Mental Health in Developing Countries:
Secrets and Lies, Shame and Denial

M. Omar Rahman, M.D., M.P.H, D.Sc.

DIRECTOR, MPH PROGRAM
Independent University, Bangladesh

Adjunct Professor of Demography,
Harvard University
Research Fellow, Department of Psychiatry,
Harvard Medical School
Road Map

- Introduction
- Range of Psychiatric Disorders
- Burden of Disease
- Inadequacy of MH services
- Data from one private practice
  - Frequency by diagnostic category
  - Clinical observations
- Role of therapist
- Psychiatry and Public Health in Dev Countries
Introduction

- Largely neglected, unexplored, underserved and under financed
- Secrets, Lies, Shame and Denial
- Supernatural, character flaws
- MH are brain disorders no different than any other physical disorder
Range of Psychiatric Disorders

- Psychotic Disorders
- Mood Disorders—Uni and Bipolar
- Anxiety-OCD, PANIC
- Substance Abuse/Dependence
- Personality Disorders
- Cognitive Dysfunction-Dementia
  - Eating Disorders
  - Sleeping Disorders
  - Sexual Dysfunction
  - Somatoform
  - Dissociative
BURDEN OF DISEASE
DALY burden in Low & Middle Income Countries

- Infectious: 25%
- Other + Injuries: 22%
- Neur-psy: 12%
- Cardiac: 10%
- Maternal & Perinatal: 9%
- Respiratory: 7%
- Neoplasms: 5%
- Neuro-psych: 4%
- Cardiovascular: 3%
- Other: 3%
Burden of Disease within Mental Health

- Mood d/o app 55%
  - Unipolar Depression = 33%
  - Intentional self injury = 12%
  - Bipolar disorder = 10%
- Psychotic d/o — 7.5%
- Anxiety d/o — app 11%
- Substance abuse — 7%
- Other — 20%
Table 1. Percent reporting Specific Disorders in the U.S. general popn
Chapter 66; Psychiatry Update. Stern and Herman, 2000

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Ever had during Lifetime</th>
<th>Active (during past 1 year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phobias</td>
<td>14.3</td>
<td>8.8</td>
</tr>
<tr>
<td>Alcohol abuse/dependence</td>
<td>13.8</td>
<td>6.3</td>
</tr>
<tr>
<td>Generalized Anxiety</td>
<td>8.5</td>
<td>3.8</td>
</tr>
<tr>
<td>Major depressive episode</td>
<td>6.4</td>
<td>3.7</td>
</tr>
<tr>
<td>Drug abuse/dependence</td>
<td>6.2</td>
<td>2.5</td>
</tr>
<tr>
<td>Dysthmia (mild depression)</td>
<td>3.3</td>
<td>n/a</td>
</tr>
<tr>
<td>Anti-social personality</td>
<td>2.6</td>
<td>1.2</td>
</tr>
<tr>
<td>Obsessive Compulsive</td>
<td>2.6</td>
<td>1.2</td>
</tr>
<tr>
<td>Panic</td>
<td>1.6</td>
<td>0.9</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>1.5</td>
<td>1.0</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>0.8</td>
<td>0.6</td>
</tr>
<tr>
<td>Cognitive impairment: severe</td>
<td>NA</td>
<td>0.9</td>
</tr>
<tr>
<td>Somatization</td>
<td>0.1</td>
<td>0.1</td>
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Inadequacy of MH services

- One physician per 4000 people in Bangladesh vs 1/400 in US and 1/2500 in India
- One psych per 7500 people in the US
- 5.4% of all US physicians are psychiatrists
- 0.4% of all Bangladesh physicians are psych
- Roughly 1 psych/million in Bangladesh - overest
- Hardly any psychologists/social workers
- Very few MH researchers
Private Practice Data on Frequency

- Middle & Upper Mclass
- 45% relationship issues
- 22% Bipolar disorder
- 10% Anxiety d/o (panic, OCD, GAD)
- 5% Psychotic disorder
- 4% Substance Abuse
- 2.5% Unipolar depression
- 11% Other (dementia, Parkinson, BPD, etc)
- clientele - people not visits
Practice related observations

