PsyTalk

2014 | Issue 3

PsySSA
Psychological Society of South Africa

President's Podium

As a presidential initiative I am establishing a structure that coordinates communication and action between heads of psychology departments in all of South Africa's universities from within PsySSA.

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Health Rites

Doctors: sometimes I love them, sometimes I don't.

Pierre Brouard
Deputy Director
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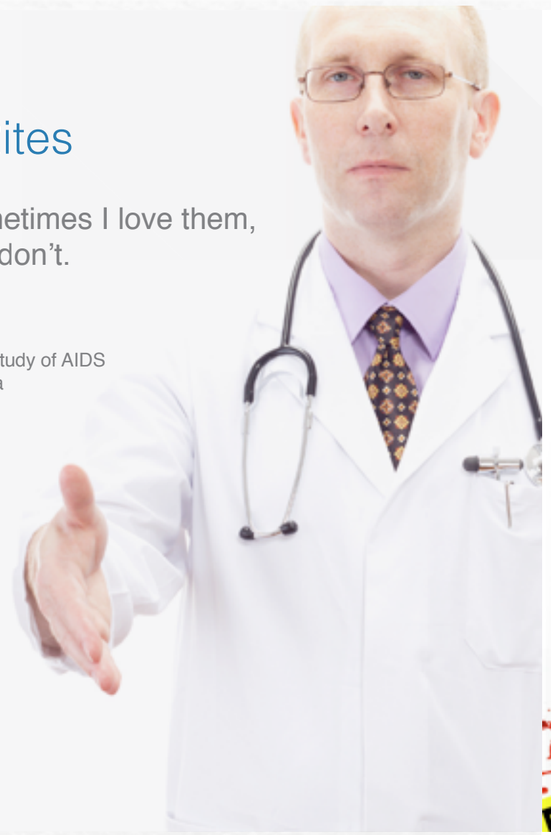

Psychology and the Law:

Reflecting on the Oscar Pistorius Trial and the Role of Mental Health Care Practitioners.

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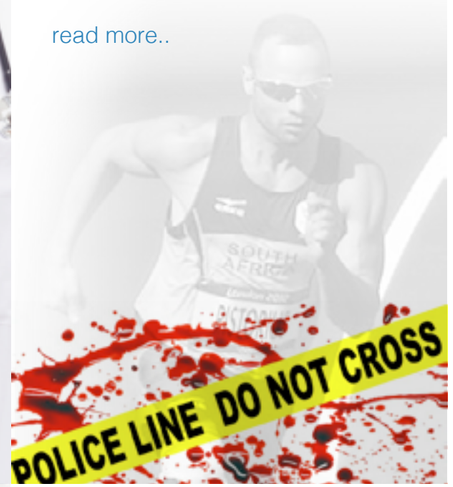

A Time of Celebration and Critical Reflection

- Register Online
- Congress Party
- Congress Update
- Pre-Congress Workshops
  Information | Register

Just over a month to go!

- The launch of the Pan-African Psychology Union **(PAPU)**
- 5-year strategy shared
- Controversial debate chaired by Eusibius Mackaiser
- 88 oral presentations
- 19 thematic areas
- 15 symposia
- 7 roundtable discussions
- 5 Workshops

Divisional **Focus**

- Division of Registered Counsellors and Psychometrists
- The Psyssa Sexuality and Gender Division
- Community & Social Psychology Division
- Division of Research & Methodology (DRM)
- Standing Committee: Equity & Transformation
- Student Division
- The Division for Psychology Professionals in Public Service (DPPPS)

Miscellaneous

- Psychologists at the helm of Higher Education in South Africa
- IUPsys
- HPCSA
- Department of Health Certificate of Need Meeting
- SAJP

- KZN Branch

- Advertising costs | Contact PsySSA

20 years of PsySSA and South Africa's democracy – an important milestone for psychology

See you in Durban in September!

Professor David Maree

President's Podium

As a presidential initiative I am establishing a structure that coordinates communication and action between heads of psychology departments in all of South Africa's universities from within PsySSA. One of the motivations for doing so was in response to the Board of Psychology's wish to establish a good working relationship with psychology departments across the country. I see PsySSA playing a facilitative role in this process. This initiative, however, goes further than establishing a forum for considering key professional psychological concerns.

We also have a need to collaborate on issues such as training, the content of courses, the structure of Master's degrees, providing adequate alternative avenues for students to enter professional psychology and the like. We all sit with a large number of undergraduate students and many postgraduate students who wish to be involved in psychology and we need ways to address this ever-growing need.

An inter-departmental structure will facilitate communication between key role players in psychology. The structure will also facilitate an increasing connectedness between academic departments, the HPCSA and PsySSA. The first meeting of the forum will take place at the Inkosi Albert Luthuli, International Convention Centre in Durban on Thursday 18 September from 17:30 – 19:00 as part of the 20th South African Psychology Congress.

The initiative represents an outcome of the positive response from psychology departments to PsySSA's roadshows that were all well attended and supported by HODs. In fact, we have decided to make the road shows an annual event in order to keep the energy and impetus going to mobilise students to become and remain involved in organised psychology. The universities that we did not reach in 2014 will be visited in 2015.

My term is quickly coming to a close and it was a great privilege to work with professionals in psychology across many levels and institutions. I strongly believe in a bright future for psychology in South Africa and beyond, and many of the initiatives from our side and other organisations are visibly stimulating the growth of psychology in Southern Africa.

I learned many lessons as well, one of which is to speak up on behalf of psychology and on what it stands for, namely, the incalculable value of the human psyche. This is why psychologists can express strong views on discrimination, unfair practices, the devaluing of human life, violence and atrocities against human beings. Having a voice (as psychologists/psychology) was a slogan for for the past year and it culminates in PsySSA expressing a strong position against the recent atrocities in Gaza and the Middle East. Psychologists are not politicians but they are in the business of caring for people and can and ought to express concern when the value of human life is disregarded and trampled down. I really hope we can continue to make a substantial impact on society in the coming year.

Prof. David Maree
President: PsySSA

Health Rites

Doctors: sometimes I love them, sometimes I don't. In his book, *Able-bodied*, psychologist Prof. Leslie Swartz talks of his wife Louise's hip operation, which left her with permanent pain. When this was shared with the surgeon, otherwise a kind man, says Leslie, he "could not and would not hear any of this. He couldn't bear it that Louise was in pain, and therefore there was no way she could be in pain. That was that."

The book is subtitled "scenes from a curious life" and in many ways being a doctor is a curious profession, tasked as they are with unimaginable responsibility to make us better, often in the face of severe illness which may be untreatable or even inexplicable. Not only do patients, and I include myself in this, expect our doctors to work miracles, they themselves are schooled into believing they should be able to fix things.

In a sense this is the "culture" of biomedicine: fixing, curing, healing, restoring are written into the script of health care. A doctor friend once said to me that if you dug into the life history of most doctors you would often find a very sick family member who had either died or lived with a difficult disease. The fantasy of the medical student, then, is that by healing their patients they are repairing, or seeking forgiveness for, their family member who was not healed.

You would think that this would give most doctors a heightened sense of empathy. Yet research suggests (see Shapiro, 2008) that during the course of medical training, empathy in medical students decreases. Shapiro argues that this is because medical students have not resolved their issues around illness, disability, decay and death and because they face expectations to protect, control, and restore, which run deep in the institutional cultures of mainstream biomedicine. Both forces can create barriers to empathic relationships.

In the absence of appropriate discourses about how to emotionally manage distressing aspects of the human condition, she argues that, it is likely that trainees will resort to coping mechanisms that result in distance and detachment.

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Health Rites

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So the inability of some doctors to empathise with the pain of their patients is not only a defence against the endless amounts of pain they have to see on a daily basis, but also a defence against the impotence they feel in the face of the impossible expectations, conscious and unconscious, placed on them. Their job is to give life and save life and this must be both exhilarating and unnerving. Furthermore, because they are often not given skills to process what they are exposed to, their default becomes denial.

Yet, mostly, society loves doctors. They are spoken of with awe. Sometimes the word “doctor” is used, as in “would doctor like a cup of tea?”, in ways which suggest the title is beyond the niceties of personal names – it is enough to be “doctor”, individuality is unnecessary, genuflection is natural. He, because the fantasy of the benign and beneficent and powerful healer is often tied up with notions of male authority, is all knowing and all powerful and must be obeyed, respected and admired, an object of our profound gratitude. He is God.

Pellegrino, (see Koppelman, 2006) defines the medical encounter in terms of three features: the patient’s dependent and vulnerable state; the unequal relationship between doctors and patients in terms of knowledge and power; and physicians’ professions to provide the best possible care for patients if they seek their help. Power, inequality and challenging ethical imperatives create a complex and loaded dynamic between patient and provider: perhaps there has always been an unspoken contract to manage this dynamic: we will be in awe of you, you do your healing work.

There are some signs that this contract is breaking down: in recent years, as patients become more informed and arrive at the consultation with their own differential diagnosis, there has been something of a shift to notions of patient autonomy. But is this a faux equality? Writing in a recent editorial of the SAMJ, Bridget Farham asks “But what is it that we are expecting patients to do?” She goes on, rightly in my view, to suggest that in asking patients to be collaborative decision makers in their treatment options, we may be placing an unrealistic burden on them around complex treatment decisions and science. “We need to think again about exactly what patient autonomy means and make sure that we don’t simply offer confusion,” she concludes.

This makes sense to me – I am not the one who has spent years with medical textbooks, smelly cadavers and anxious guinea pigs. But what happens when, say, these decisions go to the issue of life prolonging treatment with little chance of quality of life, or are about side effects which the patient must live with, not the doctor. Who decides then, and how?

I believe that many doctors cope with this confusing set of often conflicting imperatives, and the power they are given by society, through ritualising and controlling the medical encounter, leaving the patient in no doubt about who is in charge, while at the same time soothing their own anxieties.

