

The dyadic coping model of bipolar disorder patients

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Summary

The aim of the study is to look from a relational perspective at how patients with bipolar disorder (BD) cope with stress. This is done firstly in the context of dyadic coping and secondly in the context of individual coping strategies that result from patients' attachment styles. The way in which BD patients start relationships is important on many levels, including in the context of treatment effectiveness and relapse prevention. Dyadic coping can act as a protective function against both external and relational stress, and it can become a buffer that protects against relapse, or a therapeutic factor reducing the severity of symptoms and the frequency of their occurrence. Insecure attachment is considered one of the risk factors of the development of affective disorders. The insecure attachment style of BD patients makes them more often exposed to relapse when relational support is lost. Extending the coping concept of BD patients with the attachment aspect creates a new perspective for understanding their behavioral-emotional-cognitive stress responses. In addition, by approaching the problem from the dyadic level, the picture is supplemented with the impact of close relationships on the motivational processes of both partners in coping with the illness, building relationships, their mutual satisfaction and overall well-being.

Key words: bipolar affective disorder, dyadic coping, attachment style

Introduction

Stress and unsatisfactory quality of functioning in a relationship independently play a huge role in the development of affective disorders [1]. Relational stress, relationship problems and reduced relationship quality are important factors that influence the occurrence and course of bipolar disorder and increase the risk of relapse [2]. In bipolar disorder, psychosocial stressors often accelerate subsequent episodes [3] and are associated with less improvement in both depression and mania [4]. The stimulating role of stress decreases during the course of the illness [5] due to permanent changes at the level of the neurotransmitter, receptor and neuropeptide [6]. These changes, caused

by stressors, including the episodes themselves, sensitize the patient to stress, which means that even a weak stressor can cause symptoms of a mood disorder. The results of research on bipolar patients are consistent with Post's theory [6] and confirm (1) the sensitivity to stress increasing with age [7] and (2) the probability of stress-related recurrence increasing with the course of the illness [8].

Research also highlights the role of stress experienced by bipolar patients in childhood. Experiences of trauma and violence are associated with earlier onset of the illness, longer, more severe episodes, risky behaviors, more frequent suicidal thoughts, more co-morbidities from axes I and II, and greater reactivity to psychosocial stress [9].

BD itself can be a source of stress and can affect the way that couples deal with the everyday stressors experienced by both partners. BD patients experience stress more intensely than healthy people in many areas of their lives and have less competence to deal with it [10]. If we treat BD either as an additional stressor for a patient and his/her partner or as a factor that exacerbates existing stressors, then it is not surprising that interpersonal difficulties and marital conflict are so frequent in BD patients' relationships that these factors are considered by some researchers to be significant diagnostic criteria of bipolar disorder [as cited in: 11].

BD patients experience many problems in different areas of life, such as work and family responsibilities, financial issues and interpersonal relations. BD patients' stress-coping processes should be considered an assessment factor of the impact of stress on psychopathology. In the face of internal and external stressors of varying intensity and duration in various areas of life, people display a range of reactions to stress. Coping requires a broad spectrum of active strategies [12, 13]: it is a multifaceted process of solving problems, effective thinking and acting in demanding situations, assessed as stressful, and leads to the regulation of emotions and reduction of stress levels [2]. Its effectiveness depends on many external and internal factors as well as individual assessments of an individual's resources and capabilities [12–14]. Adaptive mechanisms used to cope with stress include a range of cognitive strategies regarding primary and secondary stressor assessment and behavioral strategies for the effective use of support [15]. Adaptive strategies that focus on the problem improve general psycho-physical functioning, while maladaptive ones such as avoidance, negation or rumination [16] have an impact on the severity of psychopathology [17]. Emotion-focused coping strategies that are passive and avoidant – in comparison to the healthy population – are characteristic of BD patients [18]. According to many authors, the use of ineffective forms of coping may be associated with cognitive dysfunction [19]. Emotional deregulation and the use of dysfunctional cognitive strategies are the basic clinical and psychological features of bipolar disorder [20].

