THE SUDANESE JOURNAL OF PSYCHIATRY

المجلة السودانية للطب النفسي

VOL.1 ISSUE.1 DECEMBER, 2010

Published by
THE SUDANESE ASSOCIATION OF PSYCHIATRISTS

بسم الله الرحمن الرحيم

Sudanese Journal of Psychiatry

Contents

Editorial

It is now sixty years since the first psychiatric clinic was opened in Sudan by a single-handed first Sudanese psychiatrist. Since then many leaps forward have been taken in the field of psychiatry in Sudan: the number of psychiatrists increased, more psychiatric service facilities were established, teaching and training centres started and research in psychiatric issues done. The Sudanese Association of Psychiatrists *felt* it is high time to have a venue to disseminate information and publicize work *done* in the Sudanese psychiatric community; hence the publication of the Sudanese Journal of Psychiatry. The president and members of the executive committee of the Association nourished the idea and worked relentlessly to make the dream come true. We sincerely thank the Secretary of the Sudan Medical Association for his prompt and positive response to our request to publish the Journal and through him

We extend our thanks to the president and members of the executive committee of the Sudan Medical Association.

It is a great pleasure to us that the launching of the first issue of the Journal coincides with the convening of the 11thPan Arab Psychiatric Conference and the Pan African Psychiatric Conference in Khartoum. We seize this opportunity to warmly welcome all our colleagues participating in these conferences and wish them a happy stay in Khartoum and a safe journey back home,

With a deep sense of gratitude we pay tribute to the pioneers of psychiatry in; Sudan: Tigani eI-

Mahi, Taha Baasher, Hassabo Suliman, Hassam Hag Ali and Ahmed Hassan (may Allah rest their souls) and to their contemporaries, assistants and students who are still giving us inspiration. Their followers could only see further because they stood on the shoulders of those giants.

We wish to dedicate this first issue of the journal to these great names.

The start may be modest, but the expectations are great.

Neurological and Psychiatric Complications of Traumatic Brain Injury (TBI)

Abdullah Abdelrahman*, Randa Z A M Khair**, Mohamed AR Arbab ***

*Associate Professor of Psychiatry, ** Assistant Professor of Surgery, ***Professor of Surgery;

All: Faculty of Medicine, University of Khartoum. Correspondence: randazaki@ho- tmail.com

Abstract:

Aims:

To study the early post-traumatic neurological ad psychiatric complications.

Patients and Methods:

This is a prospective study conducted on 459 patients who presented to Khartoum and Shaab teaching hospitals with TBI. A semi structured questionnaire prepared before hand was used for data collection. All patients were clinically examined, at their arrival or shortly after. Glasgow coma score (GCS) was applied on all patients.

Results:

The most common cause of TBI was road traffic accidents (39%). Loss of consciousness was the most common presentation (89.3%). The complications encountered were convulsions in 8.2%, limb paresis in 9.0%, psychiatric complications in 20.8% and amnesia in 17.0%.death was in 17.0%.

Conclusion:

Approximately one sixth of patients with TBI developed psychiatric complications and almost similar ratio developed neurological complications.

Key words: TBI, Neurological, Psychiatric

Introduction:

Traumatic brain injury abbreviated as TBI is the leading cause of death and disability (1, 2).The incidence of head injury is variable all over the world. In some counties it starts to decrease while in others it is increasing and it is also variable in different areas inside the same country.

Brain injury may result from a direct injury to the brain or as secondary effect to hypoxia, hypercapnia, hypocapnia, hypothermia,hyperthermia, hypotension, intracranial bleeding, infection, or combinations of some of these(3). These extra neurological insults to the brain, such as hypoxia and hypotension, are associated with morbidity and mortality (4).

A study done in rats proved that ischaemia and traumatic injury lead to lactate accumulation and glucose depletion and this leads to more ischaemia and may also indicate mitochondrial abnormalities and hence effect oxidative metabolism(5). TBI renders the brain more susceptible to secondary effects.

People suffering TBI may develop wide range of neuropsychiatric, psychiatric (6) and neurobehavioral (2) complications.

Following head injury, the immediate effect is mainly loss of consciousness ranging from short period or momentary dazing to prolonged coma and this is the most constant effect (7); which may

persist. Complications of TBI are of very wide range and being acute or chronic. Some of them are reversible and others are permanent. There are many neurological disabilities such as limb paresis, persistent disturbance of consciousness (some may live in vegetative form for years or life), hydrocephalus and aphasia. Cranial nerve injuries may result in anosmia, occulomotor paresis, visual field defects and others (8). Persistent rhinorrhoea and/or otorrhoea, which are associated with fracture base of the skull may need surgical repair. Convulsions or post traumatic epilepsy can result from brain laceration or haemorrhage. Headache is usually a common post traumatic symptom (9).

Depression is a known post traumatic psychiatric sequel (10, 11). Patients suffering long period of loss of consciousness following trauma are unlikely to develop post traumatic stress disorder (PTSD) (12). Post traumatic psychosis (post traumatic confessional state) is noticed before patients attain full recovery from unconsciousness, where patients pass through a phase of disorientation and impaired cognitive functions, depending on severity of injury and premorbid personality, it is more severe n elderly, alcoholics and atherosclerotics. It has a wide range of manifestations starting from apathy, restlessness and irritability to delirium. Delusions and hallucinations may develop but usually they are short lived (8). Cognitive deficit is reflected mainly by impairment of working memory (13).

The authors observed that trauma was increasing in Sudan, the largest country in Africa and Arab world, in the last decade. TBI isolated or combined with multiple trauma, affected mainly the young population with wide range of complications. Another observation was the absence of similar

studies which may reflect the complications of TBI, their extent and relation to different causes of trauma.

Objectives:

To study the early post traumatic neurological and psychiatric complications of TBI.

Patients and methods:

This is a descriptive hospital based study of patients who presented to the accident and emergency department in Khartoum Teaching Hospital, or admitted directly to the intensive care unit (ICU) or the wards of the national center of neurological sciences (NCNS) in Shaab Teaching Hospital in Khartoum- Sudan, with TBI in the period of about six months.

A questionnaire prepared before hand was filled for each patient presented alive with RBI (N=420). This questionnaire included personal data, details about the and mechanism(s) of trauma, the presenting complaints and duration, the examination findings, past and social histories, the investigations findings, resuscitation, final diagnosis, treatment including medications and surgery, follow up and condition on discharge.

Thirty nine were either brought dead or died immediately after arrival. For the latter another form was filled with postmortem findings and cause of death. The patients were observed daily until discharged from the hospital.

At discharge a psychiatric status was assessed using two different methods. In adults (more than 26 years), Psychiatric General Health Questionnaire (GHC) was filled for each patient. This questionnaire was illustrated by D Goldberg aiming at assessment of quality of life of adult

population in health and disease (14, 15). The version used was GHC-28 which is composed of twenty questions answered by the patients with one of four: much less than usual, same as usual, more than usual or much more than usual.

Another mental state assessment was designed and filled for children and adolescents (age 16 years or below). The latter was designed by the first author including mental state examination, related history and associated symptoms. According to both, patients were divided as having No, Mild/Moderate or severe psychiatric complications.

Collected data was analyzed using the SPSS computer program. The chi-square (X2) test and the p value were used for statistical significance.

Results:

The total number of patients was 459 with a mean age of 27.53 (+16.92) years, ranging from one day to 90 years. The males were 370 (80.6%) and the females 89 (19.4%), with a male to female ratio of 4:1. Patients were divided according to their age into two groups; group A included children and adolescents (sixteen or below) were 122 (26.58%) were group B were the adult patients (above 16 years of age) were 337 (73.42%)

A total of seventy eight (17.0%) patients died (half of them brought dead or died immediately on arrival and the others died within variable times of follow up; assaults followed by RTA were the common causes of death. A total of 26 (5 group A and 21 group B) patients (5.7%) were "self discharged" (or escaped) from the hospital while not fully recovered and conscious. Both, those who died and self discharged, were excluded from further study of complications.

Post traumatic amnesia showed no prominent incidence in both groups, A and B. it was only of total 7.9% initially. Adults (8.0%) show higher incidence than children (1.9%) and this value is of a near significant difference (p=0.057) but the number was small.

Radiological vault fractures were found in 98 of the total while the actual number of fractures was 136. Those having vault skull fracture which is depressed as well as being compound were 21; those are subjected to the complications of both depressed and compound factors.

A number of 65 patients had neurological complications; of them 25 had combination of two or more complications. Limb paresis was the most frequent neurological complication in 9.0% of the total and 8.2 developed convulsions **(Table (1)).**

Table (1)

Neurological Complications on Discharge in Patients with Traumatic Brain Injuries- in both age groups

	Cranial nerve injury	Limb paresis	Convulsions	Total*
Children (A)	1 (1.0%)	6 (5.8%)	8 (7.7%)	104
Adults (B)	5 (2.0%)	26 (10.4%)	21 (8.4%)	251
Total*	6 (1.7%)	32 (9.0%)	29 (8.2%)	355

*Total number of study population excluding death and "self-discharge".

About four fifths (79.2%) of the total population were discharged with stable normal mental states. Moderate psychiatric complications were related to RTA in children and adolescents while related to falls into adult group **(Table (2)).**

Table (2)

Psychiatric Problems on Discharge in Patients with Traumatic Brain Injuries-in both age groups

	No Problem	Mild Psychiatric Illness	Moderate Psychiatric Illness	Severe Psychiatric Illness	Total*
Children (A)	83 (79.8%)	11 (10.6%)	7 (6.7%)	3 (2.9%)	104
Adults (B)	198 (78.8%)	31 (12.4%)		22 (8.8%)	251
Total*	281 (79.2%)	49 (13.8%)		25 (7.0%)	355

* Total number of study population excluding death and "self-discharge".

Relation between psychiatric complication and GCS on admission is shown on **Table (3)** for both groups in children/adolescents and adults respectively. In both age groups psychiatric complications were common in the groups admitted or discharged with GCS 13-15.

Table (3)

The Relationship between Psychiatric Illness and GCS on Admission

		3-8	9-12	13-15	Total*
Group (A)	No psychiatric illness	3	7	73	83 (79.8%)
	Mild	1	2	8	11 (10.6%)
	Moderate	2	2	3	7 (6.7%)
	Severe	0	0	3	3 (2.9%)
	Total	6 (5.8%)	11 (10.6%)	87 (83.7%)	104 (100%)
Group (B)	No psychiatric illness	6	21	171	198 (78.9%)
	Mild/Moderate	1	1	29	31 (12.4%)
	Severe	1	4	17	22 (8.7%)
	Total	8 (3.2%)	26 (10.4%)	217 (86.4%)	251 (1oo %)

* Total number of study population excluding death and "self-discharge".

Children and adolescents show no significant relationship between gender and psychiatric complications but in adults psychiatric complications are more common in females.

Amnesia was in 27 (7.6%) of the patients on discharge. It shows more common incidence in adults compared to children and adolescents (9.5% and 2.9% respectively).

Discussion:

Two to three patients per day were admitted to hospital with TBI during the study period.

The total number of death was 78 (17.0% of the total study group. Half of them were brought to the casualty dead or died immediately after arrival and the remaining half died during variable times of follow up. The majority of deaths were caused by assaults and RTA; but this represents a higher percentage in assaults than in RTA (17.5% vs. 14.0% respectively). It is thought that TBI reduces life expectancy even after full recovery (16), in a study done in 1127 men with penetrating brain injury, 8% died within 15 years. Most of the deaths within the first year were secondary to the TBI or coma (17).

In this study, in addition to death, some 18.3% of the total have neurological complications; 4.5% of the total were discharged while still not fully conscious. Of those 5 belong to the moderate injury group (GCS 9-12) and 11 to the mild injury group (GCS >12) and those remained static for more than 6 weeks or they were taken out of hospital by their families before complete recovery as mentioned, seven percent of the patients had some degree of limb paresis. Around 8.2% were labeled of having post traumatic epilepsy compared to a study doe in 4541 patients with TBI; only 2.0% of them developed

one or more seizures (18).in the current study, 6,2% had aphasia 9.0% limb paresis and 1.7% had cranial nerve injury.

Variable complications of TBI are known reason for frequent re-hospitalization (19).in Korea the overall mortality rate in 73 children with severe TBI was 23%, while 22% suffered moderate disability and 12% had severe disability (20).

