THE SUDANESE JOURNAL OF PSYCHIATRY

المجلة السودانية للطب النفسي

VOL.1 ISSUE.3 AUGUST, 2011

Published by
THE SUDANESE ASSOCIATION OF PSYCHIATRISTS

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THE SUDANESE JOURNAL OF PSYCHIATRY

Volume 1 – Issue 3, August, 2011

بسم الله الرحمن الرحيم

Sudanese Journal of Psychiatry

CONTENT

EDITORIAL

The pioneer psychiatrists in Sudan, Professors El-Mahi and Baasher, had a clear vision of what to be done in the field of psychiatry in Sudan and of how it could and should be done. They brilliantly drew the plan, laid down the foundations and enthusiastically engaged in the work. The product was admired by everyone. Their successors were able men who followed their steps and contributed constructively to the evolving service. However due to great geopolitical changes in the country, for a good number of years, things did not go steadily forward. There were lulls in the work and even setbacks.

Now there is a revival. The present generation of psychiatrists feels that they must refurbish the house and even extend the frontiers further.

From its inception the plan was to integrate the psychiatric services with the general medical services and to bring it nearest to the people for whom it is meant. Hence, after establishing out-patient psychiatric services in general hospitals, in-patient wards were opened in general hospitals in various parts of the country. Plans were prepared to incorporate psychiatric services in primary health care units which form the backbone of the medical services in the country. This is found to be feasible and cost-effective

Good plans are there, but their implementation needs trained personnel and suitable infrastructure. This is not yet to the satisfaction of planners. Hence, recruitment and training of personnel is a necessity and a priority. Training of doctors made big strides forward in recent years but training of psychiatric nurses, clinical psychologists and psychiatric social workers is lagging behind. There is severe shortage of trained psychiatric nurses. In the present circumstances one may boldly say that if it is not for the cohesiveness of family ties and the close care that family members are ready to give to the sick, the psychiatric in-patient services in Sudan would be impossible.

There is great need for epidemiological work to determine the magnitude and nature of psychiatric problems in various communities. During the last two decades there have been big changes in the style of life of many people due to migration, economic reasons, global influences and other factors. This, most likely, has effect on the extent and type of psychiatric problems. Any plan for provision of services to the people must take in consideration the actual need of the people and the most appropriate and acceptable mode of delivery of the service to them. Field research is needed to provide answers to questions as what is really needed and how the need could be met.

The pioneers succeeded because they had the will-to-do and they worked with the team spirit under wise leadership. The present generation of psychiatrists can do the same and even better if they made use of that experience.

ATTEMPTED SUICIDE IN SAUDI ARABIA INDUSTRIAL POPULATION – 20 YEARS LATER

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SUMMARY:

This study is a retrospective review of patients admitted to a general hospital in Saudi Arabia because of suicide attempts. A total of 53 cases were identified in the year 2004-2005. Related variables were analyzed for attempted suicide. The results showed that para-suicide rate has decreased when compared to 20 years ago, and it was much lower than other Islamic countries. The low rate was accounted for by the improvement in psychiatric and mental health services, as well as the referral system.

Introduction

Al Jahdaly et al 2004 studied attempted suicide by overdose in Saudi Arabia (1). He found that most patients were young Saudi nationals and the majority were women. They found that previous suicidal attempts, family conflicts and psychiatric disorder represent significant risk factors. They found single overdose occurred in 30% of their sample and they concluded that intentional drug overdose is a relatively uncommon reason for hospital admission in Saudi Arabia. Deurimci-Ozguven & Sayil in 2003 investigated the rate and methods of attempted suicide in a catchment area in Turkey as part of the WHO-Euro multicenter study on suicidal behavior(2). In a four year period out of 737 (514 women) and (223 men) attempted suicide. The mean rate was 46.9 per 100,000 for men and 112.9 for women. The para-suicide rate increased by 93% between 1998 and 2001. The most used method by both men and women was self-poisoning. They found that the risk groups appeared to be younger and female.

Al Ansari et al 1997 in Bahrain conducted a one year cohort of 67 overdose attempts among youths aged 15-25 years(3). The prevalence rate was 105 per 100,000 population (one of the highest in the Arab countries). The majority of attempters were females and Bahraini nationals with the use of Paracetamol, but they had low suicidal intent. The most common difficulties preceding the overdose were problems with parents, school or work, social isolation and

interpersonal problems. Adjustment disorder was the most common diagnosis followed by depression. A seasonal variation was noted with 46 of the cases occurring in the summer months. A similar observation of Al Jahdaly et al, 2004 that the occurrence of intentional overdose peaked during the month of September (20% of the total cases)(1).In a study of a similar population tour study, Daradkeh and Al Zayer in 1988 found that the parasuicide rate was 20.7 per 100,000(4). They considered this rate low and the reason for that was due to under reporting and misdiagnosis. They concluded that the parasuicide activity phenomena is mainly in young female and disordered personal relationships with spouses and parents as precipitating factors. Acute reaction to stress was a common diagnosis followed by depression.

Deliberate self-harm by analgesics and psychotropics was the most common method used.

Method

All admissions to a large general hospital for the period between 2004 - 2005 were screened.

All files of patients who had a diagnosis of parasuicide or attempted suicide were screened against 19 variables. These were age, gender, nationality, educational status, marital status, employment status, psychiatric illness, medical illness, state of mind, method of attempt, reason for attempt, source of referral, family history, history of suicidal attempt, number of attempts, history of drug abuse, type of drugs abused, duration of hospital stay and follow up arrangements.

All cases were reviewed by the Psychiatric Ward Physician under the supervision of two Consultant Psychiatrists (Bazaid/Gaddal).

Results

A total of 53 patients were identified (14 males and 39 females). 47 of them were Saudi nationals and 6 were non-Saudis. Fifteen were employees of the company and 38 were dependent relatives. In age distribution 35% were below 20 years and 28% were between 41-50years and 17% were between 31-40 years.

In relation to educational status in suicidal attempts 90% received some form of education. Only 10% were illiterate. Twenty percent were in primary school, 20% intermediate school, 27% secondary school and 23% had college education.

Percent distributions of marital status 53% were single and 47 % were married.

The percentage of distribution of employment status among suicidal attempts: 28% were employees. 32% were dependent wife and 35% were dependent daughters. As for the diagnosis 34% had acute situational reaction, 24% had depression, 13% adjustment disorder, 9% schizoaffective disorder and 5.7% bipolar affective disorder. Almost 50% have some co-morbid medical problems, mainly anemia and diabetes mellitus. As to the "state of mind" prior to the suicidal attempt, the majority was impulsive at 86% and only 14% were planned. In regards to the method of attempt, the majority of 77% were drug overdose and 11% was cutting.

In regard to the reason for suicide Attempt, the majority were due to interpersonal relationship problems 34%, marital problems 17% and occupational problems 24%. In considering the source of referral the majority were referred by their family 94.3%. There is a family history of child abuse, psychiatric problems and divorce of parents but the majority had no family history of attempted suicide. In regard to personal history suicidal attempts 5 patients had attempted suicide before and 48 had no history. 3 attempted once, 2 attempted twice or three times and 48 had no previous attempts. The majority had no history of drug abuse. Only one patient abused cannabis, another patient abused alcohol. The majority were referred for follow up to Psychiatric Outpatient Clinic (80%), 61% were referred to the Community Counseling Clinic for counseling and 3.8% were followed by their Family Physician. Age was found to be significantly related to a diagnosis of major depression, diagnosis of acute situational reaction and a number of other psychiatric disorders. The female gender was significantly related to the same variables. Nationality was not found to be significant but employment status was found to be significantly related to the three diagnoses.

The act of attempt was either planned, impulsive or in the presence of psychotic symptoms. These were found to be significantly related to the age but not gender, nationality or employment status.

The method of attempts were cutting, drug overdose and others were found to be significant in relation to gender but not significant in relation to age, nationality or employment status.

Table 1 : Association between Reason of Attempt and selected Demographic Variables of Suicide Attempts among Saudi Aramco Employees and Dependents

Demographic Characters	Reasons of Attempt								
	Marital problem		Family problem		Mental Illness		Others		χ2 -Value P- Value
	No.	%	No.	%	No.	%	No.	%	
Age (years)									χ2 =27.91 P=0.001 (Significant)
1. < 20	-	-	12	63.2	1	5.3	6	31.6	
2. 21 - 30	2	28.6	2	28.6	3	42.9	-	-	
3. 31 - 40	4	40.0	2	20.0	2	20.0	2	20.0	
4. 41 & above	3	15.8	2	10.5	7	36.8	7	36.8	
Gender									χ2 = 17.36 P= 0.001 (Significant)
1. Male	-	-	1	6.6	7	46.7	7	46.7	
2. Female	9	22.5	17	42.5	6	15.0	8	20.0	
Nationality									χ2 = 4.73 P= 0.192 (Not Significant)
1. Saudi	8	16.3	17	34.7	13	26.5	11	22.4	
2. Non Saudi	1	16.7	1	16.7	-	-	4	66.7	
Status									χ2 = 18.81 P= 0.001 (Significant)
1. Employees	-	-	1	6.3	7	43.7	8	50.0	
2. Dependent	9	23.1	17	43.6	6	15.4	7	17.9	

Marital status, family problems, mental illness and other mental illness were found to be significantly related to age, gender, nationality and employment status, table 1.

The overall rate of suicidal attempt was found to be 14 per 100,000. This difference is a significant compared to the rate of the same population in 1988 of 20.7 per 100,000.

DISCUSSION

There were not much study of this kind in the Islamic world and developing countries. One third of attempters in this study were below 20 years old, a phenomenon that needs addressing. Most of these attempters were using non-violent means.

Comparing our study to that done almost 20 years earlier on the same hospital and similar population there was a reduction of the parasuicide rate from 20.7 per 100,000 to 14 per 100,000. We postulate that this reduction in rate may be related to improved psychiatric services by medical health services and psychiatric services for the same population and also due the referral system followed. This

may refute the claim made by Daradkeh and Al Zayer that the low rate was due to under reporting and misdiagnosis as the reporting policy and the law remains the same lower rates could also be related to under reporting by patients and physician. The stigma about involvement of the police may also be a factor. The hospital where the sample was studied and has a policy to refer all parasuicide cases to the Psychiatrist and Emergency Services staff members were trained to diagnose parasuicidal cases compared to e.g. accidental poisonings or social problems. Our results agree with Daradkeh and Al Zayer that young females and disorder interpersonal relationship, with spouses and parents as the precipitating factors. We have found that in addition to young females aged 20 there is a peak in females aged 40+. The first one was mainly dependent daughter and the second mainly dependent wives. Again acute reaction to stress was the most common diagnosis followed by depression and we found that the majority were an overdose i.e. self-poisoning. In addition to psychiatric problems we found that physical illnesses also feature predominantly with 20% of patients suffering from anemia as in this is part of the Kingdom there is high incidence of sickle cell anemia. 15% of our sample suffered from diabetes. In regard to interpersonal relationships we found marital problems 17% and interpersonal relationship problems 34% and in the industrial sample 24% had occupational problems. The Company had a program helping employees with stress called the Employee Assistance Program (EAP). Now Psychiatric Services has started an ambitious program for employees called Promoting Mental Health Awareness in the workplace. The majority of our patients had no previous suicidal attempts 90% and we found that the age was significantly related to depression and

acute situational reactions and to the female gender. The rate of depression was higher than that of Daradkeh 1985. This refutes the claim of misdiagnosis. One of Daradkeh recommendations was to amend the law in order to give the opportunity for distressed people to receive help. We feel that increased public awareness in addition to improved medical and psychiatric services population can make more significant effect than just changing the law. More prospective studies are needed especially in high risk group of young females in their 20s and those in their 40s and those with interpersonal and occupational relationship problems. These studies need a longer period of time to make more accurate recommendations about preventing measures.