Emotional self-regulation is a skill shaped by early childhood experiences of responsiveness and the availability of a primary caregiver in times of stress [21]. The quality of the primary relationship and representations of early childhood experiences affect relationship skills, self-esteem and the regulation of emotions and behavior. Therefore, it seems important to present the problem of BD patients' coping with

stress from a relational perspective: (1) the primal relationship formed in childhood, which is the basis of attachment and a prototype of later close relationships; (2) a BD patient's present intimate relationship, which in the form of dyadic coping has therapeutic potential and may be a mediator between the negative consequences of bipolar disorder and satisfaction with relationships and overall well-being.

Bipolar disorder and individual coping strategies

According to the transactional theory of stress and coping [15], stress is the result of interaction between a person and the environment. When the demands of the environment exceed the resources of the individual, the situation is considered a threat. Thus, the perception and interpretation of a stressful event is more critical than the event itself. In the primary appraisal, a person assesses the stressor and the situation. Threat perception triggers a secondary appraisal to determine the degree of stress control and the adequacy of individual resources to meet expectations. Internal resources such as personality traits, knowledge, talent and willpower, and external resources such as the support of relatives and professionals all have an impact on the coping process. Methods of coping with stress may be (1) problem-oriented, (2) emotion-oriented (e.g., wishful thinking, distancing, emphasizing positive aspects of a situation, self-blame, isolation) or (3) focused on avoiding confrontation with the problem situation [15]. Problem-oriented coping strategies lead to the control of a situation; the goal of emotion-oriented strategies is to get rid of the unpleasant emotions arising from a stressful situation; avoidance strategies aim to distract, deny and suppress at the cognitive and emotional levels.

Deficits in various spheres of cognitive functioning are observed in BD patients even when they are in the state of euthymia; this translates into worse functioning and a reduced sense of quality of life [22]. The coping style chosen by the patient affects the course of bipolar disorder and mood deregulation. Adaptive styles improve general psycho-physical functioning, while maladaptive ones translate into an increase in psychopathology [13, 14, 17, 18]. There are differences in functioning of patients that depend on the type of bipolar disorder. Patients with unipolar (UD) and bipolar I affective disorder apply the ruminative strategy to negative events more often than the healthy population [14]. Representatives of BD types I and II have a greater tendency than UD patients to use rumination in the face of positive events and engage in risky behavior in the face of negative events [14]. At the same time, BD type I patients are more likely to seek professional help and use stimulants in response to mania and depression than BD II patients. Type II is also less likely to seek support in the face of stress and is less willing to engage in mania-control strategies. This may be due to the fact that the mania phase in BD I is assessed as more negative than hypomania, which is assessed as pleasant by BD II patients [14]. In the process of coping, the specific relationship between situational elements and the personal characteristics of an individual influences the choice of strategies and their effectiveness. Mikulincer and Florian suggest

that a secure organization of attachment is the basis from which an individual derives resources, such as self-esteem or a network of social support [as cited in: 23].

Coping strategies from the perspective of attachment theory

Attachment theory is assessed as one of the most consistent theories explaining the formation, development, stability, dynamics, and quality of relationships. Its creator, John Bowlby [21], pointed to the critical importance of secure attachment in the context of future interpersonal relationships and the ability to regulate emotions. The insecure ties that are developed in experiences of rejection, neglect and lack of responsiveness on the part of the primary caregiver lead to inefficient deactivation strategies or the hyperactivation that is characteristic of those who are dismissing or preoccupied [21]. The disorganization of attachment, which is a consequence of pathological mourning or trauma, is a strategy that protects against difficult content that is pushed into the unconscious. At the cognitive and behavioral level, an individual may show signs of confusion that are expressed in subtle or more expressive forms [24].

