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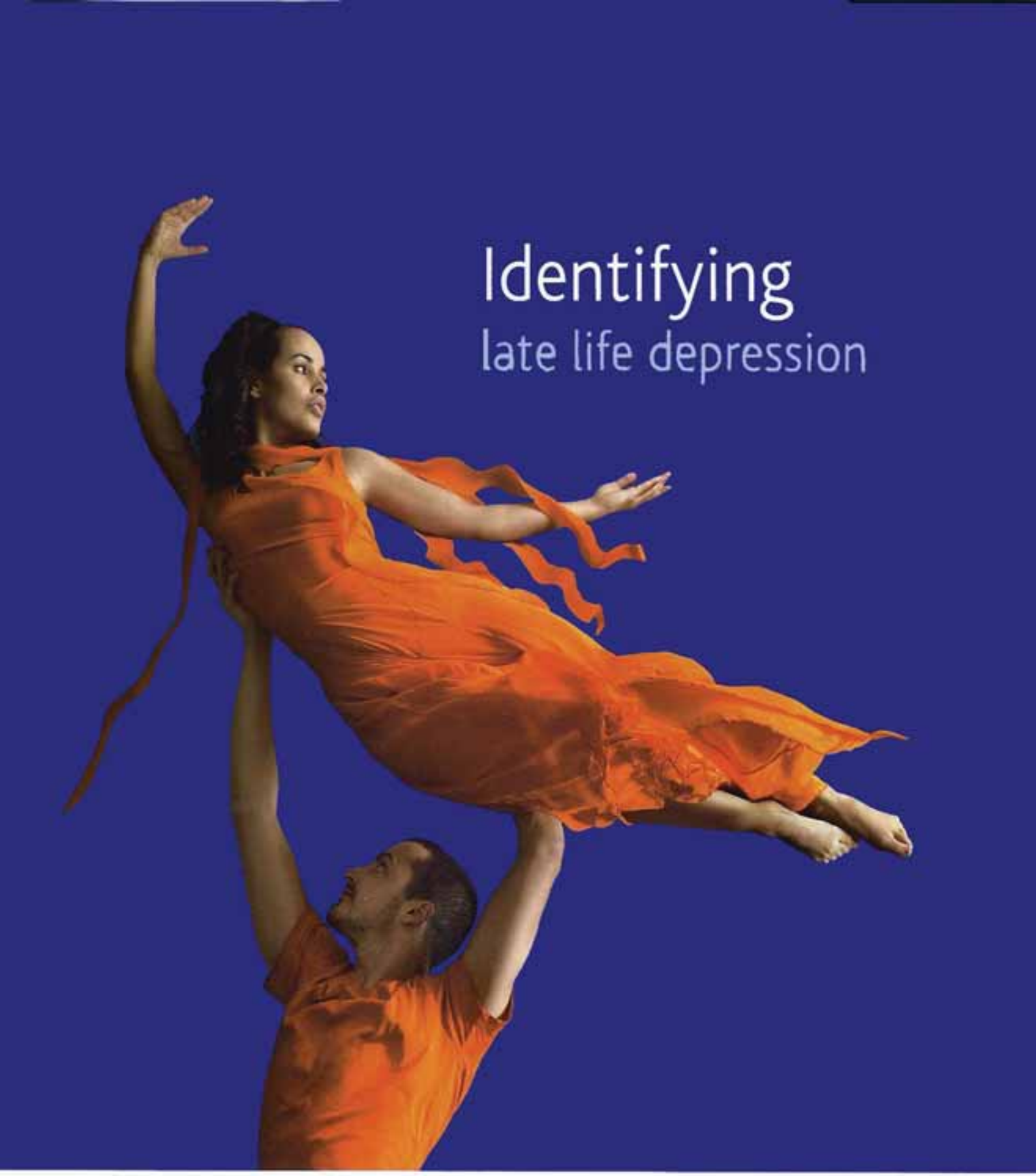


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**Volume 4 – Issue 3, December, 2014**

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# Sudanese Journal of Psychiatry

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# Editorial

(1)

At the starting point of a marathon all participants will be full of hope and enthusiasm to reach the end point. After running and covering some distance many will slow down and some will stop completely. Only those who are full with determination and persistence will continue until they reach the final destination. It is the same in all walks of life. Many good projects start at modest levels as simple innovations
and with the enthusiasm, determination and persistence of people working on them, these projects grow and develop.

Some young psychiatrists and pharmacists started some projects at Taha Baashar Psychiatric hospital. Let us hope that these initiatives will grow and develop and with the enthusiasm and determination of the people who are behind them will continue to flourish.

(2)

Psychiatric nursing in Sudan is very deficient and the remedy may take long. Some young psychiatrists in Taha Baashar Psychiatric hospital took the initiative to improve the situation in their hospital. With the approval, blessing and help of the directors of the hospital they tarted an in-service training program for the nurses in the hospital. The program did not add any financial burden on the hospital nor did it interfere with the schedule of the work of the staff. The main driving force behind it was the enthusiasm, care and thoughtfulness of the young psychiatrists.

The program found appreciation from the nurses and it is hoped that it will continue to raise the standard of performance of the

nurses and the degree of satisfaction of patients.

(3)

Doctors at the out-patient clinic in Taha Baashar hospital are aware that many patients who do not take their medicines as prescribed do so because they cannot afford to buy their medicines on regular basis. The social workers in the hospital try to help patients by getting them in contact with some charity organizations but this process sometimes takes a long time. Some young pharmacists who represent some pharmaceutical firms initiated a brave program in Taha Baasher hospital. Each month they will specify a day when they would come to the out-patient clinic and with the assistance of the doctors in the clinic they would give free medicines to patients who cannot purchase their drugs. It is done in such a way that all clinics and all patients have got chances to benefit from this offer.

(4)

The ills of the mental health services in Sudan are well identified and the treatment is also known, but the lack of facilities hinders cure. Instead of sitting idle waiting for the ideal solution to come these two initiatives in Taha Baashar hospital are good examples of practical attempts to solve chronic problems in the mental health service. However modest these attempts are, they reflect genuine interest and pragmatic answers.

The staff working in these institutes can exchange their experiences in the field and thus will be able to refine and develop their programs. Perhaps they may be able to extend their programs to other psychiatric facilities in the country and create big schemes.

# Quality of Violence Risk Assessment by Psychiatric Registrars and Medical Officers in Psychiatric Emergency Settings

**Howaida Abbas Elyass**
**MB BS, MD**

## Introduction

In society today, mental illness and violence are often seen as inextricably linked, creating a harsh stigma for patients, and at times, an uncomfortable environment for psychiatrists. The perception carries serious further discrimination and a sense of isolation from society .Violence has become of increasing concern in the practice of psychiatry. A large number of aggressive patients present to emergency departments (1).This type of patients implies specific challenges for the diagnosis and treatment of psychiatric disorders and their violent presentations, as the mental health provider is asked to identify potentially dangerous individuals and to intervene to reduce risk .Risk assessment may be legally relevant to mental health professionals in two ways:

First, in the forensic context, psychiatrists and psychologists may be called upon to assess the risk that their patients or client may be violent in the future. Risk assessment may be relevant in civil and criminal law as well as in professional conduct contexts.

Second, one of the most difficult questions for psychiatrists and psychologists concerns knowing when they should disclose a patient's confidential communication on the basis that the patient may be at risk of harming others.

If they breach confidentiality, they may leave themselves open to a legal claim or disciplinary action. If the mental health worker does not breach confidentiality, there may be a risk of the patient committing a serious offence, engaging in self-harm, or putting other people's lives and well – being at risk (2). The current groups of risk assessment tools either provide a probabilistic estimate of violence risk in a specified time period ( actuarial instruments ) , or allow for a professional judgment to be made on risk level ( for example , low , moderate , or high ) after taking into account the presence or absence of a predetermined set of factors ( structured clinical judgment instrument).

Over 150 of these structured measures currently exist (3). To the best of my knowledge up to now no study in Sudan was conducted about the risk assessment of violence by psychiatric registrars and medical officers in emergency settings. This cadre (registrars and medical officers) are the first line professional in the emergency rooms. Hence their ability to assess risk of violence is an important factor in management and safety of patients and staff.

This study aims at the study quality of violence risk assessment by psychiatric registrars and medical officers in psychiatric emergency settings**;** to determine the risk factors the registrars and medical officers considered relevant in an emergency department and to compare the accuracy of risk assessments by psychiatric registrars with those performed by general medical officers.

**Methodology**

This study consists of two parts: quantitative and qualitative

parts. It is a descriptive, cross – sectional hospital based study.

It was conducted at the emergency departments of the four main psychiatric hospitals in Khartoum state (Eltigani Elmahi , Taha Baasher , Abdalal Eledressi , and Khartoum teaching hospital ) , during the period 5 , April – 5 , JUNE 2014. The study population included all psychiatric registrars and general medical officers who were working at the emergency psychiatric settings of the above mentioned hospitals during the above mentioned period, (Total coverage). The data was collected by interviewing the study group using self-administered questionnaire. The questionnaire was distributed to the participants by the investigator and a general medical officer and a registrar and was collected in the same day. The questionnaire contained 3 main sections

First: Demographic data (sex, age, job description, and length of practicing psychiatry).

Second: Knowledge of the participants about risk assessment and how they learned it.

Third: Conduction of HCR 20 (Historical, clinical and risk management 20) through case scenario and then interpretation of the participants answers according to HCR – 20.

The HCR – 20 is an assessment tool that helps mental health professionals estimates a person's probability of violence.

The HCR-20's results help mental health professionals determine best treatment and management strategies for potentially violent, mentally disordered individuals, including parolees, forensic mental health patients, and others. The obtained data was subjected to statistical analysis by using the updated version of the SPSS program and recommendations

were made according to research results, also qualitative analysis was done by the researcher. The most common method is the qualitative research interview, but forms of the data collected can also include group discussions, observation and reflection field notes, various texts, pictures, and other materials. In my research I used semi- structured questionnaire instead of interviewing the respondents which was difficult to be done. Qualitative research often categorizes data into patterns as the primary basis for organizing and reporting results. Qualitative researchers typically rely on the following methods for gathering information: *Participant Observation, Non-participant Observation, Field Notes, Reflexive Journals, Structured Interview, Semi-structured Interview, Unstructured Interview, and Analysis of documents and mater.* Ethical approval was obtained from the scientific committee of Sudan medical specialization board. A written consent was taken from participants. Data collected were treated with a high degree of confidentiality.