There are certain limitations to this study by virtue of being a retrospective one. Some cases of attempted suicide may be recorded as accidental poising due cultural, religious or reasons associated with the stigma of mental illness. Assessing the "state of mind" of the attempters retrospectively is fraught with difficulties. The diagnoses were not standardized using ICD of DSM as the recording of the initial diagnosis were made Emergency department physicians. Some of clinical variables did not show differences in the statistical analysis and this can be expected due to the small sample size.

The implications of this study call for a larger population-based, rather than hospital-based, multi-centre study. This would be useful for increasing our knowledge about this important public issue.

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Prevalence of Postnatal Depression among Sudanese women and the associated risk factors

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Introduction

Postnatal depression is a profoundly disturbing experience that may persist for many months leading to a lot of suffering to the mother and seriously disturbing the mother, mother-baby and marital and family relationships.

It affects 10-20% of women postpartum. Unlike the even more common condition, “maternal blue’s”, which is short lived and rarely needs treatment, postnatal depression may be prolonged and it needs treatment.

Unlike the relatively rare condition, puerperal psychosis, which is easily recognized, postnatal depression is easily missed.

Depressive illness is probably the most frequently missed diagnosis in the whole medicine, and depression in the postpartum is even more difficult to recognize.

The result is that health care professionals have been largely unaware of the problem of postnatal depression and are poorly prepared to respond and only recently the extent and characteristics of postnatal depression are reviving attention.

Not only the health professionals, even the patients are unaware of the problem, many are ashamed with the result that a minority of cases of postnatal depression seeks help. If this is true for European countries, one can guess how the situation could be in our country.

A community based study was conducted in Al-Haj Yousif area, Khartoum North city.

Al-Haj Yousif is a big area and is of high population including different tribes and socio-economic levels although the majority is from the lower or middle social classes.

Methodology

This is a community based study to estimate the prevalence of postnatal depression and to identify the risk factors associated with it.

Area

The study was conducted in Al-Haj Yousif area, Khartoum North city. This area is comparable with Al-Kalaklat in the

periphery of Khartoum city and Om Beddah in the periphery of Omdurman city.

The distance between the center of Khartoum city and Al-Haj Yousif area is about 23 kilometers.

Population

According to the local authorities, Al-Haj Yousif area has a population of 350,000 which is about 12% of the total population of Khartoum state (3,000,000). Twenty percent of Al-Haj Yousif population is women of child bearing age group.

Sample

There are 10 health centers in Al-Haj Yousif area which provide mother and child health services. Five of these centers were chosen randomly. All women who attended these clinics for immunization of their babies aged four months or less were included.

Women who attended these clinics for family planning and who delivered within the last four months were also included.

Instrument and Interviewing

EPDS was used. This is a validated scale, developed by Cox, specifically to identify postnatal depression. It is a 10-item scale which is easy to complete. Response categories are scored 0, 1, 2, 3 (or 3, 2, 1, 0) according to severity of symptoms. The score is calculated by adding together the scores from each of the total ten items. The cut point of 10 was used. Those who scored 10 or more were considered depressed. The Edinburgh was translated to Arabic language. A colloquial Arabic was also used to simplify the questions, only once for each woman.

A semi-structured questionnaire included the demographic factors and other possible risk factors; past psychiatric history physical illness, socio-economic status, marital relationship, obstetric history and others.

All women were interviewed by five sisters, one sister for each health center. They were properly instructed about the application of the questionnaire. 1077 women were interviewed during the period of the study.

In the semi-structured questionnaire few observations were found to be missing, 0.1 – 0.6 % in only some of the questions. 16 out of 1077 (1.5 %) did not answer the question about the delivery time whether it was at day time or at night.

Data collected were analyzed by computer using SPSS program. Chi-square test (x^2) and the degree of freedom (DF) were used for the comparison of the categorical data. The level of significance was taken at 0.05.

Results

Prevalence of PND

Score	Frequency	Percentage
Not Depressed < 10	786	73.0 %
Depressed ≥ 10	291	27.0 %
Total	1077	100.0 %

Prevalence = 27% using a cut point of 10 on EPDS

Prevalence of PND

Score	Frequency	Percentage
Not depressed < 12	867	80.0 %
Depressed ≥ 12	210	19.5 %
Total	1077	100.0 %

Prevalence = 19.5% using the more stringent cut point of 12 on EPDS

Score by Level of Education

Score	Illiterate	Primary School	Secondary School	University	Row Total
Not Depressed < 10	103 (13.1 %)	335 (42.6 %)	313 (39.8 %)	35 (4.5 %)	786 (73.0 %)
Depressed ≥ 10	79 (27.1 %)	137 (47.1 %)	67 (23.0 %)	8 (2.7 %)	291 (27.0 %)
Column Total	182 (16.2 %)	472 (43.8 %)	380 (35.3 %)	43 (4.0 %)	1077 (100 %)

x 2 = 44.27 DF = 3 P = 0.0000

Score by Occupation

Score	Working	Not working	Row Total
Not Depressed < 10	117 (14.9 %)	669 (85.1 %)	786 (73.0 %)
Depressed ≥ 10	58 (19.9 %)	233 (80.1 %)	291 (27.0 %)
Column Total	175 (16.2 %)	902 (83.8 %)	1077 (100 %)

$x^2 = 3.97$ DF = 1 P = 0.0462

Score by Marital Relationship

Score	Stable	Not stable	Row Total
Not Depressed < 10	777 (98.9 %)	9 (1.1 %)	786 (73.0 %)
Depressed ≥ 10	280 (92.2 %)	11 (3.8 %)	291 (27.0 %)
Column Total	1057 (98.1 %)	20 (1.9 %)	1077 (100 %)

$x^2 = 8.09$ DF = 1 P = 0.0044

Score by Husband's Occupation

Score	Not working	Soldier	Worker	Employee	Business man	Working abroad	Student	Row Total
Not Depressed < 10	5 (0.6 %)	55 (7.0 %)	261 (33.2 %)	180 (22.9 %)	222 (28.2 %)	61 (7.8 %)	2 (0.3 %)	786 (73.0 %)
Depressed ≥ 10	2 (0.7 %)	29 (10.0 %)	104 (35.7 %)	43 (14.8 %)	97 (33.3 %)	14 (4.8 %)	2 (0.7 %)	291 (27.0 %)
Column Total	7 (0.6 %)	84 (7.8 %)	365 (33.9 %)	223 (20.7 %)	319 (29.6 %)	75 (7.0 %)	4 (0.4 %)	1077 (100 %)

$x^2 = 15.16$ DF = 6 P = 0.0190

Score by Presence of the Mother's Sister during Confinement

Score	Yes	No	Row Total
Not Depressed < 10	323 (41.1 %)	463 (58.9 %)	786 (73.0 %)
Depressed ≥ 10	105 (36.1 %)	186 (63.9 %)	291 (27.0 %)
Column Total	428 (39.7 %)	649 (60.3 %)	1077 (100 %)

$x^2 = 2.22$ DF = 1 P = 0.1355

Score by Presence of Mother-in-law during Confinement

Score	Yes	No	Row Total
Not Depressed < 10	101 (12.8 %)	685 (87.2 %)	786 (73.0 %)
Depressed ≥ 10	57 (19.6 %)	234 (80.4 %)	291 (27.0 %)
Column Total	158 (14.7 %)	919 (85.3 %)	1077 (100 %)

$x^2 = 7.7$ DF = 1 P = 0.0055

Score by Presence of Her Own Mother during Confinement

Score	Yes	No	Row Total
Not Depressed < 10	392 (49.9 %)	394 (50.1 %)	786 (73.0 %)
Depressed ≥ 10	114 (39.2 %)	177 (60.8 %)	291 (27.0 %)
Column Total	506 (47.0 %)	571 (53.0 %)	1077 (100 %)

$x^2 = 9.75$ DF = 1 P = 0.0017

Score by Presence of Others (not close relatives) during Confinement

Score	Yes	No	Row Total
Not Depressed < 10	163 (20.7 %)	623 (79.3 %)	786 (73.0 %)
Depressed ≥ 10	110 (37.8 %)	181 (62.2 %)	291 (27.0 %)
Column Total	273 (25.3 %)	804 (74.7 %)	1077 (100 %)

$x^2 = 32.67$ DF = 1 P = 0.0000

Score by Economic Status

Score	Low	Middle	High	Row Total
Not Depressed < 10	61 (7.8 %)	519 (75.2 %)	134 (17.0 %)	786 (73.0 %)
Depressed ≥ 10	98 (33.9 %)	152 (52.6 %)	39 (13.5 %)	291 (27.0 %)
Column Total	159 (14.8 %)	743 (69.1 %)	173 (16.1 %)	1077 (100 %)

x^2 = 114.95 DF = 2 P = 0.0000

Score by Physical Illness

Score	Yes	No	Row Total
Not Depressed < 10	9 (1.1 %)	774 (98.9 %)	783 (73.1 %)
Depressed ≥ 10	11 (3.8 %)	277 (92.2 %)	288 (26.9 %)
Column Total	20 (1.9 %)	1051 (98.1 %)	1071 (100 %)

x^2 = 8.19 DF = 1 P = 0.0042

Score by Psychiatric Illness

Score	Yes	No	Row Total
Not Depressed < 10	1 (0.1 %)	783 (99.9 %)	784 (73.1 %)
Depressed ≥ 10	10 (3.5 %)	278 (96.5 %)	288 (26.9 %)
Column Total	11 (1.0 %)	1061 (99.0 %)	1072 (100 %)

x^2 = 23.2 DF = 1 P = 0.0000

Score by Congenital Abnormality of the Baby

Score	Yes	No	Row Total
Not Depressed < 10	761 (96.8 %)	25 (3.2 %)	786 (73.0 %)
Depressed ≥ 10	274 (94.2 %)	17 (5.8 %)	291 (27.0 %)
Column Total	1035 (96.1 %)	42 (3.9 %)	1077 (100 %)

x^2 = 4.01 DF = 1 P = 0.0451

Score by Time of Delivery

Score	Night	Day time	Row Total
Not Depressed < 10	473 (61.0 %)	303 (39.0 %)	776 (73.1 %)
Depressed ≥ 10	194 (68.1%)	91 (31.9 %)	285 (26.9 %)
Column Total	667 (62.9 %)	394 (37.1 %)	1061 (100 %)

