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Journal of Psychology And Psychiatry Research

Original Research Article

Mood Disorders and Adolescence: Aspects Epidemiological and Clinical in the Service of Psychiatry Donka National Hospital Chu Conakry

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Abstract

The mood disorders in adolescence are pathologies in which the fundamental disturbance is a change of mood in the sense of elation, decreased or alternating between the two (2). The general objective of this study was to determine the frequency of mood disorders in adolescents.

This is a retrospective cross-sectional descriptive type of study in the hospital psychiatric ward National Donka Hospital in Conakry over a period of 4 years (from 1 January 2011 to 30 November 2014 inclusive) were included in this study all adolescents 10-19ans, of both sexes and regardless of their origin.

This study involved 1199 adolescents with mood disorders a frequency of 68.7% with a female predominance 63.1% and a sex ratio of 0.58. Le secondary level was the most affected. Depression was the type of disorder the most predominant mood and more substance use provider. Mood disorders deserve special attention because they sound focus primarily on educational and adolescent behavior.

Keywords: Mood disorders, Epidemiological, Clinical, Teenager

INTRODUCTION

Adolescence is a stage of personal development nowadays between the ages of 10 and 19, the duration of which varies according to the times, cultures and history of each society [1].

It is not only a stage where changes, psychological, physiological and behavioral, but also a period of psychological fragility makes the bed of several psychopathological disorders including mood disorders in the first place which are represented by the episode manic, depressive episode, bipolar disorder, dysthymia and cyclothymia [2].

Mood disorders in adolescence are pathologies in which the fundamental disturbance is the change of mood in the direction of an elation, a decrease or alternation between the two [3].

In general, some of these mood disorders are more common in girls than boys and tend to intensify with age [4].

Mood disorders have consequences that can lead to a drop in school level, poor family or friendships and an increased risk of psychoactive substance use and suicide [5].

The frequency of different types of mood disorders is variously appreciated in adolescence, certainly due to the atypical character of their symptomatology at this time [6].

In mood disorders several evolutionary modalities can be noted, the suicidal risk in major depressive states, the change in mood more often seen during treatment.

The frequency of depression in adolescence has long been underestimated, which raises from the outset the question of recognition/ignorance of mental suffering in general and in young subjects in particular; it turns out to be excessively variable depending on the definition criteria used: Thus, it ranges from 5% for major depressive states to 30% if one integrates more extensive depressive symptoms. Note that at this stage of life there is a predominance of female disorders [7].

The most recent data show that the prevalence of bipolar disorder is 1% in the general population [8] and that bipolar disorder begins in adolescence in 30% of cases before the age of 20 years [9]. In France, Marcelli [10] reported a frequency of 40% of adolescent depression cases. In Germany, the prevalence of mania varies between 10-15% and 13% in Brazil [11]. In Haiti Mario [12] reported a 50% incidence of depression among adolescents with disabilities. In Africa, many authors are interested in the question. In the Democratic Republic of Congo, manic access represents 50% of cases of psychiatric hospitalization [13]. In Guinea, Doukoure [14-16] reported a 43.03% depression rate for adolescents in 2006 and

Received: *January 25, 2022;* ***Revised:*** *February 22, 2022;* ***Accepted:*** *February 28, 2022*

Citation: Doukouré M, Keita MM, Soumaoro K, Solo C & Maminata C. (2022) Mood Disorders and Adolescence: Aspects Epidemiological and Clinical in the Service of Psychiatry Donka National Hospital Chu Conakry J Psychol Psychiatr Res, 1(1): 1-5.

a 6.6% rate of mania in 2007 and 36.20% for adolescents with mood disorders. The high frequency of mood disorders in adolescents, their diagnostic difficulties, especially the cyclothymic and dysthymic forms motivated the choice of this theme: Mood disorders and adolescence, epidemiological and clinical aspects at the psychiatric ward Donka Chu National Hospital of Conakry.

Our objectives for this study were:

1. To determine the frequency of mood disorders in adolescents.
2. To write the socio demographic characteristics.
3. To identify risk factors for mood disorders.
4. To identify types of mood disorders.

