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Psychiatry:
A destigmatised scientific medical discipline.
Fact or delusion?

Professorial Inaugural Address

by

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University of Pretoria

CURRICULUM VITAE: JOHANNES LODEWIKUS ROOS

Louw Roos was born on 27 May 1952 in Krugersdorp, Transvaal, South Africa. He matriculated at Hoërskool Monument in 1969 and obtained an MBChB degree from the University of Pretoria in 1975. He completed his internship at Kalafong Hospital near Pretoria in 1976 and then worked as a medical officer at Weskoppies Hospital in Pretoria from December 1976 until June 1977.

After completing a two-year stint of compulsory military service in July 1979, Dr. Roos was appointed to the post of Registrar in the Department of Psychiatry, University of Pretoria. In 1983 he obtained an MMed (Psych) degree (cum laude), after which he was appointed as a lecturer in the Department of Psychiatry at the same university. In 1987 he was promoted to the position of senior lecturer.

In October 1989 Dr. Roos was awarded his doctorate for a thesis entitled "An investigation into the causes of suicide by schizophrenic patients". In 1990 he became associate professor at UP and he has recently been nominated for a Fellowship of the College of Psychiatrists of SA by peer review.

Presently he is appointed as chief specialist and professor at the University of Pretoria and Weskoppies Hospital and is involved in clinical, teaching and research work.

Louw Roos is author or co-author of some 68 publications in specialist and academic journals. He has presented a number of papers relating to suicide in schizophrenia and the genetics of schizophrenia at national and international congresses.

At present he is the project co-coordinator of genetic studies in Afrikaner schizophrenia patients in collaboration with the Laboratory of Human Neurogenetics of The Rockefeller University in New York.

He is the chairman of the 5th year of the new curriculum for medical students at the University of Pretoria and has been appointed as external examiner at a number of universities and the College of Psychiatrists of South Africa. He is on the editorial board of the "South African Psychiatry Review" formerly "Journal of Depression and Anxiety" and The Medicine Journal (Psychiatry Section).

He is married to Ina Roos, who is a free-lance science journalist and has two sons, Louis (2nd year medical student) and Gert, who will hopefully complete his Grade 12 schooling this year.

Psychiatry: A destigmatised scientific medical discipline. Fact or delusion?

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By Professor J L Roos

I would like to state at the outset that I believe stigmatisation of mental illness constitutes a problem of great importance and lasting impact. This is in spite of active campaigns by several role players to counteract this problem. The South African Society of Psychiatrists (SASOP), patient support groups and legislation by the state, to mention but a few, are involved in destigmatisation.

From personal experience I have been aware of stigmatisation of this field since I decided to specialise in psychiatry. This could well have been a driving force in my final decision of field of specialisation. I can remember remarks by family members to the effect of: "Are you not afraid that you will become like the patients if you work with them for too long?" and "Don't say you are at Weskoppies, they will think you are a patient. Say you are working there" . I typically get phone calls from patients, and even from referring doctors asking whether I am a Christian psychiatrist. This may sound like a neutral remark, but once one starts dissecting the question, you realise it has several implications. Firstly, it distances psychiatry from medicine to an extent, and puts it in a spiritual sphere. Furthermore, it also casts some doubt on what psychiatrists do. I like to enquire from these people if they ask their gynaecologists/urologists the same question when they visit them.

In this presentation I would like to give an overview of the obstacle of stigmatisation in psychiatry to future progress in the arena of mental illness and health, and of how academic psychiatry may play a role to alleviate this. In the process, I will refer to historical conceptions of mental disorders and, more specifically, to treatment of patients and training of doctors at Weskoppies Hospital over the past 110 years.

Stigma:

Stigma is defined as a mark of disgrace or infamy, a strain or reproach on someone's reputation; a characteristic mark or sign of defect, degeneration or disease (American College Dictionary, 1969). It has been defined as a six-letter word for frustration, anguish, and loss of prestige.

Bringing it closer to specific examples of what patients have told psychiatrists in this regard: "No-one brings you flowers or gifts when you

are receiving electroconvulsive treatment". A patient on medical leave for recurrent depression, unbearably lonely and shunned by her legal colleagues said: "I wish I rather had something acceptable like multiple sclerosis". I recently asked a general practitioner suffering from depression if he would consider taking medication for his illness and his response was: "Are you kidding? I'd feel like a fraud! If my patients knew that I was taking medication ... well, that would be the end of my career."