And a fascinating experience I had highlights this. I had to see a specialist in Pretoria as a result of a collection of chronic problems

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Health Rites

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– I wanted him to “join the dots”. Perhaps there were no dots to be joined, and perhaps I was colluding with the fantasy that there is one thing that explains and fixes, for good.

I was told, in no uncertain terms, that I had to anticipate a 90 minute appointment and bring large sums of money. I was going to get a thorough going over, which did not come cheaply. After the obligatory form filling I was taken by a nurse to a cubicle where I was asked to take off all my clothes and was given shorts (too big) and a voluminous gown. I think I must have looked very odd – I am a short, bald and skinny person and the final effect was of a small, shaven, scarecrow in socks. I had been depersonalised.

This was followed by various measurements and tests, in preparation for, I discovered, entry into the hallowed sanctum. “Doctor” was ready to see me. I had been “worked up” (in more ways than one) and the “drama” of the consultation could begin. Because I am a “good” patient, ever keen to ingratiate myself with the person who can heal me, I had already sent all my previous year’s test results and scans and x-rays, with a detailed covering letter. This letter was an attempt to show not only that I was an informed patient, because this was my way of lessening my vulnerability, but also that I had really tried to do everything to fix myself. I was someone who was keen to participate in my wellness, was the subtext I wished to convey: I will work with you.

But by now my confidence had been rattled. Stripped of my clothes, and my identity, reduced to a series of numbers, reports and jottings on pieces of paper, I found myself sitting awkwardly in a gown, socks and underpants on a large leather chair, on the other side of a sweeping desk, with an impressive array of desk stuff, and an imposing yet elegant computer monitor. Clearly, I was in the presence of a learned and professional doctor. His gleaming desk silently spoke to his shining reputation.

Faced with this huge imbalance in power, and feeling humiliated at trying to have an “equal” conversation while dressed as a child, I stammered and stuttered my way through the encounter, trying humour, empathy and even clever questions to show that I too was a smart someone. I was a professional, not just a patient.

In the end, after a cursory physical exam – I guess this was the reason I had not been allowed to see the doctor fully clothed – and, I must admit, a very thorough review of my health reports, I was pushed out on the other side of the medical conveyor belt with no definitive answers. But the message I was able to take home with me, very clearly, was that the medical ritual keeps the patient off balance, and “manages” the anxieties of, and pressures on, the doctor. I may not have found the answers I was looking for, but I had learned my place.

Pierre Brouard
Deputy Director
The Centre for the Study of AIDS
University of Pretoria

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Psychology and the Law:

Reflecting on the Oscar Pistorius Trial and the Role of Mental Health Care Practitioners.

Introduction

With all the media coverage the Oscar Pretorius trial has received, psychology finds itself at a watershed moment and I believe we have to consider the 'post-Oscar-trial' period as a unique opportunity for growth in psychology. That said, first we have to answer an important question. Havethe contributions from psychologists and mental health care practitioners to the trial strengthened the profession as a science, or have we regressed to the point where 'psychology' is now more widely perceived as a pseudoscience, fueled by subjective opinion and biased reporting? I pose this question to practitioners in the field and would encourage an open discussion on five key issues, which surfaced throughout the trial.

Setting the scene

Let me put on record that I write this piece as a practitioner of mental health care in South Africa and not as an expert on criminal law or forensic psychology. The story follows.

Like many individuals I was exposed to the daily updates and summaries of 'expert' opinions from a range of forensic professionals while driving home from work.I run a private practice in the Southern Cape and use the 30min drive back home as time to reflect on my day's consultations and also catch up on news and sport while listening to the radio.

At first the information conveyed about the Oscar Pistorius case was received as news titbits, hidden away behind the Nkandla Saga, updates relating to the Marikana hearings, protests and promises of the 2014 Elections, and reports on the never-ending platinum strike. Indeed these are/were all-important events that might still influence our collective psyche as a nation, however, on the 12th of May Prof. Meryll Vorster (a forensic psychiatrist) was introduced to the witness stand by Adv. Barry Roux (Defense) which 'forced' me to listen with more intent.

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Psychology and the Law:

I would like to say that my consistent interest in the Pistorius trial was encouraged by the fact that I had a keen interest in the interplay between mental health care and the law, but this wasn't the case. The real reason behind my interest in the court proceedings stemmed from the events, which followed the range of media, broadcasts on this particular day. Everywhere one looked and listened (i.e., newsfeeds, Twitter, Facebook, radio etc.), *Generalized Anxiety Disorder* (GAD) was the topic of discussion and debate. Prof Vorster's testimony (i.e., that Oscar suffered from GAD at the time of the tragedy) acted as the catalyst for a significant shift in the manner in which the defendant was initially understood (i.e., a successful paralympic athlete) but now being portrayed (i.e., an insecure and vulnerable individual).

A couple of days after the news broke about Oscar's GAD diagnosis I started to receive calls from 'concerned parents' and' newly-self-diagnosed patients'. At first this was strange seeing that most callers just wanted to clarify a few concerns over the phone. But while sitting in a restaurant and overhearing at least 3 tables talking simultaneously about the trial I started to understand the influx of queries to my practice. It seems that irrespective of work or social context, people talked about 'GAD' and the impact of mental disorders on behavior. The subject of Oscar's mental health had infiltrated discussions at work and social gatherings and, most interestingly, people had strong opinions about the topic. It was during one of these social events where I realized that the shift which had taken place within the trial (i.e., the introduction of a possible GAD diagnosis by Oscar's defense team) had also on some level impacted the social context in which we live our lives and practice our profession.

Back to court

Up to this point witness testimony and expert opinions were focused on clarifying the facts about the case and contextualizing the forensic investigations, which had taken place. Now the focus shifted towards the 'unknown' (the psyche of Oscar Pistorius) and in many ways this was what the public was waiting for. Media platforms lit up with discussions and debates on Facebook and Twitter linked to the impact of *GAD* on *criminal culpability* and *diminished capacity*. It was also at this stage of the trial where the general public gained significant insight into psychology as a profession due in part to the expert commentary and analyses contributed by our colleagues. Although inputs from psychologists were from this point onward a regular part of media broadcasts, psychologists had played a central role in the trial right from the start. Our role had now shifted from a supportive and somewhat peripheral contribution to front of stage.

Contributions made by mental health care practitioners in the Pistorius trial

Although a lesser-known fact, psychologists were part of the trial right from day one. For the defendant, Dr Lore Hartzenberg, a privately contracted practitioner was on hand to comfort Pistorius throughout the trial but especially after a particularly agonizing time in the witness stand.

Similarly, the State was assisted by the police's investigative psychology unit with individuals like Major Bronwyn Stollarz and Brigadier Gerard Labuschagne (head of the unit) playing a key part in proceedings.

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Psychology and the Law:

Psychology and the Law: Reflecting on the Oscar Pistorius Trial and the Role of Mental Health Care Practitioners.

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Ironically, the founder of the police's investigative psychology unit is Dr Micki Pistorius, a well-known psychologist, criminal profiler, and aunt of Oscar Pistorius. She is not directly involved with the case, yet her contribution towards the establishment of this specialist unit cannot be overlooked.

Psychiatrist called as an expert witness for the defense

The second wave of involvement by mental healthcare practitioners came with the testimony of Prof Meryll Vorster. Prof Vorster was of the opinion that Pistorius suffered from GAD and thus argued that the court should take this fact into consideration when reviewing the evidence. Called by the Defense as an expert witness, opinions on social media revealed that a number of online posts questioned why she had only seen the defendant on two occasions. The timing of her sessions were also questioned. Prof Vorster only initiated contact with the defendant after he gave his evidence in chief. Although there were online concerns about Prof Vorster's evidence, a number of media houses lauded her ability to stand up to grueling cross-examination. As already discussed, this moment was a turning point in the case with many people not anticipating what happened next.

Following Vorster's testimony, Adv. Gerrie Nel submitted a formal application to Judge Masipa for Pistorius to be sent for mental evaluation. Nel said the defence team sought to rely on (GAD) as a 'third defense' along with the suggestion that he fired by accident at a suspected intruder, and that he fired in putative self-defence.

Despite resistance from the defense, Judge Masipa ordered the defendant to 30 days psychiatric evaluation. She told the court: *It is necessary to emphasise that an application of this nature is never taken lightly, as it is an integral part of a fair trial, having regard to the above, I am satisfied ... and I shall grant that orde*r." A third wave of involvement of mental health contributions followed.

Psychologists and psychiatrists tasked with clinical observations

In light of the application submitted by Adv Nel, and ordered by Judge Masipa, Oscar Pistorius underwent a month of observation at Weskoppies psychiatric hospital. A team of practitioners was appointed and included three psychiatrists and a clinical psychologist (Dr Scholtz). The three psychiatrists were selected as follows: one appointed by the prosecution (Dr Kotze), one by the defense (Dr Fine),

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and one appointed by the court (Prof Pretorius). An agreement was reached between the prosecution and the defense and the defendant was allowed to attend Weskoppies Psychiatic Hospital as an outpatient.

Thirty days later the observation period at Westkoppies ended and soon thereafter the official report was released. The psychiatric report stated that Oscar Pistorius did not suffer from a mental defect or a mental illness at the time of committing the offence that would have rendered him criminally not responsible for the offences *charged*. All 4 practitioners were in agreement. This report further noted that Pistorius had "*an adjustment disorder with mixed anxiety and depressed mood*", which developed after the shooting. The psychologist found that Pistorius was severely traumatized by the shooting and suffers from post-traumatic stress disorder and major depressive disorder and should continue to be treated because he is at risk of suicide.

