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HELLENIC (UK) PSYCHIATRIC BULLETIN

Editors

Maria Filippidou, MB BS, MSc, MRCPsych
*Consultant GA and liaison psychiatrist, Luton & Dunstable
University Hospital, East London NHS Foundation Trust*
email: maria.filippidou@nhs.net

Anastasios Dimopoulos, MB BS, PgC
*Consultant in General Adult Psychiatry, Brent South CMHT,
Central and North West London NHS Foundation Trust*
email: Anastasios.Dimopoulos@nhs.net

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The Hellenic Psychiatric Association (HPA) was founded in 1986 in Athens. HPA's mission is to promote the discipline of Psychiatry in Greece, to open lines of communication and encourage collaboration not only within psychiatry, but also with other medical, or psychiatry-related specialties. Among HPA's scopes is to promote and enhance excellence in psychiatric clinical practice in Greece, to assist in the prevention of mental illness, to protect the rights of the mentally ill and to promote education and research.

HPA Contact details: 11 Papdiamantopoulou St. 115 28 Athens Greece Tel.: (301) 7291389, Fax: (301) 7242032 E-mail: psych@psych.gr HPA website: <http://www.psych.gr> (information from http://www.wpanet.org/detail.php?section_id=5&content_id=228)

Please think of the environment before you print this issue.



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Editor's note

Maria Filippidou, *Editor, Hellenic (UK) Psychiatric Bulletin*

Dear friends and colleagues,

The past year has been a challenging one for our Newsletter. In its 8th year of publication, we are faced with a dilemma regarding its future for reasons that are also to do with the future of the HPA- UK Division. This is something that all Greek mental health professionals living and working in the UK, have to give some thought to, if we wish to see this group flourish. I personally hope for some expression of interest from enthusiastic colleagues who would like to get involved and more specifically take ownership of our newsletter. I feel that after nearly five years, my time as its editor has completed its course and this publication should move forward with new ideas. I am very grateful to Anastasios Dimopoulos who took on this role during my absence over the past 18 months as well as to Professor Palazidou for her continuous support.

Coming to the content of the current issue, we start with HPA-UK's Chair's message, which is of particular importance. We are very proud to host an article by a Greek consultant colleague and researcher, Dr Arnaoutoglou who gives us an overview of DLB and the latest research on the condition. Dr Dimopoulos has written a summary of his dissertation submitted for his postgraduate Master's degree in Philosophy in Mental Health; a very interesting read related to psychiatric training. Lastly, Professor Bouras has written an obituary of the life and work of Professor Sakellaropoulos, a major figure in the Greek psychiatric scene, who sadly passed away in November last year.



I hope you enjoy the issue and please do get back to us with comments or ideas about articles that you would like to read in the future.

CHAIR'S Message



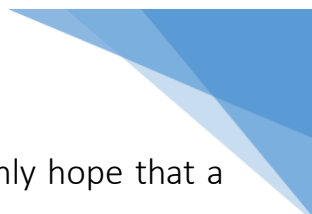
Professor Eleni Palazidou, *Chair, Hellenic Psychiatric Association, UK Division*

Dear all,

I'd like to start by extending my gratitude to Maria Filippidou, who despite her very busy schedule, has continued to take responsibility for editing yet another issue of our newsletter. A big thank you should also go to Anastasios Dimopoulos for his valuable support, as well as all those who have contributed articles to this issue.

The year 2018 is finally over but much of its turmoil has spilled over to 2019. Brexit has divided people in the UK like never before and there is no universally acceptable solution in the horizon, while the Article 50 clock is ticking. Unfortunately, Brexit, in some of its proposed forms, can





potentially affect the prospects of the newly arrived Greek doctors. We can only hope that a constructive solution is reached in the near future.

You may have heard of the “Nostos” programme – a tripartite collaboration between Greece, Cyprus and Egypt, which aims at engaging the diaspora doctors with their respective countries. Time will show how this will work out in the long run, but it may be of interest to some of you and indeed it should be to all of us as a diaspora psychiatric association.

The Hellenic Psychiatric Association (UK) has found itself in a Brexit-like tangle in terms of our relationship to the HPA (Greece). We have not been able to organize any events in 2018 because of lack of funds. The current financial status of academic and hospital institutions and other centres in the UK, impose a fee for the use of any venues and equipment. In order to survive we need to generate some income to cover such expenses. Long discussions within the Council have reached no clear consensus on the way forward and we need to bring the matter to our mailing list for a clear mandate. We shall be writing to you shortly with more information and a number of questions.