- Delayed acknowledgement-stigma
  - Character flaws

- Don’t understand chronicity-no quick fix
  - Diabetes as a model for MH

- Dhaka more med savvy than Boston
  - Change doctors, dose

- Doctors don’t explain diagnosis or meds
  - Too much medication not enough therapy
Role of Therapist

- Psychiatrists last resort—families often make things worse—blame game
- Therapist not friend, judge or advice giver
- Confidentiality and rapport essential
- Therapy takes time and is empowering
- Therapist is a facilitator not a coach
Psychiatry and Public Health

- Provide Rx in primary care
- Make psychototropic meds available
- Give care in the community
- Educate the public
- Involve communities, families, consumers
- Establish National policies & legislation
- Develop human resources
- Link with other sectors
- Monitor Community health
- Support more research
Provide Rx in primary care

- 15-30% in PHC have MH problems
- Easier said than done
  - patient ed/fu/monitor; lack of health worker knowledge about MH
- Resource shortages
- Organizational barriers:
  - Diff PH priorities in diff countries (HIV)
  - Varying levels of risk factors—level of violence
  - Heterogeneous nature of primary hlth care systems
  - Big private sector
Make psychotropic meds available

- Variable but reasonable access – Urban much more than rural
- Poor and rural access “old” meds—more side effects
- Polypharmacy
- Better education about app use
- Bio-psycho-social model
Give care in the community

- Deinstitutionalization should be norm but is not
  - Increase quality and rights of patients
- MH hospitals instead of general hospital
- Talk therapies do work in Low inc communities.
- Community Based Rehab--Ashagram
Educate the public

- Low awareness of MH problems and treatment options—stigmatization
- School education programs help in raising awareness both in students and wider community—e.g. Pakistan
- NGOs can be very effective
- Role of Media is essential
Involve communities, families, consumers

- Local NGOs led by families in Schizophrenia care
- Befriender Intl—helps suicidal persons
- Drug rehab—Alcoholics anonymous model
- Characteristics of successful NGOs
  - Strong community orientation—solicit views
  - Advocacy to policy makers, media and other sectors in health systems
  - Document and disseminate rel MH facts
  - Lobbying for changes in laws—Mental disabilities
  - Support groups and networking
Establish National policies & legislation

- National MH policies needed—48% of dev countries have them
  - Vision for the future—model for action
  - Plan implements objectives of policies
  - Broader scope than just psych services—primary, specialized care, prevention, rx and maintenance
  - Co-ordination of services within health care system and housing, education, employment
  - Financial reimbursement
- Legislation is key—WHO has models
  - Commitment, incapacity to make decisions, inheritance, stand trial etc.
Develop human resources

- Very low level of resources in Developing Countries
- Mostly urban based
- Countries need estimates of needs
- Provide resources for training, cont ed.
  - Need specialized clinicians to oversee training of generalists:
    - psychiatrists, psychologists, psychiatric nurses, mental health occupational therapists, social workers
Link with other sectors

- MH linked to employment, education, housing and criminal justice
- Focus on schools, workplace, comm MH needs
- Inapp imprisonment, treatment in prisons. MH impacts of imprisonment on prisoners and families
- Involvement of traditional healers—reduce harmful interventions and promote equally beneficial interventions
Monitor Community health

- Big gap is lack of Community MH indicators
- Integrate MH in routine demog surv
- New short screening measures
  - e.g. K6 questionnaire, Audit alcohol quest
  - WHO short screens—internationally validated
Support more research

- Research in MH in dev countries inadequate
- <10% of published research in High impact journals from dev countries
- Lack of local evidence hampers policy
- Need intervention trials not just prevalence
- Raise skills, access to literature and peer review
- Mental Health Research Networks essential
Discussion Questions

- Mental Health is a luxury for Dev countries: True or False and why
- Psych classifications based on developed country experience. How relevant are these classification systems to Developing countries?
- How do we address low numbers of MH workers in developing countries? Specialist vs Generalist
- Evidence of poverty and MH problems as a spur to Public Health action?
- Describe relative role of biology and society/environment in etiology of MH disorders. How does understanding etiology help with prevention and treatment?
Bibliography

Contact Information

- M. Omar Rahman, Director of MPH program, Independent University, Bangladesh
- Email: orahman@iub.edu.bd
- Tel: 0173-00-8347
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