## Results:

### A. Quantitative analysis:

There were 43 participants in the study, sixteen (37.2 %) were males and twenty –There were 13 medical officers (30.2 %) and 30 registrars (69.8 %).

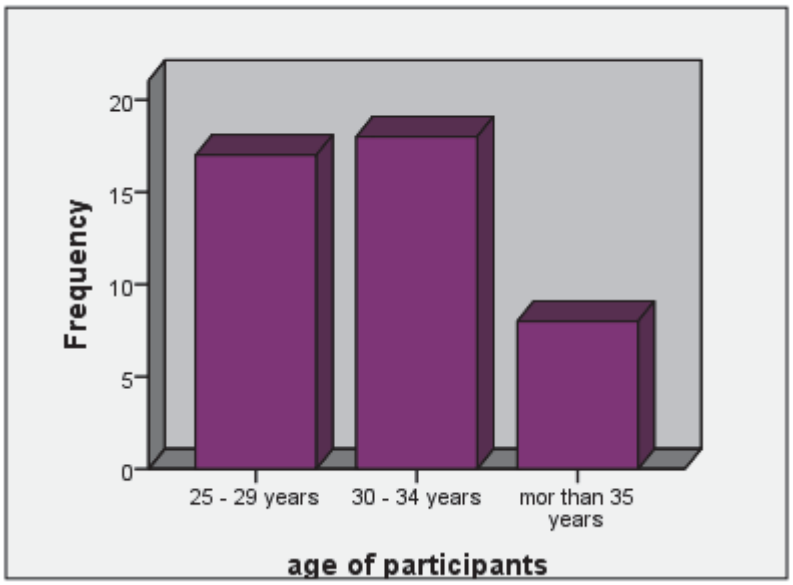


Figure (1) show age distribution among the study population

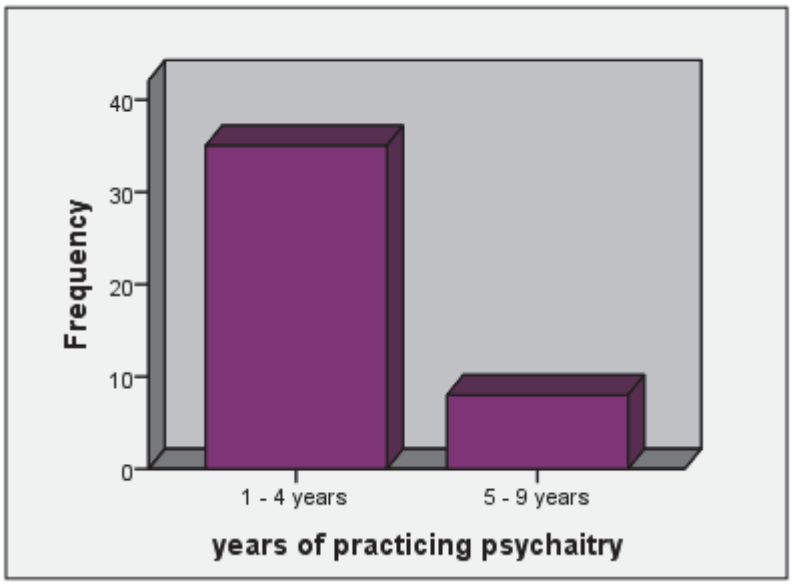


Figure (2) Duration in psychiatry practice and training

Table (1) shows the distribution of the knowledge about risk assessment among the study population

**Risk**

| Knowledge of assessment | | Frequency | Per cent |
|---|---|---|---|
| | yes definitely | 33 | 76.7 |
| | uncertain about it | 9 | 20.9 |
| | no definitely | 1 | 2.3 |
| | Total | 43 | 100.0 |

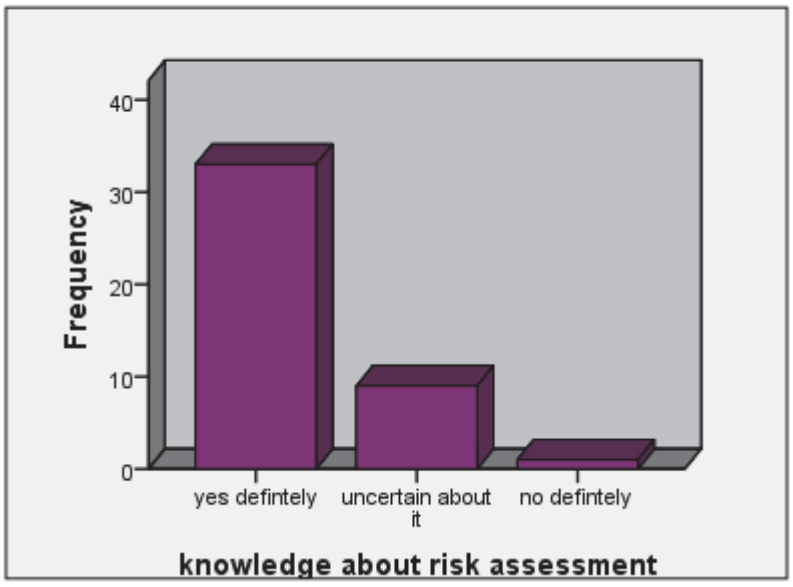


Figure (3) Knowledge about risk assessment

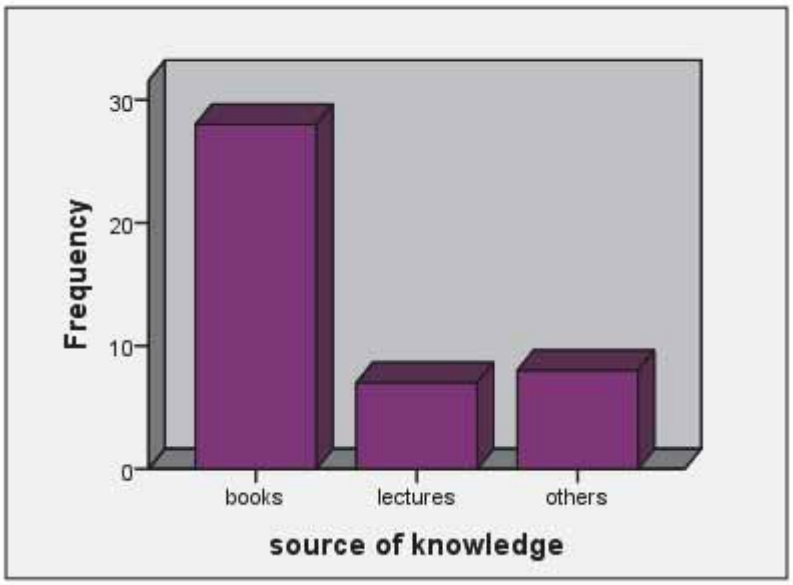


Figure (4) the source of knowledge about risk assessment

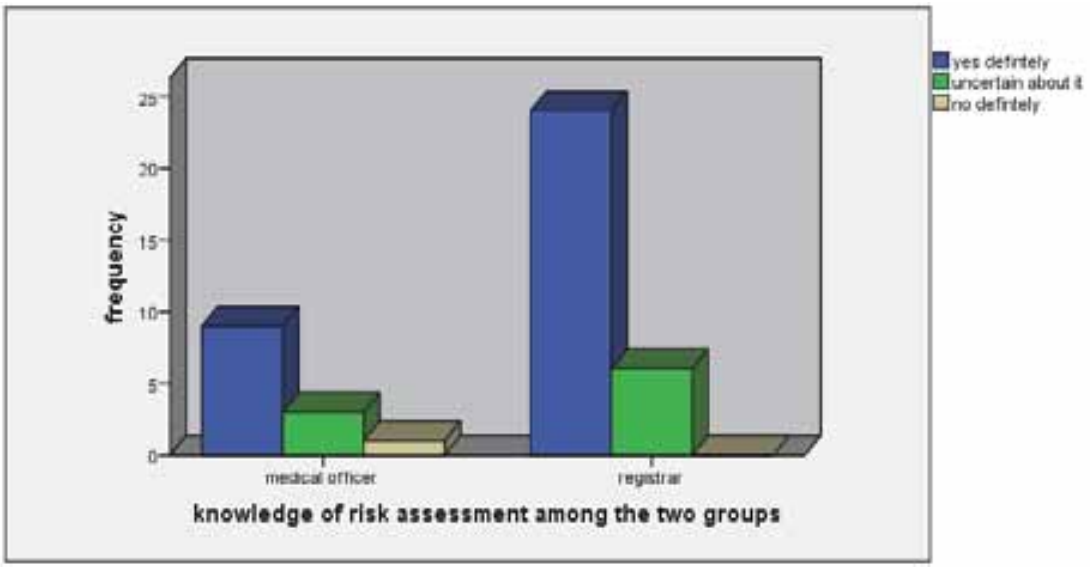


Figure (5) shows knowledge about risk assessment in the two groups (medical officers and registrars)

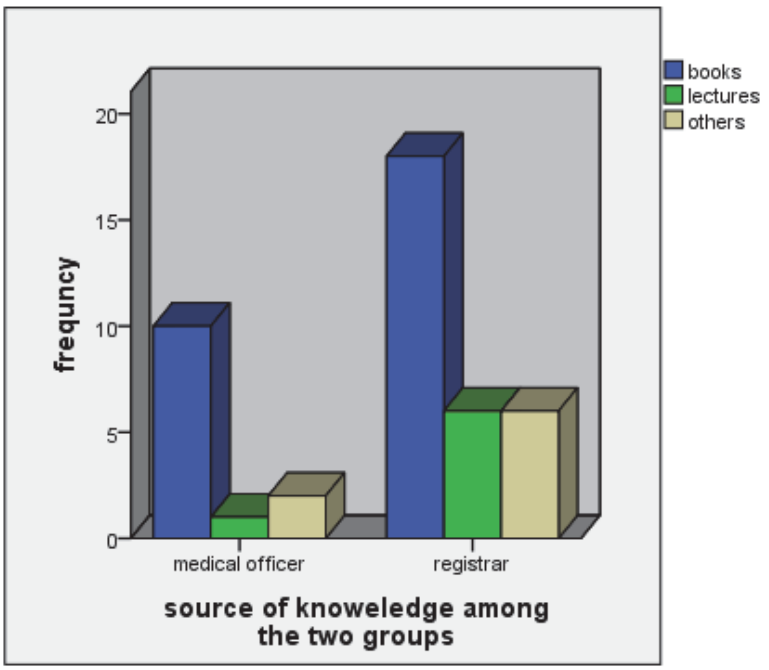


Figure (6) shows the source of knowledge about risk assessment among the two groups (medical officers and registrars)

