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The Influence of Trauma, Life Events, and Social Relationships on Bipolar Depression

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Synopsis

A growing body of research suggests that the social environment exerts a powerful influence on the course of bipolar depression. We review longitudinal research to suggest that trauma, negative life events, social support deficits, and family difficulties are common and predict a more severe course of depression when present among those diagnosed with bipolar disorder. The triggers of bipolar depression overlap with those documented for unipolar depression, suggesting that many of the treatment targets for unipolar depression may be applicable for bipolar depression.

Keywords

bipolar disorder; bipolar depression; life events; social support; family; expressed emotion; trauma; early adversity

Social Influences on Bipolar Depression

The focus of the current article is on the social environment as a predictor of bipolar depression. Although it has long been thought that bipolar disorder is largely a genetic disorder, a rather large literature indicates that psychosocial variables robustly influence the course of disorder. This is particularly well-documented for the course of bipolar depression.

Many would argue that depression should be a central target in the treatment of bipolar disorder. Although the single diagnostic criterion for bipolar I disorder is at least one lifetime episode of mania, recurrent depressive episodes are a criterion for bipolar II disorder. Even within bipolar I disorder, where depression is not a diagnostic criterion,

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depressive symptoms trigger more help seeking than do manic symptoms (1) and are related to suicide risk (2) and impaired functioning (1).

People diagnosed with bipolar disorder vary greatly in the severity and frequency of depressive symptoms experienced. Many clinicians assume that all individuals with bipolar disorder will experience episodes of depression (an assumption built into the very name of the disorder), as many as 20–33% of individuals with bipolar disorder report no lifetime episode of major depression (cf. 3). Those who do experience depressive episodes vary a good deal in the course of depressive symptoms. Some people have only one or two episodes during their lifetimes, many have frequent recurrences, and perhaps the modal profile is chronic subsyndromal depressive symptoms. Among 146 patients with bipolar disorder followed for more than 12 years, depressive symptoms were present, on average, for about one-third of weeks (4). Given this variability, a key question is what factors predict the severity of depressive symptoms in bipolar disorder. Research findings suggest that the genetic vulnerability to mania does not explain the vulnerability to depressive symptoms within bipolar disorder (5, 6), and we will argue here that psychosocial risk factors are a critical part of this puzzle. Here, we focus on the socio-environmental variables that have been consistently identified as predictors of bipolar depression: trauma, negative life events, deficits in social support, and problems in family relationships.

Differentiating the triggers for mania versus depression, though, entails some methodological complications. Much of the research in this field has been cross-sectional, and this work cannot disentangle the aftermath of episodes from factors that trigger symptoms. That is, manic episodes lead to occupational, social and financial stress, and loss of self-confidence. Understanding whether the social adversities, in turn, intensify symptoms requires longitudinal research. Given this fact, we weight prospective research heavily where available.

Early Adversity and Trauma

In one recent study of euthymic persons diagnosed with bipolar I disorder, 61% reported a history of childhood abuse (7), rates that appear to be even higher than those reported by individuals with unipolar depression (8, 9). Not only is childhood abuse far too common among those diagnosed with bipolar disorder, abuse is also associated with a more severe course of the disorder. In a comprehensive review that weighted 19 studies based on methodological rigor, childhood abuse (particularly physical abuse) was related to earlier onset, rapid cycling, psychosis, suicidality, impulsivity, aggression, symptom severity, and more mood episodes, hospitalizations, and comorbidity in bipolar disorder (10). In one study, childhood abuse was correlated with the severity of depressive, but not manic, symptoms within bipolar disorder (7).

Some work has explored the mechanisms through which trauma increases symptoms. For those with bipolar disorder, early adversity has been found to predict chronic stress (11) and reactivity to stressful life events later in life (12). These changes in the levels and vulnerability to stress in adulthood may, in turn, shape symptoms.

Unfortunately, most of the research in this domain has been cross-sectional. In the one available prospective study that we are aware of, trauma history predicted greater chronic stressors across time, and those chronic stressors then predicted greater symptoms of depression but not mania within a bipolar I sample (11).

Negative Life Events during Adulthood

Dozens of studies have considered life events and bipolar disorder (13). Fairly universally, these studies document that those with bipolar disorder experience high rates of negative life events. In parallel, population-based studies indicate that people with bipolar disorder report high rates of adult victimization, with as many as a third of people with severe mental illness reporting that they were a victim of violence within the three years before interview (14).

Nonetheless, understanding the effects of life stress is complicated. Depression and related coping styles may contribute to the generation of stress in both unipolar (15) and bipolar disorder (16), and so ruling out the influence of symptoms is an important goal. The best validated approach for differentiating life events that may have triggered symptoms from those caused by symptoms is the Bedford College Life Event and Difficulty Schedule (LEDS; 17). LEDS assessment relies on a semi-structured interview covering life events and their context. Raters who are unaware of the participant's subjective appraisal of the event then rate the extent to which symptoms may have caused an event, and events triggered by symptoms are excluded from analyses. Raters also judge the severity of events, so that participants' mood-state related biases will not influence severity ratings. Intriguingly, life events may also be more common even in unaffected family members of persons with bipolar disorder (18). Again, this highlights the need for prospective research.

Prospective studies using the LEDS and related interviews have demonstrated that severe, negative life events that are independent of symptoms predict increases in and duration of bipolar depression but not mania (19, 20, although see 21). Bipolar depressive symptoms appear particularly related to events related to loss and danger (22).