On behalf of the Council I wish you all a very happy, healthy and successful New Year in both your professional and personal life. I also hope and wish that the year 2019 will be a turning point for the HPA-UK, with growth and success in the horizon.



Philosophy of psychiatry and its potential role in higher medical education in mental health



Dr Anastasios Dimopoulos, *Consultant in General Adult Psychiatry, Central and North West London NHS Foundation Trust*

The present article is a brief synopsis of a dissertation submitted for a Master's degree in Philosophy of Mental Health. Its aim is to advance a preliminary proposal for integrating certain philosophical ideas in the higher medical education in mental health. The need for such a proposal is related to the acknowledgement that mental health practice is characterized by an increased complexity and uncertainty, something recognized by the Royal College of Psychiatry and its forthcoming curriculum redesign. Medical education has embraced fully in recent decades the positivist tradition characterized by its reliance on the scientific method and evidence-based practice. The position advanced is that an exclusive reliance of medical education on these principles isn't enough to address complexity and uncertainty in the real world of everyday mental health practice.




Past and Present

The relationship between philosophy and psychiatry has been long standing but not always as close as it was in the beginning of the 20th century. The reasons for such marginalization reflected a cultural trend that had a sweeping effect in most aspects of social life in the western societies. The German sociologist Georg Simmel was a remarkably astute observer of the organizing principles of mental life in modernity, offering a dispassionate, almost prophetic account of what kind of forces underlie the creation of identities, both individual and collective as well as those permeating institutions. In his seminal paper of 1903 “*Metropolis and mental life*” he noted that

“the modern mind has become more and more a calculating one. The calculating exactness of practical life which has resulted from a money economy corresponds to the ideal of natural science, namely that of transforming the world into an arithmetical problem and of fixing everyone of its parts in a mathematical formula. It has been money economy, which has thus filled the daily life of so many people with weighing, calculating, enumerating and the reduction of qualitative values to quantitative terms” (Simmel 1972; 327).

Around the same time, Abraham Flexner gave his recommendations about how medical education should be delivered. The 1910 “Flexner report” has been a pivotal document for modern medical education in the west. At the core of Flexner’s view was the notion that formal analytic reasoning, the kind of thinking integral to the natural sciences, should be the pinnacle of the intellectual training of physicians (Cooke et al 2006). In Flexner’s era, skilful clinical investigation, treatment and research were strongly correlated and the purpose of a medical education program would ideally be to create clinicians that would embody all three dispositions. Flexner was of the idea that the primacy belonged to skilful clinical investigation that would subsequently inform research questions and would be propagated through teaching. His motto was “*think much-publish little*” (Cooke et al 2006). The advances of science and their promise for objective findings, such as laboratory testing, had a direct effect on how






to pursue knowledge that something is the case. Within 15 years after issuing his report Flexner expressed his disappointment with regards to the course of events that followed, observing how scientism dominated medical education to the extent that it excluded the social and humanistic aspects. He wrote in 1925, “*scientific medicine in America — young, vigorous and positivistic — is today sadly deficient in cultural and philosophic background*” (Cook et al 2006).

In the same period of the 20th century, philosophical debates were engaging with Kantian metaphysics on how we acquire knowledge that something is the case. These debates led to a split between what we now call analytic and continental philosophy. The Second World War has damaged further the common ties of this tradition with the immigration of eminent philosophers to the USA. Rudolf Carnap and his assistant Karl Hempel have been central to modern psychiatry. Karl Hempel was arguably the philosophical mind behind the modern taxonomic systems that followed a categorical approach reflecting science’s ambition to carve nature at its joints. The second part of the 20th century brought the gradual marginalization of psychoanalytic theory as the main explanatory framework for psychopathology and an increased reliance on biological psychiatry and the scientific method dominated the scene. This transition, along with objections advanced on the value of psychiatry as a scientific discipline, created a fertile ground for a return in philosophical reflection within mental health.

