Child and Adolescent Psychiatry in South Asia: Present State and Future Prospect

Mohammad S. I. Mullick , MBBS, M.R.C.Psych., Ph.D.

Professor of Child and Adolescent Psychiatry and Chairman

Department of Psychiatry, Bangabandhu Sheikh Mujib Medical University (BSMMU), Dhaka 1000, Bangladesh

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ABSTRACT

Objectives: To review the present state of child and adolescent psychiatry in South Asia and indicate future direction for the development of child and adolescent psychiatry services.

Methods: The relevant epidemiological studies were reviewed.

Results: In South Asia, 40-45% of the population is under the age of 18 years. Representative studies suggest that 12-20% of children have psychiatric disorders. Risk factors include poverty, malnutrition, infectious diseases and illiteracy. Protective factors are supportive society, high degree of cohesiveness within the family, affirmative learning experience, and parental authority. Child psychiatry in South Asia differs from the West in many aspects due to socio-cultural-economic and resilience factors.

Discussion : Major limitations in this region are under-recognition and under-treatment of disorder, stigmatization and lack of availability of professionals and services. There is little prospect of meeting this need in the future by attempting to develop western models of service provision. South Asia has unique strengths like relatively stable society, strong family & neighborhood support, warm teacher-student relationship, and adequate 'potential' non-professional manpower.

Conclusions: Adopting a policy and action plan to move toward the development of child and adolescent mental health services in these countries is urgently required.

INTRODUCTION

The geographical area of South Asia includes Bangladesh, Bhutan, Democratic Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Pakistan, Sri Lanka, Thailand, and Timor-East. In South Asia, roughly 40-45% of the population is under the age of 18 years. Despite differences in cultural and religious practices, the factors influencing child mental health remain broadly similar across these countries. Children are subject to exposure to a number of risk factors for physical and psychological well being like: poverty, malnutrition, unhygienic living conditions, infectious diseases and illiteracy. Approximately 45 percent of the South Asian population lives below poverty line. The relationship between poverty and mental health is complex and multidimensional. Conversely, South Asia also has important protective factors including: uniform traditional society, high degree of cohesiveness within the family, stable and supportive environment, affirmative learning and teaching experience and parental authority. There may also be differential effects of risks on the rates for psychiatric disorder. For example, overanxious and overprotective parental attitudes, combined with dependent and unexpressive traits in children, can lead to higher rates of emotional problems and lower rates of conduct problems. At the governmental level, child and adolescent psychiatry in South Asian countries is not prioritized as an important service area and tends to be rather ignored and neglected. The opportunity for training and education are also limited due to severe shortage of resources and professionals. Overall, there is a vast gap between need and provision in these countries.

OBJECTIVES

- To review the rates of child and adolescent psychiatric disorder and the evidence for exposure to risk factors for disorder in South Asia
- To examine possible models of restructuring child and adolescent psychiatry in the region

METHODS

- ▲ A selective review of original epidemiological studies on child and adolescent mental health problems, clinical observational studies and review papers has been carried out.
- ▲ The list of the studies was assembled a hand screen of relevant journals and from computerized search of Medline and Psych info using the following key-words "epidemiology", "disorders", 'child psychiatry".
- ▲ Up until now, there has been little systemic research into childhood psychiatric disorder in South Asia that were included

RESULTS

Few epidemiological studies in South Asian countries would able to explore the extent of psychiatric disorders among children and adolescents. The prevalence estimates are shown in Table- I.

Table-I: Prevalence of child psychiatric disorder in South Asia

Study	Measure	Setting	Prevalence (%)
Lal et al,1975	Clinical interview	India	35.6
Geiel et al,1988	Reporting Questionnaire for children	India	22.0
Javad et al,1992	Rutter Scale	Pakistan	9.3
Hackett et al,1999	Rutter Scale Rutter Interview	India	9.0
Mullick & Goodman,2005	DWABA	Bangladesh	15.2
Srinath et al,2005	SDQ	India	12.5
Margot etal,2005	SDQ	Sri Lanka	23.0
Syed et al,2007	SDQ	Pakistan	34.0

The more methodologically sound epidemiological studies report conservative estimates of around 15% of the population meet criteria for child and adolescent psychiatric disorder, which are severe enough to result in substantial distress and social impairment, thereby warranting treatment. Ddefinition of cases, area of the study, age group, sampling strategy, sample size, study design, measures of psychopathology, cross cultural issues were found to be key factors for the variation of prevalence.