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In a special section on the stigma of mental illness that appeared in *Lancet* in 1998, contributors to this medical journal spoke vividly about the contention that stigma may well be the most important issue facing the mental health field.² Taking this issue head-on, Sartorius eloquently stated the following:³

"Why then invest in programmes that might change attitudes and improve the acceptance of those with mental illness? Because stigma and discrimination are the most significant obstacles to the development of mental health care and to ensuring a life of quality for those suffering from mental illness. Because there is enough money around to help those with mental illness and their families, but it is not available because of the attitude of most decision-makers and a large part of the general public towards mental illness and all that surrounds it. Because all other efforts that are undertaken to treat mental illness and rehabilitate people impaired by it are likely to be of little use if ... we cannot ensure that patients and their families do not suffer from discrimination, exclusion, and injustice because of their illness."

We see parallels between measuring stigma towards mental disorder in our society and measuring anti-Semitic attitudes in nations like Germany in the 1930s. When the cognitive models of a given society are so monolithic and uncontested that they become part of nearly every member's world view, there is little individual evidence for that view or model, because it is incorporated into everyday discourse and practice without special notation or commentary.⁴ Attempts to measure pre-democracy apartheid attitudes in contemporary South African society would be similarly thwarted, precisely because of the thorough acceptance of such attitudes.

Fear and scape goating of persons with mental disorders are extremely pervasive in our culture. A diagnosis of mental illness is indeed still devastating, given that it is linked with job loss, breakdown of relationships, and social rejection.

Why is mental illness so subject to stigmatisation? Fear is one factor. Mental illness is perceived to be dangerous, and the rare but widely

publicised violent incidents associated with mentally ill patients serve to fuel that fear. An element of personal culpability is another common perception. The common attitude of "Ag nee, man. Ruk jousef reg" leads to the belief that treatment will not help and may even be inappropriate. Assumed communication difficulties and social non-productivity reinforce the tendency to discriminate against the mentally ill ... Losing one's mind is for many the most unimaginable illness, which may prove the biggest obstacle to ridding mental illness of all forms of stigmatisation.⁴

Historical trends regarding conceptualisation of mental illness played a definite role in the stigmatisation of mental illness.

Historical trends in South Africa:

I would like to move on to the historical trends in the treatment of mental disorders in South Africa, and Pretoria Mental Asylum specifically.

Institutional medical practice began in South Africa over 300 years ago with the establishment by Jan van Riebeeck of a small hospital in Cape Town. The first hospital to cater specifically for mentally deranged persons was established in 1711. It was an apartment that was added to the new Cape Hospital, which had been completed in 1699 by Simon van der Stel. The old Somerset Hospital was the first hospital offering care for the insane from its inception in 1818. However, these facilities were regarded as inappropriate for this purpose, and in 1846 the prison colony on Robben Island was converted into a hospital for lepers, lunatics and other chronically ill patients.⁵

During this period, several other "lunatic asylums" were built, ensuring that mentally ill patients were largely isolated from the community.

The Kranzinnengesticht te Pretoria (Pretoria Lunatic Asylum) was established in 1892 as the first and only psychiatric institution in the Zuid-Afrikaansche Republiek (later named Transvaal). The asylum was later renamed Weskoppies Hospital (WKH).⁶

The early history of WKH sheds some light on the history of psychiatric care in South Africa. The more enlightened attitude towards psychiatric patients, which came to dominate psychiatric thinking in Europe during the middle to late 19th Century, also prevailed in the ZAR. This fact is amply borne out by the instructions to the hospital staff and by the annual reports of the medical director of the hospital. These show that staff was expected to make concerted efforts to help patients to recover. These included hot baths for treating acute mania, a padded cell, opiates for treatment of acute alcohol psychosis, and sulphonal for acute mania. These

efforts were as unsuccessful here as elsewhere. It was emphasised that physical restraint was not to be used, except on the direct instructions of the attending physician, and that confinement was to be used as seldom as possible.⁶

Putting these ideals into practice, however, was not easy at any asylum, and proved to be particularly difficult at Weskoppies during the Anglo-Boer War. Even in well-equipped late 19th century asylums during peacetime one patient could batter another to death with bare hands, or a former patient might claim to have been repeatedly assaulted by untrained and unsuitable attendants.⁶

