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Parental expressed emotion and suicidal ideation in adolescents with bipolar disorder

Alissa J. Ellis [a,*], Larissa C. Portnoff [a], David A. Axelson [b], Robert A. Kowatch [c,d], Patricia Walshaw [a], David J. Miklowitz [a]

[a] University of California-Los Angeles, Semel Institute of Neuroscience and Human Behavior, Division of Child and Adolescent Psychiatry, 760 Westwood Plaza, Los Angeles, CA 90025, USA
[b] University of Pittsburgh Medical Center, Western Psychiatric Institute, Pittsburgh, PA, USA
[c] Ohio State Wexner Medical Center, Columbus, OH, USA
[d] Nationwide Children's Hospital, Columbus, OH, USA

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ABSTRACT

Family environmental variables are risk factors for recurrent courses of mood disorder in adolescents. The present study examined the association between parental expressed emotion (EE)—critical, hostile and/or emotionally overinvolved attitudes toward a concurrently ill offspring—and suicidal ideation in adolescents with bipolar disorder. The sample consisted of 95 adolescents with a bipolar I or II diagnosis who had experienced a mood episode in the prior 3 months. Participants (mean age = 15.54 years, S.D. = 1.4) were interviewed and completed questionnaires regarding current and past suicidal ideation prior to their participation in a treatment trial. Parents completed five-minute speech samples from which levels of EE were assessed. High EE attitudes in parents were associated with current suicidal ideation in adolescents. This relationship was independent of the effects of age, gender, current depressive or manic symptoms, comorbid diagnoses, bipolar I/II subtypes, family adaptability, and family cohesion. These results underscore the importance of addressing the emotional reactivity of caregivers in treating adolescents with bipolar disorder who have suicidal ideation.
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1. Introduction

Suicide ranks as the third leading cause of death among adolescents (Center for Disease Control and Prevention, 2010). Among children and adolescents with bipolar disorder, approximately 20–30% report suicide attempts (Goldstein et al., 2005; Goldstein, 2012), and over 50% report one or more periods of suicidal ideation (Lewinsohn et al., 2003). Thus, bipolar disorder has one of the highest rates of suicide completion (Baldessarini and Tondo, 2003).

Family contextual variables are strongly related to the course of depressive symptoms in bipolar disorder. High levels of expressed emotion (EE) among parents – defined as high levels of criticism, hostility, or emotional involvement toward the offspring – are prospectively associated with illness recurrences and more severe depressive symptoms in bipolar adults (Kim and Miklowitz, 2004; Miklowitz et al., 1988; Yan et al., 2004). Adolescents with bipolar disorder who had high EE parents had higher depression and mania symptom ratings over 2 years than those with low EE parents (Miklowitz et al., 2006). Although there is evidence to suggest high EE family environments increase mood symptoms in bipolar adolescents, the association between parental EE and suicidal ideation has not been examined in bipolar disorder.

Dimensions of the family system such as cohesion, conflict and adaptability are also related to the course of mood symptoms in bipolar disorder (Robertson et al., 2001; Sullivan et al., 2012). Adaptability involves the roles, leadership, discipline and flexibility of the family, while cohesion involves the closeness of the family through assessment of the amount of time spent together, boundaries, and emotional bonding (Tiesel and Olson, 1992). Parents of adolescents with bipolar disorder report lower levels of cohesion and adaptability, than parents of healthy adolescents, and high EE parents of bipolar youth report lower levels of adaptability and cohesion than low EE parents (Sullivan and Miklowitz, 2010). Low cohesion and adaptability have also been longitudinally associated with higher depression scores in bipolar adolescents (Sullivan et al., 2012). Low family cohesion, low family support and high family conflict differentiate adolescents with

* Corresponding author. Tel.: +1 310 825 0118.
E-mail address: aellis@mednet.ucla.edu (A.J. Ellis).