$x^2 = 4.52$ DF = 1 P = 0.0334

Score by Delivery Place

Score	Home	Hospital	Row Total
Not Depressed < 10	380 (48.4 %)	405 (51.6 %)	785 (73.1 %)
Depressed ≥ 10	177 (60.8 %)	144 (39.2 %)	291 (26.9 %)
Column Total	557 (51.8 %)	519 (48.2 %)	1076 (100 %)

$x^2 = 13.10$ DF = 1 P = 0.0002

Score by Puerperal Sepsis

Score	Yes	No	Row Total
Not Depressed < 10	67 (8.5 %)	719 (91.5 %)	786 (73.0 %)
Depressed ≥ 10	63 (21.6 %)	228 (78.4 %)	291 (27.0 %)
Column Total	130 (12.1 %)	947 (87.9 %)	1077 (100 %)

$x^2 = 34.47$ DF = 1 P = 0.0000

Place of Delivery by Puerperal Sepsis

Place of Delivery	Yes	No	Row Total
Home	67 (12.4 %)	472 (87.6 %)	539 (51.4 %)
Hospital	63 (12.4%)	447 (87.6 %)	510 (48.6 %)
Column Total	130 (12.4 %)	919 (87.6 %)	1049 (100 %)

$x^2 = 0.0014$ DF = 1 P = 0.9696

After correction:

$x^2 = 0.0000$ DF = 1 P = 1.0000

*N.B those with other complications were excluded

Discussion

Prevalence

The prevalence of postnatal depression differs according to its definition and the population studied. Rates of as low as 3% and as highly as 60% were reported. However, the estimated rates are mainly within the range 10 to 15 percent (1). A after a literature review, *Richards* stated that the estimated rates are mainly between 5 – 22%(2). According to others it occurs I a rate of 10 – 20 %(3).

In this study, the prevalence was found to be 27% using a cut point of 10 in Edinburgh Postnatal Depression Scale which is a high rate. Using the more stringent cut point of 12, the rate was found to be 19.5%. This is still a high rate and in fact it represents the upper limit of the average range already mentioned (10 – 20%).

This high rate is probably due to the fact that all women included were seen within four months after childbirth. The peak time of onset of illnesses following childbirth is the first two weeks (4,5). According to *Cox(6)* the onset for postnatal depression is at 3 – 4 weeks but does not usually reach clinical levels of morbidity until the 4^{th} – 5^{th} month.

Another explanation for this high rate in Al-Haj Yousif area is that it is probably related to the etiological risk factors. Low level of education has been identified as a risk factor in this study and the majority of women in the study population were illiterate or had a primary school level of education. This can be applied also to low income as a risk factor. Puerperal sepsis was identified as an important risk factor, and 12.1% of the mothers had this disease.

Socio-demographic factors

The mother being illiterate was found to be highly significant as a risk factor for postnatal depression in this study with P = 0.0000. Seventeen percent (16.9%) of studied women were illiterate and this is nearly the same rate found in another study among women with postpartum illnesses (7).

Working was identified as a risk factor in this study, P = 0.046. In a rural area women and men most probably do the same work for example at farms and dissatisfaction with work is unlikely. In a previous similar Sudanese study no significant relation between working and postpartum illness was found(7)

In an urban area, as in this study, women most of whom were illiterate or with low level of education (60.7%) most probably had a low occupational status on working outside the house. In fact many of them were tea-sellers and most probably dissatisfied with their works. A study showed that those who were not working or those with lower occupational status were at greater risk for postnatal depression (8).

Instability in the marital relationship was found to be highly significant as a risk factor for postnatal depression, P = 0.0044. In fact this was recognized as a risk factor by many investigators (9,10,11,12,13,14).

Recognition of the husband being a soldier as a risk factor for PND in this study is understandable. During this war time many soldiers will be in the fighting field and away from their homes for months or years.

The husband being a student was also recognized as a risk factor for PND in this study. This is probably due to the fact that the student after coming back from his university needs to revise his lectures at home and has little time to spend with his wife or with his children.

Lack of social support during confinement is an unusual encounter in Sudanese society (15). All women in this study had assistance during confinement by close relatives of by others.

In the presence of woman's sister during confinement no significant difference was found between the rates of those who were depressed and those who were not.

In the presence of the husband's mother there was a high rate of depressed compared to non-depressed and the difference was statistically significant, P = 0.0055

In contrast when the assistant was the mother's own mother the rate of depressed was less than the rate of non-depressed and the difference was statistically highly significant, P = 0.0017. Not only a female after giving birth to her child but everybody feels happier in the presence of his or her mother. Again when the assistants were "others" and not the close relatives the rate of depression was higher and the difference was statistically highly significant, P = 0.0000.

In other countries many investigators identified lack of social support as a risk factor for postnatal depression (16,17).

Low economic status was found to be a highly significant risk factor, P = 0.0000. This was recognized as so by many other studies,(e.g.18,19)

History of important physical illness was found to be a highly significant risk factor for postnatal depression, P = 0.0042. Poor health, among other factors, is identified as a significant risk factor for postnatal depression(20).Past psychiatric illness is probably the most important risk factor for postnatal depression. It has been a consistent finding in different studies. In this study it was found to be a highly significant risk factor for postnatal depression, P = 0.0000. It was recognized as such by many others [.

Obstetric and related factors

Delivery during the night was significantly associated with higher rates of postnatal depression in this study, P = 0.0334. Delivery at night may upset the normal sleep cycle. Facing a "problem" at midnight is doubtless more distressing than doing so during the day time. Contact and transportation may be difficult at night and a husband having his wife near term may have to arrange for a car, and sometimes fuel, before going to bed.

Home delivery was found to be significantly associated with high incidence of postnatal depression in this study, P = 0.0002. *El-Mahi (1994)* similarly recognized home delivery as a significant risk factor for postpartum psychiatric illnesses. Difficulties mentioned for night delivery may apply to some extent to home delivery. It is possible that home delivery is related to other factors for example low income with inability to pay hospital fees, or to low level of education.

Postpartum vaginal bleeding was not found to be a significant risk factor in this study.

However, puerperal sepsis was found to be a very highly significant risk factor for postnatal depression (x^2 = 34.77, P = 0.0000).

A strong association was expected between postnatal depression and this distressing disease with its characteristic features of fever, pain and foul smelling vaginal discharge.

Unfortunately, more than 12% of women included in the study had this disease. Surprisingly the rates were equal whether the delivery was at home or at hospital indicating poor hygiene in both places (x^2 = 0, P = 1).

Conclusion

The prevalence of postnatal depression was estimated to be 27% using a cut point of 10 in EPDS, and 19.5% using the more stringent cut point of 12, indicating a comparatively higher rate.

Among the socio-demographic factors; illiteracy, instability in the marital relationship and low economic status were found, in agreement with findings in other countries, to be highly significant risk factors for postnatal depression. However, inconsistent with previous findings, working was found to be a significant risk factor. Consanguinity and mode of living were not found to be associated with postnatal depression.

The husband being a soldier or a student was recognized as a risk factor for PND. The presence of mother-in-law or others who were not close relatives during confinement, but not the presence of the woman's own mother, was found to be a significant risk factor.

The high importance of past psychiatric history as a risk factor was confirmed as well as the importance of history of physical illness. A congenitally abnormal baby was found to be of marginal significance as a risk factor.

Abnormal weight of the baby and whether he was bottle or breast-fed were not confirmed as risk factors.

Night delivery was found to be associated with higher rates of PND, and home delivery was confirmed as a risk factor.

Inconsistent with findings in other countries, Caesarean section and forceps delivery were found to be insignificant.

Postnatal bleeding was not found to be a significant risk factor but puerperal sepsis was found to be very highly significant.

Recommendations

Encouragement of research into this disorder to increase awareness and the knowledge of medical professionals.

Training programs for medical professionals working in the field of mother and child health should include ample information about PND and how it is diagnosed and treated.

Screening for PND in the postnatal clinics using EPDS which is a simple and easy to complete questionnaire.

Special attention appears warranted to those who were particularly at higher risk including those with low income or low level of education.

Good hygiene and proper sterilization of instruments and hands both at home and at hospital delivery rooms to minimize rates of infection related to childbirth.

Encouragement of hospital delivery.

Sending the primigravida to deliver and stay with her own mother during confinement (or bringing her mother to her) is a well known practice in our society, and a good one, which should be encouraged.

The study highlighted the need for peace. Due to war many husbands leave their homes for a long period and may be forever. The impact of war on economy is well known .For the sake of mothers and children war should be stopped as soon as possible.

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Depression in Adolescent School students: Prevalence and Socio-Demographic Correlates

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ABSTRACT

Background: knowledge of the prevalence and correlates of depressive disorders in adolescents is important for identifying treatment needs, and for provision of psychiatric services.

Objectives: To measure the prevalence and associates of depressive disorders in randomly selected samples of adolescent school students in Khartoum.

Method: Across-sectional questionnaire survey was used to assess 103 adolescents students male and female aged 14-18 years (mean age 15.5) randomly selected from sixteen secondary school in Khartoum. The 24- items modified Beck questionnaire (MBQ) was used as screening tool for the detection of depression. The socio-economic status was evaluated through the socio-demographic questionnaire. Standard errors and 95% confidence intervals for means and proportions were calculated. Logistic regression modeling was used to determine the factors that affect depression.

Result: The prevalence of depression among adolescent school students was 84.5% (95% CI 79.9-89.5) adolescents with depressive symptoms are more likely to be female and had larger family size. No association between depression and socio-economic status or adolescent's ages.

Conclusions: Depressive disorder is a prevalent condition among adolescent school students in Khartoum. There is a significant difference in depression among adolescents according to their gender in favor of females and a positive correlation between depression and adolescent's number of siblings. There is no significant correlation between depression and adolescent's ages or depression and adolescent's family monthly income.

خلاصه الدراسة

الخلفية : معرفه مدي انتشار الإكتئاب وسط طلاب المدراس الثانويه وعلاقته بالعوامل الاسريه والاجتماعيه ذو اهميه كبري في معرفه الحالات الاكتئابيه وعلاجها وفي تقديم الخدمات العلاجيه النفسيه للطلاب

الهدف:الهدف من هذه الدراسه هو قياس نسبه شيوع الاكتئاب وسط طلاب المدارس الثانويه وعلاقته بالعوامل الاسريه والاجتماعيه.