Psychologists assisting broadcasters to understand findings

With all the interest in Mr Pistorius's mental health, psychologists found themselves fulfilling the role of consultants and commentators on national and international platforms. Just some of the topics discussed which needed clarification by psychologists included the following: *the fight, flight or freeze response*; *narcissism and personality defects*; *signs of depression and suicidal risk*; *comparisons between anxiety experienced as a professional athlete and GAD*; *how disability contributed to a heightened sense of fear*; *the diagnosis of post-traumatic stress disorder following the shooting*; *psychometric testing and what conclusions can be drawn from psychiatric observations*; and the list goes on.

Clearly psychology as a profession, often misunderstood and 'hidden away', found itself at the vanguard of this quintessential example of how psychology and the law dances on the same stage.

Key points/issues which impact on psychologists open to discussion

Irrespective of the outcome of the trial I believe that we as a profession have to take note of a few important facts reinforced throughout it.

1. Psychological reports, in general, have significant influence when used and understood appropriately. *Reflection: How are we as practitioners facilitating the appropriate use of the reports we write*?
2. Defining 'mental health' and its impact on behaviour continues to be influenced by subjective opinion. *Reflection: What are we as practitioners doing (i.e., through research and published findings) to increase access to evidence-based approaches to overcome falling victim to subjective opinion?*
3. Psychometric testing and the interpretation of results remains the domain of psychologists (i.e., confirmed by Adv. Gerrie Nel by citing the Health Professions Act of 1974). *Reflection: What is the current state of test-use and the interpretation of psychometric results in SA? How are we as mental healthcare providers contributing to this important part of practice*?
4. Irrespective of reputation and expertise, keeping the roles of 'practitioner' and 'expert witness' as separate entities remains difficult. *Reflection: What are the guiding principles to follow when practitioners are called to the stand as an expert witnesses following professional/therapeutic contact with a client?* *continue...*

Psychology and the Law:

Psychology and the Law: Reflecting on the Oscar Pistorius Trial and the Role of Mental Health Care Practitioners.

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Each of these key points surfaced at some stage during the Oscar Pistorius trial. Certainly it is my opinion that the four points listed above can be used as catalysts to stimulate powerful debates on key issues affecting psychology. Yet I also believe that we could benefit from a broader focus on the trial in general by asking:

5. Was 'organised psychology' (read PsySSA) prominent enough during the Oscar Pistorius trial? *Reflection: If your answer is no, then one could ask what kind of a role could should we have played?*

It is my opinion that there is a need to revisit and discuss these points as a collective body of mental healthcare practitioners.

Dr Ewald Crause

Conclusion

Whatever the outcome to the case will be, we find ourselves as key stakeholders and co-authors of this next chapter in psychology. Has 'psychology' as a profession been affected by the Oscar trial?

The answer would most probably depend on whom you ask. In terms of the general public, the answer would most likely be 'yes'. To psychologists in the field…I look forward to hearing your answers.

Department of Health Certificate of Need Meeting

Prof. David Maree attended a Certificate of Need meeting organized by the Department of Health (DOH) on 28 July 2014.

The DoH is consulting widely with all stakeholders about the Certificate of Need (CoN) as it pertains to the National Health Act.[1] Basically the CoN requires each practitioner in the health sector to obtain a certificate of need in order to make sure that services are equitably spread through out South Africa. The CoN's aim is to facilitate access to health services by the general public. The one worrying aspect against which a number of stakeholders objected was the 24-month period within which to obtain a certificate of need. The DoH proposed a particular solution, which is briefly discussed below. The process of consultation is now crossing into collaboration whereby the stakeholders represented on the committee are required to propose the regulations. Below find some of he objections and solutions that have been documented thus far.

The current state of affairs

1. To relieve practitioners of the timeframe of 24 months, the proclamation will be withdrawn and only reinstated as law when all negotiations are done. The 24 months will commence as soon as legislation is proclaimed again. Associations and bodies will be informed as soon as the legislation is officially withdrawn.
2. There is a grandfather clause – everyone with an existing practice will get a CoN that takes matters of quality in consideration. New entrants will be subjected to additional requirements.

General remarks

1. It is not clear how the CoN will be applied to mobile units when telemedicine still has to be finalized.
2. Government health institutions should also require a CoN.
3. The issue of the number of practices per area will have to be carefully considered.
4. The consumer should obviously have a choice to go to different practitioners.
5. Competition, an oversupply of practitioners in one area, and the buying and selling of practices will have to be carefully considered when writing the regulations.

Way forward

1. Any concerns and comments can be sent to PsySSA within the next two weeks.
2. A representative for PsySSA will be appointed to further assist with the process.

[1] Available at www.hst.org.za/publications/national-health-act-2004-no-61-2003

20th South African Congress of Psychology (16 – 19 Sep 2014) Congress update

Just over one month to go!

A Time of Celebration and Critical Reflection

As you may know, 2014 not only marks the 20th anniversary of our South African democracy, but also of the Psychological Society of South Africa (**PsySSA**) as a transformed Society, representative of the interests of all psychology professionals.

Themed *A time of celebration and critical reflection*, the 20th South African Congress of Psychology aims to achieve exactly that. See the draft Congress programme which is now available here. We are preparing for no less than 800 - 1 000 participants, so be sure to register, sooner rather than later.

The opening ceremony on 16 September promises to be a memorable occasion that will also see the launch of the Pan-African Psychology Union (**PAPU**). The PsySSA AGM will be convened in one of the plenary sessions on Wednesday, 17 September, where, among other items for discussion, the strategic direction that will inform the growth and increased professionalisation of the Society in the next 5 years will be shared with all of its members.

The plenary also features two controversial debates, one invited round table, as well as two key note addresses that are sure to challenge and inform.

The 20th Congress will offer participants ample opportunity for rigorous research reporting, as well as active engagement with both the challenges and opportunities relevant to South African and African psychology in the 21st century. The scientific programme includes 188 oral and 21 poster presentations across 19 thematic areas in 7 parallel streams. These sessions will be complemented by 15 symposia and 7 roundtable discussions that cover a wide spectrum.

In this regard, note the roundtable discussion that is scheduled for Friday, 19 September, from 14.15 - 16.15: *HPCSA Professional Board of Psychology: Protecting the public and guiding the profession. Is the board striking a balance?* Chair of the Board, Prof Sodi, as well as other members of the Executive, will avail themselves to respond to related concerns and suggestions for the future.

It is also important to note that the scientific programme is preceded by 5 high-quality CEU accredited workshops, scheduled for 16 September. Registration for these is now open. Please register online to secure your place.

Prof Juan A Nel
Chair: Scientific Committee
20th South African Psychology Congress
PsySSA President Elect

PsySSA manager presents ICP2012 final report

PsySSA Office Manager Fatima Seedat addressed the International Union of Psychological Science (IUPsyS) Assembly in Paris on 10 July during ICAP2014. Fatima represented South Africa at the IUPsyS Assembly together HPCSA Vice-President Prof Tholene Sodi.

Fatima presented the concluding report on the highly successful ICP2012 that was held in Cape Town two years ago, highlighting the gains made not only by South Africa but also by psychology on the African continent. Using multimedia, the various milestones of South Africa's hosting of the first International Congress of Psychology on African soil were powerfully delivered. While ICP2012 did not boast the over 9000 attendance numbers of its predecessor, it did set the bar for country representation at 103 countries, an invited programme that had seven daily parallel tracks out of the thirty daily tracks, and the most attentive delegate presence throughout the congress. ICAP delegates who had been part of ICP2012 clearly were impressed by the latter, making comparisons, which the next ICP2016 in Yokohama, Japan will also have to contend with. The IUPsyS Assembly welcomed the announcement that the Pan-African Psychology Union (PAPU) would be launched during the 20th Anniversary PsySSA Congress, one of many outcomes of this ICP2012 milestone for South African psychology. Fatima was elected to the IUPsyS Nominations Committee, chaired by IUPsyS Past President Rainer Silbereisen.

The night before, despite pouring rain, the 125th Anniversary of the 1st ICP was celebrated at the Eiffel Tower, with some 200 guests from around the world marking this signal event in international psychology, which was hosted by South Africa's Ann Watts, who is the IUPsyS Secretary-General. Previous IUPsyS Presidents - Kurt Pawlik of Germany, Gerry D'Ydewalle of Belgium, Michel Denis of France - joined current IUPsyS President Saths Cooper in gracing the occasion.

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Photo's

1 IUPsyS Reception at the Eiffel Tower, Paris, Celebrating the 125th Anniversary of the 1st ICP: Saths Cooper, *IUPsyS President*

2 left to right: Tor Hofgaard (*IUPsyS Vice-President*), Tuomo Tikkanen (*former President of the European Federation of Psychologists Associations*), Tholeni Sodi (*Vice-President HPCSA and Chair PBP*) and his wife

3 IUPsyS Assembly: South African delegates Tholeni Sodi and Fatima Seedat (*PsySSA Administrative Manager*)

4 IUPsyS Reception at the Eiffel Tower, Paris, Celebrating the 125th Anniversary of the 1st ICP: left to right: Fatima Seedat (*SA delegate to the IUPsyS Assembly*), Ann Watts (*IUPsyS Secretary-General*) and Karl Swain of SA (*IUPsyS Administrative Coordinator*)

Charging for no-shows Response to the eBulletin issued by the HPCSA

The following online bulletin has reference http://www.hpcsa-blogs.co.za/charging-for-no-shows-3/

The common practice of charging patients who do not honor appointments is in breach of the Council's ethical rules that state:
A practitioner shall not charge or receive fees for services not personally rendered, except for services rendered by another practitioner in his or her employment or with whom he or she is associated as a partner, shareholder or locum tenens.

Practitioners are urged to uphold the ethical rules and regulations.

Background

Despite the HPCSA guidelines indicating that "*a practitioner shall not charge or receive fees for services not rendered personally*" it appears that a number of practitioners in private practice find themselves in breach of this rule.

