

2015

Quality of Life in Youth with Bipolar Disorder and Trauma

Irma De Santiago

University of Nevada, Las Vegas, irmagdesantiago@gmail.com

Andrew J. Freeman

University of Nevada, Las Vegas, andrew.freeman@unlv.edu

Follow this and additional works at: https://digitalscholarship.unlv.edu/mcnair_posters



Part of the [Psychology Commons](#)

Repository Citation

De Santiago, I., Freeman, A. J. (2015). Quality of Life in Youth with Bipolar Disorder and Trauma.

Available at: https://digitalscholarship.unlv.edu/mcnair_posters/65

This Poster is protected by copyright and/or related rights. It has been brought to you by Digital Scholarship@UNLV with permission from the rights-holder(s). You are free to use this Poster in any way that is permitted by the copyright and related rights legislation that applies to your use. For other uses you need to obtain permission from the rights-holder(s) directly, unless additional rights are indicated by a Creative Commons license in the record and/or on the work itself.

This Poster has been accepted for inclusion in McNair Poster Presentations by an authorized administrator of Digital Scholarship@UNLV. For more information, please contact digitalscholarship@unlv.edu.

Quality of Life in Youth with Bipolar Disorder and Trauma

Irma De Santiago^a, Andrew J. Freeman^a, Ph.D.

^aDepartment of Psychology, UNLV

ABSTRACT

Background: Epidemiological work suggests that youth with histories of trauma or bipolar disorder have lower quality of life (QoL) than generally healthy youth without a history of bipolar disorder or trauma.

Aim: To evaluate whether trauma and bipolar disorder have a negative effect in youth seeking services for emotional and behavioral difficulties.

Method & Sample: Participants were 596 youths and caregiver dyads from an urban community mental health center and an academic medical center in Cleveland, OH. Diagnoses were based on semi-structured interviews of the parent and youth. The KINDL-R measured Total, Emotional, Self-esteem, Family, Friend, School, and Physical QoL.

Results: Trauma history was not associated with changes in QoL. Youth with bipolar disorder had significantly lower QoL than youth without bipolar disorder. There was no interaction between trauma history and bipolar disorder.

Conclusion: Among youth seeking mental health services, trauma history was common. A history of trauma does not alter QoL compared to youth without a history of QoL in a service seeking sample. Youth with bipolar disorder had significantly lower QoL than youth without bipolar disorder suggesting that youth with bipolar disorder might require more intensive services than youth without bipolar disorder.

INTRODUCTION

In the general population, youth with histories of trauma and mood disorders tend to have poorer outcomes across a variety of domains. Both trauma and mood disorders are both causes of, features of, and consequences of emotion regulation difficulties. The impact of these disorders might best be comprehensively described as quality of life (QoL). QoL represents the subjective experience of how life is doing overall in multiple domains such as at family, peers, school, physical health. QoL is distinct from functioning as QoL is a measure of the subjective experience of a person's functioning. Thus, individuals can have high QoL and low functioning as well as low QoL and high functioning and combinations in between.

The acute experience of trauma is typically associated with hyper-arousal, fear, and other intense negative affect. When these systems remain disturbed over a long period of time, trauma becomes disordered. Youth with trauma histories experience numerous negative functional outcomes such as lower academic achievement and poorer physical health due to the long-term effects of emotion dysregulation. Youth with trauma histories are also more likely to perceive their psychosocial health and QoL as being lower or poorer than youth without a history of trauma (Roberts, Ferguson, & Crusto, 2013). Additionally, youth with more trauma, experience lower levels of QoL.

In contrast to trauma which is an exogenous stressor, most other types of severe mental illness are thought to be more strongly endogenous (i.e., genetic). Among youth in general, pediatric bipolar disorder (PBD) is rare. However among youth with severe mental illness, PBD is among the most common. Youth with PBD display long episodes of time characterized by distinct moods (both high moods such as mania and low moods such as depression). Youth with PBD tend to have poor functional outcomes such as lower academic achievement and higher risk of suicide. Like youth with trauma histories, youth with PBD subjectively rate their QoL as lower than both youth without psychopathology and youth with non-mood disorder psychopathology (e.g., ADHD; Freeman et al., 2009; Victor, Johnson, & Gotlib, 2011).

Most prior studies into the effect of trauma on QoL have sampled the general population or used case-control designs (e.g., youth with trauma matched to youth without trauma) in which a large number of participants were healthy. Current trends in mental health point to providing "trauma-informed" care on the premise that trauma exposed youth in mental health treatment settings are different than youth without trauma in mental health treatment settings.

The current study extends the present literature by examining the relationship between trauma and QoL in an outpatient mental health sample and by examining whether trauma moderates the relationship between bipolar disorder and QoL.

