

# Phenomenology and Comorbidity of Dysthymic Disorder in 100 Consecutively Referred Children and Adolescents: Beyond DSM-IV

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**Objective:** Diagnostic criteria and nosological boundaries of juvenile dysthymic disorder (DD) are under-researched. Two different sets of diagnostic criteria are still discussed in the DSM-IV, the first giving major weight to somatic and vegetative symptoms and the second, included in the appendix, to more affective and cognitive symptoms. The aim of this study was to describe prototypical symptomatology and comorbidity of DD, according to DSM-IV criteria, in a consecutive series of referred children and adolescents, as a function of age and sex.

**Method:** One hundred inpatients and outpatients (36 children and 64 adolescents, 57 males, 43 females, age range 7 to 18 years, mean age 13.3 years) received a diagnosis of DD without comorbid major depressive disorder (MDD), using historical information, the Diagnostic Interview for Children and Adolescents-Revised (DICA-R), and symptoms ratings according to the DSM-IV criteria.

**Results:** Irritability, low self-esteem, fatigue or loss of energy, depressed mood, guilt, concentration difficulties, anhedonia, and hopelessness were present in more than 50% of subjects. Differences in symptomatic profile between male and female patients were not significant. Anxiety disorders were commonly comorbid with DD, mainly generalized anxiety disorder, simple phobias, and in prepuberal children, separation anxiety disorder. Externalizing disorders were reported in 35% of the patients, with higher prevalence in male patients. Adolescents showed more suicidal thoughts and anhedonia than children.

**Conclusions:** The clinical picture of early-onset DD we found, based entirely on a pure sample without current and past MDD, is not totally congruent with the diagnostic criteria according to DSM-IV. A more precise definition of the clinical picture may help early diagnosis and prevention of superimposed mental disorders.

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## Clinical Implications

Some of the symptoms reported in the alternative DSM-IV research diagnostic criteria for dysthymia are particularly frequent. At least for juvenile DD, DSM-IV diagnostic criteria may be inappropriate.

Comorbidity with anxiety disorders is particularly frequent.

“Mixed” bipolar elements (irritability, psychomotor agitation, concentration difficulties) are present in a relevant proportion of cases, and they confirm that, in a significant minority, early-onset DD belongs to the bipolar spectrum.

## Limitations

This was a retrospective evaluation of lifetime comorbidity.

Findings on symptomatology and comorbidity will only apply to patients and cannot be regarded as valid for non-referred populations.

Reliability of both children’s and parents’ recall of previous episodes is poor.

**Key words:** dysthymic disorder, depression, DSM-IV, children, adolescents

Dysthymic disorder (DD) is a fluctuating chronic depressive disorder, characterized in children and adolescents by a minimum duration of 1 year, according to the DSM-IV (1). In clinical samples the duration typically exceeds that given in DSM-IV; that is, a mean of 3.9 years (2). Symptoms frequently begin early in life (3,4), with insidious onset, and pursue a protracted course resulting in significant functional impairment (5,6). This could distort character formation and lead to interpersonal difficulties (7). Early onset is considered to be a predictor of poorer outcome, in terms of increased vulnerability to other mood disorders (major depressive disorder, [MDD] and bipolar disorder) (8,9), as well as to other internalizing or externalizing disorders (10–13). Many issues in dysthymia still remain uncertain, such as its prototypical clinical picture. DSM-IV (1) suggested 2 alternative diagnostic criteria: the first gives major weight to somatic and vegetative symptoms (altered appetite, disturbed sleep, low energy, or fatigue), and the second derives from the DSM-IV mood disorder field trial, with more affective and cognitive symptoms (low self-esteem, feelings of hopelessness, loss of interest, social withdrawal, low energy or fatigue, feelings of guilt, feelings of irritability, decrease of activity, and difficulty in thinking). According to the DSM-IV, additional confirmatory evidence is needed for this second version.

Another uncertain topic relates to the nosological boundaries and comorbidity of DD with MDD (14,15) and with anxiety disorders (10,16,17). From 42% (9,18) to 75% (6) of children and adolescents with DD have a superimposed MDD (“double depression”). The comorbidity with anxiety disorder ranges from 11% (19) to 55% (15), and with externalizing disorders, it ranges from 20% (20) to 100% (14). Differences in sampling (community vs clinical studies, the latter including inpatients and outpatients and including children and adolescents), as well as in classification (some studies include DD and double depression in the same category, labeled as “chronic depression”), may account for these wide differences (14).

