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Retarded Adults in Bangladesh

Md. Anisuzzaman



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Causes of Psychotropic Drug Dependence among the Mentally Retarded Adults in Bangladesh

Md. Anisuzzaman*

This paper is an attempt to identify the causes of psychotropic drug dependence among the mentally retarded adults in Bangladesh. Detailed studies of 87 cases were done. Case study, observation and discussion were adopted in conducting this study to collect primary data. The paper explores the fact that convulsion, severe aggression, severe depression, neural and motor problems, hyperactivity, compulsive behaviour and self-injurious behaviour were the main causes of psychotropic drug dependence. Salivation, frequent fainting, severe sleep disturbance, physical pain, nightmare, lack of concentration, compulsive behaviour, etc, were the associated causes of psychotropic drug dependence. The researcher recommends some measures to protect the mentally retarded persons from psychotropic drug dependence.

Introduction

According to R. C. Carson, J. N. Butcher and S. Mineka (1996)¹, mental retardation is defined by the American Psychiatric Association (1994) in DSM-IV as “significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behaviour and manifested during the developmental period that is accompanied by significant limitations in adaptive functioning” in certain skill areas such as self-care, work, health and safety. To qualify for the diagnosis, these problems must have begun before the age of 18. Mental retardation is thus defined in terms of behavioural performance. The definition says nothing about causal factors which may be primarily either biological, psychosocial, sociocultural, or a combination of these. By definition, any functional equivalent of mental retardation that has its onset after age 17 must be considered a dementia rather than mental retardation. The distinction is important because the psychological situation of a person who acquires a pronounced impairment of intellectual functioning after attaining maturity is vastly different from that of a person whose

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¹ R.C. Carson, J. N. Butcher and S. Mineka. 1996. *Abnormal Psychology and Modern Life*, 10th ed. N. Y.: Harper Collins College Publishers, p.506

intellectual resources were subnormal throughout either all or most of his or her development.

Psychotropic Drug Dependence

Drug, a chemical agent that is used therapeutically to treat disease. Broadly, a drug may be defined as any chemical agent that affects living protoplasm. Few substances would escape this definition. However, the term "drug" is usually used in its narrow sense to refer to a chemical whose specific purpose is the treatment of a disease (The Encyclopedia Americana 1984)².

Drug Dependence

A state, psychic and sometimes also physical, resulting from the interaction between a living organism and a drug, characterised by behavioural and other responses that always include a compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effects, sometimes to avoid the discomfort of abstinence (Medicine International 1987)³.

Psychotropic Drugs

Ian Gregory and Donald J. Smeltzer (1977)⁴ have defined Psychotropic drugs as the chemical agents that have an effect on the mind. Psychotherapeutic drugs comprise the relatively small subset that has established indications in the treatment of mental disorders.

According to Jeffrey D. Robertson (1988),⁵ within the last 25 years, medication therapy has evolved as an effective and accepted treatment for psychiatric illness. Indeed, medication therapy has emptied many of the nation's psychiatric hospitals of the chronically ill and permitted them to live in the community as outpatients. However, psychiatric

² The Encyclopedia Americana, (Int'l. Ed.) Danbury, Connecticut: Grolier Incorporation, Vol.9 (1984)

³ Medicine International, *Psychiatry*, Bangladesh Edition, Vol.2, No.15 (1987).

⁴ Ian Gregory and Donald J. Smeltzer. 1977. *Psychiatry: Essentials of Clinical Practice*. 1st ed., Boston: Little Brown and Company. pp.89-90.

⁵ J. D. Robertson. 1988. *Psychiatric Malpractices: Liability of Mental Health Professionals*, p. n.f. John Wiley and Sons Inc. p.382.

medications have often been viewed with sarcasm, skepticism and suspicion.

Psychotropic medications used in conjunction with psychotherapy are the most commonly employed therapeutic treatments today. Not all psychiatric disorders require pharmacological therapy. However, medications often facilitate a patient's response to treatment and ultimate recovery. Although they have worked wonderfully in modern medicine, their risks and attendant side effects still pose potential dangers to patients. The decision whether to initiate medication therapy is a clinical judgment that must be based on a thorough and accurate evaluation of the patient⁶.

Categories of Psychotropic Drugs

According to Goodman, Gilman and Rall (1985)⁷, the psychotropic drugs most commonly used in the treatment of the patients fall into the following four categories:

- a) anti-depressants;
- b) anti-psychotics;
- c) anti-anxiety; and
- d) anti-convulsants and Lithium.