The quality of attachment style determines the adaptability of the individual [21]. In an insecure relationship, children exposed to repetitive stress experiences resulting from rejection and neglect from the primary caregiver, who at the same time does not act as a regulator of the child's emotions, maintain elevated cortisol levels [25]. As a consequence, the child becomes hypersensitive to even minimal stress stimuli [26]. Persistently elevated levels of cortisol in childhood and adolescence are associated with the occurrence of internalizing symptoms [27], predicts affective disorders [28] and carries an increased risk of psychopathology [29].

Starting from infancy, through childhood, adolescence, and adulthood, the mental health of the individual is associated with the quality of the relationship, which is the basis of emotional self-control and a protective factor in stressful situations [30]. Research suggests that attachment trauma may have a significant and lasting negative impact on coping ability [31] and cognitive functioning in terms of, e.g., deductive reasoning, working memory and problem solving [32]. Many studies have focused on attachment in the context of the processes that take place in close relationships. The secure style was associated with less conflict, greater acceptance of the partner, greater interdependence, more constructive methods of dealing with problems, and greater satisfaction in the relationship and its stability as opposed to insecure styles [as cited in: 33]. Researchers often suggest a significant link between insecure attachment and mood disorders [34]. In patients with mood disorders, only a small percentage is classified as having secure attachment pattern; most of them have an insecure pattern that is mainly of the preoccupied type [35]. Few attachment studies have concerned patients diagnosed with bipolar disorder [36, 37]. Studies of BD children showed that a lack of a warm relationship with their mother is one of the main risk factors associated with the recurrence of mania after recovery in children [38]. Bipolar disorder (type I, type II) is more strongly associated with the insecure attachment style in comparison to the

non-clinical population [38, 39], and the probability of relapse seems to be related to a dysfunctional childhood relationships [40].

Bowlby [21] was the first to hypothesize that attachment relationships in childhood are similar in nature to the romantic relationships that we establish in adulthood, and the attachment developed in childhood is the prototype of all subsequent close relationships. The atmosphere in the family and the quality of relationships are very important for the functioning of BD patients and are a prognostic for the development of the illness but may also support the healing process. The better the functioning in the family, the better BD patients manage the illness [12].

The relationship between partners is extremely susceptible to stress factors. Research indicates greater interpersonal problems and greater conflict in BD I compared to BD II patients' relationships, and this translates into the level of satisfaction, the consistency of the relationship and dyadic adjustment. At the same time, poor dyadic adjustment is associated with more frequent comorbidity of other psychiatric disorders, such as personality disorders, OCD, anxiety disorders, and abuse of addictive substances [11]. Differences between particular types of bipolar disorder also occur depending on the phase of the disorder. BD I patients in both depression and mania phases present greater dysfunctions in relational functioning compared to BD type II patients in these phases.

From individual strategies to dyadic coping

Bipolar disorder affects not only the patients themselves but also their relatives [41]. For a partner of a BD patient, his/her illness is an additional source of stress and a serious burden in everyday functioning [17]. Compared to partners of patients with schizophrenia, intimate partners of BD patients experience greater burden and lower satisfaction from the relationship [41–43]. Studies also indicate a two to three times higher probability of separation and divorce in the case of bipolar disorder in comparison to the healthy American population [44]. In studies carried out by Arciszewska [45], the spouses of BD patients, in comparison with spouses of UD patients and spouses of healthy partners, obtained lower results in terms of compliance, satisfaction, coherence, and emotional expression (especially in women), i.e., a generally lower level of so-called dyadic adjustment. The low level of dyadic adjustment in BD couples is associated primarily with a greater severity of social dysfunction and significantly translates into a worse quality of relationship, but it also indicates a significantly higher level of burden for the partners of BD patients.

