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Mood Disorders and Trauma – What are the Associations?

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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 family history of BD
- the presence of specific symptom clusters
- 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 disproportionate high prevalence of childhood trauma/abuse among adult patients with BD, across several studies, coupled with frequent prepubertal onset of affective symptoms (1.4, significantly younger age at bipolar illness onset, as well as higher severity of symptoms (3)).
- Findings indicate that prepubertal and early adolescent BD as well as adult BD I share the same diagnosis, with seven to eight times greater familiality in child versus adult 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.

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 Unmodified 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 on SUD.

Youth are evaluated using the following psychiatric rating scales:
1. Structured Clinical Interview for DSM Disorders, Childhood Disorders Form ( Kidd-SIDC ) mood module to establish the diagnosis of BD.
2. Brief Psychiatric Rating Scale for Children (BPRS-C)
3. Young Manic Rating Scale (YMRS)
4. Children’s Depression Rating Scale Revised (CDRS-R)
5. Childhood Trauma Questionnaire (CTQ)
6. PTSD Checklist, civilian version (PCL-C)
7. Attention Deficit Hyperactivity Disorder IV (ADHD-IV) Rating Scale
8. Substance Abuse, (UA) screen: CRAFT

Other information obtained includes:
- Demographic characteristics and socioeconomic status
- Number of medications and types
- Percent of youth with a previous history of hospitalization and/or out home placement
- Family history of psychiatric illness and substance use disorders

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• Table of family history: the number of first degree relatives with significant history. This could describe the number of relatives who have at least one first degree relative with a psychiatric history. The key indicates the average number of relatives each subject had that had either positive family history or a current diagnosis of a mood disorder.

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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


• Critical presentations:

• Mood Symptoms:

• BD+M in BPRS total score (p=0.06), BPRS Mania subscale (p=0.05), YMRB total score (p=0.05)

• BD+M in total number of mood episodes identified with KID-SID:

• 2 (p=0.14)

• Mania (with high outlying value) (p=0.07)

• Substance use:

• No difference as assessed using CRAFT

• PTSD and trauma recollection:

• No differences in PTSD symptoms as assessed by PCL-C

• BD+M abuse identified with CTQ

• Sexual abuse (without high outlying value) (p=0.05)

• Physical neglect (p=0.07)

• Medications:

• BD+M 3.3 fewer medications (t=11.9, p<0.01)