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Parenting with bipolar disorder: Coping with risk of mood disorders to children

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ABSTRACT

Children of individuals with bipolar disorder (BPD) have increased risk for mood disorders and other adverse psychosocial outcomes due to genetic and environmental risk. Though parents with BPD are aware of increased risk to children, little is known about efforts undertaken in response or their perceived utility. Among parents who self-report with BPD, this study identifies key variables associated with parental coping with children's risk of mood disorders; and explores the relationship between monitoring children's moods and perceived coping efficacy. In this U.S. study, active parental coping with, and cognitive distancing from, child's risk were measured using novel scales. Parents ($n = 266$) who self-identified as having BPD completed a web-based survey. They had at least one unaffected child. Most participants endorsed monitoring their children's moods. Monitoring was associated with increased perceived control over the child's well-being ($p < 0.005$), but not feeling less worried. Active parental coping with risk to children was positively associated with active coping with own illness ($\beta = 0.25$, $p = 0.001$), family history ($\beta = 0.24$, $p = 0.001$), and self-report of current depression ($\beta = 0.16$, $p = 0.037$), explaining 13.8% of the variance ($F = 8.81$, $p < 0.001$). Cognitive distancing from the child's risk was positively associated with confidence in diagnosis ($\beta = 0.25$, $p = 0.001$), and negatively associated with self-report of current mania ($\beta = -0.19$, $p = 0.007$), perceiving BPD as genetic ($\beta = -0.26$, $p < 0.001$) and having more children ($\beta = -0.20$, $p = 0.004$); explaining 16.2% of the variance ($F = 8.63$, $p < 0.001$). Parents' adaptation to their own BPD was modestly correlated with active coping with child's risk ($r = 0.15$, $p < 0.05$) but not with cognitive distancing. The findings support the importance of understanding causal attributions and the value of genetic education and counseling for parents with BPD. Further research is necessary to elucidate the psychological benefits of active coping versus cognitive distancing from child's risk, and explore additional variables that predict parental coping with children's risk of mood disorders.

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Introduction

Bipolar disorder (BPD) is a common and frequently debilitating mood disorder that is highly heritable and has a significant public health burden. A population-based study estimated that the 12-month prevalence of BPD in mothers was 1.6%, and the lifetime prevalence was 2.5% (Boyd, Joe, Michalopoulos, Davis, & Jackson, 2011). An epidemiologically-representative sample of women with psychosis (including but not limited to bipolar psychosis) in London (Howard, Kumar, & Thornicroft, 2001) found that 63% of the women studied had children, and the majority of mothers had more than one child.

Risk of mood disorders in children of affected individuals

A large body of literature concludes that children of individuals with BPD have increased risk for many liabilities compared to offspring of parents without bipolar disorder: for psychopathology, most specifically mood disorders (Duffy, Alda, Crawford, Milin, & Grof, 2007; Henin et al., 2005; Hodgins, Faucher, Zarac, & Ellenbogen, 2002); and negative effects on psychosocial and behavioral functioning (Bella et al., 2011; Henin et al., 2005). The empiric risk for a first-degree relative of an individual with BPD to have a mood disorder is approximately 30%–40%; that risk

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increases to upward of 60% if both parents are affected (Duffy et al., 2007; Peay & Austin, 2011).

Parental mood disorders are hypothesized to increase risk to children by several mechanisms: through genetic susceptibility (Duffy et al., 2007); and through compromises to parenting abilities and household environment caused by the parent's illness (Calam, Jones, Sanders, Dempsey, & Sadhnani, 2012; Chang, Blasey, Ketter, & Steiner, 2001; Kahng, Oyserman, Bybee, & Mowbray, 2008; Romero, Delbello, Soutullo, Stanford, & Strakowski, 2005). Many studies have demonstrated the need for interventions to reduce risk to offspring of individuals with mood disorders, including efforts to reduce parents' symptoms during acute illness (Kahng et al., 2008) and improve parenting skills and the home environment (Bella et al., 2011; Calam et al., 2012).

