CASE STUDY

Childhood Depression: About 40 Cases Treated in the Child Psychiatry Unit of the Psychiatric Department of Conakry

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Abstract

Background:
In this study we sought to determine the prevalence of depression in children, identify the contributing factors, the clinical signs and describe the various therapeutic behaviors

Methods:
It is a retrospective, descriptive and transversal study of ten years duration (from January 1, 2009 to December 31, 2019). It focused on 40 cases of depression in children aged from 1 to 12 years old and whose files included the different parameters of our study.

Results:
The prevalence of depression was 10.25%. The 20 cases collected were between 6 and 12 years old, 60% were male and 70% were referred by the nursing staff. The symptomatology described in the literature has been found in the majority of our patients. Ambulatory follow-up was the most predominant follow-up method, 95%; the combination of drug therapy and psychotherapy was the most used type of treatment, equivalent to 85%. The evolution was marked by complete remission (95%) of the symptomatology.

Depression is a psychopathological disorder whose consequences are numerous, often identified at the relational and school level. This clinical reality is still unknown by the majority of the population and even by the Guinean medical community.

Conclusion
An awareness work on psychopathological disorders in children in general and depression in particular would be necessary.

Keywords: Depression, Child, Prevalence, Conakry

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INTRODUCTION

Childhood depression is a psychopathological disorder that has long been denied in its very existence. The causes of this ignorance are multiple. It is indeed difficult to find in a child, symptoms similar to those encountered in adult depression. In addition, the polymorphism of the de-
pressive symptomatology of the child contributes to mask, under the appearance of various symptoms the existence of the depressive suffering (1).

Finally, it is difficult for an adult to conceive and accept that a child can be depressed, which seems to oppose the social representation of carelessness and happiness, that the child usually conveys (2).

However, the way parents often invest their child as a representative of their ideal ego makes this child, in the parental imagination, inaccessible to the depressive suffering that they themselves may have experienced.

So every child remains a projection of himself (3) It is a mood disorder that has been the subject of much research.

This undoubtedly explains why it was not until the 1950, with especially the work of J. Cambell (4) and particularly that of J. Sandler (5) and Valla JP, Bergeron I (6) in order to recognize the reality of depression in children.

Currently, several facts seem irrefutable because if the existence of depression in children is certain, its clinical expression varies according to the age, the degree of emotional and cognitive maturation of the child, as well as the correlative degree of differentiation of his physical apparatus. This pathology is rarely expressed in the same way as that of adults. The symptomatology is misleading and polymorphphic, but sadness is most often the central affect, although often hidden. However, bouts of sadness depending on the various moments in the child’s life are part of normal emotional states, but we cannot speak of depression.

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This sadness in childhood depression is still felt by the subject in a significant, continuous and intense way, although it is only rarely, fairly and clearly verbalized. In addition to this sadness, certain symptoms accompany depressive affects which sometimes mask them paradoxically, often identified by those around them and lead the child to the consultation.

Among these symptoms there are: behavioral disorders which are often in the foreground, causing attitudes of extreme agitation, instability with very frequent aggressive manifestations (these states of agitation are sometimes accompanied by excitement of euphoric or even logorrhea) (7); the intellectual inhibition which manifests itself both in the gestural and verbal domain giving the child an attitude of weariness, poor expression, indifference or even pseudo debility with difficulties in maintaining attention and concentration, difficulties which have a rapid impact on schooling, especially during the learning period (large section, kindergarten, CP and CE1) leading to avoidance or refusal of school work, readily called "laziness" by the parents but also by the child himself leading to school failure; the games: in the depressed child, there is a difficulty to invest the games and in general all the activities which could be for him source of pleasure; the attitudes of withdrawal, disinterest, passivity which are accompanied by feelings of rejection and isolation but also of an emotional quest and the somatic disorders which also contribute to masking the depressive element, these are disorders of falling asleep, waking up at night, anorexia or bulimia, enuresis or encopresis (8).

The prevalence of depressive states in children is variously assessed according to authors. The most recent studies estimate it between 0.5 and 2 to 3% of the general population (9). In France, Dugas and Mouren estimated 2.5% the prevalence of depression among 1 725 subjects under the age of 13 examined in their department (10).