الطريقة: مجموعة الدراسة تم اختيارها من مدرسة ثانوية للبنات و اخرى للأولاد لولاية الخرطوم كان المجموع الكلى للطلبة 776 تم اختيار 103 منهم بالطريقة العشوائية البسيطة, تم توزيع وجمع الإستبيانات (مقياس بك المعدل, وإستمارة الحالة الاقتصادية الاجتماعية).استخدمت الباحثة التحليل الإحصائى للعلوم الإجتماعية واختبار (تى) فى التحليل الإحصائى.

النتائج : بلغ معدل الإكتئاب على مقياس بك المعدل (أكثر من 10 نقاط) 84,5% كان معدل الإكتئاب أكثر عند الطالبات. الطلبة الذين لهم أكبر عدد من الإخوة والاخوات لم تكن هنالك دلالة احصائية بين الوضع المادي للاسرة والاكتئاب.

الخلاصة:

- نسبة شيوع الاكتئاب وسط المراهقين 84.5%
- معدل الإكتئاب أكثر عند الطالبات
- توجد دلالة إحصائية موجبة بين الإكتئاب وعدد الإخوة.
- لاتوجد دلالة إحصائية بين الإكتئاب والدخل الشهري للاسرة.

Introduction

Statement of the problem

Major depression is one of the most common psychiatric disorders of adolescence, and one whose many consequences can include mental health and substance abuse morbidity, academic and social derailment, and perhaps most ominously of all, high rates of attempted and completed suicide. Epidemiological and Longitudinal follow-up studies of adolescents with depression have documented high rates of recurrence, of progression into chronicity, and of continuity into adult forms of affective disorders. (1)

Adolescence is a transition period to adulthood in which youth negotiate many developmental tasks, including strengthening and expanding self-concepts, forming stable intimate relationships, making career decision, and achieving independence from parents.

Resolution of these challenges is necessary for the successful assumption of adult roles. However, experiencing major depression may interfere with the acquisition of these skills, and leads to poor adjustment in adulthood. (2)

Purpose and need

Knowledge of disease prevalence is most important in planning health services and administering medical care facilities, hence the number of prevalent cases at any time is one determinant of the demand for health care.

In recent years considerable methodological advances have been made which enable reliable epidemiological work to be conducted particularly standardized methods for assessing psychopathology have been developed and systems of classifications have been specified.

The aim of this study is to measure the prevalence of depression in a representative. School based sample of adolescents and to relate this to psychosocial and family background factors.

Hypotheses

1. Depression spreads among adolescent school students with different level.

2. There is a significant gender difference in the prevalence of major

depression starting in adolescence; the proportion is higher for females than for males (3).

3. Depressive disorders increases with increased age in children and adolescents. (4).

4. Larger family size, later birth orders, and older parental age at birth increase the risk for developing depressive disorder (5).

5. Depressive disorders increase with lower socioeconomic class.

Method

The study area and the study population:

Khartoum state is administratively divided into seven municipalities. This study was conducted in Khartoum municipality. The target population in this study was adolescent school students (14-18) years, mean 15.5, so it was decided to study, the second and the third year of secondary school students.

There are 16 secondary schools in Khartoum municipality nine for girls and seven for boys. One secondary school for girls was selected at random (El Khartoum El Gadeeda) and one secondary school for boys were selected at random (El Khartoum El Gadeema) from Khartoum municipality secondary schools for girls and boys.

The study design and sample selection:

The research is a school-based epidemiological study of a representative sample, 103 adolescent students. Simple random sample selection was used, all second and third year students have been arranged serially from 1-338 for boys and 1-438 for girls, using the table of 20,000 random digits, 52 boys and 51 girls had been selected randomly from the total number of adolescent students 776.

Instrument:

The 24-item modified Beck Questionnaire (MBQ), was used as a screening tool for the detection of depression. This (MBQ) was developed by Dr. Iklass Ibraheem (2000), for Sudanese. A review of studies on the validation of (MBQ) demonstrates its high validity and reliability as a screening tool of depression in the community. Iklass Ibrahim (2000) validity of 0.75, reliability of 0.77.

Statistical Reliability and Validity for (MBQ):

30 secondary school students had been selected by the simple random sample selection, 15 girls and 15 boys.

To investigate the internal consistency of this scale the researcher carried out the Pereason correlation coefficient between each item with sum total of all items. It can be observed from table (1) that all the correlation coefficient of depression items is positive and statistically significant, so the researcher applied all these items in calculating the reliability of the scale using Alpha Koronbakh equation which indicated that the value of reliability is (0.8307). In order to get the scale validity, these applied subjective validity equation equal the square root of the reliability, i.e. (0.911).

It can be concluded by saying that this scale is reliable and valid for measuring depression of the present population (adolescents).

The cut - off point of (MBQ) is 10.

A score of <10 correspond to no depression.

10-15 correspond to mild degree of depression.

16-23 correspond to moderate depression.

24 and more correspond to severe depression.

The socio-demographic questionnaire was used for the variables: gender, age, family monthly income and the number of siblings.

Data collection

Copies of the (MBQ) were administered to the student, who completed them individually in classrooms under the supervision of the researcher (a psychiatric registrar) who answered student's questions and checked questionnaires for missing data.

The socio-demographic variables were administered to the students with (MBQ).

Completed questionnaires were thus collected and note was taken of the response rate. All the 103 students completed the questionnaires so response rate was 100%.

Data analysis

Data relating to the survey were analyzed using the statistical package for the social sciences, SPSS version

11.0 for windows. Logistic regression modeling was used to determine the factors that affect depression. Depression was considered as dependent variable and gender, age, family income, and numbers of siblings were considered as independent variables. Using logistic regression model, the level of significance and standard deviation were calculated. Statistical significance was based on $P<0.05$ to identify predictors of potential clinical relevance. Standard errors and 95% confidence intervals for means and proportions were calculated.

Results

The prevalence of depression among adolescent school students was 84.5 %(95% cl 79.9-89.5) adolescents with depressive symptoms are more likely to be female and had larger family size. No association between depression and socioeconomic status or adolescent's age (Table I)

Table (I)
Percentages of depression and limitations of every level of depression among adolescent students.

Level of depression	Frequency	Percent	Limitation of percent in population	
			lower	upper
Normal (0-9)	16	15.5	10.5	20.1
Mild (10-15)	13	12.6	8.7	18.2
Moderate(16-23)	28	27.2	22.5	36.6
Severe(24-above)	46	44.7	38.3	50.1
Total	103	100		

Table I shows the percentage of depression and limitations of every level of depression among adolescent school students. It can be observed that 84.5% (95% CI 79.9 - 89.5) of the sample are classified as depressed. And only 15.5% (95% CI 10.5 - 20.1) of the sample lies within the normal range.

12.6% (95% CI 8.7-18.2) of the sample are classified as mild depression.

27.2% (95% CI 22.5-36.6) as moderate depression and 44.7% (95% CI 38.3–50.1) as severe depression.

Table II

T-test for independent groups to investigate the difference in depression among adolescent according to gender.

Groups	N. Cases	Mean	Std. Deviation	T-value	Sig.	Conclusion
Males	52	19.27	11.54	3.36	0.001	There is significant difference between two groups in favor of males.
Females	51	27.08	12.03			

There is significant difference between two groups in favor of females.

Table III

Pearson Correlation to know the correlation between depression and age of adolescent. (n = 103).

Variable	Correlation with Depression	Level of Significance	Conclusion
Adolescent's Ages	-0.024	0.405	There is no significant correlation between depression and adolescent's ages.

Table IV

Pearson Correlation to know the correlation between depression and numbers of siblings. (n = 103).

Variable	Correlation with Depression	Level of Significance	Conclusion
Adolescent's numbers of siblings	0.184	0.031	There is a significant positive correlation between depression and adolescent's number of siblings.

Table V

Pearson Correlation to know the correlation between depression and the monthly income of adolescent (n = 103).

Variable	Correlation with Depression	Level of Significance	Conclusion
Adolescent's family monthly income	-0.046	0.323	There is no significant correlation between depression and adolescent's monthly income.

Discussion

Major depression occurring in the adolescence may curtail the attainment of occupational and interpersonal developmental tasks appropriate for full adult status. The manifestation of depression during this period creates heightened risk for recurrence and has negative implication for subsequent function .These distinct profiles point to avenues for prevention and early intervention (6).

This study is meant to address this problem by an epidemiological survey of depression in 103 adolescent school students age (14 – 18) years, the screening tool for depression used in this study was modified Beck questionnaire (MBQ) modified for Sudan.

Hypothesis One:

The first hypothesis stated that (depression spread among adolescents with different level) . To study this hypothesis the researcher equated the limitation of upper and lower percentages of depression among the population of adolescence. This process resulted in the following statistics:

Prevalence

Prevalence of depression in this study was estimated to be 84.5% (95% CI 79.9-89.5) Birmher et al in a review of the past 10 years found a prevalence of 5%, Velez et al reported eight year prevalence among 13 - 14 year olds of 3.7% with greater prevalence in girls than in boys(7).

Fleming and Offord, and Kashani, et al reported a prevalence of 4.0%.

Fleming et al maintained that the Beck Depression inventory (BDI) range is more plausible when only severe cases are included. The overall rates of moderate to severe depression in children in studies using the BDI range from (8.6% - 36%).

In Sudan (Khartoum) Kamil M.A Estimated a prevalence of 4.2% in adolescents girls (8).

A high prevalence rate of depression in adolescents was found in this study compared to the findings of most previous studies. The discrepancies in prevalence rates may result in part from differences in research methodology, diagnostic criteria and instruments used.

The high prevalence in this study may be due to the stress of the oncoming exam especially for the third year.

Some reason epidemiological data suggest that the incidence of major depressive disorder may be increasing among people less than 20 years old. If true the observation may be related to the

increased use of alcohol and other substances in this age group.

Modified Beck for Sudan was used in this study, it may be more sensitive to detect depressive symptoms, and future study should be conducted using DMS-IV or Aicd-10 to confirm this result with modified Beck for Sudan.

Hypothesis Two:

There is a significant difference in depression among children according to their gender (male, female).

Gender

In this study a higher prevalence rate of depression in girls than in boys (45.6% V 38.8%) was found compatible with results of other surveys Velez et al (1989) reported an eight - year old of 3.7%, with a greater prevalence in girls than boys.

Fleming et al (1989) reported the six - month prevalence of major depressive disorders for (12 - 16) year old girls as 11.1%.

Before puberty, boys are slightly more likely than girls to be depressed, but between the ages of 11 and 13 this trend is reversed, with girls outnumbering boys by two to one. This predominance of females over males persists for the next 35 - 40 years. Changes in gonadal steroids are only part of the explanation for this gender gap. Hormonal changes in adolescence combined with dramatic changes in social environment and relationships stimulate the development of greater affiliative needs in females such as a preference for intimacy and emotional responsiveness.

One result of this that adolescent girls can be left more vulnerable to effects of negative life especially ones that have interpersonal consequences (9).

Hypothesis Three:

There is a significant correlation between depression and the ages of adolescent who are depressed.

Age

In this study the highest percentage of depression was found at age 15 year (39.8%) followed by age 16 year (34.0%).