A partner's bipolar disorder is perceived by loved ones not only as ballast, but it can also be a source of satisfaction [as cited in: 41, 42]. On the other hand, patients are aware of the impact of the illness on their emotional functioning, responsibility for self-care and problems at the social and developmental level [41]. Both partners are active elements in the process of dealing with the disorder and its consequences [41]. If the partners cannot see what difficulties are associated with bipolar disorder,

they cannot appreciate the efforts made in the daily struggle with the illness, both on the side of the patient and his/her partner, therefore it may be more difficult for them to understand each other in an empathic way. Studies have shown cognitive deficits in empathy in patients with bipolar disorder, even in the euthymic period [41]. Both partners in a BD couple use similar coping strategies, although Granek et al. [17] noted that patients and their partners more often seek instrumental support and emotional support, respectively, although both need professional help. Arciszewska [45] indicates that spouses of BD patients more frequently use task-oriented strategies over other coping strategies, regardless of their gender or the phase of the illness; however, this author also notes a more frequent search for emotional support in a group of male partners of BD patients that – according to this author – results from helplessness in the face of an ill wife's irrational and difficult-to-explain behavior. Women, however, as partners of BD patients, decide more quickly to seek help and interventions from other people. At the same time, it is worth mentioning that despite the dominant task-oriented strategy of spouses of BD patients, due to the burden of the partner's illness the readiness to solve problems gradually decreases and their belief in their own abilities and sense of involvement weakens, all of which may negatively affect their coping abilities and thus translate into less flexible responses [45]. The conclusions from Arciszewska's research [45] should, however, be treated with caution due to the relatively small research sample and the cross-sectional and correlational nature of the research, which prevents cause-and-effect conclusions.

Lower risk of BD recurrence (less depressive and manic episodes) depends on how BD patients cope with mania and depression, for example by reducing tasks or logistical modifications [13, 14]. Gender differences are observable. For the female partners of patients with bipolar disorder, the unsatisfactory relationship is the greatest source of stress. The most frequently used strategies are the use of humor, support from friends, as well as involvement in domestic responsibilities and social work [17]. Male partners of BD patients complain mainly about the lack of autonomy and uncertainty as to the further course of the illness [42]; their strategy is often to immerse themselves in work. Other studies considered the abandonment of the BD patient's partner's own dreams and visions in order to care for an ill partner, the problem of withdrawal from social life and "loneliness for two" [41, 42].

The individual coping styles of patients with chronic mental illness may have a decisive impact on their overall well-being [13]. For patients and their partners, coping with stress has an additional dyadic dimension. Dyadic coping is defined as part of the interpersonal process in which both partners are involved, and dyadic stress is defined as a specific stimulus that directly or indirectly affects both partners, thus motivating them to make the effort to cope at a specific time and place. The system-transactional model (STM) of dyadic coping [46] includes coping as a stress communication process. This means that dyadic coping occurs when the stress signals of one partner are passed to their partner, who perceives, interprets and decodes them, and reacts in a certain way. According to Bodenmann's theory [46], stress and coping

in the context of relationships is a dyadic phenomenon because the assessment of one partner's stress or coping efforts cannot be understood without taking into account the effects on the other partner and the relationship. Moreover, the theory maintains that due to the interdependence between partners, the well-being of one partner and his/her satisfaction depend on the well-being and satisfaction of the other. Therefore, both partners should be motivated to help each other deal with stressful events and participate in a joint coping effort.

Although the dyadic coping theory has become very popular in research, the majority of studies have concerned everyday stress in couples in the healthy population [47–51]. These studies confirm a significant relationship between positive dyadic coping and higher satisfaction with and quality of relationships. Several studies have been conducted on couples in which one of the partners suffers from chronic physical illness. According to Badr et al. [52], breast cancer patients and partners who presented more common dyadic coping behaviors declared higher relationship quality in contrast to patients and partners who used negative dyadic coping behaviors. Rottmann et al. [53] examined patients with breast cancer and found that negative dyadic coping behaviors were associated with more negative health consequences in the form of reduced mood for both patients and their partners. Patients and partners who declared more common dyadic coping behavior presented a higher quality of relationships and less depressive symptoms. In turn, a study of a population of patients with chronic obstructive pulmonary disease (COPD) [54] showed that lower quality of life of the patient's partner was strongly associated with the negative dyadic coping behavior of the patient, while higher quality of life was associated with own delegated behavior assessed by the patients. Very few studies of dyadic coping have been carried out on a population of patients with mental illness [10, 55–57]. They showed that positive dyadic coping had the potential to reduce depressive symptoms and strengthen the quality of the relationship [55, 58]. BD patients and their partners have not so far been studied in the field of dyadic coping.