Hillier et al (1997) found a high annual incidence of TBI in South Australia. One thousand of more than 4000 new admissions were discharged with a degree of residual impairment (21).

Excluding death and loss of contact (total of 104: 18 children and 86 adults), 20.8% of the study group showed psychiatric complications of different degrees. Mild to moderate complications were found in 17.3% of children and in 12.4% in adults. There was significant difference between children (2.9%) and adults (8.8%) in cases of severe degree of complications (p value 0.08).

In children, psychiatric complications revealed no significant relation to the cause o trauma. while in adults severe psychiatric complications are more frequent in people involved in road traffic accidents, while mild and moderate complications in these involved in falls and hits and these relations proved to be statistically significant (p value 0.0112)

In children and adolescent group, psychiatric complications are noticed mainly in males (19.8% o the male group) but this value shows no statistical significance (p=0.57). in adults psychiatric complications are common in females (16.9% of adult females compared to 15.5% in adult males) and this value proved to be statistically significant (p value 0.04) i.e. children show no significant

relation between post traumatic and gender; but in this study: children and adolescents Male: Female is 2.4:1 while in adults it is 5.4:1 and the number of adult females is very low compared to children. Mary V Seeman (1997) mentioned that there are differences between both genders in certain psychiatric disorders starting after puberty; women are more susceptible to develop mood disorders while schizophrenia is more common in men. The study concluded that estrogens are nuero-protective and that the cyclic fluctuations of estrogen and progesterone increase the response to stress (22). TBI in early life is thought to be a risk factor to develop schizophrenia later.

On discharge post traumatic amnesia was found in 5.9%, only 25.9% of them showed improvement. It is a known post traumatic sequel (26) and used for classification of severity of TBI (27).

Conclusions:

TBI is one of the common causes of death and disability, serious complications may develop following TBI and these include: 17.0% deaths, 18.3% neurological, 20.8% psychiatric ranging from mild to severe and 5.9% amnesia. Caring for prevention of neurological and psychiatric complications early enough after injury is of utmost importance.

References:

1. Behan LA, Phillips J, Thompson CJ, Agha A. nueroendocrine disorders after traumatic brain injury. J neurol neurosurg psychiatry. 2008 Jul; 79(7):753-9.
2. Geraldina P, Mariarosaria L, Annarita A, susanna G, Michela S, Alessandro D et al.neuropsychiatric sequelae in TBI: a comparison across different age groups. Brain Inj. 2003 Oct; 17(10):835-46.
3. Jeremitsky E, Omert L, Dunham CM, protetch J, Rodriguez A. Harbingers of poor outcome the day after severe brain

injury: hypothermia, hypoxia and hypoperfusion. J Trauma. 203 Feb; 54(2):312-9.

4. Azira M, Mataró M, Poca MA, Junqué C, Garnacho A, Amorós S, Sahuquill J. Influence of extra neurological insults on ventricular enlargement and neuropsychological problems after moderate and severe traumatic brain injury. J Neurotrauma. 2004 Jul; 21(7):864-76.
5. Krishnappa IK, Contcnt CF, Robertson CS.. Regional changes in cerebral extracellular glucose and lactate concentrations following severe cortical impact injury and secondary ischemia in rats.. J Neurotrauma. 1999 Mar; 16(3):213-24.
6. Borgaro S, Caples H, Prigatano GP. Non-pharmacological management of psychiatric disturbances after traumatic brain injury. Int Rev Psychiatry. 2003 Nov; 15(4):371-9.
7. Lishman W A. Organic Psychiatry the psychological consequences of cerebral disorder. 2nd ed. Blackwell scientific publication. London Edinburgh Boston Melbourne Paris Berlin Vienna, 1987; 137-55.
8. Irving JG. Impact of insurance covering on convalescence and rehabilitation of head injured patients. Conn Med 1972 Jul; 36(7):85-391.
9. Sosin DM, Sniezek J, Waxweilier RJ. Trends in death associated with traumatic bran injury, 1979 through 1992. Success and failure. JAMA 1995 Jun 14; 273(22):17778-80.
10. Alderfer BS, Arciniegas DB, Silver JM. Treatment of depression following traumatic brain injury. J head Trauma Rehabil. 2005 Nov-Dec; 20(6):544-62.
11. Popovic V, pekic S, Pavlovic D, Maric N, Lasovic-Gasic M, Djurovic B et al. Hypopituitarism as a consequence of Traumatic Brain Injury (TBI) and its possible relation with cognitive disabilities and mental distress. J Endocrinol Invest. 2004 Dec;27(11):1048-54.
12. Glaesser J, Neuner F, Lütgehetmann R, Schmidt R, Edert T,. post traumatic stress disorder in patients with traumatic brain injury. BMC psychiatry.2004 Mar 9; 4:5.
13. McAllister TW, Flashman LA, Sparling MB, Saykin AJ. Working memory deficits after traumatic brain injury: caticolaminergic mechanisms and prospects for treatment—a review. Brain Inj. 2004 Apr; 18(4):331-50.
14. Goldberg D P and Hillier V F. A scaled version of the general health questionnaire. Psychological medicine 1979; 9:139-145.

15. Werneke U, Goldberg DP, Yalcin I, Ustün BT. The stability of the factor structure of the general health questionnaire. Psycol medicine 2000 Jul; 30(4):823-9.
16. Shavelle RM, Strauss D, Whyte J, Day SM, Yu YL. Long term cases o death after traumatic brain injury .Am J phys Med Rehabil. 2001 Jul; 80(7):510-6; quiz 517-9.
17. Rish BL, Dillon JD, Weiss GH. Mortality following penetrating craniocerebral injuries. An analysis of the deaths in Vietnam Head Injury Registry population. J Neurosurg. 1983 Nov; 59(5):775-80.
18. Singer RB. Incidence of seizures after traumatic brain injury —a 50 year population survey. J Insur Med. 2001; 33(1):42-5.
19. Marwitz JH, Cifu DX, Englander J, High WM Jr. a multi center analysis of rehospitalizations five years after brain injury. J Head Trauma Rehabil. 2001 Aug; 16(4)307-17.
20. Song SH, Kim SH, Kim KT,Kim Y. Outcome of pediatric patients with severe brain injury in Korea: a comparison with reports in the west. Childs Nerv Syst. 1997 Feb; 13(2):8-6.
21. Hillier S L, Hillier J E, Metzer J. epidemiology of traumatic brain injury in South Australia. Brain Inj 1997; 119):649-59.
22. Seeman M V. psycopathology in women and men: focus on female hormones. Am J psychiatry. 1997;254(12):1641-1645
23. Gureje O, Bamidele R, Raji O. early brain trauma and schizophrenia in Nigerian patients. Am J Psychiatry. 1994 Mar; 151(3): 368-71.
24. Williams DH, Levin HS, Eisenberg HM. Mild head injury classification. Neurosurgery. 1990 Sep; 27(3):422-8.
25. Annegers JF, Coan SP. The risks of epilepsy after traumatic rain injury. Seizure 2000 Oct; 9(7):453-7.

ملخص:

الهدف:

دراسة المضاعفات النفسية و العصبية الناتجة عن اصابات الرأس في حوادث.

الطريقة:

هذه دراسة تتبعية على 459 مريض أتوا إلى مستشفى الخرطوم و مستشفى الشعب التعليميين باصابات في الرأس نتيجة لحوادث. جُمعت المعلومات من المرضى عن طريق استبيان أعد مسبقاً.

أجري الفحص الاكلينيكيّ على كل المرضى ساعة وصولهم إلى المستشفى أو بعد ذلك بقليل.

استعمل مقياس جلاسكو للغيبوبة على كل المرضى.

النتيجة:

كانت حوادث المرور هي الأعلى من بين أسباب الإصابة (39%)،كان فقدان الوعي هو الأكثر بين الحالات المصابة (89.3%)، كانت المضاعفات الملاحظة هي الاختلاج في 8.2% من الحالات، خدر في الأطراف في 9%، اضطرابات نفسية عند 20.8% و فقدان الذاكرة عند 5.9% و توفي 17% من المصابين.

الخلاصة:

ما يقارب سدس المرضى الذين عانوا من اصابات في الرأس نتيجة لحوادث حدثت لهم مضاعفات نفسية و مثلهم أيضاً أصيبوا بمضاعفات عص

Chronic Pain and Role of Cognitive Behaviour Therapy

Abdelgadir H. Osman*,Azza Kamal Alnourani,and Eltayeb A.Gadir*****

***, Ass.professor dept, of psychiatry faculty of medicine University of Khartoum Sudan**

****, Psychiatric registrar, *****, Consultant Anesthetist, Soba University Hosp. Sudan**

Definition of Chronic pain

The word pain comes from the Latin poena, which means punishment or penalty, after the Roman goddess of punishment. However chronic pain has several different meanings in medicine. Traditionally, the distinction between acute and chronic pain has relied upon an arbitrary interval of time from onset; the two most commonly used markers being 3 months and 6 months since the initiation of pain, though some theorists and researchers have placed the transition from acute to chronic pain at 12 months.

Classification of pain:

Chronic pain may be divided into "nociceptive" (caused by activation of nociceptors), and "neuropathic" (caused by damage to or malfunction of the nervous system.

Nociceptive pain may be divided into "superficial somatic" and "deep", and deep pain into "deep

somatic" and "visceral". Superficial somatic pain is initiated by activation of nociceptors in the skin or superficial tissues. Deep somatic pain is initiated by stimulation of nociceptors in ligaments, tendons, bones, blood vessels, fasciae and muscles, and is dull, aching, poorly-localized pain. Visceral pain originates in the viscera (organs). Visceral pain may be well-localized, but often it is extremely difficult to locate, and several visceral regions produce "referred" pain when injured, where the sensation is located in an area distant from the site of pathology or injury

Neuropathic pain is divided into "peripheral" (originating in the peripheral nervous system) and "central" (originating in the brain or spinal cord Peripheral neuropathic pain is often described as “burning,” “tingling,” “electrical,” “stabbing,” or “pins and needles Bumping the "funny bone" elicits peripheral neuropathic pain.

Pathophysiology of pain

Under persistent activation nociceptive transmission to the dorsal horn may induce a wind up phenomenon. This induces pathological changes that lower the threshold for pain signals to be transmitted. In addition it may generate nonnociceptive nerve fibers to respond to pain signals. Nonnociceptive nerve fibers may also be able to generate and transmit pain signals. In chronic pain this process is difficult to reverse or eradicate once established

Chronic pain of different etiologies has been characterized as a disease affecting brain structure and function. Magnetic Resonance Imaging studies have shown abnormal anatomical and functional connectivity, even during rest involving areas related to the processing of pain. Also, persistent pain has been shown to cause grey matter loss, reversible once the pain has resolved

Risks factors and characteristics of patients with chronic pain:

Although there are no unified traits or characteristics to the majority of patients, however literature discusses number of associations that we try and provide the two sides of the arguments.

A/Personality:

Two of the most frequent personality profiles found in chronic pain patients by the Minnesota Multiphasic Personality Inventory (MMPI) are the conversion V and the neurotic triad. The conversion V personality, so called because the higher scores on MMPI scales 1 and 3, relative to scale 2, form a "V" shape on the graph, expresses exaggerated concern over body feelings, develops bodily symptoms in response to stress, and often fails to recognize their own emotional state, including depression. The neurotic triad personality, scoring high on scales 1, 2 and 3, also expresses exaggerated concern over body feelings and develops

bodily symptoms in response to stress, but is demanding and complaining.

Some investigators have argued that it is this neuroticism that causes acute pain to turn chronic, but clinical evidence points the other way, to chronic pain causing neuroticism. When long term pain is relieved by therapeutic intervention, scores on the neurotic triad and anxiety fall, often to normal levels. Self-esteem, often low in chronic pain patients, also shows striking improvement once pain has resolved.

Gamser(1990) and others argued against any regular tendency of personality association, as by chance, a number of individuals concerned had previously been tested with MPPI instrument in an earlier epidemiological study. In these people it was found that their premorbid profiles were within normal limits, strongly suggesting that the painful condition from which they were suffering was responsible for the apparent change in the personality picture. Love & Peck later showed that this particular MMPI profile found in patients with chronic pain did not represent previous personality functioning but was a consequence of disability.