The aim of the present study is to describe symptomatology and comorbidity of DD in a large sample of consecutively referred children and adolescents. To delineate a specific profile of depressive symptomatology in “pure” DD, all subjects with current or previous MDD (double depression) were excluded.

## Methods

### *Sample*

All the patients between the ages of 7 and 18 years who were referred to our Division as inpatients ( $n = 73$ ) or outpatients ( $n = 197$ ) were screened for psychiatric disorders in the same structured way, including historical information, a clinical interview, the Diagnostic Interview for Children and Adolescents-Revised (DICA-R) (21), and symptoms ratings

according to the DSM-IV criteria. Our clinic is a tertiary level research hospital with a national catchment for children and adolescents with a wide range of neuropsychiatric disorders. The children were referred by other hospitals, community-based child psychiatrists or pediatricians, or family members. All subjects with psychosis or mental retardation, as well as subjects with poor verbal skills (expression and comprehension) were also excluded. From these patients, a consecutive series of 100 children and adolescents (57 males and 43 females, 74 outpatients and 26 inpatients, age range 7 to 18 years, mean age 13.3 years, SD 3.0), constituting 37% of the entire population of mentally ill children and adolescents referred to our center, received a current diagnosis of DD without current or previous MDD, according to DSM-IV diagnostic criteria. The high rates of patients with DD may be accounted for by the frequent referral for childhood mood and anxiety disorders, since our research group particularly specializes in this field. No patient with DD was using psychotropic drugs during assessment. The patients were divided by age into children (36 subjects, 21 males and 15 females, age range 7 to 11 years, mean age 10.2 years, SD 1.0) and adolescents (64 subjects, 36 males and 28 females, age range 12 to 18 years, mean age 15.0 years, SD 2.0). Sociodemographic variables were assessed by the parents’ education and occupation, according to the Hollingshead’s 2-factor index (22). All subjects were in the middle to upper-middle socioeconomic classes. Socioeconomic status distribution (highest vs middle categories) and family structure (intact vs monoparental families) did not differ between groups (males–females and children–adolescents). All subjects and their families participated in the study after informed consent was obtained. The characteristics of the assessing instruments and the aims of the study were explained to the subjects and their parents. The study was approved by the Human Subjects Committee of our hospital.

### *Measures*

The DICA-R was administered individually to the children and adolescents participating in the study and to their parents by separate interviewers. The DICA-R is a structured interview according to DSM-IV, organized in such a way as to explore the presence or absence of each of the symptoms in different psychiatric syndromes. Three trained child psychiatrists administered the clinical interview. The comprehension of the questions was carefully assessed; if necessary, the questions were repeated to clarify the subject’s response. All subjects participating in the study were considered competent to undergo the diagnostic interview. Child and parent ratings correlated in the moderate-to-high range on measures of children’s symptoms. To improve the reliability and validity of the diagnosis, clinical data from each subject–parent pair were reviewed by the research clinicians after each interview to

arrive at consensus. When questions arose, patients and parents were reassessed for further clarification. Structured interview diagnoses were considered positive only if DSM-IV criteria were unequivocally met. When an overlap of symptoms among different concurrent disorders was found, particularly between DD and generalized anxiety disorder (GAD), an operational methodology described by Kovacs and coworkers (8,10) was followed to decide whether the symptom belonged to one or another disorder. Symptoms were considered manifestations of DD only if symptoms had clearly started with the onset of the depression. If such symptoms were quantitatively and qualitatively the same as before the onset of depression, they were considered as correlates of GAD only but not of the depressive disorder. In all cases, the final diagnoses depended on the clinicians' symptom ratings.

In the depressive and anxiety sections of DICA-R, 15 items corresponding to depressive symptoms were selected: depressed mood, irritability, pathological guilt, anhedonia, fatigue, concentration difficulties, psychomotor agitation, psychomotor retardation, insomnia, hypersomnia, increased appetite, reduced appetite, death thoughts, low self-concept, and hopelessness.

Our previous analyses of children and adolescents assessed with DICA-R revealed a good interrater reliability for the diagnosis of DD, as well as for the identification of particular symptoms ( $K > 0.75$ ) (23). The individual reliability for the specific items, that is, the property of each question to obtain the same answer when the item is reformulated, was good for all the items.

