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The inter-relationship between mood, self-esteem and response styles in adolescent offspring of bipolar parents: An experience sampling study

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ABSTRACT

The response styles theory of depression (Nolen-Hoeksema, 1991) proposes three main strategies individuals employ in response to low mood: rumination, active coping (distraction and problem-solving) and risk taking. Although recent research has suggested this theory has utility in understanding the symptoms of bipolar disorder (BD), the role of these processes in conferring vulnerability to the condition is poorly understood. Twenty-three adolescent children of patients with BD and 25 offspring of well parents completed the Experience Sampling Method (ESM; Csikszentmihalyi and Larson, 1987) diary for six days. Longitudinal analyses were carried out to examine inter-relationships between mood, self-esteem and response styles. Increased negative as well as positive mood resulted in greater rumination in both groups. Low self-esteem triggered greater risk-taking at the subsequent time point in the at-risk group, while negative affect instigated increased active coping in the control group. In both groups, engagement in risk-taking improved mood at the subsequent time point, whilst rumination dampened self-esteem. Differential longitudinal associations between mood, self-esteem and response styles between at-risk and control children suggest early psychological vulnerability in the offspring of BD parents, with important indications for early intervention.

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1. Introduction

Instability of affect and intense shifts in self-concepts are core domains of psychological dysregulation during episodes of depression and mania in bipolar disorder (APA, 2000). Patients' inability to regulate these processes has serious and long-term consequences for their personal and professional lives. Several theories have proposed potential psychological mechanisms that might drive such fluctuations, including negative cognitive style (Beck, 1976; Alloy et al., 2006) and its differential reactivity (Teasdale, 1988), dysregulation of the behavioural activation (Depue and Iacono, 1989) and circadian systems (Goodwin and Jamison, 2007), or, in more recent accounts, extreme interpretations of internal states (Mansell et al., 2007). Specific mechanisms implicated in the psychological abnormalities vary across theories. However, they all point to an increased sensitivity to external or/and internal stimuli, leading to a vicious circle of pathological behaviour and increasingly severe symptoms.

One way of investigating behavioural oversensitivity in bipolar disorder (BD) is within the context of *response style theory* (Nolen-Hoeksema, 1991), which proposes that individuals differ in the way they respond to feelings of negative affect, with serious consequences for the duration and severity of depressive or other kinds of dysphoric episodes. Four coping strategies have been described within this framework. First, (i) *rumination* has been defined as passively directing one's attention and thoughts to current depressive feelings, to its causes and effects. In contrast, (ii) *distraction* has been described as directing one's attention away from depressive symptoms by engaging in pleasant activities. (iii) *problem-solving* involves an active effort to relieve symptoms. Finally, (iv) *risk-taking*, which is particularly important in the context of BD, involves engaging in dangerous behaviours without regard to the consequences. Factor analytic evidence suggests that distraction and problem-solving can be conceived as belonging to a single strategy of *active coping* (Knowles et al., 2005). Substantial

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research has supported the role of response styles in the onset (Just and Alloy, 1997; Nolen-Hoeksema, 2000) and maintenance of unipolar depression (Nolen-Hoeksema and Morrow, 1991, 1993), and this theoretical account has been recently employed in investigations of the maintenance of symptoms in BD with promising results.

The role of rumination in bipolar depression has been reported in student (Thomas and Bentall, 2002; Robinson and Alloy, 2003; Chang, 2004; Knowles et al., 2005), and patient studies (Johnson et al., 2008; van der Gucht et al., 2009; Pavlickova et al., 2013). It has also been reported that young non-medicated adults, diagnosed with BD, showed increased rumination in response to both negative and positive affect (Johnson et al., 2008). In contrast to studies on major depression, depressive symptoms have been also significantly related to risk-taking (Thomas and Bentall, 2002; Knowles et al., 2005; Pavlickova et al., 2013). In this vein, it has been proposed that bipolar patients employ risk-taking as a strategy to deal with low mood (Thomas and Bentall, 2002; Thomas et al., 2007), an account consistent with earlier models by psychoanalysts (Abraham, 1911/1927; Neale, 1988) who argued that mania arises from dysfunctional strategies for avoiding depression.

Only one recent study has employed a longitudinal design in order to parse out the interrelationship between daily life correlates, and symptoms, in a cohort of bipolar patients (Pavlickova et al., 2013). In this study, which used the experience sampling method to record response styles and other data from bipolar patients ten times a day over six days, depression at the start of the study was associated with high levels of all three response styles whereas manic symptoms were associated with high levels of risk taking. Longitudinally, negative affect triggered subsequent rumination, which was associated with a subsequent increase in negative mood and decrease in positive mood, but the decrease in positive mood was less marked in those showing manic symptoms at baseline. Contrary to what had been predicted, positive rather than negative affect was associated with subsequent risk-taking. One limitation of the study was the lack of comparison groups, limiting the extent to which these processes can be judged as intensified, or compromised. Another limitation is related to the inherent characteristics of patient studies, including long-term use of medication and severe recurrence of episodes, which may confound or otherwise affect the findings. The impact of both on self-concept and mood has been well documented (Gibbs et al., 2007; Harmer et al., 2009). One promising way of circumventing these limitations is to study individuals with increased likelihood of developing the disorder, yet who are currently healthy.