Distribution of knowledge of risk assessment according to years of practicing psychiatry as shown in figure (7)

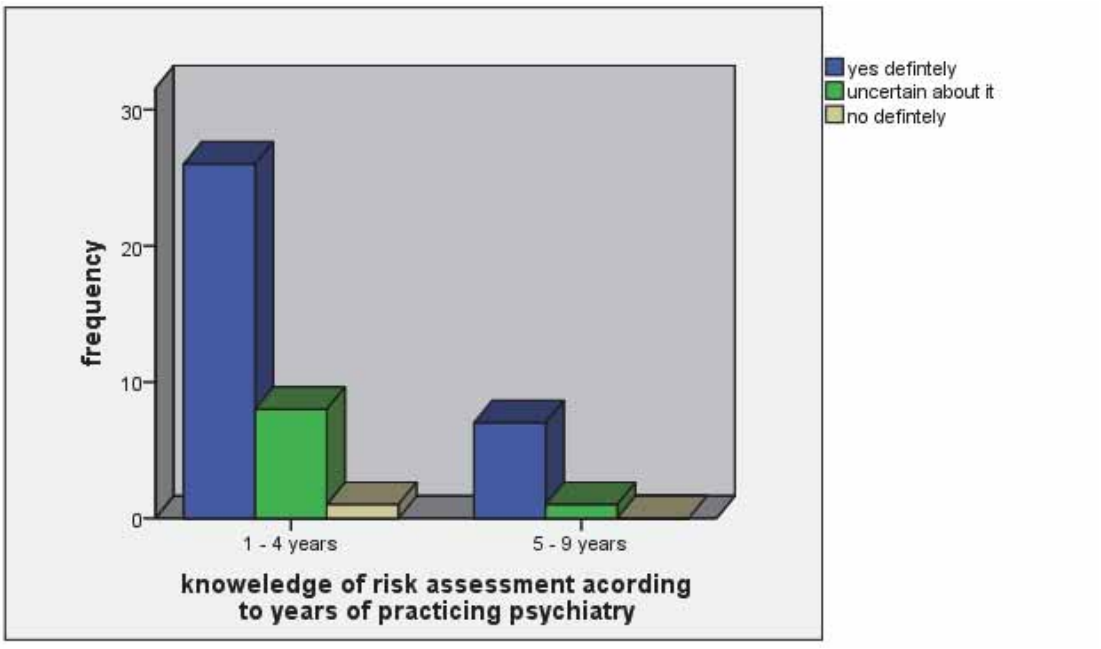


Figure (7) Distribution of knowledge of risk assessment according to years of practicing psychiatry

## B. Qualitative Analysis

### 1. Historical part of HCR- 20

Regarding the historical items in HCR – 20 of violent patients most of the participants registrars said they will consider these points in their management of patients with risk of violence : being male , young age at onset of violence behaviuors , using of alcohol or other substances of misuse , past history of violence , detailed history about the current physical aggression , presence of evidence of self-harm , past history of psychiatric illness , past history of suicidal attempts and compliance with

Regarding the historical items in HCR – 20 of violent patients most of the participants registrars said they will consider these points in their management of patients with risk of violence : being male , young age at onset of violence behaviuors , using of alcohol or other substances of misuse , past history of violence , detailed history about the current physical aggression , presence of evidence of self-harm , past history of psychiatric illness , past history of suicidal attempts and compliance with treatment.

Some of the participants mentioned social back ground and marital stability; others mentioned employment problems, personality disorders and psychopathy.

### 2. Clinical part of HCR – 20

In consideration to the clinical items of HCR – 20 most of the registrars considered these points: presence of psychotic symptoms “Hallucinations and Delusions", personality assessment, mood assessment, general appearance assessment, speech assessment, impulsivity, suicidal and homicidal thoughts, safety measures and response to medication.

On the other hand the clinical points in the risk assessment that were considered by the respondents medical officers included :

presence of psychotic symptoms " Hallucination , Persecutory delusions " , insight of the patients about their illness , appearance and behaviour assessment , mood examination , assessment of the personality and the previous response to medications.

**3. Risk management points in HCR – 20**

With regard to comparison with the risk management items in the HCR -20 , most of the registrars considered management points that must be pplied to violent patients and these included: rapid tranquilization, physical restraints, seclusion with close observation, detoxification if the violent patients were intoxicated, frequent re- assessment, psychotherapy, social intervention and collateral history.

## Discussion:

*The literature on assessment of risk of violence among psychiatric patients generally is rich, but the ability and quality of this assessment in training is not much researched especially in less developed countries where it may be seen as a luxury not worth perusing. The present study shows that, the HCR-20 does not allow for a definite prediction of violence. Predictions based on the HCR-20 are estimates of the likelihood of violence, and should be presented in terms of low, moderate, or high probability of violence. Probability levels should be considered conditional, given short- and long-term time frames, and should be considered in relation to relevant factors the individual may encounter. These factors include situations and states of being that may dispose a person to violence or help insulate them against it. Consideration of such factors can aid in reporting the type and extent of risk presented by a person and in selecting intervention strategies intended to reduce the probability that an indi-*

*vidual will demonstrate violence. These strategies when taken as a whole are called a risk management plan. Ultimately, HCR-20 results are intended to provide information for decision-makers, so that criminal and mental health-related decisions can be based on the best available estimates of risk of violence.*

*This study revealed that (62.8 %) of the population under study were females, and (37.2 %) were males. These results were probably attributed to the increased number of migration of male doctors and to the increased number of females who joined the medical schools compared to the males.*

*Regarding years of practicing psychiatry, this study revealed that (81.4 %) of the subjects under study were practicing psychiatry for less than 5 years. This is probably due to the fact that increased numbers of doctors who migrated to other countries due to the economic situations.*

*About seventy percent ( 69.8 % ) of the population in the study were registrars and ( 30.2 % ) were medical officers .This result is consistent with that reported by by Leslie wong , etal (4) in that the number of HCR-20 items identified by residents correlated with several items; more risk factors were elicited by residents in a higher year of training, those who had received more formal and informal education, the number of patients for whom they had discharged a duty to warn, and the number of suicidal and violent patients they had previously assessed.*

*Regarding the knowledge about violence risk assessment, three quarter (76.7 %) of the subjects in the study said they definitely knew about violence risk assessment, and the main source of acquiring their knowledge*

*about violence risk assessment was from books (65.1%).*

*Quantitative research dominates the field and less qualitative research is done, though numbers cannot well tell about feelings, emotions and behaviours. For example, a study may report that 6 out of 10 patients with a certain problem responded well to a specific procedure. This may be statistically significant and in favour of that procedure since 60% of patients responded well. However this does not tell about the frustration and agony that might have accompanied the procedure.*

*Hence the importance of qualitative studies.*

*In the present study ideally we should have in depth discussion, but I decided on written answers to scenarios which may be as areal cases in the emergency settings, so the respondents will focus on how to tackle such patients. The points where the participants' registrars said they will consider in their assessment of violence were compatible with historical items in the HCR- 20 which include: sex, past history of violence, substance use problems and major mental illness.*

*Many of these points which were mentioned by the participating registrars about the historical points of violent patients were consistent with the results that were found in a study conducted by Leslie wong , et al(4) , in that the number of HCR – 20 items identified by residents correlated with several items.*

*Out of the 10 – historical items included in the HCR- 20, only 2 items not mentioned by the participant registrars, which were: early maladjustment and prior supervision failure.*

*The items in the historical part of the HCR-20 which were not mentioned by the participants medical officers include: relationship instability, employment problem, psy-*

*chopathy, early maladjustment and prior supervision failure.*

*These findings reflect the importance of the level of training and years of practicing psychiatry which are compatible with the results of the study conducted by Leslie Wong, et al, (4) in that the more years of practicing the candidate, the more items in HCR – 20 were identified and those who had received more formal and informal education about HCR – 20.*

*Some of the points mentioned by the registrars were compatible with the clinical items in the HCR-20: negative attitudes and lack of insight.*

*Out of the five items included in the clinical items of HCR- 20. Only two items were not mentioned by the participating registrars: negative attitudes and impulsivity.*

*There were points mentioned by the registrars in the points of risk management which were important in the management of violent patients, but were not included with the items of risk management included in the HCR -20, which were: plans lack feasibility, exposure to destabilizers, lack of personal support, non – compliance with redemption attempts and stress.*

*There were points mentioned by the medical officers related to management of violent patients but are not parts of the risk management in the HCR-20.* In conclusion, the majority of the doctors definitely knew about violence risk assessment (76.7%) and they acquired their knowledge mainly from books (65.7%). Most of the studied group was not familiar with the most common tool used in assessment of risk of violence which was HCR-20, so their knowledge about the various items included in this tool was poor.

**RECOMMENDATIONS**

The results of the study highlight some deficiencies in the training of

trainees in psychiatry in field regarding risk assessment of violence in the emergency settings. It is thus recommended:

- To set up training programs for participating trainees about violence risk assessment to enrich the training programs of psychiatry. The programs should concentrate on tools used for violence risk assessment and plan of management of violent patients, immediate plans and future plans.
- To arrange workshops, lectures, tutorials, and short courses to update knowledge and skills about violence risk assessment.
- To conduct further studies about violence risk assessment in the emergency settings and perhaps adapt the present available assessment tools to local community.