Hypothesis 1: Youth with trauma will show more impaired QoL than youth without trauma. The more traumas experienced by youth the more impaired QoL in youth will be.

Hypothesis 2: Children with bipolar disorder will show greater impairment in QoL compared to those without bipolar disorder.

Hypothesis 3: History of trauma will be associated with lower QoL in children with bipolar disorder than in children with bipolar disorder who have not experienced trauma. The detrimental effects of trauma on QoL in youth with bipolar disorder will remain after controlling for age, gender, ethnicity, and assessment site.

METHOD

Participants: Participants were 596 youth and caregiver pairs (70% African American, 57% male) presenting to either an academic medical center or to a community mental health clinic in Cleveland, OH. Of the participants, 72% were brought in for an assessment of mood and behavior problems by their biological mother, 5% by a biological father, 5% by a maternal grandmother, and 3% by an adoptive mother. Diagnoses and severity of mood symptoms were based on a longitudinal expert review of all available evidence (LEAD; Spitzer, 1983). Lead reviews were based on KSADS-PL and mood modules of the Washington University KSADS, which followed strict DSM-IV-TR criteria. After each interview, trained research assistants met with a licensed clinical psychologist to finalize diagnoses using the LEAD process.

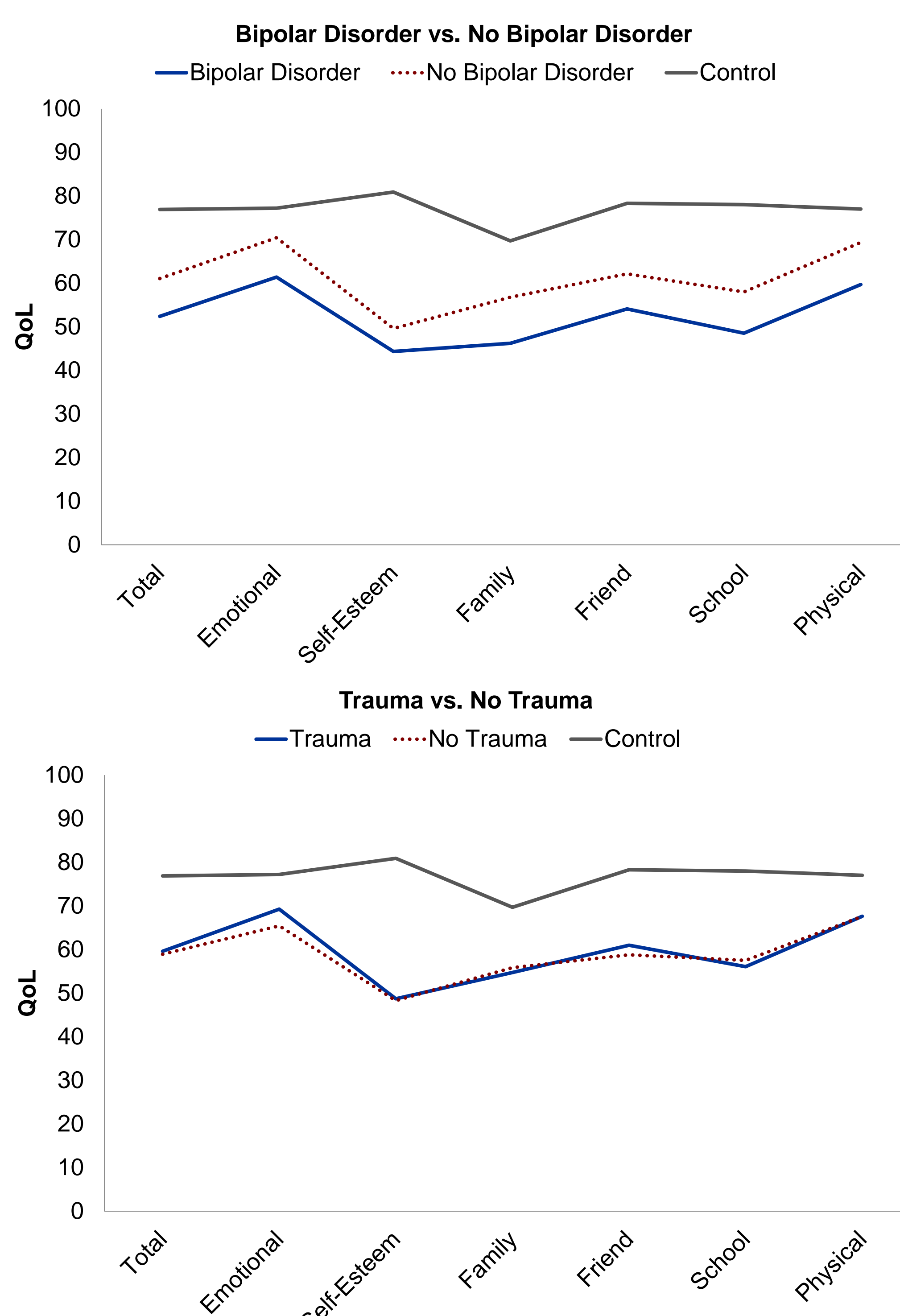
The inclusion criteria were: (a) conversant in English, (b) both caregiver and youth were present for the assessment, and (c) both caregiver and youth consented/assented to participate.