Analytical philosophers have in recent years turned their interest to the use of concepts by disciplines such as psychiatry and developed a fruitful debate on them. Moving away from the psychoanalytic jargon, an explanatory and conceptual gap has become increasingly manifest. The language of medicine and especially that of psychiatry is an evolution of natural languages with the admixture of technical terms (Sadegh-Zadeh 2015). A typical example is the controversy around the demarcation criteria between grief and depression instigated by the publication of DSM V¹. After 30 year of scientific research it is more difficult to speak about

¹ Allen Frances chair of the committee for DSM III and IV has been very critical of the medicalization of grief in DSM V in a series of articles in the press such as Huffington Post or Psychology Today. At the same time, David Kupfer, the head of the DSM V committee acknowledged *that neuroscience and biology failed to give*






these natural terms in propositional statements, compared to other specialties that offer precise anatomopathological and physiological alterations, in a way that would be assertive of *knowledge that something is the case* (Sadegh-Zadeh 2015). It has increasingly become common ground that vagueness is an essential feature when analysing concepts used in mental health, something that Allen Frances chair of the committee in DSM III and IV recognized (Frances et al 2012). The concept of vagueness is more and more discussed in disciplines such as mental health underlying the complexity of the debates around it. Vagueness is a phenomenon that emerges in the effort for conceptual clarification and provision of demarcation criteria when faced with particular problems². As a semantic property of linguistic extensions, vague terms challenge bivalence in Aristotelian logic that a statement is either true or false. They draw no sharp boundary between their extension and their anti-extension, admitting in this way the existence of borderline cases (Keil et al 2017).

Continental philosophy and especially phenomenology have witnessed their own renaissance and provided important contributions in understanding the formation of psychopathological experiences and the subjective feelings of people suffering from a mental disorder. In recent years there has been an increasing dialogue between analytic philosophers and phenomenologists. The importance of phenomenology lies in its foundational premise that consciousness has always an object, is intentional and this characteristic of it is called intentionality. The positing of the intentionality of consciousness negates the subject/object dichotomy and paves the way for an understanding of truth as fundamentally intersubjective. This is particularly important in modern times where transdisciplinarity is the expected organizational principle of mental health services that are delivered mainly in the community.

us a level of sensitivity and specificity that we would be able to introduce into the diagnostic manual” (Cuthbert 2014; 28).

² The sorites paradox can be traced back to the ancient philosopher Euboulides of Miletus, who used the examples ‘heap’ (Greek *sōros*) and ‘bald man’ to show how by using incremental arguments you can have impeccable premises that lead to absurd conclusions (Keil et al 2017)





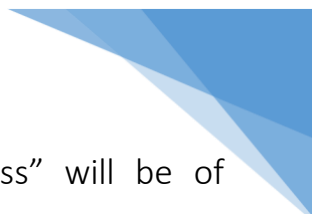
The King's Fund report on the 5-year forward view is clear about the direction that needs to be followed and furthermore emphasizes the need for prevention that, if successful, will reduce the expected demand on mental health services in the future.

The future

Psychiatry as a practical discipline still needs metaphysics (Zachar 2014), but it has been increasingly evident that, unless it constricts dramatically its field of enquiry, it will be unable to operate using a top down-approach, where theory will dictate practice (Thornton 2017). The everyday language of mental health practice is imbued nowadays with linguistic expressions, which are remotely related to the language of psychiatry but serve mainly the operational purposes of various institutions and stakeholders involved in the provision of mental health care. In such a fast-paced system that tries to accommodate increasing demands with fewer resources available (ironically the language of resource is nowadays the dominant one in mental health settings), one of the victims is the trainee psychiatrist. Trainees are induced to a logic that isn't often explicated in its foundations, contributing to a formation that embodies interests that evade the scope of psychiatric discipline as a scientific one. The schism experienced between training as delivered in academic institutes and the complex reality of clinical practice can become even bigger if the trainee attempts to protect his/her professional identity by adopting a disproportionate scientism as a defence mechanism that will alienate him/her further.