Table -II shows the pattern of Psychiatric disorder in a study in Bangladesh among 5-10 years children. It reveals that of the group of disorders, the rates were highest for behavioral disorders, closely followed by anxiety disorders. Of the individual disorders, Oppositional defiant disorders were the commonest followed by conduct disorder and other anxiety disorders.

Table-II: Prevalence of groups and types of child psychiatric disorder

ICD-10 Diagnosis	Weighted prevalence (95% confidence interval)
	Total
Any disorder	**15.2% (10.9-20.8%)**
Any anxiety	**8.1% (5.1-12.7%)**
Separation anxiety	1.5% (0.6-3.6%)
Specific phobia	1.0% (0.3%-3.1%)
Social phobia	0.1% (0-0.8%)
PTSD	1.3% (0.4-4.5%)
OCD	2.0% (0.7-5.9%)
Generalised anxiety	0.8% (0.4-1.6%)
Other anxiety	2.5% (1.0-5.9%)
Hyperkinesis	2.0% (1.0-4.1%)
Any behavioural	**8.9% (5.6-13.6%)**
Oppositional defiant	5.9% (3.4-10.0%)
Conduct disorder	2.9% (1.3-6.4%)
Autistic spectrum	**0.2% (0-0.9%)**

Obsessive compulsive disorder is considerably prevalent. The two commonest themes were compulsions related to cleanliness and obsessional concerns of having offended God.

Somatization disorders are also common and wide varieties of physical symptoms in somatoform disorders were reported. Some specific somatic symptoms such as burning sensation of the hands, feet or all over the body, feverish sensation, sensation of fleeting or moving pain all over the body, feeling of hotness in the head or ear, buzzing noise or cracking sound in the head, ears or other parts of the body, sensation of something moving in the abdomen, passage of white discharge through urine (in adolescent boy) were remarkably found in the cases. Again expression of few somatic symptoms was difficult to specify or translate into English, hence was not considered for the diagnoses. For hysteria, mixed types of physical symptoms were common and another variant of hysteria with psychotic symptoms, which was clinically recognized as "psychotic hysteria". Mass hysteria among school children in Bangladesh was reported characterized by dissociation, motor changes and mixtures of histrionic and psychotic behavior. Of the purely culture bound syndromes, 'possession state' was well recognized. Conversely, eating disorders were reported to be rare compared to western countries. Depressive disorder were also less commonly recognized and found to be present with significant numbers of somatic symptoms.

The correlates of psychiatric disorders were reported in some studies. Proposed risk factors for behavioral disorders include: poor school performance, low parental education, low economic status, inadequate social amenities, overcrowded living condition, poor dwelling condition, rapid urbanization, and social disintegration. Problem rate was higher in boys. On the other hand, authoritarian and overprotective parental attitude, dependent and unexpressive nature, tendency of internalizing distress and sufferings among the children in general were associated with emotional disorders. Stigma among family members of patients with severe mental disorders is common. Some specific pattern of stressors like overprotective parents, inappropriate parental pressure, chronic interpersonal stress associated with school, underage marriage exist in this region. Possible associated protective factors included relatively stable traditional society, strong family support, a high degree of cohesiveness within the family, supportive family environment, strong family and neighborhood support in child care and warm teacher-student relationship inherent in the culture. Other potential strengths of South Asia were excellent infrastructure of national health services, adequate 'potential' manpower, good number of non-government agencies for child care, increased awareness at all level about child psychiatric problems and increased medical education. The "potential" manpower in South Asia included: parents, teachers, child health working staff, primary care physicians, social workers, counselors, traditional healers, religious leaders and volunteers. Addiction treatment programs with involvement of trained religious leaders and family members were proven to be effective in achieving better compliance and better outcomes.