In Bangladesh, most of the parents or guardians of the mentally retarded persons are not aware of their wards' actual condition. Even they do not know the causes and symptoms of mental retardation. The majority of the mentally retarded persons in this country are treated as mentally ill by their parents or guardians. The parents or guardians usually seek help of different types of medical practitioners for the treatment of their mentally retarded wards.

A large number of mentally retarded persons develop drug dependence due to faulty treatments and ignorance of the concerned medical practitioners. Ignorance of the guardians jeopardises the condition a little more. It could be avoided if the mental retardation condition could be detected in the early ages of the affected persons.

Indiscriminate uses of psychotropic drugs cause a number of problems to the persons with mental retardation. Psychotropic drugs are meant for

⁶ *Ibid.*, p. 383

⁷ L. Goodman, A. G. Gilman and T. W. Rall. 1985. *The Pharmacological Basis of Therapeutics*. p. n.f. p.438.

mental illness not for mental retardation. Before prescribing any psychotropic medication, psychiatrists must take a complete history and record it in the patient's clinical chart.

This research is an attempt to investigate the causes of psychotropic drug dependence, how the problem can be removed or at least be reduced, steps required for further promotion of appropriate medical care programme, etc.

Numerous scientific investigations on mental retardation are being carried out throughout the world. Following are the synopses of some research works in the field of psychotropic medication related to the persons with mental retardation.

Masi and Luccherino (1997)⁸, in their paper entitled *Psychiatric Illness in Mental Retardation: An Update on Pharmacotherapy*, have reported that according to the DSM IV, all types of psychiatric disorders can be observed among the mentally retarded subjects, with prevalence estimated to be three or four times higher than in the general population. Clinical features, longitudinal course and triggering factors are influenced by the characteristics of the intellectual disability. The aim of this paper is to discuss the specificity of the psychopharmacological therapy in mental retardation (sensitivity to specific psychotropic drugs, incidence of side effects, predictive criteria for evaluating risk factors, etc.) and to propose an update in the pharmacotherapy in the most important psychiatric disorders, mood disorders, psychotic disorders, behavioural disorders, anxiety disorders, and attention deficit disorders with or without hyperactivity.

Meins (1988)⁹, in his paper entitled *Use of Psychotropic Drugs in Mentally Handicapped Adults*, has analysed the type and the frequency of psychotropic drug treatment in the case of 1,154 institutionalized and noninstitutionalized mentally retarded adults. The psychotropic drug prevalence amounts to 21.7%, only about one half of the corresponding rates in other studies. Neuroleptics are prescribed most frequently by far, succeeded by anxiolytics. The psychotropic drug prevalence is significantly related to age, sex and setting. A comparison of the psychotropic drug treatment in 1980 with that in 1986 above all shows a distinctly rare prescription of anxiolytics and hypnotics as well as a decrease in polypharmacy in 1986.

⁸ G. Masi and L. Luccherino. 1997. "Psychiatric illness in mental retardation: an update on pharmacotherapy", *Panminerva Med.* 39 (4), Pp. 299-304.

⁹ W. Meins 1988 "Use of psychotropic drugs in mentally handicapped adults", *Psychiatr Praxis*, [Article in German], 15 (6), Pp. 218-22.

Aman (1985)¹⁰, in his research paper entitled "Drugs in Mental Retardation: Treatment or Tragedy?" -, reports that treatment with psychotropic and anti-convulsant drugs is common in mental retardation with prevalence ranging from about 20% in noninstitutionalized children to about 50 to 60% in institutionalized populations. It is suggested that the main objective of pharmacotherapy is that of suppressing acting-out behaviours and the extreme attitudes sometimes expressed by workers in the field regarding the priority of drug treatment.

It is noticed that both the studies were done in those countries where there are residential institutions for the mentally retarded persons. In Bangladesh, most of the mentally retarded persons live in their parental houses or with their close relations. In this country, people preserve their medical reports rarely.

Methods and Procedure

Selection of Day Centres

Considering the availability of case history and medical records preserved by the professional staff members, services rendered by the organisations, etc, four day centres of the Society for the Welfare of the Intellectually Disabled Bangladesh (SWID Bangladesh) in the cities of Dhaka, Chittagong, Rajshahi, and Khulna were selected. One day-centre of the SIVUS Institute was selected in Rajshahi metropolitan city.