Psychiatric trainees will be invited to provide leadership in a transdisciplinary environment. Davis and Sumara define transdisciplinarity as the research attitude, in which it is understood that the members of a research team arrive with different disciplinary backgrounds and often different research agendas yet are sufficiently informed about one another's perspectives and motivations to be able to work together as a collective (Davis & Sumara 2006; 3). This widespread relationality is the intrinsic fabric of complexity. The acquaintance of






trainees with the philosophical concepts of “intentionality” and “vagueness” will be of assistance in engaging in the delivery of mental health services in the community. The educational medium where these concepts can acquire the role of an invisible fulcrum for engagement and reflective practice is Problem Based Learning. One of its pioneers, Howard Barrows suggested that learning should take place in the context of the precise environment where the learner will operate after graduation. The rationale is that learners should encounter problems as they appear in the real world, thus triggering free enquiry on their behalf. Group learning is central, insofar as it provides feedback from different disciplines (doctors, nurses, social workers, managers etc) and it is expected to provide an in-depth assessment of problems.

By design PBL offers the opportunity to address practical issues in a way that will account of deeper layers of complexity. The philosophical concepts of vagueness and intentionality in conjunction with intersubjectivity can be of assistance in this direction. The potential gains can be manifold helping the practitioner, both as an individual and as a member of a multispecialty team. Reflective practice, team and individual resilience, ability to communicate, coordinated care based on local needs can be only some of further areas of research on the effectiveness of PBL. Furthermore, PBL creates ecology of learning and practice by bringing different perspectives in the field of enquiry. Future challenges or opportunities are recognizable and may be dealt within the PBL framework. In a world where changes occur rapidly, this line of action can lead to a workforce that is creative and able to find sustainable ways to address demands on the mental health services.

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Feature article

Dementia with Lewy Bodies, a Newsletter Article



Dr Nikitas Arnaoutoglou, *Consultant in old age psychiatry and visiting researcher at the Department of Psychiatry of Cambridge University.*

Introduction

Dementia with Lewy bodies (DLB) is a common clinical entity, which affects many areas of the brain. Compared to Alzheimer's disease (AD), Parkinson's Disease (PD) or Vascular Dementia (VaD) it is less known to clinicians and its complex clinical presentation could make it challenging to diagnose. In the following newsletter article, we will have a journey through the disease's history, present the current clinical criteria of DLB, describe the core clinical features and the early presentations, review the latest treatments and future research possibilities.



A. Short History

In 1912, Friedrich Heinrich Lewy found the inclusion bodies in the and seven years later Konstantin Nikolaevich Tretiakoff identified the association between them and substantia nigra. He was the one who named them Lewy bodies ("corps de Lewy") (Goedert *et al.*, 2013).



FIG. 4. In the laboratory of the neurology clinic, Munich: 1, F. Lotmar; 2, Frau Grombach; 3, St. Rosenthal; 4, Ugo Cerletti; 5, Allers(?); 6, F. Bonfiglio; 7, A. Alzheimer; 8, N. Achucarro; 9, G. Perusini; 10, F. H. Lewy.

In 1976, the first post-mortem case was described by Dr. Kenji Kosaka and sixteen years later the first consensus criteria of the Senile Dementia of Lewy Body type were defined (Kosaka *et al.*, 1976). Since then, four consensus criteria have been set, with the latest [published in 2017](#) (McKeith *et al.*, 2005; I G McKeith *et al.*, 2017).

B. Definition

Dementia or major neurocognitive disorder (DSM-5) is an umbrella term used for diseases that impact the previous level of performance of patients in one or more cognitive domains (memory, learning, language, attention, executive function, perceptual-motor or social cognition). In order to justify the diagnosis, the deficits should affect the patient's everyday

functioning or domains of daily activities (American Psychiatric, American Psychiatric and Force, 2013). Currently, 10 million new cases of dementia are being diagnosed every year (World Alzheimer Report 2015, Prince *et al.*, 2015).

The two most common types of dementia are Alzheimer's Disease (AD) and Vascular Dementia (VaD). The second most common neurodegenerative type and third overall is DLB. Like Parkinson's Disease (PD), it is characterized by intracellular inclusions mainly composed by α -synuclein (Spillantini *et al.*, 1997; Jellinger, 2017). These abnormal deposits are called Lewy Bodies (LBs) and can be found in different areas of the brain including the cortex. The key difference between the two diseases, lies in the distribution of LBs. In PD, LBs are mainly located in the basal ganglia, causing primarily motor symptoms (Braak and Del Tredici, 2017). In DLB, the abnormal deposition of LBs is more widespread and may affect the cerebral, the limbic, the hippocampus, the midbrain and substantia nigra, areas of the brain stem and olfactory pathways (Donaghy and McKeith, 2014). Depending on the brain areas involved, DLB may affect information processing, perception, thought, language, memory, motor, alertness, sleep or smell.