#### Statistical Analyses

Descriptive analyses were used. To identify differences among subjects an independent sample *t*-test or an analysis of variance (ANOVA) was used with the number of symptoms as the within-subject values, and age and sex as among-subject variables. Chi-square analyses were performed on categorical variables (for example, presence or absence of symptoms and comorbid diagnoses). In comparisons with small expected cell frequencies, Fisher's exact tests were performed. All tests were 2-tailed; statistical significance was set at 5% level ( $P = 0.05$ ). Bonferroni correction was applied where necessary, to minimize type I errors.

## Results

Regarding the number of depressive symptoms, no statistically significant differences (*t*-test) were observed between children (mean 6.83, SD 1.68) and adolescents (mean 7.51, SD 1.99) and between female patients (mean 7.35 SD 2.00) and male patients (mean 7.07, SD 2.07). ANOVAs did not reveal significant age by sex interaction. The distribution was acceptably normal (skewness = -0.067; kurtosis = -0.63).

Prevalence of depressive symptoms in the whole sample of 100 children and adolescents with DD is presented in Table 1. Data show that irritability was the most frequently reported symptom, followed by low self-concept, fatigue and loss of energy, depressed mood, guilt, concentration difficulties, anhedonia, and hopelessness. Psychomotor agitation was present in about one-half of the patients, and retardation occurred in less than 20%. The least-frequent symptoms were hypersomnia (10%; contrasted with insomnia, which was reported by 45% of patients) and increased appetite (12%; contrasted with reduced appetite reported by 29% of patients). Significantly, 36% of the patients had thoughts of death. No significant differences in symptomatic profile were apparent between male and female patients (Table 1).

Comparisons between children and adolescents indicate that 2 symptoms were more frequently reported in adolescents: thoughts of death (48.4% vs 13.9%) ( $\chi^2 = 10.5$ , df 1,  $P = 0.001$ ) and anhedonia (64% vs 33.3%) ( $\chi^2 = 7.5$ , df 1,  $P = 0.006$ ). Only differences in thoughts of death remained significant after the Bonferroni correction, which set  $P = 0.003$ .

Comparisons among age-sex groups (male children, female children, male adolescents, and female adolescents) (Table 2) showed that anhedonia ( $\chi^2 = 9.2$ , df 3,  $P = 0.034$ ) and thoughts of death ( $\chi^2 = 17.47$ , df 3,  $P = 0.001$ ) distinguished the 4 groups, but only thoughts of death remained significant after the Bonferroni correction.

The comorbidity of DD was analyzed separately in the whole sample as a function of sex and age (Table 3). Anxiety disorders were frequently comorbid with DD: 59% of the patients had GAD, 28% had simple phobias, 18% had separation anxiety disorder, 14% had obsessive-compulsive disorder, 13% had social phobia, and 10% had panic disorder. Comorbid externalizing disorders (that is, attention deficit disorder with hyperactivity, oppositional defiant disorder, and conduct disorder) were reported in 35% of patients. Statistical analyses (Bonferroni correction,  $P = 0.007$ ) showed that children had more frequent separation anxiety disorder than adolescents (36.1% vs 7.8%) ( $\chi^2 = 10.6$ , df 1,  $P = 0.001$ ). Externalizing disorders were more frequently reported in male than in female patients (47.4% vs 18.6%) ( $\chi^2 = 7.7$ , df 1,  $P = 0.006$ ).

Table 4 compares comorbidity in age-sex groups (male children, female children, male adolescents, and female adolescents): separation anxiety disorder ( $\chi^2 = 16.17$ , df 3,  $P = 0.001$ ) and externalizing disorders ( $\chi^2 = 4.79$ , df 3,  $P = 0.01$ ) distinguished the 4 groups, but only separation anxiety disorder remained significant after Bonferroni correction ( $P = 0.007$ ). The group effect of separation anxiety disorder was due to its prevalence in children vs adolescents, as well as to its prevalence in female adolescents vs male adolescents.