MATERIALS AND METHODS

Our study was conducted in the psychiatric ward of Donka National Hospital, Conakry University Hospital. This service has a capacity of sixty-four (64) beds managed by a team composed of an associate lecturer of child psychiatry, a master assistant, 11 doctors, 05 specialists 06 nurses and 5 surface technicians. It is divided into 3 pavilions A, B, C. This is the only psychiatric service in the country that provides care for mental disorders and behavior, including cases of addiction. It has a triple vocation: care, training and research.

Our study focused on adolescents with mood disorders. Served as support for the realization of this work: patient records; hospitalization and consultation records and a data collector card.

This was a descriptive cross-sectional retrospective study lasting 4 years from January 1, 2011 to November 30, 2014, inclusive, whose target population consisted of all the adolescents admitted to the service (hospitalized or followed up by outpatients) diagnosed with mood disorders in any form.

Our sampling was exhaustive and we have in this study all adolescents aged 10 and 19, of all sex, hospitalized or outpatient regardless of their origin, in whom the diagnosis of mood disorder was made according to the ICD-10 diagnostic criteria and having a correctly completed file.

Ethically, the various information collected in the files was kept in anonymity in order to keep the study confidential.

We conducted a manual tabulation of our data (records, records and data collection records) and the results were presented in tabular, graphical and figure format, discussed commented on current literature data, and entered using a computer with Microsoft Office 2007 software.

Our limits: In this research work, we have been confronted with constraints such as the incomplete filling of medical files, the absence of certain important data in the files such as the level of education.

RESULTS

This study involved 1199 adolescents with mood disorders, with a frequency of 68.7% of cases. In 31.3% of cases of other diseases, a predominance of female gender was noted (63.1%). and a sex ratio of 0.58. The secondary level was the most affected (62.9% secondary and 27.4% primary). Depression was the most prominent type of mood disorder (50.2%) and the highest provider of psychoactive substance use (74.9% of cases).

DISCUSSION

During the study period, 1746 adolescents were seen in consultation among which 1199 cases of mood disorders were diagnosed with a hospital frequency of 68.7%. Doukoure [16] reported in their study of 846 adolescents, 306 cases of mood disorders in 2007, a frequency of 36.20%. Halfon [40] reported in their study of a small sample of adolescents a frequency of 85.71% of mood disorders. This high frequency of mood disorders could be explained by the fact that adolescence constitutes a great period of psychological fragility during which the majority of psychopathological disorders begin, including mood disorders in the first place.

The age of our patients was between 10 -19 years old. All age groups were affected, with a predominance of the age group 17-19 years 58.3% followed by the age group 14-16 years or 33.2%. This high frequency in the 17-19 age group may be explained by the fact that there is an increase in the risk factors for mood disorders for the elderly. Many authors agree that the incidence of mood disorders increases after puberty [41]. The majority of our patients 58.8% had a time greater than or equal to 1 month against 41.2% who had set a time less than or equal to 1 month before the first psychiatric consultation. This high rate of time before the consultation could be explained by the fact that the majority of our patients had depressive episodes that are most often seen in consultation after several weeks or months after the onset of first symptoms on the other hand, after failure of traditional treatment. A difference emerges in adolescence between girls and boys in the manifestation of mood disorders. The study population is predominantly female 63.1% with a sex ratio 0.58. In 1996, Durif [42] reported in their study a female predominance of 31%. This female predominance could be explained by the interplay of several factors (genetic, hormonal, socio-cultural and psycho-emotional). For Graber and Petersen [43,44], body changes related to image and self-esteem, changing social relationships, broken friendships, or more difficult family relationships are experienced more girls have a negative tendency to mull over boys. The majority of the study population 56.4% came from the city of Conakry followed by 26.9% of patients from Lower Guinea. This high rate of our patients coming from the city of Conakry could be explained by the existence of the psychiatric service in the city of Conakry. The majority of the study population evolved in the formal training sector 66.4%, followed by the informal sector that is 16.8%.

This result is comparable to that of Doukoure [16] who reported a rate of 61%. This predominance of adolescents in the formal training sector could be explained by the precarious financial situation of this layer and the difficulties of attentions and concentrations that constitute a source of stress and / or the factors that trigger these disorders mood.

