The impact of bipolar disorder upon work functioning: a qualitative analysis


Objectives: One important but sometimes poorly-captured area of functioning concerns an individual’s ability to work. Several quantitative studies have now indicated that bipolar disorder (BD) can have a severe, and often enduring, negative impact upon occupational functioning. While this data indicates that employment rates are relatively low in this patient population, it throws little light on the specific ways in which this complex psychiatric condition can affect work, or upon how these effects are subjectively interpreted by individuals with BD. In order to further elucidate the relationship between BD and work, we report here on a series of exploratory qualitative interviews undertaken to develop a disease-specific measure of quality of life in BD.

Methods: We conducted 52 interviews with people with BD (n = 35), their caregivers (n = 5) and healthcare professionals (n = 12) identified by both convenience and purposive sampling. The affected sample came from a variety of employment situations, ranging between people with no employment history through to those in highly skilled, stable professional positions. Interviews were tape recorded, transcribed verbatim and analysed thematically.

Results: Respondents described the different ways in which the symptoms of depression and hypo/mania presented in the workplace. Five main themes emerged from the data: lack of continuity in work history, loss, illness management strategies in the workplace, stigma and disclosure in the workplace, and interpersonal problems at work.

Conclusions: Patient outcome in BD has traditionally been determined by the assessment of clinical characteristics such as rates of relapse, hospitalization, or degree of symptom reduction. More recently, however, there has been increasing interest in expanding the assessment of outcome to include the measurement of indices such as functioning, a key facet of which relates to an individual’s ability to work. The qualitative data obtained here highlights the often complex, varied and intermittent effects of an episodic condition such as BD upon work functioning, and points to the importance of developing more sophisticated and precise measures of occupational functioning for this population.

Although the symptoms of bipolar disorder (BD) have been recognized for centuries, attention has only fairly recently been directed towards improving our understanding of the impact of the condition upon everyday functioning. One important but often overlooked (or poorly-captured) area of functioning concerns an individual’s ability to work. At a basic level, this can be interpreted simply as a person’s ability to obtain and maintain paid employment. At a more complex level, it can refer to an individual’s ability to engage in work, paid or unpaid, that they perceive to be
meaningful, personally satisfying and in keeping with their educational achievements, expectations, skills or vocational aspirations. Although there is a far larger body of research addressing the relationship between employment and schizophrenia, several quantitative studies have now been conducted in bipolar populations, and have generally indicated that BD can have a profoundly negative impact upon occupational functioning. In a recent review, Dean and colleagues identified 14 quantitative studies that had assessed work impairment in patients with BD (1). The studies were quite heterogeneous, alternatively assessing degree of work impairment by rates of long-term unemployment, occupational functioning, and absenteeism due to emotional or physical problems and reduced work performance. For example, several studies have indicated that rates of employment are low in patients with BD in comparison to those observed in the general population, and those observed in patients with other affective disorders. In a study that prospectively followed patients (n = 67) for 6 months following hospitalization for an episode of mania, 43% were employed during this time, with only 21% working at their expected level of employment, although 80% of the sample were considered to be symptom free or mildly symptomatic (2). Another prospective study reported that only 42% of a sample of 73 patients with BD were in continuous employment over a 1.7-year observation period (3). Other studies have painted a similarly bleak picture (4–13).

Several variables have been shown to be predictive of poor occupational functioning in patients with BD, including certain demographic or clinical characteristics and lack of social support. For example, Dickerson et al. (14) examined variables associated with employment status in individuals (n = 117) diagnosed with BD type I or II, including demographic variables, cognitive functioning, symptom severity and course of illness. Multivariate analysis indicated that current employment status was significantly associated with level of cognitive functioning (especially verbal memory abilities), severity of symptoms, and history of psychiatric hospitalization and level of maternal education. An interesting study of patients (n = 52) with BD type I found that the presence of a strong, supportive relationship was actually a stronger predictor of work functioning than clinical status (recent or current symptomatology or number of previous hospitalizations) (9). Similar results have been reported in other studies; level of current psychiatric symptomatology does not uniformly predict occupational functioning (2, 15). Instead, for some patients, there appears to be a marked time-lag between recovery from a mood episode and return to the workforce, if indeed that return occurs at all. For example, a study of first-episode patients (16) reported that 98% of the sample achieved syndromal recovery within 2 years, compared to only 38% achieving functional recovery (defined as the proportion of patients who regained occupational and living situations equivalent to those they held prior to their episode), suggesting that the speed with which a person restores their occupational functioning after an episode is influenced by more than disease state alone.

Bipolar disorder represents a major public health concern, with an estimated 0.3–1.5% of the population experiencing BD type I (17), and up to 8% experiencing bipolar spectrum disorders (18). In the year 2000, the World Health Organization estimated that BD was the sixth leading cause of disability worldwide amongst young adults (i.e., 15–44 years of age) (19). In a widely cited study, the direct and indirect costs associated with BD were estimated to be $45 billion in the United States during 1991, of which only $7 billion was due to actual treatment costs (20). Lost productivity within salaried employees and homemakers, however, accounted for costs of approximately $20 billion. The costs of the disorder to society via its impact upon the workforce are obviously substantial, yet surprisingly little research has focused upon the specific ways in which BD can affect peoples’ working lives. While extant quantitative research indicates that BD can have a profoundly negative impact upon work functioning, it is marred by inconsistent definitions of employment (i.e., not distinguishing sheltered and competitively obtained positions), differing methods (i.e., cross-sectional versus prospective) and the fact that there are few well-validated, comprehensive instruments available to assess the work domain. In order to better understand the effects of BD upon employment, it is important to take into consideration the ways in which these are subjectively experienced by individuals with BD themselves, and a small number of qualitative studies have now addressed this issue. In a notable study, Tse and Yeats (21) used a grounded theory approach to assess the factors related to successful employment in a relatively large sample (n = 67) of patients with BD in New Zealand. Their results indicated that two main factors determined an individual’s readiness to re/join the workforce: (i) recovery from their acute episode of BD and (ii) goodness of fit between the individual, their job, the support available to them and wider contextual components. Specifically, having a sense of determination,
good professional qualifications, a good work record, faith in God and good illness management skills were important individual factors in determining whether vocational integration was successful or not. Work factors related to the meaning and value the person derived from their occupation, and the nature and structure of the job (i.e., whether there was a balance between routine and flexibility). Perceived support consisted of either support within the workplace (i.e., from managers, colleagues or in terms of entitlement to leave) and wider social support (friends and family, professional or community support groups). Finally, wider contextual components included factors such as lack of perceived stigma towards people with psychiatric illness and appropriate governmental policies and legislation. Importantly, Tse and Yeats note that: ‘being employed should not be viewed as the end of the rehabilitation process in itself. Achieving an employment status can potentially act as a catalyst to prompt the person concerned to further advance his/her career pursuits and recovery from BD’.

