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Ruminative and dampening responses to positive affect in bipolar disorder and major depressive disorder

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ABSTRACT

Background: Although previous research has focused on distinguishing cognitive styles between Bipolar Disorder (BD) and Major Depressive Disorder (MDD), little is known about differences in positive affect regulation between these affective groups. The aim of the present study was to extend previous research by investigating such differences between BD and MDD, and between the bipolar subtypes (BD-I vs. BD-II and predominant polarities), using large, clinical, outpatient samples.
Methods: In total, 298 participants (96 BD-I, 27 BD-II, and 175 MDD) were included. All completed the Responses to Positive Affect (RPA) questionnaire. Mood symptoms in BD patients were clinically assessed by means of the Clinical Global Impression for Bipolar Disorders (CGI-BP), while depressive symptom severity in MDD patients were assessed by means of the Inventory of Depressive Symptomatology (IDS-SR).
Results: Results showed differences between affective groups and bipolar subtypes. The most salient finding was that both BD-I and BD-II patients were more likely to ruminate about positive affect than MDD patients, while MDD patients were more likely to engage in dampening responses to positive affect.
Conclusions: Differentiation of responses to positive affect between BD and MDD may have relevant clinical implications in terms of symptomatology, course, and treatment.

1. Introduction

Bipolar Disorder (BD) is a disabling and lifelong condition characterized by recurrent manic, hypomanic and depressive episodes, with an estimated 12-month prevalence of 0.8–1.8%, and a life-time prevalence of 1.3–2.5% [1–3]. Although BD is primarily positioned as a biological disorder, with mood stabilizing medication as the first-line treatment, there is increasing recognition of psychological factors affecting the illness course of BD [4–6]. Accumulating evidence associates BD with difficulties in affect regulation, contributing to the onset and maintenance of mood symptoms [7, 8]. Most research is still directed at negative affect regulation, although there is increasing recognition for the role of positive affect regulation in psychopathology [9–12]. Feldman, Joormann [9] differentiate three processes related to positive affect regulation: dampening (i.e. the tendency to actively decrease positive feelings), and two positive rumination strategies: emotion-focused rumination (i.e. repetitively focusing on current positive states) and self-focused rumination (i.e. repetitively focusing on positive self-qualities). Several studies have found significant correlations between the way people respond to positive affect and the presence of (hypo) manic and depressive symptoms. For example, in college students, dampening of positive affect has been found to be predictive of depressive symptoms [9, 11, 13], while rumination on positive affect has been found to be correlated with (hypo)manic symptoms [9, 11, 14]. People with BD have been shown to be more likely to engage in both dampening and ruminative responses to positive affect than healthy controls [6, 8, 15].

Guidelines emphasize the use of Cognitive Behavioral Therapy (CBT) as one of the psychological interventions in the treatment of BD in addition to psycho-education [16–19]. CBT interventions for BD are largely drawn from CBT interventions for Major Depressive Disorder [MDD; 20]. However, less improvement of mood symptoms is generally observed in BD following CBT. Amongst others, one explanation for this finding might be that the use of CBT in BD is more complex than in MDD and, therefore, might require a higher level of therapist expertise [20, 21]. For example, when bipolar patients experience racing thoughts as part of a (hypo) manic episode, is it possible they will forget plans that were made during sessions. Therefore, it might be harder for therapists to break through the spiraling circle of thoughts, feelings, and behavior [22]. To improve CBT for BD, it is important to distinguish differences in positive affect regulation between BD and MDD [15]. Only a few studies have addressed this issue. In relatively small, undergraduate samples ($n = 28$ BD, $n = 35$ MDD), Johnson, McKenzie [6] showed that BD patients engaged in significantly

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more emotion-focused rumination than MDD patients. Another small study amongst 62 remitted patients, including 31 patients diagnosed with BD and 31 diagnosed with MDD, found no significant differences between BD and MDD regarding responses to positive affect [23]. A third study, limited by the reliance on undergraduate samples, also showed no significant differences in responses to positive affect between BD and MDD patients [15]. To our knowledge, only one study investigated differences in positive affect regulation in a relatively large, clinical sample of 208 BD patients and 114 MDD patients [4]. That study showed that BD patients engaged in significantly more emotion-focused and self-focused rumination in response to positive affect than MDD patients. No significant differences on dampening responses to positive affect were found.

The studies described above, with an exception of the study of Fletcher, Parker [4], did not differentiate between the two most distinctive bipolar subtypes; BD type I (BD-I) and BD type II (BD-II). BD-I is characterized by both depressive and severe manic episodes, while BD-II is characterized by both depressive and less severe hypomanic episodes [24]. However, differences in symptoms and illness course between these bipolar subtypes cannot be ignored [25] and examination of differences in positive affect regulation between BD-I and BD-II might be of interest to inform development and refinement of psychological models and interventions for BD. Fletcher, Parker [4] did not find any significant differences between the bipolar subtypes in terms of responses to positive affect. Another issue that warrants further scrutiny is the association of positive affect regulation and predominant depressive or (hypo)manic polarities. Colom, Vieta [26] propose that depressive polarity is defined when at least two-thirds of past episodes fulfill the criteria of depressive episodes, while (hypo)manic polarity is defined when at least two-thirds of past episodes fulfill the criteria of (hypo)manic episodes. No predominant polarity is defined when the criteria of either a depressive or (hypo)manic polarity are not fulfilled. Depressive polarity appears to be more prevalent amongst BD-II patients, while (hypo)manic polarity seems to be more prevalent amongst BD-I patients [26–28]. These differences in illness course might be associated with the use of differential positive affect regulation strategies. Indeed, Gruber, Eidelman [8] found a significant positive association between the frequency of manic episodes and dampening and ruminative responses to positive affect, while the frequency of depressive episodes was only positively associated with ruminative responses to positive affect. However, to date, no study investigated differences in the use of positive affect regulation strategies between clearly distinguished predominant polarity groups.