Area differences of prevalence were reported in few studies. Setting aside the national differences in absolute percentages, the similarity in pattern was very striking. Thus, in each country, children from rural and urban areas had similar rates of probable psychiatric disorders, whereas the rates for children from the slum were roughly twice as high. The slum families were generally poorer in all respects. By comparison with the relatively prosperous urban area, the families in the rural area were less affluent and less well educated, but they had greater social capital, as judged by high ratings for neighbourhood helpfulness and low ratings for neighbourhood danger. The rural families' greater social wealth may have offset their financial and educational disadvantages. By contrast, the slum families were poorer in all ways - experiencing even more financial and educational disadvantage than the rural families, but without the extra social capital to offset this.

Provision of child and adolescent mental health services were reported to be insignificant and there was huge gap between need and provision of services.

DISCUSSION

Overall, the prevalence of child and adolescent mental health problems in south Asian countries is nearly parallel to that of Developed countries. However, the pattern and presentation of child and adolescent disorders differ from Western countries in many aspects. South Asia has higher rates of emotional disorder than behavioral disorder, although this trend is changing. Some studies have found that children in South Asia have lower conduct problems, perhaps reflecting the resilient effect of social capital of traditional societies. This hypothesis could best be tested by future studies that involved many randomly selected areas, examining how area rates of child mental health problems correlate with the area averages for material, educational and social wealth.

For the better identification, it has been suggested that diagnostic criteria need to be modified for South Asian populations by including specific patterns of somatic symptoms for Depressive disorder. For Somatization disorder, the type and frequency of somatic symptoms are found different across culture. Therefore, it would be better by reducing list of symptoms and adding some other common prevailing symptoms Because, absence of one or two symptoms of DSM criteria for somatization disorder, the cases are not diagnosed as Somatization disorder despite of having many other symptoms that are not included in this criteria. Same is true for DSM criteria for Conversion disorder, where psychotic symptoms are not included for the diagnosis despite of having such presentation in this region. Therefore, there should have provision including transient psychotic symptoms by extending DSM criteria for the diagnosis of Conversion disorder. Overall, observations indicate that cultural factors of Somatoform disorder need to be investigated in depth.

The main limitation for the region is under-recognition of disorder and therefore low rates of treatment resulting in a greater than necessary burden of distress, impairment, social disability, and stigmatization. There is also a massive gap between perceived need and service provision. Access to clinical services is poor because of inadequate provision of services and the few specialized services are restricted to tertiary hospitals. There is no formal referral pathway to psychiatric services for the children. School health services are poorly organized or do not exist. There is weak coordination between health, social and educational sectors and a lack of communication, integration and cooperation between individual treatment agencies. In the majority of countries in this region, there are no established policies or plans for child and adolescent mental health issues. There is little prospect of developing professional services similar to the western models.

Developments in child and adolescent psychiatry for the South Asian countries will likely to be different from western models. Although some screening and structured diagnostic measures are validated to be culturally appropriate, many instruments have proved inadequate and some new instruments have been developed. Methodologically sound epidemiological surveys are needed for better information and service planning. In order to make use of scare resources of the South Asian countries, possible solution could be developing pediatric-psychiatric liaison services, establishing alternate multidisciplinary team by using 'potential manpower', training of the health professionals, and involvement of the community giving training & psychoeducation to the teachers, religious leaders, families and other community workers. There is urgent for adopting resource-based and cost-effective protocols to assist the management of mental health problems of children and adolescents.

CONCLUSIONS

- It will be necessary to identify strengths, resources, challenges and opportunities, to restructure child and adolescent psychiatry in South Asia.
- South Asian psychiatry requires the development of culturally sound measures of psychopathology, risk and protective factors.
- Governmental policy development and service planning could be formed by this development.
- It will also be necessary to develop non-western models of service delivery by using the strengths of local resources including non-specialist child and adolescent psychiatric services.
- Collaboration between similar professional organizations and assistance programs at international and regional levels is essential to achieve these developments.

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