The vast majority of the study population 62.9% had at least the secondary level. This high level of secondary schooling is explained by the fact that mood disorders have a particular impact on schooling via concentration difficulties, the inhibition or the need for investment in schooling and especially the declining schooling which contributes to aggravate the personal misunderstanding and thus becomes a depressogenic risk factor.

Patients in the study population are predominantly from a polygamous home 47.2%. This could be explained by the existence of socio-economic and relational problems. In addition, poor family cohesion is an additional risk factor for depressive episodes [45].

We found that the vast majority of the study population 95.6% were single, although early marriage is a practice in Guinean society. This high frequency is explained by their psychological predisposition on the one hand and by the early age of onset of the first episode. The reasons for consultation noted in our study are those described by some authors [46-49]. The most common reasons for consultation were insomnia, behavioral disorders, anxiety, headache, fear, decline in academic performance, forgetfulness, fatigue, psychomotor agitation, psychomotor instability, hyper syntonia and logorrhea. These different reasons for consultation constitute a source of suffering for the entourage and for the child on the one hand, and on the other hand considered by the entourage as a caprice generating punishments. It is difficult for the adult to conceive and accept that a child may be depressed, which seems to oppose the social representation of carelessness and happiness that the child usually conveys [50]. Depression was the most predominant type of disorder at 50.2% followed by mania 35%. This could be explained by the fact that adolescence is a period of psychological fragility. For some authors [25, 41, 51, 52] disorders begin in adolescence with a depressive episode in 32 to 75% of cases. The vast majority of the study population 52% had used one or more psychoactive substances compared to 48% who had not used. As some authors [9, 8] found that depression was the largest provider of substance use in 35.2% against 13.4% during mania and 3.4% in bipolar disorder. This result is consistent with some data from the literature [5, 53].

This could be explained by the fact that adolescents often use psychoactive substances during mood disorders to manage their anxieties or overcome negative feelings. The Indian hemp + tobacco + alcohol association was the most represented 17.2% followed by Indian hemp 10.8%. Yu [54] reported a rate of 10% that associated alcohol, tobacco and hemp during mood disorders. In the majority of cases, 52% of adolescents had used one or more psychoactive substances compared to 48% of adolescents who did not consumed. This finding is consistent with some data from the literature [5, 52]. Yu [54] reported a rate of 10% that associated alcohol, tobacco and drugs during mania. In our study, the association + alcohol + hemp + tobacco was the most popular, 17.2% followed by hemp 10.8%.

This high rate of consumption of these psychoactive substances could be explained by their anxiolytic and antidepressant effect on the one hand, and by the availability, easy access and affordable cost of these psychoactive substances. Half of our patients 50.6% had no previous psychiatric history followed by those with a personal psychiatric history 27.6%. This high rate of no personal history could be explained by the fact that half of our patients were on their first psychiatric decompensating. As for the scarcity of psychiatric family history of the first or second degree, it is due on the one hand, by the lack of knowledge of psychic disorders as such, difficult to report on the other hand by the adverse prejudices relating to mental disorders that often lead to the family of patients to deny the existence of such disorders within them because of the negative image they convey.

In our study family conflict and illness were the most prominent triggers with respectively 34.2% and 23.8% of cases against 10.6% of no triggers.

This observation is comparable to that of Bowlby [55] and Baron [56]. In general, adolescents are very sensitive to changes in the home environment and any level of disruption may favor the occurrence of psychological disorders such as mood disorders.

The vast majority of adolescents lived with both parents 79.6% followed by those living with other people 11% this is explained by the fact that adolescents living with their two parents are under more pressure on the one hand. On the other hand, by a parental relationship, disturbed intrafamilial dynamics.

The majority of adolescents were referred by parents 71.1% followed by other people 18.3% this would be explained by behavioral disorders, insomnia, fatigue, psychomotor agitation, forgetfulness, nervousness and decline in school performance, observed by parents.

CONCLUSION

The frequency of different types of mood disorders is variously appreciated in adolescence, because of the atypical character of their symptomatology at this time. These mood disorders are more common in girls than boys and tend to intensify with age. The risk factors are multiple, dominated by the conflict of status or with the entourage, the illness and the consumption of the psychoactive substances. Depression and mania were the most common mood disorders. Insomnia,

behavioral disorder, decreased performance, anxiety and headache were the most common reasons for consultation.

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