The aim of the present study was to extend previous research by investigating differences in positive affect regulation strategies between affective groups (BD vs. MDD), and between the bipolar subtypes (BD-I vs. BD-II and predominant polarities), using large, clinical, outpatient samples. First, it was hypothesized that BD patients would report less dampening and more ruminative responses to positive affect compared to MDD patients. Second, it was expected that BD-I patients engage in more positive rumination and less dampening than BD-II patients. Third, it was hypothesized that BD patients with predominant depressive or (hypo)manic polarities are more likely to engage in more dampening and ruminative responses to positive affect compared to BD patients without a predominant polarity. Finally, it was hypothesized that dampening is associated with greater depressive symptom severity, while positive rumination is correlated with more (hypo)manic symptom severity.

2. Method

2.1. Participants

Participants were 123 patients diagnosed with BD (96 BD-I, 27 BD-II) and 175 patients diagnosed with MDD, recruited from a specialized outpatient clinic for BD and a specialized outpatient clinic for MDD, both part of Altrecht Institute for Mental Health Care in the Netherlands. BD patients were approached during their scheduled appointments, while data from MDD patients was collected as part of the regular intake procedure. Patients (aged 18+ years) were eligible to participate if they had received a prior diagnosis of a mood disorder (BD-I, BD-II, or MDD) from a clinical practitioner (psychiatrist or psychologist) based on semi-structured clinical interviews. Exclusion criteria were current psychosis, neurological disorders, severe suicidality, poor Dutch comprehension, and severe alcohol and/or substance abuse.

2.2. Measures

2.2.1. Clinical Global Impression - Bipolar [CGI-BP; 29] (Dutch translation, Altrecht 2004)

The CGI-BP is a modified version of the CGI to assess the severity of mania, depression, and overall illness severity in the past week. In the present study, clinicians were asked to rate either the depressive or (hypo)manic subscale, depending on the current mood status of the participants. Quantification of the depressive and (hypo)manic symptoms occurred at a 7-point scale, from 1 = no display of symptoms to 7 = extreme display of symptoms. The current mood status of patients was designated as stable with a CGI-BP score of one. The current mood status of patients was designated as depressed or (hypo)manic when the CGI-BP score was two or higher (2–3 = mild, 4–5 = moderate, and 6–7 = severe) on the depressive subscale or the (hypo)manic subscale, respectively. The inter-rater reliability of the CGI-BP has been shown excellent on both the depression ($\alpha = 0.92$) and mania (no variability) subscales [29].

2.2.2. Inventory of Depressive Symptomatology – Self-report [IDS-SR; 30]

By means of the IDS-SR, the severity of depressive symptoms in MDD patients was determined. The IDS-SR is a 30-item, self-report measure of depressive symptoms, with total score ranges from 0 to 84 (<13 = not depressed, 14–25 = mild, 26–38 = moderate, 39–48 = marked, and 49 ≥ severe depression). Psychometric properties of the IDS-SR have been found to be adequate [30]. In the present study, the Chronbach alpha coefficient was 0.86.

2.2.3. Responses to positive affect questionnaire - Dutch version [RPA-NL; 9]

The RPA-NL is a 17-item self-report questionnaire tapping responses to positive affective states. Responses are rated on 4-point scales (ranging from 1 = almost never to 4 = almost always). The questionnaire consists of three subscales, including Dampening (e.g. “My streak of luck is going to end soon”), Self-focused positive rumination (e.g. “It makes me think I am achieving a lot in my life”), and Emotion-focused positive rumination (e.g. “I feel full of energy”). Psychometric properties of the English [9] and Dutch version [14] are adequate. The present study found a good internal consistency for each of the subscales of the RPA-NL as well, with Chronbach's alphas of 0.83, 0.85, and 0.82 for dampening, self-focused rumination, and emotion-focused rumination, respectively.

2.2.4. Study – specific questionnaire

The illness course of BD patients was determined using a self-report questionnaire specifically designed for the present study. This questionnaire recorded age of onset of mood episodes, polarity of onset, life-time number of depressive, (hypo)manic, and mixed episodes, as well as use of alcohol and/or drugs.

2.3. Procedure

The study was approved by the Research Committee of Altrecht, Institute for Mental Health Care (CWOnr = 1621). Eligibility of BD patients for participation in the current study was determined by their clinicians, who had diagnosed them with either BD-I or BD-II. Eligible