**Table 1 Depressive symptomatology in patients with dysthymic disorder according to age and sex**

Symptoms	Whole sample ( <i>n</i> = 100) <i>n</i> (%)	Males ( <i>n</i> = 57) <i>n</i> (%)	Females ( <i>n</i> = 43) <i>n</i> (%)	Children ( <i>n</i> = 36) <i>n</i> (%)	Adolescents ( <i>n</i> = 64) <i>n</i> (%)
Irritability	86	47 (82.4)	39 (90.7)	31 (86.1)	55 (85.9)
Low self-concept	79	46 (80.7)	33 (76.7)	30 (83.3)	49 (76.5)
Fatigue	73	43 (75.4)	30 (69.7)	30 (83.3)	43 (67.2)
Depressed mood	69	37 (64.9)	32 (74.4)	27 (75.0)	42 (65.6)
Guilt	61	30 (52.6)	31 (72.1)	24 (66.7)	37 (57.8)
Concentration difficulties	58	37 (65.0)	21 (48.8)	19 (52.7)	39 (61.0)
Anhedonia	53	31 (54.3)	22 (51.2)	12 (33.3)	41 (64.0)
Hopelessness	52	30 (52.6)	22 (51.2)	16 (44.4)	36 (56.2)
Psychomotor agitation	46	29 (50.8)	17 (39.5)	15 (41.7)	31 (48.4)
Insomnia	45	25 (43.8)	20 (46.5)	16 (44.4)	29 (45.3)
Death thoughts	36	19 (33.3)	17 (39.5)	5 (13.9)	31 (48.4) <sup>a</sup>
Reduced appetite	29	18 (31.6)	11 (25.6)	11 (30.5)	18 (28.1)
Psychomotor retardation	17	9 (15.8)	8 (18.6)	6 (16.6)	11 (17.2)
Increased appetite	12	7 (12.3)	5 (11.6)	2 (5.5)	10 (15.6)
Hypersomnia	10	4 (7.0)	6 (13.9)	2 (5.5)	8 (12.5)

<sup>a</sup>Statistically significant (Bonferroni correction,  $P < 0.003$ ).

**Table 2 Depressive symptomatology in patients with dysthymic disorder according to age–sex groups**

Symptoms	Male children ( <i>n</i> = 21) <i>n</i> (%)	Female children ( <i>n</i> = 15) <i>n</i> (%)	Male adolescents ( <i>n</i> = 36) <i>n</i> (%)	Female adolescents ( <i>n</i> = 28) <i>n</i> (%)
Irritability	17 (80.9)	12 (80.0)	22 (61.1)	20 (71.4)
Low self-concept	19 (90.5)	11 (73.3)	27 (75.0)	22 (78.6)
Fatigue	17 (80.9)	13 (86.6)	26 (72.2)	17 (60.7)
Depressed mood	15 (71.4)	12 (80.0)	22 (61.1)	20 (71.4)
Guilt	12 (57.1)	12 (80.0)	18 (50.0)	19 (67.8)
Concentration difficulties	10 (47.6)	9 (60)	27 (75.0)	12 (42.8)
Anhedonia	8 (38.1)	4 (26.6)	23 (63.9)	18 (64.3)
Hopelessness	9 (42.8)	7 (46.6)	21 (58.3)	15 (53.6)
Psychomotor agitation	10 (47.6)	5 (33.3)	19 (52.8)	12 (42.8)
Insomnia	10 (47.6)	6 (40.0)	15 (41.6)	14 (50.0)
Death thoughts	5 (23.8)	0 (0.0)	15 (41.6)	17 (60.7) <sup>a</sup>
Reduced appetite	8 (38.1)	3 (20.0)	10 (27.8)	8 (28.6)
Psychomotor retardation	3 (14.3)	3 (20.0)	6 (16.6)	5 (17.8)
Increased appetite	2 (9.5)	0 (0.0)	5 (13.9)	5 (17.8)
Hypersomnia	4 (7.0)	6 (13.9)	2 (5.5)	8 (12.5)

<sup>a</sup>Statistically significant (Bonferroni correction,  $P < 0.003$ ).

Externalizing disorders were equally prevalent in male patients, among both children and adolescents.

## Discussion

Our findings on the entire sample of patients with DD showed that irritability, fatigue or loss of energy, low self-esteem, depressed mood, guilt, concentration difficulties, anhedonia, and hopelessness are present in more than 50% of subjects. Other studies have underscored that the predominant mood in

early-onset depressive disorders is irritability and dysphoria rather than sadness or melancholia (24). Most reported symptoms pertain to emotional or cognitive, rather than somatic and vegetative, domains. Only fatigue is more frequently represented in our sample, compared with the only previous study of the symptomatic expression of juvenile DD. Our data seem to underline the high frequency of some of the symptoms reported in the alternative DSM-IV research diagnostic criteria for DD (especially feelings of irritability, guilt, and