In another interesting study, an Australian research group used the phenomenological approach to assess the psychosocial issues faced by patients with BD (n = 18) more broadly (22). One interesting new theme that emerged from their data related to the notion of self-efficacy (the expectation that one can successfully perform a behaviour in a specific situation) (23). Existing quantitative research has indicated that patients with BD are relatively adept at detecting prodromal symptoms of relapse (for example, 24, 25); participants in the study by Lim et al. (22), however, did not feel they had the ability to predict the onset of a mood episode. Moreover, they described a general lack of ability to control their illness and their environment, which the authors interpreted as a lack of self-efficacy, although it is worth noting that their sample was drawn from a hospital outpatient clinic. It is possible that these results would have been different had the sample included more individuals who were managing their BD well with minimal intervention from the healthcare profession (26).

Rational for the current study

In a recent review of research examining quality of life (QoL) in BD (27), we concluded that an important step forward in the bipolar disorders field would be made with the development of a disease-specific measure of QoL for this population, and further noted the importance of maximizing the relevance and validity of the scale through thorough consultation with patients, their families and their healthcare providers. We subsequently began to develop such a measure, the Quality of Life in Bipolar Disorder (QoL.BD), and performed a series of in-depth qualitative interviews in order to generate the scale’s items. As BD is a highly heterogeneous condition, we aimed a priori to garner the viewpoints of a fairly representative sample of people diagnosed with the disorder (e.g., BD type I and II, low functioning versus high functioning individuals). We also aimed to interview caregivers of people severely affected by BD (in the belief that the individuals themselves might be unable to undergo a lengthy qualitative interview), healthcare workers with expertise in BD (in the belief that they would be able to describe the impact of BD upon QoL at a broader group level) and international experts in bipolar disorders research. Elsewhere, we have described six themes (routine, independence, stigma and disclosure, identity, social support and spirituality) that respondents described as being important in determining their QoL (28). Here, we present a sub-analysis of the same body of data, focusing specifically upon participants’ comments regarding the impact of BD upon work. The data adds to existing qualitative literature addressing work functioning in patients with BD in that it was conducted in North America, recruited participants from several sources (inpatients, outpatients, the community) and a variety of employment situations (ranging from people with no employment history through to those in highly skilled professional positions). We aimed to provide a detailed description of the different ways in which BD can impact upon occupational functioning, and to use this and other data to provide some practical solutions for supporting individuals with BD in the workplace.

Methods

We used a combination of convenience and purposive sampling to identify potential participants. In the first phase of recruitment we sent a standard letter of invitation to the central office and six regional (within the Lower Mainland of British Columbia) branches of the Canadian Mental Health Association (CMHA), the Mood Disorders Association (MDA) and eight regional mental health teams in British Columbia, Canada. In the United States, we sent the recruitment letter to 95 (of approximately 400) randomly selected branches of the Depression and Bipolar Support Alliance (DBSA). The advertisement stated the purpose of the study and asked for people with BD, their
caregivers, or healthcare providers to contact us if they would be willing to conduct a qualitative interview about their perceptions of QoL in BD. To be eligible to participate, affected individuals had to be 18 years or older and fluent in English; no limitations were placed on the type of BD they had been diagnosed with. Demographic and diagnostic details were recorded on a standardized report form at the onset of each interview, but no confirmation of diagnosis was made. Affected individuals were also asked to indicate how they felt ‘right now’ on a visual analogue scale (VAS) ranging from −5 to +5, where −5 represented ‘the most depressed or down you have ever felt’ and +5 indicated ‘the most hypomanic or high you have ever felt’.

Approximately 2/3 of the participants we interviewed were identified in this manner. Most of this initial sample consisted of outpatients with BD who reported being either euthymic or mildly/moderately depressed on the basis of their VAS-measured current mood state. A number of healthcare workers were also interviewed at this time, however, as well as all of the caregivers interviewed. In the second stage of recruitment, we used purposive sampling to obtain a more heterogeneous group. Examination of the clinical characteristics of our initial convenience sample indicated that we had interviewed few individuals who were severely depressed or hypomanic, or people who were functioning exceptionally well. To rectify this we actively recruited patients with BD from the University of British Columbia hospital in and outpatient departments. For these patients, diagnoses of BD had been made on the basis of all available medical information, which included a clinical interview by a board-certified psychiatrist. Within the inpatient sample (n = 5), we interviewed patients hospitalized for an episode of depression (n = 2) or mania (n = 3), but we did not interview any patients who were acutely manic. Within the outpatient sample (n = 7), we interviewed four patients who had experienced a recent episode of depression and three who had experienced a recent episode of hypomania. At this time, we interviewed three individuals with BD who appeared to be functioning exceptionally well with the disorder (self-reported episode-free for at least 2 years and performing well occupationally). We also purposefully recruited (via networking) a wider range of healthcare professionals (psychiatrists, nurses, occupational therapists, social workers and psychologists) both locally and internationally who had a specific interest in the treatment of BD, or an extensive history of working with this patient population. Finally, several internationally recognized experts in BD research were interviewed, as well as people who both worked in healthcare professions and had a diagnosis of BD.

