E. Allers
<b>Production Editors:</b>	Ann Lake Publications
<b>Sponsors:</b>	Wyeth South Africa
<b>Submissions/Enquiries:</b>	Ann Lake Publications PO Box 265, Gallo Manor 2052 Tel/Fax: (011) 802-8847; Email: <a href="mailto:lakeann@mweb.co.za">lakeann@mweb.co.za</a>

*The views expressed by the editor or authors in this newsletter do not necessarily reflect those of the sponsors.*

**PHOTOGRAPHS IN THIS ISSUE:**  
*Lost City / Sun City by Ann Lake*