The prevalence of DLB in primary care practice is less than 5% and around 7% in secondary care (Vann Jones and O'Brien, 2014). Unfortunately, neuropsychological tests cannot effectively diagnose this clinical entity and around 20% of DLB patients are being misdiagnosed with other types of dementia, usually AD (Cummings *et al.*, 1994; Kemp *et al.*, 2017; Rizzo *et al.*, 2017; Sadiq *et al.*, 2017). In order to assist the DLB diagnosis, the Newcastle Research group has recently published [the Diamond Lewy - DLB toolkit](#) (Thomas *et al.*, 2017).

C. Diagnosis of DLB

In 2017, the updated [Consortium criteria of DLB were published](#). In DLB, dementia is defined as: a progressive cognitive decline of sufficient magnitude to interfere with normal social or occupational functions, or with usual daily activities (I G McKeith *et al.*, 2017).

Core clinical criteria include: 1) Visual hallucinations 2) fluctuation in concentration and attention and 3) rapid eye movement (REM) sleep behaviour disorder without atonia. The last core clinical feature is spontaneous parkinsonian motor signs, which could present later on.

Supportive biomarkers include a) reduced dopamine transporter uptake in DAT Scan, b) abnormal MIBG myocardial scintigraphy and c) polysomnographic confirmation of REM sleep without atonia (Surendranathan and O'Brien, 2018).

The diagnosis of DLB can be probable or possible, based on the number of core criteria and indicative biomarkers. A full list of supportive clinical features, indicative biomarkers and supportive biomarkers can be found in [table 1 of the Nature Neurology Reviews website](#) (Arnaoutoglou, O'Brien and Underwood, 2018). Lastly, we have to note that structural brain imaging (MRI/CT scan) may be useful in the differential diagnosis between dementias, as the median temporal lobe is relatively preserved in DLB (Barber *et al.*, 2000; Mak *et al.*, 2014).

D. Key Clinical Features

Fluctuation in consciousness

These include impulsive changes of concentration, alertness and wakefulness (Tiraboschi *et al.*, 2015). They vary on the course of the day in an unspecific pattern. During these episodes, ideas seem disorganized, unclear and even illogical. In other instances, the same patient could be alert and be able to have lucid conversations or even watch a film.

Hallucinations

Around 70 % of DLB patients experience visual hallucinations mainly in the early stages of the disease. They could be pleasant (animals, choir) but could also be of frightening content. The latter might frustrate the patient and put a burden on the carer and family.

Sleep

During sleep patients could experience nightmares or even vivid dreaming. This core characteristic was included in the 2017 consensus criteria as REM sleep disorder (Pao *et al.*, 2013). Other symptoms may include excessive daytime sleeping, insomnia and restless legs syndrome.

Motor Symptoms

Usually motor symptoms are present at a later stage of the disease, even after years. Some symptoms might be like PD and may include muscle rigidity, shuffling gait, handwriting disturbances, reduced facial expressions, difficulty in swallowing and changes in voice. If motor symptoms are misdiagnosed as PD and are treated with antiparkinsonian medication, the psychotic symptoms might increase.

Other behavioural and mood problems

The most commonly met emotional disturbance is depression which is twice more frequent in DLB as compared to AD (Yamane, Sakai and Maeda, 2011; Bronnick *et al.*, 2016). Other symptoms might include apathy, anxiety, agitation, delusions and increasing suspiciousness/paranoia.

E. Causes

The actual cause of DLB has not been found. We are aware that the presence of LBs is associated with loss of neurons producing acetylcholine and dopamine. Acetylcholine is associated with deterioration in cognition and memory, while dopamine reduction is linked to behaviour changes, sleep, motivation, hallucinations and apathy (O'Brien *et al.*, 2004; Knight *et al.*, 2018). Age is the greatest risk factor.