Current position

An online search revealed that a number of South Africa psychologists clearly indicate that a fee for missed appointments or late cancellations will apply. The general trend seems to be that a cash fee is charged at these practices if appointments are not cancelled, or rescheduled, within 24 hours of the appointment. That said, although the majority of practitioners reviewed were firm in their commitment towards charging a fee, most were found to be sympathetic to the client and encouraged clients to communicate their reasons for missing appointments to the practice as soon as reasonably possible.

Examples of online contracts and guidelines to practitioners

Three examples are listed below which demonstrate that the topic of charging for missed appointments and late cancellations requires urgent attention.

1. A contract by a counselling psychologist (accessed August 2014)
2. A contract by a clinical psychologist (accessed August 2014)
3. Guidelines in PsySSA's *Psytalk* (2008) relating to *Practitioners in Private Practice*

Example 1: Counselling Psychologist

Cancellations Policy

The practice has a 24-hour cancellation policy.
If appointments are not cancelled within this period a late cancellation fee will be billed to the patient's account. Likewise if a patient does not cancel their session and fails to appear for their session the full hourly rate will be charged to the patient's account.
Late cancellation fee - R350
No show fee - R702.00

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Charging for no-shows
Response to the eBulletin issued by the HPCSA

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Example 2: Clinical Psychologist

Contract

The practice is not contracted to any medical aid and charges private fees (referto fees schedule in the practice website). Medical aid clients are required to pay the difference between the practice's tariffs and medical aid tariffs. Discounted fees (10% off) apply to clients who settle in full before the session.

Payment of fees is the client's responsibility. Medical aid clients are required to complete a debit order mandate authorising account the administrators ***(removed to protect the privacy of the practitioner)*** to recover unpaid fees.

Appointments should be cancelled 24 hours in advance, e.g. a 17h00 appointment on a Monday must be cancelled before 17h00 on the preceding Friday. No-shows are charged a full session fee. Session end times are not adjusted to accommodate late coming, e.g. a 10h00 session scheduled to end at 11h00 will still end at 11h00 even if the client arrived at 10h30. A full hour's fee will still be charged.

Example 3: PsySSA's Guidelines to Practitioners in Private Practice (2008)

PsyTalk 2008 (Issue 2, p. 6)

Useful hints for private practitioners:

Make sure that each new client signs a contract of payment before the initial interview. The contract should state the terms of payment, client acknowledgement of an understanding of expected fees and due process should these not be received and that a fee will be charged for no-show (that the appointment has not been cancelled 24 hours before the time).

Why practitioners feel it is necessary to charge for 'no-shows'

One has to ask why practitioners would put themselves at risk of disciplinary inquiry if they are found in a position where a clear ethical rule is transgressed. It seems that the answer to this question is twofold:

1. Many practitioners have decided to charge a 'missed appointment' or 'late cancellation' fee to increase the chances of patients honoring their appointments.
2. Considering that moneys received from 'consultations' is the only source of income for some practitioners, there is significant ramifications towards the sustainability of private practice if 'missed appointments' and 'late cancellations' are not addressed

continue on next page...

Charging for no-shows
Response to the eBulletin issued by the HPCSA

...continued

A position statement

Indeed it is widely acknowledged that practitioners are not to charge patients if they do not pitch up for appointments. Unfortunately, this rule seems biased towards solely protecting the rights of the patient and does not consider the impact of missed appointments or late cancellations on private practice. It is for this reason that a revision of the above rule should be discussed, and possibly implemented, to ensure that both parties' (i.e., the client and the service providers') needs are adequately met.

If a 'missed appointment' or 'late cancellation' fee is approved
(i.e., a regulated fee), three benefits are envisioned:

1. That the commitment of the patient towards the process of therapy can strengthened (i.e., benefitting the patient/client).
2. That the sustainability of private practice (i.e., in cases where there is a high frequency of missed appointments and late cancellations) can be supported to benefit the practitioner.

3. That the rights of the patient can be considered when it is the practitioner that is responsible for a missed appointment (i.e., such as in the case of a double booking).

Dr Ewald Crause

Autism in the classroom: A teacher's perspective

Autism is a condition that is gaining increasing visibility in various sectors of mental health and education. This attention can largely be attributed to the high level of advocacy from health practitioners and parents of children living with autism. There is now the recognition that autism is distinct in its presentation from intellectual disability and from other pervasive developmental disorders. As such there has been a move to provide specialist education services for children with autism within the school system. Whilst this initiative is still in its infancy in KwaZulu-Natal it is a very important step in the right direction.

PsySSA Durban Branch invited Ms. Lynette Govender, an autism specialist teacher in one of the forerunner classes at school in the north of Durban to share some of her insights with the group. She presented an illuminating talk at a meeting of the PsySSA Durban Branch on 10 July 2014. Audience members gained an awareness of the intense level of routine, structure and persistence required of the educator's and educator's assistants. Ms Govender described minutely planned routines and teaching practices she and her team implement in and out of the classroom. She also shared an appreciation of the role and commitment of school management in implementing the Department of Education policies in operationalizing the initiative to provide a suitable educational context for children with autism. Ms Govender answered some questions for the PsySSA newsletter:

Q: What is the biggest challenge that you have as a teacher working exclusively with kids with autism?

Some of the most common challenges include maintaining a regular routine in the classroom whilst accommodating each child's needs. Children with autism can have specific and unique behaviors and requirements that must be accommodated for things to work in a classroom. It is also quite a challenge to manage one's role as a teacher with working with parents and ensuring what is established in the classroom is continued at home. Communicating with children that do not use spoken language is also challenging in the classroom setting.

Q: What are the most rewarding aspects of your work as a specialist teacher of autistic kids?

The children responding to interventions and instruction after the teacher has worked on this for some time is amongst the most rewarding experiences for teachers. Getting a group of children to adjust to class routine is a rewarding milestone. Good feedback from parents is also a big triumph as this lets us know that there is improvement outside the classroom context and this is what we are ultimately trying to achieve.

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Q: What is the most important point/s for health professionals to be aware of when working with children with autism from your experience?

It is important for healthcare professionals to develop their skills and training that facilitate early identification and intervention with children with autism. Intervention in autism should be persistent. Change does not come quickly or easily so it is crucial to be patient and not given up when one is not seeing the desired changes. Constant verbal input on behaviours that one is trying to introduce or change is fundamental and it also helps to support this with pictures. For example a series of pictures that outline the day's routine is useful to supplement a verbal intervention. Providing clear and understandable information to parents regularly is most helpful to ensure their understanding and co-operation.

Q: What directions do you see education with children with autism taking in the future?

Currently attention is focused on efficient self-care over the lifespan. So far good inroads have been made into work on diagnosing the condition and working with younger children in the classroom. A great deal of work needs to be done for adolescents and adults as many if not most people with autism will need varying degrees of care over the course of life. In the future there should be centres to accommodate adults with autism. Assisted living facilities will also be required. However I must stress these are still long-term ideas in this country and they will require a high degree of commitment and co-operation from all stakeholders including parents, educators, civil society and government to be realised. It is encouraging to note there is a fair degree of activism around autism but still more is required.

Q: What are the practical steps should be followed in getting a child admitted to a specialist autism class at a government school?

The child will need an unabridged birth certificate and a complete immunization record. In addition to that it is always helpful to have as much medical and personal history information as possible. An assessment and diagnosis by a health professional such as a speech therapist, occupational therapist medical doctor or psychologist is required. Admission at schools is restricted to 6-8 children.

Dr Thirusha Naidu
Chair PsySSA Durban Branch

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Congratulations

Psychologists at the helm of Higher Education in South Africa

Hearty congratulations are due to two of South Africa's most prominent psychologists and stalwarts of PsySSA.

Professor Tyrone Pretorius was recently appointed as Rector and Vice-Chancellor of the University of the Western Cape while **Professor Norman Duncan** was appointed as the Deputy Vice-Chancellor (Academic) at the University of Pretoria in July 2014. They join **Professor Cheryl de la Rey**, the Vice-Chancellor and Principal at the University of Pretoria as psychologists entrusted with leading higher education in South Africa.

For more on Prof. Pretorius's appointment please see
http://www.uwc.ac.za/News/Pages/New-Rector-Appointed-at-UWC.aspx#.U-SIOkj1iBA

For further details on Prof. Duncan's new role please consult
http://web.up.ac.za/res.asp?ipkCategoryID=26652&subid=26652&ArticleID=21137