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# Child Sexual Abuse presenting to police centers in Khartoum, Sudan: Pattern and Victim Associated Factors

# الإساءة الجنسية للأطفال في مراكز الشرطة بالخرطوم/ السودان: النّمط والعوامل المرتبطة بالضحيّة

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**University of Medical Science and Technology**

## ABSTRACT:

Recently, the issue of Child sexual abuse (CSA) in Sudan started to become public, following recurrent accidents of severe injuries and deaths. A cross- sectional survey including 282 sexually abused children was conducted from 1/3 to 30/6/ 2012. The aim was to identify patterns of child sexual abuse in Khartoum, Sudan, in addition to pre abuse, peri- abuse and post-abuse factors that put the children at a risk of abuse. The survey was conducted through a questionnaire which was analyzed using SPSS 16. Pattern of child sexual abuse was found to be through contact, mainly sexual intercourse (60.2%). Offenders were extra familial figure (88.3%), mainly neighbors (44.0%) and people in the surrounding (17.4%). Only 14.2% were total strangers. (11.7%) abused by an intrafamilial figure, and (3.6%) by incest. Repeated sexual abuse was (18.1%) and significantly linked to females and older children and significant when living with stepfather, stepmothers and when offender used persuasion to commit the abuse. The most targeted age group was from 5-10 years (45.4%). Most of the abuses took place in areas significantly known to child and family and significantly related to offenders (44.1%) and the family (23.8%). Associated family factors to child sexual abuse were low income, crowdedness,

restricted values, absence of sexual education and parent's low education. Areas of difference from international studies were; high rates of penetrative sexual abuse (SA), low rate of intrafamilial SA, no significant gender differences. Crowdedness and low income were significantly associated with CSA. For prevention and management; child protection programs and more wide scale research are needed.

**Keywords:** CSA Patterns, pre abuse, peri abuse, post abuse.

**Declaration of interest:** this research was implemented using kind grant from UNICEF. Sudan.

## Introduction

The subject of CSA inspired a large number of book authors and researchers since the late 1970s[1]. Almost all aspects of the abuse were well studied worldwide. It is true that human experiences share faces of similarities but some kind of cultural identity always exists. These cultural entities necessitate in-depth studies to differentiate elements of power and prevention from elements of weakness and vulnerability. To the best knowledge of this researcher, very few researches were conducted in Sudan up to date, these researches focused on prevalence [2], characteristics[3]and consequences [4; 5].

Sudan is a multicultural multi ethnic country which has gone through the longest civil war in Africa ever. This resulted in displaced families and tribes and whole local societies. Among those displaced by the war 1.8 million children lived in camps and slums in greater Khartoum[6]. The British organization Hope and Homes estimates that in 2006 about 44000 of these displaced children live in a protected street situation in Khartoum state alone in[7]. To assess various elements of CSA, the effect of poverty, illiteracy, increasing numbers

of household members, crowded houses and increasing rates of unemployment should be studied. Authoritarian mode of discipline at homes and schools that enforces children to be obedient to old people, living in extended or joint families, using of corporal punishment, emotional abuse and neglect, restricted family values and other aspects of Sudanese beliefs and practices should be studied. We need to explore elements of weaknesses that expose our children to CSA and delay or prevent disclosure.

A police unit for family and child protection in Khartoum and other states in Sudan founded in 2007[8]; documented in its data base about 1111victim of CSA from 2007-2010. And due to collaborative work of governmental and non-governmental institutions and organizations finally the new child act in Sudan came out in 2010 with clear incrimination of child sexual abuse in chapter 9 which also included sexual harassment[9].

## Objectives:

**The general objectives of this research were:**

- To study pattern of child sexual abuse in Khartoum- Sudan.
- To study pre abuse factors that expose children to CSA.

**Specific objectives:**

- **To study The Pattern of CSA:**
  - Type of abuse; with sexual contact/ or sexual non-contact (sexual request, exhibitionism and pornography).
  - Type of offenders; from Intrafamilial or /Extrafamilial figures).
- **To study peri- abuse variables:** (Use of force or persuasion, Frequency and duration).
- **To study pre- abuse exposure factors: (Subjective factors: (**socio demographic data, Physical and mental health, social relations). **Situational factors:**

(Situational relation between child and offender, Place of abuse). **Family factors:** (General family factors, Parental or care figure characteristics).

## Methodology:

Cross sectional survey, took place in three police centers in Khartoum state, that belong to Child and Family Protection Unit-Khartoum(CAFPU) and CEMA center which is an NGO that works in partnership with this police units.

There were three centers serving CAFPU in Khartoum at (Al mogran), (Om durman) and (Sharg Alneel). Those centers are receiving direct reports from victims and their families or indirect reports through hotlines 24 hours a day.

The study was carried out in the period from the 1st of March 2012 to the 30th of June2012. Target groups were sexually abused children under age of 18 years old regardless of their gender, and who accepted to participate in the research, or those presented in 2010 after the emergence of new child act in April where new assessing forms were used in the unit including telephone numbers of the victims. The inclusion of the targeted group was conditional on having valid phones. The children were selected consecutively when they attended the units, or through their old records. 283 of the children were selected. 162 of the children were new cases interviewed face to face. 120 of the children and their parents were interviewed over the phone after their old records were fully revised and only one family apologized from participating in the study. All children who fulfilled the inclusion criteria were interviewed with their families face to face or through phones. Direct permission was taken from the victims and their families whom we offered free sessions of psychotherapy and parental coaching. The children

were interviewed by the researcher and a team of six data collectors working in different centers of CAFPU as psychologist or social workers. Some of them were working with the police either as employees or volunteers. Before conducting the interviews the data collectors were trained, 4 hours per day for 6 days in how to fill the questionnaire and to investigate the victims of child sexual abuse according to UNICEF''s training manual on caring for survivors of sexual violence in conflict situations that based on international research, writing and clinical interventions that have been developed over 30 years in the field of sexual violence survivors[10].

The questionnaire was designed to collect data about pattern of abuse, peri abuse, pre abuse and post abuse and disclosure variables that related to the experience of CSA. Most of the research questions were applied before in other international research situation and were based on literature review[11]. The questionnaire was corrected and organized after pilot study.

### Analysis:

Statistical package for social sciences (SPSS for Windows version 16.0) was used for data analysis. Frequencies, cross tabs and Chi-square test were used to describe victims associated factors and to elaborate high associations. A low significance value (typically below 0.05) indicated that there was some relationship between the two variables.

## Results:

### Pattern of abuse:

It looks like the age of the child was critical in determining pattern of (CSA). Older children were significantly abused through sexual intercourse (P value .015), the commonest pattern of CSA, (60.2%) in this study. Attempted

intercourse was (19.2%) and significantly related to younger children, (p value .038). Other patterns of (SA) were, touching sex organs (15.3%), fondling (12.6%), Frotteurism (12.3%) and oral SA (2.7%), (p value.001, .001, .001, .001, .001) respectively.

**Intrafamilial / extra familial sexual abuse:**

Offenders were mainly extra familial figures (p .001). But only (14.2%) were total strangers. (P value .001). Among those cases of intrafamilial, one out of 40 stepfathers was involved in CSA, (p value .001). Incest rate was (3.6%).

**Abuse factors:**

Fortunately CSA was significantly single event (p value .001). Repeated SA was significantly related to females (p value .007) and older children (p value.014). Offender's Use of force was significantly towards male gender (p value .022), and older children (p value .002). Offender's Use of persuasion as a grooming tactic was significantly exposing children to repeated SA and delayed disclosure (p value .002, .001) respectively.

**Pre- abuse exposure factors:**

No association between gender and CSA was proved. (P value .057). Females were significantly exposed to CSA within certain situation namely emotional (p value .001) and blood relation to offender (p value .013). Sexually abused females were more abused inside houses (p value .001).

CSA seems to be increasing with age with significant high rates between 5-10 years old, then children above 10 years old. The least group were children under 5 years old (P value.001). Younger children were significantly abused in side houses (p value .006).

The majority of children were physically and mentally healthy. Only (1.4%) were suffering from speech problem, deafness and Diabetes Mellitus, (p value .001). and

(3.2%) were diagnosed before the interview as either suffering from learning disabilities (1.8%) or obsessive compulsive disorder (.4%), (p value.001).

When testing situational relation between children and offenders; (44.0%) were neighbors, (17.4%) were surroundings like family friends, milk maids, workers and others. (16.0%) were strangers, (8.5%) blood related, (7.1%) were in love relation, (1.1%) teachers, (.4%) stepfather and (.4%) school mates, table (4).

Most of the abuses took place in areas known to families and children, either related significantly to offenders; houses (36.2%), and shops (8.9%) or family's houses (23.8%). (16.0%) were in public places, (10.6%) in distant place and (2.1%) in vehicles (P value .001).

Low socioeconomic status was significantly associated with CSA. (46.1%) of children's families were living with monthly income 100-500 SDG, (33.7 %) between 500-1000, (12.1%) more than 1000 and (3.2%) with less than 100, (p value.001). (100$ = 500 Sdg).

(70.2%) of children were living in nuclear families, 17.0% in joint families and only 11.0% in extended families, (p value .001).

Living in crowded houses was significantly associated with CSA, (p value .001). Most of the victims were significantly coming from religious and restricted family values (36.5%), rather than liberal family values (17.0%),(p value.001). Liberal and modest family values was significantly related to female gender (p value .048).

## Parental characteristics:

Living with stepmothers; increase the risk of repeated SA especially that goes for weeks and years, (p value.029). There was significant relation with duration of CSA that went for weeks and years and living with stepmothers, (p value.033).

The majority of fathers (57.8%), and mothers (64.9%) weren't able to finish their high school education and this was significantly associated with CSA (p value.001).

Mothers were significantly using corporal punishment (cp) with their older children, (p value.046). The mother's use of cp in disciplining children was significantly delaying child reporting of sexual abuse, (p value.001).

