Psychiatry on Tobago in 1989

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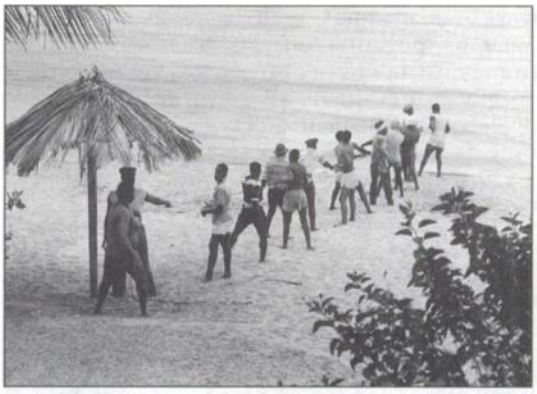
An unstructured observation concerning low rates of observed psychological disturbance was explored by estimating rates of suicide, and psychotropic drug use. Recorded suicide, overdose, and 'minor' tranquilliser and antidepressant use were strikingly low on Tobago, when compared with the United Kingdom. Tobagonians were unlikely to medicalise distress by presenting with overt psychological symptoms. Most local doctors felt that patients preferred spiritual support, e.g. from charismatic religious groups and traditional healers (some using *obeah*). A rich network of social and recreational groups may also give important support, as may 'liming' (a local conversational pastime). *Tabanka* (a local culture specific syndrome) may also be a non-medical outlet.



Seine net fishing

While working as a district medical officer on Tobago in 1989, I was struck by how rarely patients presented with emotional or psychiatric problems in the district health centre clinics and by how seldom psychotropics were requested or prescribed. By contrast, 26% of the UK population are said to consult their doctors annually with a mental health problem (Goldberg, 1991) and 25% of UK pharmaceutical costs are for psychotropic drugs (Thornicroft & Strathdee, 1991). African-Caribbeans are more likely than whites to be admitted to UK hospitals under the Mental Health Act (McGovern & Cope, 1987) in part because of an excess of psychosis (Balarajan & Soni Raleigh 1993; King *et al*, 1994). What is the pattern of mental illness in the West Indies?

Background

Tobago lies in the Caribbean 12 °N of the Equator and is 25 miles from the main island of Trinidad. The islands became independent in 1962. At the last census in 1980, there were 45,176 residents, and today's population is estimated at 50,000 – 93% of African origin (mainly Ibo and Ashanti) and the remainder Asian, with a few whites and Chinese. Thirty-seven per cent of the population were under the age of 15 and 9% were over the age of 60 years (Tobago House of Assembly, 1980). This is a young population compared with that of the UK where 19% were under 15 years of age and 21% over 60 in 1989 (Department of Health, 1994). The economy is very depressed and most employment is in homestead agriculture, fishing and public works, e.g. road-mending. Although material poverty is common, general health and life expectancy are better than in many Third World countries. There are several tourist hotels with a total of 750 beds but the island has been protected from over-development by government policy.

The Tobago County Hospital in Scarborough has a psychiatric out-patient clinic and facilities for brief admission of psychiatric patients to general medical beds. All treatment and follow-up of patients regarded as psychiatrically ill is centralised on the hospital psychiatric out-patients department run by community psychiatric nurses with flying visits from a Trinidad-based psychiatrist. The Mental Health Act of 1975 is based on the UK Act of 1959 providing for compulsory admissions, Review Tribunals and community psychiatric facilities. There is no resident psychiatrist and persistently

https://doi.org/10.1192/pb.19.7.421 Published online by Cambridge University Press

disturbed patients are transported to Trinidad for admission to the psychiatric hospital in Port of Spain. Hospital facilities are very limited due to the economic crisis with shortages of drugs, equipment and staff.

Primary care is provided by 15 private doctors whose prescriptions are dispensed by the island's seven private pharmacies at market price. Some of these doctors also work as hospital staff or district medical officers, the latter offering free primary care from government health centres with a limited supply of free medication. All of the island's five district medical officers also work part-time as primary care doctors.