The interviews (45 of which were conducted by the first author, with the remainder being performed by a student under supervision) lasted approximately 1 h (range 20–90 min). It is important to note that the primary aim of conducting the interviews was to generate the items for the QoL BD scale. We wished to give participants as much freedom as possible to describe their own experiences, and in turn, to generate the items and domains of QoL that would eventually be included in the scale. Thus, we began and finished the interviews according to a standard script, but otherwise left them unstructured, and we did not use any standardized direct probes. At the beginning of each interview, affected individuals were asked the question, ‘What do you need to have good quality of life?’ The interviewer then recorded the list of initial topic areas (or ‘domains’) identified by the respondent (for example, social support, work, mental health). When this initial list was exhausted, participants were asked to describe in more detail whether and how their BD had impacted upon each of these areas; respondents often thought of additional areas for discussion as the interview progressed. Interviews with healthcare professionals were similar in format, except that we asked these respondents to limit their responses to their experiences with patients diagnosed with BD, not other psychiatric conditions. Caregivers for people with BD were asked to describe their perceptions of how BD had affected the QoL of the person they cared for. Data from the proxy interviews was coded and analysed in the same manner as the data from interviews with people affected by BD. Interviewing was discontinued once no additional information appeared to be forthcoming. All of the interviews were tape recorded, transcribed verbatim and coded by the first author using basic qualitative research methods (29) which included the following steps:

(i) the transcripts were initially read through (without coding) in order to gain an overview of the main issues and themes raised by participants;
(ii) the transcripts were read again several times, with all pertinent references to work being highlighted and detailed memos being made concerning emerging themes;
(iii) the number of participants describing a particular theme, and the frequency with which themes were mentioned, was recorded, as were

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instances where opposing viewpoints were apparent; and
(iv) themes for discussion were selected on the basis of how many participants mentioned them, and how frequently they were mentioned.

The coding was performed manually by the first author: computer-assisted qualitative data analysis software was not used in order to avoid ‘alienation from the data’ (30). Indeed, through the lengthy process of conducting and transcribing the interviews, the author became highly familiar with the dataset and emergent themes. Informant feedback was used to protect against researcher bias; a draft report of the study findings was sent to 10 previously interviewed participants, who provided feedback regarding the interpretation of the data (31). This process indicated that there good closeness of fit between our interpretations of the data and respondents’ perceptions, and no changes were deemed necessary. Furthermore, an experienced mental health educator with a diagnosis of BD type I (third author) was actively involved in the analysis, interpretation and write-up of the data. Finally, we conducted a more in-depth analysis of four specific cases. The first pair of selected cases consisted of two females who had experienced a fairly severe course of BD type I, yet had succeeded in obtaining a high degree of occupational functioning (selected as we wished to investigate commonalities between the two participants). The second pair of cases consisted of two individuals who had experienced similar academic backgrounds, onset of BD type I in their early 20s and a severe initial course, but had very different outcomes in terms of their level of occupational functioning at the time of interview (selected as we wished to investigate whether there were any factors that distinguished the two individuals). The Ethics Committee of the University of British Columbia approved the study, and all participants signed consent forms prior to participation.

Results
Sample characteristics

In total, 52 interviews were conducted, 29 in person and 23 by telephone. Interview format was determined by participant preference and geographical restrictions; all interviews with participants from the US, for example, were conducted by telephone. Mode of administration did not appear to affect quality or intensity of the interviews. Clinical and demographic details for the sample of people affected by BD (n = 33) are presented in Table 1.

<table>
<thead>
<tr>
<th>Clinical characteristic</th>
<th>n (%)</th>
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<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>22 (67)</td>
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<tr>
<td>Male</td>
<td>11 (33)</td>
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<tr>
<td>Age (mean ± SD)</td>
<td>43 ± 11 (21-68)</td>
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<tr>
<td>Diagnosis</td>
<td></td>
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<tr>
<td>Bipolar disorder type I</td>
<td>21 (64)</td>
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<tr>
<td>Bipolar disorder type II</td>
<td>9 (27)</td>
</tr>
<tr>
<td>Bipolar spectrum</td>
<td>1 (3)</td>
</tr>
<tr>
<td>Missing data</td>
<td>2 (6)</td>
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<tr>
<td>Age at first episode of hypo/mania (n = 31)</td>
<td>30 ± 12 (6-58)</td>
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<tr>
<td>Years with illness (n = 30)</td>
<td>24 ± 11 (0.3-43)</td>
</tr>
<tr>
<td>Employment status</td>
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</tr>
<tr>
<td>Full-time (FT) open employment</td>
<td>8 (25)</td>
</tr>
<tr>
<td>Part-time (PT) open employment</td>
<td>1 (3)</td>
</tr>
<tr>
<td>Sheltered employment (FT/PT)</td>
<td>1 (3)</td>
</tr>
<tr>
<td>Employed, on sick-leave (FT/PT)</td>
<td>2 (6)</td>
</tr>
<tr>
<td>Student (FT/PT)</td>
<td>3 (9)</td>
</tr>
<tr>
<td>Unemployed – job seeking</td>
<td>1 (3)</td>
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<tr>
<td>Unemployed – out of job market</td>
<td>5 (15)</td>
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<tr>
<td>Long-term disability</td>
<td>11 (33)</td>
</tr>
<tr>
<td>Missing data</td>
<td>1 (3)</td>
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<tr>
<td>Number of previous episodes</td>
<td></td>
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<tr>
<td>Depression (n = 33)</td>
<td></td>
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<tr>
<td>0–2</td>
<td>3 (9)</td>
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<td>3–5</td>
<td>4 (12)</td>
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<td>6–10</td>
<td>5 (15)</td>
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<tr>
<td>Many</td>
<td>20 (61)</td>
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<tr>
<td>Missing data</td>
<td>1 (3)</td>
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<tr>
<td>Mania (n = 24)</td>
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<tr>
<td>0–2</td>
<td>8 (33)</td>
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<tr>
<td>3–5</td>
<td>6 (25)</td>
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<tr>
<td>6–10</td>
<td>0 (0)</td>
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<tr>
<td>Many</td>
<td>9 (38)</td>
</tr>
<tr>
<td>Missing data</td>
<td>1 (4)</td>
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<tr>
<td>Hypomania (n = 12)</td>
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<tr>
<td>0–2</td>
<td>2 (17)</td>
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<tr>
<td>3–5</td>
<td>1 (8)</td>
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<tr>
<td>6–10</td>
<td>2 (17)</td>
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<tr>
<td>Many</td>
<td>6 (50)</td>
</tr>
<tr>
<td>Missing data</td>
<td>1 (8)</td>
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<tr>
<td>Number of hospitalizations</td>
<td></td>
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<tr>
<td>0</td>
<td>7 (21)</td>
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<tr>
<td>1–2</td>
<td>13 (40)</td>
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<tr>
<td>3–5</td>
<td>5 (15)</td>
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<td>6–10</td>
<td>4 (12)</td>
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<tr>
<td>11–20</td>
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<td>&gt;20</td>
<td>1 (3)</td>
</tr>
<tr>
<td>Missing data</td>
<td>1 (3)</td>
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<tr>
<td>Current episode</td>
<td></td>
</tr>
<tr>
<td>No current episode</td>
<td>12 (36)</td>
</tr>
<tr>
<td>Depression</td>
<td>12 (36)</td>
</tr>
<tr>
<td>Mania</td>
<td>4 (12)</td>
</tr>
<tr>
<td>Hypomania</td>
<td>4 (12)</td>
</tr>
<tr>
<td>Mixed</td>
<td>1 (3)</td>
</tr>
<tr>
<td>Visual analogue scale score</td>
<td></td>
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<tr>
<td>+3 to +5</td>
<td>2 (6)</td>
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<tr>
<td>+1 to +2</td>
<td>7 (21)</td>
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<tr>
<td>0</td>
<td>8 (24)</td>
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<tr>
<td>−1 to −2</td>
<td>10 (30)</td>
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<tr>
<td>−3 to −5</td>
<td>4 (12)</td>
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<tr>
<td>Missing data</td>
<td>2 (6)</td>
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</table>
Twelve (36%) of this group were recruited via UBC Hospital and were residents of the Lower Mainland of British Columbia. A further 12 (36%) were identified either via the CMHA or MDA and were residents of Canada, six (18%) were identified via the DBSA and were residents of the United States, and the remaining three (9%) were identified via recruitment through regional mental health teams in Canada. More females than males responded to our recruitment advertisements, resulting in our conducting more interviews with females (67%). We also interviewed more people (64%) with a diagnosis of BD type I than BD type II or not otherwise specified/spectrum. If we compare the clinical characteristics of the current sample to those of the first 1,000 patients enrolled in the STEP-BD program (32), we see a similar gender (67% female versus 59%) and age (43 ± 11 versus 41 ± 13) distribution, as well as a similar distribution of clinical characteristics. For example, 64% of the current sample was diagnosed with BD type I compared to 71% of the STEP-BD program. Although duration of illness data is not presented for the STEP-BD sample, it is available for the first 261 patients recruited to the Stanley Foundation Bipolar Network (33), where a mean duration of 20 ± 2 years was reported, in comparison to 24 ± 11 years for the current sample. In the present study, we asked participants to retrospectively recall when they experienced their first full episode of hypo/mania (mean reported age 30 ± 12 years). STEP-BD, in comparison, utilized more robust clinical interviews to determine the initial onset of patients’ mood disturbance (either depression or hypo/mania, mean 17 ± 9 years). Other clinical characteristics (for example, number of previous episodes of depression or hypo/mania, number of hospitalizations) are not directly comparable across the studies. Employment characteristics for the current sample (approximately 25% in full-time employment, 18% unemployed, 33% on long-term disability) are relatively comparable to those reported for the STEP-BD sample (35% in full-time employment, 22% unemployed, 15% disabled), with the exception of the number of people classified as being disabled. For the healthcare professional sample (n = 12), we interviewed four psychiatrists, four nurses, one social worker, one psychologist, one nurse/researcher and one occupational therapist. For the caregiver sample, we interviewed five individuals, three mothers who spoke on behalf of their sons, one woman who spoke about her brother, and the partner of a man with BD.