B/Depressive mood:

Evidence suggested that patients with chronic pain symptoms have increased point prevalence and psychological disorders, compared with normal populations (1). This was stated in many studies that people who experience chronic pain are more depressed on average than the general population (2,3,4). Suggesting that emotional state such as, depression, plays role in pain experience in chronic pain.

Pincus and colleagues found that there is strong evidence for the role of psychological distress/ depressive mood in the transition from acute to chronic LBP.

Carroll et al in recent population-based random study in adults investigated depression symptoms as a risk factor for an episode of troublesome neck and back pain, using a population-based prospective design, n=1131 subjects in the original sample at baseline, of which 790 had no or mild pain at baseline,; in this study depression was found to be strong and independent predictor for the onset of an episode of intense and or disabling neck and low back pain. However, these results suggesting that other factors like socio-economic, health, lifestyle and medical factors as possible risk factors for pain, and any of these factors could therefore potentially confound the relationship between depression and onset of neck or low back pain.

C/ Effect on cognition

Most chronic pain patients complain of cognitive impairment, such as forgetfulness, difficulty with attention, and difficulty completing tasks. Objective testing has found that people in chronic pain tend to experience impairment in attention, memory, mental flexibility, verbal ability, speed of response in a cognitive task, and speed in executing structured tasks. In 2007, Shulamith Kreitler and David Niv advised clinicians to assess cognitive function in chronic pain patients in order to more precisely monitor therapeutic outcomes, and tailor treatment to address this aspect of the pain experience.

Role of CBT in pain management:

Cognitive behavioral treatment (CBT) for pain management is based upon a cognitive-behavioral model of pain. The hallmark of this model is the notion that pain is a complex experience that is not only influenced by its underlying pathophysiology, but also by individuals' cognitions, affect, and behavior.

CBT for pain management has three basic components. The first is a treatment rationale that helps patients understand that cognitions and behavior can affect the pain experience and emphasizes the role that patients can play in controlling their own pain. The second component of CBT is coping skills training. Training is provided in wide variety of cognitive and behavioral pain coping strategies. Progressive relaxation and cue-controlled brief relaxation exercises are used to

decrease muscle tension, reduce emotional distress, and divert attention from pain. Activity pacing and pleasant activity scheduling are used to help patients increase the level and range of their activities. Training in distraction techniques such as pleasant imagery, counting methods, and use of a focal point helps patients learn to divert attention away from severe pain episodes. Cognitive restructuring is used to help patients identify and challenge overly negative pain-related thoughts and to replace these thoughts with more adaptive, coping thoughts. The third component of CBT involves the application and maintenance of learned coping skills. During this phase of treatment, patients are encouraged to apply their coping skills to a progressively wider range of daily situations. Patients are taught problem solving methods that enable them to analyze and develop plans for dealing with pain flares and other challenging situations. Self-monitoring and behavioral contracting methods also are used to prompt and reinforce frequent coping skills practice.

CBT for pain management is typically carried out in small group sessions of 4 to 8 patients that are held weekly for 8 to 10 weeks. The groups are typically led by a psychologist or psychologist-nurse educator team.

Evidences proving effectiveness of CBT

Although CBT can be used in managing acute pain, the treatment procedures described above are those that are most commonly used in the management of persistent pain. Randomized, controlled studies have been carried out with a number of patient populations. The usefulness of CBT in the management of chronic low back pain is demonstrated. CBT produced significant decreases in physical and psychosocial disability when compared to a waiting list control condition. The improvements reported by patients receiving CBT were maintained up to 12 months following treatment. Bradley, Young, Anderson et al. conducted a study of CBT in patients having rheumatoid arthritis and found that CBT was superior to both a social support control and no treatment control group in reducing pain behavior, disease activity, and trait anxiety. At post-treatment, CBT produced significant reductions in pain and psychological disability relative to an arthritis education and standard care control conditions. Syrjala, Donaldson, Davis et al. have demonstrated the efficacy of CBT in managing cancer-related pain. Thus, evidence suggests that CBT is effective in treating both chronic pain conditions such as back pain and persistent disease-related pain conditions such as arthritis or cancer.

B _ why it works:

Cognitive and behavioral therapists help people learn to actively cope with, confront, reformulate, and/or change the maladaptive cognitions, behaviors, and symptoms that limit their ability to function, cause emotional distress, and accompany the wide range of mental health disorders.

A minority of patients with chronic pain do fulfill the criteria for the diagnosis of a somatoform disorder. In such conditions there is continued presentation of physical symptoms together with persistent requests for medical investigations despite negative findings of organic illness and reassurance by doctors that the symptoms have no physical basis.

Because cognitive behavior therapy (CBT) is based on broad principles of human learning and adaptation, it can be used to accomplish a wide variety of goals. CBT has been applied to issues ranging from depression and anxiety to the improvement of the quality of parenting, relationships, and personal effectiveness.

How it works:

The seven key factors addressed in a successful programme will now be described.

Direct positive reinforcement of pain behavior:

All overt behaviours communicate pain to others, including tone and content of speech, gait and posture, facial expression and the use of medical aids. Often, the consequences of pain behaviours are detrimental for the patient and add to suffering. A CBT environment would be sensitive to the situations in which patients are directly reinforced for pain behaviours and would seek to minimize their effects.

Indirect positive reinforcement of pain behaviour

Avoidance behaviour is the most common form of reinforcement of pain and disability. Patients will continue to avoid pain-eliciting situations, believing this avoidance to be analgesic when in fact it promotes further pain. Patients develop a symptom-contingent pattern of activity: doing more when one feels good and less when one is in more pain. Over time, this leads to a steady decline in overall activity. These patterns are replaced within CBT by encouraging patients to behave time-contingently and to plan for achievable goals. Successes can then be reinforced.

Positive reinforcement of well behavior:

Chronic pain patients are rarely reinforced for well behaviours. Most staff members are trained to attend to problems and family members are used to responding to need rather than wellness. Lack of reinforcement of health behaviours extinguishes or diminishes the behaviour. In a CBT environment, staff should be trained to recognize and reinforce well or healthy behaviour. They should also be trained to encourage patients and family members to be self-assessing and self-reinforcing of well behaviour.

Physical fitness and function:

Chronic pain patients typically lose any sense of normal sensation and normal physical stress and strain. Therefore, the unfit and sedentary patient will experience many symptoms of physical disuse that can be regarded as pain-related and potentially harmful. Increasing general fitness is thought to reduce fatigue and reduce the number of fatigue-related somatic symptoms that can be judged to be pain related. Personal achievement in fitness and function are common goals for patients and can often provide a first point of positive reinforcement and self-reinforcement.

Cognitive reframing:

Patients are encouraged to develop insight into the automatic nature of self-defeating and self-denigrating patterns of thinking. Patients are then encouraged to test the reality of these patterns of thinking and develop ways of challenging the premises from which these thoughts arrive. This principle of developing a controlled metaperspective in which one can understand the effects of thoughts upon feelings and feelings upon thoughts underpins a number of the typical contents of therapy, including communication skills, improved problem identification and problem solving, anger management, stress reduction, and the development of a self-relaxation response.

Education and empowerment:

Often, a first stage in treatment is to provide a credible rationale for treatment. Education alone is not an effective treatment for chronic pain. However, an understanding of the self-management approach is essential. Key areas that are commonly addressed are the causes and consequences of pain, managing doctor–patient communications, anatomy and biomechanics, the rules of social interaction, and sleep hygiene.

Evidence against:

One of the inhibiting factors is the cost of establishing and training staff to undertake such treatment. This factor is even stronger as an

argument against such therapy in developing countries. However, when long term costs of such chronic condition and the drain in resources it costs is weighed against the costs of CBT, the latter benefit overweighed such costs .This became well established to many similar condition such as, depression, anxiety, marital discord, aspergers and ect.

S. Tyrer Argues in his book psychosomatic pain against the mere labeling of psychosomatic disorder, and neurotic personality to patients with chronic pain when in his 25 years experience in the field tells him that most of his chronic pain patient had had an organic initial causation to their pain. diagnosis par excellence of a somatoform disorder is somatisation disorder, where pain is just one of many symptoms exhibited by the (usually) female patient. This diagnosis is not common, ranging from 0.2% of patients referred to a liaison psychiatry service to 5% of medical patients. This figure is higher than the previous figure of Smith et al (2000) because Fink et al (2004) used ICD-10 criteria. The ICD-10 diagnosis of persistent somatoform pain disorder was 1.5% in this same population (Fink et al, 2004). This low figure is not too surprising, as the latter diagnosis can be made only if the pain described by the patient 'occurs in association with emotional conflict or psychosocial problems that are sufficient to allow the conclusion that they are the main causative influences' (World Health Organization, 1992: p. 168). Contrast this with the diagnosis of pain disorder listed in the somatoform

disorders section in DSM-IV., 'psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain' (p. 461). Although cases largely due to physical illness are excluded, as also are cases where the pain is 'better accounted for by a mood, anxiety or psychotic disorder', more cases with pain and emotional sequelae achieve this level of diagnosis on the DSM-IV schedule than on ICD-10.)

Conclusion:

Patients suffering from chronic pain present formidable challenge to health profession, due to the human suffering of individuals involved and their families, costs of investigations and various analgesics treatment, more important of all their considerable risks to psychiatric morbidity and risks of suicide.

Evidences proof that, patients suffering, individuals life quality, and coping ability would considerably improve via cognitive behavioural therapy.

References:

1. Rush AJ, Polatin P, Robert J, et al. (2000). Depression and Chronic Low Back Pain. Spine. 25 (20); pp, 2566–2571.

2. Keefe, F. J., Caldwell, D. S., Williams, D. A., Gil, K.M., Mitchell, D., Robertson, D., Robertson, C., Martinez, S., Nunley, J., Beckham, J. C., & Helms, M. (1990). Pain coping skills training in the management of osteoarthritic knee pain: A comparative study. Behavior Therapy, 21, 49-62.

3. Hagglund KJ, Haley WE, Reveille JD, et al. (1989). Predicting

Individual differences in pain and functional impairment

Among patients with rheumatoid arthritis. Arthritis Rheum

32; pp, 851-858.

4. Banks SM, Kerns RD. (1996). explaining high rates of depression in chronic pain: A diathesis-stress framework. Psychol Bull **119**; pp, 95-110.

Compliance with anti-schizophrenia drug therapy in Sudan

Dr. Amira Mohammed Osman Hamid Haroun

MBBS, Clinical MDpsych (S.M.S.B)

Abstract:

Medication compliance has become a focus of concern in the treatment of psychiatric disorders.

The aim of this study is to estimate the prevalence of compliance among adult schizophrenic patient on maintenance treatment at Tigani Al-Mahi Psychiatric hospital in Sudan. It was found that (64.1%) of the schizophrenic pateins followed up were poorly complying.

ملخص:

إن إتباع إرشادات المعالجة من قبل المرضى أصبحت محط اهتمام المعالجين.

أجريت هذه الدراسة على المرضى المصابين بالفصام والمتابعين للعلاج بمستشفى التجاني الماحي بالسودان. خلصت الدراسة إلى أن (64.1%) من هؤلاء لا يتبعون إرشادات المعالجة بصورة جيدة.

Introduction:

Medication compliance has become a focus of increasing concern in the treatment of psychiatric disorders in recent years for many reasons. It was found that at least up to 60% of patients in the

community are episodically non compliant and relapse rate could possibly be halved if compliance were significantly improved [1].

Thus, it is very important to evaluate the compliance among the patient with psychiatric disorders especially patients with schizophrenia and to find factors that influence compliance or in other words the predictive factors of medication's poor compliance [2].

The aim of this study is to estimate the prevalence of compliance with medication among adult schizophrenic patients on maintenance treatment attending the out patients referred clinic in Al-Tigani Al-Mahi psychiatric Teaching hospital.

Methodology:

It is a cross sectional descriptive study, done in Al-Tigani Al-Mahi Psychiatric Teaching Hospital, which is one of the three major psychiatric hospitals in Sudan, the hospital receives patients from all over the country. It has a 24 hours emergency psychiatric clinic with twelve emergency beds with a total number of 107 in-patents beds and also a daily out-patient referred clinic.