The study

I set out to estimate several ways in which psychological disturbance might present in this relatively demographically stable and ethnically homogenous rural West Indian island community.

I studied:

(a) patients presenting to the Health Service with psychological problems
(b) voluntary and compulsory psychiatric admissions
(c) totals of psychiatric drugs dispensed for the whole island; (1) private, (2) health centre and hospital sources
(d) overdose and suicide numbers
(e) local doctors' attitudes to mental illness by questionnaire to reflect on their influence on local levels of diagnosis and treatment.

Island landscape

Findings

Patients presenting to health centres

Only 0.5% of all health centre attendances were recorded by clinic doctors and nurses as being due to psychological disorder or substance abuse (Tobago House of Assembly, 1980).

Compulsory and voluntary psychiatric admissions

There had been 12 compulsory admissions in the previous year, 8.4% of a total of 143 admissions, of which 30 (21%) were transferred to Trinidad for further management. I was told that most admissions were for acute psychosis. The 143 admissions represent a rate of $286/10^5$ per year.

Psychotropic dispensing totals

Private chemists

I visited each private chemist. Recording of psychotropic dispensing was obligatory and I was able to count the number of prescriptions, amounts prescribed, and numbers of patients for all psychotropics. In practice, this only involved the benzodiazepines as no major tranquillisers including depots and lithium were dispensed privately during the study period. Antidepressants were rarely supplied and I asked each chemist to estimate how often they dispensed these. The estimate is shown in Table 1.

Hospital pharmacy psychotropic dispensing

This supplied hospital out-patients, in-patients and the district health centres. Figures of minor and major tranquillisers, antidepressants, lithium and depot preparations are shown in Table 1.

It is of interest that Tobago's doctors in their private, but not their public, capacity had prescribed 40% of all minor tranquillisers but only 5% of antidepressants and no lithium, depot preparations or major tranquillisers. Thus drugs were prescribed rarely for depression, and never for 'major' psychiatric illness by private family doctors.

Suicides

There had been six suicides in the previous six years (range 0–2 per annum), representing a rate of 2 per 10^5 per annum. For comparison,

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Table 1. Psychotropic dispensing on Tobago in 1989 (Totals extrapolated for 12 months from a five month study period; estimated population 50,000 in 1989)

Type of psychotropic	From hospitals and health centres	From private chemists	Total per year	Comments
Antidepressants[a]	24,266 tablets	Estimated 80 prescriptions per year=1200 tablets	25,466 tablets	Sufficient for 1 tablet three times daily for 23 patients (46 per 10^5)
Minor tranquillisers (e.g. benzodiazepines)[b]	27,540 tablets	19,565 tablets	47,105 tablets	Sufficient for 1 tablet three times daily for 43 patients (86 per 10^5)
Major tranquillisers (e.g. chlorpromazine)	94,370 tablets	nil	94,370 tablets	Sufficient for 1 tablet three times daily for 86 patients
Depot injections	Piportril injections 50 mg × 385 ampoules Modecate 25 mg/ml × 1040 mls	nil	50 mg × 385 ampoules 25 mg/ml × 1040 mls	Sufficient for 118 patients receiving a monthly depot injection throughout the year[c]
Lithium preparations	9,244 tablets	nil	9,244 tablets	Sufficient for 12 patients receiving 300 mg twice daily continuously[c]

[a]cf. use in England (community): 7.28 million prescriptions per year for solo/combination antidepressants, representing 23% of UK psychotropics.
[b]cf. use in England (community): There were 24.27 million prescriptions per year for sedatives, hypnotics and tranquillisers (all classes).
[c]A total of 216 patients (432 per 10^5) on major psychotropics of which 12 (24 per 10^5) are on lithium.

the rate in England and Wales was 11.1 per 10^5 in 1990 (Department of Health, 1992).