Clarke et al reported that age 15, adolescents have more internalizing behavior problems (10). This highlights the importance of biological, genetic and environmental factors in the family domain.

In this study there is no significant correlation between depression and adolescent ages. Rutter et al, Kandel and Davies, Kandel and Davies 6) and Kaplan et al reported older adolescents were

found to have higher depression scores in self-reporting instruments.

With growth and maturation the expression of emotional symptoms and behavior may change, altering the prevalence of mental disorders. MC Gee et al found the greatest increase was in the prevalence of major depression (11).

Klerman (1988) argued that when depression assessed by symptom scales, there is an aging effect, the elderly reported more depressive symptoms. However when clinical diagnostic categories are assessed using structured interviews, surprisingly there is no increase of prevalence with age.

The expected increase of depression with aging has intuitive 'face validity'. As individuals grow older they experience more losses, children grow up become independent and move away, with age there is increased likelihood of medical illness, limitation of activities and disability. The expected increase in depression in response to this biological and social change is often explained by reference to psychodynamic concept of object loss and narcissism Klerman (1988).

The lack of significance with age in this study may be due to the fact that the age variation is not marked.

Hypothesis Four:

There is a significant correlation between depression and the number of siblings of adolescent who are depressed.

Family factors

This study revealed a significant positive correlation between depression and number of sibling. Family composition at birth is important Lewinshn et al found that later - born children in large families report estrangement from parents and perceive their families as punitive and unsupportive(12).

Later-born children are also at risk for depression, anxiety and lower self-concept. Furthermore, being born into a large family and / or to older parents was a significant risk factor.

Self-reports of family violence and low family cohesion were also significant markers.

This study, also investigated the impact of the parents loss, 10 out of 103 adolescents had lost one of their parents at different ages. All the 10 students scored above the cut - off point of MBQ, but the data in this variable cannot be statistically analyzed.

It is important to note that none of the adolescent students, who had scored above the cut-off point of modified Beck Questionnaire (MBQ), were known to the

health care services. This is consistent with other epidemiological reports from England (Cooper CI Goodyer 1993) and USA (Whittaker et al 1990).

Hypothesis Five:

There is a significant correlation between depression and the family income of adolescents who are depressed.

Socioeconomic status

This study revealed no significant correlation between depression and adolescent's family income. Similar result had been obtained by Kandel and Davies (1982) who found no effect of family income or father education in high school children. This is in contrast with finding of Kaplan et al (1984a) and Schoenbach (1982) who found a higher mean score and higher symptom score of depression in adolescents of lower socioeconomic class, Kamil M.A. (1998) found strong association with poor financial status and depression in adolescent girls. The lack of effect of socio - economic status within this study may reflect lack of variability within the adolescent's family income.

Conclusion

The point prevalence of major depression among adolescent school students in Khartoum municipality (84.5%) is higher than that reported in USA and England.

There is significant difference in depression among adolescents according to their gender (male, female) in favor of females.

There is no significant correlation between depression and adolescent ages.

There is a significant positive correlation between depression and adolescent number of siblings.

There is no significant correlation between socio-economic status and depression among adolescent students.

Limitations

The main outcome was a self-reported assessment of depression which could be strengthened by validation using a psychiatric interview.

Single-informant rather than multi-informant (parents, teachers, older children) had been used which is associated with poorer sensitivity.

Rural areas need to be included.

Acknowledgement:

This work was supervised by Dr. Osman Abdu to whom I am grateful.

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Psychosocial profile of Sudanese detained children

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Abstract:

Background: Children juvenile correctional facilities (reformatories) are living in special situation which need evaluation. There is marked association between juvenile offender and a number of psychopathological characteristics as well as other related factors; social, family and factors related to the child.

Objectives: The study was conducted to assess the psychosocial profile of detained children, and to identify factors associated with offending.

Methods: A group of 120 detained children with age ranging 10 – 17 years were enrolled in the study during the period from July 2003 to January 2004. It is a descriptive, prospective institutional-based study conducted in the educational homed for juveniles (reformatories) using a standardized questionnaire and another special questionnaire (strength and difficulties questionnaire) for data

collection. All data collected was analyzed by computer using SPSS.

Results: The prevalence of psychiatric disorder was detected in 40% with dominance of conduct disorders (83.3%) substances; alcohol abuse was detected in 54.1% of cases. There was significant association between offending and low social class (94.2%) of cases (P. value < 0.000).

Conclusion: One quarter of juveniles in correctional care facilities suffered one or more psychiatric co-morbidity substance/ alcohol abuse was encountered in half of detained children. Being an offender was significantly (P < 0.000) affected of poverty and low social class.

Introduction:

Educational homes for juveniles (Reformatories) are homes where reformation: rehabilitation and education of such children takes place in a period not exceeds 5 years according to the court judgment.[1]

Those who are living outside the framework of the normal adolescent support system of the family and school frequently receive no medical care during adolescent.[2]

Historical background:

The need of this care was appreciated by the American Academy of Paediatric (AAP) in 1997 when a policy statement about health care facilities was published, to assist in improving their system for providing health care. [3, 4]

In Sudan juvenile homes were established in 1951 as reformatories under the Prison Department.[5,6] First it was for the whole group (10-18 years), then it was separated to 10-15 years in Algreif reformatory,[5] and 15-18 years in Kober.[6] In 1987 it was put under the Welfare Department, then back to the Prison Department in 1994.

Objectives of the reformatories:[5, 6]

1. Psychosocial rehabilitation.
2. Academic education and eradication of illiteracy.
3. Occupational education and training.
4. Spiritual development.

There is marked association between juvenile offender and a number of psychopathological characteristic. [7]

It had been estimated that 60% of juvenile in juvenile justice system have behavioral, mental or emotional disorders. [7]

In Ontario in USA the prevalence of psychiatric disorders in incarcerated adolescents showed that 63.3% of such

youth had two or more (Psychiatric co-morbidity) psychiatric disorders. [8]

This overlap between: conduct disorders (CD), oppositional defiant disorder (ODD), attention deficit hyperactivity disorders (ADHD) substance abuse, depressive, manic disorders, anxiety disorder and psychosis. [9]

The prevalence of (CD) is 80%, substance abuse is reported in 25% to 50%, while ADH in up to 46%. An affective disorder was reported in up to 78%, anxiety disorders, psychosis and personality disorders in 4%, 6% and 17% respectively.[10]

In Correctional Care Centre in Spain, the most frequent health problems were found to be smoking habits in 91% and alcohol/drug abuse in 54%.[11,12] While Droeleijers et al at Netherlands found that 4% of delinquents are alcohol abusers, 9% marijuana dependence abuser and 4% are hard drug dependence.[13]

In USA, in 1999 the gender demographic show the vast majority (86%) of individuals detained in residential facilities are males.[14] While in Spain in 2001 the social characteristic of children entering foster centre showed that the mean age is 7.3 ± 5.7 years.[12]

Michael Gelders and his colleagues summarized the social factors in poverty, low social class, poor housing, poor education, broken homed, very large families, poor parenting and child raring practices.[15] It was found that offenders were highly concentrated or run in families with the father being to most important relative.[16] Children with one parent are at higher risk of offending.[17] Peers are another factor that have implication for delinquent behaviour because delinquency often is a group event.[18] In USA correctional facilities approximately 40% of adolescent appearing in juvenile court are repeated offenders.[19]

Patients and methods:

This is a descriptive, prospective, institutional-based study, conducted in two reformatories (Elgrif and Kober) in Khartoum State, during the period from July 2003 to January 2004.

All detained children during the study period were enrolled in the study with a total population coverage of 120 children.

A written consent was obtained from the authorities in the Prison Administration as well as from the Reformatories Administration, while informal consents were taken from the children.

A standardized questionnaire was designed which included the demographic characteristics, family history,

drug/substance abuse and detailed information about the crime.

Another questionnaire; strength and difficulties questionnaire was also used which is a brief behavioural screening for 3-16 years age group. It contains 25 items on psychosocial attributes which are divided between 5 scales: emotional symptoms, conduct, hyperactivity, peer relationship problems and prosocial behaviour. The children were directly interviewed and data collected was analyzed using SPSS.

Results:

The demographic characteristics of 120 children enrolled in the study showed that 68 children (57%) were in the age group 15-17 years, while 52 children (43%) were in the age group 10-14 years (Fig. 1).

Considering sex distribution, 107 children (89%) were males, while 13 children (11%) were females that gave a male to female ratio of 8.3: 1 (Fig. 2).

The prevalence of psychiatric disorders was detected in 48 children (40%) (Fig.3). The pattern of which, 40 children (83.3%) had conduct disorders, while 25 children (52%) were affected with prosocial disorder. Hyperactivity disorders were found to affect ten children (20.8%), peer problems and emotional disorders were encountered in eight children (16.6%) and five children (10.4%) respectively (Fig. 4).

Substance/alcohol abuse was looked in 120 detained children, it was found to be a health problem in 65 children (54.1%) distributed as follows: alcohol abuse in 33%, cigarette smoking in 23% silisyon abuse in 20%, while tomback and benzene in 18% and 10% respectively (Fig. 5). Fourteen children (11.6%) complained of enuresis.

The study tested the associated factors with juvenile delinquency which are either individual factors or family factors. Being an offender was found to be associated with poverty; 113 children (94.2%) were of low social class (P. < 0.000). Thirteen children (10.8%) were illiterate (P = 1) and 36 children (30%) were from very large families (P = 1). In 17 children (13.8%) cases there were another offender in the family, nine of them (7%) were the brothers (P. = 1.1 and 0.292) respectively. Forty one children (34.8%) committed the offence in groups of peer (P. value = 1), while 31 children (26.1%) committed the offences twice or more (P = 0.99) (Table 1).