Despite this, statistical data in Africa are relatively scarce and we have little information. In Guinea, no study has been carried out on this condition, hence this study, whose objectives were to determine the prevalence of this condition, identify the contributing
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factors and clinical signs and describe the various therapeutic behaviors.

2 | METHODOLOGY:

Our study was carried out in the Child Psychiatry Unit, whose consultation activities began in July 1999 in the Psychiatry Department of the Donka National Hospital, University Teaching Hospital of Conakry. This Department dates from March 17, 1959.

It is a retrospective, transversal and descriptive study of ten years duration from January 1, 2009 to December 31, 2019. It covered all the files of children aged from 1 to 12 years seen in consultation during the study period in which the diagnosis of depression was made. Data were collected from clinical files of patients and consultation register. During this study period, 40 cases of depression were identified and included in our study, all the files of children aged 1 to 12 years seen in consultation in the Department during the study period in which the diagnosis of depression was accepted and whose files included the different parameters of our study.

The data collection sheet included two sections:
- The first section concerned the child (sex, source of orientation, accompanying person, symptoms, follow-up methods, type of drug treatment, frequency, age, and triggering circumstances).
- The second section concerned the parents (the marital status of the parents, the socio-professional category of the father, the educational level of both parents).

3 | RESULTS:

During this study period the prevalence of depression was 10.25%. The 6–12 age group was the most affected, 89% of the cases compared to 11% for those under 6. Boys made up 60% while girls made up 40%.

Regarding the parents’ marital status, the vast majority was married (85% of the cases). As for the socio-professional category of fathers, they worked in the formal sector in 70% of the cases, followed by those who worked in the informal sector, in formal training and those without an occupation (10% for each). In 80% of our patients, mothers did not have any level of education versus 15% of fathers (see Table 1).

| Education level      | Father % | Mother % |
|----------------------|----------|----------|
| With no education    | 15       | 80       |
| Primary education    | 10       | 10       |
| Secondary education  | 15       | 5        |
| Higher education     | 60       | 5        |
| Total                | 100      | 100      |

In 60% of the cases, they were the ones who accompanied children in consultation against 5% by both parents, 20% by the father and 15% by other family members. Health personnel were the first source of referral to child psychiatric consultation (70%). (See Table 2)

| Orientation sources | Number of cases | %  |
|---------------------|-----------------|----|
| Parents             | 10              | 25 |
| Health personnel    | 28              | 70 |
| Knowledge           | 2               | 5  |
| Total               | 40              | 100|

The existence of mental pathologies and / or conduct disorders in the parents, dysfunction of the family dynamics were the most represented triggering circumstances, respectively 30% and 25% and these triggering factors were often associated in the same patient. (See Table 3).

As for the symptoms, the sadness of the mood, sleep disturbances (difficulty of falling asleep, night awakenings, nightmares and morning awakenings ...), instability, the search for punishment, easy crying, forgetfulness and / or loss of objects, the no, the drop in attention and concentration, the provocations and aggressiveness and the disinterest were noted in 100% of the cases. In 90% of the cases we noted headache, tiredness, anxiety and anorexia. In 50% of the cases, there were feelings of abandonment, guilt of thefts, games with the little ones, accidents and injuries and endangerment. Bedwetting and loss of
self-esteem were found in 40%. Ambulatory follow-up was the most predominant follow-up modality equivalent to 95%. The combination of drug therapy and psychotherapy was the most used type of treatment 95% of the cases compared to 5% of psychotherapy only. Tricyclic antidepressants were the most used drugs 90%. In 90% of the cases, the course of treatment was marked by complete remission after two months of treatment on average.

The majority of parents (89%) did not know what depression is and 100% in total, they never imagined that a child could suffer from depression.

4 | DISCUSSION:

During the study period 390 children were consulted among which 40 cases of depression were diagnosed, representing a prevalence of 10.25%. For KOLVIN et al. (11) the frequency of childhood depression in the clinical population (meaning children consultant and admitted) is higher, reaching 20 to 25%. Dugas and Mouren (10) estimated the prevalence of depression at 2.5%.