The majority (n = 31) of the sample of 33 participants with BD and the entire sample of healthcare professionals (n = 12) and caregivers (n = 5) discussed the relationship between work and BD during the interview process. During analysis, we focused upon comments relating to current or previously held open employment, sheltered employment, volunteer or community work or aspirations for future employment. Whilst we recognize that household, childcare and caregiver responsibilities constitute work, they were not the focus of the present paper, nor were the themes of leisure, finances or education, although these QoL domains are clearly related to the domain of work or occupation more broadly. We present the data by initially summarizing participants’ descriptions of how the symptoms of depression and hypo/mania commonly manifest in the workplace. We subsequently describe 5 themes that were frequently (i.e., discussed by at least 1/3 of the sample) raised in relation to how BD impacted upon work.

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Symptoms of depression, hypomania and mania in the workplace

Bipolar disorder is a highly complex psychiatric condition that can be characterized by symptoms of depression, hypomania or mania, or indeed, a combination of these mood states in an individual at the same time. The ways in which the symptoms of BD can manifest in the workplace appear to be just as varied and complex. Overall, episodes of depression were more commonly described by participants as being associated with lack of energy, enthusiasm, decreased confidence (‘… because I was depressed, I wasn’t making eye contact. I wasn’t shaking hands as confidently. I wasn’t walking in knowing that I could do the job’), decreased productivity (‘I can’t work at all when I’m depressed. I just feel like all I want to do is die’) and withdrawal from others in the workplace. Hypomanic states tended to be associated more with increased enthusiasm and confidence, greater productivity, creativity, more goal-oriented behaviours and increased multi-tasking. Nine participants with BD described the positive effects of hypomania in the workplace, in particular in relation to increased productivity and problem-solving abilities. For example, a 26-year-old female academic with BD type I reported that:

‘… a lot of my best work is done when I’m hypomanic; I can solve a problem that’s just been bugging me for the past 2 months, you
know, all of a sudden it will seem as clear as day, and there you go, it will be publishable.'

In the words of other respondents: 'I find it will help get me over really, really big road blocks at work'; however, the hypomania was often short-lived:

'There were times when I would kick into being hypomaniac and then suddenly everything would be great and I'd be turning out ideas all over the place, but then that would fade away and then I would go back to my normal depressed state.'

One expert in bipolar disorders research and treatment said, 'I definitely have a significant number of patients who've been highly successful when hypomaniac'. He went on to describe in detail two particular patients he had worked with. The first individual was a lawyer who had made some legal breakthroughs and written key articles when hypomaniac that had brought him international recognition ('that person clearly attributes some of those ideas, those breakthrough ideas to intense thinking when high'). The second patient he described was a real estate agent who when originally undiagnosed, went through a 7-year period which happily coincided with a steady and unexpected rise in housing prices; during that time period this person had frequent hypomaniac episodes and as a result always bought when they bid on a house. And because the market was buoyant they always made money.

Far from being a state of utopia, however, hypomania was often also associated with increased anxiety and interpersonal problems in the workplace. Furthermore, heightened productivity was not always channelled in an appropriate direction. Four respondents talked about times when they had overstepped the boundaries of their jobs when hypomaniac, taking on tasks that were not within their job description or interfering with others' work. Three respondents described situations where they had gone to their place of employment during a full-blown episode of mania, and the disastrous consequences of this. For example, one senior healthcare professional with BD type I described an episode in the following way:

'... my sleeping was not regular, my hours were not regular ... my memory was shot, I was having trouble making decisions, and that did not bode well. And then I had an acute manic episode, the worst I've ever had, and that just more or less ended my career.'