All schizophrenic patients who attended the hospital during a two calendar months period and who fulfilled the criteria of inclusion were studied. Criteria for inclusion were age group 15-65 years and being on maintenance treatment of schizophrenia for at least one year. The total number of patients was 130.

Diagnosis for schizophrenia was made according to DSMIV criteria.

All patients were interviewed directly using two questionnaires; one for socio-demographic data, and the other for their compliance with treatment. When patients were not able to complete the questionnaire, the attending relatives were asked.

Verbal consent was taken from the patients or their attended relatives

Results:

Of the 130 patients who were examined, ninety two fulfilled DSMIV criteria for the diagnosis of schizophrenia. Their age group was 15-65 (average 33 years).

Sixty eight patients (73.9%) were males and 24 patients (26.1%) were female.

Fifty patients (54.3%) were living outside Khartoum state, forty two patients (45.7%) were living inside Khartoum state.

The prevalence of compliance with medication among this study population: only 33 patients (35.9%) were complying with their treatment and 59 patients (64.1%) were poorly complying (i.e, they were not taking their drug treatment regularly)

Discussion:

Compliance can be defined as patient’s acceptance of recommended health behavior [3]

Also it can be defined as the degree to which a patient's behavior is consistent with medical advice [4].

The level of compliance varies over time, following hospitalization or a recent exacerbation. Patients are likely to take their medication relatively consistently but as time passes the likelihood of non compliance increases [5].

Compliance is broader than just bill-taking, it includes making clinic appointment, participating in psychosocial treatment and rehabilitation and other treatment related activities.

Assessment of medication compliance should include an evaluation of these other components of treatment.

In the present study the non compliance rate was 64.1 percent this is higher than what was found by Young [6], who reviewed a number of studies that assessed rates of compliance, in which a mean non compliance rate of 41% for oral medication and 25% for long acting injection (depot) were found, but at the same time this result is similar to what was found by Anon [7], who found a rate of 60% of poor compliance among the out patients.

The fact that more than 50% of the study population came from various parts of Sudan other than Khartoum state, may indicate that this problem is wide spread and national.

This study shows that poor compliance with medication in schizophrenic patients is high and hence, it is an important area of study.

Many factors may influence compliance and to study all these factors, it needs a larger number of population and longer duration of time and a longitudinal study using a standardized scale.

References:

[1] Kissling, W, compliance, quality assurance and standards for relapse prevention in schizophrenia. Arch Psychiatrica Scandinavic, 1994;89(supple382) 16-24

[2] Larco LP, Dunn LB, Dolder CR, leckband SG. Jeste DV. Prevalence of and risk factors for medication non adherence in patients with schizophrenia: a comprehensive review of recent literature. J Clin Psychiatry. 2002 Oct; 63(10) 892-909.

[3] Wright EC. Non compliance Or how many aunts has matilda? The lancent 1993;342,909-913.

[4] Haynes RB, Sacketi DL. Compliance in health care. Baltimore. Md: Jhonhns Hopkins press, 1979.

[5] Owen RR, Fisher EP, Booth BM, et al. medication non compliance and substance abuse among patients with schizophrenia. Psychiatry Serv, 1996;47:853-858.

[6] Young, JL. Zonana, HV and Shepler, L. medication non compliance in schizophrenia co deification and update. Bultetin of the American Academy of psychiatric law 1986; 14, 105-122.

[7] Anon, The drug treatment of patients with schizophrenia. Drugs and Therapeutics Bulletin, 1995;33:81-86

CO- MORBIDITY BETWEEN MAJOR DEPRESSION AND ANXIETY OR OTHER PSYCHIATRIC DISORDERS IN PSYCHIATRIC SETTING

Salah M.A.Haroun

Taha Baashar Teaching Psychiatric Hospital;

Abstract

Major depressive disorders have been consistently found to co-occur with other psychiatric and physical conditions, in both clinical settings and epidemiological studies.

This paper intended to shed light and demonstrate co-morbidity patterns of anxiety disorders or other disorders and depressive syndromes.

The subjects of the study were 351 female patients, with a mean age of 34.2 years, who were attending the out-patient clinic of Taha Baashar Teaching Psychiatric Hospital during a period of four years. All patients satisfied DSM-IV diagnostic criteria of major depression. Estimates and cross-tabulation between pairs of disorders were used to study basic patters of morbidity and co-morbidity. The number of patients with secondary depression was greater than the number of patients with primary depression or with anxiety disorder alone. Secondary depression was associated with ten co-morbid disorders including GAD, OCD and Specific Phobias.

Introduction:

Major depressive disorders have been consistently found to co-occur with other psychiatric and physical conditions, in both clinical settings and epidemiological studies. Subtypes of anxiety disorders are the most common conditions co-morbid with depression. Their co-morbidity rates, in epidemiological studies differ across sites, 25% to 62% in community samples were reported (1), . These different rates across and between populations are re-attributable to different host factors, as well as different methodological approaches employed. In psychiatric clinical samples, more than half of the depressed patients had an anxiety disorder (2). In general health care settings, co morbidity appears to be more common than either depression (11.7%) or anxiety disorder (10.2%) alone, as nearly half of the cases of depression and anxiety appears in the same patients and at the same time(3).

The majority of patients attend general health care settings where clinicians are more focused on the depressive symptoms neglecting co morbid conditions such as anxiety disorders and others; or more likely , as trained in traditional nosological concepts, incorporate anxiety symptoms in neurotic depression diagnosis where-as the features may justify a separate diagnosis of anxiety disorder.

The paper is intended to shed light and demonstrate co-morbidity patterns of anxiety disorders or other disorders and depressive syndromes, in order to provide a rationale for importance of conducting a comprehensive assessment of all persons present with depressive features.

Method

The study subjects were 351 female patients, with a mean age of 34.2 years , attending the outpatient clinic of Taha Baashar Teaching Psychiatric hospital during the period from September 1998 to May 2002. All patients satisfied DSM-IV diagnostic criteria of major depression. 18 patients are excluded for they developed manic features during the fellow up and 17 were excluded for they never came back for fallow up. Assessment included psychiatric interviewing of the patient, her relatives and husband, and scrutinizing the referral notes and previous medical records if available. DSM-IV diagnoses of axis 1 disorders were reached by using Structured Clinical Interview for DSM-iv clinical version (SCID- cv). Trichitolomania, behavioral disruptive and mixed anxiety depression disorders , which are not covered by SCID-cv ,are diagnosed clinically and compared against their DSM-iv diagnostic criteria.

Temporally primary and secondary diagnoses of MPD and anxiety disorders were distinguished by using retrospective age-of-onset reports to define which condition occurred at an earlier age.

Lifetime and cross-sectional major depression disorders were generated by the SDID-cv. Anxiety and other disorders were generated from the personal psychiatric lifetime history, previous medical psychiatric records and predominant clinical features during the presentation & follow up period.

Estimate and cross- tabulation between pairs of disorders were used to study basic patterns of morbidity and co morbidity. Chi-square statistics and symmetric measures are used to measure the

association of variables. Odds ratio (ORS) were calculated as measure of the strength of co-morbid.

Results and Discussion

Half of the study subjects are housewives and 23.1% were students and 18.2% were working women, mostly of low occupational status. The majority received either no (10.3%) or low level of education (77.5%) table (1).

In this regard the sample does not represent the general population of women in Sudan where illiteracy rate is above 50%. And it is derived mainly from the low socioeconomic statues families.

Patients with secondary depression, n= 208 (59.2%, P> 0.05), were significantly greater than those with primary or pure depression (17.1% & 15.1% respectively) as well significantly greater than patient with pure anxiety disorders (8%) (Table2). Therefore patients with depression attending psychiatric clinical settings are more likely to have secondary depression. This finding is consistent with other research results (4).

Secondary Depression was associated with 10 Co-morbid disorders and three of them are Anxiety disorders, GAD (P 0.000), OCD (P 0.001) and Adjustment Disorders (P <0.000), Panic Disorders (P 0.017), Specific Phobias (P 0.043) Other conditions significantly associated with secondary depressions are: trichotillomania (P0.001), Conversion Disorders (P 0.004) and benzodiazepine misuse (P 0. 028) (table 3).

These results were consistent with preciously published research findings(4,5,6), but in this study sample, PTSD and Panic Disorders are not significantly associated with secondary depression for their samples were small & biases of retrospective reports might occurred. Lifetime Depression is significantly associated with co-morbid disorders than cross- sectional Depression (table 4). Nine disorders including GAT, PTSD, Agoraphobia, Specific Phobias, Post Traumatic Stress Disorder PTSD, Somatoform Disorder, Mixed Anxiety & Depression States, Disruptive behavior Disorder and Benzodiazepine Dependency. This result confirms that co- morbid disorders, not only Anxiety Disorders may contribute to persistence of depression in the patient life.

Conclusion:

The study findings indicate that patients with Depressive Disorders attending health care settings should be examined for co morbid Anxiety States & other Psychiatric Disorders, since these Disorders predict future recurrence of Depression.

Table (1):

Demographic Characteristics of 351 Female Outpatients

Marital Status	**Single**	**140**	**39.9 %**
	Married	**171**	**48.7%**
	Divorced	**24**	**6.8%**
	Widow	**16**	**4.6%**
Educational Level	**Primary-Intermediate**	**153**	**43.6%**
	Secondary	**83**	**23.6%**
	University/College	**79**	**22.5%**
	No formal education	**36**	**10.3%**
Occupational Status	**Low**	**25**	**7.1%**
	Middle	**21**	**6.0%**
	High	**18**	**5.1%**
	Student	**81**	**23.1%**
	House Wife	**178**	**50.7%**
	Not Applicable	**28**	**8.0%**
Religion	**Moslem**	**346**	**98.6%**
	Christian	**4**	**1.1%**
	Other	**1**	**0.3%**

Table 2:

Estimates of Pure, Primary, Secondary MDD and Pure anxiety Disorders in 351 Female Outpatients

condition	No	%
Pure Depression	53	15.1
Primary Depression	62	17.7
Secondary Depression	208	59.2*
Pure Anxiety Disorders	28	8.0
Total	352	100%

* P<0.05

Table (3):

Distribution of Subtypes of Anxiety Disorders across Patients with Primary and Secondary Depression

Disorders	Primary MDD		Secondary MDD		X^2 Chi square.	P
	No		No			
Adjustment Disorder with anxious mood	4	(6.5%)	59*	(28.9%)	27.3	12
Agoraphobias	0		2	0.6%	1.1	0.573
Disruptive Behavior disorder (DBD)	1	1.6%	3	1.4%	0.79	0.673
Generalized Anxiety Disorder (GAD)	5	8.1%	77*	91.9%	42.7	0.000
Conversion/Dissociative Disorder	11	17.7%	18*	8.7%	11.1	0.004
Mixed Anxiety & Depressive states	2	3.2%	17*	8.2%	6.1	0.045
Obsessive Compulsive Disorder (OCD)	0		24*	11.5	14.3	0.001
Panic Disorder (PD)	5	8.1%	17*	8.2%	8.2	0.017
Post traumatic Stress Disorder (PTSD)			4	1.2%	2.3	0.321
Social Phobia	1	1.6%	10	4.8%	3.7	0.063
Specific Phobia	1	1.6%	16*	7.7%	4.109	0.043
Somatoform	2	3.2%	8	3.8%	2.1	0.352
Trichotolomania			16*	7.7%	14.5	0.001
Benzodiazepine			8*	3.8%	7.2	0.028
				100%		

P<0.05

Table (4):

Patterns of Co- morbidity between Depression and Anxiety Disorders

Anxiety Disorders	Lifetime MDD			1-month MDD episode		
	%	OR	(95%cl)	%	OR	(95%cl)
Generalized Anxiety Disorder (GAD)	37.5	1.8*	(1.4-2.3)	17.5	0.6	(0.5-0.2)
Adjustment Disorder with Anxious Mood	21.9	0.92	(0.8-1.6)	18.5	1.13*	(0.7-1.2)
Agoraphobia	0.8	1.3*	(0.3-5.1)	0.5	0.8	(0.2-3.3)
Obsessive Compulsive Disorder (OCD)	10.2	1.4	(1.0-2.1)	5.6	0.8	(0.5-1.2)
Panic Disorder (PD)	5.5	0.8	(0.4-1.5)	7.7	1.1*	(0.9-1.5)
Conversion/Dissociative Disorder	7.0	0.8	(0.4-1.3)	10.3	1.2*	(0.9-1.5)
Post-traumatic Stress Disorder (PTSD)	1.6	1.3*	(0.5-3.4)	1.0	0.8	(0.3-2.2)
Social Phobia	2.3	0.7	(0.3-1.8)	4.1	1.2*	(0.8-1.8)
Specific Phobias	6.3	1.1*	(0.7-1.9)	5.1	0.9	(0.6-1.4)
Somatoform Disorder	3.9	1.3*	(0.7-2.4)	2.6	0.8	(0.4-1.5)
Trichotolomania	2.3	0.5	(0.2-1.3)	6.7	1.4*	(1.1-1.8)
Mixed Anxiety & Depression states	8.6	1.5*	(1.0-2.3)	4.1	0.7	(0.4-1.2)
Dysthymia	3.1	1.7*	(1.0-3.1)	1.0	0.6	(0.2-1.7)
Disruptive Behavior Disorder (DBD)	2.3	1.9*	(1.1-3.4)	0.5	0.4	(0.1-2.3)
Benzodiazepine Dependant	4.7	2.6*	(0.7-8.2)	1.0	0.5	(0.3-0.8)

P<0.05

ACKNOWLEGDMENT

I wish to acknowledge the contribution of all our hospital psychologists without whom this work would not have been realizable.

