Psychiatry in the 'New South Africa'

DEAR SIRS

Dr Kaliski's article on Psychiatry in the 'New South Africa' is to be welcomed (*Psychiatric Bulletin*, June 1992, **16**, 343–345). He alludes to the crux of the problem when noting that more than half of the 200 registered South African psychiatrists are "lucratively" engaged in private practice.

This situation has arisen from the neglect of the Society of Psychiatrists of South Africa (SPSA) to discourage newly graduated psychiatrists from commencing private practice immediately after qualifying. The failure of the SPSA to promote transcultural issues and community orientated services is understandable since more than 50% of their members are engaged solely in private practice.

A good beginning for psychiatry in the 'New South Africa" would be the dissolution of the SPSA and the formation of a new representative body – possibly under the auspices of the National Medical and Dental Association. One of the new organisation's first tasks should be a thorough review of the psychiatric training scheme. Transcultural psychiatry should form the cornerstone of the academic syllabus and trainees be encouraged to enter a period of higher training in the wider community *before* registration as specialists.

On a recent visit to South Africa I was disheartened to see many of my recently qualified peers in private practice in various shopping malls in Johannesburg and Sandton. If they continue to ignore the demands of the 'New South Africa', their colleagues around the world will be justified in continuing to ignore them.

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Psychotherapeutic models of the skiing experience

DEAR SIRS

Psychotherapy has many models to describe similar experiences.

Psychoanalytical theory has been applied to the description of the allure of downhill skiing. Balint (1987), in describing the thrill of amusement rides, states that it is the mixture of "fear, pleasure and confident hope in the face of external danger" that is the fundamental basis; that the thrill is greater the "further we dare get away from safety – in distance, speed or exposure".

I wish to report the use of techniques (mainly cognitive and group) by a trainee psychotherapist in the role of a group ski instructor.

1. *Cognitive therapy – anxiety management* techniques were used to identify the muscular tensions resulting from fear of the slope and how they prevented the students adopting a posture which enabled them to control their skis. The use of large muscle group relaxation to diminish anxiety enabled the body position to become more 'natural', to achieve better ski control. Symptom reattribution techniques were used to help the group feel the symptoms of fear as excitement and exhilaration. Modelling, of the instructor and other students, was used to show the correct posture and to demonstrate the enjoyment achieved by feeling the exhilaration. Assertiveness training was used for more timid members, encouraging them to demonstrate aggression and thereby achieve control over the slope by being more active. In the assertiveness work, issues frequently encountered in women's group work arose – allowing themselves to become frustrated inside because of being passive in situations where it was non-beneficial to be so. Behavioural testing of new techniques was a prominent part of the sessions.
2. *Group therapy* – several therapeutic factors of group therapy were evoked (Yalom, 1985). The promotion of group cohesiveness in encouraging trust among members, by self disclosure of fear and "trust" skiing exercises. The universality of experiences of skiing was identified and the instillation of hope in the less proficient members was achieved by encouragement from the "therapist" and testament from other members. Similar group processes are apparent in the all-important phenomenon of *aprés-ski*.

Perhaps the allure of alpine skiing may also be defined in terms of cognitive symptom mastery and a positive group experience.

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The training of psychiatrists for the developing world

DEAR SIRS

We read with great interest the article 'The Training of Psychiatrists for the Developing World' (*Psychiatric Bulletin*, June 1992, **16**, 352–354). We agree with the suggestions made by the authors regarding the training needs (training methods

and patterns, administration, health economics, psychotherapy and research) and the difficulties encountered by graduates from overseas.

To achieve the objectives mentioned, and to improve training, there is a dire need for sponsored training schemes, e.g. Overseas Doctors Training Scheme etc, to have clear and well-defined goals over a defined period, preferably four to five years. These objectives should be of common interest to all overseas trainees and the training be governed by a central committee that monitors its activity (For example, the Royal College of Psychiatrists).

The initial part of the training should be streamlined with the UK postgraduates to obtain the relevant clinical experience necessary to take the Membership of the Royal College of Psychiatrists which of course is not mandatory, though advantageous. After obtaining the MRCPsych and/or after a defined period of time, the trainees should be sent to specified centres (regional basis) in the UK where special training relevant to the developing world can be imparted, ideally for 12 months, along with clinical attachments/training in sub-specialities. The trainees will then be fully equipped in the necessary skills and clinical acumen to bring about useful changes on their return home.

This could be construed as a pilot phase of a 'devolved system' as suggested by the authors. Moreover, these specified centres could over time obtain the necessary experience to have a better understanding of the changing needs and training requirements relevant to the developing world. Only when this system in its pilot phase has been successfully established should trainees be allowed to be incorporated directly into the special training phase of the suggested system.

Such a clearly defined route would make overseas trainees feel more secure and less disillusioned. Once the trainees have completed their training they should be kept in constant touch after return to their home countries to have an appraisal of the relevance of their training, changing needs and its implications for future requirements. This on-going monitoring would help form a syllabus to enrich the future of this potentially useful and novel undertaking.

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Music therapy

DEAR SIRS

We agree with Ms Bright (*Psychiatric Bulletin*, July 1992, **16**, 452–453), that it is a matter of regret that a professional music therapist was not available for our patients. It is our impression that music therapy is seen as an optional extra or as an unknown and unproven entity. We welcome this opportunity to advertise the value of music therapy.

The aim of our article was to encourage other psychiatric care-givers to explore the possibilities of this type of therapy when they "have no music therapist to call on". The training of occupational therapists includes training in the use of music as a therapeutic activity.

Ms Bright takes issue with several points but we affirm that our differences are probably of definition or emphasis.

(a) *Our comment that music therapy is non-analytical.* Where analytic principles are used in music therapy, this is a combination of two types of therapy. Psychoanalysis and its derivatives did not arise out of music therapy and music therapy is not necessary for psychodynamic therapy. Conversely, music therapy can be conducted without recourse to analytic principles.

(b) *Our comment that music therapy is non-verbal.* Our type of music therapy (particularly with the very regressed patients) is non-verbal. We combined verbalisation with music for then more socialised patients, as our article shows, but not counselling with music therapy, thinking this not feasible with our patients.

(c) *Our comment that a major key sounds happy and a minor key sad.* We stated that the connection between key and mood "seems" to be "instinctive". The statement is tentative. We stated that "with varying combinations of key, rhythm, pitch, volume and quality of sound, and especially where the composer uses contrasting variations, many ideas and feelings may be expressed and evoked". In 'Danny Boy' the words, the slow rhythm, the muted sound and the modulations into minor key over-ride the major key in which the piece is written to produce a sad effect. In 'God rest ye merry gentlemen' the words and season in which it is sung, the fast rhythm and the occasional modulation into major key produce a happy effect, despite being in a minor key. Perhaps it would have been less ambiguous if we had written "chord" instead of "key".

By starting music therapy for patients we hope to encourage the employment of trained music therapists and we thank Ms Bright for her support.

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Reference

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