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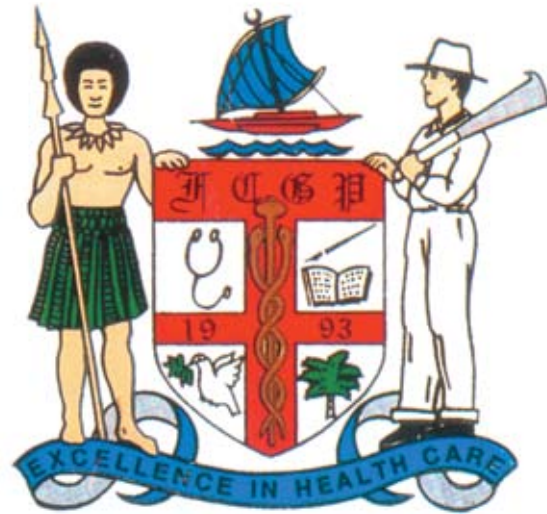
**UNTAPPED RESOURCES FOR
IMPROVING MENTAL HEALTH
SERVICES IN DEVELOPING COUNTRIES**

**PSYCHOSOCIAL REHABILITATION
TREATMENT METHODS LEADING TO
IMPROVEMENT IN QUALITY OF LIFE
AND REDUCTION OF DISABILITY IN
PSYCHIATRIC PATIENTS**

UNDERSTANDING ANXIETY

**TYPES OF PSYCHOLOGICAL
TREATMENTS**

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**Theme: PSYCHIATRIC HEALTH
IN PRIMARY CARE-1**

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GUEST EDITORIAL

UNTAPPED RESOURCES FOR IMPROVING MENTAL HEALTH SERVICES IN DEVELOPING COUNTRIES

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Background

Mental Health despite its prominent position in the definition of health in the 1946 constitution of the World Health Organization, (WHO 1946) remains a neglected field of health care in large areas of the developing or Low and Medium Income (LAMI) countries of the world. There was a time when the provision of mental health care revolved around the existence of a qualified psychiatrist and a mental hospital. In the 1960s and 70's many developing countries sent aspiring doctors to train in psychiatry in the mother colonial countries such as Britain, US, France or the USSR. Though numbers were small these graduates returned to take over the services developed by colonial psychiatrists in such places as India, Singapore, Fiji, Trinidad or Uganda and improve services using knowledge they had gained overseas. Unfortunately that experiment deteriorated rapidly in the face of declines in economic conditions in post colonial era in many countries. Thus in most countries that became independent in the 50s and sixties the mental health care that in the pre war era revolved around overcrowded mental hospitals, remained so with reduced budgets and lack of progress in care.

Although the first truly psychotropic medicine, Chlorpromazine, was introduced in the 50's the mental hospitals did not empty and in fact became more overcrowded.. In Malaysia in 1971 a large mental hospital housed over 5,000 patients in wards meant for about half that number. Overcrowding, bred poverty of care, bringing in its wake abuse, maladministration. Training of psychiatrists and nurses overseas only led to emigration of the trained mental health manpower. The mental health services often at the bottom of the health care budget suffered from both lack of funding and trained human resources. As conditions deteriorated, morale in mental health services of many. Thus despite newly introduced local training for psychiatrists and psychiatric nurses in several countries in Africa, and Asia the numbers of qualified psychiatrists in LAMI countries actually dropped. Clearly non-health related factors were beginning to have a bad impact on psychiatric services in LAMI countries. Thus at a WHO meeting (WHO 2003) to discuss the human resources in mental health in the LAMI countries of the western Pacific in Nadi, there were 7 countries that had no psychiatrist or psychiatric nurses to man rudimentary services. Many psychiatric emergencies in these widely separated

islands were managed by police rather than health care staff

Primary Care Psychiatry

The World Health Report (WHO 2001) emphasized the need to deliver mental health services in primary care settings. A far departure from the mental institutional care of old, Primary care psychiatry aims to offer care for the vastly larger numbers of less disturbed persons than those in mental hospitals but far larger numbers with conditions such as anxiety, depression, stress related problems. Persons with these problems constitute well over a quarter of all persons who attend primary care clinics with a variety of non psychiatric diagnoses that remain untreated for their emotional distress. While those persons with the more disturbing psychotic illnesses have coloured the public's and indeed the health care profession's view of all of mental illnesses, they constitute but 7 per cent of all mental illnesses. The primary care psychiatry on the other hand concerns a much larger number of 60-70 % of all psychiatric problems that take a human work related toll on the suffering individual. In the Pacific Islands the figures are no less glaring but patients do not have the benefit from professional help as most of the doctors and nurses do not recognize these milder but very distressing disorders.

Human Resources in Health care and Mental Health Care

While there is clearly a shortage of trained mental health personnel to provide services for the mentally stressed the provision of physical health services in the Pacific LAMI countries given enormous problems of distances and cost is remarkably good. Trained SRN nurses, and some doctors man both hospital and community based services for most of the populated islands of these countries. They provide most services in medical, surgical, pediatric and OBGYN fields as well as preventive and specialized TB, Leprosy and Malaria – but not mental health services. This gap in skills attitudes and knowledge on matters relating to mental symptoms as well as treatments is sad as the alternative will often be leaving treatment to the traditional healer or rarely the policeman. Clearly the long neglected emphasis on mental health as a part of health care has deprived the mentally ill of basic services. The good distribution of nurses throughout the islands puts them in unique positions to provide mental health care if only they were prepared to shoulder that essential task.

Finding a Simple Solution

What appears to be holding back that essential provision of care is a mindset in many health care delivery systems in LAMI countries. Mental Health is associated with fear, unpredictability and fear whereas the opposite is by and large true. Most mentally ill are not violent, most are distressed and suffer in silence and the vast majority never get the treatment they deserve.

In the absence of any viable policy that is likely to train and retain psychiatrists and psychiatric nurses to provide mental health services in the Pacific Is, the obvious answer is to train both available doctors and nurses in primary care psychiatry using adapted versions of the WHO-ICD-X- PHC which was produced by the WHO in Geneva in 1996. (WHO 1996) This simple kit focuses on 6 primary care diagnoses commonly encountered in primary care practices the world over and add training in managing psychiatric emergencies as the primary care provider would be expected to provide that services as well in the absence of psychiatrists. A provision for senior nurse-practitioners to be authorized to prescribe specific drugs for treatment of psychiatric conditions under the authorization of a medical practitioner should also be put in place to make this service viable. Basic counseling training to equip nurses in the simple principles of counseling of emotional distress should be taught.

The primary care psychiatry training for general practitioners and nurses will seldom exceed 1 week and has been carried out successfully in Malaysia and Thailand since the 1970s and in other countries modified forms of the same training such as Solomon Is, Fiji , Cambodia, China, Vanuatu and Micronesia.

It appears that what is holding back this type of cost effective training is prejudice among health care decision makers and availability of funds. There will be a need for refresher courses and a periodic visit by the trainer to ensure the Practice of Primary care psychiatry is carried out smoothly.

In the Cook Is and in Federated states of Micronesia, NGOs have spearheaded demands for training and provision of mental health care for the community.

Conclusions.

Gone are the days when delivery of Mental Health care at primary care level can successfully be segregated from delivery of physical health care, in the face of demands for rights that is growing day by day.