Fig. 1: Age group distribution of 120 detained children

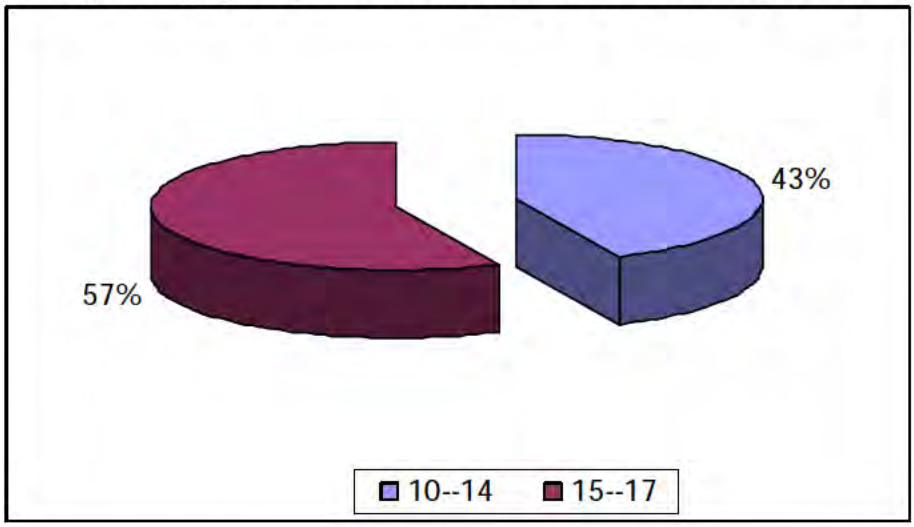

Fig. 2: Six distribution of 120 detained children

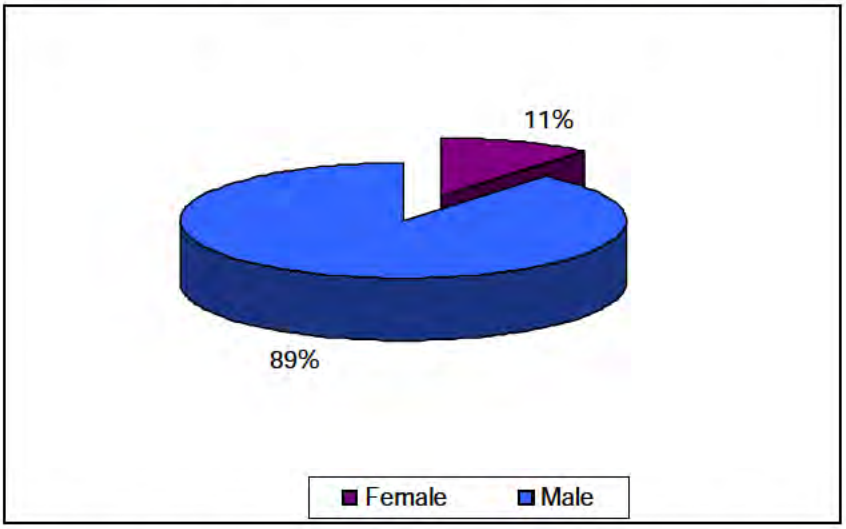

Fig. 3: Pattern of psychological disorders among the 48 detained children of the study group

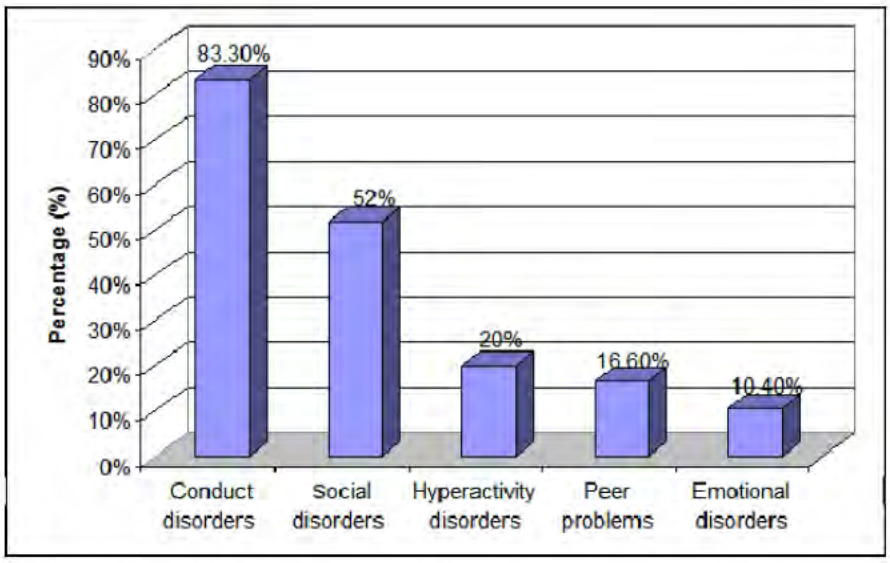

Fig.4: Substance abuse by 65 detained children of the study group

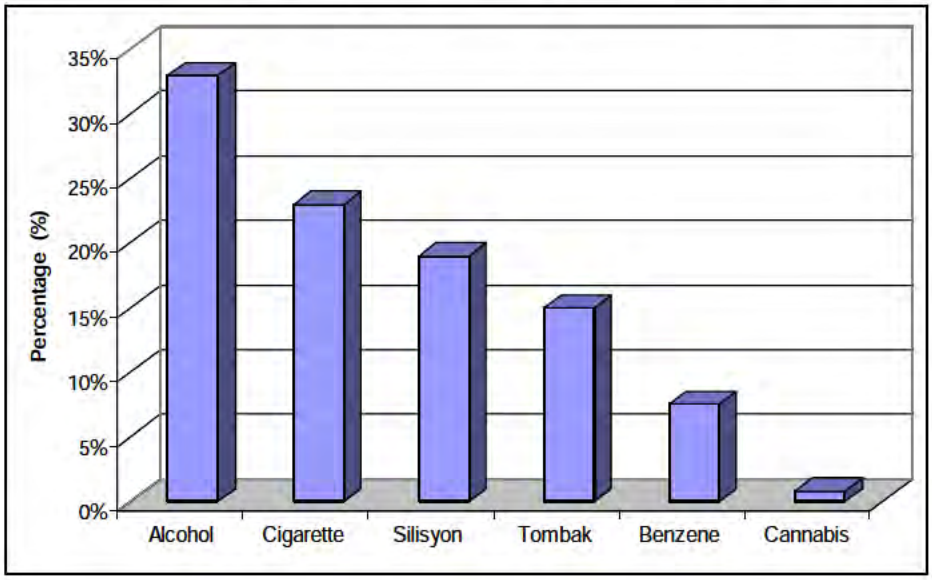

Table 1: Factors associated with offending

Factor	Response Yes	P. value
Low social class	0.942	0.000
Poor education	0.133	1
Very large families	0.30	1
Other offender in the family:		
- Father	0.235	1
- Mother	0.059	1
- Brother	0.529	0.292
Peer effect	0.43	1
Repeated offenders	0.26	1

P. value = 0.05

Discussion:

The study was conducted to assess the psychosocial profiles of detained children and to identify factors associated with juvenile delinquency.

The peak age group among the study population was found to be (15-17 years, which is higher than what was reported from Spain (7.3±5.7) years.[2] This result was in line with the fact that during adolescence there was a peak of behavioural problem such delinquency and substance abuse.

The study documented that males outnumbered females 8.3: 1, this result was in agreement with what had been reported in USA in 1999 that the vast majority (86%) of detained children in residential facilities were males.[14] This gender difference and male predominance possibly explained by both biological and psychosocial predisposition of boys and males are more likely to be accepted and raised when they display aggression.

Psychiatric disorders was found to be prevalent among (40%) of the study group which was less comparable to what was reported from Ontario in USA (63.3%) of incarcerated adolescents had two or more psychiatric disorders.[8] This may be due to the small number of the study group.

Conduct disorders was found to be the most prevalent psychiatric domain among detained children (83.3%). This is similar to what was found by Edens JE, Oyyo PK in 1997 in USA that the prevalence of conduct disorders was 80%.[10] This could be attributed to the fact that conduct disorders is the commonest child psychiatric problem according to most epidemiological studies.

Less prevalent psychiatric disorders among the study population were hyperactivity, peer and emotional disorders with overlapping in all domains, this comorbidity attributed to the common predisposing and risk factors, so many meets the criteria for more than one psychiatric diagnosis. As a common adolescent behavioural problem; substance/alcohol abuse was looked for by the study which revealed that substance/alcohol abuse in (54.1%), this result was in agreement with (54%) what was reported from 8 Spain,[11]which reflects that the use of such mood altering psychoactive substance for pleasure or relief of stress or escaping from an intolerable situation is a universal problem among such children. The main substance that was abused by the study group is alcohol in (33%) which is higher comparable to 4% which was reported from Netherlands,[13] perhaps this is due to the fact that some Sudanese families depends on native alcohol drinks as a source of income.

On the other hand cigarette smoking was detected in (23%) a finding which was far less than (97%) reported in Spain study,[11] this may be explained by their extreme economic deprivation.

Other less used substance confirmed by the study were silisyon (20%), tombak (18%) and benzene in (10%), on the contrary to what was found in other areas of the world in which substance abused were mainly hard drugs, toxic overdose and marijuana.[10,11,15] This may be due to availability of such drugs as well as due to the cultural background.

The study also showed that (11.6%) suffered from enuresis, this is expected due to the co-morbid of enuresis with emotional and behavioural disorders which were prevalent among the study group.

Being an offender was found to be significantly affected by poverty and low social class (P. < 0.000), this is supported by what was reported by Michael and his colleagues in 1963.[15] who were summarized the social factors related to offending in poverty and low social class. This explained by that the economic

deprivation is the motive of the offence. Unexpectedly all other associated factors reported by Michael and his colleagues in 1963[15] and tested by the study whether family factors or individual factors; illiteracy (P = 1) large families (P = 1), other offender in the family (P = 1.1), peer effect (P =1), reported offender (P = 0.99), all were insignificant unlike what was reported from other studies.[15,16,18,19] This surprising results raise a big question to be answered by further research in this field.

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Seminar

Organic Psychiatric Disorders

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This century-old distinction between organic and functional disorders is outdated and has been deleted from the nomenclature. Every psychiatric disorder has an organic (i.e., biological or chemical) component. Because of this reassessment, the concept of functional disorders has been determined to be misleading, and the term functional and its historical opposite, organic, are not used in DSM-IV-TR. The term organic illness in modern psychiatric classification, however, refers to those conditions with demonstrable aetiology in CNS pathology.

Presentations of organic illness

Many psychiatric syndromes can have an organic aetiology. For this reason, every patient who presents with psychiatric symptomatology requires a thorough physical examination (in most cases including neurological examination and special investigations) before a diagnosis of functional illness is made.

While psychiatrists do not have to be expert neurologists, a sound knowledge of those conditions that bridge neurology and psychiatry is essential. Historically, these disciplines have not always been separated and, in this era of biological psychiatry, they are once again converging as increasing evidence emerges of brain dysfunction underlying most psychiatric disorders. Having said this, it is important to remember that biological, psychological, and social factors interact in a dynamic two-way process in the generation of psychiatric symptoms.

Classification of organic mental states

Global syndromes…

- Delirium.
- Dementia.

Specific syndromes…

- Amnesic syndrome.
- Organic mood disorder.
- Organic delusional disorder.
- Organic personality disorder.

Delirium

Delirium is defined by the acute onset of fluctuating cognitive impairment and a disturbance of consciousness .it is a syndrome, not a disease, and it has many

causes, all of which result in a similar pattern of signs and symptoms relating to the patient's level of consciousness and cognitive impairment.

Population	Prevalence Range (%)	Incidence Range (%)
General medical inpatients	10–30	3–16
Medical *and* surgical inpatients	5–15	10–55
General surgical inpatients	N/A	9–15 postoperatively
Critical care unit patients	16	16–83
Cardiac surgery inpatients	16–34	7–34
Orthopedic surgery patients	33	18–50
Emergency department	7–10	N/A
Terminally ill cancer patients	23–28	83
Institutionalized elderly	44	33

N/A, not available.