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suicidal ideation from non-suicidal patients and non-clinical controls (Wagner et al., 2003). Further, bipolar adolescents with suicidal ideation endorse lower family adaptability and more conflict with their mothers than those who do not endorse suicidal ideation (Goldstein et al., 2009). Combined, these results suggest an association between symptom presentation and the family environment.

This study examined the relationships between EE, family cohesion, and family adaptability and suicidal ideation in adolescents with bipolar disorder. We hypothesized that low family cohesion, low adaptability, and high EE would be independently associated with suicidal ideation beyond the effects of other demographic or clinical variables, including age, sex, socioeconomic status (SES), current manic or depressive symptoms and the presence of comorbid axis I disorders.

2. Methods

2.1. Participants

Ninety-five youth meeting DSM-IV-TR (APA, 2000) criteria for bipolar I or II disorder were evaluated to determine eligibility for a randomized trial of family-focused treatment. Of the 145 adolescents who participated in the trial, parents of 95 adolescents completed a taped five-minute speech sample (FMSS) that could be evaluated for EE. Of these 95, 79 of the adolescents had both parent and self-reported measures of adaptability and cohesion. The 16 youths with incomplete data did not differ in bipolar diagnosis subtype (I versus II), current manic or depressive symptoms, age, sex or ethnicity from those 79 who provided complete data (all $ps > 0.10$). Thus, analyses involving cohesion and adaptability are based on fewer ($N=79$) participants than all other analyses ($N=95$). Adolescents and parents signed informed assent and consent forms prior to participating in the study. The institutional review boards of the three participating universities (University of Colorado, Boulder, University of Pittsburgh School of Medicine, and University of Cincinnati/Cincinnati Children's Hospital) approved all procedures.

To be eligible for the randomized trial, participants had to have a lifetime diagnosis of bipolar I or II disorder and be 12 years 0 months to 17 years, 11 months in age. They were required to have had a mood episode (i.e., a (hypo)manic or depressive episode) in the previous 3 months and moderate symptoms for at least 1 week in the prior month prior to study intake. Participants were excluded if they (1) met criteria for substance abuse/dependence disorder in the past 3 months, (2) had a pervasive developmental disorder, (3) met criteria for a primary psychotic disorder or a life threatening eating disorder, (4) had a severe medical condition that required urgent treatment, or (5) were victims of current physical or sexual abuse. Youth who were ineligible were given referrals to other treatment sources.

2.2. Procedures

2.2.1. Diagnostic assessment

The Kiddie Schedule for Affective Disorders and Schizophrenia, Present and lifetime Version [K-SADS-PL] (Chambers, 1985; Kaufman et al., 1997), a semi-structured diagnostic interview, was utilized for diagnostic purposes. Independent KSADS-PL interviews were completed with the youth and one parent, and summary scores were generated. In the case of significant discrepancy between parent and child reports, the parent and youth were interviewed conjointly to determine consensus. The diagnosis was confirmed further through a separate evaluation with the parent and youth by a board certified psychiatrist.

To obtain a more comprehensive mood assessment, the KSADS Mania Rating Scale (Chambers, 1985) and Depression Rating Scale (Axelson et al., 2003) were substituted for the mood modules of the K-SADS-PL. These measures convert the KSADS items to 1–6 or 1–7 scales of severity, allowing for a more fine-grained assessment of symptom severity. Criterion A symptoms (elevated or irritable mood) were rated as present only if a distinct and notable change from the adolescent's normal mood was observed. Criterion B symptoms were rated if they began or intensified with the onset of the criterion A symptoms. In addition, significant mood symptoms during at least 1 week of the prior month, as assessed by the MRS (total score >17) and DRS (total >16) was required for participation. Reliability among 12 independent raters from all three sites was strong for both the DRS and MRS ($\kappa=0.89$ and $\kappa=0.81$, respectively; 12 examples).