Diagnoses: PBD was characterized as meeting the DSM-IV criteria for bipolar I, bipolar II, cyclothymia, or bipolar not otherwise specified (NOS).

Trauma: The K-SADS-PL-Plus, a semi structured interview measuring trauma, was conducted by trained interviewers with parent and child.

Quality of Life: The KINDL-R measured the QoL of youth and caregiver. The parent-report about adolescents version of the KINDL-R consists of six subscales measuring Emotional, Self-esteem, Family, Friend, School, and Physical QoL.

Characteristics (N = 596)	M (SD) or N (%)
Age (8-18 years)	
Median	12
Mean	12 (2.6)
No. of diagnoses (0 – 10 diagnoses)	2.5 (1.75)
Gender, n (%)	
Boy	340 (57)
Girl	256 (43)
Ethnicity, n (%)	
White	138 (23)
Black	417 (70)
Hispanic	13 (2)
Asian/Pacific Islander	2 (.3)
Other	25 (4)



RESULTS SUMMARY

TRAUMA vs. NO TRAUMA

- Hierarchical linear regression indicated no significant difference in overall QoL in youth who experience trauma compared to youth who do not experience trauma $p > .10$.
- Regression indicated that experiencing additional traumas was associated with a mild ($b = -.70$) decrease in Total QoL, $p < .05$.

BPSD vs. NO BPSD

- Hierarchical linear regression indicated that youth with bipolar disorder had significantly lower QoL than youth without bipolar disorder, all $p < .05$.

BPSD AND TRAUMA vs. BPSD AND NO TRAUMA

- Hierarchical linear regression indicated no significant interaction between trauma history and having a bipolar diagnosis for QoL, all $p > .05$.
- Regression indicated that there was no significant interaction between the number of traumas and PBD for QoL, all $p > .05$.

CONCLUSIONS

- Trauma was common among youth seeking mental health services. The experience of trauma did not significantly lower or raise QoL in a sample of impaired, treatment seeking youth. More trauma was weakly associated with lower QoL. The importance of trauma as a risk factor for poor outcomes is likely dependent on the comparator. In community samples, trauma history is associated with impairment; however in mental health treatment-seeking samples where all youth are impaired, trauma history was not uniquely associated with better or worse outcomes.
- Youth with PBD had significantly lower QoL than youth without PBD. This finding is consistent with prior work indicating that bipolar disorder in both children and adults is typically associated with more severe impairment than other disorders.
- Trauma history and PBD did not interact to increase or decrease a youth's QoL. Prior evidence associated trauma history with increased illness severity. Our current findings suggest that youth with BPD are more impaired than other youth and that the experience of trauma does not improve or worsen the youth's perception of their overall functioning.

Limitations: Participants were from an outpatient mental health setting and an academic medical center specialty clinic resulting in a sample with increased prevalence of both PBD and trauma. Hence, the participants of this study had a lower QoL than the general population. Therefore, we are not saying that trauma is not negative to a youth's life.

Parent-reports of QoL were used. Given that QoL is subjective, our findings are indicative of how the parent's perceive their offspring's QoL. Future studies should evaluate youth self-reports of QoL so as to more directly measure the youth's subjective experience of their life.

REFERENCES

- Freeman, A. J., Youngstrom, E. A., Michalak, E., Siegel, R., Meyers, O. I., & Findling, R. L. (2009). Quality of life in pediatric bipolar disorder. *Pediatrics*, 123(3), e446-e452. doi:10.1542/peds.2008-0841
- Freeman, A.J., Youngstrom, E. A., Youngstrom, J. K., Freeman, M. J., & Findling, R. L. (2011). Is caregiver-adolescent "disagreement" due to differences in thresholds for reporting manic symptoms? *Journal of Child and Adolescent Psychopharmacology*, 21(5), 425-432. doi:10.1089/cap.2011.0033
- Roberts, Y. H., Ferguson, M., & Crusto, C. A. (2013; 2012). Exposure to traumatic events and health-related quality of life in preschool-aged children. *Quality of Life Research*, 22(8), 2159-2168. doi:10.1007/s11336-012-0330-4
- Victor, S. E., Johnson, S. L., & Gotlib, I. H. (2011). Quality of life and impulsivity in bipolar disorder. *Bipolar Disorders*, 13(3), 303-309. doi:10.1111/j.1399-5618.2011.00919.x