Several people (n = 4) described their mood and behaviour at work as being highly changeable and unpredictable, and stated that it was this lack of consistency that disconcerted others. In the words of a woman with BD type I:

'I guess there were times when I was pretty quiet at work and that didn't go over very well, and it didn't go over very well on the other end of the spectrum when, you know, my boss would tell me I'm too loud.'

Or in the words of another woman, 'My behaviour was becoming increasingly erratic ... I would have fits of anger ... I would have fits of crying'. Both depressed and hypomanic states were associated with an increased likelihood of making mistakes. One woman described her behaviour at work during a manic episode in the following way:

'I was behaving bizarrely, I was sarcastic, and I made a lot of mistakes, like, I couldn't file for the life of me because it was according to numbers and I just, inverted numbers, and I couldn't even spell. Taking messages wasn't working, and I couldn't communicate with staff.'

Three other respondents described how both symptoms of depression and hypomania directly impinged upon their safety at work, and the safety of others. For example, a man who had held a job that involved working on road crews described how, 'I could get killed or kill somebody else', either because he was not confident enough when depressed to flag down vehicles, or because he believed he was invincible to the dangers of traffic when hypomaniac. He explained that when hypomaniac:

'The speed of your thinking goes up and you have lots of different ideas that float through your head. And you're not exactly concentrating on what's at hand. And when you're depressed, you're ruminating about something and your concentration on what's going on sucks. Plus your memory's gone too. You know you're supposed to be out there, but you might not remember why.'

Other respondents described an increased likelihood of making irrational or ill-calculated decisions at work. As overspending is a potential symptom of hypomania, we were interested to know whether participants had experienced this symptom in their working lives. Three of the respondents with BD we interviewed held positions with significant financial responsibility (for example, a senior buyer for a large manufacturing company), but none of this sample reported financial indiscretion at work associated with their BD. However, some (n = 4) of the healthcare workers we interviewed described situations where patients they had known had made financial mistakes at work whilst hypomaniac, sometimes serious enough to culminate in the loss of their job or business.
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Five main themes emerged from the data: (i) lack of continuity in work history; (ii) loss; (iii) illness-management strategies in the workplace; (iv) stigma and disclosure in the workplace; and (v) interpersonal problems at work.

Lack of continuity and consistency. ‘I have a 1–2 year timeframe on most jobs ... and my decisions to leave were always rash.’

A small number (n = 3) of the more severely affected participants we interviewed (or their caregivers) reported that they had never been employed, and a second small cohort (n = 2) described having had a highly stable work history with little job turnover. However, more participants with BD (n = 12) described instead a lack of continuity in their work history, where cycles in their working lives often mirrored the cycles they were experiencing in their mood episodes. Often, decisions to quit were described as being ill thought out, made rashly and the subject of regret. One man with BD type I who had held several senior positions in advertising described a common train of events:

‘Every time I would start a new job I would kind of be hypomaniac ... I would get there early in the morning, get everything done, but as longer time would pass I would begin to come in later and drift down ... and it would be harder for me to get up in the morning, harder for me to get things done, and I always got into trouble. And then I would start a new job and I would be up and hypomaniac again.’

He further described how these cycles became shorter with time, ‘the first time it was 7 years, the next time it was 3 years, the next time it was 2 years, the next time it was 1 year; the last time I could only last 6 months’. In the words of another woman with BD type II:

‘... the longest I’ve ever worked for is a year and a half ... there have been times when I’ve been full of energy and I’ve worked so hard and people are like ‘you do the job of 2 or 3 people and it’s amazing how hard you can work’ and you know, I’ll do anything and I’ll do everything and then it’s like I crash.’

Other respondents (n = 4) described this pattern of moving from being ‘employee of the month’ workers when hypomaniac through to periods of being reprimanded for poor work performance, tardiness, mistakes or interpersonal problems at other times. Three respondents voiced their belief that their employers and work colleagues did not understand that their overall work output was equal to (or above that) of other employees who worked in a more consistent fashion (‘I used to have one boss that was a stats person, you know, you got to do 10 [things] a day or you got to do 12 a day, right. And I said, well, one day I do 100 and the next day I only do 3 ... it doesn’t mean I haven’t done 12 a day, I’ve exceeded 12 a day. You know, but he could never figure that one out’).

Lack of consistency in mood state was described as being particularly problematic when they felt they little control (or self-efficacy) over moods. In the words of a former psychiatric nurse on long-term disorder (LTD), ‘the other thing that really makes me afraid is that I can’t make a commitment, you know? And I, I can’t commit to anything because it’s always in the back of my mind that, when’s this going to hit?’ Or, as an expert in BD research put it, ‘there’s uncertainty about employment, there’s uncertainty about money, and there’s uncertainty about when their next episode of illness might be. So there’s a kind of constant fear that something will go wrong’. Three respondents on LTD clearly stated that this lack of control over their mood states represented the main barrier to their remaining in or rejoining the workforce [(I think) maybe I could go back to work ... I check the paper out every day to see what kinds of jobs there might be, and then all of a sudden it just hits me that, why the hell bother, it’s only going to happen again].

Loss. ‘I’m going like a chicken with my head chopped off trying to make up for lost time.’

Over half of the sample of respondents with BD (n = 18) referred to the notion of loss: loss of time, loss of job prospects, loss of identity or financial loss.

Loss of time at work occurred as a result of extended leave due to mood episodes (‘I feel like my career was arrested at age 26 when I was diagnosed’) or associated physical illnesses, hospitalizations, or having to reduce the number of hours or days worked. For example, a man with BD type I who worked in a university talked about his decision to move from a 5- to a 4-day week to help manage stress, and how he doubted: ‘very much whether I would have made that 80% choice if I hadn’t been ill’. Some respondents talked about the psychological effects of this (‘any person that loses that kind of time to mental illness is going to feel a bit cheated’) and feelings of continually having to ‘make up for lost time’ at work, particularly in terms of maintaining skill levels:

‘It’s taken me away from work and the biggest drawback of that is catching up. And it took me awhile to realise anybody who has lost say 4 years of their work life out of the last 15 would feel exactly the same way.’
Loss of job prospects or career of choice was also discussed. In the words of a skilled professional: ‘it really robbed me of a great career … after being out of the game for 6 years, it’s very hard to get back into it’. Another 47-year-old woman with BD type II on LTD described losing her graphic design company as a result of ‘grinding to a complete halt at work’ due to depression, and how this also represented the loss of a creative outlet, and a loss of the identity she derived from her career. The relationship between loss of career and loss of identity was also described by a woman on LTD with BD type I:

‘There’s been a loss of identity. You know, if you can imagine if you’re 50 years old, you know, you’ve lost your career … and you’re trying to figure out what you’re going to do with your life, and … you forget about who you are and what you do, and where to start.’