Syndromes	Whole sample ( <i>n</i> = 100) <i>n</i> (%)	Males ( <i>n</i> = 57) <i>n</i> (%)	Females ( <i>n</i> = 43) <i>n</i> (%)	Children ( <i>n</i> = 36) <i>n</i> (%)	Adolescents ( <i>n</i> = 64) <i>n</i> (%)
Generalized anxiety disorder	59	35 (61.4)	24 (55.8)	19 (52.8)	40 (62.5)
Simple phobias	28	19 (35.1)	9 (21)	10 (27.7)	18 (28.1)
Separation anxiety disorder	18	7 (12.3)	11 (25.6)	13 (36.1)	5 (7.8) <sup>a</sup>
Social phobia	13	7 (12.3)	6 (14)	2 (5.5)	11 (17.1)
Obsessive–compulsive disorder	14	8 (14)	6 (14)	3 (8.3)	11 (17.2)
Panic disorder	10	6 (10.5)	4 (9.3)	1 (2.7)	9 (14)
Externalizing disorder	35	27 (47.4)	8 (18.6) <sup>a</sup>	13 (36.1)	22 (34.4)

<sup>a</sup>Statistically significant (Bonferroni correction, *P* < 0.007).

Syndromes	Male children ( <i>n</i> = 21) <i>n</i> (%)	Female children ( <i>n</i> = 15) <i>n</i> (%)	Male adolescents ( <i>n</i> = 36) <i>n</i> (%)	Female adolescents ( <i>n</i> = 28) <i>n</i> (%)
Generalized anxiety disorder	27 (47.3)	23 (53.5)	15 (41.6)	35 (54.6)
Separation anxiety disorder	7 (33.3)	6 (40.0)	0 (0.0)	5 (17.8) <sup>a</sup>
Panic disorder	0 (0.0)	1 (6.6)	6 (16.6)	3 (10.7)
Social phobia	2 (9.5)	0 (0.0)	5 (13.9)	6 (21.4)
Simple phobias	7 (33.3)	3 (20.0)	12 (33.3)	6 (21.4)
Obsessive–compulsive disorder	1 (4.7)	2 (13.3)	6 (16.6)	2 (7.1)
Externalizing disorder	10 (47.7)	3 (20.0)	17 (47.2)	5 (17.8)

<sup>a</sup>Statistically significant (Bonferroni correction, *P* < 0.007).

anhedonia). Otherwise, these findings suggest that, at least for juvenile DD, DSM-IV diagnostic criteria may be inappropriate. As reported in other studies on clinical samples (6,14), boys and girls were equally represented.

Symptomatic profile is generally similar in children and adolescents; only thoughts of death were significantly more frequent in adolescent males. Affective and cognitive symptoms are commonly reported both in children and in adolescents. Most interesting is the high frequency in young children of low self-image (76.5%), depressed mood (65.6%), and guilty feelings (57.8%), which are often neglected or denied by parents (25,26) and are considered typical of adolescence. An interview with questions that specifically explore these areas has shown that they are much more common in children than previously recognized.

Notably, psychomotor agitation is present in 45% of our patients, which is 3 times more frequently than psychomotor retardation. This finding, as well as the high frequency of other symptoms such as irritability and poor concentration, suggests the presence of “mixed” bipolar elements in a relevant proportion of patients. Hypomanic and mixed features during major depression and dysthymia in children and adolescents

have been previously reported by others (27,28). These symptoms, either spontaneous or pharmacologically induced, can represent a significant complication during the course of the depressive illness in a substantial minority of children and adolescents. Further, this observation confirms that, in a significant minority, early-onset DD belongs to the bipolar spectrum.

Anxiety disorders are commonly comorbid with DD, especially GAD and separation anxiety disorder (31). Sex did not appear to affect anxiety comorbidity, except for separation anxiety disorder, which was not reported in male adolescents. Lower rates of anxiety comorbidity (40% to 55%) are reported by Kovacs and others (6) and by Goodman and others (15). Although we have paid specific attention to distinguishing DD from GAD, a particularly high comorbidity between these 2 disorders was seen in our study. In the Goodman and coworkers’ study, based on a community sample, the rate of GAD in pure DD was 9%, even though it climbed to 44% when associated with MDD (15). In Kovacs and coworkers’ study, considering only ambulatory children, 17% of the pure DD and 31% of the DD–MDD patients had a comorbid over-anxious disorder (10). The fact that we used patients who had

been referred to our research group (both inpatients and outpatients) may have amplified this comorbidity.