The readily available untapped trained manpower of primary care providers in many LAMI countries need to be trained in simple skills of diagnoses and management of common psychiatric problems that affect over a quarter of all primary care attendees.

Easily conducted training lasting days can help bridge that gap in mental health care in many countries

It is time that a holistic approach replace a policy of prejudice and fear, so that mental health for all can become a reality in the LAMI countries of the Pacific

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- Medico-political column.

NEXT ISSUE:

PSYCHIATRIC HEALTH IN PRIMARY CARE-2

Vol 15, No 2, June 2007.

THE FIJI MEDICAL COUNCIL.

*Dr Neil Sharma,
Editor in Chief*

Under the Laws of Fiji, the Medical and Dental Practitioners Act (chapter 255) lays down the provisions for medical practitioners dated, 12/11/1971. Under this act, is established the Fiji Medical Council. The council is then given its makeup, terms of appointment and procedures. All aspects of registration including applications and decisions are elaborated. Misconduct, Appeals and publication of registers are discussed. Complaints, Inquires and regulations are finally dealt in the act.

The Fiji Medical Council is the supreme council which regulates the medical profession and all its activities. The Fiji College of General Practitioners has been given due recognition by the Ministry of Health as representative of the private sector, primary health care providers. Under the new interim government the College has been offered a seat in the council. I make the following points with reference to the council and its activities.

An Active and independent Fiji Medical Council

The Fiji College of General Practitioners (FCGP) endorses a robust and efficient Fiji Medical Council (FMC). This organization needs to work independent of the Ministry of Health and undertaken its role meaningfully.

The FMC must meet regularly to deal with Registration, De-registration, accreditation, policing and mediation. The organization must gazette annually all medical personnel practicing in this country and delete the migrated, dead and deregistered. Seniors in the profession, who are vibrant, forward thinking, accountable and transparent, must be represented on the organization.

New systems of continuing/maintaining registration must be addressed. Continuing Medical Education (CME) must become part and parcel of maintaining ones annual registration in the effort to upgrade efficiency in service delivery.

Service providers such as the Fiji Medical Association and the College are providing the necessary CME and they must be supported in their efforts.

Efforts of the council must include effective policing of alternative practitioners and those who are not fully registered.

Mediation Forum

There is no independent mediation forum, apart from the Ombudsman's office whereby allegedly aggrieved individuals can have their cases discussed. Technically individuals can approach the Fiji Medical Council but the independence of this organization has been

suspect due to its proximity in the medical hierarchy and administration. Only two issues were leveled to this organization in 2005 at last count.

Overseas experience indicates that a lot of times individuals just need to be explained of adversity, side effects and complications. Sometimes the medical profession may need to swallow its paternalistic approach and understand issues in patient autonomy and self-determination. A simple apology is all that is required.

Medical misadventure and negligence need to be separated too. A system of no claims compensation may need to be addressed akin to the Sweden experience but possibly unlike New Zealand Accident Compensation Scheme, which is costing the N.Z. Government excessively now and is under revision.

Cases of infamous behavior, unprofessional conduct and professional misconduct can then be redirected to the Criminal justice system and Fiji Medical Council for necessary action.

The composition of a mediation forum will need the endorsement of the government and leaders in the legal and medical fields and senior members within the civil society to give credence to the whole concept.

An active process of Law Reform in the area of Health Delivery

It would appear that the process of Health law reform has been given little priority in Fiji. The Health Law Reform is under staffed and under funded with very little commitment at senior level. Many areas of Law are archaic and needs readdressing with changing societal needs and necessities. This is an issue the Fiji Medical Council must address and redress. The legal unit at the Ministry of Health does not seem to be visible even in areas such as HIV-AIDS. The council in its wisdom must address these issues and not leave them to the health administration alone.

Conclusion.

The College is grateful for the eventual inclusive approach taken by the current Minister of Health. We can only hope that our delegate can make a difference. We trust the council re-looks at the issues facing our profession with transparency. The need to weed out the rot and place the profession on a truly ethical and professional trajectory is overdue. The council's role is not adjudication only. Its multifaceted actions include laying the ground rules, policing, guidance, counseling, mediation, advocacy, adjudication and implementing change, i.e. upgrading medical laws.

Following the recent judicial review /adjudication by Justice Ajit Singh where the Full Council was ordered to review its decision as the council had made certain orders out of fear of possible legal action by an individual. The robust Council must not be seen to be toothless, spineless and gutless. It must reign supreme.

INVITED REVIEW ARTICLE

PSYCHOSOCIAL REHABILITATION TREATMENT METHODS LEADING TO IMPROVEMENT IN QUALITY OF LIFE AND REDUCTION OF DISABILITY IN PSYCHIATRIC PATIENTS

INTRODUCTION

Mental and Behavioral disorders tend to be chronic and disabling and thus place a large burden on individuals, families and communities. Global Burden of Disease study 2000 reported by WHO shows that mental and neurological disorders account for 30.8% of all years lived with disability (YLD,s) and Depression causes largest amount of disability accounting for 12% of all disabilities. It ranks fourth in the ten leading cause of burden of disease and will become second leading cause of disability in twenty years time. (1) Disability and quality of life issues are becoming an important priority for both developing and developed countries health services. Interventions that reduce the disabilities and improve quality of life for mentally ill persons are important treatment and service components of mental health systems.

Psychosocial rehabilitation is recognized as an essential form of treatment for patients having psychiatric disability as a result of suffering from chronic forms of mental illness. There have been several international studies looking at outcome of psychosocial rehabilitation in hospital and community settings. In hospital setting psychosocial rehabilitation if carried out effectively helps to facilitate early discharge, decrease relapse rates,

increase community tenure, creates more frequent work opportunities and provide greater life satisfaction opportunities (2).

Chronically mentally ill patients suffer from disabilities in many areas of their life. Some of these disabilities are personal disabilities, social disabilities, occupational disabilities and caring out activities of daily living. Effective psychosocial treatment aims to correct these disabilities and teach independent living skills to patients which results in reduction of stigma and discrimination and results in better assimilation in the community

Various types of psychosocial treatment methods are being used to rehabilitate mentally ill patients. Most of the larger studies that have been carried out looking at effectiveness of these treatments have been conducted in developed countries. Developing countries often have limited financial resources, underdeveloped psychiatric services and lack of trained professionals so there is a need to identify those treatments that are most cost effective and can be adapted to the local situation. It is also important to identify factors that affect treatment outcome.

AIM

The aim of this review is to carry out a literature search to identify psychosocial treatment methods that lead to an improvement in quality of life and reduction of disabilities in psychiatric patients.

OBJECTIVE

To identify psychosocial treatment methods leading to reduction of disabilities in psychiatric patients and improvement in quality of life. The main treatment methods studied will be Vocational Training, Cognitive Behavior Therapy, Life Skills Training, Psychoeducation and other Treatments which are traditionally part of Occupational Therapy such as Relaxation and meditation Techniques, Exercise and music as well as art therapy. The main indices used for Disability will be studies identifying improvement in cognitive abilities, self care, clinical improvement, activities of daily living, and occupational and vocational skills. The main indices used to identify improvement in quality of life will be physical and psychological health, social relationships and environment.