Absence of sexual education was significantly associated with CSA. Only fifth of parents were discussing some sexual educative issues with their children.

| Pattern and abuse factors: | | | |
|---|---|---|---|
| **Type of abuse:** | | | .001 |
| Contact | 261 | 92.6 | |
| Non- contact | 21 | 7.4 | |
| Intrafamilial | 33 | 11.7% | .001 |
| Extra familial | 249 | 88.3% | |
| **Offenders relation to family** | | | .001 |
| Known to the child and family | 221 | 78.4% | |
| Not known | 40 | 14.2% | |
| **Frequency:** | | | .001 |
| Single | 231 | 81.9% | |
| repeated | 51 | 18.1% | |
| **Victim Gender:** | | | .05 |
| Male | 125 | 44.3% | |
| Female | 157 | 55.7% | |
| **Age at Onset:** | | | .001 |
| < 5 | 45 | 16% | |
| From 5-10 | 128 | 45.4% | |
| > 10 | 105 | 37.2% | |
| **Place of abuse** | | | .001 |
| Offender house | 102 | 36.2% | |
| Family house | 67 | 23.8% | |
| Public place | 45 | 16.0% | |
| Distant place | 30 | 10.6% | |
| Offender shop | 25 | 8.9% | |
| Vehicle | **6** | **2.1%** | |
| **Family values:** | | | .001 |
| Religious and restricted | 103 | 36.5% | |
| Liberal and open | 48 | 17.0% | |
| Modest | 130 | 46.1 | |
| **No Sexual education** | 219 | 77.7% | |
| | | | |

## Discussion:

The amount of penetrative SA is higher than findings in international research, Finkelhor writes: Around 20% to 25% of child sexual abuse cases involve penetration or oral-genital contact[12]. That difference could be attributed to cultural differences like concepts of sexual act and increase age of children. Interfamily perpetrators in this research were less than that found in international research and no gender difference was found. Where interfamily perpetrators constitute less than half of the total in retrospective studies and interfamily perpetrators constitute from one-third to one-half of all perpetrators against girls, and only about one-tenth to one-fifth of all perpetrators against boys[13]. Less intrafamilial abuses in Sudan could be attributed to the nature of family constituents where child care and protection is responsibility of all members of extended families. Add to these religious and cultural values that made issues of honor and virginity matters especially to people in charge of the child. Despite low rates of intrafamilial SA, it was significantly related to repeat SA (p .015) and that was similar to literature on the topic. No question that interfamily abuse is more likely to go on over a longer period of time and in some of its forms, particularly parents-child abuse, has been shown to have more serious consequences[14]. One interpretation of these findings might be that the emotional injury caused by parents abuse, e.g. increased feelings of powerlessness and betrayal as described in Finkelhor and Browne's (1986) 'traumatogenic model', produces greater psychological harm[15]. Despite that 40 children (14.2%) had stepfathers. Only one was involved in CSA. The victim was female more than 10 years old that suffered repeated SA for years. Stepfathers were significantly related to repeated abuse by neighbors and people in the surroundings. This result was going with international studies

that showed; the presence of a stepfather in the home doubles the risk for girls, not only for being abused by the stepfather but also for being abused by other men prior to the arrival of the stepfather in the home[16]. Low rate of CSA by stepfather be explained by Sudanese cultures and values where sexual relation with step daughter even if she is mature adult and the mother dead or divorced was incriminated by religion of Islam. As in holly Quran (Forbidden to you (for marriage) are: your mothers, your daughters, your sisters, your father's sisters, your mother's sisters, your brother's daughters, your sister's daughters, your foster mother who gave you suck, your foster milk suckling sisters, your wives' others, your step daughters under your guardianship, born of your wives to whom you have gone in - but there is no sin on you if you have not gone in them (to marry their daughters)[17].

Definition of incest in Islam extended to cover step daughters. This definition is different than international one: (the legal definition of incest applied to vaginal intercourse between male and female whom the offender knew to be his daughter, sister, or mother and didn't include stepfathers or adoptive fathers or actions other than vaginal intercourse(Smith and Bentovim)[18].

According to Anne and others sex offenders are not easily identifiable and they don't generally fit (the dirty old man) or (perverted strangers) stereotypes. Rather, many offenders are trusted individuals who appear to be highly regarded in their communities, successful in their works, and particularly engaging with children[19]. In adult retrospective surveys, victims of sexual abuse indicate that no more than 10% to 30% of offenders were strangers, with the remainder being either family members or acquaintances. The importance of acquaintance perpetrators; especially neighbors, teachers, coaches, religious leaders, and peers, should not be ob-

scured by an exclusive emphasis on family abuse[20]. Neighbors in this research were representing people in the neighborhood including shop keepers. Neighbors are honored in Sudanese and Muslims communities they are trusted and counted like family. To be intimate to neighbors for example, Sudanese construct their houses in such a way that it makes access to neighbors easy through common doors. High rates of neighbors, shop keepers and low rates of peers SA were new elements in this research reflecting Sudanese entities.

Most of the abuses took place in areas significantly related to people known to family and the child. This result was goes with international studies that found the most common location for all CSA was the offender's own home[21].

The gender was an area of disparity in research , Rogers and Terry (1984) report that boys are more likely than girls to be sexually abused by multiple perpetrators, but other authors (Farber et al., 1984 and (Reinhart, 1987) do not find this to be the case[22]. There was no significant gender difference in victim rates between males (44.3%) and females (55.7%). This result was different from international studies but consistent with other research in Sudan[23]. This finding was similar to pattern found in other studies on sexual maltreatment in Jewish and Arab schools in Israel[24]. The research disparity in this result could be attributed to cultural differences in Islamic, Arab and Jewish societies in which boys were less protected and outgoing. So boys were more available for indoors and outdoors SA, and females kept inside and more available for indoors SA. Also we can add family sexuality regarding gender differences which concentrate much on female's protection and desensitize boys towards their bodies. Regarding the age at onset of abuse, children from 5-10 were significantly more targeted (45.4%). then children more than 10 (37.2%) and children who

were less than 5 years (16.0%). There was significant relation between females and age at onset less than 5 and more than 10 years. These results were consistent with international studies which proved that; Risk for CSA rises with age. Data from 1996 indicate that approximately 10% of victims are between ages 0 and 3 years. Between ages 4 and 7 years, the percentage almost triples (28.4%). Ages 8 to 11 years account for a quarter (25.5%) of cases, with children 12 years and older accounting for the remaining third (35.9%) of cases. Some authorities believe that, as a risk factor, age operates differentially for girls and boys, with high risk starting earlier and lasting longer for girl[25]. Repeated SA was significantly found to be related to older children (p value.014). And that was consistent with research where CSA after age 12 was associated with an increased number of abusers in the last 2 months of abuse[26].

Socio- economic classes were areas of disparity in international research that found low socioeconomic status was a powerful risk factor for physical abuse and neglect, and has much less impact on CSA. Such as low socioeconomic status, have received little support from research results[27].This difference could be attributed to Sudanese culture where poor families, either go for long working hours or sending their children for work them self. Child labor is acceptable in Sudan where national research found 7-10% of Sudanese children economically active[28]. Sometimes poverty can create state of deprivation that can put children at risk for exchanging sexual advantages by money or gifts. Also neighborhood in poor areas could be dangerous for children.

Absent sexual education and restricted family values rather than liberal one was significantly associated with CSA .According to literature; whatever the precise mechanism, it is clear from this finding that it is not sexually

lax, but sexually reserve families that foster a high risk for sexual exploitation, and some priority should be given to investigating this connection further[29]. Liberal and modest values were significantly associated with being female. International studies, found sexual education in schools and homes has benefits[30] .The weight of currently available evidence shows that it is worth providing children with high-quality prevention-education programs.

Mother use of cp was significantly associated to older children and delayed report. and the later finding was consistent with international studies that found Children whose caretakers were "supportive" disclosed at a rate 3.5 times greater (63%) than those whose caretakers were "non- supportive" (17%)[31]. In the literature CSA may be a risk factor for subsequent physically abusive parenting[32]. CSA was mostly prevalent in homes were children witnessed violence or were subjected to physical or psychological abuse, as well as amongst children who perceived lack of family affection[33].

## Conclusion:

Some findings were consistent with international studies and other findings showed difference either in the rates or in associated / not associated factors.

**Areas of Similarities were;** 5 to 10 years old group were more targeted and then children above 10 years old. Age operates differentially for girls and boys, with high risk starting earlier and lasting longer for girls. Offenders were mainly from acquaintance. The majority of places of SA was significantly known to family and abused children and related mainly to offenders and family members. . Father and mother not finishing high school, restricted values, and absent sexual education were associated to CSA. Abusive mothers significantly associated to delayed disclosure.

**Areas of Differences** that reflect the entity of Sudanese socio- cultural con-

text were; High rates of penetrative SA. Low rates of intrafamilial SA and incest. No gender differences were found. Low income and crowdedness were associated to CSA.

**Recommendation:**

It is most needed if we are able to prevent child sexual abuse (primary prevention). Or at least; encouraging early disclosure and prevent re abuse (secondary prevention).

1. Advocate for in- depth wide scale and community based surveys for both victims and offenders communities to advance the understanding of the problem and to suggest effective preventive practices.
2. Child empowerment especially in issues of relationships, and sexuality; that enable them to differentiate between good people, good touch and bad people and bad touch.
3. Promote environments and education that support healthy development.
4. Revising norms, behaviors, images, and messages; that put children at risk of CSA, like sending younger children to neighbor houses and shops without observation.

## Limitations:

- The research was limited to Khartoum State. Although most of Sudanese ethnic groups were adequately represented in the Capital, geographical generalizations cannot be possible.
- The research was limited to police centers where the entire sample from victims was drawn, No control group. And unless it is further supported by community based studies the results of the research will not represent Khartoum community.
- Social variables that test emotional relations, happiness, closeness and treatment were subjective and difficult to be assessed accurately.

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**مستخلص البحث:**

بدأ موضوع الإساءة الجنسية للأطفال يطرح للعامة مؤخرا نتيجة لتكرار الحوادث الوخيمة وتواتر الوفيات. هذا البحث :

دراسة مقطعية ، اشتملت على عينة من 282 طفل تم اختيارهم بالتتابع في الفترة مابين الأول من مارس الى نهاية يونيو 2012 .جمعت الإستبيانات معلومات عن الخلفية الإجتماعية والديموغرافية للطفل ومعلومات عن نمط الإساءة وماحول الإساءة ومابعد الإساءة تم تحليلها عبر استخدام النسخة 16 من حزمة البرامج الإحصائية للعلوم العلوم الإجتماعية SPSS .الإساءة الجنسية الإتصالية ، لا سيما الإتصال الجنسي كان النمط الأكثر شيوعا.في معظم الحالات كان المعتدي من خارج الأسرة. لكن في (78.4%) كان معروفا للطفل والأسرة. وهو في الأساس اما جار (44.0%) او شخص في محيط الطفل (17.4%). فقط 14.2% من المعتدين كانوا غرباء تماما ونسبة قليلة كانت من داخل الأسرة (11.7%) وأقل منها سفاح القربى (3.6%). في (81.9%) كانت حالات الإساءة لمرة واحدة . وحالات الإساءة الجنسية المتكررة (18.1%) أثبتت بالأخص مع الفتيات والأطفال الأكبر سنا وحين كان الطفل يقيم مع زوج أم او زوجة أب أو في الحالات التي يستخدم فيها المعتدي الإقناع او الإستدراج لإرتكاب الإساءة. الأطفال في فئة 5-10 سنوات كانوا أكثر عرضة (45.4%). أغلب الإساءات حدثت في أماكن معروفة للطفل والأسرة ولها علاقة بالمعتدي (44.1%) او العائلة (23.8%). عوامل الأسرة التي أثبتت علاقتها بالإساءة كانت (الدخل المحدود، المنزل المزدحم، قيم الكبت والمحافظة ،غياب التوعية الجنسية وتعليم الوالدين المتدني).