Self-identity appeared to be derived, for some, from being engaged in meaningful, worthwhile or rewarding work. In the words of a 37-year-old woman with BD type I:

‘When I was diagnosed with BD I was very afraid that the illness would disable me to the point that I either couldn’t work, or I’d have to work at something that I thought was below my original potential … so that I would be able to be a housecleaner, but it wasn’t what I wanted to do and it didn’t give me meaning. And there’s nothing bad about housecleaning, but if it doesn’t give me joy or doesn’t give me fulfillment, then to me that’s a problem.’

When asked what she missed about not working, a senior healthcare professional who had been placed on LTD replied: ‘The feeling that I’m being useful, I miss contact, I miss structure, I miss meaningful activities, I miss paying my own way’. Participants also talked about having to redefine their interpretations of work fulfillment. For some people, volunteer or community work provided meaning and identity in the place of paid employment. In a notable interview, a woman with BD type I on LTD stated that, ‘First of all, I felt really guilty not working and having no career … but I started doing volunteer work … when people talked to me I’d say, well, I volunteer at so and so’. She went on to talk about her sense of shame in no longer having a recognized career, ‘so I housesit and that’s what I say my career is. And I don’t care what people think if they tell me I’m a house sitter. It’s better than saying I’m on LTD. Or I say I’m a pet sitter, which is even more interesting’.

Finally, financial loss was described by several respondents, resulting mostly from lost earnings during periods of unemployment, and not ‘moving up the ladder’ as quickly as peers (‘… because I had to work part time for a lot of it and I wasn’t able to advance my career very substantially, and I had to work in a job that was quite below my earning potential’). In the words of a 41-year-old man with BD type II who worked in finances ‘I wish I had an extra 10 years. I feel like 10 years was just wasted, and I look at my peer group and I don’t have as much money as them now’. For a former nurse who had been on LTD for several years, fear of financial loss was a large factor in her decision not to return to work (‘I feel really handcuffed because if I went out to do another job, and wasn’t successful, I would fear losing my LTD, and then be left with nothing’).

Illness management strategies in the workplace. Over half (n = 18) of the sample of respondents with BD talked in some capacity about the illness management strategies they used in the workplace. Strategies included:

- Removing themselves from occupational settings when symptomatic (‘I generally try to stay away from people and things when I’m depressed because I’m not a nice person to be around and I can’t be very productive anyways; 26-year academic with BD type II).
- Reducing workload when symptomatic (i.e., fewer days per week, fewer hours per day).
- Changing work schedules (in the words of one clinician: ‘I’ve helped a number of nurses who are on rotating schedules be granted special medical permission to only be on a day shift so that they don’t have to deal with the circadian interruptions’).
- Changing work activities when symptomatic (e.g., working on ‘mundane’ tasks that require less concentration when depressed, reducing contact with customers when irritable, avoiding work in noisy areas, etc.).
- Making transitions to less stressful work environments (in the words of an expert in the treatment of BD, ‘I’ve treated over 100 bipolar lawyers and a number of bipolar physicians … and some have decided, lawyers for instance, that they’ll go from a big firm to a small firm. Physicians have decided they’ll take somewhat less busy clinics’).
- Enlisting emotional or practical support from trusted co-workers [‘… if they (my co-workers) weren’t as accepting and supportive it would be really awful’].
- Seeking help from their healthcare team (i.e., changes in medications, counselling sessions).
Using occupational routine to help maintain emotional health (‘it starts at 7:30 and it ends about 3:30, 4:30 every day and that works really well for me … the routine of getting up at the same time every morning, going to bed at the same time, going to work and doing it at approximately the same time every day’; school teacher with BD type I).

Avoiding occupational routine to help maintain emotional health (‘I worry about how my quality of life is going to change once I … enter into the workforce and have to be there at a certain time every day, and doing something at a certain time every day’; 24-year PhD student with BD type II). Further examination of the data showed that illness severity (VAS scores, number of previous episodes, number of previous hospitalizations, years of illness) was not significantly different between respondents who utilized routine as an illness management strategy and those who did not.

Working on a casual rather than a salaried basis (‘that was easier to handle for me in terms of being able to refuse work when I was casual because I didn’t have to give them any reason why’; nurse with BD type I).

Stigma and disclosure in the workplace. ‘… the other thing I felt at work was as a sense of alienation, that I was different than other people.’

Nearly half (n = 15) of respondents with BD talked about stigma in the workplace, and/or about disclosure of their diagnosis to others. Several respondents clearly believed that stigma relating to BD had resulted in their being dismissed from positions, passed up for promotion, demoted, or had held back their career in other more subtle ways. In the words of one woman:

‘… other people were off with back injuries, stubbed their big toe, whatever, but when I came back for being on, well you know, I’d say it was depression or whatever, no one wanted to talk about it and I felt further alienated.’

However, other respondents viewed stigma in the workplace as a two-way street. One occupational therapist we interviewed talked about her experiences of employers ‘getting burned’ by employees with BD (for example, by engaging inappropriately in litigation against the employer while still symptomatic) and becoming ‘gun shy’ when considering their return to work. Only a minority (n = 3) of the people with BD we interviewed reported that they had not experienced any stigma in the workplace, or described their employers as being particularly supportive in their

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return to work following an episode (‘I am lucky that my institution has not tried to punish me for this … they’re just really wonderful people and I know that is not necessarily the experience of many people with bipolar’). Those people who had not experienced stigma tended to have worked in one institution for a long period of time, and to have developed close relationships with work colleagues and supervisors. One such woman described her return to work following an episode of mania in the following way:

‘I think for the first year I sort of sensed that there might be some change in the people I worked with but not really, I think that it was more of an internal perception if anything else. I think the difference for me was that many of the people that I worked with were actually the majority of people that I worked with for 20 some odd years … Plus a lot of the people that I deal with are fairly educated people.’

