

Editorial

Coping style and bipolarity

A peer article in this issue is the contribution by Fletcher and colleagues from the Black Dog Institute on 'The role of psychological factors in bipolar disorder: prospective relationships between cognitive style, coping style and symptom expression' (1). Indeed, they are pioneering an area with little evidence and many speculations: are psychological factors and coping style different in bipolar I and II? Will this lead to personalised, bipolar subtype-specific psychological interventions?

Many studies have demonstrated that environment, especially childhood adversities such as abuse of any kind, negatively impact on almost all illness parameters (2). But does the negative experience itself, possibly via epigenetic mechanisms, modify the course of the illness, or is it the way we process it cognitively and the coping style we develop? Or vice versa, is it possible that cognitive and coping styles are inherent and may be different in bipolar subtypes? In their large sample of 151 bipolar patients evaluable after 6-month follow-up, including 82 bipolar II patients, Fletcher and colleagues found that the majority of cognitive styles showed relationships with depressive symptom severity and/or variability during the 6-month study period. Positive relationships were also observed between depressive severity and/or variability, and maladaptive coping styles. These findings held true for both bipolar subtypes. However, there were subtle differences in cognitive and coping style between subtypes, and it appeared after logistic regression and controlling for baseline symptomatology and age that different cognitive styles can predict bipolar I depression: low self-esteem, negative attributional styles regarding consequences and self-worth implications and negative automatic thoughts related to self-concept.

Only one coping style predicted bipolar I depression: low levels of seeking support to cope with stress were associated with increased likelihood of a depressive episode at follow-up. Similar to bipolar I depression, bipolar II depression was predicted by negative automatic thoughts related to self-concept – but with unique relationships observed for negative automatic thoughts related to personal maladjustment

and desire for change, low self-esteem and helplessness. Coping styles predicting bipolar II depression included rumination about negative affect, and self-blame in response to negative affect.

It is an intriguing idea that subtype-specific identification of cognitive and coping styles can identify and quantify risk of relapse, and this risk could possibly be reduced by modifying specific areas of negative cognition and maladaptive coping styles. However, this is still up for proof of concept trials.

With all respect and enthusiasm for this innovative approach, we should take note of potential weaknesses and biases of the study. Self-rated higher depression severity scores at baseline in bipolar II might have impacted on responses in cognitive and coping questionnaires, and the use of a euthymic sample may have been more informative for finding differences between bipolar I and II. Therefore, the author's assumption of a higher predominance of depressive episodes over (hypo)manic episodes in bipolar II patients is controversial. In the probably most accurate prospective study, using daily mood ratings, Kupka et al. showed that the relation of days with depression versus those with (hypo) mania is not different in bipolar I and II (3). Thus, another one of their findings – that a broader set of negative cognitive style relationships emerges for bipolar II depression – might be based on an incorrect assumption, and other explanations should also be considered. A possible explanation could be a greater number of episodes in bipolar II patients as they are more prone to a rapid cycling course: unfortunately, the study did not gather information on or matched for the number of episodes.

In summary, there may be many more illness variables than just categorical bipolar subtype that contribute to cognitive and coping style, and more research is clearly needed before we may come to the point of personalised psychotherapeutic interventions tailored around a specific cognitive risk profile. Nevertheless, this should in no way derogate this piece of pioneering work by our Australian colleagues.

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