Table 1: Delirium prevalence & Incidence in multiple sittings

Delirium by Other Names

Intensive care unit psychosis, Acute confusional state, Acute brain failure, Encephalitis, Encephalopathy, Toxic metabolic state, Central nervous system toxicity, Paraneoplastic limbic encephalitis, Sun-downing, Cerebral insufficiency , Organic brain syndrome

Aetiology

The major causes of delirium are central nervous system disease (e.g. Epilepsy), systemic disease (e.g. Cardiac failure), and either intoxication or withdrawal from pharmacological or toxic agents (Table.2). When evaluating patients with delirium, clinicians should assume that any drug that a patient has taken may be etiologically relevant to the delirium.

DIAGNOSIS & CLINICAL FEATURES

The core features of delirium include altered consciousness , such as decreased level of consciousness ; altered attention, which can include diminished ability to focus, sustain , or shift attention; impairment in other realms of cognitive function, which can manifest as disorientation(especially to time and space) and decreased memory relatively rapid onset (usually hours to days) ; brief duration(usually days to weeks) and often marked ,unpredictable fluctuations in severity and other clinical manifestations during the course of the day, and the presence of Associated clinical features for the underlying cause .

Central nervous system disorder	Seizure (postictal, nonconvulsive status, status) Migraine Head trauma, brain tumor, subarachnoid hemorrhage, subdural, epidural hematoma, abscess, intracerebral hemorrhage, cerebellar hemorrhage, nonhemorrhagic stroke, transient ischemia
Metabolic disorder	Electrolyte abnormalities Diabetes, hypoglycemia, hyperglycemia, or insulin resistance
Systemic illness	Infection (e.g., sepsis, malaria, erysipelas, viral, plague, Lyme disease, syphilis, or abscess) Trauma Change in fluid status (dehydration or volume overload) Nutritional deficiency Burns Uncontrolled pain Heat stroke High altitude (usually >5,000 m)
Medications	Pain medications (e.g., postoperative meperidine [Demerol] or morphine [Duramorph]) Antibiotics, antivirals, and antifungals Steroids Anesthesia Cardiac medications Antihypertensives Antineoplastic agents Anticholinergic agents Neuroleptic malignant syndrome Serotonin syndrome
Over-the-counter preparations	Herbals, teas, and nutritional supplements
Botanicals	Jimsonweed, oleander, foxglove, hemlock, dieffenbachia, and *Amanita phalloides*
Cardiac	Cardiac failure, arrhythmia, myocardial infarction, cardiac assist device, cardiac surgery
Pulmonary	Chronic obstructive pulmonary disease, hypoxia, SIADH, acid base disturbance
Endocrine	Adrenal crisis or adrenal failure, thyroid abnormality, parathyroid abnormality
Hematological	Anemia, leukemia, blood dyscrasia, stem cell transplant
Renal	Renal failure, uremia, SIADH
Hepatic	Hepatitis, cirrhosis, hepatic failure
Neoplasm	Neoplasm (primary brain, metastases, paraneoplastic syndrome)
Drugs of abuse	Intoxication and withdrawal
Toxins	Intoxication and withdrawal Heavy metals and aluminum

SIADH, syndrome of inappropriate secretion of antidiuretic hormone.

Table 2: common causes of delirium

Management

Pharmacotherapy

The two major symptoms of delirium that may require pharmacological treatment are psychosis and insomnia. Haloperidol Daily dose of may range from 5 to 40 mg for most patients with delirium, Use of second-generation antipsychotics & Insomnia is best treated with benzodiazepines with short or intermediate half-lives as Benzodiazepines with long half-lives and barbiturates should be avoided unless they are being used as part of the treatment for the underlying disorder (e.g., alcohol withdrawal).

Dementia

Dementia is defined as a progressive impairment of cognitive functions occurring in clear consciousness. Global impairment of intellect is the essential feature, manifested as difficulty with memory, attention, thinking, and comprehension. Other mental functions can often be affected, including mood, personality, judgment, and social behavior.

Aetiology

Main causes are Degenerative neurological disorders (Alzheimer's disease, Vascular dementia, Lewy body dementia, Frontotemporal dementia, Huntington's chorea, prion disease, Parkinson's disease), normal pressure hydrocephalus , Intracranial tumor, Other space –occupying lesions & severe head injury.

Management

Start from Detailed history (informant). Going through doing Mini mental state examination & Investigations (e.g. CT for diagnosis of both focal & diffuse cerebral pathology, psychological testing, specific tests of memory &Wechsler Adult Intelligence Scale)

Treatment

Aims of treatment are to maintain any remaining ability as far as possible and to relieve distressing symptoms putting in consideration arrangement for the practical requirements of the patient & supporting the family

Pharmacotherapy

	Drugs	Status
Symptomatic treatments		
Cholinesterase inhibitors	Doneperil, rivastigmine, galantamine	Licensed for mild-to-moderate Alzheimer's disease
NMDA receptor antagonist	Memantine	Licensed for moderate-to-severe Alzheimer's disease
Treatments for neuropsychiatric symptoms		
Atypical antipsychotics	Risperidone, quetiapine, olanzapine, aripiprazole	Rispendone licensed for short-term treatment of severe aggression in Alzheimer's disease; other treatments are used off licence
Antidepressants	Citalopram, sertraline	All antidepressants used off licence in Alzheimer's disease
Anticonvulsants	Carbamazepine	Used off licence

Table 3: common drugs used for treatment of Alzheimer's disease

Specific Organic psychiatric syndromes:

Amnestic disorders:

The amnestic disorders are syndromes characterised by memory impairment (anterograde and/or retrograde amnesia), which are caused by a general medical condition or use substance, and where delirium and dementia have been excluded as causative of the amnesia. Amnestic disorders may be transient or chronic (< or > 1mth). Amnestic conditions usually involve some or all of the following neuroanatomical structures: frontal cortex; hippocampus and amygdala; dorsomedial thalamus; mamillary bodies; and the periaqueductal grey matter (PAG). In terms of neurochemistry, glutamate transmission at the NMDA receptor is often implicated in amnesia, mainly due to its role in memory storage in the limbic system (LTP). A number of amnestic disorders are recognized.

Head injury

An open or closed head injury involving acceleration or deceleration forces may result in injury to the anterior temporal poles (as this structure collides with the temporal bone). Anterograde or post-traumatic amnesia (PTA) is prominent with retrograde amnesia relatively absent. Prognosis is related to length of PTA-better prognosis associated with PTA of less than 1wk.

Transient global amnesia (TGA):

This is a syndrome of amnesia lasting 6-24 hrs. caused by transient ischaemia of the temporal lobes and/or diencephalon. It is more common over 50 yrs. and may occur in the context of hypertension or migraine. Differential diagnosis includes dissociative disorders and malingering, and diagnosis is often unclear.

Normal pressure hydrocephalus (NPH)

A syndrome where there is dilatation of cerebral ventricles (especially 3rd ventricle) and normal CSF pressure at lumbar puncture. It typically presents with the triad of: dementia, gait ataxia, and urinary incontinence. Importantly, the dementia is potentially reversible if NPH is treated promptly. Clinical features Include progressive slowing of cognitive and motor functioning consistent with a pattern of subcortical dementia. Ataxia is due to pyramidal upper motor neuron paraparesis. Urinary incontinence is a late symptom.

& the Treatment is by ventriculo-peritoneal shunt.

Epilepsy

Epileptic patients are quite frequent at Psychiatric refer clinic in Sudan & as we knew between 10% and 50% of patients with epilepsy have psychiatric symptoms. The Psychiatric aspects of epilepsy may be related to:

- Psychosocial consequences of diagnosis (e.g. unemployment, stigma, restricted activities, dependency).
- Psychiatric syndromes directly attributed to epilepsy.
- Neuropsychiatric effects of medication

However, psychiatric syndromes attributed to epilepsy are best considered by their temporal relationship to seizures (pre-ictal, ictal, post-ictal, inter-ictal.)

Pre-ictal

Patients may experience a variety of vague symptoms during the days and hours leading up to the seizure. These are termed prodromal symptoms and include feelings of tension, dysphoria, and insomnia.

An aura may occur immediately prior to seizure onset. This is most common in complex partial seizures ,temporal lobe epilepsy or extra-temporal epilepsy .

Auras are typically stereotyped e.g.

autonomic or visceral aura (epigastric sensation); derealisation and depersonalisation experiences; cognitive symptoms (dysphasia, forced thinking, ideomotor aura, dj vu, jamais vu, fugue

and twilight states); affective symptoms (anxiety, euphoria); perceptual experiences (auditory, visual, sensory, and olfactory hallucinations or illusions).

Ictal Automatisms

May occur during the seizure and suggest a focal origin for the seizure such as medial temporal lobe. There is amnesia for the automatism, which usually lasts < 5 minutes. There are simple or complex stereotyped movements that tend to be disorganised and purposeless (although complex actions may be carried out). At this time the individual seems out of touch. Automatisms may be the basis of twilight and fugue states (EEG may aid differential diagnosis.)

Epilepsy partialis continuans (EPC)

A condition of prolonged CPSs, lasting hours-days (may be confused with delirium or psychosis) (e.g. temporal, frontal, or cingulate seizures). There are variable behavioural, cognitive, and perceptual symptoms and periods of amnesia.

Bizarre aggressive behaviour

Post-ictal

Post-ictal delirium A very common (10%) confusional state following a seizure with disorientation, inattention, variable levels of consciousness, and sometimes paranoia. Tends to last hours to days and shows a trend towards improvement and normal consciousness. If prolonged, suspect EPC.

Post-ictal psychosis

Usually follows a cluster of seizures or an increase in the frequency of seizures; may follow withdrawal of anticonvulsant therapy. Thought to result from sub-threshold kindling activity. It usually only occurs in individuals with epilepsy for >10 yrs. (particularly associated with a left temporal lobe focus). Clinically, there is an initial non-psychotic interval (lasting hours to weeks) following a seizure. Thereafter, the individual develops a brief psychotic episode with variable psychotic and affective symptoms. The episode resolves after a period of days to 1 month. It may recur 2 or 3 times in a year. EEG shows marked changes during the psychotic episode.

Inter-ictal

Chronic inter-ictal schizophrenia-like psychosis

A chronic schizophrenia-like psychotic illness is 6-12 times more common in epileptics than in the general population. It is particularly associated with left temporal lobe epilepsy and is more common in early onset severe epilepsy and in women with epilepsy.

There is often a period of 10-15 years that elapses between diagnosis of epilepsy and onset of the psychotic illness.

Clinically the illness is very similar to idiopathic schizophrenia although there tends to be a prominent affective component. The chronic course is likewise similar & there is typically no family history of schizophrenia and an absence of premorbid schizotypal traits.

Pathologically, it may represent the cumulative effects of chronic kindling due to a temporal lobe focus (e.g. in TLE).