This concept of education affecting levels of stigma was raised by other respondents, some of whom (‘I find I generally get an alright response … but I associate very much with academics and very educated people’) but not all of whom (‘I found a kind of peer support group, those people were more understanding than actually the educated people were, which is kind of ironic’) believed that higher education was associated with reduced stigma. Discussion of stigma was also often interwoven with peoples’ descriptions of whether or not they disclosed their diagnosis to others. At one end of the spectrum, we spoke to participants who had chosen not to disclose their diagnosis to anyone at work. At the other end, some people were completely open about their diagnosis, or even described going through a stage of ‘telling too many people’. Reasons for choosing not to disclose to too many people centred on previous experiences of stigma, in the words of a woman with BD type II, ‘I’ve had friends at work and … have told them because I thought they were friends … and it’s like there’s something scary about me, or, you know, I was diseased and it might be catching’. Another woman with BD type I talked about her concerns of being appraised differently if people knew about her diagnosis:

‘If I go into a situation where people don’t know that I have a mental illness I have a better chance of being seen as an equal. I have jobs where people sometimes know that I have a mental illness, sometimes don’t. If I’m having a bad day then I’m just having a bad day.
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If people know that I have a mental illness and I’m having a bad day they may think that I’m getting sick again.’

Other respondents (n = 2) reported that they had lost their jobs following disclosure (‘I was pushed out of the firm … it was a sign of weakness in a corporate environment’). However, choosing not to disclose was associated with problems in optimally managing the disorder for some (e.g., a healthcare professional described how one of her clients was ‘afraid to ask for sick time because he wants to present that he’s well’). Nor was disclosure in the workplace a universally negative experience – several participants (n = 4) talked about positive experiences with employers characterized by understanding, compassion and practical support. Overall, most respondents described using a strategy of judicial disclosure in the workplace, making often complex decisions about when (‘I’m at the end of my career at this point … so I can speak out and I don’t have any concerns about saying I’m bipolar – and here I am, functioning in a very high level, high stress job’), how (‘I’m judicious’) and to whom (‘I’ve done some childcare recently and I won’t disclose to them that I have a mental illness’) to disclose.

Interpersonal problems at work. ‘I don’t have a problem getting in – it’s staying and getting along with others.’

Although respondents described interpersonal problems at work occurring during depressive episodes, they tended to relate to desire to socially isolate or withdraw from other people, or less commonly to increased irritability when depressed. In contrast, interpersonal problems during episodes of hypo/mania were more frequently cited as being related to irritability or interfering, inappropriate or volatile behaviour. For example, a woman described how during episodes of mania she would be: ‘…getting into fights, arguments. Probably telling everybody else what to do … I had one job where I basically told the boss off, I think I ended up in a screaming match with him over something very trivial’. Or, the words of a woman with BD type I who had been a senior healthcare professional: ‘I was irritable, I was provoking people. I ended up talking about one staff member to another, which is just totally inappropriate’. A small number of respondents (n = 3) described a process of ‘damage control’ by removing themselves from their work environments during episodes. One academic with BD type II stated, ‘If I’m feeling one way or the other I generally don’t associate with people that I work with’. However, this respondent had the flexibility of working from home; other participants whose jobs were not so malleable often felt obliged to work when unwell.

One specific interpersonal problem described by several people with BD (n = 5) concerned colleagues’ ‘over-vigilance’ for symptoms. One respondent talked with some resentment about her relationship with a previous supervisor, who had: ‘felt free to make observations about my moods, like, “gee, I think your mood’s really decent today” … it was none of her business as long as I was doing my job’. Other participants described difficulties arising with work colleagues because they needed to keep to a different work schedule due to the side-effects of medications:

‘People used to make fun of it that I would come in so late in the morning. (I was) very well respected for my work, but, it began to be this problem of, (respondent’s name) is great, but why is he coming in at 10 o’clock in the morning? Or 11 o’clock?’

In the words of another respondent who worked in advertising: ‘Occupationally it’s a nightmare … it’s affected me many, many times in my career, being late for work’. Other respondents (n = 4) talked about a related issue of work colleagues and supervisors not understanding the nature of the inconsistency in their work output. Several of the respondents we interviewed described how they would go through periods of higher than average output at work when hypomanic, often followed by periods of reduced output when depressed. Many respondents felt that their overall output, although inconsistent, was equal or superior to that of their peers at work, and bemoaned the fact that this was often not recognized.

Exploration of pairs of case studies²

Sandra (37 years old, BD type I, in full-time employment in the arts, functioning at a high level occupationally) and Marsha (51 years old, BD type I, in full-time employment in a government position, functioning at a high level occupationally) had both been hospitalized once in their lifetime for an episode of (late onset) severe mania with psychotic symptoms, and had also experienced several subsequent episodes of depression. Despite experiencing ongoing symptoms and mood episodes, both Sandra and Marsha had for several years been functioning at a high level vocationally, maintaining continual employment, advancing in their careers and finding meaning and pleasure through

²Fictitious names have been used.
their chosen occupations. Detailed review of their interview transcripts suggested that they were able to maintain their occupational functioning due to the following commonalities:

- Both respondents reported that they had not experienced much stigma in the workplace. Sandra worked as mental health educator, and had in fact turned ‘the black cloud inside out’ by making a living through teaching about BD and becoming a well-recognized figure in the bipolar community. Marsha reported that she had not experienced any significant stigma in the workplace, and put this down to the fact that she had worked with the same organization for 20 years, and had a ‘long-term relationship’ with both her employer and co-workers.
- Both respondents had felt able to fully disclose their diagnosis to their colleagues. Marsha stated that she was able to do this because she was already established in her career when she was diagnosed with BD, and ‘I can speak out and I don’t have concerns about saying I’m bipolar, and here I am functioning in a very high level, high stress job’.
- Both respondents reported having significant independence and autonomy at work.
- Both found meaning and identity through their work.
- Both used a variety of self-management strategies to maintain their emotional health. For example, both respondents fostered routine in their work and personal lives.

