Mood Disorders and Trauma – What are the Associations?

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Et al.
Objectives

- To characterize the relationship between childhood trauma/abuse and mood disorder symptoms, and between childhood trauma/abuse and pediatric bipolar disorder (BD).
- To describe the clinical correlates and demographics of children with trauma/abuse and comorbid mood disorders in a community mental health setting.
- To explore associations between the diagnosis of BD in youth with histories of trauma and the presence of specific symptom clusters.
- The presence of pretnaoma mood symptoms.

Background

- Mood dysregulation in traumatized children may be misdiagnosed as bipolar disorder (BD) and conversely, the diagnosis of BD overlooked.
- Such distinctions may be especially important among individuals with BD given the disproportionate high prevalence of childhood trauma histories (reported in about half of adult patients with BD, across several studies) coupled with frequent pretrauma onset of affective symptoms (1-4), significantly younger age at bipolar illness onset, as well as higher severity level of symptoms (3).
- Findings indicate that prepubertal and early adolescent BD is as well as adult BD I share the same diagnosis, with seven to eight times greater familiality in child versus adult BD (5), suggesting that family history of BD and first degree relatives is more common in children with BD.
- Not all traumatized children develop PTSD, and the consequences of trauma may vary.

Methods

- We are assessing youth ages 8-18 who present with mood symptoms and past trauma divided into two groups:
  1. Trauma Mood Disorder NOS (T+MD)
  2. Trauma-Modified DSM-IV TR BD (T+BD).
- Differences in clinical variables between groups are analyzed using t-tests for continuous and chi-square tests for categorical variables.
- Youth are evaluated using the following psychiatric rating scales:
  1. Structured Clinical Interview for DSM Disorders, Childhood Mood Disorder Form (KID-SCID) mood module to establish the diagnosis of BD.
  3. Childhood Trauma Questionnaire (CTQ).
  4. PTSD Checklist- Civilian Version (PCL-C).
  5. Attention Deficit Hyperactivity Disorder IV (ADHD-IV) Rating Scale.
  6. Substance Abuse (SA) screen: CRAFFT.
- Other information obtained includes:
  - Demographic characteristics and socioeconomic status.
  - Number of medications and types.
  - Percent of ever use of a history of psychiatric hospitalization or out of home placement.
  - Family history of psychiatric illnesses and substance use disorders.

Conclusions

- We are assessing youth ages 8-18 who present with mood symptoms and past trauma divided into two groups:
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Table of Family History: the number of first degree relatives with significant history. This could indicate the number of relatives who have at least one first degree relative with a possible history. The table includes the range of number of relatives with each symptom that contribute to a positive family history.

<table>
<thead>
<tr>
<th>Type of Trauma</th>
<th>Number of Incidents</th>
<th>T+MD</th>
<th>T+BD</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Violence</td>
<td>13 (12, 15)</td>
<td>12</td>
<td>14</td>
<td>0.16</td>
</tr>
<tr>
<td>Sexual assault</td>
<td>9 (8, 10)</td>
<td>10</td>
<td>9</td>
<td>0.21</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>7 (6, 8)</td>
<td>6</td>
<td>8</td>
<td>0.25</td>
</tr>
</tbody>
</table>

- Clinical presentations:
  - Mood Symptom:
    - BD-MD in BPRS total score (p=0.06). BPRS Manic subscale (p=0.05). YMRBS irritability (p=0.08).
    - BD-MD in total number of mood episodes identified with KID-SCID (p=0.001).
    - Mania (with high hostility value) (p=0.07).
  - Substance use:
    - No difference as assessed using CRAFT.
    - PTSD and trauma reoccurrence.
    - Differences in PTSD symptoms as assessed by PCL-C.
    - BD-MD abuse identified with CTQ.
    - Substance abuse (without high hostility value) (p=0.05).
    - Physical neglect (p=0.07).
  - Medications:
    - BD-MD 3.3 fewer medications (t=0.12, p=0.17).

References:

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