Selection of Respondents

Parents, guardians or siblings of the mentally retarded adults connected with the above mentioned day centres were selected as the major respondents. Concerned special education teachers, professional staff members, and the counsellors of the day centres were consulted to verify the responses given by the guardians. In addition, some concerned people like psychologists, psychiatrists, general physicians, pharmacologists, pharmacists and biochemists were also interviewed on various related issues.

¹⁰ M. G. Aman. 1985. "Drugs in mental retardation: Treatment or tragedy?" *Australia and New Zealand Journal of Developmental Disabilities*, vol. 11(4), Pp. 215-226.

Methods Used

The researcher mainly followed case study method in this study. In addition, observation, interview and free discussions were extensively done during the case studies. The researcher observed all the cases for several months under different conditions (when the drugs were used and when the drugs were withdrawn).

Materials Used

Questionnaire

The researcher used this questionnaire during interview sessions. Followings were the main bases for the item selection of the questionnaire:

- medical histories and records of the mentally retarded persons;
- hazards in psychotropic drug used for a long period as described in the books of Psychiatry, Abnormal Psychology and Pharmacology;
- open information given by the respondents during interviews with about 10 parents of mentally retarded children at the special education schools in Rajshahi and Dhaka cities;
- discussion with some experts in the related disciplines;
- discussion with some special education teachers, counsellors, welfare staff, etc, who worked with the mentally retarded persons; and
- general observation of the researcher.

Procedure Followed

The researcher mainly followed the Case Study method. To complete the case studies, the researcher had to follow some other methods as follows:

- Observation,
- Interview, and
- Free Discussion.

The researcher visited the day centres at first. He observed some of the activities of the subjects at the day centres. He was given an opportunity to read their personal files and detailed case histories. Then he contacted the guardians of the subjects and sought their help to study the subjects at their residences.

The researcher mainly interviewed the parents, guardians or siblings at home. The respondents were given the opportunity to talk more. The researcher used to keep notes in his diary. The respondents told him about the birth, illnesses, treatment patterns, problems and prospects of the subjects. Then during follow-up visits, the researcher obtained answers to the questionnaire and rated behaviour through administering a behaviour checklist.

During the follow-up visits, the researcher also observed the subjects in different household activities, interpersonal relations, and social situations. The researcher's main interest was to investigate the causes of the psychotropic drug dependence of the mentally retarded persons.

The researcher used to record his observation in his notebook. Finally, he compiled the information obtained from questionnaire, case history and observation in the tabulation sheets in numerical figures.

Results

Table 1. Major Causes of Psychotropic Drug Dependence

Major causes	f	%	Remarks
Frequent Convulsion	54	62.07	
Neural and Motor Problems	5	5.75	
Severe Aggression	14	16.09	
Severe Depression	12	13.79	
Others (Hyperactivity/ Compulsive behaviour, etc.)	2	2.30	These two persons are dependent on anti-psychotic drugs.
Total	87	100.00	

$$\chi^2 = 101.8, \quad df = 4, \quad p < 0.01$$

In response to the question why the subjects are given psychotropic drugs at present, the guardians mentioned many causes. The specific major causes are shown in the above table. The causes vary among the

subjects. Many subjects had to take the psychotropic drugs for two or more difficulties or symptoms.

This table projects data accumulated only from 87 psychotropic drug dependent subjects of four cities in Bangladesh. In the first column of the above table major problems are shown in different rows. In the above table, the frequencies and percentages are shown in the second and third columns respectively.

The chi-square value of the findings of this table is 101.8 at the degree of freedom 4. The value of χ^2 is significant at 0.01 level, which indicates that the percentages found are highly significant. That is, convulsion is the top ranking cause of drug dependence. Severe aggression, severe depression, neural and motor problems, and hyperactivity or compulsive behaviour are also the major causes of psychotropic drug dependence among the urban mentally retarded adults.

