Mental dis-ease in a Tongan general practice

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Introduction

Not many people suffer from serious mental or psychiatric disease, but many do suffer from temporary dis-ease or uneasiness in their mental and/or emotional status. Problems arise when this dis-ease either affects their ability to carry out the ordinary duties of life, or it produces physical symptoms which induce fear of serious physical disease, and this fear can itself be incapacitating. The majority of these patients never get to see a psychiatrist and rightly should be dealt with by the primary care physician. A 1985 study in Manchester found that "one third of all patients with new episodes of illness [in general practice] were diagnosable according to the DSMIII system as having psychiatric disorders."[1] Or looking at it from another way, "Somatisation [is] the commonest way for psychiatric disorder to present."[2] This study is an attempt to examine the clinical impression above.

Method

Records of all patients from 1/8/97 to 31/7/98 who had been recorded in the daily attendance book as having a mental health diagnosis were examined. This was dependent on the receptionist, who has no medical training and is relatively new to the practice, to recognise psychiatric diagnoses. (She was given a list of possible entries.) Some patients were probably missed because if there are two diagnoses for a patient, with the mental health one listed second on the patient's notes, it would often have not been recorded in the daybook. The records were reviewed by the medical practitioner, looking for age, sex, ethnicity, occupation, presenting complaints, number of visits, and diagnoses.

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Results

There were 56 consultations with a psychiatric diagnosis, which was 1.8% of the total consultations for the study period. The male/female ratio was 1 to 1.7. Children <16 years were under-represented in the psychiatric diagnosis compared to the general clinic population. (See Table 1)

They came from a variety of occupations, the commonest being housewife (7), professional (5), office worker and student (3 each), labourer and elderly unemployed (2 each), shop assistant and unknown (1 each).

Table 3 shows the psychiatric diagnosis by age, group and sex. The depression cases tended to be older, while the panic attacks tended to occur in younger people. Also all four Europeans fell in the depression category. (The two organic diseases and one unclassified have been excluded.)

All but one showed somatisation: 17/21 had HVS (hyperventilation-type symptoms); only two, both Europeans, presented saying they were depressed; and all the rest presented with physical symptoms.

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Discussion

In small countries like Tonga, most doctors are called on to be generalists. If these doctors only consider physical illness, treats physical symptoms, or only rules out serious physical disease, these may fail to meet the patient's needs. Though it is reassuring for a patient to exclude serious disease, it is also important to give him an explanation for the presenting complain. If a physical disorder is found, there may be unrealistic fears because of ignorance, and a background psychological, social, or spiritual problems that may need to be addressed if a successful treatment is to be achieved. This would require awareness, empathy, and time which at a very busy accident and emergency department may not be readily available.

Primary health care in the Pacific has tended to be hospital based. Since the Alma-Ata Declaration in 1978[3] there was the development of primary health care facilities out in the communities. These facilities have mainly concentrated on

Table 1. Frequency of psychiatric diagnosis by age, sex and ethnicity

	Frequency %	No. of cases	Frequency %
Consultations		59	1.8
Male	37%	9	37.5%
Female	63%	15	62.5%
Total		*24*	
Age group			
<16 years	46%	2	8.3%
21-40 years		11	45.8%
41-60 years		7	29.1%
>60 years		4	16.6%
Ethnicity			
Tongan		19	79.2%
European		20	20.8%
No. consultations: approx. 3.300			

Table 2. Frequency of psychiatric diagnosis

Diagnosis	Number
Depression	9 (5 with anxiety or HVS)
Panic attacks	8
Anxiety	4 (all with HVS)
Vague somatisation - unclassified	1
Organic brain disease	2
Total	**24**

physical problems of nutrition, sanitation, maternal and child health and immunisation, prevention of endemic diseases and treatment of common diseases and minor injuries. Mental Health is not usually considered. However, in physical complaints may be a call for help for a mental or spiritual uneasiness. Although initially succeffful[4] it now appears that people tend to bypass the village clinics and go direct to the hospital clinic or one of the private clinics. Consequently the hospital accident and emergency department is swamped and there is no time for health personnel to adequately consider or deal with mental dis-ease presenting somatically. Also locally trained health officers (and possibly doctors) have not always been aware of this connection. There may be a degree of embarrassment in suggesting to people that their problem is more psychological than physical. However, my experience with these

Table 3. The four most common physical symptoms

Weakness / tiredness / lethargy (lolomai)	12 / 21	57%
Breathing difficulty	10 / 21	48%
Palpitations	8 / 21	38%
Chest pain / discomfort	7 / 21	33%

patients has been that in most cases they are very open to the idea of underlying psychological problems and are ready to talk about them, and appreciate the time being given to them.

This paper is to raise awareness of the needs of those with mental disease who present with somatic symptoms, so that individual health workers will look out for it, and so that health planners will provide services that can cater for these needs. Quotes from two of the wise men of the ancient world can well sum this up. From Plato - "for this is the great error of our day in the treatment of the human body, that physicians separate the soul from the body."[5] And from Solomon - "A cheerful heart is good medicine, but a crushed spirit dries up the bones" These statements are as applicable today as when they were first written.

Conclusion

Somation is a common way for mental dis-ease to present. The underlying mental stress will often be missed or inadequately treated if not considered by the doctor or if there is not enough time to question the patient and discuss the possibility. Normally these kinds of problems can be dealt with adequately in the primary health care facility, by careful history and examination, explanation, relaxation techniques, and sometimes drugs for the minor physical problems which are often also present and for the underlying mental disorder eg. depression. However, this kind of approach is not very suitable for the over-busy outpatients' departments of the government hospitals which is where many patients first present in Tonga.

References

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5. Plato Charmides 156-7, Symposium 186, Timaeus 87-91, Republic III 408. (Quoted in Kelsey M. *Psychology, Medicine and Christian Healing.* San Francisco: Harper and Row: 1988. p.36).
6. Proverbs 17.22, *Bible*

If you are physically sick, you can elicit the interest of a battery of physicians; but if you are mentally sick you are lucky if the janitor comes around.

M.H. Fischer (1879 - 1962). In Fischerisms