It has been well documented that children of parents with BD, in comparison to offspring of control parents, have an increased risk of psychiatric disorders. A meta-analytic study has reported that 26.5% of bipolar offspring meet diagnostic criteria for affective disorders, compared to 8.3% of control children (Lapalme et al., 1997). However, little research has been done on the psychological characteristics associated with the familial risk for BD. A few studies have employed the Child Behaviour Checklist (Achenbach, 1991), a dimensional assessment tool examining behavioural problems and competencies. In these studies at-risk children with psychiatric diagnoses scored consistently higher on a number of subscales (Wals et al., 2001; Dienes et al., 2002; Reichart and Nolen, 2004; Giles et al., 2007). Furthermore, Giles et al. (2007) found that at-risk children with no history of psychiatric problems show increased aggression, depression/anxiety, withdrawal, and attention problems. Other studies have pointed to the role of early disruptive and attention problems (Carlson and Weintraub, 1993; Henin et al., 2005), high emotional lability (Birmaher et al., 2013; Doucette et al., 2013), and poor social functioning (Whitney et al., 2013).

However, studies on psychological processes typical of individuals with diagnosed mood disorder are rare. In this direction, a study employing a behavioural high-risk paradigm (with participants selected using questionnaire measures) indicated that increased anger, hyperactivity and lower emotional symptoms were associated with hypomanic personality characteristics (Cooke and Jones, 2009). Also using a behavioural high-risk paradigm, Bentall et al. (2011) found that, in individuals with hypomanic personality characteristics compared to controls, both rumination and risk-taking led to a greater decrease in self-esteem whereas, in the high risk group only, active coping led to an increase in self-esteem. However, to our knowledge, only one study has so far examined psychological processes typical of individuals with BD in adolescent children of bipolar parents (Jones et al., 2006). The findings indicated fluctuating self-esteem, increased rumination and negative affect in the at-risk children, but only in those children who had current or lifetime mood diagnoses.

The aim of the present study was to examine the interplay between affect, self-esteem and response styles in a population of adolescents at genetic risk of BD, versus offspring of control parents, using the experience sampling method. The study aimed, firstly, to identify early behavioural abnormalities in response to changes in mood and self-esteem; secondly, to examine whether at-risk children show an increased sensitivity to the engagement in BD relevant behaviours (i.e. response styles).

More specifically, on the basis that response styles might be a risk factor for future affective disorder, we hypothesised that low mood would lead to greater engagement in rumination in the at-risk offspring at a subsequent time point, whilst high mood would lead to a greater engagement in risk-taking. Second, on the same basis, we expected that rumination would lead to more pronounced decreases in mood and self-esteem in the at-risk children, whilst risk-taking would lead to a greater increase in mood and self-esteem.

2. Methods

2.1. Participants

Thirty adolescent children between 13 and 19 years of age, who had parents with BD, and 30 children of control parents participated in the study; of these only 22 index children and 25 control children completed the ESM protocol (see below). Recruitment of participants was carried out in two stages. First, adults with diagnosis of BD who have children between 13 and 19 years of age were approached via a number of venues: self-help groups (including advertisements in self-help group newsletters and websites), community mental health teams and psychiatric services in Wales and England. A researcher explained the protocol to interested parents, and provided them with an information sheet to give to their children. Informed consent was obtained from both parents and child before the commencement of the study. The inclusion criteria for index children were (a) age between 13 and 19 years and (b) having a biological parent diagnosed with BD. The only exclusion criterion was an insufficient command of English language.

Control participants were recruited via snowballing from index participants (in one case), from the Bangor University Community Panel, and by word of mouth. The inclusion criteria for control children were (a) age between 13 and 19 years, and (b) having a parent with no history of mental illness. Insufficient command of English was the only exclusion criterion. The study was conducted in accordance with the Helsinki Declaration as revised in 1989, and ethical approval was obtained from a National Health Service research ethic panel. Parental diagnosis, or no history of BD in case of control parents, was confirmed by completing the Structured Clinical Diagnostic Interview for DSM-IV Axis I Disorder (First et al., 1995). Adolescents were interviewed with the Schedule for Affective Disorders and Schizophrenia for School-Aged (K-SADS; Kaufman et al., 1997).

2.2. Clinical measures

All offspring completed two face-to-face interviews in order to assess their current level of mood symptoms.

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