Illness, risk, and parenting perceptions of individuals with serious mental illness

Individuals with serious mental illness tend to appreciate the complex etiology of their disorder, and commonly endorse both genetic and environmental risk factors (Meiser et al., 2007; Peay, Hooker, Kassem, & Biesecker, 2009; Targum, Dibble, Davenport, & Gershon, 1981). A significant proportion of individuals with serious mental illness have been shown to be concerned about their children's risks for mood disorders (Austin, Smith, & Honer, 2006; Quaid, Aschen, Smiley, & Nurnberger, 2001). These concerns appear to be related to worries about genetic predisposition along with perceived negative effects of their mental illness on parenting quality, family functioning and home stability (Austin et al., 2006; Calam et al., 2012; Hirschfeld, Lewis, & Vornik, 2003; Wilson & Crowe, 2009). In a systematic review of qualitative studies exploring mothering with severe mental illness, Dolman and colleagues identified recurring themes (Dolman, Jones, & Howard, 2013) related to affected mothers' perceptions and needs. These included the centrality of motherhood; difficulty managing dual roles as parent and individual with mental illness; guilt over perceived parental inadequacies and the impact of their illness on their children; and concern about genetic and environmental risks to their children (Dolman et al., 2013). Given advances in understanding the etiology of serious mental illness, parental concerns about risk to offspring may become more prevalent.

The majority of research on parenting and serious mental illness is focused on predictors of risk to children, and associated risk reduction interventions. Oyserman and colleagues (Oyserman, Mowbray, Meares, & Firminger, 2000) and Montgomery and colleagues (Montgomery, Tompkins, Forchuk, & French, 2006) present critical reviews of literature in which affected parents are described in terms of the risk they pose to their children. This focus on pathology and risk is described by Wilson and Crowe (Wilson & Crowe, 2009) as reinforcing "inadequacy, fear, and dire predictions for their own and their children's futures" for parents with BPD. Investigation is needed into effective ways that parents manage their cognitions and affect surrounding risks to their children.

Conceptual model

To investigate variables associated with parents' coping strategies for managing concerns about their children's risk for BPD, we selected the Transactional Model of Stress and Coping (Folkman, Lazarus, Gruen, & DeLongis, 1986). In this study, there are two potential stressors: experiencing BPD and perceiving a child to be at increased risk for a mood disorder. The model posits that in response to a stressor, individuals form illness appraisals. Those appraisals lead to coping, which (when effective) lead to adaptation over time. Evidence for the appropriateness of this model for a BPD population comes from a previous qualitative study (Peay et al., 2009). Participants described relationships among illness appraisals, coping with the illness, coping with risk to their children, their perceived coping efficacy, and their overall wellbeing that is consistent with the model. The large majority of parent participants were concerned about their children's risk for serious mental illness. Participants' coping efforts were often influenced by a perception of limited control over risk in the family. Many participants described using monitoring (watching/being aware) and/or cognitive distancing (identifying specific reasons why their relative would have less risk, e.g., because of protective personality factors) as methods of coping with family risk (Peay et al., 2009). Coping with risk to children through cognitive distancing has some conceptual overlap with Miller's blunting style of coping (Miller, 1987).

Study aims and population

We have described literature reporting that parents with BPD are aware of the risk to their offspring and that they engage in efforts to limit exposure of their children to the manifestations of bipolar disorder—efforts that are consistent with the research and clinical community's endorsement of the need for risk-reduction strategies for at-risk offspring (Brockington et al., 2011). This paper aims to evaluate how parents cope with the increased risk of mood disorders to their children; the data originated from a larger study that also investigated coping and adaptation of the parents to their own bipolar disorder, and their perceived risk to their children. The parents' increased active coping and dispositional optimism were positively associated with higher levels of adaptation, while denial coping was negatively associated with adaptation. Eighty-seven percent endorsed a somewhat greater or much greater risk for mood disorders in one's child(ren) than someone without a family history (Peay, Rosenstein, & Biesecker, in press).

This paper focuses on novel measures of parental coping to manage the stress of perceived risk of mood disorders in one's children. The measures included active parental coping efforts and parental coping through cognitively distancing the child from the risk. We also assessed the relationship between watching the child's moods as a means of coping and perceived coping efficacy; and analyzed open-ended responses to a question about changes in parenting due to the child's chance for a mood disorder. We hypothesized that variables associated with parental coping with risk would include dispositional optimism, illness perceptions (perceived illness severity, etiology, risk to children, and confidence in diagnosis), and the parents' success in coping with their own illness.

Measures and procedures

This cross-sectional survey was self-administered online from Fall 2009 through Fall 2010. The survey was advertised through mental health advocacy organizations in the United States and word-of-mouth recruiting. Adults who self-reported as having 1) BPD and 2) at least one unaffected biological child aged 30 or younger were eligible to participate. The reasoning for limiting the child's age to 30 or younger is that the average age at BPD onset is in the late 20s (Goodwin & Jamison, 1990), and parents may accurately attribute less risk to their children as the children age.

We aimed to understand the coping of individuals who ***self-identify as having*** BPD. The accuracy of participant self-identification was assumed, and the survey did not include a mental health evaluation. Though this is later described as a limitation, employing Internet-based surveys that recruit affected participants through a source known to be heavily enriched with