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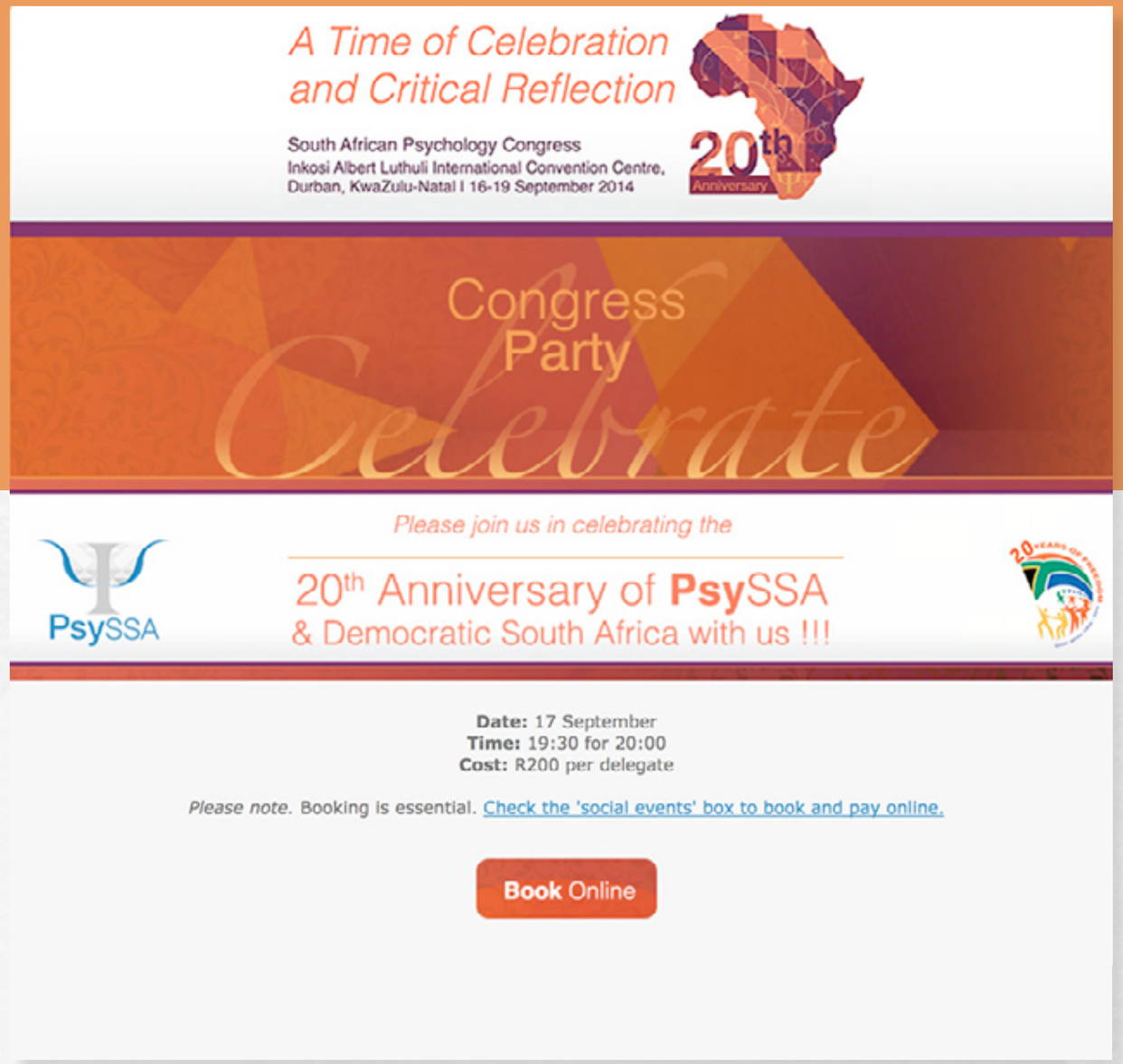

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Rooms to rent

Sea Point – New Checkers Center. We are 2 general practitioners who would like to share the space with a psychologist. The rooms will available July 2014. Please contact :

Dr Ryan Janks on 082 829 1100 or rjanks@gmail.com
Dr Jane Benjamin on 084 820 1270 or janebenjamin@gmail.com

Contact **PsySSA**

Enquiries: PsySSA | Tel: 011 486 3322 | Fax: 011 486 3266/77 | Email: psytalk@psyssa.com

When is a mental disorder a mental defect? The contribution of psychological practitioners, assessments and expert opinion to South African court proceedings.

Mirah Wilks

The Oscar Pistorius Trial has raised multiple professional issues for the psychology practitioner to consider. I draw the reader's attention to the psychological practices which are in line with Annexure 12, Chapter 5: "Psychometric testing" and Annexure 12, Chapter 7: "Psycholegal activities".

To be specific, I refer to the following acts in the Annexure of the scope of practice of psychology practitioners: **Registered Counsellors,** (please *refer to Regulations Defining the Scope of the Profession of Psychology DOH R704 dated 2 September 2011, Amendment by the addition of the Annexure, to Government Notice R933 of 16 September 2008).*

The registered counsellor, scope of practice allows for:

a. Performing psychological screening, primary mental status screening, basic assessment and psychological interventions with individuals aiming at enhancing personal functioning
b. Performing psychological assessment excluding projective, neuropsychological and diagnostic tests
c. Providing expert evidence and / or opinions

Similarly, I refer to the same Annexure for the scope of practice of psychometrists, which allows for:

a. Performing assessments and contributing to the development of psychological tests and procedures
b. Measuring psychological functions including cognitive, interest, aptitude, and personality

Both registered counsellors and psychometrists use screening assessments for various mental health issues, for which they are accredited/trained. In the case of evaluating outcomes of assessments they refer to the DSM 5, (the DSM IV-TR is now obsolete) in order to correctly refer on clients to various medical, legal or educational specialists or psychologists.

Prof James Grant PhD (Criminal Law), Associate professor of Law, University of Witwatersrand, has on his website "Criminal Law of South Africa" (http://criminallawza.net/)[1] deals with multiple aspects of criminal law, educating students, lawyers, psychology practitioners and the South African public in the specific 'language' of the court and the meaning of certain terms such as criminal liability (the *fault requirement* must extend or relate to all the essential requirements of the *unlawful conduct requirement).*

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When is a mental disorder a mental defect? The contribution of psychological practitioners, assessments and expert opinion to South African court proceedings.

...continued

A. In the case for murder

The well-entrenched defence in South African Law, must find the following two requirements:

1. the fault requirement - is there *intention?*
2. theunlawful conduct requirement – *is there the unlawful killing of another human being?*

What does this mean for psychology practitioners?

It is important for psychology practitioners who might be called as expert witnesses or be asked to carry out mental health assessments on a defendant for the use of the court, to understand the fault requirement above is a "*purely subjective enquiry*" according to Grant. This means *intention* reflects the *actual subjective mental state of the accused.* Therefore a murder conviction in South Africa, is dependent on if you intend: 'not only to kill another human being, but if you intend to *unlawfully* kill another human being'. The tautological nature of court language can also cause one to present facts through a sieve of negatives. For example, Grant, states that one must be aware, that a claim that – *one did not act unlawfully* - is actually a claim to have acted lawfully!

One of the most well used grounds of justification – is the *self or private defence,* and in order to succeed in this form of justification, both requirements related to the *attack itself* and those related to the *response to the attack,* must be satisfied.

Attack requirements are:

- one must be under an *unlawful attack,* which has *commenced or is imminent*, against a *legally protected interest*: life, bodily integrity, property of significant value.

Requirements of the defence are:

- force used in response must be *directed at the attacker* (no one else), force *must be necessary*, extent of force must *be necessary and reasonable*

What does this mean for psychology practitioners?

- If one satisfies both these requirements – one's conduct is lawful, and one escapes criminal liability.
- Alternatively, if one does not satisfy both sets of requirements – one's conduct is deemed *unlawful.*
- As 'intention' mentioned above, is regarded as a 'subjective mental state', South African law takes a wide view of it understanding that the foresight of a possibility and reckless persistence is seen as intention.

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Pistorius's original defence against murder

- Pistorius acknowledged there was no unlawful attack upon him or Reeva Steenkamp. Pistorius conceded this in his original defence. Pretorius must convince the court that he genuinely believed he acted in self/private defence. Thus Grant states that an accused Pistorius, having conceded that he foresaw the possibility (and reconciled himself to the risk) that he was not under attack, that any possible attack had not actually commenced/ and was not imminent, and that no legally protected interest was under threat, he may be regarded as having *intended to act unlawfully* – and can be convicted of murder. Alternatively, even if Pistorius was mistaken (with regard to all of the requirements of his attack response) he may also be convicted of murder, if:
  - he foresaw the possibility that one of the requirements of the response may not have been satisfied;
  - if the state can show he foresaw the possibility (and reconciled himself to the risk) that he was not acting against the supposed attacker;
  - that force was not necessary, or;
  - that the extent of the force was not necessary and reasonable

B. In the case for culpable homicide

- Assuming Pistorius succeeds in his defence (of the mistake as to unlawfulness) against the murder charge, the question would be – was this mistake a reasonable one? Such a question on a 'reasonable mistake', is judged – objectively, whereas 'intention' is judged – subjectively.
- The *objective* standard of the reasonable person - is the basis on which our courts judge negligence. If there is any deviation regarding what a reasonable person would have done, the accused would have been judged to have acted negligently.

What does this mean for a psychology practitioner?

- In assessing a client for 'reasonableness', South African law has steadfastly refused to take account of any subjective factors, peculiar to an accused, including *any disability* with which the accused suffers. While this is controversial, the law does not waver on this.
- The psychology practitioner must understand that, if a reasonable person would not have made the mistake Pistorius claims to have made – even if the court accepts Pistorius made this mistake – he may be convicted of culpable homicide.

Pistorius' second defence turns on "involuntariness"

While murder is the *intentional unlawful* killing of another human being, culpable homicide – is the *negligent unlawful* killing of another human being. Pistorius accepts he acted unlawfully and that he was not entitled to shoot anyone on sight. Such an accused is judged on the facts:

- Whether you are under attack and entitled to act in self-defence is judged objectively. Pistorius denies the required guilty mental state hoping to be excused on a murder charge for *unintentionally unlawfully* killing another human being. This defence of involuntariness is a mental state defence. Here if you are mistaken and believe you are acting lawfully (in private-defence) you cannot be convicted of murder; to escape culpable homicide – this mistake – must be

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When is a mental disorder a mental defect? The contribution of psychological practitioners, assessments and expert opinion to South African court proceedings.

...continued

viewed objectively and if the mistake is seen to be reasonable, you can escape a conviction of culpable homicide.

- If the accused is subjectively mistaken, a defence that if you thought you were entitled to act in private defence, the defence of involuntariness (responding during an epileptic fit or during sleepwalking) – where your mind did not control your conduct. Hence, firing into the door by accident – is a claim in law of 'involuntariness'. But claiming the discharge of a firearm is an accident (or that his conduct was not under the control of his mind) – is another defence. Our courts accept that ordinary conduct is voluntary, hence a claim of 'accident' as a claim of involuntariness is technical.

What does this mean for psychology practitioners?