2.2.2. Suicidal ideation

To be consistent with the two prior studies of suicidal ideation in pediatric BD (Algorta et al., 2011; Goldstein et al., 2009), individuals were grouped based on their response to the 'suicide ideation' item of the KSADS. Those with a score of at least a "3" (i.e., occasional thoughts of suicide but no thoughts of a specific method) on this item were classified as having current suicidal ideation (SI, $n=40$). Those scoring below a "3" on this item were classified as low-SI ($n=55$). This cutoff describes individuals whose thoughts have shifted from thoughts of death to the actual act of suicide (e.g., taking an action to harm oneself purposefully with the intention of death). These thoughts had to have occurred for at least 1 week in the prior month.

2.2.3. Expressed emotion assessment

The five-minute speech sample (Magaña et al., 1986) was completed by parents regarding their relationship with the child. The parent was instructed to "talk for 5 min about what kind of person (your child) is and how the two of you get along together." FMSS audiotapes, masked regarding treatments, were coded by the developer of the FMSS-EE system (Magaña et al., 1986). Families were classified as high in EE ($n=50$) if one or both parents made at least one critical comment, displayed evidence of emotional over involvement, or demonstrated hostility during the FMSS. Families in which neither parent expressed criticism, hostility or over involvement were classified as low EE ($n=45$). Within the sample, only 27 (28.4%) of fathers provided an FMSS, while 84 (88.4%) of mothers provided a sample. Single-parent families were classified according to the FMSS of the individual parent. A subset of 10 FMSS tapes were coded during the study interval by a group of 12 newly trained raters. Reliability for high versus low-EE classification was excellent ($\kappa=0.95$) between the primary rater and these trained raters.

2.2.4. Self-reports of family environment

To assess family cohesion and flexibility, the self- and parent-report versions of the Family Adaptability and Cohesion Evaluation Scale-II (FACES-II: (Olson and Tiesel, 1991)) were administered to the parents and child. The two subscales of Cohesion and Adaptability were computed for each participant. In order to reconcile single and dual parent homes, the parent score was determined using the higher of the two scores, which in the majority of cases (97%) was from the mothers' report.

2.3. Data analysis

The factors correlated with SI classification were determined using univariate statistics. Categorical variables (e.g., sex, gender, bipolar subtype, EE) were compared to the low and high SI groups using χ^2 tests, whereas t-tests were used to assess whether continuous variables (e.g., depression severity, age, family adaptability and cohesion scores) were associated with SI group. Next, we compared high and low-EE families on proportion of adolescents in the high and low SI groups, as well as the relationships between family adaptability/cohesion (child and parent) and SI classifications. The variables associated with SI classification in univariate analyses were then entered into a logistic regression model to estimate the variance explained by each variable on current suicidal ideation.

3. Results

3.1. Sample characteristics

Of the 95 adolescents, 40 (42.1%) endorsed suicidal ideation on the KSADS-DRS for at least 1 week of the prior month. Of these, 20 (50%) had mild thoughts (i.e., occasional thought of suicide but no method), 15 (37.5%) reported moderate thoughts (i.e., often thinks of suicide and has thought of a method), three (7.5%) had severe thoughts (i.e., often thinks of suicide, has thought of a method, and has mentally rehearsed a plan/made a suicidal gesture), and two (5%) reported extreme thoughts (i.e., made preparations for an attempt). Within this same sample, three (3%) reported making a "definite" attempt during this same time period (i.e., worst week in the past month). There were no differences between youth with and without SI in gender, age, ethnicity, SES, bipolar type (I versus II), parent marital status or comorbid diagnoses (Table 1).

To determine the concurrent validity of the KSADS measure of suicidal ideation, we examined the relationship between baseline SI groups (based on the DRS) and scores on the Suicidal Ideation Questionnaire-Junior (SIQ-JR; (Reynolds, 1988)), which were available on 87 of the youth covering the prior 4 weeks. The current sample's scores ranged from 0 to 90 ($M=24.07$, S.D.$=24.95$), which falls below the clinical cutoff (Reynolds, 1988). This comparison revealed a significant relationship between the variables ($r=0.43$, $p<0.001$). The low SI ($n=50$, $M=14.86$, S.D.$=18.48$)

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