



Adverse childhood experiences worsen cognitive distortion during adult bipolar depression

Sara Poletti*, Cristina Colombo, Francesco Benedetti

Scientific Institute and University Vita-Salute San Raffaele, Department of Clinical Neurosciences, Milan, Italy

Abstract

Background: Cognitive distortion is a central feature of depression, encompassing negative thinking, dysfunctional personality styles and dysfunctional attitudes. It has been hypothesized that ACEs could increase the vulnerability to depression by contributing to the development of a stable negative cognitive style. Nevertheless, little research has been carried out on possible associations between adverse childhood experiences (ACEs) and cognitive distortion, and whether any gender differences exist.

Aim: The aim of this study was to examine the association between ACEs and cognitive distortions and possible differences between genders in a sample of patients affected by bipolar disorder.

Method: 130 patients with bipolar disorder (BD) (46 men and 84 females), completed the Risky Family Questionnaire to assess ACEs and the Cognition Questionnaire (CQ) to assess cognitive distortions.

Results: A positive association was found between ACE and the CQ total score. Investigating the 5 dimensions assessed through the CQ, only the dimension “generalization across situations” was significantly associated to ACE. An interaction between ACE and gender was found for “generalization across situations”, while no differential effect among females and males was found for CQ total score.

Conclusion: This is the first study to report a relationship between negative past experiences and depressive cognitive distortions in subjects affected by BD. Growing in a family environment affected by harsh parenting seems to a cognitive vulnerability to depression; this effect is especially strong in females.

© 2014 Elsevier Inc. All rights reserved.

1. Introduction

Cognitive distortion is a central feature of depression, encompassing negative thinking, dysfunctional personality styles and dysfunctional attitudes. Depressive episodes are characterized by negative thinking [1] and distortions in self perception, which persist despite clinical remission [2] therefore suggesting an enduring cognitive characteristic, which includes a negative bias in information processing and in evaluating one’s self with increased guilt and both self-deprecatory and self-accusatory thought [3]. Among cognitive distortions a negative view of the future, or hopelessness, has been identified as a regular cognitive correlate of depression [4,5]. Generalization of hopelessness from a specific negative

life-event also seems to be a key element in the development of depression [6]. According to the hopelessness theory of depression [7], developing depression is more likely when making stable, global attributions, inferring negative characteristics about the self, and anticipating negative consequences when negative life events occur.

Following this perspective a role of personality styles [8–12] and cognitive constructs [13–16] in precipitating depression has been documented in both BD and major depression. Dysfunctional attitudes correlate with a longer duration of depressive episodes [17,18]. Moreover an association exists between a higher severity of cognitive distortion and a lower response to antidepressant treatment, with a persistent negative correlation between low levels of self-esteem and global functioning [19].

Although the interest in cognitive styles in bipolar disorder (BD) is much more recent, it is evident from the literature that they show striking similarities to those of patients affected by major depression [20–23]. Patients with BD demonstrate similar patterns of cognitive style to

* Corresponding author at: Istituto Scientifico Ospedale San Raffaele, Department of Clinical Neurosciences, San Raffaele Turro, Via Stamira d’Ancona 20, Milano, Italy. Tel.: +39 02 26433156; fax: +39 02 26433265.
E-mail address: poletti.sara@hsr.it (S. Poletti).

unipolar patients but differ from controls particularly on self esteem [23] which persists beyond depressive symptomatology with euthymic bipolar patients showing significantly higher scores on the Dysfunctional Attitudes Scale (DAS) as well as the ‘Need for Approval’ and ‘Perfectionism’ subscales than healthy control [24].

Adverse childhood experiences (ACEs) have been shown to influence both physical and mental health [25] and in patients with BD have been reported to affect both the onset and course of illness [26]. Exposure to physical, sexual, and emotional abuse in childhood is associated with earlier onset of BD, rapid cycling [27,28], an increased likelihood of self-injurious behavior [29], and higher severity and number of suicide attempts [27,28,30]. Moreover exposure to certain types of parenting practices or to maltreatment during childhood increases individuals’ vulnerability to mood disorders [31] possibly altering permanently the stress response system, sensitizing individuals to later stress, and leading to early onset and severe course of the disorder [32]. The possible influence of sex on the resilience to the detrimental effects of early stress is debated [33], but a higher specific sensitivity to family conflict [34] and to the effect of ACEs [35,36] was found in females.