Dyadic coping and attachment in the context of bipolar disorder

In situations of real or perceived stress and uncertainty, the attachment system and behaviors in line with the learned strategy are activated [21]. In contrast to insecure styles, a secure attachment style can be considered a safety element that leads to positive appraisals and constructive strategies in the face of stress [50, 59]. The selection of effective strategies is related to the tendency of securely attached people to seek support and assess the problem as solvable and their own resources as sufficient [23, 60]. In the face of stress, dismissing individuals isolate themselves at the cognitive, emotional and behavioral levels. Despite the apparent lack of tension, the avoidance strategy is not effective in coping with stress [23, 59]. For preoccupied persons, the primary goal is to maintain closeness with the partner at all costs and divert attention away from the problem, the solving of which can paradoxically cause the partner to withdraw attention [50, 61].

Solving problems in a relationship is defined as an interdependent process: support in difficult situations can either be given or received. The partner sees, decodes and evaluates the messages sent by the person experiencing stress and decides about their own reactions [46]. The interdependency dilemma is particularly difficult for people with an insecure relationship [49]. Dismissing individuals avoid exposing themselves to expected rejection by abstaining from seeking the support they really need. They react with anger and withdrawal to any attempts to build closeness. Escaping into independence and self-sufficiency also prevents empathic approach to a partner seeking support. Thus, both the role of the partner in need of support and the role of the partner from whom such support is expected are extremely uncomfortable for them [50]. Pre-occupied persons who are focused on the relationship and their partner are able to see the signals he/she sends and become generously involved in providing help, but due to their sometimes inadequate interpretations the provided support can be ineffective. At the same time, oversensitivity and constant fear of the durability of the relationship does not allow them to appreciate the received support and use it effectively [62]. The mental illness of one of the partners can modify the natural dynamics of dyadic stress and coping. The context of the illness imposes the roles of patient or partner of the patient. In this situation, the psychological interdependence of the partners is disrupted in favor of a caring relationship, in which dyadic coping may take other forms.

The dyadic coping model of BD patients

The model of dyadic coping of BD patients (Figure 1) should be understood in the context of attachment theory [21] and systemic-transactional theory [46]. The occurrence of symptoms, relapses and the course of bipolar disorder is caused by the complex interactions of various biological, psychological and environmental factors, and the immediate reason preceding their disclosure is usually the occurrence of stressful life events, which, in combination with the lack of adaptability, pose a risk of symptoms of the disorder [2]. High variability is observed among BD patients in the level of reactivity to stress, suggesting the impact of other psychological factors [5]. In research on risk factors for affective disorders [63], there is a fairly large consequence confirming the view that attachment is the basis of development processes whose successful course allows effective management of both stressful internal processes and external stressors. An insecure attachment style, through a system of internal operating models based on negative experiences of early childhood, shapes negative attributions and limits access to social support [61], including dyadic one [50]. At the same time, bipolar disorder creates a specific context in which the illness itself becomes a chronic stressor, which can further intensify the effects of other potential stressors. In the context of a close relationship, BD is creating unique stressors and resources for each partner. Although the illness may initially manifest itself as an internal stressor in the patient, the additional internal and external stressors that it precipitates quickly spread throughout the entire system [65].

