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Abstract:

Prevalence of child and adolescent psychiatric disorders in Bangladesh is around 15% which is more or less similar with other countries. Rate of behavioral disorders are comparatively lower and emotional disorders are relatively high than that of developed countries. OCD is relatively high with preponderance of religious content. Tendency of more somatization exists that caused increased number of somatic symptoms disorders. Conversion disorder is relatively more prevalent including significant number of psychotic presentation commonly known as "psychotic hysteria ", and "Jinn possession"; a pattern of possession state. Further, somatic presentation of anxiety and depressive disorders are important issues in diagnostic and treatment purpose. There is low rate of autism though it is increasing. Poverty, stigma, unfavorable parental behaviors, effect of urbanization, culture specific stressors is the main risk factors. It is evident that supportive family environment, high social capital, religiosity are the notable protective factors. Vast gap exists between service need and provision. Resource-based alternative service model is required to combat the need.

Child and adolescent psychiatric disorder in Bangladesh: cultural perspective

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Introduction

Bangladesh lays in the north-eastern part of South Asia, with geographical area of 1, 47,570 sq km with a total population of 124 million people, of whom 45% are under the age of 18 years. Bangladesh is a low-income country and measures of deprivation include the following: an infant mortality rate of 53 per thousand live births; an adult literacy rate of 54% and 41% for males and females respectively. However, it has unique emerging economic characteristics. The country is very prone to floods and cyclones, reflecting the fact that it is largely made up of river deltas, with about 75% of the land being less than 3 metres (10 feet) above sea level. Bangladesh is the home of nearly 2,500 years ethno-cultural heritage.

Psychiatric disorders are universal in term of their core symptoms and management. Psychiatric disorders are also either culturally variant or culture specific. Practicability Perspective is that cultural perspective is prime important in child and adolescent psychiatry that successfully blends with universal concept of psychiatric disorder to understand and make accurate diagnosis and treatment. The wide variations of child development across culture are reminders of the dynamic interactions of biological parameters with the diversity of human conditions. Cultural perspective is therefore integral part of universal concept of child and adolescent psychiatry and mental health.

The cross cultural variations of child and adolescent psychiatric disorder are generated mainly from the epidemiological studies of child and adolescent psychiatric disorders. However, most of these studies lack one or more of the methodological features required for generating believable prevalence estimates, namely: an adequate sample size; a representative sampling frame; standardized assessment measures that are suitable for generating exact diagnoses; explicit and internationally accepted diagnostic criteria; and assessment not just of symptoms but also of resultant distress and social impairment .The studies that do meet these crucial methodological requirements report a range of prevalence ranging from 5 to18% . These studies also indicate cross cultural variation of child psychiatric disorder.

First epidemiological study on child psychiatric disorder in Bangladesh (Mullick & Goodman, 2005) based on sound methodological foundation that generates the basic indicative findings that Bangladesh shares universal representation of majority of child and adolescent psychiatric disorders in terms of prevalence, correlates, trends, presentation, course, outcome, diagnosis, assessment & treatment. Bangladesh has inevitable influence of the West as it inherits tendency of acceptance of science, modernity and evidence based medicine. Believe-behavior relationship and several factors influencing on almost all aspects of child and adolescent psychiatric disorders that must be considered, explored and addressed.

Objectives

•to recognize the cultural influence on child and adolescence psychiatric disorder in Bangladesh

•to identify the areas need to be considered in better understanding of child and adolescent psychiatric problems of Bangladeshi children and young people

Method

An online search with the terms 'child and adolescent psychiatry', 'child and adolescent psychiatric epidemiology ', prevalence of child psychiatric disorder, correlates of child and adolescent psychiatric disorder', 'child psychiatry, cross cultural context', etc was conducted. The representative epidemiological and clinical studies, review articles along with evidence-based comments, observation and recommendations were analyzed.

Results and Observations

Child and adolescent psychiatric disorder in Bangladesh: prevalence

Overall prevalence rate of 5-10 year old children in Bangladesh is 15.2%. This compares with prevalence of 9.8% for British 5-16 year olds (Meltzer et al, 2000) and 20.3% for American 9-17 years olds (Shaffer et al, 1996). Measure of psychopathology for Bangladesh and UK studies was Development and Well-Being Assessment (DAWABA) for generating ICD-10 and DSM IV diagnosis. That for US was Version 2.3 of Diagnosis Specific Impairment Criteria (DISC-2.3) for Children's Global Assessment Scale (CGAS) to generate DSM III-R diagnosis. Results of the combined informants were considered for comparison. Table -1 shows the comparison of overall prevalence and prevalence of group of disorders between Bangladesh and UK and US findings. 'Anxiety" group includes Separation Anxiety Disorder, Specific Phobia, Social Phobia, PTSD, OCD, Generalized Anxiety Disorder, and other anxiety disorder. 'Behavioral" group includes oppositional defiant disorder and conduct disorder.