REFERENCES

(1) Kessler RC, McGonagle KA, et al. Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Results from the National Comorbidity Survey. *Arch Gen Psychiatry.*1994; 51:8 –19

(2) Rohde, Paul; Lewinsohn, Peter M.; Seeley, John R.

Comorbidity of unipolar depression: II. Comorbidity with other mental disorders in adolescents and adults.

Journal of Abnormal Psychology, Vol 100(2), May 1991, 214-222.

(3) Sartorius N, Ustün TB, Lecrubier Y, Wittchen HU.r J Psychiatry Suppl.

Depression comorbid with anxiety: results from the WHO study on psychological disorders in primary health care.

Br J Psychatriy Suppl. 1996 Jun:(30):38-43.

(4) Kessler, Robert L. DuPont, Patricia Berglund, and Hans-Ulrich Wittchen
Impairment in Pure and Comorbid Generalized Anxiety Disorder and Major Depression at 12 Months in Two National Surveys Am J Psychiatry, Dec 1999; 156: 1915 - 1923.

(5) Hans-Ulrich Wittchen*1, Peter Schuster and Roselind Lieb

Comorbidity and mixed anxiety-depressive disorder:

clinical curiosity or pathophysiological need?

Hum Psychopharmacol Clin Exp 2001; 16: 21-30.

(6) Kaufman J, Charney D. Comorbidity of mood and anxiety disorder .

Depress Anxiety 2000; 12(suppl 1) 69-76

Towards developing chemical dependency services in Sudan

ABDEL AZIZ A. OMER MBBS, D.P.M,MRC Psych, Associate professor, Faculty of medicine, University of Khartoum

The WHO defines dependency as a psychic and sometimes also physical state resulting from interaction between a living organism and a drug, characterized by behaviors and other responses that always include compulsion to take the drug on periodical basis in order to experience psychic effect and sometimes to avoid discomfort of its absence; tolerance may not be present.

Dependence is divided into psychological or physical dependence. Psychological dependence is a feeling of satisfaction and a psychic derive that require periodic or continuous administration of the drug to produce pleasure or to avoid discomfort. Physical dependence is the presence of tolerance and/or withdrawal symptoms. The commonest substances that can cause dependency are: Alcohol, amphetamines, cannabis, cocaine, hallucinogens, inhalants, nicotine opioids, phencyclidine and sedatives hypnotics.

The prevalence of substance related problems varies from one country to another and between different substances. Most of research especially community based surveys indicates that dependency is a real health hazard problem worldwide and Sudan is not an expectation, on the contrary there is emerging evidence from research carried among young people and from police reports and hospital records that the problem is escalating in our country although proper epidemiological surveys are needed to find out the magnitude of the problem. Most of the

research indicates that treatment is successful in reducing the number of dependent people. But in order that the treatment be effective it should consist of certain ingredients. First, the treatment programs must be well structured, rules are set out clearly for both patients and staff; second the treatment must be in stages and patients are moved between stages when they complete each one successfully; the goals in each stage are well defined and tasks are clearly laid out. Education is very important in dependency treatment programs to remove the myth and misconception and treatment and expectation and it should be continuous through the treatment and should be directed both to patient and families. Treatment programs should also include urine testing facilities which are important for diagnosis and follow up.

The most effective type of treatment of dependences is psychotherapy, and group psycho therapy is singled as the best regardless of the school it adopts. Also individual psychotherapy is beneficial for certain patients, especially those with interpersonal problems. Self help groups are also important and either they should be affiliated to treatment programs or patients can be directed to attend self-groups meetings.

In the previous paragraphs we defined dependency and stated the magnitude of the problem, we stressed on the importance of treatment and briefly we mentioned some of the most important ingredients of a successful dependency treatment program.

What about the situation in Sudan? Dependency in Sudan is dealt with entirely in psychiatric units or hospitals a usually does not exceed the stage of detoxification although in Eldrisi hospital there

is some effort to carry out some psychological interventions beyond the detoxification.

Patients are admitted compulsory in Eldrisi hospital which put some restriction in out passes and freely movement of patient, things that are usually required in relapse prevention programs. Also the presence of police although might be of value during the detoxification phase might intimidate patients on relapse prevention and recovery phases.

So where shall we start in Sudan? I think there is a great need for an independent center in Sudan which should provide treatment for patients with dependency in different stage i.e. detoxification stage, relapse prevention stage and recovery stage. We can start with small units in the three phases for example about 20 beds for detoxification, 10 beds for relapse prevention and 10 beds for the recovery phase. The treatment program should include a variety of approaches, pharmacological, psychological, and social and religion approaches. Treatment should also have outpatient programs which should be affiliated to psychiatric units, and with multiple team approach and should supervise other outpatient programs. The second task of this center should be training of the staff. One of the most important- factors in success of treatment programs is the presence of well trained staff and this is lacking now in Sudan, we need to train doctors in the treatment of Dependency and make them understand the recovery process. Psychologists need training groups psychotherapy and behavior therapy.

Nurses should be trained in handling of disturbed patients. The center should also be able to provide training for psychiatrists, family physician and medical students.

This center should also be active in conducting and supervising research, both in assessing the real size of the problem in the country and the effectiveness of different treatment approaches. As we said earlier now whatever treatment is available is done through psychiatric units, we want the center to keep a strong relationship with these units, to utilize the facilities especially in the outpatient department so that we can make the center cost effective.

The center should also have strong links with community organizations like sports organizations, youth clubs, universities and academic intuitions, religion schools and worship places should also be involved. Some of the nongovernmental organizations are usually interested and directly involved in dependency treatments, counseling and prevention and they are usually willing to help.

At the end there is a great demand in our country for dependency treatment so it is a high time to start some proper and organized services even if it does not fulfill the international standard, but by we can gain more experience and improve our self and even we might be able to tailor it to our traditions and demands and be able to provide the world with a different model.

ملخص:

عرفت منظمة الصحة العالمية الاعتماد على العقاقير على أنه حالة نفسية وأحيانا جسمانية تتسم بسلوك واستجابات تتضمن دائما دافعية شديدة لتعاطي عقار ما على فترات لإحداث آثار نفسية و أحيانا لتجنب الشعور بعدم الراحة الناتج عن عدم التعاطي.

وينقسم الاعتماد الى قسمين : نفسي وجسماني

وأكثر العقاقير التي تسبب الاعتماد شيوعا هي :

الكحول, الامفيتامين ، الحشيش، الكوكايين ، عقاقير الهلوسة، المواد الطيارة ، النيكوتين ، الافيون / فنسايكلدين والعقاقير المهدئة والمنومة .

يختلف مدى انتشار المشاكل المرتبطة بتناول هذه العقاقير من شخص لآخر وأيضا باختلاف المواد المستعملة نفسها.

إن أغلب البحوث في هذا المجال وخاصة البحوث الميدانية بينتا أن الإعتماد على هذه العقاقير هو مشكلة مهددة للصحة وهي مشكلة عالمية والسوادن ليس استثناء .

بل بالعكس فإن البحوث التي أجريت وسط الشباب وتقارير الشرطة وسجلات المستشفيات تشير إلى أن المشكلة في تصاعد إلاّ أن البحوث الميدانية لابد منها لتحديد حجم المشكلة.

إن علاج الاعتماد على العقاقير في السودان لا يزال في إطار وحدات العلاج النفسي في المستشفيات العامة ولا يتعدي معالجة حالات الانسحاب إلاّ أن مستشفى الادريسي به محاولات للتدخل فيما بعد الحالة الانسحابية.

أعتقد أننا بحاجة شديدة لقيام مركز متخصص لعلاج حالات التعاطي في السودان ليعالج مرحلة الانسحاب عن العقار ومرحلة منع الانتكاسة ومرحلة التعافي. يمكن أن يبدأ المركز صغيرا في حدود عشرين سريرا لعلاج حالات الانسحاب وعشرة أسرّة لمنع الانتكاسة وعشرة أسرّة لمرحلة التعافي. ويكون هناك برنامج للعلاج خارج االمستشفى يعتمد على وجود فريق متكامل. ويقوم هذا المركز أيضا بوظيفة تدريبية لكوادر متخصصة في علاج التعاطي. أطباء وممرضين واخصائيين نفسيين. ويطلع أيضا بالابحاث في هذا الشأن. كما يستقطب مساعدة الأندية الرياضية ومراكز الشباب والجامعات ومراكز العبادة والتعليم الديني والجمعيات الطوعية.

وقد يسهم هذا المركز في تقديم نموذج آخر لعلاج الاعتماد على العقاقير.

Health hazards of gold mining in Sudan: case report.

Abudoam, Abdelrahman*; Mahgoub, Yasir**; Idris, Eman** and ELnyal,Elkbashi**

Introduction:

For the last two years many people are rushing to the desert of the northern state and the northern Kurdufan state in search for gold. Apart from the adverse environmental conditions in the desert, the job itself carries many health risks, but those engaged in the race have the least concern for the immediate and long term health problems they may face.

There is no doubt about the multifactorial etiology of mental disorders. The biological endowment of an individual predisposes him/her to certain psychological disorders and the psychological stressors and/or adverse environmental condition precipitate these disorders and make them manifest.

Psychosocial circumstances in the place contributed to the development of psychiatric disorders in these patients, but it seems there is more to that in these cases.

Here we report three cases of acute- onset psychiatric disorders from among those who were digging for gold in that area.

Case description:

Case 1

A married Sudanese male, 38 years old from Bara district working as a gold miner presented to Taha Baashar Psychiatric hospital on 16.2.2010. He was restrained in ropes and showed pressure of talk, verbal and physical aggression with disinhibition,

persecutory delusions, preoccupation with homosexual assault, nihilistic delusions and auditory hallucination. He had insomnia for 4 days prior to admission .he also had a homicidal attempt.

He had an irritable mood, with intact abstract thinking but impaired attention and concentration; he was oriented with average intelligence, no memory loss but without insight.

On physical examination: pulse 100, BP 110/20, RR 14, Temp 37.5 C°. H e was pale with no jaundice.

His chest had left side bronchial breathing and right side wheeze. There was a palpable liver.

CNS examination revealed no abnormality. Investigations including complete blood count, blood film for malaria, Widal test, blood urea and electrolytes plus creatinine, all were normal. The chest X-ray showed bilateral interstitial infiltration.

He was put on Olanzapine 10 mg once/day + Diazepam 5mg tab. Azithromycin 500mg tabs, but unfortunately 2 days later he escaped from the hospital.

Case 2

A newly married male, 20 years old from Barber used to work as a casual laborer, six months prior to admission he joined gold mining.

He was admitted to Taha Baashar psychiatric hospital on 2.4.2010 with the complaint of excessive speech, fearing females, lack of sleep, bouts of weeping, unlimited socialization, occasional violence and impoliteness.