Overdoses

I counted the number of patients treated in Tobago County Hospital after an overdose during a 26 week period. Three overdoses were recorded out of 12,000 casualty department attendances. Tobago County Hospital is Tobago's only hospital and patients would not have been treated elsewhere. Resident medical staff confirmed this figure. This gives an overdose rate of 12 per 10^5 per annum in Tobago, compared with 200 per 10^5 per annum in the United Kingdom (Vale & Meredith, 1981).

Local doctors' attitudes to mental illness

Using a questionnaire, I asked local medical officers and family doctors about their experiences of managing mental illness. At that time two doctors were not on the island. The remaining 13 responded and most felt that mental health services were less than adequate, that psychological medicine was important, that the seriously mentally ill should be managed in hospital and that treating such patients could be rewarding but also stressful. The majority felt that drug abuse was often a problem on Tobago. They were divided about the value of minor tranquillisers for anxiety but most were not in favour of sleeping tablet use. Most agreed that medication helped with depression but that advice and support were important. Perhaps the most significant finding was that most doctors felt that spiritual treatment was preferred by patients for psychiatric problems.

Comment

Limitations of method

Caution is necessary in comparing Tobago's rates with those of the UK because of their different population structures which would predict less psychogeriatric illness, and more illness of young adults, on Tobago. Estimating patient numbers from amounts of medication dispensed can only give approximations although the numbers treated for psychosis with major tranquillisers, depots and lithium may be reasonably accurate as these drugs

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were consistently used in the same way, i.e. with regular standard doses.

My estimated total of 216 patients treated for psychosis (0.43% of total population or 430/105) would be depleted by those who became long-stay patients in hospital on the mainland; 30 patients had been sent across in the previous year. I was told that despite many other shortages the supply of psychotropics was adequate. Suicide is notoriously under-reported in many societies but my source, police figures, was likely to be accurate, particularly as local suicides tended to be dramatic and attract much attention. It would not be easy to conceal such events in a closely knit community with a native police force. There may be suicides concealed among accidental deaths, the rates for which are high as in any developing country. Some suicides by drowning could appear accidental but local sources considered this unlikely. I was told that suicide was much commoner on the main island of Trinidad among the Asian population where paraquat poisoning was said to be a commonly used method, even among children.

Local doctors' views

I asked local doctors why the levels of overdose, suicide and use of minor tranquillisers and anti-depressants were so strikingly low. Suggested reasons were:

(a) that the crowded public clinics, short of supplies and staff were a difficult setting for the presentation of psychological problems. Having worked as a district medical officer, I had realised that patients rarely presented non-physical symptoms at these clinics which were geared to prescribe remedies for acute and chronic physical illness, and to screen for tropical infectious disease. Private surgeries offered more convenient settings for personal discussions for those who could afford the modest charges although these consultations led to tranquilliser rather than anti-depressant prescribing

(b) that psychological problems such as depression might present with somatic symptoms

(c) that local doctors' training was geared towards the physical model with less emphasis on recognition of social and psychological problems

(d) that the elaborate network of local families means that there are many non-medical sources of social support. Despite material poverty, there is a rich background of church groups, sewing circles, 'pan' (steel) bands, evening classes and other groups, as well as regular public and religious holidays, 'fêtes', and the carnival which are occasions for community festivity and periodic catharsis ('baccanal'). Another outlet is 'liming', a commonly used term for vivid, drug free relaxing and socialising, leaving life's pressures behind. 'Liming' typically takes place outdoors on street corners or casually constructed 'liming' seats and participants will engage passers by in lengthy friendly conversational tours de force and gossip. Employers recognise 'liming' as a threat to staff efficiency as the participants' entire attention is distracted from more serious matters. This cost-free recreation is eagerly anticipated by many Tobagonians but considered faintly disreputable by more respectable residents

(e) that the various religious groups (often with a strong West African influence) and traditional healers in Tobago, some using charismatic techniques and *obeah*, may also facilitate emotional catharsis