Table 1. Comparison of Prevalence of groups of child and adolescent psychiatric disorder across countries

Group of disorder	Bangladesh Mullick & Goodman, 2005 %	UK Meltzer et al,2000 %	USA Shaffer et al, 1996 %
Overall rate	15.2	9.8	20.3
Anxiety	8.1	3.8	13.0
ADHD	2.0	1.4	4.1
Behavioural	8.9	5.3	9.3
ASD	0.2	0.9	-

*Co-morbidity was considered

It reveals that Behavioral disorders are proportionately lower in Bangladesh than that UK study. However, the trained is changing that has been observed. Several factors could be the reason and it might be due to rapid urbanization, urban migration, loss of social capital, economic drifting, increasing substance misuse, breaking of social institution & values. In contrast; Emotional disorders are proportionately higher in Bangladesh than that of UK and that is at least one evidence of young people's learning of more internalization. These scenarios have similarities with many other findings of countries with traditional societies. The prevalence is probably higher still in adolescents (Ford et al., 2003). On the conservative assumption that 10% of Bangladeshi children and adolescents have a psychiatric diagnosis, this represents over 5 million individuals who are experiencing substantial distress and social impairment; their disorders will also be affecting family members, classmates and teachers. These childhood problems will have substantial long-term costs, including higher rates of adult psychiatric disorders, criminality, substance abuse and under-employment.

Child and adolescent psychiatric disorder in Bangladesh: presentation

There is strong tendency of more somatization among children and adolescents as broader part of cultural learning. Somatic Symptom disorders were 20.5% of a child and adolescent psychiatry clinic population in Dhaka City. The commonest somatic symptom among this population is pain in the abdomen, chest and head and wide varieties of physical symptoms in somatic symptoms disorders are reported. Somatic presentation of anxiety and depression among children and adolescent are one of the key issues in diagnosis and treatment. Misidentification of psychogenic complaints causes undiagnosed, under diagnosed, hassles for overanxious caregivers, burden for other health professionals and distress and impact over the effected children and adolescents. Conversion disorder is proportionately high among children and adolescents. Along with neurological symptoms, psychotic presentation is significant can be called as "Psychotic Hysteria" that sometimes blended with "Jinn possession", a culture specific variation of possession state. These should be well placed in classification. "Jinn Possession" itself is a strong source of maltreatment that warrants culture appropriate treatment and prevention. Mass hysteria revisited among school children in recent past characterized by dissociation, motor changes & among histrionic/psychotic behavior. There is Strong possibility of future 'epidemic" due to cultural-cognitive constructs and evidence of sporadic outbreak. Deliberate self harm is far more common than suicide and is possibly fast becoming a common reason for emergency medical treatment. "Group self harm among the adolescence is recently reported in a correction center as means of protest or demand fulfilment. Possibly it shares common psychopathology with mass hysteria where group influence blended with social learning.

The prevalence of Obsessive Compulsive Disorder (OCD) among Bangladeshi 5-10 year olds was 2.0% (Mullick & Goodman, 2005). This compares with prevalence rates of 0.1% for British 5-10 year olds (Ford et al, 2003; Meltzer et al, 2000).This twenty-fold difference of prevalence of OCD with preponderance of religious content that possibly has complex psychopathology.Bangladesh is a religious country; about 90% of the population are Muslim, and there are also significant numbers of Hindus, Buddhists and Christians. In a religious society, it is unsurprising that religious concerns are more common; the occurrence of an OCD-like 'scrupulosity' has been noted for many centuries among practicing Christians . Islam particularly emphasises the importance of cleanliness in preparation for prayer; the themes of cleanliness and religion were explicitly linked by one of the children with OCD in this study, and may implicitly have been linked by some of the others. Furthermore, since Bangladesh is a country with a high mortality from diarrhoeal diseases spread by poor hygiene, and since health promotion in Bangladesh emphasises this link, heightened concerns about the dangers of poor hygiene are understandable. Most favoured interpretation, therefore, is that children with a constitutional tendency to obsessions and compulsions are more likely to present with frank obsessive compulsive disorder in societies such as Bangladesh that emphasise and link cleanliness and piety.