SEARCH STRETEGY

- (1) Electronic search of journal articles
- (2) Hand Search of Journal Articles, both local and international
- (3) Books on psychosocial Rehabilitation
- (4) Dissertations

METHODS

An electronic search involving MEDLINE and COCHRANE LIBRARY was carried out to select Randomized Control Trials, Clinical Control Trials and review articles that identified psychosocial treatment methods that resulted in reduction of disabilities and improvement in quality of life for patients with chronic mental illness attending outpatient or community based rehabilitation program. While study design involving larger samples will be included, smaller studies, especially those conducted in developing countries which are of relevance will also be mentioned.

Studies that use reliable and valid measuring instruments to measure changes and appropriate statistical tests to analyse the results will be included as will studies that look at treatment methods across several diagnostic groups.

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See results next page

DISCUSSION

This paper aims to identify some recent methodologically sound studies that looked at the issue of reduction of disability and improvement in quality of life for psychiatric patients undergoing rehabilitation.

Vocational training is an effective treatment that brings about a reduction in disability and significant improvement in quality of life. In this study Supported vocational training (on job training) was superior to prevocational training as people tend to remain employed longer although the changes in self esteem and clinical symptoms are the same in both groups. Cognitive deficits like the presence of negative symptoms is also a predictor of vocational outcomes as identified in some other studies (16)(17). Patients with these symptoms who are suitable for vocational training will benefit from additional psychological measures.

Life skills training teaches patients self help and activities of daily living as well as problem solving techniques such as management of common problems like transport and budgeting etc. Reddons study showed that there was improvement in disability and social skills and the patients were highly satisfied with the treatment offered. The study was limited by its small sample size and it was not a random controlled trial. Glynn's study indicates that when Clinic Based Skills training is augmented by In Vivo training there is significantly greater and faster improvement in social disability symptoms and quality of life. Both the groups were on medication (olanzapine and haloperidol) and no differential effects of medication was noted on both the groups.

Psychoeducation has a positive effect on understanding illness and ensures compliance with medication. In Poplawska's study there was improvement in clinical symptoms in both groups. Behavioral family therapy was superior to culturally modified behavior therapy in the outcome for all variables at 6 months but the improvements with culturally modified Behavioral therapy in clinical psychopathology and social disability as well as decreases the family burden lasted longer at 12 months evaluation.

Music Therapy study by Yangs in socially disabled patients indicated improvement in this area in the short term. No comments can be made about the long term effects of this therapy. The minimum number of sessions needed to bring about a change was more than 20 sessions.

Relaxation techniques (Vedic Maha mantra) bring about a change in clinical symptomatology but no comments could be made as to whether there was any significant change in the quality of life for these patients.

The exercise therapy study states that there is an improvement in depressive symptoms and motivation for the patients. In the control group there was negative correlation between aerobic fitness and the level of depression. This study was limited by its small sample size and lack of variety of exercise programs. It does not include quality of life changes although it is a known fact that by improving the level of physical fitness there would be a positive change in ones physical health and therefore the quality of life..

The study using art as a form of therapy provided inconclusive results as to its benefits although the study mentions that it helps to improve communication skills and group cohesion.

Conclusion

Psychosocial treatment is an important form of treatment for mentally ill that should be commenced as soon as possible (18). The inpatient rehabilitation should be complemented by availability of outpatient rehabilitation program to enhance their improvement further. The outpatient rehabilitation treatment has to be flexible and adaptable to suit the environment and should be individually tailored to the persons need. There are many models of rehabilitation treatment methods describe in literature. Resources should be invested in those programs that are evidenced as being useful. Activities such as Vocational and Life Skills training, cognitive and behavior therapies, exercise and life skills program help to reduce disability and improve quality of life. The learning of skills is usually facilitated by concurrent administration of psychotropic drugs and other psychosocial treatments. Social skills can be acquired by engaging in non specific group activities that promote socialization but proper skills technique involves behavioral learning techniques conducted by trained professionals in a structured approach (19). Patients with severe mental illness benefit from vocational treatment programs where available. Supported employment is more beneficial to the patient than prevocational training.

In developing countries there is a dearth of such programs due to lack of financial resources and trained personnel. In such cases attempt should be made to link the patients suitable for rehabilitation to any existing community development programs that may be available. This has been found to be effective in some countries ("piggy back" phenomenon).

Active involvement of Consumers in rehabilitation will benefit the community and help ensure the success of the program. Managers need to invest resources in those services that are most cost effective. Innovative community based treatments are not necessary cheaper but the savings made from shortened inpatient

Results

Psychosocial Treatment Methods	Journal Articles	Outcome	
		Disability	Quality of life
Vocational Training Review of 18 Randomised Control Trials (RCT), (3) comparing Prevocational Training to Supported employment (On job Training)	(3) Crowther et, al., Drake RE,et,al.(4),Bond GR.,et al.,(5), Drake RE.,et, al.(6) Drake RE,et,al.	Improvement in clinical symptoms, improvement in occupational and vocational skills in the both group	Improvement in psychological health, social relationships,environment and finance in both group.
Cognitive Behavior Therapy (RCT) comparing regular treatment (R.T) -medication only with R.T. plus Cognitive Behavior Therapy.	(7) Granholm et, al.	Improvement in cognitive ability and social skills in second group.	No difference noted in overall psychological health, social relationships or environment in both groups.
Life Skills Training a. Not RCT, (N=31), 16weeks trial. b. RCT (n=63). Cognitive Behavioral Skills Training (CBST) compared to CBST plus In Vivo skills training	a.(8) Reddon,John R.et al b.(9) Shirley M, Glynn, et.al.	Improvement in self care, activities of daily living, social skills, improvement in clinical symptoms b. improvement in cognitive ability and clinical symptoms in the second group	Improvement in psychological health, environment and social relationships b. improvement in social relationships, and psychological health in the second group.
Psychoeducation a.RCT, (n=52), inpatients. schizophrenia,depressed patients, compared those on medication to medication plus psychoeducation b. Behavioral Family Therapy(BFT) compared to Culturally Modified Family Therapy(CMFT).	(10) Poplawska R , et, al. b. (11) Razali SM.et al	Improvement in clinical symptoms in both groups. b. BFT was superior in improving clinical and social skills in both groups	Improvement in psychological health in the second group. b. improvement in psychological health in second group and social relationships.
Relaxation Therapy/meditation RCT, 13 patients.Vedic Mahamantra. Compared with placebo and control group.	(13) Wolf DB. Et,al.	experimental group showed improvement in clinical symptomatology	Improvement in psychological health for experimental group,
Music Therapy RCT, (n=70) patients with social disability. Medication alone compared to medication plus music therapy	(12)Yang et al	Improvement in social disability and cognitive abilities in second group.	No information
Exercise Therapy (n=31), RCT,	(14)PelhamTW. Et, al.	Exercise group showed improvement in clinical symptoms	No information
Art Therapy RCT, comparing art therapy plus standard care with standard care alone.	(15)Ruddy R, et al.	Some improvement in socialization in experimental group.	Unclear as to its effectiveness

stay for the patients can be used further to develop these services further. Involvement of business sectors and non governmental organizations and other stakeholders are important component of community based rehabilitation programs and as such should be encouraged particularly with Supported Vocational Programs.