The selection of coping strategies and the perception of the stressor, situation and partner result from the system of internal operating models based on early childhood experience [61]. In the case of people who are securely attached, an understanding of one's own emotions, adequate assessment of the situation, strength of the stressor and one's own resources, a strategy of searching for closeness and support, lead to regulating negative emotions and effective search for solutions. A secure attachment is the basis for greater stress resistance and more effective methods of coping. In people with insecure attachment, deactivation or hyperactivation strategies are not effective in coping with stress [21]. The use of deactivation strategies results in cut-off at (1) the emotional level (lack of discernment in emotions, suppression of emotions); (2) the behavioral level (isolation, avoidance of closeness and support); and (3) the cognitive level (excessive independence of decisions, lack of openness to advice and opinions of others, perception of a partner as unsupportive), all of which result in an incomplete picture of the problematic situation. The use of hyperactivation strategies is related to (1) hypersensitivity (exaggerated level of emotional experience, transferring attention from the problem to exaggerated emotions); (2) inaccurate assessments (low self-esteem, perception of the partner as being insufficiently supportive and the situation as exceeding possibilities of the ill person); and (3) inappropriate behavior (controlling, intrusive behavior that is a deterrent for the partner) [61]. In the case of the disorganization strategy, the chaotic selection of elements of various strategies gives the impression of unpredictability and chaos at the emotional, behavioral and cognitive levels [24]. In addition, a negative assessment of one's own resources in relation to the expectations of the problem situation and the interdependence dilemma (limited ability to give and receive support) in people with an insecure and disorganized attachment style make it difficult to cope with stress [34].

The insecure attachment system, acting according to automatic schemes developed in childhood and fixed in the experience of subsequent relationships, shapes susceptibility to the emotional problems of the individual and has a direct impact on his/her cognitive, motivational and behavioral processes, but does not determine them [65]. The quality of relationships represents a context that can generate additional stressors [66], but also a strong relational system can potentially buffer the effects of the health-related stressors of both the patient and the partner [67]. The partner's behavior, assessed by a person experiencing stress, may modify their assessment of the situation, relationship and influence the selection of coping strategies and their ultimate effectiveness [61]. The relationship between attachment and dyadic coping within the model (Figure 1) has been described as two-way because the presence of a partner and the quality of the relationship can ultimately determine the quality of dyadic coping strategies [61], which translates into better coping with the illness [2] and into the motivational processes of both partners in building relationships, mutual satisfaction with the relationship and general well-being [51].

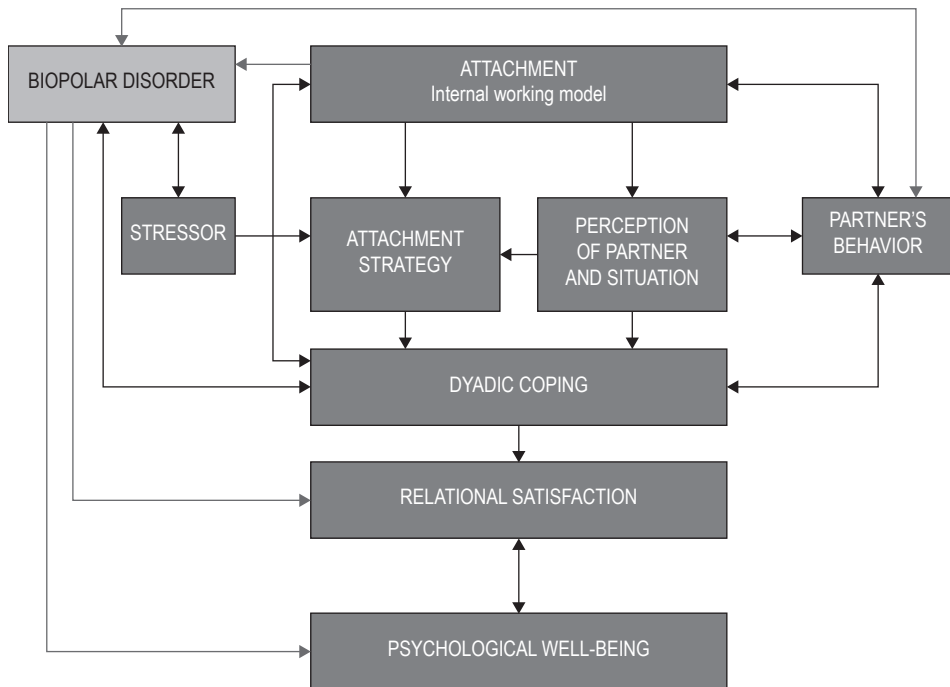


Figure 1. Model of dyadic coping in the context of bipolar disorder (own elaboration, based on 46, 61)