Given extensive evidence linking negative cognitive style to depression, it is important to investigate if family environment could play a role in the development of cognitive distortion. Mezulis et al. [37] proposed an “integrated, developmental model of cognitive vulnerability to depression in which children are hypothesized to develop their unique cognitive style during the middle-to-late childhood period through their experiences with negative life events”.

It has been hypothesized that ACE could increase the vulnerability to depression by contributing to the development of a stable negative cognitive style. Repeated experiences of negative life events during middle to late childhood could then increase the cognitive vulnerability to depression in adult life. A first step to test this hypothesis is the investigation of possible relationships between ACE and cognitive distortion in adult life. In the general population ACE associated with increased hopelessness [36]. Here we hypothesized that ACE will be associated to cognitive distortion in a sample of adult bipolar patients. Moreover, given the evidence of a higher sensitivity to family conflict in females compared to males, we hypothesized that gender could influence this association.

2. Methods

2.1. Sample

The sample included 130 biologically unrelated inpatients in the course of a depressive episode without psychotic features and with a diagnosis of Bipolar Disorder I (DSM-IV criteria, SCID-I interview). Exclusion criteria were: additional diagnoses on axis I, mental retardation on axis II,

pregnancy, major medical and neurological disorders, history of drug or alcohol abuse or dependency. Physical examination, laboratory tests and electrocardiograms were performed at admission. No patient received electroconvulsive therapy (ECT) within 6 months prior to study enrolment. After complete description of the study to the participants, written informed consent was obtained. The study was approved by the local ethical committee.

2.2. Treatment

All patients received antidepressant drug treatment upon clinical need. A subsample of 106 patients was administered three consecutive total sleep deprivation (TSD) cycles (day 0–7); each cycle was composed of a period of 36 h awake. On days 0, 2, and 4 patients were totally sleep deprived from 07:00 a.m. until 7.00 p.m. of the following day. They were then allowed to sleep during the night of days 1, 3, and 5. Patients were administered light therapy (LT) (exposure for 30 min to a 10,000 lux bright white light, color temperature 4600 K) at 03:00 a.m. during the TSD night and in the morning after recovery sleep, half an hour after awakening, between 8 and 9 a.m. Some of the patients were taking lithium ($n = 81$) together with the chronotherapeutic procedure to enhance its effect and prevent relapse [38–40]. Some of the patients were also taking benzodiazepine, antidepressant and other mood stabilizers.

2.3. Clinical assessment

Severity of depression was rated (day 0, 1, 2, and 6) on a modified version of the 21-item Hamilton Depression Rating Scale (HDRS). A delta score was calculated subtracting HDRS after one week of treatment from HDRS at baseline to assess clinical improvement.

Severity of ACE was rated on the Risky Families Questionnaire (RFQ) [41]. The RFQ has been adapted from an instrument originally developed to assess the relation of family stress to mental and physical health outcomes in adulthood [25]. The instrument is aimed at rating the degree of harsh parenting with overt family conflict and deficient nurturing experienced by the children in their familial environment. Previous research validated this questionnaire against clinical interviews conducted and coded by trained clinical interviewers; the dual assessments (questionnaire and interview) demonstrated high agreement and reliability [42]. This approach has been proven successful in detecting structural and functional brain correlates of ACE in adult patients affected by psychiatric disorders [41,43].

Cognitive distortion was rated on the Cognition Questionnaire (CQ) [44] a measure of dysfunctional attitudes which assesses dimensions of negative thinking in relation to a number of hypothetical events. This questionnaire comprises five dimensions which are applied to the consequences of the hypothetical situations: emotional impact, attribution of causality, generalization across time, generalization across situations perceived uncontrollability.

Download English Version:

<https://daneshyari.com/en/article/10297730>

Download Persian Version:

<https://daneshyari.com/article/10297730>

[Daneshyari.com](https://daneshyari.com)