Genetic studies have shown that homozygosity for the $\epsilon 4$ allele of apolipoprotein E is one of the known risk factors. In some cases, there are some pathogenetic variants, such as CHMP2B, PSEN2, PARK2 and SQSTM1 (Arnaoutoglou, O'Brien and Underwood, 2018). Similar to PD, mutations in the glucocerebrosidase (GBA) gene are a risk factor and associations with APOE genotypes has also been found. Other risks factors may include inflammation processes and early microglia activation (Singleton *et al.*, 2002; Nalls *et al.*, 2013; Shiner *et al.*, 2016).

F. Early Symptoms DDX

Table 2 was created by the Lewy Body Dementia Association (LBDA) association in order to assist clinicians identify early symptoms in DLB, AD and PD.



EARLY DIFFERENTIATING SYMPTOMS

	LBD	Alzheimer's	Parkinson's
Decline in thinking abilities that interferes with everyday life	Always	Always	Possible years after diagnosis
Significant memory loss	Possible	Always	Possible years after diagnosis
Planning or problem-solving abilities	Likely	Possible	Possible
Difficulty with sense of direction or spatial relationships between objects	Likely	Possible	Possible
Language problems	Possible	Possible	Possible
Fluctuating cognitive abilities, attention or alertness	Likely	Possible	Possible
Changes in mood	Possible	Possible	Possible
Hallucinations	Possible	Unlikely	Possible
Severe sensitivity to medications used to treat hallucinations	Likely	Unlikely	Possible
Changes in walking or movement, such as slower, smaller steps, problems using hands, tremors	Possible	Unlikely	Always
Balance problems and/or falls	Possible	Unlikely	Possible
Rapid eye movement (REM) sleep behavior disorder	Possible	Unlikely	Possible

Picture downloaded from Lewy Body Dementia Association website - <https://www.lbda.org>

G. Treatment of DLB

There is no cure for DLB, but there are medicines and other treatments that can help ameliorate the symptoms of the disease. Due to the frequent visual hallucinations, DLB is commonly misdiagnosed with other types of dementia (e.g. AD), delirium or late onset psychoses. Clinicians **should avoid antipsychotics**, as second-generation antipsychotics (SGA) significantly increase the mortality in elderly and the risk of EPS and NMS due to population sensitivity. Memory symptoms of the disease and early visual hallucinations are currently treated with Acetylcholinesterase inhibitors (AChEIs), with the best evidence supporting the use of donepezil and rivastigmine. If perception disturbances are persistent and significantly disturb the patient, then some evidence support the use of low dose quetiapine. The use of memantine is advised in the [2018 NICE guidelines](#), only when AChEIs are not tolerated (Pink *et al.*, 2018). As sleep disturbances could be an early symptom, low dose of clonazepam is suggested. Nonetheless, both quetiapine and clonazepam might increase the risk of drowsiness or falls, and clinicians need to have the patient's or family's consent prior to their use because of the potential risks (Stinton *et al.*, 2015; Ian G McKeith *et al.*, 2017).

H. Research Potentials - «Κάλλιον το προλαμβάνειν ή το θεραπεύειν» (meaning «Best to prevent than treat») (Hippocrates)

In medicine the early detection of patients at risk is imperative. The same principle applies to all mental conditions, dementia and DLB cases. Thus, apart from biological biomarkers, such as DNA, epigenetics, inflammation theories, or imaging techniques, clinicians also need to focus in environmental factors and early changes in cognition and behaviour. The availability of new technologies (internet, machine learning, apps) and the creation of enhanced computerized cognitive tests could help improve the early detection of dementia patients. This multidimensional approach could result in early interventions for dementia, before the presence of significant neuronal loss.



Related articles and links suggested for further reading:

- [Dementia with Lewy bodies — from scientific knowledge to clinical insights](#), *Nature Reviews Neurology Journal*, N. Arnaoutoglou, J.T. O'Brien and B.U. Underwood (Ahead of print)
- [Diagnosis and management of dementia with Lewy bodies - Fourth consensus report of the DLB Consortium](#), *Neurology Journal*, Mckeith et al. (2017)
- [The Diamond Lewy DLB assessment Toolkit - Newcastle DLB research group](#)
- [NICE Guidelines for Dementia \(June 2018\)](#)
- [Lewy Body Dementia Association](#)
- [Lewy Body Society](#)
- [Michael J. Fox Organization for Parkinson's Research](#)

Conflict of interests

None

About the Author

Dr. Nikitas Arnaoutoglou is a visiting researcher at the [Department of Old Age Psychiatry, University of Cambridge](#). He is a Consultant in Old Age Psychiatry working for the [Cambridgeshire & Peterborough NHS Foundation Trust](#) and the [Windsor Unit](#).