Mental health practitioners who screen, identify or diagnose mental disorders must understand that there is no relationship to mental defect in law. If defence is involuntariness, because of mental illness or mental defect (a legal term, not a psychological term), such defence must be proved by the accused – on a balance of probability.

This defence is open to be challenged as unconstitutional. There is no definition in the Act or the law for mental illness or defect. Case law defines mental illness/ defect as being a pathology and of endogenous origin. Pathology is a synonym for illness – so the explanation is tautological. The only clear explanation of any mental disorder in the DSM 5 which had its origins in an external stressful event is PTSD. Most disorders are seen to be 'triggered' by some internal or external event.

Furthermore, one of the greatest challenges to expert witnesses is the concept of neutrality or objectivity. The credibility of a psychological expert is overturned if this expert produces opinion favourable to the defence or prosecution team who did the hiring. Cohen (2013) points out that not only is such expert opinion unethical, but such allegiances and biased opinion reduce the credibility of the expert's evidence.

Here lies the problem of an experienced mental health practitioner advising on whether a disorder is a mental illness or not, as they are legal constructs. The experienced forensic specialist, Dr Meryll Voster, identified Generalized Anxiety Disorder (GAD) and offered a GAF level of functionality using the obsolete DSM IV-TR, only to be stumped by Prosecutor Gerrie Nel waving the current DSM 5 'bible' in the air. Voster's emphatic adherence to GAD as the single cause of Pistorius' mental illness or defect is legally insignificant, as mental illness is undefined in South African Law. This turned the case against the defence. Pistorius's mental state at the time of the killing, as well as his current functioning hinged on Voster's insistence that her diagnosis of GAD (deduced after only two face-to face assessment sessions) might have affected Pistorius's capacity for self-control. This in turn lead to the third defence of Pistorius: pathological incapacity (insanity).

Pistorius's final defence: Pathological incapacity appears in s78(1) of the Criminal procedure Act. This act states:

A person who commits an act or makes an omission which constitutes an offence and who at the time of such commission or omission suffers

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When is a mental disorder a mental defect? The contribution of psychological practitioners, assessments and expert opinion to South African court proceedings.

...continued

from a mental illness or mental defect, which makes him/her incapable of 1) appreciating the wrongfulness of his/ her act or omission and 2) of acting in accordance with the appreciation of the wrongfulness of his/ her act or omission, shall not be criminally responsible for such an act or omission.

Once Pistorius' capacity for self-control at the time of the killing was questioned and may have been affected by GAD, the court used s78(2) and had no choice but to refer him for further observation. This expert evidence unwittingly led to Pistorius' 30 day observation by a panel of psychology and psychiatric specialists.

The use of *pathological criminal incapacity* as defence requires that the accused at baseline suffers from 'mental illness or defect' at the time of the killing. Since this is at best a legal construct no baseline criteria can be elicited, and at best such descriptions are meaningless because such analysis is unfounded, ill-considered or at best a distraction, as the term is redundant.

Assessment of a person's risk or potential for dangerousness in society had greater validity than pathological criminal incapacity. Such a view is supported by Cohen (2013) who suggests that 'dangerousness' is a matter of judgement or opinion which is of necessity subjective, reflecting social and personal values concerning what one is prepared to tolerate. Also, Cohen states that there is no single definition of violence, violent behaviour or danger, thereby further obstructing the assessment of danger or risk in an individual.

Cohen (2013) points out that psychometric tests can make valuable contributions to psychological assessment for court, provided that they are applied appropriately. Mental health professionals and psychometrists should avoid professional criticism for assessing risk, given the poor reliability and validity of current risk assessments.

Mental health care professionals called on to provide expert opinion must be aware of possible multiple roles of counselling/ therapy and expected objectivity/neutrality and understand that any evidence given is grounded in some form of social or political context (Cohen, 2013). Remembering Prof. Wayne Derman's conflicted relationship with the accused and his extensive expert testimony - his expert opinion was upended by prosecutor Gerrie Nel, based on research cases unrelated to the case itself, assessments and integrated reports were often challenged on the basis of dual relationships, lack of pertinent empirical evidence, strengths and limitations of the psychological research underpinning the evidence, and the lack of neutrality and objectivity of the evidence presented in court.

Finally, while expert opinion is often presented in court by psychology practitioners, the court is not bound to uphold such opinion for any legal decision making.

Mirah Wilks

PsySSA Chair: Division Registered Counsellors and Psychometry.

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Student Division

Divisional Focus

Earlier in the year we spoke about expanding the student division through partnerships with student divisions on university campuses. The PsySSA student division and Psyche, a student division from the University of Pretoria, have formed a partnership to support University of Pretoria students in finding entry points into the field of psychology. Psyche hosts a number of projects aimed at supporting students at the University of Pretoria in gaining experience through a network of organisations that host volunteers.

Psyche also hosts a series of socials where students can meet each other and share their passions, interests and challenges. Psyche hosted three socials during the course of the year which were a great success. Psyche also welcomed the Cancer Association of South Africa (CANSA) as a community partner this year. The partnership between CANSA and Psyche links passionate psychology students with parents of children who have been diagnosed with cancer.

The PsySSA student division embarked on a drive to support students in participating in the annual PsySSA congress. The PsySSA student division worked with Psyche students and students from the University of South Africa to guide them toward submitting abstracts for the 20th Anniversary PsySSA Congress. We are pleased to announce that the majority of the students from both University of Pretoria and University of South Africa who participated in the presentation mentoring process had their abstracts accepted. During the course of July and August, the PsySSA student division will continue to assist students to prepare their presentations for the congress in September.

On the 25th July, the North West University (NWU) will be launching their newly formed psychology students association. The chair of the PsySSA Student Division, Mr Angelo Fynn, will be speaking at the launch to welcome the new association into the network of psychology students in South Africa. The PsySSA student division looks forward to a long relationship with the NWU psychology student division.

The Student Division is on Facebook (https://www.facebook.com/groups/276152612414171/) where we meet online to share internship opportunities, research projects, make conference announcements, and anything else you feel other psychology students need to know.
Joining the Student Division is quick, easy and affordable. Becoming a PsySSA student member costs R 210 and provides the additional benefit of joining the other divisions at reduced rates.
We look forward to meeting you in sunny Durban!

Psyche
We've got

Mr Angelo Fynn
PsySSA Chair: Student Division

Sexuality and Gender Division

Divisional Focus

Prof Carien Lubbe-De Beer

In this issue I share with you highlights of the past few months, as well as critical commentary on gender and sexuality related topics. However, in the first place I would like to flag the screening of the film *Ndiyindoda* at the upcoming 20th PsySSA congress in Durban. Filmmaker Mayenzeke Baza will bespeaking about his film, and others from Sonke Gender Justice will form part of a discussion panel. Do not miss this event on Thursday 18 September at 08:00.

I have to mention how proud I am of each researcher and practitioner who decided to share their knowledge and expertise with us at the upcoming congress. We are looking forward to the biggest program ever hosted that relates to sexuality and gender. It is going to be an intense three days of critical reflection. Now for some highlights from various members of the Sexuality and Gender group:

1) The revision of the ICD-11 (Dr Megan Campbell)

The International Classification of Diseases (ICD) is in the process of being revised by the World Health Organisation (WHO) with publication of the ICD-11 planned for 2017. Clinical utility has been identified as a key goal during this revision process, and five developing countries, namely Brazil, India, Lebanon, Mexico and South Africa, have been identified as clinical field testing sites to evaluate the clinical utility of proposed

ICD 11 revisions in the field of sexual disorders and sexual health. At the recent International Congress of Applied Psychology (ICAP) in Paris the proposals for field studies at each of these sites were presented.

Studies will focus predominantly on testing the clinical utility of proposed revisions to F52 and F64 disorders, while legal and policy reviews will consider some of the legal and human rights implications of proposed revisions to F64 and F65 disorders. The proposals will be published online for public comment. Clinicians interested in participating are encouraged to sign up to the WHO Global Clinical Practice Network using the following link: www.globalclinicalpractice.net.

2) Cornelius Victor shares an article that relates to the recent symposium on ICD sexuality and gender identity classifications at ICAP in Paris.

The proposed declassification of disease categories related to sexual orientation in the International Statistical Classification of Diseases and Related Health Problems (ICD-11) is available at http://news.sciencemag.org/sites/default/files/CochranWHO.pdf.

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This article talks to one part of the work that also includes dealing with gender identity, paraphilias and sexual dysfunction such as erectile dysfunction. Please take note of Adele Marais from the Gender Reassignment clinic at Grootte Schuur in the list of authors - probably the only public clinic of its type that is functioning well as internationally renowned). The article relates specifically to 'disorders associated with sexual orientation and gender identity' (F66 in ICD -10 - which incidentally is only now being implemented in the US).

My personal favourite is:

F66.2 Sexual relationship disorder - The gender identity or sexual preference abnormality is responsible for difficulties in forming or maintaining a relationship with a sexual partner.

So I wonder how many heterosexual men knocked on their GP's door realising that it is their sexual preference abnormality that is responsible for their difficulties in maintaining a relationship with sexual partners.
Ai tog!

3) Joachim Ntetmen of Cameroon shares his involvement in the field of sexual health.

Joachim is one of the African delegates partaking in the PsySSA African LGBTI Human Rights project. Over the last year Joachim has been invited to lecture participants on Mental Health of MSM. The invitation was from an Association defending LGBT rights in Cameroon. This was an opportunity to spread some elements of the Position Statement (adopted by PsySSA in 2013). He also shared his knowledge in a catholic newspaper, engaged with counsellorsspecialising in HIV and MSM clients and published an article in April 2013 (http://www.tandfonline.com/doi/abs/10.1080/13691058.2013.779025#.U6MRwnbce1s).Come and listen to Joachim on Friday 19 September at 14:15-16:15.