تشابه نتائج هذه الدراسة لحد كبير النتائج المنشورة في دراسات مشابهة بمناطق مختلفة حول العالم. يستثنى من ذلك (معدلات الإساءة الإتصالية العالية ونسب المعتدين من داخل الأسرة ، انعدام الفروق النوعية،ازدحام المنزل والدخل المحدود كعوامل مرتبطة بالإساءة الجنسية).

# Prescribing Practices in the Treatment of Depression at Taha Baasher's Teaching Psychiatric Hospital

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## Abstract

**Background:** Depression is rapidly becoming a major global burden in the recent years and according to the World Health Organization (WHO), depression is the fourth most disabling disease in the world.

**Aim:** To describe the current prescribing practices in the treatment of Major depressive disorder at Taha Baasher's Teaching Psychiatric Hospital.

**Method:** an observational study done through full coverage of all prescribers practicing in the hospital during the study period, where 44 health care givers were enrolled (n = 44).

**Results**: 45.5% of the practitioners were medical officers, 27.3% registrars, (22.7%) consultants and 4.5% medical assistants. 42(95.5%) of practitioners indicated SSRIs as their first-line preference for treatment of depression. 24 (54.5%) of the participants preferred Psychosocial interventions plus antidepressant for mild depression treatment, whereas 21 (47.7%) of the participants preferred ECT for severe depression. In case of resistant depression, 40.9% of prescribers preferred the augmentation of antidepressant with an atypical antipsychotic. The most important criterion in the selection of antidepressants was found to be the effectiveness (52.3%). The most influencing factor affecting choice of antidepressant was Presenting symptoms 41(93.2%). The hospital has no local guideline for management of depression. No one of the practitioners requested pre-treatment ECG before starting TCA therapy.

**Conclusions:** Studying the prescription patterns can help the practitioners adopt rational prescribing practice in a better manner throughout Sudan

## Introduction

Depression is a common mental disorder, also called major depression, major depressive disorder or clinical depression, characterized by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, feelings of tiredness and poor concentration.[1]

Untreated clinical depression is a serious problem. Untreated depression increases the chance of risky behaviors such as drug or alcohol addiction. It also can ruin relationships, cause problems at work, and make it difficult to overcome. Depression is an illness that involves the body, mood, and thoughts [2]

Prescribing practice for depression is widely studied. A study done at University Psychiatric Clinic in Belgrade revealed that Antidepressants were prescribed for unipolar depression either without comorbidity (46.2%) or with comorbidity (24.7%), mostly as a monotherapy. 91% had one antidepressant. 65% of the patients were females, aged 50.1 ± 8.9, most of them with 12 years of education (52.6%), married (69.3%) and employed (55.9%). The most prescribed antidepressant group was selective serotonin reuptake inhibitors (SSRI) (47.8%), followed by tricyclic antidepressants (TCA) (25.3%) and new antidepressants – venlafaxine, tianeptine, mirtazapine, bupropion, and trazodone (15.1%). Most of the drugs were prescribed in doses which are at the lower end of the recommended dose-range. Regarding severity of the actual depressive episode, TCA were prescribed for severe depression with psychotic features, while SSRI were choice for episodes with moderate symptom severity ($p = 0.01$). Psychiatrists with longer working age (20–30 years) hesitated to prescribe new

antidepressants in comparison to younger colleagues (p-0.01)

Another study done in a tertiary care psychiatric centre of north India, to observe prescription pattern of antidepressants as well as other psychotropic medications for the treatment of depression found that a large number of patients (84%) were co-prescribed Clonazepam. It was observed that 16% of the patients were prescribed a combination of two antidepressants. 19% of the patients were co-prescribed antipsychotics for the treatment of their psychotic symptoms. Duloxetine was found to be the most frequently prescribed anti depressant while Paroxetine was the least frequently prescribed. [4]

Also there was a retrospective observational study was carried out in the psychiatric unit of a tertiary care hospital in Eastern India, the study showed that depressive disorder was the most common psychiatric diagnosis in the population and that antidepressants were the most commonly prescribed psychotropic medicines. There was a higher prevalence of antidepressant prescribing for women. A majority of the antidepressants were prescribed to young and older adults between 21and 40 years. The SNRI, duloxetine, the SSRIs, escitalopram and sertraline and the atypical antidepressant, mirtazapine, were the most commonly prescribed antidepressants, with or without other concomitant psychotropic medicines. The preference for duloxetine over SSRIs as the first line drug in depressive disorders did not conform to the standard prescribing guidelines. Most of the patients were treated by a single antidepressant. However, poor response and/or tolerability considerations made the prescribers change the antidepressant or add a second antidepressant. Antidepressants were prescribed for many indications other than depressive disorders and the psychiatrists' choice of the drug was influenced by the diagnosis, the severity of the disease/disorder, co-

morbidity, drug efficacy, and the considerations for the patients' tolerability, but not primarily on the cost of medication. The consumption of antidepressants in the community was low. [5]

In Malaysia there was study in Hospital Klang. SSRI is the most widely used class of antidepressant drugs in this study. Fluvoxamine turned out to be the most frequently prescribed antidepressant and sertraline ranked second in the hierarchy of prescriptions followed by venlafaxine from SNRI class. But these SSRIs were upstaged by escitalopram in the study duration. Venlafaxine however recorded a decreasing trend over the study period. Therapeutic pattern (monotherapy vs. combination therapy) in the use of depression. Generally, combination therapy is not practiced in Malaysia as we can see the number of prescriptions being very low while monotherapy is strongly favored registering high number of prescriptions each year. The monotherapy category was initially largely dominated by fluvoxamine in 2009 but then a significant downward trend was observed where the usage dropped from 37.7% in 2009 to 20.9% in 2011. However, this drift was in contrast to the pattern seen in escitalopram where a tremendous increase can be seen, about 9% over the 2 years period. Monotherapy antidepressant drugs are concomitantly prescribed with antianxiety and anti-psychotic drugs. A tremendous increase in co-prescribing anti-depressant drug with clonazepam was recorded, with increases amounting to 19% from the year 2009 till 2011. On the other hand, lorazepam which was initially the highest anti-anxiety drug prescribed illustrated a downward trend from 13.9% in 2009 to 5.4% in 2011. Diazepam also showed a drop in usage, around 2.5%, although it was not as popular as the other anti-anxiety drugs. Risperidone and sulpride are the most common anti-

psychotics prescribed together with anti- depressant drugs.[6]

Also there was study done among psychiatrists' doctors providing psychiatric Care in Trinidad and Tobago. It shows that 72% (21/29) clinicians indicated SSRIs as their first-line treatment preference for a first episode of depression. 55% (16/29) clinicians indicated a belief that SSRIs were the most efficacious. 79% (23/29) indicated that the SSRIs had the least side effects and 76 %( 22/29) indicated that the tricylics had the most side effects. The most influential factor affecting choice of antidepressant was previous response to treatment 97 %( 28/29). Fluoxetine was endorsed as most likely to be associated with sexual dysfunction, a discontinuation syndrome, agitation and insomnia and amitriptyline with weight gain. 86% (25/29) treated a first episode of depression for 6 months or greater and 38 %( 11/29) never used ECT.[7]

## NICE clinical guideline90 (2009)

- Do not use antidepressants routinely to treat mild depression because the risk–benefit ratio is poor, firstly start with psychosocial interventions (CBT, CCBT or structured group physical activity program) but consider them for people with mild depression that persist(s) after other interventions.
- For patients with moderate or severe depression, provide a combination of antidepressant medication and a high-intensity psychological intervention (CBT or IPT).
- Do not routinely vary the treatment strategies for depression described in this guideline either by depression subtype (for example, atypical depression or seasonal depression) or by personal characteristics (for example, sex or ethnicity) as there is no convincing evidence to support such action.
- Consider ECT for acute treatment of severe depression that is life

threatening and when a rapid response is required, or when other treatments have failed[8]

The goals of treatment of the acute depressive episode are to eliminate or reduce the symptoms of depression, minimize adverse effects, ensure compliance with the therapeutic regimen, facilitate a return to a premorbid level of functioning, and prevent further episodes of depression. [9]

## Non pharmacologic Treatment

• The efficacy of psychotherapy and antidepressants is considered to be Additive. Psychotherapy alone is not recommended for the acute treatment of patients with severe and/or psychotic major depressive disorders. For uncomplicated non chronic major depressive disorder, combined treatment may provide no unique advantage. Cognitive therapy, behavioral therapy, and interpersonal psychotherapy appear to be equal in efficacy. [9]

• Electroconvulsive therapy (ECT) is a safe and effective treatment for major depressive disorder. It is considered when a rapid response is needed, risks of other treatments outweigh potential benefits, there has been a poor response to drugs, and the patient expresses a preference for ECT. A rapid therapeutic response (10 to 14 days) has been reported. Relative contraindications include increased intracranial pressure, cerebral lesions, recent myocardial infarction, recent intracerebral hemorrhage, bleeding, and otherwise unstable vascular conditions. Adverse effects of ECT include confusion, memory impairment (retrograde and anterograde).[9]

## Pharmacologic Therapy
### (General Therapeutic Principles):

• Factors that influence the choice of antidepressant include the patient's history of response, history of familial response, concurrent medical conditions, presenting symptoms, potential for drug–drug interactions, comparative side-effect profiles of various

drugs, patient preference, and drug cost.

• Between 65% and 70% of patients with major depression improve with drug therapy.

• Psychotically depressed individuals generally require either ECT or combination therapy with an antidepressant and an antipsychotic agent.

• The acute phase of treatment lasts 6 to 10 weeks, and the goal is remission (i.e., absence of symptoms).

• The continuation phase lasts 4 to 9 months after remission. The goal is to eliminate residual symptoms or prevent relapse.

• The maintenance phase lasts at least 12 to 36 months, and the goal is to prevent recurrence of a separate episode of depression.

