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Mental state of subjects diagnosed 15 years earlier (in childhood and/or adolescence) with depressive disorders

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The aim of the study was to assess the current mental status of subjects, who in childhood or adolescence were diagnosed with a depressive disorder. In adulthood, various mental disorders occurred in more than 1/2 of the subjects, especially mood disorders: recurrent major depression, dysthymia, bipolar affective disorder (in about 1/3 of subjects) and alcohol or other psychoactive substance abuse or dependence (in about 1/4 of subjects), with and without depressive disorders. Complex diagnosis: depressive disorders and personality disorders or depressive disorders and alcohol or psychoactive substance abuse or dependence, or depressive disorders and anxiety disorders, was made in about 1/6th of subjects. Adult mood disorders were noted in patients who in the past had various depressive disorders. In childhood, before occurrence of the first episode of depressive disorders, some of those patients had anxiety disorders, conduct disorders, specific learning disorders and/or ADHD.

Key words: depressive disorders, children and adolescents, evaluation after 15 years

Attempts made in the 1980-ies, aimed at the standardisation of the criteria for diagnosing mood disorders in children and adolescents, are still continued. At present most researchers agree, that depressive disorders should not be diagnosed in subjects of developmental age if there are no evident affective symptoms [1, 2, 3, 4, 5, 6, 7, 8], because there is no sufficient evidence which would allow to make such a diagnosis in children and adolescents, based only on the presence of the so called depression equivalents (e.g. abdominal pain, nocturia, aggressive behaviour), without depressed mood [9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30].

In the past 15 years, despite the earlier views, the prevalence of mood disorders, mostly major depression among adolescents, was found to be comparable with the prevalence of those disorders among adults (2–5%) [4, 31, 32, 33, 34, 35, 36, 37, 38, 39]. The fact of statistically significantly more prevalent depressive disorders in the last decade, as compared to the previous ones, in the developmental age subjects, may result from the better competence of doctors diagnosing those patients. Furthermore,

attempts to standardise the criteria for diagnosing those disorders are also important. Yet, we could not possibly deny that the prevalence of depressive disorders in children and adolescents is really increasing.

In the 1970-ies, in a well-known epidemiological study on children and adolescents – Isle of Wight – carried out by Rutter et al., symptoms of depression were found in 0.2% of those aged 10, and in 2% of those aged 14, and major depression (diagnosed according to the criteria adopted for adults) – in 1–2% of children before puberty and in 2–5% of adolescents. In over 50% of the subjects, comorbidity of mental disorders (mostly behavioural or anxiety disorders) was found. Similar results were obtained in the studies carried out in the 1980-ies and 1990-ies [11, 16, 28, 40, 41, 42, 43, 44, 45, 46, 47]. It was further demonstrated that most children and adolescents reached a complete remission of major depression, and the prevalence of deterioration and recurrences did not differ significantly from the data characterising the course of those disorders in adults. Also, only a minority of subjects who in childhood or adolescence were affected with major depression, later on undergo sub-maniac and maniac episodes, and the comorbidity of non-mood disorders increases the risk of the adverse course of depression. So far, reliable data on the prevalence of dysthymia in developmental period has been scarce. The studies carried out in Poland in the 1980-ies demonstrated that dysthymic disorders diagnosed according to DSM-III criteria constituted the most prevalent clinical manifestation of depressive disorders in children and adolescents [8, 27, 48].

Many medical practitioners and researchers diagnosing the depressive disorders of developmental age follow the principles of NIMH – National Institute of Mental Health of 1999. These demonstrate that the following symptoms of major depression occur in adults, adolescents and children:

- Chronic sadness or irritation
- Loss of willingness and interest in activities which so far have given pleasure
- Significant change of appetite or body weight
- Dyssomnia or excessive sleepiness
- Psychomotor retardation or agitation
- Loss of energy
- Sense of worthlessness or inadequate guilt
- Recurrent thoughts about death or suicide.

Admittedly, at least 5 of the above mentioned symptoms must persist for at least 2 weeks. It is assumed that the specific manifestation of depressive symptoms in children and adolescents encompasses: many variable nonspecific somatic complaints, e.g.headaches, muscular pain, gastric pain or fatigue, frequent absences at school, worse grades and school performance, outbreaks of shouts and complaints, incomprehensible irritation or crying, avoidance of effort, boredom, loss of interest in playing with other children, in adolescents – alcohol and drugs, social isolation, poor communication, fear of death, hypersensitivity to rejection, increased irritability, anger, hostility, difficulties in contacts with people, risky (dangerous, without considering

the consequences) behaviour [49].