Suggested readings:

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Pick from the Abstract Book of the 11th. Pan Arab Psychiatric Congress

1. Children Victims of Conflict and War Trauma: Their Maladaptive Behavioral Patterns and its Relation to Substance Abuse

Sudan Case Study

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Abstract

A miasma of political and social disputes has resulted in conflicts erupting across Sudanese Society. Tow civil wars have consumed thirty- five years and claimed the lives of nearly two millions since the independence in 1956.These conflicts began brewing before independence, but have intensified lately. The mass migration of people fleeing the war or the drought has created an estimated four millions internally displaced persons who have encouraged the population of the main cities to swell to unmanageable proportions. Women and children were among the most affected.

The potential for continued conflicts remains considerable. Hence, as long as the war persists, children will continue to be psychosocially disturbed, children of the last two generations in Darfur will be the major victims of violence traumatized. Unless the community is educated to tolerate and accommodate those victims, they shall be potential source and victims of antisocial behavior and violence.

In view of the above, it was decided that a psychosocially recovery prevention/counseling, rehabilitation, healing and advocacy program in the affected areas be set up by the research. The choice of a comprehensive recovery program is based on the anticipated benefits associated with wider opportunities for collaborative work by concerned partners in a more structured and effective manner based on mixing of experience and specialized sharing of activities.

The study target group was seven hundred children representing different ethnic, cultural, geographical background, all of them were screened as war traumatized children, a psychological rehabilitation recovery program was introduced, expressive techniques based and designed on the local cultural heritage were proposed, background and

magnitude of factors responsible for causing children psychological trauma were assessed, and psycho-social rehabilitation support for affected children was provided.

Specific Objectives Regarding the Psychosocial Recovery Program:

- Develop trauma counseling intervention program.
- Elevate depressive silent assumptions due to substance abuse.
- Control self-destructive attitude.
- Promote self-confidence, healing and forgetfulness
- Building resilience social and family support.
- Develop self-tolerance and respect.

The main case study were the studying the psychological and social impact of war trauma in children, and in turn to introduce psycho-social rehabilitation support based on cultural heritage as recovery program.

To say a comprehensive intervention addressing children facing severe difficult circumstance that due to neglect, violent and war trauma acts was conducted.

The result of the study showed that most of the children are affected by war trauma, their emotion and adaptive abilities were severely affected. Neurotic reactions; lack of concentration, anxiety, enuresis, lower self-confidence, withdrawal tendencies, lying habits and aggressions were observed. And when having introduced to local rehabilitation support, their social attitudes and adaptive abilities improved.

The study reviewed the available services for war affected children in Darfor and Kordofan and recommended certain immediate and long term interventions in order to deliver a broad program for child trauma prevention, peace culture, forgiveness, healing and tolerance education in Sudan.

2. The Psychosocial impact of mentally retarded children on their parents in Sudan

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ABSTRACT

This study was conducted on a community sample from Khartoum state to study the psychological and social impacts of the mentally retarded child on his or her parents and to assess the relationship of the age, number of handicapped children in the family and the degree of disability with these impacts. Seven centres for teaching and training of handicapped children were visited in Khartoum State. Ninety one children aged 5 –16 years were selected and their intelligence quotients were determined. Interviews for 82 mothers and 64 fathers were held using a structured questionnaire including socio-demographic data and information about the psychological and social impacts, the disability of children have on each parent. These parents were also subjected to the Hospital Anxiety and Depression Scale (HADS) to assess presence of anxiety and depression. Results showed that intelligence degrees were similar to the international classification. However, the degree of mild retardation is much lower, due to the lack of assessing this degree and to its high prevalence in normal schools where the child loses chance of education suitable for his or her condition. The parents were subjected to different psychological effects when they realize the child's disability. However, they overcame their problem and adapted to the situation. Sometimes, problems arise in the marital life and in social participation. Parents found extra burden on upbringing a disabled child. The research showed that most parents suffered from different degrees of anxiety and depression ranging from severe to moderate. The social and psychological impacts on the parents were not affected significantly by the number, age or degree of retardation of the children. The study recommends decreasing the factors that lead to mental retardation. It also recommends the provision of services for rehabilitation and training of children in schools and special institutes, besides supporting their families psychologically and socially to reduce their burden.

3. Hypno- psychotherapy and the Psychiatrist

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ABSTRACT

Psychotherapy is the art of enabling clients to take control of their psychological problems through helping them to understand the causes, and then develop new patterns of thoughts, feelings and behavior enabling them to function satisfactorily in all aspects of their lives. Hypnosis can be used to facilitate and speed up the process of change more effectively.

Hypno- psychotherapy is the branch of psychotherapy which uses hypnosis to that effect. The term was formerly adopted by the United Kingdom Counsel of Psychotherapy in 1997. Almost most techniques of psychotherapy are used under hypnosis, the choice of the technique depends on which suits the client or patient best.

For over two hundred years the art of hypnosis has been used in medicine to treat a wide range of physical, psychological and emotional disorders. In 1955 the British Medical Association endorsed hypnosis as a valuable medical tool, and in 1958 the American medical Association followed suit. In 1962 the American Psychiatric Association recognized hypnosis as a valuable treatment for some psychological problems.

Currently hypnosis is used in most branches of medicine to facilitate and accelerate the treatment and the healing process.

Nowadays increasing number of clinical psychologists and psychiatrists are using hypnotherapy and Hypno- psychotherapy techniques in the management of psychological disorders with rewarding results.

Hypno-psychotherapy complements pharmacotherapy bringing about speedy and more effective results. Techniques like behavior, cognitive, analytic, brief and interpersonal therapies are commonly used. In fact many patients who show poor response to pharmacotherapy voluntarily seek Hypno- psychotherapy or readily accept it if suggested to them. This is mostly due to the increased awareness of the general public of its advantage and safety.

4. Psychological disorders and quality of life among Sudanese dialysis patients and renal transplant recipients

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ABSTRACT

Introduction: Psychiatric illness is common among patients with chronic disorders, particularly in those with end-stage renal disease on renal replacement therapy (RRT). Patients with a functioning renal allograft have improved quality of life (QOL) compared to patients on dialysis.

Objective: the aim of this study is to evaluate the psychological disorders and QOL among dialysis patients and renal transplant recipients.

Patients and Methods: This is a prospective cross-sectional study that included 168 patients on RRT. Their psychological health status was assessed through clinical examination and relevant designed questionnaires in its Arabic version .The data obtained were fed to the SPSS program computer system for analysis. The results were expressed in numbers and percentages. Significance was assumed at $P< 0.05$.

Results: This is a prospective cross-sectional study, which included 168 Sudanese patients with ESRD on renal replacement therapy. 43/168 (25.6%) of them received renal allograft And 125 on dialysis only. The frequency of depression was found to be 9 out 43 25.6 and 90 out of 125 respectively. . Anxiety was reported with a significant difference in dialyzed patients 75/125 (60%) compared to kidney transplant recipients 1/43 (2.3%) ($P < 0.001$). Sleep disorders were experienced by 81/125 (64.8%) of dialyzed, and 9/43 (20.9%) of kidney transplant recipients $P < 0.001$).

Conclusion: Psychological disorders in dialyzed ESRD patients have significant effect on the quality of life and may have a tremendous impact on mortality and morbidity. For most patients with ESRD kidney transplantation offers the greatest potential for restoring healthy productive life.

في البدء..

علاقة عيادة الأمراض العصبية والنفسية في مدينة الخرطوم بحري بمسيد الشيخ ود بدر في "أم ضواً بان"

ذكريات السيد/أحمد محجوب عبدالمتعال المسئول الإداري بمستشفى طه بعشر التعليمي للطب النفسي

قال السيد أحمد محجوب أنه لما إلتحق بالعمل في عيادة الأمراض العصبية والنفسية في الخرطوم بحري في مارس 1968 وجد أن هناك زيارات أسبوعية منتظمة يقوم بها فريق من العاملين بالعيادة إلى مسيد الشيخ ود بدر في "أم ضواً بان" لعلاج حالات مرضية هناك. وقد كان هناك إتفاق بين الشيخ يوسف ود بدر والدكتور طه بعشر بإعطاء بعض المرضى جلسات تخليج كهربائي "ECT " في "أم ضواً بان". ولقد إنضم السيد/أحمد إلى هذا الفريق في العام 1970 وكانت مهمة السيد أحمد إدارية إذ يتولى صرف البنزين للسيارة التي تقل الفريق من إدارة مصلحة النقل الميكانيكي في بحري. وكانت الزيارات تتم يوم الإثنين من كل أسبوع. كانوا يذهبون في سيارة "لاندروفر استيشين" يقودها أحمد السنوسي وكان يقود الفريق السيد/نصرالدين بشير المساعد الطبي بالعيادة.

ومعهم الممرض عبدالوهاب من المصحة في كوبر. كانت الرحلة من العيادة الى المسيد تستغرق نحو ساعتين إذ لم يكن الطريق معبداً آنذاك.

وعند وصولهم "أم ضواً بان" يذهبون مباشرة لمقابلة الخليفة يوسف ود بدر والذي كان رجلاً بشوشاً ودوداً كما يصفه أحمد. وبعد السلام عليه يستأذنونه في مباشرة عملهم. وكان هناك بيت معين يحضر إليه المرضى. وكان أحمد والممرض عبدالوهاب يقومون بتثبيت المريض على العنقريب الذي يستلقي عليه المريض أثناء إعطائه التخليخ الكهربائي الذي يقوم به السيد/نصرالدين المساعد الطبي. وكان السيد نصر الدين يقوم بإعطاء المرضى أدويتهم التى وصفت لهم من عيادة بحري, حبوباً كانت أم حقناً.

وفي نهاية اليوم يذهب الفريق مرة أخرى لمقابلة الخليفة يوسف ووداعه والاستئذان بالانصراف.

استمر السيد/أحمد مع هذا الفريق نحو خمسة عشر سنة لم ينقطعوا خلالها عن هذا الترتيب.

توقفت هذه الزيارات قبل نحو سنة من تقاعد الدكتور حسبو سليمان(كبير استشاريي الطب النفسي في وزارة الصحة) عن العمل في عيادة الأمراض النفسية في بحري.

Note to contributors:

The Sudanese Journal of Psychiatry (SPJ) is published every four months by the Sudanese Association of Psychiatrists under the auspices of the Sudan Medical Association.

The Journal publishes original peer reviewed papers, review articles, case reports and material related to psychiatric services delivery.

Authors are expected to have had clearance from the ethical committees and other regulatory bodies in their respective places for publishing their material.

Manuscripts should be prepared in a doubled space typed-written size A4 paper. The format of the article should include the following sections: Abstract, Introduction, Method Result, Discussion, Conclusion and references. Three copies should be submitted with the original.

The journal is published in English but Arabic articles are accepted.

Each paper or article should have an abstract or summary in both English and Arabic.

Authors should follow international agreed rule for nomenclature and abbreviations.

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