• Some clinicians recommend lifelong maintenance therapy for persons at greatest risk for recurrence (i.e., persons younger than 40 years with two or more prior episodes and persons of any age with three or more prior episodes).

• Educating the patients and their support systems regarding the delay in antidepressant effects (typically 2 to 4 weeks) and the importance of adherence should occur before therapy is started and throughout treatment. [9]

## Research Objectives

To describe the current prescribing practices in the treatment of clinical depression at Taha Baasher's teaching psychiatric hospital.

## Methodology

The study was done through cross-sectional Hospital-based study design by direct interviewing of the prescribers using a questionnaire

The study was conducted in Khartoum State at Taha Baasher's teaching psychiatric hospital which is the second biggest psychiatric hospital in Sudan

### Study population

Full coverage of all prescribers practicing in the hospital at the time of the study .

## Ethical Considerations:

Ethical approval was obtained from University of Medical Sciences and Technology, also hospital agreement was obtained

## Data management and analysis

Data was analyzed by a statistician and SPSS version 19 was used

## Results

This research has been approached through full coverage for all prescribers present in the hospital during the study period , the total number of the prescribers were 47 subjects , where two of the prescribers were not responsive and one was in a leave, so 44 prescribers were enrolled (n = 44). All participants were met by the researcher through personal interviews using a specifically pre-tested questionnaire for collecting the required data.

Genders distribution of the prescribers (n = 44) showed that 26 (59.1%) of them were females, as shown on figure 1 below.

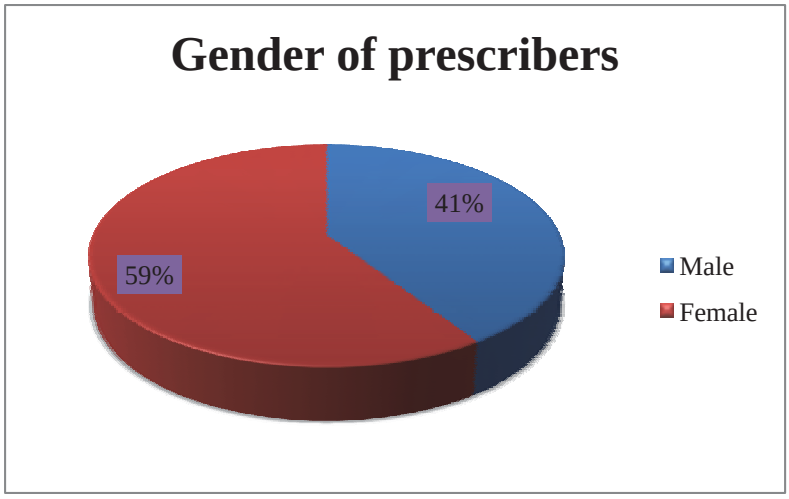


**Fig1: Gender distribution of prescribers included in the study.**

When they were classified according to their specialty, it was noticed that 20 (45.5%) of them were medical officers, whereas 12 (27.3%) were registrars. Table 1 below classifies.

**Table1: Distribution of prescribers included in the study according to Specialty.**

| Specialty | No. of prescribers | Percent |
|---|---|---|
| Medical officer | 20 | %45.5 |
| Registrar | 12 | %27.3 |
| Consultant | 10 | %22.7 |
| Medical assistant | 2 | %4.5 |
| **Total** | 44 | %100 |

When the respondents were asked about the most important criteria in the selection of antidepressants, 23 (52.3%) of them said effectiveness, whereas 8 (18.2%) said according to consultant experience. Table 2 below shows and gives more details.

**Table 2: Distribution of prescribers according to the most important criteria in the selection of antidepressants.**

| the most important criterion in the selection of antidepressants | No. of prescribers | Percent |
|---|---|---|
| Effectiveness | 23 | 52.3 % |
| According to consultant experiences | 8 | 18.2 % |
| Less side effects | 7 | 15.9 % |
| Cost | 6 | 13.6 % |
| **Total** | 44 | 100 % |

When the study subjects were asked 4 dichotomous questions (yes/no question) their answers came as shown on table 3 below:

**Table3: Distribution of prescribers according to the Factors that influence the choice of antidepressants.**

| Factors that influence the choice of antidepressant | No. of prescribers | Percent |
|---|---|---|
| Presenting symptoms | 41 | 93.2% |
| Concurrent medical conditions | 12 | 27.3% |
| Patient preference | 7 | 15.9% |
| History of familial response | 5 | 11.4% |

When they were asked about the first line preferences in the treatment of depression, in general, 42 (95.5%) of them mentioned SSRI, as shown on figure 2 below.

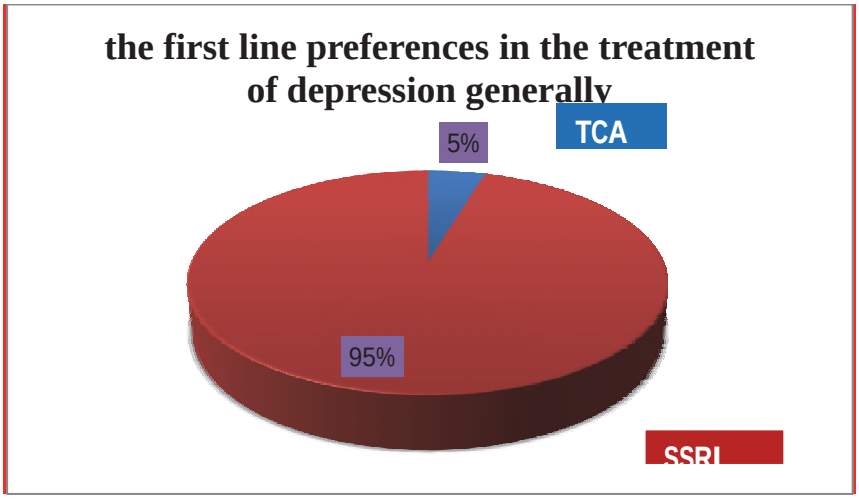


**Fig 2: Distribution of the prescribers according to the first line preferences in the treatment of depression.**

When they were asked whether they routinely vary the treatment strategies for depression by personal characteristics or by depression subtype 25 (56.8%) of the respondents said yes. Figure 3 shows

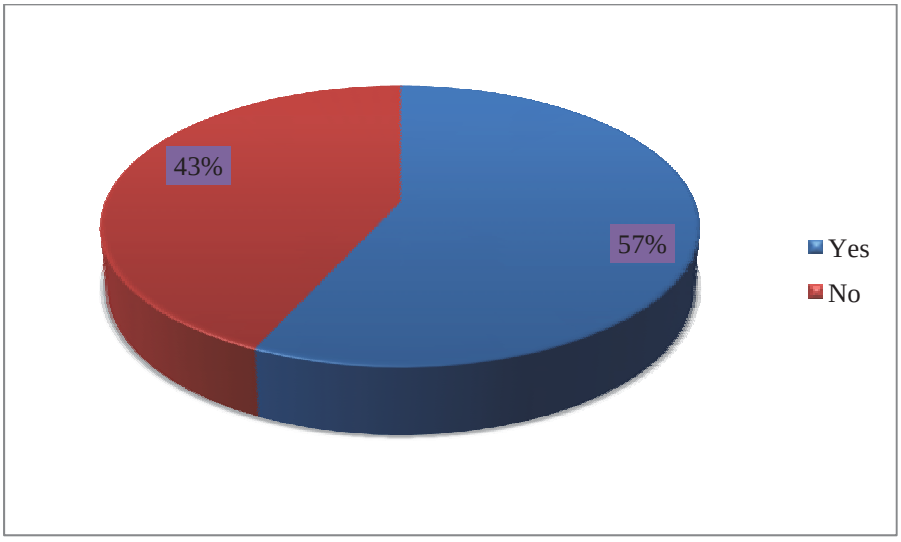


**Fig 3: Distribution of prescribers according to whether they routinely vary the treatment strategies for depression by personal characteristics or by depression subtype**

When the participants were asked their preference for mild depression treatment, 24 (54.5%) of the said combination of A and B (Psychosocial interventions plus antidepressant), whereas 17 (38.6%) mentioned antidepressant. Tables 4 below indicate.

**Table 4: Distribution of prescribers according to their preference for treatment of mild depression.**

| Prescribers preference for treatment of mild depression | No. of prescribers | Percent |
|---|---|---|
| Psychosocial interventions plus antidepressant | 24 | 54.5% |
| Antidepressants | 17 | 38.6% |
| Psychosocial interventions (CBT, structured group physical activity program est....) | 3 | 6.8% |
| **Total** | 44 | 100% |

When they were asked about their preference for treatment of severe depression, 21 (47.7%) of them said ECT and 19 (43.2%) of them said combination of A and B (Psychosocial interventions plus antidepressant). Table 5 below indicate.

**Table5: Distribution of prescribers according to their preference for treatment of severe depression.**

| prescribers preference for treatment of severe depression | No. of prescribers | Percent |
|---|---|---|
| **ECT** | 21 | 47.7% |
| Psychosocial interventions plus antidepressant | 19 | 43.2% |
| Antidepressants | 4 | 9.1% |
| **Total** | 44 | 100% |

When they were asked about their preference for treatment of resistant depression, 40.9% said augmentation of an antidepressant with the atypical antipsychotic where as 27.3% said trial of another agent (i.e., switching to another antidepressant) as shown in table 6 below.

**Table6: Distribution of prescribers according to their preference for treatment of resistant depression.**

| Prescribers preference In the treatment of resistant depression | No. of prescribers | Percent |
|---|---|---|
| Augmentation of an antidepressant with the atypical antipsychotic | 18 | 40.9% |
| Trial of another agent (i.e., switching) | 12 | 27.3% |
| Augmentation of an antidepressant with antidepressant | 7 | 15.9% |
| Other (ECT) | 3 | 6.8% |
| Augmentation of an antidepressant with a benzodiazepine | 2 | 4.5% |
| Others (No answer) | 2 | 4.5% |
| **Total** | 44 | 100% |

When they were asked that in which case do they recommend lifelong maintenance therapy, 29 (65.9%) of them said they recommend it to patient of any age with three or more prior episodes, whereas 11 (25%) said to persons younger than 40 years with 2 or more prior episodes. Tables 7 classify more.