Community Based Rehabilitation Treatments which are more accessible to the patients has become a general global trend to treat mentally ill persons. It should be made a part of National Mental Health Plan and be incorporated in the Mental Health policy of the country. There are still some developing countries in the Pacific region which do not have a mental health policy.(20)

Research in disabilities and quality of life issues for psychiatric illness especially in developing countries is inadequate. More research in this area is needed so that better resource allocation and provision of service is ensured.

Finally research is needed involving larger patient groups, ethnic minorities, and benefits of culturally sensitive programs to advance the knowledge in this field.

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UNDERSTANDING ANXIETY

*Dr. Yvonne Entico
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Most commonly missed out or not critically given attention to as a serious illness among psychiatric disorders in general practice are anxiety disorders. The main reason being that, most doctors would see patients presenting with anxiety symptoms as not warranting serious and immediate attention compared to those having more pressing medical illnesses. Indeed, this is because, anxiety with its concomitant autonomic nervous system responses, is commonly experienced by virtually all human beings. It is generally seen as part of a normal adaptive physiologic response to an impending threat that positively leads a threatened person to take measures to deal with the threat. This is a remnant adaptive mechanism of the so-called flight or

were equipped with through the evolutionary process to deal with its predatory assailants. In present times though, threats to daily life vary and could be emotional or physical pain, possible punishment, frustration of social or bodily needs, separation from loved one's, menace to one's status or success, helplessness, bodily damage, or threat to one's unity or wholeness, among other things. Pathological anxiety on the other hand is an inappropriate response to a given stimulus by virtue of either its intensity or duration. It is the pathological counterpart of normal fear manifested by disturbances in mood, thinking, behaviour and physiological activity.

In clinical setting it is imperative that a clinician be able to distinguish between normal physiological and pathological types of anxiety,

as patients with pathological anxiety require thorough medical and neuropsychiatric evaluation. As anxiety can be a component of many medical conditions, as well as mental disorders, including alcohol or substance use, which may mask anxiety symptoms or make them worse. It is also frequently associated with depression as both are individual expressions of related biochemical and physiologic disorders of brain function, such that they have been termed affective spectrum disorders.

The experience of anxiety has 2 components: (1) the awareness of the physiological sensations (autonomic nervous system arousal such as palpitations and sweating) and (2) the awareness of being nervous or frightened. The anxiety may be increased by a feeling of shame. In addition to its motor and visceral effects, anxiety affects thinking, perception, and learning. Anxiety tends to produce confusion and distortions of perception, not only of time and space but of people and the meaning of events. These distortions may then interfere with learning by lowering concentration, reducing recall and impairing the ability to relate one item to another (making associations).

An anxious patient will describe feeling of a diffuse, unpleasant vague sense of apprehension with or without associated autonomic nervous system signs and symptoms. In severe anxiety, however, there is a variety of autonomic nervous system manifestations. These could be: tachycardia, palpitations, irregular heart rhythm, tightness in the chest, dizziness, tremors, excessive sweating, dry mouth, diarrhea, abdominal pain and headache. An anxious person may also feel restless. These physiologic manifestations maybe present regardless of the specific type of anxiety disorder with the constellation of symptoms varying among patients.

In Fiji, patients who experience anxiety problems seldom consult a doctor for various reasons. One of the primary reasons would be the lack of basic awareness as to what they are experiencing. In Fijian lexicon *loma ocaoca* refers to somatic and physiologic symptoms typical of anxiety but for which most people would not associate with the western medical concept of anxiety.

Patients with anxiety disorders would usually present to general practitioners, internists, or cardiologists seeking treatment for the somatic component of the disorder. Patients with panic attacks would usually present to a medical clinic for life threatening heart attacks. Shortness of breath could be misconstrued for severe asthma. A patient, whose hypertension is refractory to most anti-hypertensive regimen, could actually be just a manifestation of the increased autonomic responses in anxiety.

Another reason could be that patients have been habituated and are able to personally deal with their somatic and physiologic symptoms without medical help and are thus, able to relatively function but not to their optimal best. These are the walking sick.

Another reason that is shared with most patients is the stigma of going to St. Giles Hospital for treatment. How unfortunate is a man who is branded as a St. Giles patient with its corresponding ostracism!

PSYCHOBIOLOGY OF ANXIETY

Most biological theories regarding anxiety were developed by studying animal models of anxiety. In these studies, the limbic system, the cortex and the pre-frontal cortex were distinguished to be the significant organs in the genesis of anxiety disorders. It has been found that the amygdala in the limbic system has the important role of triggering the fear response. The amygdala then fires up to the hippocampus which is the organ responsible for learning and forming new memories through the short-circuit system. There is a long circuit system though, through which the amygdala sends half of its signal directly to the brain cortex. Studies have also revealed that the hippocampus is small in some people who were victims of abuse as a child or who served in military combat. The significance though to its role in flashbacks, fragmented memories, and deficits in explicit memory in this group of patients still needs understanding.

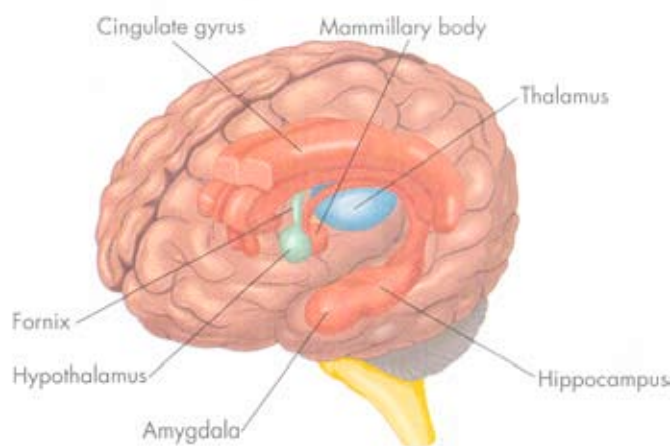


Figure 1 – The Limbic System

The limbic system is responsible for receiving noradrenergic and serotonergic (5-HT) innervations, as well as contains a high concentration of gamma-aminobutyric acid (GABAA) receptors. The general theory regarding the role of norepinephrine is that affected patients have poorly regulated noradrenergic system that has occasional bursts of activity. Human

studies have found that, in patients with panic disorders, beta-adrenergic agonists and alpha2-adrenergic antagonists can provoke severe and frequent panic attacks. On the other hand, clonidine, an alpha2-adrenergic agonist, reduces anxiety symptoms in some experimental and therapeutic situations.

The observation also that serotonergic antidepressants such as clomipramine have therapeutic effects on some anxiety disorders led to the identification of many serotonin receptor types in the pathogenesis of anxiety disorders.

Moreover, the role of GABA in anxiety is strongly supported by the undisputed efficacy of benzodiazepines in some types of anxiety disorders. Benzodiazepines enhance the activity of GABA at the GABAA in the treatment of some types of anxiety disorders. Studies revealed that autonomic nervous system symptoms of anxiety are induced by benzodiazepine inverse agonist, and a benzodiazepine antagonist flumazenil, causes frequent panic attacks in patients with panic disorder.