He reported a history of depression 3 years ago for which he was admitted to Kadabbas hospital and he received three sessions of ECT. A year after that he developed a condition similar to the present one

for two months and it resolved spontaneously without medication. He didn't report associated fever, drug abuse or any other physical disease.

Mental state examination revealed a restless young male who is easily irritated with a high tone pressure of talk; he was in a reasonable dress and he had, high mood with insomnia but no suicidal ideas. He showed no thought or perceptual disorder.

His cognitive functions were intact apart from slightly impaired judgment and he was fully insighted. He was diagnosed as having bipolar affective disorder, manic phase, accordingly he was put in Olanzapine 10mg daily and Sodium Valproate 500mg.he showed good response and he was discharged on 23.4.2010.

Case 3

The third case was also a young male, 20 years old who reported to hospital having fever, running away with over talkativeness, physical aggression for few days before admission. He was brought directly from the gold mining area. He didn't report previous history of such a problem. It was his first time to join mining.

On examining him he exhibited a relatively large thyroid, low grade fever, irritability, over talkativeness, preservation and preoccupation with "haboob" (sand storm), he was elated by delusion of being wealthy, with impaired attention and concentration. His thinking was concrete. Cognitively he showed impaired orientation to time, place and person, impaired judgment and lack of insight.

Standard investigations done revealed no abnormality. He was euthyroid. He was put on injectable Haloperidol 5mg + Phenergan 25mg twice a day. His aggression resolved and he was put on the

same dose orally + sodium valproate 200mg but he continued to persevere and was apprehensive. After 10 days he improved.

Valproate was increased 500mg/day and he was discharged two weeks later. He was readmitted with depressive symptoms for which he received Citalopram 40mg/day + the valproate. Serum mercury level was considered but for practical reasons it could not be done.

Discussion:

Two patients were quite healthy young men with no apparent physical or mental illness until the time of departure for the gold mining area, the third patient had a past psychiatric history which was exacerbated by the very tough environment. After some time in the field their companions noticed rapid abnormal behavior in these men and had to take them to their relatives who sought help from traditional healers ad when they failed they brought them to the hospital.

The fact that these men presented with psychotic features with acute onset raises the suspicion that some factors related to the work space and nature of work might have contributed to the development of these disorders, these workers use mercury to treat the stones they dig. Hence mercury contamination is a possible factor.

The second case demonstrated very clear chest signs and symptoms manifested in low grade fever, chest wheezing coupled to the X-ray findings of interstitial infiltration which could be attributed to the mercury or dust inhalation. Unfortunately he escaped and the investigations were not followed.

In a health evaluation of gold miners in mercury contaminated village in Sera PoladPore in Brazil symptoms that were reported included: fatigue,

irritability, insomnia, memory loss, tremors, parasthesia and visual field constriction. It was concluded that these symptoms possibly resulted from mercury toxicity 1.

We did not examine for mercury concentration in the blood or urine of these patients because at that time we were not aware of the procedures they use in their work, even if these patients did not handle mercury directly their presence to the vicinity to the area where it is being used without protective measures might cause toxicity. In a report of acute mercury vapor poisoning in a shipyard a patient presented with acute pneumonitis and later there was a transient mild neuropsychiatric symptoms and residual peripheral neuropathy 2. We think that these are perhaps first alarms to a large problem yet undiscovered. There may be many other patients with disorders of a mild nature who may have been taken to other places or might have just suffered in silence.

Certainly the magnitude of this psychiatric problem is not known together with other disorders of other bodily systems…

There is a great need for an immediate call to the health authorities to coordinate efforts to plan for management of health hazards in these yet uncharted areas.

References:

1. Corbett, C.E. et al. (health evaluation of gold miners in a mercury contaminated village in Sera Poladpara) Brazil. Arch Environ Occup health. 2007, 62(3):12-8.
2. Hus, L.F. et al (acute mercury vapor poisoning in a shipyard worker: a case report). Ann Acad Med Singapore, 1999, 2 (2):294-8.

*Department of Psychiatry, Faculty of Medicine, Africa International University.

**Taha Baashar Teaching Psychiatric Hospital.

Short communication

Wealth first, Health last

Abudoam, Abdelrahman*; Mahgoub, Yasir**; Idris, Eman** and ELnyal,Elkbashi**

This is a report of a short survey done at gold mining area at El-Bawga district in the northern state of Sudan. Fifty workers in the area were interviewed using a questionnaire that tries to determine the factors related to the development of behavioral disorders in the old miners.

1- **Socio-economic factors:**
   a- The infective urge for immediate quick health affected all the villagers living in the vicinity of the claimed gold areas to the extent that no healthy youth remained behind in the villages. This phenomenon affected negatively the traditional economic activities.
   b- More than 80% of the interviewed miners were from the age group of 15-40 years old. 60% of them were 15-25 years old, reflecting lack of life experience and minimum exposure to difficulties and life stresses.

c- miners work in small groups of 2-5 maximum and they might not have been acquainted to each other before joining the mining work, some may be of different geographical and ethnic background. This led to lack of social support in the field.

Building new social relations with other laborers is difficult because of lack of socialization in the field as they place their working and rest stations (Tents) apart from each other in distances mounting 2-3 kilometers, the nearest would be half a kilometer, although there are some tented cafeterias run with generators having lights and TV in the midst of the desert yet they are very few, usually crowded and far away. The major reason inhibiting attending these cafés is fatigue and need for rest because search for gold is day and night….

2- <u>Environmental factors:</u>

A- The area is a plant less desert with unlimited golden sand extended to the horizon not interrupted except by occasional sand dunes, hills or small mountains, or otherwise solitary dark protruding tip of a large stone probably a burg of a huge buried mountain.

B- The temperature is very hot during the day never less than 40°C sometimes reaching up

to 50°C. It becomes cool rather cold during nights.

C- The nature of work resembles the duties of those sentenced to life imprisonment and heavy labor. It is digging deep open trenches in a ladder step form or deep narrow wells, that may require breaking stones into small pieces or to pierce through rocks blocking the way for further hunt for gold downwards reaching depths around 30-40 meters below the surface of the ground, where oxygen level may be low in a very hot temperature.

D- The Haboob (wind/sandstorm): sometimes unexpected wind storms blow suddenly in a fierce manner leading to the loss of the tent leaving the group with no shelter, unlocked utensils may fly with the wind; eyes get filled with small tiny sand particles causing some to quit the place for eye injuries or infections. Mouth, ears and noses get filled with sand.
Young workers with no previous experience get terribly frightened and become insane. Whatever little drinking water either gets poured out and lost or get filled with sand to be brickly yellowish in color very similar to the water ponds used for gold filtering.

E- There is risk of getting lost when moving away from the tent during the night search of gold specially if a Haboob blows or when the partner takes a different direction leaving his colleague alone without support or knowledge of direction (GPS device is not commonly used there). It is reported that many never returned.

F- Food and water: the only food available for most of the miners in their tents is lentils and hard dry bread (Gargosh). Rarely a visit to a cafeteria may take place usually for unplanned unexpected reasons.
Water is very precious and costly, it is a source of fortune for the water sellers, it is only allowed for drinking or filing the water ponds to filter the gold or to cool the generator or the stone grinding mill.

G- Camping duration takes a period not less than a month unless a big amount of gold is explored. During camping how long it takes bath or use of water for any cause other than gold mining, even for ablution to pray

is strictly prohibited, clothes are never changed or washed.

3- **Psychological factors:**

It has been reported that major reasons for the acute behavioral changes were:

a- Sudden huge wealth, some people get tens of kilograms of gold which inspite of the huge expectations that is a wealth beyond their capacity to endure.
b- Dismay in response to huge expenditure and long stay in this harsh environment ending with very little yield, although it is always never empty hands, but in comparison to high expectations many get depressed and develop abnormal behavior.

4- medical factors:

a- There is lack of proper medical services, or even basic health facilities. This led to the flourishing of malpractices of selling rugs and prescribing traditional herbal medications by quacks.
b- The trade hazard:
c- Almost all of the laborers who don't have the gold detecting device work on the grinding and filtering the sand in water using mercury thus they are exposed to the:
    i- Hazard of metal toxicity, including mercury, asbestos ad other metals.
    ii- Dust inhalation exposing them to different types of chest infections.

Stages of gold extraction:






d- Malnutrition because of the unbalanced diet, decreasing immunity raising susceptibility to infections.
e- Over exhaustion and hazards of heat stroke.

Conclusion:

It is expected that the continuation of gold mining the way it is undertaken in these areas, known to be poor areas of he country without measures to prevent negative impact of this sudden wealth will

lead to a great change which will affect negatively or positively:

1- The demography and the ethnic constitution of the mining areas.
2- The socio-economic equilibrium of the area.
3- The culture, tradition and morals
4- New health hazards including increased rate of mental disorders.

References:

1. Corbett, C.E. et al. (health evaluation of gold miners in a mercury contaminated village in Sera Poladpara) Brazil. Arch Environ Occup health. 2007, 62(3):12-8.
2. Hus, L.F. et al (acute mercury vapor poisoning in a shipyard worker: a case report). Ann Acad Med Singapore, 1999, 2 (2):294-8.

ملامح من تاريخ الطب النفسي في السودان

لواء طبيب : نور الهدى محمد الشفيع

استشاري الطب النفسي استاذ مشارك

رئيس قسم الطب النفسي / جامعة الرباط

مقدمة :

اشارت حفريات علماء الاثار الى وجود جماجم آدمية بها ثقوب كانها عمليات جراحية اجريت قبل نحو 500 سنة قبل الميلاد واعتبر هذا قرينة على ان هذه طريقة لعلاج المرض النفسي آنذاك.

وقد عارض ابقراط (ابو الطب 322-460 قبل الميلاد) فكرة ان المرض هو عقاب من الاله وسخر من مفهوم الصرع مرض مقدس ، وفي العصور الوسطى اعتبر المرض العقلي حزن روحاني مرتبط بالساحر والعراف.

واسس اقدم مستشفى في لندن عام 1247م للعناية بالمخبولين.

وفي عصر النهضه والاصلاح ظل المرضى العقليون مبعدين اجتماعيا ولكن في القرن السابع عشر طورت اماكن مخصصه لهم وكان اول من استخدم مصطلح الطب النفسي هو (RIEL) استاذ الطب (1808م) بالمانيا .

الطب النفسي في السودان:/

الطب النفسي في السودان ووضعه كطب نفسي حديث لم يكن موجودا حتى بعد الحرب العالمية الثانية وقد تم افتتاح اول مستشفى للعلاج النفسي للحالات في الطب النفسي الشرعي في العام 1950م في الخرطوم شمال تبعها بعض الوحدات الخاصة للعلاج النفسي في بعض المستشفيات مثل ود مدني وبورتسودان والابيض وعطبرة وفي العام 1964م تم افتتاح قسم به (30) سرير في مستشفى الخرطوم وفي العام 1971م وضعت الخطة للعمل لمستشفى الطب النفسي في امدرمان وهنا كانت البداية الجديدة والتي نظنها طفرة للطب النفسي في السودان .

ومن ثم اصبحت السياسة للعلاج النفسيه وجود وحدات قريبة من العلاج العام وقريبة المجتمع.

المرحوم التجاني الماحي هو اول طبيب تخصص وتفرغ لعلاج المرضى المختلين عقليا والمضطربين نفسيا في السودان وعمل استشاريا لمنظمة الصحة العالمية في مكتبها الاقليمي لشرق البحر الابيض المتوسط واصبح عضوا في مجلس السيادة السوداني بعد ثورة اكتوبر 1964م وشغل كرسي ورئاسة قسم الطب النفسي بكلية الطب جامعة الخرطوم .

وقد ساهم واشرف على تاسيس وافتتاح مصحة الخرطوم بحري (كوبر) عام 1950م لرعاية وعلاج مرضى الاضطرابات العقلية والجنائية وقد اطلق عليه لقب اب الطب النفسي في افريقيا.

مستشفيات الصحة النفسية :

مستشفى بروفسير عبد العال الادريسي (مصحة كوبر سابقا)

وضع حجر الاساس لمصحة كوبر للامراض النفسية والعقلية في العام 1948م وقد تم افتتاحها في العام 1950م وكانت تابعة ادرايا للسجون وفنيا تحت اشراف وزارة الصحة . وكانت بداية الطب النفسي الحديث بعودة البروفسير التجاني الماحي من بلاد المهجر عام 1949م بعد تخصصه في الطب النفسي وقام بالاشراف والمتابعة والمشاركة في افتتاح المصحة في العام 1950م.

