



Research paper

Coping with amplified emotionality among people with bipolar disorder: A longitudinal study

CHAN Sunny H.W.^{a,*}, TSE Samson^b^a Department of Rehabilitation Sciences, The Hong Kong Polytechnic University, Hong Kong, China^b Department of Social Work and Social Administration, The University of Hong Kong, Hong Kong, China

ARTICLE INFO

Keywords:

Bipolar disorder
Coping
Amplified emotionality

ABSTRACT

Background: The amplified emotionality characteristics of bipolar disorder (BD) may interfere with goal pursuit in the recovery process. This is the first study to test the coping flexibility model empirically among people with BD. Finding ways to cope with goal-striving life events should shed light on managing elevated mood states.

Methods: Using a 12-month longitudinal follow-up design, this study examined the stability in coping flexibility with experimentally-devised Behavioral Approach System (BAS) activating life events and mood states at 6- and 12-month time points for individuals with BD ($n = 83$) and healthy controls ($n = 89$). Hierarchical linear modeling tested the individual growth model by studying the longitudinal data.

Results: The findings showed fluctuations in different components of coping flexibility and mood states across time. They confirmed the amplified emotionality characteristics of BD. Moreover, coping flexibility took precedence over BAS sensitivity and psychosocial functioning levels in predicting mood states.

Limitations: Measurements of BAS sensitivity may focus on trait nature only and prone to subjective bias. The assessment of mood or coping flexibility may not accurately capture actual experience in daily life. Lack of respective data on bipolar subtypes and significant differences in some dimensions between the BD and control groups are further limitations of the study.

Conclusions: The study's findings have implications for coping with amplified emotionality within the personal recovery process for people with BD. Judicious application of coping strategies and adjustment of perceived controllability are crucial for individuals to reach goals pertinent to personal recovery and manage potential manic mood symptoms.

1. Introduction

Bipolar disorder (BD) is a serious mental illness characterized by chronic and recurrent mood fluctuations between depression and mania. According to worldwide mental health surveys, BD is the second highest ranking cause of missed work or school days (Alonso et al., 2011), which indicates a disability or role limitation in carrying out daily activities (Mall et al., 2015; Merikangas et al., 2007). In general, persistent psychosocial disability in individuals with BD fluctuates in parallel with changes in affective symptoms (Judd et al., 2005), concomitant with a high relapse rate and a chronic recurrent course (Miziou et al., 2015; Reinares et al., 2014; Yatham et al., 2009). On the other hand, amplified emotionality (Gruber et al., 2013) can be another crucial characteristic of BD. Behavioral Approach System (BAS) dysregulation theory (Alloy and Abramson, 2010) can help to illustrate. Having a high BAS sensitivity level (Nusslock et al., 2009; Urosevic

et al., 2008), people with BD tend to be overresponsive in relation to BAS-activating or goal-striving life events that easily result in manic/hypomanic mood symptoms (Johnson et al., 2008; Johnson et al., 2016; Nusslock et al., 2007). In addition to this overresponsiveness to life events, poor emotion regulation (Green et al., 2007; Johnson et al., 2007; Phillips and Vieta, 2007) further leads to the maintenance of elevated mood states (Farmer et al., 2006). Thus, finding ways to cope with amplified emotionality and extreme mood changes is vital for people with BD to manage their illness.

Instead of focusing on symptom reduction or relapse prevention in clinical recovery, a paradigm shift is placing more emphasis on personal recovery (Tse et al., 2014a) in which there is more focus on goal setting or self-empowerment (Tse et al., 2014b). Goal setting serves as an important element in the mental health recovery process (Clarke et al., 2009) and an integral component of strengths-based interventions, which self-directed empowerment can facilitate (Shanks et al., 2013;

* Corresponding author.

E-mail address: sunny.hw.chan@polyu.edu.hk (S.H.W. CHAN).

Tse et al., 2014b; Tse et al., 2016). Capitalizing on the individual's own vision of recovery, goal setting can even promote hope and enhance motivation (Clarke et al., 2012; Michalak et al., 2012). Goal setting can lead to the enhancement of positive emotions (Greenglass and Fiksenbaum, 2009; McCarthy et al., 2010) or vice versa (Marien et al., 2012; Orehek et al., 2011). However, goal pursuit could intertwine with emotional response for people with BD (Gilbert and Gruber, 2014). Specifically, ambitious or excessive goal striving may easily elicit a manic mood in people with BD (Alloy et al., 2012; Stange et al., 2013; Tharp et al., 2016). This dilemma is quite challenging, especially when people with BD have difficulties in regulating their positive emotions. Thus, further investigation is needed to fill this research gap and to see if any dilemma-breaking means can help people with BD to achieve the set goals and go through a personal recovery process.

Coping with BAS-activating life events appears to be an outlet to counter the emergence of manic symptoms. In essence, coping is a dynamic process that changes according to the varying demands and appraisals of situations over time or from stage to stage (Carver et al., 1989; Holahan et al., 1996). Therefore, a flexible coping mechanism is necessary (Cheng, 2001; Cheng et al., 2014). Individuals' experience and cognition change over time. The cognitive interpretation of an experience sets the coping process in motion (Folkman et al., 1986; Roesch et al., 2002). Specifically, perceived controllability is seen as a key element in a cognitive appraisal with implications for how an individual determines his or her available personal or interpersonal resources for responding to a situation (Cheng, 2001; Folkman et al., 1986). These processes emerge and reemerge, influencing the selection and use of coping strategies (Lazarus, 1993). Therefore, repeated measures of appraisal and coping are necessary to identify both changing and relatively stable variables (Cheng and Cheung, 2005; Lazarus, 2000; Ptacek and Pierce, 2003). The use of longitudinal studies to identify the unknown issue of stability in coping flexibility, especially the temporal effect of the BAS response to experimentally manipulated BAS-relevant stimuli (Urosevic et al., 2008), has been suggested (Cheng, 2001; Lazarus, 1999). Thus, further investigation is needed to fill this research gap.