All the above mentioned types of behaviour actually result from the presence of depressive symptoms, such as those in adults.

Still unclear are also the correlations between depressive disorders occurring in developmental age and those occurring in adulthood. Most of the prospective studies carried out so far in children and adolescents until their adulthood cover small groups, and several large-scale, mainly retrospective studies indicate that adults with diagnosed mood disorders suffered more frequently in childhood and adolescence from various forms of mood disorders and ADHD (attention deficit hyperactivity disorders), as compared to the general population [27, 50].

In the well-known study, The Oregon Adolescent Depression Project, carried out in the 1990-ies, the prevalence of mood and other disorders was evaluated in subjects aged from 19 to 24, who experienced major depression (261 persons) in puberty or exhibited adjustment disorders with depressive mood (73) and in those with other than mood disorders (133 subjects) and without mental disorders (272 subjects) [51]. It was established that the prevalence of recurrent major depression in those who in puberty suffered from major depression, adjustment disorders, other disorders and did not exhibit any symptoms of mental disorders, was as follows: 9.0% vs 5.6% vs 3.7% vs 0.9%, whereas the prevalence of dysthymia and bipolar disorders in the whole group was below 1.0% [3]. Furthermore, it was established that the prevalence of mood disorders was statistically significantly more frequent in those who suffered from depressive disorders in puberty.

My study was aimed at confirming the prevalence of mental disorders, especially mood disorders, in adult subjects, who 15 years earlier, in childhood or adolescence, were treated for depressive disorders, based on the data from systematic psychiatric observation of subjects – a prospective study and catamnesis related to their mental status.

Material

Mainly in the 1980-ies, 314 subjects aged 5-18 were qualified for the study. They were patients of the Mental Health Outpatient Clinic for Children and Adolescents in Łódź, Psychiatric Ward for Adolescents at the 2nd Department of Psychiatry, and Therapeutic-Consultative Outpatient Clinic at The Department of Psychiatry of the Medical University of Łódź, in whom various psychiatrists diagnosed depressive disorders, usually defining them as a "depressive neurosis". Based on the evaluation carried out according to DSM-III criteria, analysis of data from the documentation and anamnesis, a subgroup of 99 children was selected, with confirmed mood disorders (diagnosed with dysthymia – 56 children, 56.6%; major depression – 28 children, 28.2%; and atypical depression – 15 children, 15.1%) as well as the adolescents subgroup consisting of 74 persons (diagnosed with dysthymia – 35 persons, 47.3%; major depression – 27 persons, 36.5%, and atypical depression – 12 persons, 16.2%). Altogether, mood disorders were found in 173 subjects [27].

Method

1. Prospective study: 54 persons were under a systematic care of the Therapeutic-Consultative Outpatient Clinic at The Department of Psychiatry, Medical University of Łódź, or were treated by privately practising psychiatrists, and the patients' state was evaluated at least once in 6 months.

2. Catamnestic study:

Three times the questionnaires and invitation for an evaluating visit were sent out to 64 subjects who were not in touch and were seen sporadically. The questionnaire was completed by 31 persons, whereas 18 came to the visit.

With the consent of the Ethical Committee, Medical University of Łódź, the medical records (case histories) were evaluated from the Mental Health Outpatient Clinics and J. Babiński Psychiatric Hospital, as well as psychiatric hospitals in Pabianice, Zgierz, Warta and Bełchatów, and data on 23 patients were obtained, who in the past had participated in the first part of the study.

Altogether, information on 105 subjects (57 women and 48 men) was obtained, i.e. 59.0% of the group subjected to the first evaluation. 95 subjects were examined psychiatrically again. The diagnoses were made according to the DSM-IV criteria [52].

The analysis covered the information from:

Medical documentation
Direct interview with the patient
Psychiatric examination
Interview with the family and partner.

The obtained results were analysed statistically (test chi2 with Yates correction, statistical significance $p<0.05$).

