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Cognitive styles in depressed children with and without comorbid conduct disorder



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ABSTRACT

Little is known about patterns of cognitive impairment in depression comorbid with conduct disorder. The study included clinically depressed children with ($N = 23$) or without conduct disorder ($N = 29$), and controls without psychiatric disorder ($N = 37$). Cognitive biases typical of depression and patterns of social information processing were assessed. Both depressed groups had substantially higher rates of negative cognitive distortions, attributional biases and ruminative responses than non-depressed children. Children in the comorbid group made more hostile attributions and suggested more aggressive responses for dealing with threatening social situations, whilst children with depression only were more likely to be unassertive. Depression has a number of similar depressotypic cognitive biases whether or not complicated by conduct disorder, and may be potentially susceptible to similar interventions. The results also highlight the importance of recognising social information processing deficits when they occur and targeting those too, especially in comorbid presentations.

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Introduction

The World Health Organisation has reported that depression is one of the main contributors to the global burden of disease (Üstün et al., 2004). Depression often starts in childhood or adolescence (Kim-Cohen et al., 2003), and early onset depression shows strong continuities with adult affective disorder and adult suicide (Fombonne, Wostear, Cooper, Harrington, & Rutter, 2001a, 2001b; Harrington, Fudge, Rutter, Pickles, & Hill, 1991). At the same time, recent evidence highlights heterogeneity in clinical presentation, symptom patterns, course of illness, and response to treatment (Thapar, Collishaw, Potter, & Thapar, 2010). Research suggests the importance of taking account of comorbid disorders in understanding this variation and long-term prognosis (Copeland, Shanahan, Costello, & Angold, 2009).

Research has shown that certain cognitive styles (e.g. internal-stable-global attributions for negative events, cognitive distortions, and hopelessness) are central features of childhood depression (Birmaher et al., 1996) and cognitive-behavioural therapy is a commonly employed and effective treatment for depression by targeting such cognitive biases (Klein, Jacobs, &

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Reinecke, 2007). There is evidence that CBT is a moderately effective treatment for many but not all young people with depression (Thapar, Collishaw, Pine, & Thapar, 2012). Variations in treatment response may be due to variations in cognitive biases between different identifiable subgroups of children with depression. Understanding possible variations is important so that treatments such as CBT can be better tailored to address specific maladaptive cognitive deficits in specific subgroups (Johansson et al., 2012).

However, often children with depression also exhibit conduct problems (Angold & Costello, 1993). This subgroup appears to have a similar depressive symptom profile to depressed children without conduct disorder (Ezepleta, Domenech, & Angold, 2006; Simic & Fombonne, 2001) but appears to differ in other ways, e.g. adult outcomes, familial correlates (Harrington et al., 1991), functional impairment (Ezepleta et al., 2006) and treatment response (Wolff & Ollendick, 2006). It is unclear if this comorbid group also displays differences in type and origin of cognitive styles, and therefore if similar or different forms of treatment are required.

Cognitive aspects of depression

Depression in adults is associated with a range of characteristic cognitive styles (Beck, 1967), e.g.: a tendency to perceive the self, the world and the future in negative ways (Gotlib, Lewinsohn, Seeley, Rohde, & Redner, 1993). Depression in childhood and adolescence is associated with similar biases in information processing, e.g. negative interpretations of events when alternative positive interpretations are possible, selective attention to negative environmental cues, and over-generalisation of adversity and down-playing of positive information (Meyer et al., 2004; Rohde, Lewinsohn, & Seeley, 1990). In line with the learned helplessness model (Abramson, Seligman, & Teasdale, 1978), depressed children are also more likely to blame themselves for negative events, to view causes of negative events as being stable over time, and to see causes of negative events to generalise across situations (Gladstone & Kaslow, 1995). On the other hand, depressed children are more likely to make external, unstable, and specific attributions for positive events (Gladstone & Kaslow, 1995). Finally, studies focussing on cognitive behavioural responses to depression have found that self-focused rumination maintains or increases depressed mood (Nolen-Hoeksema & Morrow, 1991; Nolen-Hoeksema, Morrow, & Fredrickson, 1993). Rumination can be defined as repetitive or uncontrolled attention to perceived problems an individual is experiencing, including symptoms of depression.

Epidemiological studies show that many children with depression also suffer from comorbid conduct disorders (conduct disorder or oppositional defiant disorder) (Angold & Costello, 1993). Remarkably little is known about the cognitive styles of children and adolescents with comorbid depression and conduct disorder. A small number of studies using questionnaires screens found similarly elevated rates of depressotypic cognitions in children with high internalizing/externalising problems compared to children with high internalising problems only (Frey & Epkins, 2002; Leung & Wong, 1998). To our knowledge, only one study has directly compared clinically depressed children with and without comorbid conduct disorder (Kempton, Van Hasselt, Bukstein, & Null, 1994). This study found that both groups of children demonstrated higher levels of distorted thinking as assessed using the Child Negative Cognitive Errors Questionnaire when compared with non-depressed children. No differences in scores between depressed subgroups were found. The present study provides an important extension by focussing on a broad range of measures of depressotypic cognition (including negative cognitive errors, attributional styles, rumination) in clinically depressed children with and without conduct disorder.

A further important addition is a focus on social information processing deficits. Dodge (1993) has argued that aggressive behaviour can be explained with reference to deficits and biases at several stages of cognitive processing in social situations (Dodge, 1993). Attentional biases affect social cue encoding, followed by biased interpretation of these cues. This often results in a view of others as hostile. Furthermore, children with conduct disorder are more likely to generate and favour aggressive responses as a way of reacting to ambiguous or conflictual social situations. Few studies have investigated whether such patterns also exist in depression. However, depression like conduct disorder is also associated with abnormalities in peer relationships, including peer rejection, social withdrawal and isolation (Deater-Deckard, 2001) and a social information processing theory of depression may therefore be relevant too (Dodge, 1993). Depressed children's pessimistic outlook may mean that they perceive others as more hostile to them, particularly considering depressed children's own negative self-concept (Rudolph & Clark, 2001). However, unlike conduct disordered children, depressed children may be more likely to show passive or non-assertive responses (Quiggle, Garber, Panak, & Dodge, 1992).

Given these contrary expectations, it is important to examine social information processing in children with comorbid depression and conduct disorder. Quiggle et al. (1992) assessed social information processing in a community sample of children with high aggression scores, high depression scores, or both. Children were presented with hypothetical scenarios involving children in situations that had negative outcomes (e.g. rejection, provocation or failure). Aggressive children displayed a hostile attributional bias and were more likely to report that they would engage in aggressive behaviour. Depressed children also demonstrated a hostile attributional bias, but were more likely to attribute causes for these negative situations to internal, stable and global causes. Depressed children were less likely to choose assertive responses than other children, expecting that assertive behaviour would lead to more negative outcomes. Comorbid children displayed some cognitive styles typical of both aggression and depression. When assessed on cognitive measures typically associated with aggression, they responded like aggressive children, and when assessed on measures associated with depression, they responded like depressed children. A broadly similar conclusion comes from other more recent studies of community samples where children with high levels of depressive and aggressive symptoms or both are compared. For example, Rudolph and Clark

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