Anxious comorbidity has been associated with a risk of bipolarity (32), increased severity of the chronic depression, and a poorer outcome in adult patients (33), but it did not affect recovery rate in children and adolescents with DD (8). Our cross-sectional data do not permit us to draw prognostic implications.

Externalizing disorders are reported in about one-third of our sample and, as expected, are more common in male than in female patients, both among children and adolescents (1). Similar rates of comorbidity, ranging from 31% to 41%, were reported by Kovacs and others (6) in a clinical sample and by Goodman and others (15) in a community sample. Higher rates of behavioural disorders were reported by Ferro and others (14), who found externalizing disorders in all their 18 children with DD, and by Asarnow and Ben-Mair (19). In our previous study (23), in which children were the main source of information, a lower rate of externalizing disorder (14%) was reported, while rates of anxiety comorbidity were similar to the present study. In children's reports, greater weight is given to subjective experiences, while parents are more prone to report behavioural symptoms (25,26).

A limitation of this study may be that the severity of the symptomatology and the rates of comorbidity are greater in referred samples than in the general, nonreferred population (34). The mean number of symptoms (about 7) and the rate of thoughts of death and anxiety comorbidity, which were higher than in a previous report (6), suggest that our patients may represent a particularly severe sample of DD. On the other hand, this study provides information about DD as observed in practice settings of child and adolescent psychiatry.

DD has an insidious onset during childhood or adolescence (6). Considering the interval between the onset of DD and other superimposed mental disorders (that is, superimposed MDD usually occurs 2 to 3 years after the onset of DD) (6), and the possibility of a bipolar evolution (27,28,30), an early diagnosis is crucial. A timely intervention, indeed, provides the best opportunity for possible prevention of subsequent psychopathological and functional impairment.

It is finally noteworthy that, as in adults (3,35), pure DD is characterized primarily by emotional-cognitive manifestations, which are less prominent in the DSM-IV list. As discussed, these are the very symptoms reported by children and adolescents—not their parents.

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### Résumé : Phénoménologie et comorbidité du trouble dysthymique chez 100 enfants et adolescents dirigés consécutivement : au-delà du *DSM-IV*

**Objectif :** Les critères diagnostiques et les limites nosologiques du trouble dysthymique (TD) juvénile sont sous-étudiés. Deux ensembles différents de critères diagnostiques sont encore présentés dans le *DSM-IV*, le premier accordant beaucoup de poids aux symptômes somatiques et végétatifs, et le second, paraissant en annexe, à des symptômes plus affectifs et cognitifs. Le but de cette étude était de décrire la symptomatologie et la comorbidité prototypiques du TD, selon les critères du *DSM-IV*, dans une série d'enfants et d'adolescents envoyés en consultation consécutivement, en fonction de l'âge et du sexe.

**Méthode :** Cent patients hospitalisés et externes (36 enfants et 64 adolescents, 57 garçons et 43 filles, de 7 à 18 ans, âge moyen de 13,3 ans) ont reçu un diagnostic de TD sans trouble dépressif majeur comorbide, à l'aide des antécédents, d'une entrevue clinique structurée (DICA-R) et du classement des symptômes d'après les critères du *DSM-IV*.

**Résultats :** L'irritabilité, la faible estime de soi, la fatigue ou perte d'énergie, l'humeur dépressive, la culpabilité, les difficultés de concentration, l'anhédonie et le désespoir étaient présents chez plus de 50 % des sujets. Les différences de profil symptomatique entre les filles et les garçons n'étaient pas significatives. Les troubles anxieux étaient souvent comorbides avec le TD, principalement un trouble anxieux généralisé et de simples phobies; et chez les enfants pré-pubères, le trouble d'anxiété de séparation. Des troubles d'extériorisation ont été déclarés chez 35 % des patients, la prévalence étant plus élevée chez les garçons. Les adolescents présentaient plus d'idées suicidaires et d'anhédonie que les enfants.

**Conclusions :** Ce portrait clinique de l'apparition précoce du TD que nous avons constaté, entièrement fondé sur un pur échantillon sans trouble dépressif majeur courant ou antérieur, n'est pas totalement congruent avec les critères diagnostiques du *DSM-IV*. Une définition plus précise du portrait clinique peut aider le diagnostic et la prévention précoces des troubles mentaux superposés.