ADHD is significant (Table-I) in Bangladesh as with UK and USA and 'mixed' type is proportionately high that certainly related with cultural issues of child development and pattern of child rearing. Autism is less prevalent that ranged from 0.9-4.0 % and that is increasingly evident. Self harm among young people is far more common than suicide and is possibly fast becoming a common reason for emergency and demands special treatment protocol

Child and adolescent psychiatric disorder in Bangladesh: prognosis

There evidence from a small scale study on better outcome in First Episode Psychoses among adolescents. Better outcome of childhood schizophrenia can be assumed by equating such finding among the adults.

Child and adolescent psychiatric disorder in Bangladesh: correlates

Most notable specific risk factors identified are, poverty, stigma and myth related to child and adolescent mental health, rapid, disproportionate and unplanned urbanization. specific pattern of stressors : Under-aged marriage, educational rat race, father lives abroad for job, open sky caused cultural infiltration-sexual harassment, some unfavorable parental belief, attitudes & behavior like extreme authoritarian and overprotection. Well recognized protective factors are uniform & relatively stable society with traditional norms and values, supportive family environment, social capital, religiosity, girl education.

Child and adolescent psychiatric disorder in Bangladesh: treatment

The scope of pharmacotherapy is adequate but lack of availability of stimulants mainly due to placing this drug within illicit category. Psycho-social therapy observed to be applied with modification in almost every sphere. It is observed that involvement of trained religious leaders and teachers in managing young people's addiction could be effective. Active involvement of family members in management provides better compliance and thereby better outcome.

Child and adolescent psychiatric disorder in Bangladesh: training

Inadequate undergraduate training and limited opportunity for postgraduate training in child and adolescent that fail to meet the need. There is emergence of need-based short training for GPs, HWs and non specialist professionals(Teachers, Parents, Child related NGO service providers, Volunteers).There is strong need to start local need based with fully flavored evidence-based program to create good number of child and adolescent psychiatrists and other allied professionals.

Child and adolescent psychiatric disorder in Bangladesh: research

A good numbers of universally used screening & structured measures of child psychopathology are validated to make it culturally appropriate. Best example are Child Behavioral Checklist (CBCL), Strength and Difficulties Questionnaire(SDQ), Development and Well-Being Assessment(DAWBA).Many of the rating scales are proved to be not applicable and some new scales need to be developed. Methodologically sound epidemiological surveys on child and adolescent psychiatric disorder provided basic information. Nation-wide survey is required for better information and service plan. Research on cultural presentation of disorders need to be more wide and diverse. Research on existing CAMH Services should come forward with a lot of ideas for better coverage.

Child and adolescent psychiatric disorder in Bangladesh: services

Child and adolescent mental health resources both in manpower and facilities are extremely scarce and mal-distributed and little or no possibility of meeting the huge need in near and far future. Vast gap between need and provision, most of the children and young people are out of mental health coverage. Bridging the vast gap between need and provision will probably need to involve three strands: increasing the number of child mental health professionals; disseminating assessment and treatment techniques to other professionals, including teachers, family doctors and paediatricians; and preventing disorders where possible by tackling identifiable risk factors. Approaches to meeting mental health needs in developing countries are discussed by Rahman et al. (2000) and Patel (2003).It seems that systematic and planned CAMH Services are practically impossible & not foreseeable thus caused unsuitability of Western models of care. There is immediate need affordable and culturally suitable CAMH Services. Family is the main source of care giving. There is existence of "potential" manpower which includes: parents, teachers, child health working staff, primary care physicians, social workers, counselors, traditional healers, religious leaders and volunteers. There is growing consensus on local resource based non-specialist services with adequate training & supervision plus training center based specialist services to combat the need.

Conclusions

The cultural perspectives of child and adolescent psychiatric disorders of Bangladesh raise the need of modifying nosology & diagnostic criteria, developing culturally sound measures of psychopathology, developing resource based alternative services along with required manpower training. Important issue is to learn child and adolescent psychiatry from each other of the globe that will help in assimilation, restructuring and integrating child and adolesnt mental health practice in Bangladesh as well as services for Bangladeshi children in multicultural societies of the West.

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