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Research report

Personality, coping, risky behavior, and mental disorders in the offspring of parents with bipolar disorder: A comprehensive psychosocial assessment

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ABSTRACT

Objectives: It has been proposed that the offspring of parents with bipolar disorder (OBD), through genetic mechanisms and early family interactions, develop a heightened sensitivity to stress, maladaptive coping, and dysregulated behavior, which ultimately increases the risk for affective disorders. The current study tested certain predictions of this model by assessing different psychosocial and health-related outcomes in the OBD, including personality, coping style, smoking, suicidality, high-risk sexual behaviors, criminality, and mental health.

Method: The sample was composed of 74 OBD and 75 control offspring, who were between 14 and 27 years of age (mean: 19.38 ± 3.56). Participants underwent a diagnostic interview and a structured interview to assess high-risk behavior and other maladaptive outcomes, and they completed the Revised NEO Personality Inventory and Coping in Stressful Situations questionnaire.

Results: The rates of affective (31.1%) and non-affective (56.8%) disorders were elevated in the OBD compared to controls (9.5% and 32.4%). Relative to controls, OBD endorsed fewer task-oriented and more distraction coping strategies [Wilk's $\lambda = .83$, $F(1, 136) = 6.92$, $p < .01$], and were more likely to report engaging in high-risk sexual behavior (OR = 2.37; Wald = 4.13, 1 df, $p < 05$). Importantly, OBD reported elevated high-risk sexual behavior relative to controls, irrespective of affective disorder diagnosis.

Conclusion: The results highlight a potential risk profile for the OBD, consisting of ineffective coping strategies and risky sexual behavior and are discussed in the context of current knowledge of stress and coping in this population.

Limitations: The present findings were based on cross-sectional data and relied on offspring self-report. It would be useful to corroborate these findings with biobehavioural and longitudinal measures.

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1. Introduction

Bipolar disorder (BD) is among the ten most burdensome medical conditions worldwide (Murray and Lopez, 1997; WHO, 2001). It is associated with marked psychosocial dysfunction, including high rates of impulsive behavior such as suicidality (Tondo et al., 1998), substance abuse (Weissman et al., 1996), hypersexuality (Adelson et al., 2013), and criminal behavior (Soyka and Zingg, 2010; Swann et al., 2011). Furthermore the offspring of parents with bipolar disorder (OBD) is at greater risk of developing maladaptive development (see Jones and Bentall, 2008), likely by virtue of inherited traits combined with sub-optimal rearing environments (Rutter, 2009). There is a substantial evidence of psychopathology among the OBD (i.e. Birmaher et al., 2009; Duffy et al., 2010; Henin et al., 2005; Hillegers et al., 2005; LaPalme et al., 1997; Vandeleur et al., 2012). Rates of affective disorders have been estimated at 15–56% in adolescent and young adult OBD, compared to 0–12% in control samples (Birmaher et al., 2009; Duffy et al., 2006; Henin et al., 2005; Hillegers et al., 2005; Hirschfield-Becker et al., 2006; Mesman et al., 2013; Vandeleur et al., 2012). In children, rates of disruptive behavior disorders and anxiety disorders are roughly two to nine times those observed in controls (Birmaher et al., 2009; Hirschfield-Becker et al., 2006; Vandeleur et al., 2012). Recent clinical staging models suggest that the OBD are likely to display different age-specific internalizing and

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externalizing pathologies (Duffy, et al., 2010; Klimes-Dougan et al., 2010), suggesting that an underlying vulnerability that manifests in different symptom presentation across development. Most research on the OBD has focused on rates of psychopathology: few studies have examined personality and non-psychiatric psychosocial risk factors in the OBD.

Personality and psychopathology have been inextricably linked, although the exact nature of this relationship has been debated (see Widiger et al., 1999). In our model of the OBD (Ellenbogen and Hodgins, 2004; Ostiguy et al., 2012), we hypothesized that one marker of the genetic vulnerability for mood disorders is high levels of the trait of neuroticism (Fanous et al., 2002) – a tendency to react emotionally to stressors and daily hassles. Being raised by one or two parents who themselves model over-reactivity to daily hassles and ineffective coping with stress may compromise the ways in which their offspring cope with life stress. The parents' neurotic behavior creates a family environment that is stressful, chaotic, and unpredictable (Chang et al., 2001; Ellenbogen and Hodgins, 2004), and these parents fail to provide adequate support and structure for their children (Ellenbogen and Hodgins, 2009). The family environment and parenting practices, we postulate, in interaction with a genetic vulnerability, lead to deficits in emotional and behavioral regulation among the children (Derryberry and Rothbart, 1997; Ellenbogen and Hodgins, 2009; Loman and Gunnar, 2010). In sum, these adverse family-environmental effects associated with high neuroticism in parents are postulated to elicit a number of subsequent environmental outcomes that have a negative impact on offspring, including a high sensitivity and inability to effectively cope with stress, dysregulated behavior, and high neuroticism.