(f) *Tabanka* – a locally recognised cause of outbursts of bizarre, self-neglecting behaviour following disappointment in a broken relationship. Sufferers, usually socially aspiring males such as teachers or policemen, are objects of pity and ribald, satirical mirth. A typical sufferer would abandon his job, neglect his appearance and hygiene, and be seen sitting in the dust in torn clothing, withdrawn and dejected. This would follow his partner abandoning him by having a baby with another man. Observers find this condition hilarious, perhaps as the spectacle of collapsed social ambition and middle class values. Their disturbed behaviour does not seem to call for medical attention and may be an acceptable form of outlet, sanctioned by local culture, and may provide a model for other types of personal distress. This may be seen as a Tobagonian parallel to overdose in the United Kingdom but does not explain

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the low female parasuicide rate (Littlewood 1985, 1988; Cembrowicz, 1992)

(g) despite being strictly illegal and felt by most local doctors to be a risk to mental health (Cembrowicz, 1991), ganja use was common. It may conversely have been used in the place of minor tranquillisers for a 'tonic-hypnotic' or euphoriant effect. Other herbal remedies were also widely used usually before seeking conventional medical help. Older residents were said to know of over a hundred 'bush' remedies, some of which could perhaps be pharmacologically active, as well as of subjective effect.

In addition to the reasons suggested by local doctors, other explanations are possible. Although the rate reported here ($286/10^5$ per year) may be artificially low for the reasons discussed, it is higher than the strikingly low rate of $69/10^5$ per year reported for Jamaica in 1988 (Hickling, 1991). Hickling ascribes the low admission rate to Jamaica's decentralisation policy whereby patients are treated close to their communities of origin by community psychiatrists who live locally or visit frequently. This facilitated earlier presentation and easier out-patient management. Geographic and economic difficulties make access to a psychiatrist less easy for Tobagonians, and this may partially explain the higher admission rates. 'Major' tranquilliser use was greater than 'minor' use in the ratio 2:1 – perhaps because psychoses are illnesses less likely to be perceived as everyday distress and managed by traditional healers, coped with by family and friends or kept from the attention of medical and civil authorities.

Late diagnosis – or non-presentation?

Burke's study (1984) of a West Indian community in Birmingham found much unrecognised depression and he postulated that local general practitioners "(had) an uncanny tendency to under diagnose psychological problems when confronted with West Indian patients ... (and) may be withholding the right of referral from West Indians ... (so) patients will be identified to be ill at a later stage than those who have been to out-patient clinics and are British". He went on to suggest that this process could be responsible for the excess in compulsory admissions in this group. However, I found in Tobago a strikingly low level of presentation of psychological problems and of prescribing of psychotropics for anxiety and, in particular, for depression. This, and the rarity of overdose and suicide, suggested profound differences in patients' expectations of medical services, and in the way psychological disturbance was expressed. Tobagonian patients were unlikely to present overt psychological symptoms to their family doctors.

Acknowledgements

I am most grateful to the Tobago House of Assembly, and the Ministry of Health for their permission for this study and to Tobago's County Medical Officer, pharmacists, community nurses, and Chief of Police for their time and trouble. Drs Roland Littlewood, Chris Vassilas and David Jewell helped with inspiration and support, and Glen Gocoul kindly advised on ethnic issues. I was helped by grants from the RCGP and the Mental Health Foundation. Thanks also to Anne Gaulton for her help.

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Corrigendum

Psychiatric Bulletin, May 1995, **19**, 290. *Services for adults with learning disabilities and mental health needs*. By Shaun Gravestock and Nick Bouras. The first two sentences of the first paragraph on page 290 should read: Most respondents acknowledged that the additional clinical service and staff resources needed to support community care developments had not been agreed between local providers. Furthermore, the worrying lack of reliable local service planning data and the diverse views of respondents about responsibility for care co-ordination suggest continuing confusions about appropriate mental health and social care provision for adults with LD and MHN in several districts.

https://doi.org/10.1192/pb.19.7.421 Published online by Cambridge University Press