تم تحويل المرضى من كل السجون في السودان الى المصحة وكان عددهم (100) نزيل وكان يطلق عليهم لفظ المعاتيه.

تم تحويل مسمى مصلحة السجون الى الادارة العامةللسجون والاصلاح وتم تحويل المصحة فنيا وادرايا للسجون.

كانت تسمية النزيلاء من المرضى النفسيين المنقولين من السجون بالسودان بالمعاتيه وهم من العنصر الرجالي حتى العام 1960م.

وقد تم عسكرة كل الكادر العامل في العام 1987-1988م بينما تم تحويل الاسم الى مصلحة الخرطوم بحري للامراض

النفسية والعقلية . يوجد نص في قانون السجون يوضح كيفية الدخول وهنالك تعريف للمعتوه (المريض النفسي) بالقانون.

وقد كان يوضع في القيد كحفظ له ووقاية للاخرين ولا يوجد علاج حيث كان العلاج المتوفر عبارة عن علاج بالصدمات الكهربائية وكان الدخول الى المصحة بلا خروج ولايوجد كادر طبي متكامل انما فقط يوجد طبيب واحد يشرف على كل المرضى ولايوجد ملفات طبية ولا تدوين يومي للملاحظات عن المرضى.

في العام 1994م تم ضم جميع المصحات الى دائرة الخدمات الطبية بعد زيارة وزير الداخلية الى مصحة الخرطوم بحري دون ان تكون هناك اضافة او تغيير في طريقة العلاج او الفهم للمعاملة للمريض النفسي.

في العام 1995م تم انتداب الدكتورة نور الهدى محمد الشفيع من قبل وزارة الصحة بدات المحاولات بمجهود شخصي في توفير العلاج حيث جلبت بعض الادوية من مضادات الذهان والاكتئاب واستحدثت عمل الملفات الطبية للمرضى وكانت توفر بعض معينات العمل واحتياجات المرضى من ملابس واشياء اخرى.

وفي العام 1998م تم تعيين الدكتوة نور الهدى محمد الشفيع في وزارة الداخلية برتبة العميد شرطة وفي نفس العام تم تعيينها مديرا لادارة المصحات. وبدات العمل بوضع خطة على عدة محاور لتطوير المصحات والسير بها في اتجاه جعلها مستشفيات للصحة النفسية. المحور الفني والذي اشتمل على توفير الخدمات الصحية المتكاملة وذلك بايجاد وتوفير العلاج واستكمال الحلقة بالنسبة للكادر الطبي العامل. ايضا توفير الغذاء والكساء وكيفية كسر القيود من جميع المرضى داخل السجون عن طريق المتابعة وعمل الملفات وتوفير الدواء وتوفير الفريق الذي يقوم بالاشراف الطبي واهمها تدريب مساعدين طبيين نفسيين للولايات.

وفي العام 2000م تم تحويل مسمى الخرطوم بحري للامراض النفسية والعصبية الى المستشفى المركزي للطب النفسي وبالغاء كلمة مصحة لتخرج من قانون السجون ويجري العمل الان لاجازة قانون الصحة النفسية الموجود على

شكل مسودة وهناك لجنة من عدد من الاستشاريين تقوم بهذا العمل.

وتوسعت المستشفى بعد ذلك في اتجاه تقديم الخدمات العلاجية النفسية والعلاج بالادوية الحديثة والعلاج بالعمل والرياضة والفنون المختلفة بجانب الانواع الاخرى للعلاج النفسي.

تم استقطاب عدد من اخصائيي الطب النفسي واخر من المعالجين النفسيين والاجتماعيين وقبل ذلك تم عسكرة عدد منهم في مختلف الرتب لاكمال الفريق العلاجي، اماعلى مستوى المباني فقد تم تشييد عنابر جديدة وتمت تهيئة المكان هندسيا وبيئيا لصبح منشاة علاجية لها كل صفات المستشفى الحديث.

وتم تعيين طبيب صيدلاني للاشراف على الامداد الدوائي من الادوية الحديثة التي يتم اعطاؤها للمرضى مجانا والاشراف على توزيعه كحصص على بقية المصحات.

بالاضافة الى ادخال بعض الادوية التي لم تكن موجودة بالبلاد بعد الاتصال بالجهات ذات الصلة للموافقة على استيرادها.

تم تحويل مسمى ادارةا لمصحات الى دائرة الصحة النفسية وفي العام 2006م تم تحويل مسمى المستشفيات المركزي للطب النفسي الى مستشفى البروفسير عبد العال الادريسي، تم ارسال عدد (10) ممرضات خريجات ضابطات بمختلف الرتب لجمهورية مصر العربية للتدريب في مجال التمريض النفسي وهي اول تجربة بالسودان لايجاد الممرض المتخصص لتمريض المريض النفسي.,

تتواصل الجهود لتنفيذ هذه الخطة التي احدثت نقله استطعنا عبرها استعادة وحفظ حق المريض النفسي في العيش الكرينم الذي يستحقه ولم يكن متوفرا له من قبل.

ولازالت المحاور في تسلسلها لتدفع بالتوعية والتنوير لمفاهيم المرض النفسي قدمابتصحيح الاتجاهات السالبة نحوهم.

بعد ذلك بدات مرحلة جديدة وذلك بانشاء مباني جديدة بمواصفات تقدم خدمات صحية ونفسية متطورة وعلى اعلى مستوى للمريض النفسي الذي وقع تحت طائلة القانون ومازال العمل جاريا لتنفيذ الخطة المتكاملة لمبنى يحتوي على العيادات الخارجية والادراة.

مستشفى طه بعشر:

كان للمرحوم الاستاذ الدكتور طه بعشر تلميذ وصديق الرائد المرحوم د. التجاني الماحي دور في تنشيط وتفعيل الاداء في الطب النفسي ، بدا مستشفى طه بعشر كعيادة صغيرة وتم ايجار منزل معها لاقامة المرضى واهلمهم الحاضرين من الولايات المختلفة، وبعد تزايد عدد المرضى تم انشاء عيادة اكبر من الناحية الشمالية الغربية من مستشفى الخرطوم بحري ووضع حجر الاساس عام 1959م تم بناؤها وافتتاحها العام 1960م حيث اصبحت مكان مناسب للعلاج والتدريس والتدريب، بعد ذلك تطورت لتصبح مستشفى بها اسرة للتنويم والمتابعة واستقبال الحالات الحرجة وايضا يقوم بالتدريب والتاهيل لطلاب الجامعات وطلاب الدراسات العليا من الاطباء النفسيين والاجتماعيين واطباء الامتياز.

مستشفى التجاني الماحي:

ظل مستشفى الارسالية الانجليزية بامدرمان يدعم من وزارة الصحة حتة العام 1969م حيث توقف الدعم واصبح من الصعب على الارسالية تسييره وعرض على الاقسام العامة بالوزارة لتقديم طلباتهم حتى يتم تخصيصه لواحدة منهم ولكن لم يتقدم الا الطب النفسي ومن ثم تم ضمه بصورة رسمية وفي العام 1971م اكتمل المستشفى بوحداته المختلفة وتم تسميته باسم (التجاني الماحي) .

يعتبر المستشفى من اكبر المستشفيات النفسية في السودان ويستقبل جميع المرضى النفسيين على مختلف اعمارهم من الجنسين وبها حوادث للحالات الطارئة.

تستقبل المستشفى الطلاب للتدريب والتاهيل من طلاب الطب والدراسات العليا ايضا في مجال علم النفس والاجتماع، تم اعلانها عام 2009م كمركز للتدريب.

المستشفى النفسي العسكري بالسلاح الطبي:

يقدم الخدمات للمرضى من افراد الجيش الى ان تم تحديث مبانيه ليصبح مستشفى يقدم العلاج لكل افراد المجتمع ومن ضمن اقسامه قسم علاج الاطفال وقسم علاج الادمان.

مراحل التطور:

من عام 1957م – 1969م تم التخطيط لوضع استراتيجية بناء وتطوير الخدمات الصحية والنفسية في اطار النظام العام.

- في العام 1960م تم انشاء عيادة الامراض النفسية والعصبية في الخرطوم بحري.
- 1962م تاسيس قسم النفسية في مستشفى الخرطوم التعليمي.
- اعطي المرضى النفسيين الذين ارتكبوا جرائم اعتبارا خاصا وكان هنالك تعاون تام بين وزراة الداخلية ووزارة الصحة من الناحية الفنية، كانت البداية بمصحة الخرطوم بحري التي افتتحت في العام 1950م ثم تحولت في اواخر التسعينات الى المستشفى المركزي للطب النفسي وقد اعلنت دائرة المصحات العام 1998م وتحولت من مصحات دائرة الصحة النفسية في العام 2005م تضم هذه الدائرة مستشفى كل من ولاية الخرطوم – الجزيرة – القضارف – كسلا- البحر الاحمر.
- انشات وحدات للطب النفسي في كل من عطبرة – مدني – بورتسودان- الابيض – كوستي – الفاشر .

وضعت وزارة الصحة سياسة للصحة النفسية تتضمن:

- وضع برامج خاصة بتطوير خدمات الطب النفسي والصحة النفسية والاشراف المباشر على تنفيذها.
- الاشراف على مزيد من التوسع في تقديم خدمات الطب النفسي والصحة النفسية بدمجها داخل مؤسسات الرعاية الصحية الاولية.

- التوسع في تقديم خدمات الطب النفسي والصحة النفسية للاطفال والمراهقين وذوي الاحتياجيات الخاصة بجميع ولايات السودان.,
- التوسع في تقديم خدمات الطب النفسي والصحة النفسية للمسنين.
- التوسع في تقديم خدمات الطب النفسي والصحة النفسية لمتعاطي ومدمني الخمور والمخدرات.
- التوسع في تقديم خدمات الطب النفسي والصحة النفسية للفئات الاكثر عرضة للاصابة مثل الشباب والفتيات.
- التوسع في برامج التثقيف الصحي ورفع مستوى الوعي داخل المجتمع فيما يتعلق بالامور النفسية ونوعية الخدمات المتاحة من اجل تشجيع المزيد من الافراد والاسر للاقبال.

كما وضعت الخطط لتدريب الاطباء والكوادر في مجال الطب النفسي والصحة النفسية واتاحة الفرصة لمزيد من الاطباء للتخصص في الطب النفسي وللاختصاصيين بالتخصص الدقيق في مجالات:

الطب النفسي للاطفال والمراهقين، الطب النفسي في مجال التعاطي والادمان، الطب النفسي والصحة النفسية المجتمعية، استشارية الطب النفسي داخل المستشفيات العامة ، تدريب الكوادر المساعدة.

البحوث في مجال الصحة النفسية:

اجريت عدد من البحوث في مجال الصحة النفسية منها على سبيل المثال :

- الاثار النفسية وعلاجها على اثر تهجير وترحيل الجماعات السكانية مثل لذلك بهجرة اهالي حلفا في شمال السودان الى خشم القربة في وسط السودان عام 1961م عند بناء السد العالي جنوب مصر.
- دراسة ممارسة العلاج الشعبي لمرضى الاضطرابات النفسية والعقلية في كل من ان ضوا بان (البطانة) وبعض قرى الجزيرة.
- تنظيم برنامج مشترك مرة في الاسبوع مثل ما يم في طيبة الشيخ عبد الباقي بغرض تقييم وتقديم العلاج

التقليدي الشعبي والتدريب على مستوى الرعاية الصحية الاولية.

الدراسات العليا في جامعة الخرطوم (1989م) وتخصص الطب النفسي:

كانت اول مجموعة لهذا التخصص والتي تخرجت بدرجة الدكتوراه في الطب النفسي الاكلينيكي في بداية العام (1995م) اضافة حقيقية لتطور خدمات الطب النفسي وقد قدمت لنيلها اطروحات تكميلية شملت عددا من المواضيع الهامه.

وثم بدات الدراسات العليا بمجلس التخصصات الطبية بتخريج دفعات من الزمالة في تخصص الطب النفسي مما جعل الزيادة الملحوظة في توفير الخدمات الطبية والتوسع فيها على جميع انحاء السودان.