Genetic studies have also showed strong correlation between some genetic components and anxiety disorders. Almost half of all patients with panic disorders have at least one affected relative. Figures for other anxiety disorders, although not as high, also indicated a higher frequency of illness in first-degree relatives of affected patients than in the relatives of non-affected persons. Data from twin registers also support that anxiety disorders are partially genetically determined.

TYPES OF ANXIETY DISORDER

In anxiety disorders, anxiety is either experienced as the predominant disturbance or is experienced as the patient attempts to deal with phobias, obsessions or compulsions. It is therefore classified depending on the prevailing symptoms exhibited by the patient. All of them however, produce significant impairment in social or occupational functioning, or marked distress in the patient.

I - GENERALIZED ANXIETY DISORDER

Generalized Anxiety Disorder is defined as having excessive or pervasive worry, usually accompanied by varied somatic symptoms such as restlessness, easy fatigability, poor concentration, irritability, muscle tension, and sleep disturbances. Furthermore, the patient finds it hard to control the worry. Oftentimes, it co-exists with another mental disorder; either depression or another anxiety disorder.

II - ACUTE STRESS DISORDER AND POSTTRAUMATIC STRESS DISORDER

For patients to be classified as having Acute

Stress Disorder, they should have been exposed to a life-threatening trauma (i.e. exposure to natural catastrophes, serious accidents, rape, torture, assault, assault, etc.) with consequent feeling of fear, helplessness, or horror. Other accompanying symptoms would be a subjective feeling of detachment, numbing, or absence of emotional responses, feeling of "being in daze", derealization, depersonalization, or dissociative amnesia. (1) Re-experiencing the traumatic event (through recurrent images, thoughts, dreams, flashbacks, etc.), (2) avoidance of stimuli that arouse the recollection of the traumatic event, and (3) marked symptoms of anxiety or increased arousal (i.e. exaggerated startle response, poor sleeping pattern, hypervigilance, poor concentration, irritability) are also manifested by the patient.

All of these symptoms should be present in patient within 4 weeks after exposure to the traumatic event for it to be classified as Acute Stress Disorder. Otherwise, if symptoms persist beyond 4 weeks, it will be categorized as Post-traumatic Stress Disorder.

III - OBSESSIVE-COMPULSIVE DISORDER

The main symptoms in Obsessive-Compulsive Disorder are obsessions and compulsions. An obsession, is a recurrent and intrusive thought, feeling, idea, or sensation, whereas, a compulsion is a conscious, standardized recurrent thought or behaviour, such as counting, checking, or avoiding. While obsessions increase a patient's anxiety, compulsions on the other hand decrease a patient's anxiety. If however, a patient tries to resist carrying out the compulsion, the anxiety is increased. No matter how much the patient realizes the irrationality of the obsessions and/or compulsions, the patient is unable to control them.

IV - PHOBIA

Phobia is typically characterized by a marked and persistent fear that is excessive or unreasonable cued by the presence or anticipation of a specific object or situation with immediate anxiety response. Therefore, the phobic situation is intensely avoided or endured with consequent intense anxiety or distress. Again, the patient realizes the irrationality regarding the fear.

Phobic disorders could be categorized into 2, the Specific Phobia and Social Phobia. The specific phobia could be further sub-categorized depending on feared objects or situations.

V - PANIC DISORDER AND AGORAPHOBIA

Panic attacks are relatively short-lived periods of intense anxiety or fear accompanied by somatic symptoms such as palpitations, sweating, trembling or shaking, shortness of breath

or sensation of smothering, choking sensation, chest pain or discomfort, nausea or abdominal distress, dizziness or lightheadedness, derealization (feeling of unreality), depersonalization (being detached from oneself), fear of losing control or going crazy, fear of dying, paresthesias, or chills or hot flushes. The attack typically has an abrupt onset, building to a maximum intensity within 10 to 15 minutes and rarely lasts an hour. Panic attacks do not always signify a mental illness as up to about 10% of otherwise healthy people experience an isolated panic attack per year. Furthermore, they commonly occur in the course of social phobia, generalized anxiety disorder, and major depressive disorder.

Recurrent panic attacks on the other hand with corresponding development of persistent concern or worry about having further attacks or changes his or her behaviour to avoid or minimize such attacks characterize Panic Disorder. Whereas the number and severity of the attacks vary, the concern and avoidance behaviour are essential features. The repeated panic attacks may provoke a strong urge to escape or flee where the attack begins. In fact, half of patients with Panic Disorder, at some point, they develop such severe avoidance as to warrant a separate diagnosis of Panic Disorder with Agoraphobia.

Agoraphobia originated from the ancient Greek word meaning fear of open places. Today, however, agoraphobia describes a severe and pervasive anxiety about being in situations from which escape might be difficult or avoidance of situations from which escape might be difficult or avoidance of situations such as being alone outside of the house, traveling in a car, bus, or aeroplane, or being in a crowded area. Patients who do not meet the full criteria using DSM IV or ICD 10 for Panic Disorder are categorized under Agoraphobia.

VI - OTHER ANXIETY DISORDERS

Mixed Anxiety and Depressive Disorder have been seen mostly in out-patient clinical setting in Fiji. There is, however, as with other psychiatric disorders, a strong need to collate a nationwide epidemiological data as to its prevalence. This disorder covers patients who have both anxiety and depressive symptoms but who does not meet the diagnostic criteria for either an anxiety or a mood disorder.

A wide range of medical conditions can cause symptoms similar to those in anxiety disorders. Hyperthyroidism, hypothyroidism, hypoparathyroidism, and Vit B12 deficiency are frequently associated with anxiety symptoms. Pheochromocytoma produces epinephrine consequently producing paroxysmal attacks of anxiety symptoms. Certain lesions on the brain and post-encephalitic states reportedly produce symptoms identical to those seen in obsessive-compulsive disorder. Both cardiac

arrhythmias and hypoglycemia can mimic the symptoms of anxiety disorders. The diverse list of medical conditions that can cause symptoms of anxiety disorder may do so through a common mechanism, the noradrenergic system. Effects on the serotonergic system are still being studied though.

A wide range of substances can cause symptoms of anxiety. Sympathomimetics such as caffeine, cocaine, and amphetamine have been mostly associated with the production of anxiety symptoms, but a wide range of prescription medicines have also been associated with production of anxiety symptoms in susceptible persons.

Other patients who manifest anxiety symptoms but do not meet the criteria established by ICD 10 or DSM IV are diagnosed to have Anxiety Disorder Non Otherwise specified.

TREATMENT AND MANAGEMENT OF ANXIETY DISORDERS

Most anxiety disorders respond quite well with some form of psychotherapy or pharmacotherapy, either singly or in combination. Before treatment begins, a doctor must conduct a careful diagnostic evaluation to determine whether a patient's symptoms are caused by an anxiety disorder or by a physical problem. The type of anxiety disorder should also be determined as treatment for each type will be different. Any co-existing condition, such as alcoholism, should be managed first with the treatment of anxiety put on hold until the co-existing conditions are under control.

I – PSYCHOTHERAPY

Among the various psychotherapies available, Cognitive Behavioural Therapy and Interpersonal Therapy have been medically proven to be effective. Recent preliminary imaging studies conducted by Eric Kandel and his associates have shown metabolic abnormality in the caudate nucleus of patients with obsessive-compulsive disorder. After improving with psychotherapy, this metabolic abnormality reversed, similar to what happens after giving patients with pharmacological agents such as fluoxetine. However, there are certain patients who do not respond to psychotherapy alone and might need pharmacological adjunct. Other group of patients might respond to psychotherapy alone as the primary method of management, whereas others respond to pharmacological agent only. Currently, there is still no way of determining which group of patients would respond to which or what forms of treatments.

