The Treatment of Anxiety Disorders. Clinical Guides and Patient Manuals


This is a handbook on the treatment of anxiety disorders that is intended for both clinicians and patients. It contains a step-by-step account of the process and problems involved in conducting cognitive-behavioural therapy in patients with anxiety disorders. Although the authors admit in their concluding chapter that the book is fairly conventional in part, it must be emphasised that this book really provides a unique and informative combination of ‘clinician guides’ and ‘patient treatment manuals’ for clinicians who treat anxious patients.

The clinician guides are concise, up-to-date reviews on non-drug treatments for each of the anxiety disorders: panic disorder and agoraphobia, social phobia, specific phobias, obsessive-compulsive disorder, generalised anxiety disorder, and post-traumatic stress disorder.

The patient treatment manuals, designed as workbooks, correspond to each of the disorders and are primarily intended for use by patients. These manuals provide a valuable forum for clinicians to work alongside patients in explaining, supervising, and supporting the treatment process. Further, the manuals are written in a format that encourages patients to continue with their own cognitive-behavioural therapy after treatment with the clinician has been terminated. Patients can proceed by using the manual and the knowledge and techniques provided by the clinician during therapy sessions. The section on post-traumatic stress disorder (which did not feature in the first edition of the book) is timely and makes a valuable contribution to the field. In addition to benefitting adults, the self-help manual can arguably also be used by adolescents with post-traumatic stress disorder.

This book goes a long way towards increasing awareness of both the art and science of conducting cognitive-behavioural therapy in clinical settings. It is a state-of-the-art, well-written and easy-to-read text for psychiatrists, clinical psychologists and pharmacologists who do not view cognitive-behavioural therapy as a first-line treatment for anxiety, will likely find this a handy resource.

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Alan George Blyth

Alan George Blyth of Ladismith, Cape, passed away on 20 August 2003 at the age of 93. He led a full life in which the principled practice of medicine was of prime importance.

Born on 10 May 1910 in Heidelberg, he and his family moved to the family home in Ladismith, where his grandfather had settled from Germany in 1860, following the death of his father in 1912.

After matriculating from the Ladismith High School in 1926, he entered the University of Cape Town Medical School. After a year in College House he became a founder member of the men’s residence (Smuts Hall). As a student he served on Men’s Residence House Committee, the Medical Students’ and Students’ Representative Councils. He represented Western Province at hockey and played good cricket. He remained proud of and loyal to his school, his university and his teachers over the years.

Qualifying in 1932, he was Houseman to Professors Saint and Falconer at Somerset Hospital. After a period at Grey’s Hospital in Pietermaritzburg, Dr Dirk Hoffman, who had greatly influenced his choice of career, persuaded him to join him in association in Ladismith for 5 years. A lifetime later he retired from general practice in 1985.

The early years were complicated by a lack of appropriate medicines, poor roads — trips by cart or horseback — and the need to deal with emergencies singly as they arose. He gained a deeper understanding and insight into his patients and their families with lasting bonds being formed. The development of children he had delivered was keenly watched. He believed in listening to his patients, firmly convinced that they would most times give him the diagnosis, and he wrote, ‘nothing in our art can take the place of the untrained and unaided senses’. He always recognised old patients who called to see him when they passed through Ladismith in later years.

A unique and durable partnership arose with the arrival of Dr CFA Garisch in 1941 and Dr JDJ Uys in 1953 (their combined years together numbered around 120). Both were men of integrity, each with special qualities allowing for a well-rounded practice. When Dr Garisch left to practise in Stilbaai in 1979, Dr C Paauw joined them and he is now senior partner in the ongoing practice. The friendships and camaraderie endured to the end.

The Ladismith Cottage Hospital, where he was the Superintendent from 1940 to 1993, was named after him on his retirement. It played a key role in his life as it enabled him to perform the surgery and obstetrics he loved with the assistance of his partners and the ever-loyal staff. Expansion and improvements in the hospital (after many a battle) in the later...
years were cause for great satisfaction. The care he received there terminally was special.

He served as Branch President of the then MASA in 1956, receiving a Meritorious Service Award and Honorary Life Membership. He was elected Provost of the Cape of Good Hope Faculty of the College of General Practitioners, was an Associate Founder of the Colleges of Medicine of South Africa and a long-standing member of the Royal College of General Practitioners in London. He was a town councillor and held the positions of District Surgeon (his thoroughness in medico-legal matters earned him commendations in the High Court), Honorary MOH and Railway Medical Officer, some for close on 50 years. He revived cricket and golf in Ladismith, represented South Western Districts at cricket, and was active in other sports, particularly bowls.

He believed general practice was the bedrock of medicine — he made a plea for a Chair of General Practice at UCT in 1950 and that time spent in general practice prior to specialisation would give a better understanding of the human element and reinforce the view that medicine was as much an art as it was a science. He was thrilled to lecture to final-year students on general practice.

His passing, and he was the last of the 3 of the original practice, also marks the passing of one of the last clinicians to have experienced the pre-antibiotic era, and a form of general practice now gone. His lasting Christian faith played an important role in his approach to medicine.

Blessed in marriage, he married Enid Featherstone in 1935 and they had 2 sons. She died in 1968. Later he married Catherine Murray who died in 2001. One of his sons and 2 of his grandchildren followed him into the medical profession.