Negative life events have also been found to predict the onset of mood disorders in a five-year follow-up study of 140 offspring of parents with bipolar disorder, as assessed using the adolescent version of the LEDS (23). Each negative life event increased risk of onset by approximately 10%. Parallel findings emerged when the authors studied the onset of either first or recurrent episodes in a narrower 14-month period (24). As most (34 out of 38) onsets were depressive, negative life events appear particularly related to depression onset among those at risk for bipolar disorder.

Researchers have also considered whether the effect of negative life events vary across the life course. Despite long-held theory (25), there is no consistent finding that life events are more powerful at predicting earlier episodes than later ones in bipolar disorder (26). The most careful research has not provided much support for the idea that later episodes can be set in motion by less severe events (27). Rather, older individuals with bipolar disorder, like those who are younger, seem to experience a very high rate of serious life events (28).

Although research on bipolar depression has focused on the negativity of life events, other dimensions of events may also be important to consider. Sylvia and colleagues (29) found that life events that disrupted social rhythms were predictive of depressive symptoms and episodes in a sample of bipolar spectrum participants. Other research, however, suggested that life events that disrupted social rhythms were related to manic, but not depressive, episodes (30). To date, then, findings are less clear concerning the role of life events that disrupt social rhythm as a contributor to depression severity. We refer readers to the review of social rhythm disruption in bipolar disorder covered in this volume for more detail.

Low Social Support

As has been well-documented in unipolar depression (cf. 31), social support appears to be an important predictor of illness severity and recurrence within bipolar disorder (cf. 32, 33, for an exception see 34). Social support deficits predict increases in depressive, but not in manic, symptoms over time (35–39). People with bipolar disorder, on average, report being highly sensitive to interpersonal rejection, and those who report this sensitivity experience more depression over time (40).

Research confirms that social support remains important in BD across the life course, in that older (age 50 and older) adults with BD report lower perceptions of social support than controls, and they appear to have comparable deficits in social support to younger individuals diagnosed with bipolar disorder (41). Social support also seems important in guiding for older adults with bipolar disorder to seek treatment more quickly when symptoms do occur (42).

Taken together, findings suggest that social support is an important prognostic indicator for depression within bipolar disorder. These findings appear to generalize across age groups.

Family Functioning

Family functioning is often poor for those with bipolar disorder (43). In prospective research, family impairment has been shown to predict depressive more than manic symptoms among adults (39, 44, 45). Nonetheless overall social support (from a range of sources) has been found to be a more important predictor than the specific support obtained from family members (39).

More specific indicators of family processes can powerfully predict the course of illness. One of the strongest predictors of course of illness is Expressed Emotion (EE), which is defined as criticism, hostility, and emotional over-involvement of family members towards the patient with bipolar disorder (46, 47). Patients with bipolar disorder have a risk of relapse that is two to three times greater within 9 months if they live with a family member characterized by high EE (48). Of the various facets of EE, criticism appears to most predictive of outcome (49, 50). Two studies indicate that family criticism predicts depressive symptoms, but not manic, in bipolar disorder (51, 52).

In the past ten years, there has been tremendous growth in the literature examining the effect of family functioning on the outcome of youth with bipolar disorder. Poor family

functioning is linked to suicidal ideation in youth with bipolar disorder (53–55). Likewise, low levels of family cohesion and adaptability, and high levels of conflict predicted symptoms of depression (56).

Although the adult literature links poor family functioning primarily with bipolar depression, the adolescent literature is more mixed (57–59). Causal interpretations of family functioning on the course of adolescent bipolar disorder, however, must be approached cautiously. One of the strongest predictors of risk of bipolar disorder is parental psychopathology (43). In addition, family conflict may arise as parents attempt to exert control over the manic symptoms they observe in their children.

In sum, Expressed Emotion and poor family functioning have a clear deleterious impact on the course of bipolar disorder. Although it appears that family functioning and EE specifically affect the course of bipolar depression among adults, family concerns may relate to both depression and mania among youth with bipolar disorder.

Summary

Research findings indicate that early adversity, negative life events, low social support, expressed emotion, and poor family functioning may each help predict depression within bipolar disorder. These risk variables share remarkable overlap with the social variables that have been shown to be important predictors of major depressive disorder. Given the strong parallels, it is not surprising that psychosocial treatments developed for unipolar depression fare well in addressing bipolar depression (60). Clinicians would do well to consider that reducing life stress, enhancing social relationships, and reducing family conflict may help improve the course of bipolar depression. Particularly given the chronicity of depressive symptoms, such treatment targets may have major repercussions for improving quality of life and well-being for persons with bipolar disorder.

Although not reviewed here, most of the psychosocial variables that predict unipolar and bipolar depression appear less predictive of mania. Rather, in longitudinal research, mania appears to be predicted by a set of variables that are related to positive affectivity, impulsivity, reward system activity, and sleep and schedule dysregulation (61). Understanding and addressing mania may require targeting a host of other risk factors.

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Key Points

- Social environmental factors can predict a more severe course of bipolar depression.
- Childhood abuse is associated with a more severe illness course. Trauma exposure is associated with more severe chronic stress and greater reactivity to negative life events.
- Negative life events, even those independent of the disorder, predict increases in depression.
- Low social support predicts increases in depression, possibly through its impact on self-esteem and the experience of fewer daily positive events. This may be particularly relevant for patients who are sensitive to interpersonal rejection.
- Poor family functioning, and in particular, family criticism, predicts in bipolar disorder.
- Clinicians should consider these social risk factors when establishing a treatment plan for clients with bipolar depression.