II – PHARMACOTHERAPY

A - BENZODIAZEPINES

Benzodiazepines are a large class of medications that have rapid and profound anti-anxiety and sedative-hypnotic effects. They are best used for patients with GAD and Panic Disorder, however, they do not have strong anti-obsessional effects. Hence, their use for OCD and PTSD are generally viewed as palliative. Furthermore, it is potentially addictive and should not be used for patients who have chronic symptoms, particularly for short-acting benzodiazepines such as alprazolam and lorazepam. On the other hand, long acting benzodiazepines such as diazepam and clonazepam, should also be used judiciously due to its longer period of action. Diazepam also has multiple active metabolites that increase the carry over effects such sedation and hang-over.

Usually, benzodiazepines are initially used with antidepressant while waiting for the antidepressant to manifest its effects. When effective, benzodiazepines should be tapered after several months of use, although there is a substantial risk of relapse.

B - ANTIDEPRESSANTS

Most antidepressant medications have substantial anti-anxiety and anti-panic effects in addition to their antidepressant effects. Moreover, a large number of antidepressants have anti-obsessional effects as well. It is also preferable to use Selective Serotonin Re-uptake Inhibitor (SSRIs) compared to the older antidepressants such as the Tricyclic or the Tetracyclic antidepressants (TCAs) such as Imipramine, Clomipramine, and Amitriptyline, due to its tolerability and low side effect profile. Otherwise, both are equal in their efficacy. There are even some patients who responded to the TCAs favorably after failing to improve with the SSRIs. SSRI's are: fluoxetine, paroxetine, sertraline, fluvoxamine and citalopram. The SSRI's are so called as they selectively block the re-uptake of the serotonin. The doses of the SSRIs also differ depending on the type of anxiety disorder.

Clomipramine with its relatively potent re-uptake inhibitory effects on serotonin neurons, has been the only TCA with specific antiobsessional effects.

When effective in treating anxiety disorders, antidepressants should be continued for 4 – 6 months before tapering off gradually to avoid discontinuation-emergent activation of symptoms. Although, less extensively studied than depression, it is likely that many patients with anxiety disorders may warrant longer term, indefinite treatment to prevent relapse or chronicity.

C - OTHER MEDICATIONS

There are other pharmacotherapeutic agents found in other countries, such as Bus-

pirone and Monoamine Oxidase Inhibitors that are currently unavailable locally. Buspirone is a relatively selective 5-HT_{1A} partial agonist that has been approved in other countries as an anxiolytic. It is not habit forming and has no abuse potential though as compared to the benzodiazepines, with safety profiles comparable to the SSRIs, and significantly better tolerated than the TCAs.

Beta-blockers, such as Propranolol, could also prevent physical symptoms due to the increased autonomic nervous system activity such as stuttering, trembling, or tachycardia that accompany certain anxiety disorders in particular, social phobia.

III – OTHER APPROACHES TO MANAGEMENT OF ANXIETY DISORDERS

Exercise is a simple but effective method taking anxiety symptoms under control. Previously, scientists believe that it is due to the release of natural opiates called endorphins, although current researches have questioned this. Even if the rationale behind this is still to be discovered, working out regularly; meaning most days of the week for at least 30 minutes or so may help recalibrate the anxious brain.

Breathing and relaxation exercises are also beneficial for people who suffer from anxiety disorders. Yoga, which is both a form of exercise and a way to calm the mind, also utilizes focusing attention on breathing as a way to quiet the mind. They both could quell an anxiety episode by slowing a racing heart and lengthening the rapid, short, and shallow breaths of panic attacks. Other anxiety sufferers find solace and relief in meditation, massage, aromatherapy, guided imagery, or even acupuncture.

Lifestyle changes could also help, which could range from cutting back or totally eliminating sugar, nicotine, caffeine, alcohol or other recreational drugs. Also finding time to relax, having enough sleep and eating right may prove to be useful. Finally, moving to a less stressful environment or finding a different line of work may mean a lot of difference.

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TYPES OF PSYCHOLOGICAL TREATMENTS

Defined as the range of techniques that utilize psychological principles to help people overcome their difficulties, psychological treatments offers an alternate non-drug option for improved patient outcome. From more than hundred approaches – with newer ones being added regularly – an overview of the major types of psychological therapies will enable awareness of, and maximum utilization of, the various services available.

Psychodynamic Therapy

“Say everything that enter your mind. Do not select anything. No not leave out anything”. This simple but difficult rule forms the basis of free association that is geared to bring into awareness that repressed childhood conflicts.

According to Freud's psychodynamic theory, the repressed memories, though unconscious, continue to influence adult personality and psychopathology. He derived a method – that he called psychoanalysis – in which the repressed conflicts are brought into consciousness. Dreams, fantasies, relatively insignificant thoughts and parallism of present acts are analysed and used to probe the unconsciousness.

When the repressed memories are uncovered and expressed freely, the emotional tension is reduced in a process called abreaction or catharsis. Self analysis of the roots of the conflicts also results in insight. Examination of the same conflicts repeatedly results in learning process that leads to deep seated modification of personality that enables the patients to be able to deal with their problems more effectively (Hilgard et al 2004).

Variants of Freud's method soon proliferated. Adlerian psychotherapy that emphasizes the need to overcome subconsciousness inferiority complex, and Jung's Analytic Psychology that included culture, myth and spirituality, are two prominent examples from early 1900s. By 1950s object-relations school appeared to emphasize the internalised unconscious childhood relationship and Kohat's modification of self psychology that gives prominence to the need for attachments.

All these variants retain the key ideas of transfer of emotions from past significant ones to the therapist, unconscious motives from early childhood and ego defences (Wade and

Travis, 2005) and thus are collectively referred to as psychodynamic psychotherapy.

The orthodox therapy is very intensive: several times a week for several years. Modern approach is time-limited to 20 – 25 sessions. The main advantage of psychodynamic psychotherapy is that it delves into the root cause of the abnormalities. A select few will benefit from t, not only to overcome from personality disorders or mood disorders but for personal development as well.

Humanistic – Existential Psychotherapy

Humanism emphasizes people's freewill to change; and based on this philosophy Carl Rogers developed his client – centered non-directive therapy. He listens to clients in an accepting non-judgemental manner, offering unconditional positive regard, to help develop the clients' self esteem and be able to manage the problems more effectively (Wade and Travis, 2005)

The therapy is client-centered because the clients arrive at their own insight. It is non-directive because the therapist does not direct but allows the clients free rein to choose whatever topic needs to be covered. Humanist therapists are not concerned about the past experiences but deal with the present, the problems, the clients personalized experiences and their unique abilities to search for their own solutions.

The role of therapist is to acknowledge and accept the clients feelings, to help clarify issues and enable the clients to face their problems, bring up own resources and become more positive. Above all, counselor warmth, genuiness, empathy and unconditional positive regard are paramount.