David F Blyth, Robert G Blyth, C Paauw


Renée Bernstein

Renée Bernstein died, aged 76 years, in Irvine, California on 3 June 2003.

She was born on 24 October 1926 in Antwerp, Belgium, to parents who hailed from Kiev and Latvia. When Renée was a young child, the family moved to Johannesburg and Renée was educated at Johannesburg Girls’ High School and at the University of the Witwatersrand (BSc in Physiology and Biochemistry in 1947; and MB BCh in 1951). She did house jobs in the UK (where her husband, Basil de Saxe, trained as a general surgeon during their time there). From 1954 to 1968, Renée was in general practice in Johannesburg, spending much of her time working as a medical officer (sometimes in an honorary capacity) in the health centre and university clinic in the large Alexandra township on the outskirts of Johannesburg, caring for the disadvantaged community.

In June 1968, when she felt that her children were sufficiently grown up to allow her to take up a more academic research career, she began working in the cytogenetics unit at the South African Institute for Medical Research (SAIMR) in Johannesburg, recently established by Dr Sarah Klempman and Dr Eugene Wilton. From March 1973 she worked for 3 years in the Department of Haematology at the SAIMR, under the dynamic leadership of Professor Jack Metz, immersing herself in the care of patients with lymphoproliferative disorders and mastering the laboratory aspects of the investigation of these patients.

When the SAIMR and Wits University established the Department of Human Genetics in the School of Pathology in 1975, Renée was appointed to head the cytogenetics laboratory within that department. Over the following 13 years she built up a laboratory which had an enviable international reputation in many aspects of cytogenetics and clinical genetics. In 1982 she was made Associate Professor at Wits University for her contributions in various fields to the School of Pathology at the SAIMR and, in 1984, she became a Fellow of the Royal College of Pathologists, London.

Renée trained dozens of technologists in the field of cytogenetics and a number of scientists and medical doctors completed MSc and PhD degrees under her supervision.

But it was in the field of the identification of the chromosomal aberrations underlying the haematological malignancies that her reputation became established on the world stage. She was for many years a valued member of an elite international panel of experts in this specialised field of research.

In 1988, at the age of 62 years, Renée and Basil moved to Irvine, California where two of their children and their families were living. The thought of retirement was not attractive to Renée, however, and she soon had a number of job offers, accepting that of Professor and Director of the Cytogenetics Laboratory in the University of California at Irvine Division of Human Genetics. She successfully sat the examinations of the American Board of Medical Genetics, becoming board certified in both cytogenetics and clinical genetics.

Renée Bernstein was one of the founders of human genetics in South Africa. She was a superb teacher, lecturer and researcher whose career in the discipline extended from 1968 to 1988 in South Africa and continued for another 15 years in the USA.
I was associated with Renée for 20 years at the SAIMR and she gave me unstinting support in establishing a new department of human genetics. We all learned a great deal from Renée, including what is meant by sustained hard work. Her productivity was amazing and her zest for life was infectious. She has been a precious role model to many. Her colleagues and friends in South Africa and throughout the world will miss her very much.

She is survived by her husband, Basil de Saxe, daughters Margot and Alvyn and son, Brian, and their families, to all of whom we extend our deepest sympathy and thanks for sharing this remarkable woman with so many of us, her colleagues, and countless numbers of patients who benefited from her dedicated counselling and laboratory expertise.

Trefor Jenkins

Books Received
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Less frequent Pap smears for low-risk women?

The United States Preventive Services Task Force (PSTF) has recently recommended that annual screening for cancer of the cervix be replaced by screening every 3 years in low-risk women. The reason cited for this change is the lack of direct evidence that annual screening leads to better outcomes. The American Cancer Society concurs with this view and has recommended the same interval in women over the age of 30 years who have had three consecutive negative cytological tests. However, many clinicians continue to resist these recommendations possibly due to the perception that there would be an unacceptably high excess risk of cervical cancer.

Recently, attention has been paid to the addition to the cervical cytology test (Papanicolau test — ‘Pap’ smear), of more sensitive tests, such as detection of oncogenic human papillomavirus (HPV) DNA. The combined test has been recommended by the American Cancer Society as a ‘reasonable’alternative to cytological testing alone with the explicit recommendation that the test not be performed more frequently than every 3 years.

To determine the excess risk of neoplasia, groups of researchers in the USA led by George F Sawaya of the University of California, San Francisco, studied the records of over 31 000 women aged 30 - 64 who had had three or more consecutive negative tests. They found that the excess risk of cervical cancer was approximately 3 in 100 000 (N Engl J Med 2003; 349: 1501-1509), which is roughly equal to the risk of breast cancer among men 45 - 64 years of age. This low risk may be lowered even further with improvements in the sensitivity of the Pap smear with new technologies, by the addition of the HPV DNA test, and with adherence to new guidelines for the interpretation and appropriate follow-up of abnormal Pap tests.

One of the limitations of the study is the determination of which patients are at low risk and which at high risk. The American Cancer Society includes factors such as age, screening history, type of Papanicolaou test, and history of immunosuppression.

In the same issue of the New England Journal of Medicine, Sarah Feldman of the Brigham and Women’s Hospital in Boston, USA, writes that cost-benefit analyses of cervical cancer screening have suggested that lifelong annual screening may not result in substantially better outcomes than less frequent screening, and is much more costly (2003; 349: 1495-1496).