Recapitulation

Stress associated with the illness can potentially affect the health and quality of the relational system, both positively and negatively. Research shows that stress is negatively correlated with marital satisfaction [68]. Laboratory tests have shown that the quality of marital communication under stress conditions is reduced by as much as 40% [68]. Stressed partners showed more negative patterns of communication (criticism, peremptoriness, contempt, and withdrawal), which are predictors of worse marital functioning, lower relationship satisfaction and may be the reason for divorce [69]. Difficult life events do not significantly affect the level of satisfaction, except for those that are directly related to relationships, such as marital problems, conflicts with a partner, separation or divorce [51]. Chronic stressors, like everyday problems or illness, have a direct impact on the level of satisfaction with a relationship. Chronic stress can affect a relationship in a variety of ways. It can be a reason to minimize time spent together, which in turn leads to a reduction in the number of shared experiences, emotional exchanges, satisfying sexuality, and in the sense of the value of the relationship [46]. However, the illness may also be a chance to get closer, to express interest in the partner's needs and to improve the quality of the relationship [23, 42, 43]. A relational

problem solving approach is a complex process of coping with difficulties based on the interdependence of partners in a common behavioral and cognitive context [46].

The presented model of dyadic coping of patients with bipolar disorder is an attempt to find a mechanism for coping with stress that combines individual attachment strategies that are a result of the quality of the primary dyad relationship and the dyadic coping strategies used in the context of the current intimate relationship. Extending BD patients' coping concept with the attachment aspect, as one of the important factors deepening the understanding of the etiology and mechanisms of manifestation of disorder symptoms, creates a new perspective for understanding their behavioral, emotional and cognitive stress responses based on the processes of interpersonal emotional regulation. Higher competences of the partners in this area help to deal with negative emotions, which in turn translates into the motivational processes of both partners in dealing with the illness, building relationships, mutual satisfaction, and general well-being [70]. Empirical verification of the presented model will be a valuable addition to existing models that explain the mechanisms of the illness and may contribute to the development of physicians' and therapists' skills in the search for more effective methods of working with BD patients.

Understanding by patients and their partners the mechanisms of dyadic coping strategies and their impact on experienced emotions, effectiveness of actions and quality of relationships seems so important in the treatment process [18] that the partners' skills in this area should be supported in therapy and educational programs [68, 71]. Looking at the problem of bipolar disorder from a relational perspective gives the opportunity to construct effective intervention models in therapeutic work with couples, aimed at understanding mutual security needs and closeness of partners, as well as finding ways of more effective functioning under stress.

At the same time, projects aimed at raising the parenting competences of parents of high-risk children [72], working with families to develop emotional self-regulation skills, reformulating inefficient cognitive strategies, strengthening social support networks, and raising communication competences [73, 74] may be effective preventive and intervention ideas, which can provide children and youth with the competence to deal with difficult emotions and feel secure in close relationships.

Despite the fact that the quality of a relationship and the support it provides are considered important factors in the course and effects of BD treatment [2, 39], dyadic coping has not been the subject of research in this population. Attachment is considered one of the risk factors in the development of affective disorders, and the probability of relapse seems to be related to dysfunctional childhood relationships [40]; however, there are few studies that explore the relationship between attachment and bipolar disorder [36, 37]. In addition, most studies use self-report methods that do not investigate early childhood experiences or the disorganization strategies that arise from trauma and mourning experiences [exception: 75], which in the case of bipolar disorder may be significant, as shown by many studies that point to parental negligence and developmental trauma in the life history of BD patients [76, 77].

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