Although some experts use the terms counselling and psychotherapy interchangeably, counselling most closely resembles humanistic psychotherapy. Rogers furthered the distinction by limiting counselling to treatment of everyday problems; with psychotherapy used to address diagnosable mental illness. Other authorities use an all encompassing term: Helping (Egan 2003).

Existential Therapy is based on life philosophy and is designed to help explore the meaning of existence with the aim to face the great questions of life. Emphasis is on self responsibility. Subjective experiences as own

Rajeshwar Sharma, Suva

truths are also proffered. Discovering one's chosen meaningfulness in every experience, even the harsh ones, is the ultimate goal of therapy, many GP's will find existential philosophy very enlightening.

Cognitive Behavioral Therapy Cognitive Restructuring

In accordance to rubic constructivism our cognitions – thinking perspectives, mindsets: both normal as well as abnormal – are constructed. It is therefore possible to restructure the dysfunctional components. Indeed cognitive therapists attempt to do just that,

Albert Ellis, for example, has developed rational emotive behavior therapy (REBT) in which he uses no-nonsense approach by directly disputing clients' unrealistic beliefs and expectations. He also teaches them not to drive themselves crazy with unrealistic ideas that they must be always liked, must be always successful, must always have their own way and so on. His approach is to dispute these irrational beliefs and reformulate them with logical ideas (Ellis and Blau 1998).

Aaron Beck (1991), taking a softer approach, helps his clients choose more realistic perceptions mainly on inference rather than facts and this gives rise to perceptual distortions. He also noted that negative thoughts precede depression, anxiety and anger. His cognitive therapy helps clients to learn skills to restructure the distorted perceptions.

Behavior Modification

Behavior therapy is based on the philosophy that many of our actions are learned. Principles of classical and operant conditioning, together with social learning theory, are utilised to unlearn the undesired actions and relearn appropriate behaviours.

Techniques may involve exposure of stimuli. Either through imagery or in actual; with gradual progression as in systematic desensitisation or abruptly as in flooding. In systematic desensitisation clients learn to relax deeply and get introduced to mental, virtual, or actual fearful stimuli; from the least frightening to the most dreadful. In flooding, exposure is all of a sudden. For example, an agoraphobic is taken to a department store and placed there until the panic is lessened (Hilgard et al 2004).

Aversive conditioning, on the other hand, pairs a punitive event with unwanted stimulus to help learn to eliminate the offending behavior. Pairing nausea-producing drugs with intake of alcohol, breaking smoking habit by machine induced blowing of stale cigarette are two examples of aversive conditioning.

Self assessment of patterns of behaviours, their triggering stimuli. Reinforces and con-

sequences form the basis of behavior therapy. Clients are encouraged to keep records of behaviours that they wish to change. Once details are identified treatment programs are designed and implemented.

Behavioural therapy also places major emphasis on skills training. The therapist uses modelling, role-playing and shaping to teach the clients the required skills. A shy person may learn to be assertive by observing and imitating an assertive model. She may also role-play as an assertive person with her therapist.

In shaping behaviour, principles of operant conditioning are used and the desired response is achieved by successive approximations – step by step – while each successful approximation is reinforced; the failures ignored. Most complex skills such as driving, dancing, and many medical procedures are learned with this form of conditioning, and it can be utilized to help clients learn many required skills.

Cognitive Behaviour Therapy

Early behaviorist like Watson and Skinner were not concerned about cognition. However, as knowledge of learning evolved and social – cognitive theory was developed by Bandura (1968) and Mischel (1973), therapists began to consider integration of thoughts, emotions, impulses and perceptions with actions (Strisik, 2006)

Meichenbaum, for example, developed Cognitive Behavior Therapy (CBT). Other variants of behavior therapy incorporated cognitive elements as well. Acceptance and Commitment Therapy, Dialectical Behaviour Therapy, Reality Therapy, Transactional Analysis and Rational Emotive Behaviour Therapy all have integrated approach, for instance.

Cognitive Behaviour Therapy is a brief – 20 sessions over 12 – 16 weeks – and is very beneficial for panic disorders, sleep disorders, childhood/adolescent problems, and depression (Wade and Tavis, 2005). It has been the type of therapy most scientifically validated.

Moreover, CB can be easily applied in General Practice. Tiller concludes "CBT is a useful, effective, practical and economic treatment for use by doctors in all areas of medicine" (2001: 37).

Multicultural Approach

The view taken by multicultural approach takes into consideration external environment factors such as poor socio-economic status, racism, sexism, and such. Multicultural therapists see individuals in a family within cultural context and consider intervention at three levels. First, the clients' concerns, issues, abnormalities are dealt with using cognitive behaviour therapy or similar psychotherapy. Second, the oppressive conditions are managed. Finally,

the major issues of injustice in the community are addressed (Ivery et al 1993).

Family and couples therapy

Difficulties in relating to others form the basis of many psychopathologies. Relating to spouses and other family members is very important. Family therapists work with all members of the clients' family and attempt to remedy the negatives. Family-systems perspective recognizes that people's behaviours within a family is interconnected like that of two dancers and is able to deal with cases in which it is not possible to treat the whole family.

Couples therapy has been designed to help couples resolve conflicts within the relationship. Couples therapists get both sides of the story and focus on resolving to live with the differences rather than getting stuck on blaming and attacking each other.

Other therapies

In Gestalt Therapy dreams, fantasies and both sides of conflicts are allowed to be brought up to form figures and are acted out to emphasize intensely the feelings and actions. The present moment's total perceptual experience is highlighted with the aim of resolving conflicts and removing blocks to be ultimately become aware of the "whole" personality. Gestalt therapy has features of psychoanalysis, cognitive/behaviour therapy and humanistic approach (Hilgard et al 2004).

With added pressure on time as well as influence from profit minded insurance companies, Brief Therapy has been developed. In general, Brief Therapy helps clients express feelings and clarify difficulties. Alternate understandings are projected and clients are encouraged to solve their own problems. De Shager (1998) introduced a theory of solution with a central map that is oriented to find solutions from the client's past success. Interpersonal psychotherapy, another Brief Psychotherapy consisting of 12-16 weekly sessions, is directed at depressives to help improve their interpersonal functioning.

Problem solving, potentially briefer and simpler than other therapies, is based on the strategy of exploring the problem, determining possibilities and discovering ways to attain the goals. According to Egan, problem solving is embedded in all approaches since all deal with constructive change. Nevertheless, specific problem management strategies have been worked out for many difficulties.

Besides the above mentioned major types of psychological treatments, several approaches and variations exist. With so many types, therapists have tried to integrate them. Lazarus (1981), for example, has come up with multimodel therapy in which he integrates many approaches. At the same time, up to forty percent therapists and counselors borrow freely from all the approaches to form eclecticism. The borrowed techniques are integrated to enable client specific requirements.

Conclusion

Psychological treatments can help in the management of psychopathologies as well as everyday problems. They enhance personal development and enrich one's life. Since there are many types of psychotherapies, the most effective therapist needs to tailor the approach to client's specific requirements.

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CME PAGE



This is an abdominal x-ray of a 64 year old Fijian female who presented with diminished appetite, feeling full very easily after a small amount of food and weight loss. The investigations eventually showed she had an oesophageal stricture. However, the above condition was found incidentally during the course of her investigations. What condition do you see on the erect abdominal x-ray other than scoliosis?