Such incidents indicate that the enlightened approach was only practicable where patients could be adequately segregated and supervised by trained staff. These conditions could seldom be met until the advent of effective methods of treatment (beginning with insulin therapy, first applied in South Africa at Weskoppies Hospital in 1935) and, more particularly, antipsychotic medication. The enlightened approach therefore represented not so much an advance in psychiatry as a humanistic ideal that could be partly realised only in the most affluent countries during the 19th century.⁶

The availability of effective medication since the 1950s has changed, but not removed, the limitations of the enlightened approach; consequently, the early history of WKH also holds a lesson for contemporary psychiatry: humane institutional care of the psychiatric patient is not guaranteed by humanistic ideals, but by sufficient resources to put these ideals into practice.

It was during these years (1950s) that academic psychiatry started at the University of Pretoria with Professor PJG de Vos as head of the department from 1944 to 1951. Subsequent heads of the department were: Dr IR Vermooten (1951 – 1959); Professor AM Lamont (1959 – 1965); Professor AJ van Wyk (1966 – 1973); and Professor W Bodemer (1974 – 1999).⁷

Forces sweeping through Psychiatry:

In the past couple of decades, three forces swept through psychiatry, namely the biological revolution, emphasis on empirical description (DSM-IV) and the economic revolution.⁸ I would like to touch on aspects of these three forces and how they influenced academic psychiatry.

Biological revolution:

The biological revolution was fuelled by a growth in a strong scientific base in neurobiology, the development of new and effective pharmacological treatment of psychiatric illnesses and a growing body of evidence that demonstrated brain changes and abnormalities in a variety of mental illnesses.⁸ Referring to the last aspect, please allow me at this stage to mention ongoing research in this department in collaboration with Rockefeller University's Laboratory of Human Neurogenetics in New York on the genetics of schizophrenia in the Afrikaner population.

The first findings of the research, led by Maria Karayiorgou, Professor and Head of the Laboratory, were published in the March 12 Early Edition of *Proceedings of the National Academy of Sciences* (PNAS) 2002. In a systematic study of 13 genes on human chromosome 22 in an area of the chromosome previously linked to schizophrenia, scientists have identified two genes from this group that contribute to the susceptibility to this psychiatric disorder.⁹

Variants were found in two genes, PROD H2 and DGCR6, enriched in patients with schizophrenia as compared to unaffected individuals who served as normal controls for the study. Two additional lines of evidence showed that of the two genes, PROD H2 may play the more important role.

Firstly, experiments on a PROD H2-deficient mouse conducted by the same laboratory in 1999 revealed deficits in sensorimotor gating, the ability to filter sensory inputs such as sounds. Sensorimotor gating is also affected in people with schizophrenia.

Furthermore, a linked "pseudo gene" of PROD H2 was discovered that serves to introduce in the gene missense mutations that confer susceptibility through a process called gene conversion.

Pseudo genes, such as variations of PROD H2, may present synthesis of a fully functional enzyme and seem an important factor in increased susceptibility to schizophrenia. These variations modulate the onset age of schizophrenia.

An implication of this work is that it points to pseudo genes as a possible constant and renewable source of variation that can be effectively transferred to linked susceptibility genes via gene conversion.

PROD H2 encodes for a brain enzyme called proline dehydrogenase, which is involved in neuron signal transmission, as well as cell death.

The particular pathway in which PROD H2 is involved is largely undescribed, and is a novel pathway that will open up several different avenues for new drug development.

And then there are still people who say psychiatry is not a scientific discipline!

Important scientific breakthroughs are leading to better knowledge of fundamental mechanisms, spurring on advances in treatment and care that, though still insufficient, are showing signs of real progress. An important by-product will be, I hope, improved training, and awareness among scientists, professionals and staff of mental health and its stigmatisation. As the public becomes better educated about the nature of mental health disorders, and an atmosphere of normalised disclosures, another by-product may be the freedom to reflect with tolerance and acceptance, rather than shame and fear, on these disorders and on families struggling with mentally ill members.⁴

On the other hand, fast-growing molecular genetic technology is confronting society with the potential for detection of risk for mental disorder. I cannot dwell on this large and potentially explosive topic at this point, but I would like to quote Lander and Weinberger (2000) who authoritatively reviewed the past and future of genetics and genomics for the prestigious journal, *Science*, at the beginning of the year 2000:¹⁰

"The prospects for 21st century biology are surely breathtaking. At the same time, we must confront this new world soberly and with trepidation. The genetic diagnostics that can empower patients to seek personalised medical attention may also fuel genetic discrimination So the most serious impact of genomics may well be on how we choose to view ourselves and each other. Meeting these challenges, some quite insidious, will require our constant vigilance, lest we lose sight of why we are here, who we are, and what we wish to become."