Our entire sample was between 6 and 12 years old, or 100% of the cases.

The high rate in this age group could be explained by the fact that it corresponds to school age, because education constitutes a situation through which one succeeds in detecting a good number of signs in the majority of cases of depression of children and teenagers.

In terms of sex, the two sexes were affected with a male predominance, 60% against 40% of the female sex with a sex ratio of Boys / Girls equal to 1.5. Mc Gee et al. (12) reported a male predominance in children. For Beads Lee et al. (13) before puberty, boys and girls share an equal risk for depression. However, according to Klerman et al. (14) at puberty, this trend would give way to a gradual increase in risk in the female sex, leading to a sex ratio of two women for a man in adulthood.

The majority of our patients’ parents were married, 85%. This high frequency in children whose parents are married could be explained by the very high marriage rate and that the marriage bond is not only a protective factor since difficulties in the couple can constitute a risk factor for childhood depression. The majority of the mothers of our patients were uneducated, equivalent to 80% without finding a relation between the level of education of the mother and the infant depression apart from the fact that the rate of illiteracy in the female population in Guinea is important (15) in one hand and on the other hand when the mother is of a low level of education, this can contribute to a delay of consultation or to not spotting the consequences of the symptomatology of childhood depression because in the social distribution of work it is the father who is responsible for ensuring the material needs of the family and the mother for the care and education of the children.

Most of the children were oriented by the health staff, 70%. This high frequency of orientation of patients in the department by the health personnel is explained by the fact that it represents the group to be consulted as a first line as soon as symptoms appear, especially after the failure of traditional treatment.

In our study, 60% of patients were accompanied by their mothers. This high proportion of support for patients by their mothers is explained by the role that the mother plays in interactions, when we know that it is her responsibility to constantly ensure the safety of the child and to appease his/her Internal temptations (hunger for example).
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In the majority of the cases, we noted triggering circumstances among which: separations, existence of mental pathologies and / or conduct disorders at the parents, the dysfunction of the family dynamics were the most predominant with respectively 30% and 25% of the cases.

This finding is consistent with that of Bowlby J. (16). In general, children are very sensitive to changes in the family environment and whose disruption of this network can promote the occurrence of psychopathological disorders such as depression.

The symptomatology noted in our work is that described by several authors (17–20). The most predominant symptoms were: sadness, sleep disturbances (difficulty falling asleep, nightmares, night awakenings), psychomotor instability, opposing attitudes, seeking punishment, easy crying, forgetfulness and / or loss of tools, the no, drop in attention –concentration, drop in school performance, aggressive and / or provocative attitudes, disinterest. These various symptoms are very often considered by those around them as a whim leading to punishment. It is difficult for adults to conceive and accept that a child can be depressed, which seems to oppose the social representation of carelessness and happiness that childhood usually conveys (2).

Children were followed on an ambulatory basis in the majority of cases, 95% versus 5% hospitalization. This high frequency of ambulatory follow-up is explained by the fact that it is, in one hand, an adult service and on the other hand by the fact that after all information, family structures assisted themselves to the follow-up on an ambulatory basis.

The children benefited from drug treatment and psychotherapy, equivalent to 95%.

This high rate of use of antidepressant and psychotherapy treatment could be explained by the fact that children are seen in a situation where drug treatment was essential given the intensity and consequences of the depressive episode. This is usually a short-term drug treatment not exceeding three months. Tricyclic antidepressant including amitriptyline has been the only antidepressant used because only tricyclics have a Marketing Authorization (AMM) for depression of children.

5 | CONCLUSION:

Depression is a well individualized psychiatric disorder in children; its prevalence is variously assessed according to the authors. In this clinical study, it occupies the second place in the department’s child psychiatry consultation activities. The symptomatology is polymorphic, often misleading and identical to that described in the literature. As the majority of psychopathological disorders, boys were the most affected, ambulatory treatment was the basis of the treatment modalities and tricyclic antidepressants, in this case, amitriptyline were the main treatment. Remission was complete in the majority after three months of treatment. Depression is a psychopathological disorder whose consequences are numerous, often identified at the relational and school level. An awareness work on psychopathological disorders in children in general and depression in particular would be necessary.

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