Moreover, the coping flexibility model has just been applied to the normal population, but it has never been applied to people with mental health concerns (Cheng et al., 2014). Coping flexibility may apply differently to people with BD than to people without BD. First, individual affective states may color the judgment of an appraisal or coping response (Forgas and Eich, 2013). Second, the presumed effective coping in a normal population may be of no use to people with BD during their mood episodes (Urosevic et al., 2008; Wright et al., 2009). Further investigation is warranted. In addition, most previous studies focused only on coping with general stressors or prodromes (Lam et al., 2001; Wong and Lam, 1999) rather than life events. Detailed investigation of the impact of different styles of coping in relation to life events, particularly those that are BAS relevant, has yet to take place.

An exploration of how individuals cope with life events is relevant to the management of amplified emotionality, especially when taking the effects of individuals' BAS sensitivity and psychosocial functioning levels into account as well. Coping may play a role between mood states and an individual's BAS sensitivity level (Alloy and Abramson, 2010; Alloy et al., 2009) or psychosocial functioning level (Weinstock and Miller, 2008, 2010). A BAS hypersensitivity trait (Nusslock et al., 2009; Urosevic et al., 2008) and psychosocial functional impairment (Nolen et al., 2004; Weinstock and Miller, 2008, 2010) can be significant risk factors for affective symptoms in BD. Therefore, further investigation can identify the role of coping, on top of BAS hypersensitivity and psychosocial functioning, in predicting mood symptoms.

This study had two aims. First, we examined the differences in the stability of mood states and coping flexibility across a year between participants with and without BD. Second, we investigated time-invariant variables (BAS sensitivity level and psychosocial functioning level) and time-varying variables (different components of coping

flexibility) as predictors of changes, if any, in mood states over time. We hypothesized that coping should play a crucial role in managing amplified emotionality in people with BD. A 12-month longitudinal follow-up study design examined the stability in coping flexibility and mood states across time. Within the prospective analyses, corresponding measures occurring at two subsequent follow-up time points, 6 months and 12 months after the initial baseline measurement, indicated changes.

2. Materials and methods

2.1. Participants

Ninety participants diagnosed with BD I or II by a regional hospital and 90 healthy controls from the community were recruited through convenient sampling. The participants were fluent in Chinese, aged 18–65, and had a primary level of education or above. The participants with BD had to have been in a state of full remission for more than two months (Tohen et al., 2009). Exclusion criteria included a comorbid diagnosis of schizophrenia, schizoaffective disorder, substance misuse, organic brain syndromes, or intellectual disability. The diagnoses of BD were confirmed by corresponding psychiatrists with reference to the criteria cited in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* (American Psychiatric Association, 2002). Participants underwent reassessment at 6-month and 12-month follow-ups. During the 12-month follow-up, seven participants with BD and one healthy control dropped out of the study (4.2% dropout rate); the reasons for dropping out were relapses or lack of interest in continued follow-up. The remission status of the participants with BD was strictly checked through the medical records in the hospital to ensure they met the criteria. Each participant was offered a coupon worth HK\$100 (or US \$12.80) after the completion of the whole study. Ethical approval was obtained from the Institutional Review Board of the University of Hong Kong/Hong Kong West Cluster of the Hospital Authority (UW13-176). Throughout the 12-month study period, the research participants' data were kept in password-protected files and the questionnaire booklets were put in a locked file cabinet. Participation in the study was on voluntary basis, and the services provided to the research participants were not affected if they decided to withdraw from the study.

2.2. Measures

We measured the baseline pre-event affective symptoms (including depressive and manic mood) with the Modified Hamilton Rating Scale for Depression (MHRSD; Miller et al., 1985) and the Bech-Rafaelsen Mania Scale (BRMS; Bech et al., 1979), respectively. Both scales use a standardized interview format, with higher scores representing higher symptom severity. We measured the post-event mood states with the Internal State Scale (ISS; Bauer et al., 1991), which consists of four subscales: Activation (ACT), Well-Being (WB), Perceived Conflict, and Depression Index. The ISS is a self-report instrument that is sensitive to changes in affective states. Higher scores, specifically in the subscales of ACT and WB, indicate elevated mood states. Translation of all the participant-report assessment tools took place with reference to the guidelines for the translation and cultural adaptation of psychometric scales (Wild et al., 2005). The translated materials (in Chinese) are available from the corresponding author upon specific request. For the present study, we used Mansell and Lam's (2006) present state version of ISS, and we only report the ISS_ACT and ISS_WB subscales. The assessment took place immediately after mood induction.

We measured coping flexibility in terms of cognitive appraisal and coping responses by means of the Coping Flexibility Questionnaire (Cheng, 2001, 2003). For the corresponding measurements, we developed a total of 10 BAS activation-relevant life-event scenarios with reference to the Life Events Scale (Francis-Raniere et al., 2006). To make the life-event scenarios vivid, all of them were role-played and

Download English Version:

<https://daneshyari.com/en/article/8815125>

Download Persian Version:

<https://daneshyari.com/article/8815125>

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