In less detail, I would like to mention the other two forces that influence psychiatry, namely empirical description and the economic revolution.⁸

Empirical description:

DSM III was published in 1980, and it had a major impact on psychiatric education and clinical practice. The importance of evidence-based approaches to diagnosis and treatment are emphasised. I ask myself if it is not time for reassessment and readjustment, particularly in the area of psychiatric education.

In addition to learning and using diagnostic criteria, young psychiatrists must be taught to think first about the whole person and to appreciate that each one is interesting and unique, not simply a composite of symptoms that are used to make a DSM diagnosis and provide treatment according to a standard algorithm, making the erroneous assumption that "one size fits all".

Economic revolution:

The economic revolution is starting to have its impact on South Africans. It has dramatically changed the philosophical framework that guides medicine. Spending time talking to patients, or listening to them, is now considered an expensive luxury to be avoided whenever possible. But talking, and especially listening, are central to good psychiatric evaluation, and they form the basis for most psychotherapies. Medical care is now perceived and discussed primarily in economic terms, often to the dismay of both physician and patient.

Psychiatry will have to make corrective adjustments to prevent losing its identity as the most humanistic of the medical specialities. Modern neuroscience shows that the brain is plastic and that it can also be changed by psychotherapy – and should be.⁸

Reducing stigma:

I would like to devote the last part of this talk to the role of academic medicine in reducing stigma of psychiatry in the South African context. Aspects I would like to discuss include: issues of education, policy initiatives, and a new alliance between patients, their families and psychiatry.

Issues of Education:

There are 429 registered psychiatrists in South Africa. It is not known exactly how many are currently practising in the country, although a recent survey indicated that 73% of registered psychiatrists were in fact practising (Flisher et al, 1997). The majority of the others were practising abroad, and some were retired. South Africa has approximately one registered psychiatrist per 100 000 inhabitants. Although there are 167 psychiatrists working in state hospitals, only 4,7% work exclusively in a rural setting.¹¹

Keeping the above in mind, one realises that the medical doctor who qualifies in South Africa will have to be able to diagnose and treat psychiatric patients and know when to refer for tertiary management.

That psychiatry should occupy a major part in the medical curriculum is now generally agreed world-wide.¹² The following three reasons are given:

- The general approach of psychiatry which stresses the unity of body and mind is important in the whole of the medical practice;
- Skills learnt in psychiatry are important for all doctors; and
- Psychiatric problems are common amongst patients seen by doctors working in all branches of medicine.

Based on findings of the Global Burden of Disease Study (Murray and Lopez, 1996), the report noted that in the United States, mental disorders collectively account for more than 15 per cent of the overall burden of disease from all causes, and slightly more than the burden associated with all forms of cancer.¹³ Indeed, world-wide four of the 10 leading causes of disability are mental disorders (depression, schizophrenia, bipolar disorder, and obsessive-compulsive disorder), with depression soon to become the number one cause of disability among those over five years of age. Devastatingly, however, approximately two-thirds of all persons with mental disorders do not seek treatment. Stigma associated with mental illness appears to be a critical deterrent in many cases.

The World Psychiatric Association and the World Federation for Medical Education have collaborated to define the core curriculum in psychiatry for equipping all future doctors to identify and treat mental illness and disability (Sartorius).¹² I am a member of the pre-graduate medical curriculum committee at the University of Pretoria and am thus in a position to monitor the progress made at the University in pre-graduate training in psychiatry, and to compare our standards to those of a core curriculum in psychiatry. I want to thank the chairman and curriculum committee for having psychiatry on board and for the fact that it has never been necessary for me to convince the School of Medicine of the value of psychiatry in the medical curriculum. Psychiatry has a definite presence in the first, second, fifth and final years of training.