4) The Centre for the Study of AIDS, University of Pretoria

Pierre Brouard is the director of the Centre for the Study of AIDS. He shared some of the key acitivities over the last year. The centre trains students as volunteers, trainers and peer HIV counsellors on themes of sexualities and gender (in our Future Leaders @Work programme at UP) and we run community projects, which encompass or touch on these themes.

The centre is represented on the Gender Research @ UP (GR@UP) network, where monthly seminars on gender take place. The Centre has contributed to the development of a Gender Audit tool to be used in higher education institutions - the tool explores how gender equality is achieved in universities and the centre ensured that equality around sexual orientation and gender identity were included as an indicator in this tool. In September 2013 Pierre gave a talk at the HIV Unit at UCT (HAICU) which explored ideas around how universities should create safe spaces to talk about sexuality and gender. In October 2013 he gave a talk at the Centre for Human Rights at Eduardo Mondlane University in Maputo on the right to dignity for sexual and gender minorities.

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Sexuality and Gender Division

Divisional Focus

In October 2013 Pierre helped to organise and facilitate a course called *Engaging Men and Boys in Gender Equity* (the key players are the Sonke Gender Justice Network and the Centre for Human Rights at UP) - the course explores gender in general but also touches on sexual and gender minorities.

In February 2014 he helped to conceptualise, and taught on, a sexual minority rights course run by the Centre for Human Rights at UP (the course includes students completing their Masters in Human Rights as well as people working in the field from NGOs, government and aid agencies).

He was invited as an "expert reader" for reports on two pieces of research on LGBTI issues, one for the HSRC and the other for NACOSA. Pierre gave a talk at a colloquium at UWC on the links between gender violence, rape and HIV.

Come and listen to Pierre on Thursday 18 September, 15:30-17:30.

5) ASSAf Humanties conference

Carien Lubbe-De Beer was invited to share her expertise on the state of families in South Africa from a non-heteronormative perspective. She was joined by Mbuyiselo Botha, Media and Government Liason, Sonke Gender Justice and the Commissioner, Commission on Gender Equality who spoke about male fathers; Monde Makiwane Chief Research Specialist at the HSRC who spoke about masculinities; Zitha Mokomane, Chief Research Specialist, HSRC, who spoke about work-life balance especially for mothers; Mmapaseka Steve Letsike, National Council Against GBV, SANAC, and Anova Health Institute, who spoke about non-heteronormative positionings. The hosts were Linda Richter, the Director of the DST-NRF Centre of Excellence in Human Development, Universities of the Witwatersrand and KwaZulu-Natal and Leila Patel, the Director of the Centre for Social Development in Africa. Discussions centred around the state of families in South Africa, looking at the changes over the past twenty years in our young democracy, and how the family has changed: the impact of apartheid on the narrative of the family, the challenge of poverty, gender inequality and changes in the labour force and their related impact on work-life roles, to name but a few.

The following questions were interrogated by the panel:

Do families matter, are they in crisis, how they are changing, should we be worried and if so, what should and can be done to enhance family well-being?

6) SGD members interrogate taken-for-granted assumptions around parenthood decision-making and sexual and reproductive health (Contributed by Ingrid Lynch)

South Africa will not meet its 2015 Millennium Development Goals on reducing child and maternal deaths, in part due to inadequate government reproductive health programmes. At the recent Partnership for Maternal, Newborn and Child Health (PMNCH) conference hosted on 30 June,

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Sexuality and Gender Division

Divisional Focus

Health Minister Aaron Motsoaledi expressed concern at the continued inequality in the area of sexual and reproductive health rights. SGD members Tracy Morison and Catriona Macleod are conducting research that turns the assumption underpinning much of research and policy on sexual and reproductive health on its head: that women have the freedom to make reproductive choices, such as deciding when and how to access and use contraception, or to access their legal right to terminate unwanted pregnancies.

Tracy Morison is a research psychologist and post-doctoral fellow in the Human and Social Development programme at the Human Sciences Research Council and has an interest in critical approaches to reproductive decision-making. Her research highlights the limits of a rights-based approach, which is premised on an assumption of uncomplicated individual choice. Instead, she argues that a reproductive justice lens allows researchers to attend to the manner in which socioeconomic and political issues impact on reproductive concerns. She notes that factors like poverty, access to care and health insurance, gender-based violence, sexual coercion and stigma all contribute to women's ability to exercise choice regarding their bodies and their reproductive capabilities. In her review of current approaches to sexual and reproductive health rights, she highlights that social problems are often individualised and located in women, such as through the blame and stigma often afforded to teenaged mothers.

Such an approach ignores that many young women do not have a say in whether or not to have sex, yet they are commonly blamed for bearing children at a young age and perpetuating cycles of poverty and supposedly encouraging the "moral decline" of society (Morison, 2013).

Catriona Macleod, a Professor of Psychology at Rhodes University, has taken up the issue of unsupportable pregnancies among young women in her book *Adolescence, pregnancy and abortion: Constructing a threat of degeneration*. Her analysis considers the social anxieties that surround teenage pregnancies and focuses in particular on the invention of teenage pregnancy as a social problem. Further to this, she explores how issues of race, tradition and culture influence how teenage pregnancy is regarded and responded to, particularly by health service providers. An individualising tendency that locates blame for social problems in women ignores the limitations posed on women when they find themselves in contexts where exercising sexual and reproductive choice is constrained.

Morison (2013) notes that "it is not enough to grant women choices; we need to consider what prevents us from exercising our rights and making decisions that are in line with our fertility preferences and desires" (p. 4). Research such as that conducted by Morison and Macleod encourage policy makers to expand their lens beyond individual factors to also consider how women's circumstances shape their access to contraceptive and reproductive resources and care.

7) Finally, join us for the exciting launch of the Sexuality and Gender Division, on Thursday 18 September at 17:30. Refreshments will be served

Carien Lubbe-De Beer
PsySSA Chair: Sexuality and Gender division

References

Morison, T. (2013). *Moving from reproductive choice to reproductive justice.HSRC Review.* Available at http://www.hsrc.ac.za/en/review/hsrc-review-may-2013/moving-from-reproductive-choice-to-reproductive-justice

Macleod, C. (2011). *Adolescence, pregnancy and abortion: Constructing a threat of degeneration.* London: Routledge.

Appreciating the multicultural dimensions of a community through Grade Three learners in Soweto.

Some time ago while visiting a friend in a very poor area of Soweto where the houses are close, over crowding is widespread, the roads are not yet tarred and crime is common, my 12 year old granddaughter, commented that Soweto was the safest and happiest place in the world. Why? Because there were no high walls, everyone talked to everyone else, the children ran in and out of the houses playing, the men stood in the street drinking their beer and talking; everywhere people were mixing with each other. Admittedly this is a child's simplified viewpoint. However it got me thinking. If she could see the underlying unity in the community what could be done to more visibly encourage this acknowledgement and acceptance of each other. And thus started a most amazing, exciting adventure into a world hitherto not visited by me.

I approached the principal of a school in the area where I had been doing some volunteer work and asked her opinion. She was very enthusiastic and we had a long discussion on the obstacles we might encounter – the main one being the differences in culture. I quickly realised that I needed further skills, so went back to university to further my education. Here I discovered that there was little written about the multicultural situation in South Africa. I would have to learn as I went along!

Starting work in a community is not as easy as it sounds. I had already been working in that community for a few years but now I really had a breakthrough. I was allowed to work with the children directly. After getting over my fear of the children and their principal I began to develop a programme that I thought would help the children's emotional responses to their environment and encourage acceptance of all in the community regardless of culture or anything else that appeared to be different. At first we talked about emotions and what they mean. I don't know if anyone has tried talking to a class of 62 grade threes in an overcrowded classroom about abstract things like emotions. It doesn't work. The boys wanted to talk about fighting and the girls about love. As I was not an experienced teacher, discipline was a very big problem for me. Quite frankly they ate me for breakfast!

Well, what with my studies and the help of the principal and my own experiences we realised that smaller classes would be more effective, so we broke the class into six groups. This was much easier but some formal structure needed to be in place. I then designed a programme with the central theme "Who am I?" I have been presenting this programme now for four years.

It is an interactive programme with discussions, craft work, colouring-in, stories and at times physical games. The aim is to teach the children how to recognise different emotions, be able to name them and to have some

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Appreciating the multicultural dimensions of a community through Grade Three learners in Soweto.

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idea on how to deal with each emotion from their own perspective. We also spend time teaching the children how to show the emotion in an appropriate way. Emphasis is given to understanding the meaning of community. The family, the school, the soccer club, the neighbourhood are all explained as communities. This is where personal culture needs most to be understood. What is unacceptable in one community is sometimes quite acceptable in another. The children are quick to point out the differences and similarities.

The programme puts great value on the ability to pay attention so the children learn to work quietly and to justify right from wrong. We take the view that without learning to pay attention we cannot listen to each other effectively. This quite naturally led to acceptance of each other and the values held by each other. The programme works in four sections; Body, Mind, Heart and Spirit. This helps the children to understand that everything works together and that the human being needs to understand the differences in these order to function effectively.

Is it working? The teachers have remarked that the children who have completed the programme are quieter and work more carefully. They appear to be more confident in expressing themselves and more tolerant of the other children. How much of this is due to the programme and how much is due to the opportunity to work in small groups with the undivided attention of the teacher is difficult to ascertain. However the following story, from my perspective, sums it all up. After break one day, one of the groups came into class very excited. They then told me that they had witnessed a man going into one of the houses opposite the school and stealing, amongst other things, a baby. They went on further to say that the man was chased by the community and then threw the baby away into a dustbin. The community caught the man and beat him until the police arrived. During the scuffle someone produced a gun and started shooting. This was of course, altogether an alarming situation.