Table 2. Associated Causes of Psychotropic Drug Dependence (N=87)

Associated causes	f	%	95% CI (%)
Salivation	32	36.78	27- 47
Loss of appetite	28	32.18	22-42
Frequent fainting	17	19.54	11-28
Speech problem	3	3.45	0-7
Severe sleep disturbance	18	20.69	12- 29
Physical pain for no biological cause	11	12.64	6-20
Nightmare	16	18.39	10-27
Lack of concentration	15	17.24	9-25
Tired physical appearance	11	12.64	12-29
Palpitation	21	24.14	15- 33
Vomiting	5	5.75	1- 11
Excretory problems	9	10.34	4- 17
Regressive behaviour or regression	7	8.05	2- 14
Compulsive behaviour	14	16.09	8- 24
Blurred vision	23	26.44	17- 36

The above table shows the associated causes of psychotropic drug dependence. The parents and guardians mentioned all these physiological and psychological causes. The causes varied among the subjects. Some of the subjects were given psychotropic drugs for two or more problems mentioned above in addition to the major causes as shown in table 1.

In the first column of the above table, the psycho-physical problems are shown in different rows. The frequency, percentage and Confidence Interval are shown in the second, third and fourth columns respectively. According to the data shown in the above table, it is assumed that the psychotropic drugs were prescribed for different associated causes in addition to the major causes. Salivation (36.78%), loss of appetite (32.18%), frequent fainting (19.54%), speech problems (3.45%), severe sleep disturbance (20.69%), physical pain for no apparent biological cause (12.64%), nightmare (18.39%), lack of concentration (17.24%), tired physical appearance (12.64%), palpitation (24.14%), vomiting (5.75%), excretory problems (10.34%), regressive behaviour or regression (8.05%), compulsive behaviour (16.09%), and blurred vision (26.44%) are the associated causes of using the psychotropic drugs on a regular basis.

Table 3. Persons who Prescribed the Present Psychotropic Drugs to the Subjects

Prescribed by	f	%	Remarks
General physicians	19	21.84	None of these cases was consulted with psychiatrists.
Psychiatrists	52	59.77	All these cases were given the first dose of psychotropic drugs by the general physicians.
Neurologists	10	11.49	All these cases were referred to neurologists by general physicians or psychiatrists.
Paramedics/ Pharmaceutical shop keepers	6	6.9	First doses of psychotropic drugs were given by qualified medical people later, the cases being handled by the paramedics/ pharmaceutical shopkeepers.
Total	87	100.00	

$$\chi^2 = 60.18, \quad df = 3, \quad p < 0.01$$

From the above table it is seen that 21.84% were prescribed psychotropic drugs by the general physicians. Psychiatrists prescribed psychotropic drugs in 59.77% cases. In 11.49% cases, psychotropic drugs were prescribed by the neurologists. And unexpectedly in 6.9%

cases, the paramedics/ pharmaceutical shopkeepers prescribed the psychotropic drugs.

It is also found that the calculated value of chi-square is 60.18 at degree of freedom 3. The value of χ^2 is significant at 0.01 level, which indicates that the findings are highly significant.

Table 4. Daily Minimum- Maximum Doses of Drugs Consumed by the Subjects

Types of drugs	Minimum dose	Maximum dose	Number of cases	Percentage (%)
Anti-convulsants	20 mg	200 mg	54	62.07
Anti-psychotics	50 mg	200 mg	16	13.79
Anti-depressants	30 mg	200 mg	12	18.39
Anti-anxiety	30 mg	180 mg	5	5.75
Total			87	100.0

$$\chi^2 = 66.61, \quad df = 3, \quad p < 0.01$$

The above table shows the daily minimum and maximum doses of anti-convulsants, anti-psychotics, anti-depressants and anti-anxiety drugs as consumed by the subjects at present.

Out of 87 cases, 54 (62.07%) cases are taking anti-convulsant drugs regularly. The cases who are taking the lowest doses of anti-convulsant drugs are taking 20 mg per day. The cases who are taking the highest doses of anti-convulsant drugs are taking 200 mg per day.

Among the 87 cases, 16 (13.79%) are taking anti-psychotic drugs everyday. The lowest dose is 50 mg per day while the highest dose is 200 mg per day.

Out of 87 cases, 12 (18.39%) are taking anti-depressant drugs on a regular basis. The lowest dose is 30 mg per day and the highest dose is 200 mg per day.

Among the 87 cases, 5 (5.75%) cases are taking anti-anxiety drugs everyday. The lowest dose is 30 mg per day and the highest dose is 180 mg per day.

The calculated value of chi-square is 66.61 at degree of freedom 3. This value of χ^2 is significant at 0.01 level, which indicates that the large majority of the cases are taking anti-convulsant drugs regularly. They are taking 20mg to 200mg as daily doses. Only 37.93% cases are taking three other types of psychotropic drugs and the doses are different.