Results

Comorbidity of mental disorders

Within the second evaluation, the diagnoses most often made, covering the diagnosis of depressive disorders and other comorbid mental disorders, are: recurrent major depression, or dysthymia and personality disorders (8.4%), or depressive disorders and alcohol and other psychoactive substances abuse/dependance (usually benzodiazepines – 5.6%), or depressive disorders and anxiety disorders (2.8%). A double diagnosis was established in 16.8% of subjects.

In the first study, 15 years earlier, the most prevalent complex diagnoses were: 1) anxiety disorders and mood disorders (dysthymia or major depression or atypical depressive syndrome); 2) specific learning disorders and/or ADHD + disruptive behaviour disorders. Most subjects (altogether 5.6%) with the latter combination of diagnoses, revealed in anamnesis the so called obstetrical complications (abnormal

Table 1

The prevalence of depressive disorders in subjects from the first study (in childhood of adolescence)

Affective disorders Acc. DSM-III	Children (n=99) n	%	Adolescents (n=74) n	%	Total n	(n=173) %
Major depression	28	28.2	27	36.5	55	31.8
Dysthymia	56	56.7	35	47.3	91	52.6
Atypical depression	15	15.1	12	16.2	27	15.6
Total	99	100.0	74	100.0	173	100.0

Table 2

The prevalence of mental disorders in adult subjects who 15 years earlier (in childhood and adolescence) were diagnosed with depressive disorders

Diagnosis acc. to DSM-IV	n	%	Commentary
Without mental disorders	44	41.9	
Mood disorders	34	32.4	in first study in 173 subjects
Anxiety disorders	18	17.1	in first study in 11.9% subjects
Personality disorders	12	11.4	in first study -
Alcohol abuse or dependence	14	13.3	in first study -
Psychoactive substances abuse or dependence	11	10.5	in first study -
Schizophrenia	3	2.8	in first study -

Table 3

Mood disorders in adult subjects who 15 years earlier (in childhood and adolescence) were diagnosed with depressive disorders

Mood disorders (acc. to DSM-IV)	n	%	% of subjects with this diagnosis in first study who took part in second study
▪ Recurrent major depression	20	19.0	24.0 (major depression)
▪ Dysthymia	11	10.5	22.1
▪ Bipolar affective disorders	3	2.8	-
Total	34	32.3	46.1

course of pregnancy, labour, clearly low points on the Apgar scale).

Recurrent major depression

Recurrent major depression (acc. to DSM-IV) was diagnosed in 20 persons –19.0% of subjects (previously 24.0%). Those persons in the first evaluation were diagnosed as follows (arranged in order of prevalence): recurrent major depression, major depression or dysthymia, statistically significantly less frequently the adjustment disorders ($p<0.05$), whereas the diagnosis preceding the occurrence of mood disorders, diagnosed in the first evaluation, was related to ADHD and anxiety disorders.

Dysthymia

After 15 years dysthymia was diagnosed twice less frequently, i.e. in 11 persons – 10.5% (previously in 22.1%), in patients who in the first evaluation were mostly (7 persons) diagnosed with dysthymia, but also with adjustment disorders comorbid with depressive mood.

In subjects with recurrent depression in childhood, prior to the occurrence of the first symptom of depressive disorders, the anxiety disorders, dysthymia, disruptive behaviour disorders and ADHD were diagnosed, whereas in dysthymic subjects – disruptive behaviour disorders, specific learning disorders and/or ADHD and anxiety disorders.

Familial occurrence of mood disorders

It was confirmed that in the first degree relatives of 25 patients (2 persons without mental disorders and 23 persons with mood disorders –21.9%), mood disorders were also diagnosed (mainly the recurrent major depression). No statistically significant

Table 4

Duration of individual depressive disorders

Diagnosis	Duration (in months)	Mean time	SD
▪ Dysthymia	24-84	37.2	1.2
▪ Major depression	3-9	5.4	0.78

SD – standard deviation

difference was found in the prevalence of disorders in relatives of those with recurrent major depression and in relatives of those with dysthymia.

Discussion

All patients who took part in the study 15 years later were adults (aged over 18), average age 26.1, SD 0.83. There were more women – they constituted 54.3% of the examined group, whereas in the first study (15 years earlier) – 48.3%.

