Mood Disorders and Trauma – What are the Associations?

Yael Dvir
University of Massachusetts Medical School

Et al.
Mood Disorders and Trauma – What are the Associations?

Yael Dvir M.D., Michael Hill B.S., Jean A Frazier M.D.
University of Massachusetts Medical School, Community Healthlink

Yael.Dvir@umassmed.edu, Michael.Hill@umassmed.edu, Jean.Frazier@umassmed.edu

Objectives

To characterize the relationship between childhood trauma/abuse, and mood dysregulation, 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 (a) a family history of BD, (b) the presence of specific symptom clusters, and (c) the presence of pretrauma 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 disproportionality high prevalence of childhood trauma among adult patients with BD, across several studies, coupled with frequent prepubertal onset of affective symptoms (1-4), significantly younger ages at bipolar illness onset, as well as higher severity of symptoms (5).

• Findings indicate that prepubertal and early adolescent BD is as well as adult BD I share the same diathesis, with seven to eight times greater familial risk as adults BD I (6), suggesting that a family history of BD in first degree relatives is more common in children with BD.

• Not all traumatized children develop PTSD, and the consequences of trauma may vary.

• DSM-5 proposed new mood disorder Disruptive Mood Dysregulation Disorder (6, 7): a direct result of the controversy surrounding the diagnosis of early onset BD, emphasizes the study of mood dysregulation that is comorbid with trauma/abuse.

• Such distinctions have important implications in terms of treatment approaches, biological markers and social/psychological factors.

• We expect that traumatized children who meet full criteria BD are more likely than children with MD-NOS to have: (a) family history of BD, (b) mood symptoms preceding trauma, and (c) specific neurovegetative symptom clusters.

Methods

We are assessing youths ages 8-18 who present with mood symptoms and past trauma divided into two groups:

• 1. Trauma Mood Disorder NOS (T-MD)
• 2. Trauma-Undiagnosed DSM-II-TR BD (T-BD).

• Differences in clinical variables between groups are analyzed using t-tests for continuous and chi-square tests for categorical variables on SPSS.

• In youth are evaluated using the following psychiatric rating scales:

- Structured Clinical Interview for DSM Disorders (KID-SIDC) mood module to establish the diagnosis of BD.
- Brief Psychiatric Rating Scale for Children (BPRS-C)
- Young Mania Rating Scale (YMRS)
- Children’s Depression Rating Scale Revised (CDRS-R)
- Childhood Trauma Questionnaire (CTQ)
- PTSD Checklist (Civilian Version) (PCL-C)
- Attention Deficit Hyperactivity Disorder IV (ADHD-IV) Rating Scale
- Substance Abuse (SA) Screen: CRAFT

• Other information obtained includes:

- Demographic characteristics and socioeconomic status
- Number of medications and types
- Percent with a history of psychiatric hospitalization and/ or home placement
- Family history of psychiatric illness and substance use disorders

Results

• Table of family history: the number of first degree relatives with significant history. This could indicate the number of siblings who have at least one first degree relative with a positive family history. The family entry is the the average number of relatives each subject cited as having a positive family history.

• Table of diagnosis: the number of those who meet criteria for each diagnosis of traumatic events and psychiatric diagnoses.

Table of family history: the number of first degree relatives with significant history. The number indicates the number of subjects who have at least one first degree relative with a positive family history. The family entry is the the average number of relatives each subject cited as having a positive family history.

<table>
<thead>
<tr>
<th>Family History</th>
<th>Total Number</th>
<th>Number of Siblings (Mean ± SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADD/ADHD</td>
<td>1.9 ± 1.5</td>
<td>0.9 ± 0.8</td>
</tr>
<tr>
<td>Anxiolytic</td>
<td>0.3 ± 0.7</td>
<td>0.7 ± 0.8</td>
</tr>
<tr>
<td>Depression</td>
<td>0.4 ± 0.6</td>
<td>0.8 ± 0.7</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>7.6 ± 1.0</td>
<td>0.6 ± 0.5</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>7.6 ± 1.0</td>
<td>0.6 ± 0.5</td>
</tr>
<tr>
<td>Bradyphrenia</td>
<td>0.4 ± 0.6</td>
<td>0.8 ± 0.7</td>
</tr>
<tr>
<td>Mania</td>
<td>7.6 ± 1.0</td>
<td>0.6 ± 0.5</td>
</tr>
<tr>
<td>Panic</td>
<td>0.4 ± 0.7</td>
<td>0.8 ± 0.8</td>
</tr>
<tr>
<td>PTSD</td>
<td>0.4 ± 0.7</td>
<td>0.8 ± 0.8</td>
</tr>
<tr>
<td>Trauma</td>
<td>7.6 ± 1.0</td>
<td>0.6 ± 0.5</td>
</tr>
<tr>
<td>Total Number</td>
<td>13.4 ± 9.7</td>
<td>6.4 ± 4.7</td>
</tr>
</tbody>
</table>

Conclusions

• Further data collection is ongoing to achieve our targeted sample size in order to identify clinical correlates in mood dysregulated, traumatized youth.

• This will promote future research aimed at identifying biomarkers and preventive interventions.

References