It was also found from case histories that a large number of the subjects consumed some other drugs in conjunction with these psychotropic ones for other different problems, such as, stomach problems, respiratory problems, physical weakness, etc.

Discussion

Major Causes of Psychotropic Drug Dependence

In response to the questions why the subjects are given psychotropic drugs the parents and guardians mentioned many causes. The specific major causes are shown in different tables of the preceding section of this paper. The causes vary among the subjects. However, the large majority of the subjects had to take the psychotropic drugs for at least two or more difficulties or symptoms.

It is found that convulsion associated with high fever is the prime cause for which the subjects started taking psychotropic drugs. Severe aggression is the second ranking cause for initiating the intake of psychotropic drugs. Severe depression is the third ranking cause. Neural and motor problems are also the major causes for using psychotropic drugs. It was also found that hyperactivity, compulsive behaviour, etc. are also important causes for psychotropic drug dependence.

Fascinating issues have been raised by recent studies on childhood psychopathology in different cultures. In a certain culture like that of Thailand, adults are highly intolerant of under-controlled behaviour such as aggression and disrespectful acts by their children. Children are taught to be polite, and deferential and to inhibit any expression of anger. This raises interesting questions about whether childhood problems of under-controlled behaviour would be lower in Thailand than in the United States where such behaviour is tolerated to a greater extent. Conversely, it also raises the question of whether over-controlled behavioural problems such as shyness, anxiety and depression would be over-presented in Thailand relative to the United States. Two cross-national studies (Weisz et al., 1987, 1993)^{1&2} have confirmed that the Thai

¹ J. R. Weisz et al., 1987, Over and Undercontrolled clinic reference problems among Thai and American children and adolescents: The wat and wai of cultural differences, *J. Cons. Clin. Psychol.*, 55, 719- 726 referred in R.C. Carson, J. N. Butcher and S. Mineka, *Abnormal Psychology and Modern Life*, 10th ed. (N. Y.: Harper Collins College Publishers, 1996), p. 109

² J. R. Weisz et al., 1993, Behaviour and Emotional problems among Thai and American adolescents: Parent reports for ages 12- 16 J. *Abnorm. Psychol.* 102, 395- 403 referred in R.C. Carson, J. N. Butcher and S. Mineka, *Abnormal Psychology and Modern Life*, 10th ed. (N. Y.: Harper Collins College Publishers, 1996), p. 109

children and adolescents do in deed have a greater prevalence of over-controlled problems than do the American children.³

Kleinman and Good (1985)⁴ surveyed the experience in depression across cultures. The important elements of depression in Western societies, for example, the acute sense of guilt typically experienced, do not appear in other cultures. The symptoms of depression, such as sadness, hopelessness, unhappiness, lack of pleasure in the things of the world and in social relationships have dramatically different meanings in different societies.¹⁵

Secondary Causes of Psychotropic Drug Dependence

The parents or guardians mentioned many secondary causes for which the psychotropic drugs were first given to their wards. The causes varied among the subjects. The large majority of the subjects were given psychotropic drugs for at least two or more secondary or associated problems in addition to a major cause. These secondary causes are salivation (36.78%), loss of appetite (32.18%), frequent fainting (19.54%), speech problems (3.45%), severe sleep disturbance (20.69%), physical pain for no apparent biological causes (12.64%), nightmare (18.39%), lack of concentration (17.24%), Tired physical appearance (12.64%), Palpitation (24.14%), Vomiting (5.75%), excretory problems (10.34%), regressive behaviour or regression (8.05%), compulsive behaviour (16.09%), and blurred vision (26.44%). It is found that salivation, loss of appetite, sleep disturbance, palpitation, blurred vision and frequent fainting are relatively important secondary or associated causes.

Persons Who Prescribe the Psychotropic Drugs

It was found that in 21.84% cases psychotropic drugs were prescribed by the general physicians. Psychiatrists prescribed psychotropic drugs in 59.77% cases. In 11.49% cases psychotropic drugs were prescribed by the neurologists. And surprisingly in 6.9% cases the

³ R.C. Carson, J. N. Butcher and S. Mineka. *Op cit.* p. 109

⁴ A. M. Kleinman and B. J. Good. 1985. *Culture and Depression*. Berkeley, CA: University of California in R.C. Carson, J. N. Butcher and S. Mineka. 1996. *Abnormal Psychology and Modern Life*. 10th ed. N. Y.: Harper Collins College Publishers. p. 109

¹⁵ *Ibid.*, p. 109

paramedics/pharmaceutical shopkeepers prescribed the psychotropic drugs.