Consistent with the model, there is evidence that the OBD, relative to control offspring, experience more moderate to severe stressful life events (Ostiguy et al., 2009), display a greater biological sensitivity to stress (Ostiguy et al., 2011), and exhibit a ruminative coping style (Jones et al., 2006). Furthermore, for those who go on to develop a disorder, stressful life events are likely to precede onset of the disorder (Petti et al., 2004). As such, it would seem that the OBD are not only more prone to experience stress in their lives, but also may experience or cope with stress differently than others. In a recent longitudinal study of the OBD, it was found that high neuroticism in parents predicted poor interpersonal functioning in their offspring 10 years later in late adolescence and early adulthood (Ostiguy et al., 2012). The association between parents' personality and interpersonal functioning in offspring was mediated by offspring's dysregulated behavior in middle childhood. Although this study was consistent with our model, little is known of the personality profiles of OBD, nor about their coping or risky behaviors in late adolescence and early adulthood.

The study of health-related risk behaviors such as criminality, risky sexual behavior, and suicidality have rarely been studied in the OBD. It is important because, as adolescents take an active role in shaping and selecting their environments, they may create stressful circumstances for themselves in the form of impulsive or risk taking behavior. Such behavior is particularly likely in the OBD, who display higher levels of sensation seeking (Nurnberger et al., 1988), a trait associated with the development of delinquent behavior, and externalizing problems (Linnen et al., 2009). Moreover, there are important links between the endorsement of behaviors such as illicit drug use, smoking, high-risk sexual behavior, and criminality and increased risk of developing a mental disorder (Fergusson et al.2002; Lahey et al., 2005). To the best of our knowledge, there is only one study that directly addresses risk-taking in the OBD. Jones et al. (2006) found that OBD who had developed an affective disorder were more likely to endorse a response style indicative of general risk taking than OBD who had not developed an affective disorder, as well as unaffected controls. However, no study to date has explored specific sexual, health-related, and criminal risk taking behaviors in this population.

In contrast to studies of mental health in the OBD (i.e. Goldstein et al., 2010; Hillegers et al., 2005), the present study focused on *non-psychiatric* outcomes, in addition to the rates of affective and non-affective disorders among high-risk offspring. The objectives of the current investigation were twofold: (1) to examine differences in personality traits, coping style, and risk-taking behavior (smoking, anti-social behaviors, high risk sexual behaviors, self-injury, and suicidality) between the OBD and controls, and (2) to compare these psychosocial profiles in offspring who have developed an affective disorder with those who have not, so as to tease apart prodromal markers from those that are present by virtue of having an affective disorder. It is hypothesized that the OBD will report higher ratings of neuroticism and lower ratings of extraversion, more frequent use of maladaptive coping, and more risky behavior than control offspring, and that these differences will be present irrespective of having developed an affective disorder.

2. Method

2.1. Participants

Participants included 148 (65 female, 83 male) offspring between the ages of 14 and 27 years (M=19.38; SD=3.56) from 91 families (71 OBD, 77 control). The sample was composed of two cohorts recruited at different times. One hundred and twenty eight of the offspring (80 families; 86.5% of the full sample) were participants of an ongoing prospective longitudinal study of families with a parent diagnosed with BD or parents with no mental disorder. A small number of offspring were recruited more recently in an effort to increase the sample size (15 offspring [6 OBD, 9 controls] from 11 families (4 OBD, 7 controls); 9.9% of the total sample).

Families in the longitudinal study were recruited between 1996 and 1998. Inclusion criteria for entry into the longitudinal study were (a) adults raising at least one biological child between the ages of 4 and 14, (b) fluency in either English or French, and (c) children being raised and educated in Canada. Families in which either a parent or child had a chronic physical disease or handicap, and/or an IQ below 70, were excluded. Parents with a diagnosis of BD and their families were recruited from psychiatric outpatient clinics in the province of Québec, as well as from advocacy and support groups. Families in which parents had no mental disorder were recruited from the same neighborhoods as the families with BD, through physicians' offices and community organizations. Detailed demographic and psychosocial information on the original sample is described in Ellenbogen and Hodgins (2004). The new cohort was recruited through advertisements in local newspapers in 2006–2007. Inclusion and exclusion criteria were the same, except for the age requirement for offspring, which was set at 13–23 years of age. Informed consent was obtained from all participants.

All parents were assessed using the Structured Clinical Interview for *DSM-III-R* (SCID-I; Spitzer et al., 1992). Parents from the control families had no current or lifetime axis-I disorder, except for past episodes of substance abuse, anxiety disorders, or eating disorders, as indicated by the SCID-I. Eighteen percent of the OBD and 17% of the controls who were originally part of the longitudinal study refused to participate or have not been located for the current assessment. Children who did not participate were compared to those who did on measures of problem behavior and IQ assessed during middle childhood. No significant differences were found among the groups. One OBD participant failed to complete their questionnaires and six returned personality

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