Answer to CME Exercise in Oct-Dec 2006 Journal:

A depression skull fracture is seen to the left frontal skull bone involving the frontal sinus plate. Overlying soft tissue edema is also seen over. There is no obvious cerebral hematoma or swelling seen.

Email your answers to National CME Officer, Dr Maria Chung-Harrison at mariachungharrison@yahoo.com.au for your CME POINTS.

REPORT

GENERAL PRACTICE RESEARCH AND THE RELEVANCE OF REGIONAL JOURNALS

As 2006 draws to a close, this is a good time to reflect on the many challenges we have all faced throughout the year. It has been a year that has seen the network of family physicians form even stronger bonds globally, as we have faced challenges from many quarters:

- * both new infectious disease threats such as avian influenza,¹ and old ones such as the continual decimation of populations in developing countries by HIV;

- * implementing and disseminating concepts of preventive medicine;

- * addressing the issues of health inequalities, whether they be gender, ethnic or socio-economically based; and

- * dealing with the scourge of chronic disease and comorbidity that forms the daily bulk of problems presented in GP waiting rooms around the world.

This concept of professional commonalities, irrespective of the locale of our practice, was emphasized most recently at the Asia-Pacific Wonca meeting in Bangkok. This meeting also highlighted the importance of research by our profession, in order to gain a greater understanding of our patients' needs and to encourage better directed health care and policy initiatives for individual countries within our region. In line with this, the "Research Networks within the Asia Pacific Region" seminar was well-attended and broad vision issues were discussed. The need for adequate funding and protected time to promote and support research initiatives was highlighted, and ways of doing this were debated. This focus on research closely supports the mission statement of our journal, which has always been dedicated to providing a platform for disseminating regional research and helping raise the standards within our region.

As the Journal enters its 6th year of publication we, the editors, continue to search for the most effective and efficient way for the journal to meet your needs. As most of you will be aware, changes to publishing have been fast and furious over the last 5 years, with electronic publishing being a standard way of disseminating information.^{2,3} However, this has to be consistent with maintaining publishing standards, something to which we at Asia Pacific Family Medicine (APFM) have always been committed. Our survival over the past 5 years has been challenging, but the need for a journal such as ours has never been greater. In a searching article dealing with the reality of an ongoing place for local journals in an environment of international competition,⁴

Ofori-Adjei argues that "the time has come to recognize local journals as a resource for health." While internationally recognized "quality" criteria in publishing mean that many authors seek publication in the larger international journals, this underestimates the question of readership. Topics of pressing need and interest locally may have little importance or relevance on a world-wide scale. Does this mean the topic is not suitable for general debate or in need of dissemination? Not at all. It means that the audience needs to be carefully selected, and this is what smaller, more targeted journals specialize in. For this reason, we believe that the APFM journal has an essential part to play in the discipline of family medicine in this region. Its place on the library shelf is beside local, national journals, to provide a repository of locally relevant research that supplements each local national journal's impressions and discussions of their national policies and interests.

In 2007, revisions to our publishing process will see the journal being delivered to you, the reader, in a more timely fashion with reflections on the issues and research of regional importance. We welcome articles from all authors on the diversity of topics and interests that fall under the umbrella of general practice/family medicine, but we are particularly seeking papers that address four key topics of relevance for our region: avian influenza pandemic planning; mental health; diabetes; and medical education. We particularly welcome new or aspiring authors to join the research debate.

Finally we, the editors, would also like to extend our gratitude to the editorial board and all the reviewers who have worked so hard behind the scenes over the previous year to keep the journal ongoing. In addition, we also want to express our thanks to the editorial team of Rod, Alex and Emilin, without whom it would be impossible to have a journal at all. So from all of us, we thank you for your support over the last few years and look forward to further exploration with you in the exciting world of general practice in 2007.

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(Courtesy reprint of Asia Pacific Journal of Family Medicine Volume 5 Issue 3)

Lyn CLEARIHAN,
Tai Pong LAM,
Zorayda LEOPANDO

MEDWATCH



1. The Brown Street approach to The Fiji School of Medicine Hostel is a sight to behold. A wide range of female undergarments are constantly being aired and on display for the traveling public. One wonders if the medical students are making a point. Is it fashionable to go bare-*a la naturelle* or is it an exercise to wash our linen in public?
2. A visit to the towns and cities of Fiji is indeed an eye-opener. When passing General Practitioners consulting offices in such areas, the range of credentialing is mind blowing. Great credence is given to membership of the College. Even "associates" have this declared on their signage when this is not warranted and unethical. "AMFCGP"
These same associates are seldom seen at workshops, mini-seminars and conferences. They have not acquired their voluntary Continuing Medical Education points to suggest any formal on going educational upgrade.
3. The cleansing exercise undertaken by the military will have its extension into the health delivery organization in Fiji. A soul-searching exercise should start proactively. How about getting the players together to synchronize the effort? For example, can we not look at getting our pharmaceutical services to become efficient and cater for the needs of all retail pharmacies, general practice supplies along with the current needs of the primary and clinical services of the State health services? The pharmaceutical services will give the bigger wholesalers a good run for their money. This healthy competition can generate sizable revenue for the ministry. This demonstrated revenue generation has in the past gone to general government coffers only to be squander leaving the health portfolio, beggars so to say.
4. Use and misuse of progestogenic hormones is rampant in Fiji. It is largely the result of primary care providers not keeping abreast with new developments in the pharmaceutical industry and trying to make do with whatever is generally available. Many women are treated with hormones when non-steroidal agents will be agents of choice and provide better and quicker resolution. Take the example, a young lass who has just started her menstruation and experiencing Dysfunctional spotting. The GP offers provera or nor-ethisterone tablets. A rebound follows the moment she stops her medication. A vicious cycle of consultations follow until hospitalization is warranted for blood transfusion. Likewise the peri-menopausal patient is not cleared of pathology but offered the same till she gets frustrated and seeks an independent gynecological appointment for an endometrial sampling or D&C. to regularize her cycles and have a histological diagnosis made.
5. Off-label use of Misoprostol by G.P's is of grave concern. The dispensing of such agents in massive doses, by pharmacists is also of greater concern. In USA, several deaths have been associated with indiscriminate use of such medication with protracted bleeding and septicemia. Some practitioners thrive in this trade, attempting to manipulate the physiological cycle.
6. Unfortunately the prescribing habits of most practitioners are dependent on pharmaceutical detailing by drug company representatives. Recently an analgesic which was introduced by one of the wholesalers was rather toxic with full doses of "paracetamol" and "indomethacin" in one dosage tablet/syrup. An attempt to get the Fiji Pharmaceutical Society president to respond has proven futile. Maybe we should look elsewhere on matters which concern patient safety? The Consumer Council under the vibrant Mrs Premila Kumar may be another future option if our Pharmacy and Poisons Board remains in deep slumber.

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GERD accounts for up to **60%** of patients with NCCP¹

Acid suppression with Omeprazole effectively improves chest pain in patients with NCCP and GERD²

In GERD associated NCCP International Journals recommend...

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Omeprazole 40 mg in the morning	Omeprazole 20 mg in the night

For 7 days

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Omeprazole 20 mg Cap. & 40 mg Tab.
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