Abstract

The article describes some aspects of the history of psychiatry is Sudan. Modern psychiatric service in Sudan stated in 1950 by the first African psychiatrist the late processor Tigani El – Mahi. Since then there was gradual but steady development.

The beginning was out patient psychiatric services in general hospitals, then in-patient services. The general policy since the late 1950s and early 1960s is to have the psychiatric service incorporated with the general medical service. However there are now three tertiary psychiatric hospitals.

The largest of these (El-Idrisi hoapital) developed from a psychiatric unit for the mentally-ill offenders within the Prison system. It became under the leadership of its present director, a modern medium security hospital and the

development scheme is still going on. The other two hospitals are : Taha Basher hospital which was the first out-patient psychiatric facility in the country and later became a teaching hospital and Tegani EL-Mahi hospital which started in 1971 and is now a training centre. The medical corps have their own psychiatric hospital.

Psychiatric units have been opened in many large state hospitals in the country.

They provide out-patient and in-patient services.

Postgraduate training in psychiatry was started at the University of Khartoum in 1989, and in the 1990 became the responsibility of the Sudan Medical Specialization Board.

القاموس النفسي

بروفسور الزين عباس عمارة

يقول العالم الراحل ابو الطب النفسي الحديث في افريقيا والمستشار الاسبق لهيئة الصحة العالمية للصحة العقلية في اقليم شرق البحر الابيض المتوسط الدكتور التجاني الماحي استاذ الطب النفسي بجامعة الخرطوم سابقا في رسالة نقدية للمجمع اللغوي بالقاهرة حول (قاموس حتى الطبي) يقول:

(إن المؤلف الدكتور يوسف حتى لم يشر الى بعض المؤلفات المطبوعة او المخطوطة والتي اصبحت تمثل مصدرا من مصادر الاصلاحات ، خاصة الكتاب الملكي والقانون لابن سينا والحاوي وغيره من كتب الرازي، ولا لآراء المدارس المختلفة ومفهومها).

اوردت هذه الحقيقة للتأكيد على مدى صعوبة التأصيل والتحديق في العلوم الطبية نتيجة ازدواجية دلالة المفردات في الترجمة وفي ظل حبس التعبير في إطار الكلمة المنقولة خاصة في مجال الطب النفسي والذي يرتكز على تفسير الدلالة النفسية للالفاظ والامثال العامية وهي اكبر مجالات الممارسة المهنية في ايضاح ضرورة تذويب المفاهيم الخاصة في اطار اللغة العامة الموحدة بين الاطباء والمرضى وجميع العاملين في حقل الصحة النفسية.

ان تعريف المصطلحات (الطبنفسجسدية) العقلية) تقع في مزالق الترجمة الحرفية والتعريفات الضيقة والقوالب الجامدة التي تكاد تسلبها شفافية الشعور المرادف للظاهرة ، لان الظاهرة هي الاصل والمصطلح هو الوعاء الناقل للتعبير، ولذلك نجد ان هنالك ثلاثة مستويات من التفكير في تفسير الظاهرة النفسية أو ثلاثة أبعاد للرؤية في المصطلح الواحد للطب النفسي أولها دلالة الظاهرة كما شاعت وليس في أصلها اللغوي ككلمة (انتحار) وثانيها معنى الظاهرة النفسية ووظيفتها.

وغايتها من منظور وعلاقة التنظيمات الشخصية ببعضها البعض في كلمة (ادمان) وثالثها مفهوم الظاهرة من

منظور مرضى منقولا بالنص او الترجمة من السايكوباثولوجيا مثل كلمة (هذاءات اوضلالات).

في نظري ان هذا المدخل ضروري واساسي لتبيان صعوبة وصول حقائق الطب النفسي بسهولة الى ذهن القارئ بعد محاولات اشبه بالولادة المتعسرة للخروج من دهاليز الفلسفة والانعتاق العقلاني من متاهة مصطلحات (النرجسة) و (العقد النفسية) (العقل الباطن) وبعد هذه الولادة القيصرية خرج الطب النفسي من اقبيه التنويم المغنطيسي وغرف التحليل النفسي واضغاث احلام الحاسة السادسة وعمليات غسيل المخ فكان اشبه بالخروج من قوقعة الانغلاق الفصامي الى هوس الانفتاح ... كالمستجير من الرمضاء بالنار فاستبدل عقد الفلسفة بسناريو الافلام التجارية والمسلسلات التلفزيونية والدوريات الشهرية المسطحة والتي رجعت به الى الخلف من عدة طرق اخرى ودخلت به في منطقة الظل ساحة الشبهات بين الحرام والحلال والخطا والصواب والحق والباطل واصبحت حصيلة القاموس كالدليل المشوه او الكمبيوتر المعطوب الذي يعطي معلومة خاطئة يستقي منها المرضى اعراضهم بصورة مرتبة وجاهزة ويتقمص منها الوسواسيون مخاوفهم المرضية واوهامهم ويستلهم منها الجمهور الطرائف والفكاهه ويختصون بها السينمائيون مشوراهم الى جزيرة الكنز.

وكما ان هناك ثلاثة مستويات في تفسير المصطلح النفسي فهناك ثلاثة منطلقات في التعامل مع الظاهرة النفسية ، اولها سمات الشخصية، وثانيها الاعراض المرضية، وثالثها المرض النفسي ذاته. فاذا اخذنا الوسواس القهري كمثال الامراض النفسية الشائعة فنجد سمات الشخصية الوسواسية التي تتميز بالافراط في التدقيق و التمحيص واعادة التنسيق والترتيب والالتزام بكل ضوابط الحياة ، كما نجد الاعراض الوسواسية التي تتمثل في عدم القدرة على مقاومة الرغبة القهرية في الشك والحذر والحساسية المفرطة

تجاه ما يقال من مدح وذم، وتستحوذ هذه الاعراض على قدر كبير من نشاط الفرد الجسمي والحركي واخيرا المرض النفسي ذاته.. الوسواس القهري الذي يتميز بوجود افكار او تخيلات خاطئة يعلم المريض عدم منطقيتها ولا يقوى على مقاومتها، او وجود حركات ولوازم حركية متكررة يعي المريض عدم جدواها ولكن لا يستطيع مقاومة القيام بها تحت ضغوط آلام نفسية قاسية تشل قدرته في الحياة الطبيعية.. فلذلك قد تكون شخصية الفرد وسواسية وهذا طبيعي وقد تكون لديه اعراض وسواسية وهذا معقول وارد في حدود الطبيعي، ولكن عندما يصل مرحلة الشلل الحسي والحركي في تكرار الحركان اللاردية قسرا والتفكير القهري في دائرة مفرغة يكون قد وصل مرحلة المرض النفسي ، وقس على هذه المستويات امراض الاكتئاب والفصام وغيرها من هذه المستويات الثلاثة.

وحتى نصل الى الحد الادنى من الاتفاق على الحقائق العلمية عندما نقول هذا مجنون وذاك عاقل وهذا منبسط وذلك منطوي وذلك كثير الشك والاخر طيب القلب ، علينا ان نجد قياسا نفسيا في قاموس نفسي عربي موحد يضع الضوابط بين المعايير النسبية في الحكم الاخلاقي والتفسير العلمي للسلوك الانساني.

شيئ صعب للغاية يقتضي ان تفتت صخرة المرض النفسي الى جزيئات يمكن تحريكها من القمة الى السفح لدراسة خصائصها الجيولوجية لمعرفة العلامة الفاصلة بين الجنون والعبقرية والتفسير العلمي للظواهر النفسية كالحلم والرؤية والهذيان والفارق بين الخوف والوهم والوسواس

والتمييز بين الهيستيريا (العصاب الطرحي) والصرع او الهجاج.

اذا كان الطب البشري بصفة عامة يعاني من قصور القاموس الطبي في استيعاب المطلحات لمدلول الحقائق العلمية في مجال السرطان والايدز وعلم الفيروسات فان الطب النفسي يعاني اضافة صعوبة الفارق بين عتبة الشعور الحسي والحركي وصعوبة الفصل بين العضوي والوظيفي ومشكلة التحديد لمفهوم الطبيعي وغير الطبيعي، فالطبيب العام ينتهي دورة عند تحديد الخط الفاصل بين الصحة والمرض والطبيب النفسي تبدا مهمتعه بظهور المرض ولا تنتهي بتحقيق الصحة لان معيار العافية نسبي في المرض النفسي وهذه الحقيقية هامة قد تفوت على بعض الاطباء ذو التخصصات الاخرى والذين يرونه بعيدا عنهم ونراه قريبا منهم واقرب اليهم من حبل الوريد.. ولهذا تنبع ضرورة القاموس النفسي من اهمية وجود لغة مشتركة بين الاطباء في شتى المجالات والعاملين في حقل الصحة النفسية خاصة كما قال العالم الالماني النفسي المعروف كارل جاسبر عام 1923م (ان الضلال Delusion يمثل لنا احد تلك التحديات التي لا يمكن حلها الا اذا حددنا الحقائق بشكل واضح لانه لو ان كل خطا او حكم خاطئ غير قابل للتصحيح سمي ضلالا فاننا لن نجد فينا من ليس عنده ضلال فكل منا له قناعته وانها لخاصية عالمية ان نتمسك جميعا باحكامنا) وبعد نصف قرن من ذلك التاريخ وفي مؤتمر كندا عام 1978م يثير الاتحاد العالمي للاطباء النفسانيين مناظرة حول سوء

استخدام الطب النفسي في ممارسة حقوق الانسان بين الشرق والغرب في قضية (المنشقين السوفيت) الذين حجزوا في معتقلات روسيا وهاجروا الى منتجعات امريكا وكادت تحدث تصدعا في بنية الاتحاد لان كلمة (ضلالات) لها مدلول نفسي في كل قاموس فكري وقد برزت بعض هذه السمات في ورقة عمل بعض المشاركين في مؤامر اتحاد الاطباء النفسانيين العرب في الاردن العام الماضي حول (اسلمة المعرفة وطرق العلاج النفسي) انطلاقا من ضرورة وجود نواة لاتحاد الطب النفسي الاسلامي وكان السؤال المطروح ... هل حسم الطب النفسي عامة والعربي خاصة قضية وجود تحقيق ذاته حتى يبحث في ازمة تعدد الهوية الفكرية ... وهل عاد هناك وجود للافتراض الخاطئ القديم بوجود تعارض بين علم النفس فان الطب النفسي خاصة قد اكد حقيقة (العلم والايمان) لان التفسير العلمي والنفسي لكثير من الظواهر يعترف بوجود اشياء غائبه عنا وهذا هو لب الايمان بالغيب والذي يدعو له الدين في قوله تعالي (الم ذلك الكتاب لاريب فيه هدى للمتقين الذين يؤمنون بالغيب ويقيمون الصلاة ومما رزقناهم ينفقون) سورة البقرة... وفي التراث العربي كتاب (الرعاية لحقوق النفس) للحارث المحاسبي او (احياء علوم الدين) للامام الغزالي او (احوال النفس) و (الاشارات والتنبيهات) لابن سينا ... نجد محاولات جادة لتفسير بعض وظائف النفس امثال (الحس المشترك) و(الادراك الحسي) و (المخيلة) و (التصوير) .

ان الطب النفسي اصبح احد ضرورات العصر في الحياة .. كالملح في الطعام في هذا العصر الجديد او الطبق الطائر الذي يعلق على صدر لوحته الالكترونية عباة (سترة النجاة تحت المقعد) وتؤكد حقائق الحياة في وضوح ان (علم النفس طوق نجاتك) وفي متناول يدك لابد ان تقنية اي انسان مثل قطعة الاثاث في البيت الحديث بالداخل ولابد ان يتعامل معه كاشارات المرور في الخارج.

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.

Referencing should follow the Vancouver style (giving a number to the reference in the text and

at the end list references in sequence of their appearance in the text)

Publication of the article does not imply the journal's or editor's agreement with statements or opinions expressed there in; authors take responsibility for these and for accuracy of references.

Correspondence:

Contact Info:
Email: sudapsych2010@hotmail.com
Telephone: +249 155 232940
Fax: +249 1555 3495
P.O Box: 943, Tigani Al Mahi Hospital, Omdurman: Khartoum, Sudan
Website:
www.sudanesepsychiatrists.org.sd