**Table 7: Distribution of prescribers according to In which case you recommend lifelong maintenance therapy.**

| In which case prescriber recommend lifelong maintenance therapy | No. of prescribers | Percent |
|---|---|---|
| patient of any age with three or more prior episodes | 29 | 65.9% |
| persons younger than 40 years with two or more prior episodes | 11 | 25% |
| Patient with one episode but sever symptoms | 4 | 9.1% |
| **Total** | 44 | 100% |

When they were asked about the group of antidepressant that they prefer in case of depression with suicidal ideation, 36 (81.8%) of them said SSRI, whereas 5 (11.4%) said ECT. Table 8 below gives more details.

**Table 8: Distribution of prescribers included in the study according to their preference in case of depression with suicidal ideation.**

| Prescribers preference in case of depression with suicidal ideation | No. of prescribers | Percent |
|---|---|---|
| SSRI | 36 | 81.8% |
| ECT | 5 | 11.4% |
| No answer | 2 | 4.5% |
| TCA | 1 | 2.3% |
| **Total** | 44 | 100% |

When they were asked what group of antidepressant that they prefer in case of depression with narrow angle glaucoma, 30 (68.2%) of them said SSRI, whereas 10 (22.7%) gave no answers as indicated by table 9 below.

**Table 9: Distribution of prescribers according to preferred antidepressant group in case of depression with narrow- angle glaucoma.**

| The group of antidepressant prescribers prefer in case of depression with narrow- angle glaucoma | No. of prescribers | Percent |
|---|---|---|
| SSRI | 30 | 68.2% |
| no answer | 10 | 22.7% |
| TCA | 3 | 6.8% |
| SNRI | 1 | 2.3% |
| **Total** | 44 | 100% |

When they were asked if they have local guideline for management of depression, all of them said no. When they were asked what group of antidepressant do they prefer in case of depression with anxiety disorders, 33 (75%) of them said SSRI whereas 6 (13.6%) said SNRI, as shown on table 10 below.

**Table 10: Distribution of prescribers according to the group of antidepressant they prefer in case of depression with anxiety disorders.**

| The group of antidepressant prescribers prefer in case of depression with anxiety disorders? | No. of prescribers | Percent |
|---|---|---|
| SSRI | 33 | 75% |
| SNRI | 6 | 13.6% |
| TCA | 5 | 11.4% |
| **Total** | 44 | 100% |

When they were asked do they do pretreatment ECG before starting TCA therapy, all of them said no.

When the respondents were given a number of antidepressant and asked which are they prefer in case of pregnant women with depression, 36 (84.1%) of them said SSRI, whereas 5 (9.1%) said SNRI. Table 11 classifies more.

**Table 11: Distribution of prescribers included in the study according to their preference in case of pregnant women with depression.**

| Prescriber's preference in case of pregnant women with depression? | No. of prescribers | Percent |
|---|---|---|
| SSRI | 37 | 84.1% |
| SNRI | 4 | 9.1% |
| no answer | 2 | 4.5% |
| TCA | 1 | 2.3% |
| **Total** | 44 | 100% |

## Discussion

It has been stated previously that the major objective of this study was to describe the current prescribing practices in the treatment of clinical depression at Taha Baasher's teaching psychiatric hospital.

The study involved 44 doctors. Female doctors were dominant (59.1%). Medical officers constituted almost the highest number of health care givers 46 % of the total number of the participants (n=44) whereas Medical assistant constituted the lowest number 4.5%.

Effectiveness was found to be the most important criteria in selecting antidepressants as mentioned by 52.3% of the participants , 18.20% of participants said that the most important criteria in selecting antidepressants was consultants experiences. Presenting symptoms were the most common factors influencing the choice of antidepressant as mentioned by 93.2% of the study subjects .

SSRI was the most common first line preference in the treatment of depression mentioned by 95.5% of the participants , The SSRIs were probably the drug class

of choice because the side effects are better tolerated than the older drugs, there is better patient compliance with once a day dosing and the suicide potential is low, as study done in tertiary hospital in Malaysia mathcalagan [12] which revealed that SSRI group was found to be the most widely utilized antidepressants. 25 (56.8%) of the respondents vary routinely the treatment strategies for management of depression according to personal characteristics or depression subtype and this findings were inconsistent with NICE clinical guideline 90(2009) [8] as there is no convincing evidence to support such action.

Combination of Psychosocial interventions plus antidepressants was found to be the most common preference of treatment of mild depression as mentioned by 54.5% of the respondents ,but the NICE clinical guideline 90(2009) [8]clearly states that do not uses antidepressants routinely to treat mild depression because the risk–benefit ratio is poor, firstly start with psychosocial interventions (CBT, CCBT or structured group physical activity program) if not respond then start antidepressants.

ECT and combination of Psychosocial interventions plus antidepressants were the most common preference for treatment of severe depression as mentioned by 47.7% and 43.2% of the participants respectively, where this finding is consistent with the NICE clinical guideline 90(2009) [8]which states that ECT is an option for management of severe depression .

Almost 66% of the respondents mentioned that they recommend lifelong maintenance therapy for patient of any age with 3 or more prior episodes, so this finding is consistent with Patricia[5] because those patients at greatest

risk for recurrence so they need maintenance therapy .

All the prescribers predominantly they preferred SSRI in case of depression with suicidal ideation, narrow- angle glaucoma or anxiety disorders as by (81.8%), (68.2%) and (75%) respectively. in case of suicidal ideation with depression 11.4% of the respondents preferred ECT the interpretation is that antidepressants can increase the risk of suicide whereas ECT is safe and effective treatment for major depressive disorder.

Worth mentioning medical assistants gave no answer for allot of questions and this reflect their poor knowledge about the use of antidepressants. The respondent has no local guide lines for management of depression . A noteworthy finding is none of the study subjects was found to be doing pretreatment ECG before starting TCA therapy which is correct practice .SSRI was preferred by almost 82% of the participant in case of pregnant women with depression and this finding was consistent with Patricia[5] which said no major teratogenic effects have been identified with the SSRIs or TCAs, However, evaluations to date suggest a possible association of fluoxetine with low birth weight and respiratory distress. Another study reported a six fold greater likelihood of the occurrence of persistent pulmonary hypertension of newborn infants exposed to an SSRI after the twentieth week of gestation.

## Conclusion

This study has shed much light on prescribing practices in the treatment of clinical depression at Taha Baasher's Teaching Psychiatric Hospital. Effectiveness was found to be the most important criterion in the selection of antidepressants; also presenting symptoms was

found to be the most common factor that influences the choice of antidepressants among the prescribers. Also this study found that Use of SSRIs were in majority of patients, this is similar to the antidepressants prescription pattern being practiced worldwide. All the prescribers predominantly preferred SSRI in case of depression with suicidal ideation, narrow- angle glaucoma or anxiety disorders. The study was found that no one of the prescribers do pretreatment ECG before starting TCA. There was no local guideline for management of depression. Studying the prescription patterns help the mental health professionals in understanding how the available drugs can be best put to use practically and this study too was a step in that direction

## RECOMMENDATIONS

- To develop local guidelines relevant to our community.
- To educate the prescribers to follow the guidelines.
- To restrict the prescription of antidepressants to medically qualified prescribers.
- We recommend that further studies need to be conducted.
- We recommend also the presence of clinical pharmacist in hospital.

Such measures will promote the rational use of medicines also the cost of therapy and ultimately, the quality of healthcare.

## Acknowledgment

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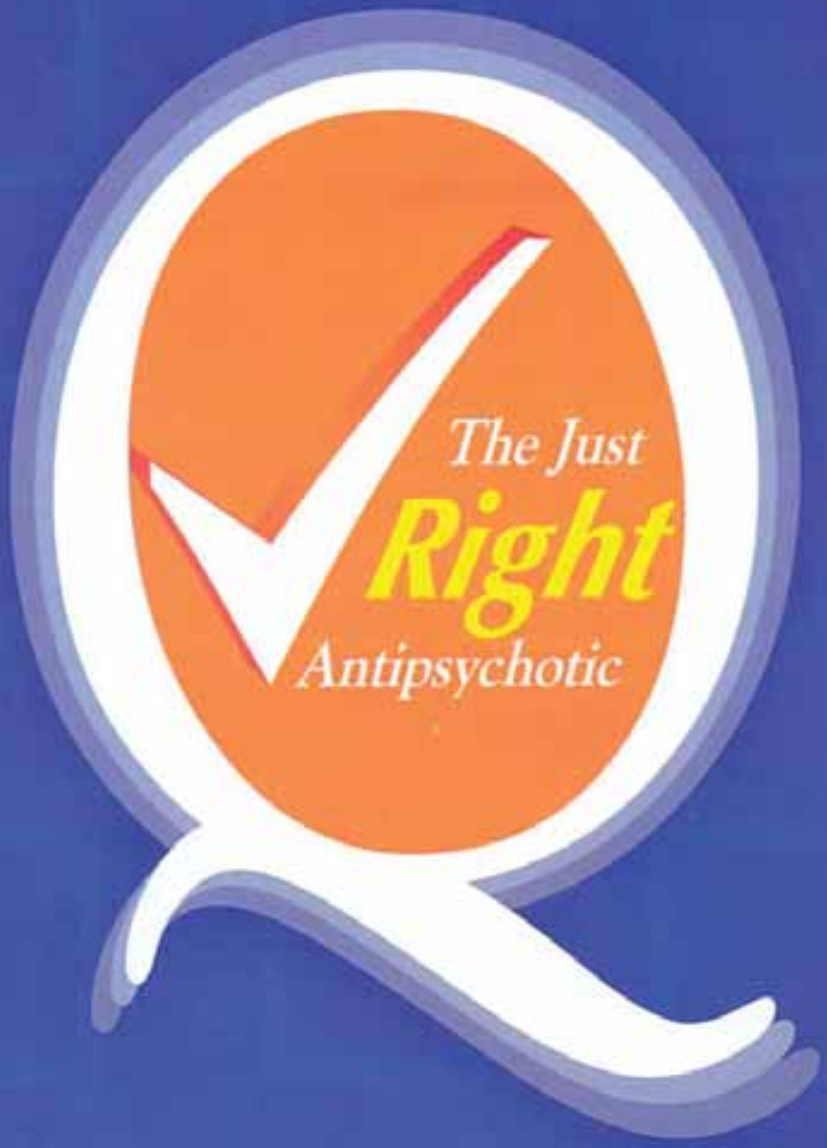


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