It was found that nearly 60% of the cases are now under the supervision of the psychiatrists. But the cases were referred to them by the general physicians. Actually, the general physicians started the psychotropic drugs and handled the cases for some years. In some cases, the paediatricians also initiated psychotropic drugs and later referred the cases to the psychiatrists mostly via general physicians. It was not studied systematically but now it is assumed by the researcher that the easy availability of the psychiatrists has some relationship with the rate of psychotropic drug dependence. In Dhaka city, the rate of drug dependence is higher than that those in other cities or towns.

Daily Minimum-Maximum Doses of Drugs

It was found that out of 87 cases 54 (62.07%) were taking anti-convulsant drugs regularly. The cases who are taking the lowest doses of anti-convulsant drugs are taking 20 mg per day. The cases who are taking the highest doses of anti-convulsant drugs are taking 200 mg per day. It is revealed that the persons who are taking the highest doses of anti-convulsant drugs cannot engage in daily activities.

Among the 87 cases, 16 (13.79%) are taking anti-psychotic drugs everyday. The lowest dose is 50 mg per day and the highest dose is 200 mg per day. It is learned from the pharmacists and pharmacologists that the daily consumption of 200 mg anti-psychotic drugs for a prolonged period can cause drug dependence.

Some 18.39% subjects are taking anti-depressant drugs on a regular basis. The lowest dose is 30 mg per day and the highest dose is 200 mg per day. These drugs also affect respiratory system, blood pressure, and excretory system. The prolonged use of anti-depressants may affect the motor system.

Among 87 cases only 5 (5.75%) are taking anti-anxiety drugs everyday. The lowest dose is 30 mg per day and the highest dose is 180 mg per day. All the relevant experts said that the doses were relatively high and that their prolonged use would definitely lead to many complications.

The researcher came to know that all the drug dependent cases used to take minimum doses at the beginning. The doses of the drugs were increased gradually, mostly by the guardians themselves with the deterioration of the behavioural conditions of the subjects. Sometimes the guardians consulted related medical personnel before the change of

doses but the pattern of such consultation is not systematic. On the other hand, in most cases, the recommended pathological tests were never done to assess the exact physiological condition of the subjects.

The researcher suggests that the drug policy should be amended to control the use of psychotropic drugs. Appropriate laws are needed so that if someone administers psychotropic drug without any prior pathological tests will be penalized. Actually, the proper use of and control over psychotropic drugs are needed to save the mentally retarded persons from drug abuse.

The data shown in different tables are based on information given by the guardians. Emotion, attitude, knowledge of the guardians are mixed with the information given by them. If the researcher could study the chronological changes of the subjects the study was supposed to be more informative. On the basis of his detailed study and observations, the study concludes that:

1. the large majority of the urban middle class mentally retarded children who have severe convulsion, depression, aggression, neural and motor problems are treated with psychotropic drugs. Many of them ultimately become drug dependent in their adult life.
2. psychotropic drug dependence of the mentally retarded persons is closely related to the easy availability of the drugs and doctors. Social status and the place of living are also the main reasons for psychotropic drug dependence.
3. convulsion is the first major cause for dependence on psychotropic drugs. These cases are dependent on anti-convulsants, mainly Ethosuximide and Phenytoin Sodium.
4. the second major cause for psychotropic drug dependence is severe aggression. anti-psychotic drugs, mainly chlorpromazine Hydrochloride and Haloperidol which are consumed by the concerned cases.
5. the third major cause for psychotropic drug dependence is severe depression. Anti-depressant drugs mainly amitriptyline and nortriptyline drugs are consumed by the concerned cases.
6. the fourth major cause for psychotropic drug dependence is neural and motor problem. Anti-anxiety drugs - mainly diazepam is consumed by the concerned cases.
7. the fifth major cause for psychotropic drug dependence is hyperactivity, compulsive behaviour, self-injurious behaviour, etc. These subjects are dependent mainly on anti-psychotic drugs. Some cases are also dependent on anti-anxiety drugs.

The researcher recommends that the drug policy in Bangladesh should include compulsory pathological tests before prescribing and changing the doses of psychotropic drugs. The guardians should consult professional psychologists to assess their mentally retarded wards before any chemotherapy. Multidisciplinary research works need to be encouraged to study the real problems and prospects of the use of psychotropic drugs.

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