They were ready to discuss this as a group and allowed each other to speak without interruption. One girl said she was feeling ‘indignant’ (we teach appropriate english words for the emotions). Another girl said she felt compassion for the mother. Another was disgusted that the baby had been thrown into the dustbin. A boy replied that at least the dustbin was full and the baby had not been hurt. One of the girls said she was scared when she heard the gunshots. A boy replied that the shooting was into the air so there was no need to be scared. One boy remarked that it was a good thing that the man had been caught and then beaten. Another boy said he did not agree with the beating, that was not the right thing to do, we must not take justice into our own hands, we must leave the beating to the police. And so on. Each was given the opportunity to express themselves fully. For me this was remarkable. This group had nearly completed the programme and were able, as 10 and 11 year olds to discuss a traumatic situation freely and appropriately. All had differing views but there were no arguments about right or wrong.

I really do not know who has learnt more – me or the children. To have an opportunity like this to penetrate deeply into the workings of a community is indeed a privilege.

Cheryl Combrink

Division of Research & Methodology (DRM)

Divisional Focus

The DRM has had an extremely productive year. The DRM Executive has met three times in the last year but communicated frequently over email to ensure that the division remained active and vibrant. This year saw the revival of the division newsletter, the DRM News which provided members with the latest information on conferences, funding, research and study opportunities, CPD opportunities and general information and debates in the field. Members received this information in their inboxes almost immediately as the information became available courtesy of exec member, Ms. Lavanya Pillay. If you are an existing and paid up DRM member e-mail Ms. Lavanya Pillay (lavanyapillay2@gmail.com) to ensure that your name is on the mailing list. If you would like to become a member, membership fees for the DRM are nominal at R60 for PsySSA members and R10 for PsySSA student members.

The broader PsySSA community received some of this information via the regular DRM contributions to *PsyTalk*. To promote the sharing of opportunities, the division also took to social media this year creating pages on Facebook (https://www.facebook.com/groups/psyssadrm) and Linked In (http://www.linkedin.com/groups/Psychological-Society-South-Africa-Division-7436796?trk=my_groups-b-grp-v) which were regularly updated by exec member Ms. Sherianne Kramer. The pages are frequently accessed and have received positive feedback. Exec member, Mr Angelo Fynn also distributed the information on various student networks. The PsySSA DRM page also went live this year (http://www.psyssa.com/divisions/drm.asp). There, we provide links to relevant HPCSA documentation, internship sites, university programmes and much more on this forum.

The DRM is currently working on receiving abstracts to put together South Africa's first open access psychology textbook – an idea initiated by Mr. Fynn. The aim of the book is to provide students, academics and practitioners with free access to quality online chapters dealing with various issues in psychology. If you would like to contribute a chapter to this online resource, please e-mail your title and abstract (max 300 words) to Angelo Fynn (fynna@unisa.ac.za), Sherianne Kramer (sheriannekramer@gmail.com) or Sumaya Laher (Sumaya.laher@wits.ac.za).

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local conferences to diarise.....

Division of Research & Methodology (**DRM**)

Divisional Focus

Local conferences to diarise:

International Education Association of South Africa (IEASA) – 20-23 August, Johannesburg (http://www.ieasa.studysa.org/)
World Congress for Psychotherapy – 25-29 August, Durban (www.wcp2014.com)

Annual PsySSA Congress – 16-19 September, Durban (www.psyssa.com)
Assessing the role of Political Psychology in South Africa – 7-9 December, Cape Town (politicalpsychologysa2014@gmail.com)

Interesting websites to visit:
www.researchgate.net
www.methodspace.com

The DRM hopes to have another productive year in 2015 and hopes to meet all members at the DRM AGM which will be taking place on Thursday, 18 September at 17:30. Members at the 2013 AGM were instrumental in setting the agenda for the Divisions activities this year.

Let's do it again for 2015!

Sumaya Laher
PsySSA Chair: Division of Research and Methodology

The Division for Psychology Professionals in Public Service (**DPPPS**)

Divisional Focus


Mr. Tebogo Fafudi

The division is proud to announce its nomination for Prof Anthony Pillay for Award in Public Service, the prize is awarded to an individual who has developed, refined, and implemented practices, procedures and methods that had or have an impact on both people in public service settings and the profession of psychology.

Prof. Anthony Pillay is currently an Associate Professor & Principal Clinical Psychologist at Nelson R Mandela School of Medicine, UKZN & Midlands Hospital. He has a long career in public service and supervised and mentored psychologists in all levels of psychology training. Prof. Pillay is widely regarded as the leading national and international researcher, scholar and thinker in mental health. His contributions to this field are pioneering. He has fully embraced our motto 'Serving our public with dignity, loyalty and pride' and it is for that reason that we feel that he deserves this award.

The celebratory 20th anniversary of the PsySSA Congress, coinciding with South Africa's 20 years of democracy, promises to be a landmark event in our 2014 calendar. The DPPPS has embraced this opportunity by marking the birth of the division by having a dedicated stream for paper and poster presentations. This stream aims to attract a large audience and thus this would be an enormous opportunity to make our voices heard. The DPPPS Exco hopes that Psychology Professionals in Public Service make use of this opportunity to present at the 2014 PsySSA Congress and future congresses on the challenges, weaknesses and strengths of their work in Public Service.

The DPPPS will also host a round table discussion at the 2014 congress. Our esteemed panel of presenters will include Prof. Anthony Pillay, Dr Emmanuel Tlou, Prof. Freeman and Dr Thirusha Naidu, who will be discussing *Career Development as a Psychologist in the Public Service* and Mr. Tebogo Fafudi will be the facilitator.

DPPPS – 20th PsySSA Congress Activities

Activity	Date	Venue	Time	Chair
Roundtable	18 Sept 2014	7	11h30-12h30	Daniels B
AGM	19 Sept 2014	5	10h15-11h30	Fafudi, BTA

The DPPPS Exco invites all Psychology Professionals in Public Service to join our Division and to share their views and experiences. To register, go to the PsySSA website www.psyssa.com. The DPPPS has also made provision for seven categories of membership, in accordance with the provisions of PsySSA (Article 5). Registration for full membership is R100.00 and Students - R50.00. For more information regarding the division, email the chairperson at fafudit@yahoo.com or 072 507 8269 As public servants, let's make our voices heard because together we can make a difference.

Mr. Brian Tebogo Fafudi
(Chairperson)

Standing Committee: Equity & transformation


Bradley Daniels

Change is a constant

Like the seasons, change is a constant. Psychology as a profession has not been renowned as being open to change. All one needs to look at in a room filled with psychologists is the rigid ways in which we sometimes cling onto our own frames of comfort in front of our peers, never mind our clients.

However, as PsySSA Executives, we have been talking about heralding in an era of transformation for our profession. This year's annual PsySSA conference to be held in September in sunny Durban announces itself as a "Time of celebration and critical reflection."

The timing is ideal as South Africa celebrates twenty full years of transformation into democracy. There have been major shifts in our political and social landscape since 1994. However, as psychologists have we been keeping up with these changes so as to remain relevant in these modern times?

In attending a continuing professional development (CPD) course on unleashing children's inner magic, I realised how few of us are willing to make adjustments to be relevant to the practice of psychotherapy. Children, and modern adults by implication and coercion, are more creative, connected and conscious in this era than ever before with the advent of empowering social media tools such as Facebook and twitter amongst others. Do we continue to stop them from accessing these tools as therapists or do we get on board and use it safely and intelligently to enhance our communication with our clients?

Whether we embrace the change, or cower away from it: it is a definite in all our lives.

It is with enthusiasm that I look forward to walking the halls at this years PsySSA conference. I look forward to critically engaging the presentations in the critical reflections plenary which tackles topics such as *Rethinking family therapy in African context* and *The Space between white and black psychology in transforming a profession* There is also a lively debate lined up on psychology's role in shaping our young democracy.

As psychologists we are often also not earmarked as being the fun crowd, but I challenge each delegate to attend the conference and join the celebration of fun in the play city of Durban. I look forward to engaging and celebrating you further.

South African Journal of Psychology (**SAJP**)

The third issue of the *South African Journal of Psychology* (*SAJP*) of 2014 is a Special Issue that commemorates twenty years of democracy in South Africa as well as the formation of the Psychological Society of South Africa (PsySSA). The Guest Editor, Saths Cooper has put together an interesting collection of articles that includes reviews of psychology and its development in the country over the apartheid and post-apartheid periods. In addition, Psychology's responsiveness to social justice issues, and the challenges of transformation are addressed. The special issue also carries an incisive interview with the International Union of Psychological Science (IUPsyS) President, Saths Cooper conducted by *SAJP* Associate Editor, Brendon Barnes. The interview takes a look at the role of psychologists and the use of psychological methods in the apartheid era prison and policing systems that served to support the regime. The interview also looks at psychology in the international arena, and South Africa's contribution to international developments.

The special issue coincides with the 20th annual PsySSA congress taking place in Durban during September. In this context, the *SAJP* publisher SAGE, together with PsySSA will be sponsoring a Psychology Handbook as well as copies of the *SAJP* special issue to a few 'lucky draw' delegates.

Readers are also advised of the cutting-edge *State of the Science* features from forthcoming issues that are immediately available through SAGE's *OnlineFirst* feature on the Journal's webpage http://sap.sagepub.com/content/current. The *SAJP* is proud to publish a two-part series from the renowned Yale University academic and researcher, Alan Kazdin. The series titled *Evidence-based psychotherapies* is certain to be of interest, and advances newer ways of thinking on this issue. In addition, there is a stimulating account by Gregory Fricchione of Harvard University, titled *The science of mind body medicine and the public health challenges of today*. Fricchione provides the reader with the latest research developments and examines their value in illness prevention and broader public health programmes.

Professor Anthony Pillay
Editor-in-Chief: South African Journal of Psychology

South African Journal of PSYCHOLOGY PsySSA

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