The guidelines for the teaching and learning of psychiatry as proposed by the World Psychiatric Association and the World Federation for Medical Education are:¹²

- Self-directed, problem-based learning
- Locally produced teaching aids
- Exposure to a range of patients in different settings
- Integrated psychiatric teaching and learning in the curriculum

These aspects are all addressed in the University of Pretoria's psychiatry curriculum and psychiatry teaching and learning are consistent with that of the medical school curriculum as a whole.

Whilst planning this new pre-graduate psychiatry curriculum, we as medical teachers realised that concentrating on curative medicine is no longer enough, and we have identified the preventative and promotive aspect of our teaching. Psychiatric symptoms and syndromes and their treatment are to be taught and learned in the context of an integrated biopsychosocial approach. The psychosocial issues include stigmatisation.

With the emphasis on life-long learning, the department is aware that doctors will need further periods of training after graduation to extend their psychiatric skills. It has been suggested to the Minister of Health by all heads of psychiatry departments at medical schools in South Africa that a compulsory period of rotation at a psychiatric facility should be included in the doctors' community service period.

The interpersonal skills training of medical students as a golden thread in the medical curriculum is appropriately included, and a definite bonus aspect of the new curriculum.

The role of psychiatry in society certainly includes public education and the battle against misunderstanding and destigmatisation of mental illness. Its role is to treat diseases, and not the social discontent of "unhappy people" or pervasive psychosocial malaise. Psychiatrists simply lack the knowledge to cure society as well as individuals. They are frequently called on to prescribe quick treatments for rising rates of crime and violence. The answer to our many current social problems must come from individual people, who must reappraise their sense of "self" and reach an appropriate perspective on what constitutes a sound moral compass and meaning in life. This is a need that transcends medical intervention, but which has a very real impact on how we choose to employ medical science and what we expect from it.⁸

In the educational process we must continue to reflect on stigma and identify and aggressively attack discrimination when we see it. We are obliged not to use the name of disorders to designate people.

Policy initiatives:

In South Africa, the Mental Health Act was set in motion in 1973. For 29 years there were no changes to this act.¹⁴ In September 2002, the new Mental Health Care Bill will be promulgated. If one looks at the preamble to, and the Health Care Bill as a whole, certain aspects of mental health

care will have to be clarified and academic psychiatry has a definite role to play in the implementation thereof, namely:

- Discrimination against persons with mental disorders is not acceptable or tolerable;
- Equal access to care must be made available to all individuals, regardless of their stage in the life cycle or their life circumstances;
- Health is seen as a state of physical, mental and social well-being. In other words, not only serious mental disorders (brain disorders) are included, but all mental disorders should receive equal access to care and should receive parity with non-mental disorders in terms of insurance coverage.

In other words, the emphasis is on increasing service availability and decreasing the stigma associated with mental illness, and we will have to see that this Mental Health Care Bill is enforced.

We hope that after a change in policy, hearts and minds will follow.

Alliance between patients, their families and psychiatry:

Medicine has come a long way from being regarded as a vocation. It has since been viewed as a profession, and is now often considered a trade. The effort to eradicate all disease from society has also recently given way to an attempt to assist people in "living" with their illnesses. So too have the attempts to prevent death at all costs been replaced by efforts to enhance pain control. In the past, the doctor has always been afforded expert status in the care of individuals. Today the trend is to view the experience of the doctor as being complemented by that of the patient and the caregiver.

The partnership between treating professionals, our patients and their families hold the greatest promise in the fight against stigmatisation and the implementation of the Mental Health Care Bill. In the South African context, psychiatrists can learn a lot in this regards from the fight against discrimination of HIV/AIDS patients and the united forum that was constituted by patients, families and advocacy groups.¹⁵

I would like to end. The initial question that I posed was: Psychiatry: A destigmatised scientific medical discipline – fact or delusion?

The scientific basis of psychiatry as a medical discipline is well established. The fight against stigmatisation is ongoing, and academic psychiatry has a prominent role to play in this regard.

We live in a highly technological world. In the process of living in this world, it is easy to forget the power of our own goodness and place value instead on our skills, our knowledge and our expertise. We must always remember that who we are can change the world far more than what we know.¹

We live in an exciting age of new psychopharmacological discoveries, PET scans and functional MRI's. This is the post "decade of the brain" era of the 1990s. We feel pressured to get our patients "fixed" fast. We must not forget or neglect the doctor-patient covenant, the matrix of curing.¹

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