Picture courtesy of CPFT NHS FT and Windsor Research Unit, with the participant's and Dr. Underwood's consent.

From 2015 until 2017 he was an Honorary Clinical and Research Fellow at [the Department of Psychiatry, University of Oxford, UK](#) and part of [the neurobiology of ageing group](#).

The absence of primary mental care in Greece and the increased suicidality risk during the economic crisis, urged him to develop a non-commercial, stand-alone website (<http://www.psyxiatros.gr>) offering freely anonymised online [anxiety](#) and [depression](#) screening tests (Greek Language).

In collaboration with the European Federation of Psychiatric Trainees (EFPT) and the European Psychiatric Association (EPA), he was one of the MOOC facilitators at the [1st EPA Massive Online Course titled: Introduction to #CBT](#) and chapter author of the [1st EFPT Online Guidebook for Psychotherapies \(online or pdf\)](#). His current work focuses on identifying accurate and effective screening assessment tools and machine-learning techniques.

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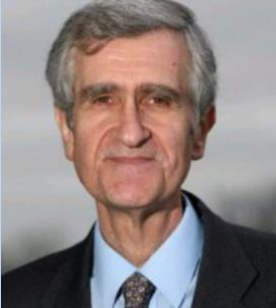
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Obituary- Professor Panagiotis Sakellaropoulos



Professor Nick Bouras, Institute of Psychiatry, Psychology and Neuroscience, King's college London

Panagiotis Sakellaropoulos

Panagiotis Sakellaropoulos, known as Takis, who died last November at the age of 92, was a leading and influential psychiatrist in Greece. He was instrumental for the mental health reforms in Greece and introduced the initial community care developments.

I first came across him as a medical student by his impressive teaching of psychoanalytical orientation with French flavour. Several young psychiatrists were inspired by him and followed a psychoanalytic training in France during the 1970s. In the early 1980s he founded the Association of Social Psychiatry in Athens, a non-Governmental Organisation, that started campaigning for deinstitutionalisation, closure of the asylums and development of community care services and facilities. Initially he was influenced by the French developments on “sectors” but soon blended his approach with the British

community and social psychiatry movement. His influence was pivotal for the improvements that occurred in the Leros asylum and the overall mental health reforms.

He was appointed Professor of Psychiatry and Child Psychiatry at the Medical School of Democritus University of Thrace. His work with mobile psychiatric units in the border area of Evros, near Turkey, was innovative and ground breaking. This area was lacking any psychiatric services with available options being to be treated either by some sort of private care, or as in-patient, quite likely resulting in long stay admission in a hospital unit far away, in the city of Thessaloniki.



I collaborated with him on several occasions and was honoured to be invited to attend and participate in several of his training, service and research activities over the years. I described his community care services in Northern Greece in an

article at the Psychiatric Bulletin in 1993 (Bouras, 1993). A wide range of community mental health services including residential, day care, community mental centres, mobile units, cooperatives, supported employment schemes were developed in several areas of Greece notably Fokida, Evros, Attika and Athens municipalities. They continue working to this day by providing invaluable services, support and training to many service users and their families.

Several generations of Greek psychiatrists and allied professionals were trained by him but most importantly were inspired by him for over three decades. The development and delivery of his postgraduate programmes attracted a great deal of interest and continued to be delivered for years.

Takis was born in Athens in 1926, studied medicine at the Medical School of Athens University and trained in France in neurology, psychiatry, and child psychiatry. He was a member of the International Association of Psychoanalysis. He was also a member of numerous professional and other associations, participated in national and international organisations, was adviser to the government and member of planning committees for health and mental health. He received undisputed recognition for his contribution, involvement and influence of his efforts to alleviate the stigma and improve the life of people with mental health problems and their families.

He was very inspirational, highly committed, determined, charismatic speaker inspiring confidence and a certain degree of passion. Furthermore, he was a very approachable, friendly and elegant person. He is survived by his wife, Athina Fragouli, a devoted companion and colleague. Takis will be remembered by his

colleagues, friends and service users, who had the opportunity of knowing, working and be supported by him.

Nick Bouras

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