More than half (51.4%) of the group are patients who were under systematic psychiatric care because of recurrent or incomplete remission of mood disorders or other comorbid mental disorders. It might be surmised that the second study involved mainly the patients on the most part affected by chronic or periodical presence of psychopathological symptoms. Yet, this hypothesis would be false, because among the patients as many as 41.9% did not show any mental disorders after the first episode. Usually in the first study they were diagnosed with dysthymia, significantly less frequently – atypical depressive syndromes, only in one person major depression was found. Mental disorders were diagnosed in 58.1% of patients, of this 32.3% were mood disorders, usually – recurrent major depression, dysthymia, and in single persons – bipolar disorders.

In 17.1% of subjects, anxiety disorders were diagnosed, sometimes accompanied by mood disorders, whereas in 11.4% – various types of personality disorders, usually in those with earlier diagnosis of disruptive behaviour disorders and ADHD and dysthymia.

In 16.8% of subjects a complex diagnosis was made: depressive disorders and personality disorders, or alcohol/psychoactive drug abuse or dependence, or anxiety disorders, in part anxiety disorders and personality disorders.

Only in 3 subjects schizophrenia was diagnosed (2.8% of the examined group).

In this group 13.3% (mainly men) had a diagnosis of alcohol abuse or alcohol dependence, 10.5% of subjects exhibited symptoms of other psychoactive substances dependence (mainly benzodiazepines, but also marijuana and amphetamine). Totally alcohol or psychoactive drug abuse or dependence, sometimes comorbid with mood disorders, was diagnosed in about 1/4th of the subjects (in 23, 8 %), statistically significant more often in men than in women ($p<0.05$).

It should be emphasised that in the subgroup of subjects without mental disorders, there were statistically significant more women than men. In the subgroup of subjects with mental disorders in women statistically more often ($p<0.05$) than in men the recurrent major depression was diagnosed, along with bipolar disorders.

Dysthymia was diagnosed as often in men as in women. In the first evaluation, 15 years earlier, there were the following differences: bipolar disorders were not diagnosed at all, whereas dysthymia was a bit more prevalent in boys, but the difference was not statistically significant.

Summing up, it should be emphasised that in the examined group the prevalence of various mental disorders, including mood disorders, was high – in more than 1/2 of the subjects. More than half of the patients required regular or periodical psychiatric treatment, which is consistent with the findings of other authors [6, 37, 38, 52, 53, 54, 55].

Mood disorders (mainly major depression but also atypical depression, much less often – dysthymia) and anxiety disorders, especially comorbid with ADHD and disruptive behaviour disorders occurred in part in childhood or adolescence of subjects with mood disorder symptoms found in adulthood (mainly – recurrent major depression). Earlier findings of some authors indicate that among adults with mood disorders a significant percentage of patients had exhibited ADHD and various disruptive behaviour disorders in childhood [9, 27, 46, 51, 56].

Noteworthy is the high percentage of dysthymic disorders diagnosed in the first

study according to DSM-III criteria: they were then found in 22.1% of subjects, and were by twofold lower 15 years later, when DSM-IV criteria were applied. Probably, some disorders subsided spontaneously or due to pharmacological treatment and psychotherapeutic intervention. In some of the subjects in adulthood the recurrent major depression was diagnosed, similarly as in the subjects with primary diagnosis of atypical depression. These persons constituted 1/4th of subjects (5/20) with recurrent depression diagnosed 15 years later.

Thus the criteria, adopted 15 years ago for diagnosing mood disorders in children and adolescents, such as were established for adults by the authors of DSM-III, allowed for a proper diagnosis of depressive disorders in most developmental age subjects.

Conclusions

- Among those who in childhood and adolescence fulfilled the criteria of depressive disorders (diagnosed according to DSM-III criteria), various mental disorders were found in most of subjects (58,1%), most frequently mood disorders, and alcohol or psychoactive substance abuse or dependence.
- Mood disorders (recurrent major depression, dysthymia, and bipolar affective disorders) were diagnosed according to DSM-IV criteria in about 1/3rd of subjects (32,4%), most frequently – recurrent major depression (19.0%).
- Alcohol or psychoactive substance abuse or dependence were found in about ¼th (23,8%) of subjects with and without depressive disorders.
- Complex diagnosis was made in 16.8% of subjects: depressive disorders and personality disorders, or alcohol/psychoactive substance abuse or dependence, or anxiety disorders, or anxiety and personality disorders.
- In subjects with adult depressive disorders (especially with recurrent major depression) in childhood or adolescence various depressive disorders were found, which very frequently were comorbid with anxiety disorders, conduct disorders, specific learning disorders and/or ADHD.

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