The second pair of case studies compares two individuals, Jane (26 years old, BD type I) and Paul (31 years old, BD type I). Jane reports having had one major episode of depression during her lifetime, and five episodes of full-blown mania in her early 20s, when she had two jobs and was finishing graduate school. However, she has been employed as a primary school teacher over the past year and half, and has been functioning well during this period, both emotionally and occupationally. Paul, in comparison, has not been employed since his first episode of mania at the age of 24 years, after which he reported having another two severe episodes of mania. He has had at least six severe episodes of depression over his lifetime, and has been hospitalized on seven occasions. Both respondents had similar academic backgrounds, onset of BD in their early 20s and experienced a relatively severe initial course. However, Jane managed to finish her education and teacher training; although she experienced several mood episodes during this period, she relied heavily upon her family as a source of social support and her strong spiritual faith to keep on-track occupationally. She then used her job as a vehicle to improve her emotional functioning, which is now more stable. Specifically, she reported that occupational routine was crucial in keeping her stable (‘that’s one reason I went into teaching’) and described a system she had put into place whereby she had disclosed her diagnosis to her mentor at work, but chosen not to disclose to all of her colleagues. Paul has not succeeded in stabilizing his mood since his diagnosis 7 years ago, and feels he has little control over his mood state. Although he had graduated at the top of his class in technology school, he hasn’t been able to enter the workforce due to repeated episodes (‘I was so ready to be in the workforce … it’s a huge frustration’). He thinks a major barrier to his return to work is the stigma associated with being diagnosed with a psychiatric condition, and his perceived lack of ability to cope with this (‘I feel like I’m somebody who’s got a mark that people will identify right away’). Paul also voiced concerns regarding his loss of career potential, and his need for meaning occupationally [‘it (my career) is destroyed, and you feel like the only job for me is going to be a parking attendant where I go, ‘Okay here’, and punch your ticket. Yeah, I could do that, but I’d like to do more than be a parking attendant’].

Impact of bipolar disorder upon work functioning

Patient outcome in BD has traditionally been determined by the assessment of clinical characteristics such as rates of relapse, hospitalization, or degree of symptom reduction. Over recent years, however, there has been increasing interest in expanding the assessment of outcome to include the measurement of indices such as functioning, a key facet of which relates to an individual’s ability to work. We report here on a series of exploratory qualitative interviews conducted with patients with BD, their caregivers and healthcare providers concerning the impact of the disorder upon quality of life. The majority of the sample talked about the relationship between BD and work during the interview process, and some common themes emerged from the data, specifically: lack of continuity and consistency at work, loss, illness management strategies in the workplace, engaging in meaningful work, stigma and disclosure in the workplace, and interpersonal problems at work.

Lack of continuity and consistency

Several participants talked about lack of continuity in their working lives (i.e., moving relatively
rapidly between employers and job positions, having a short time frame on jobs, making rash decisions to quit) and lack of consistency within their working lives (i.e., the effects of cycling between hypo/mania, depression and euthymia in the workplace, variation in work output). Overall, participants tended to describe the intermittently disruptive effects of BD upon work rather than chronic, consistent work impairment. At times, symptoms of BD or mood episodes were described as being associated with reduced work output and quality and increased interpersonal problems with work colleagues, but several respondents stated that their employers and work colleagues failed to understand that these were often offset by periods of increased productivity and output. Lack of consistency in mood state was described as being particularly problematic when there was little perceived control over moods, or low self-efficacy. Other qualitative research has reported that a sample of patients with BD did not feel as though they had the ability to predict or control the onset of a mood episode (22). This research is in contrast, however, with quantitative data that suggests that patients with BD who have undergone a brief psychoeducational intervention aimed at detecting prodromal symptoms are able to detect impending relapse, and that this can have a positive effect on outcome (34). There may therefore be a role for the clinician to play in assisting the patient in developing a strategy for recognizing and acting upon prodromes (and distinguishing these from normal responses) in the workplace. Enhanced feelings of self-efficacy may then in turn have a positive impact upon employment outcomes (e.g., 35).

Loss

The notion of occupational loss (loss of time, loss of job prospects, financial loss and loss of identity) was also an emergent theme. Loss of time at work occurred as a result of leave due to mood episodes, hospitalizations, or having to reduce the number of hours or days worked, and was often associated with subsequent activity on the individual’s part to ‘make up’ for lost time. In our clinical experience, a common reason given for non-adherence with medications in patients with BD concerns a sense of loss for the periods of increased productivity associated with highs in mood. Our data indicate that there are times when individuals experience seductive periods of increased work productivity, creativity and lateral thinking when hypomanic, and that these can be associated with occupational gains for both the employer and employee. When encountering patient ambivalence about taking mood stabilizing medications, it may be constructive to ask the individual to perform a simple cost–benefit analysis. For example, question whether the increased productivity experienced is worthwhile if the episode escalates into a full mania, resulting in the loss of even more time from work? Is the patient aware of the potential physiological and psychosocial impacts of experiencing repeated mood episodes? Is the productivity always associated with good quality, appropriate work? Is the person’s creativity or productivity actually hampered by mood stabilizing medications?

In addition to losing time at work, respondents talked about the effects of BD upon entering or continuing in their career of choice. Onset of BD typically occurs in the late teens or early adulthood, a key period for developing academic, occupational and social skills, and several respondents described how the disorder had interrupted their occupational development during this time. Furthermore, participants talked about the difficulties associated with maintaining and developing their occupational skills when experiencing hospitalizations or sick leave due to mood episodes. Several respondents also talked about the potential impact of BD upon their ability to engage in meaningful work. There is some evidence that educational levels in patients with BD are higher than those observed in the general population (e.g., 36), yet affected individuals may be more likely to work in jobs that are not commensurate with their skills or intellectual abilities, and reported levels of work satisfaction in patients with BD are low (15). Tse and Walsh also found that the meaning attached to a job was of importance (21), and noted that individuals with BD may be more likely to be placed in unskilled, entry-level jobs or poorly-paid positions that are below their potential, contributing to this work dissatisfaction (37). Several respondents in the present study talked about their quest for meaningful employment, and how they sometimes redefined their interpretations of what constituted meaningful occupation, a finding consistent with other qualitative research in people with persistent mental illness (38). Patients should be encouraged in their efforts to take a creative approach towards identifying rewarding and satisfying forms of employment, such as volunteer work, self-employment, competitive employment, sheltered work, transitional work or casual work (39). Further, patients who are being reintegrated back into the workforce should be encouraged to remember their long-term occupational goals. Whilst initial work placements may appear demeaning or unrewarding, these are often impermanent phases that may be replaced by
more satisfying and positive employment opportunities as their stamina, strengths and capabilities improve over time. It should be noted that a minority of respondents in the present study talked about the positive ways in which BD had impacted upon their working lives. In some cases, having had first hand experience of the disorder opened up new avenues of employment or vocation, for example, in mental health advocacy or education. On the whole, however, even these individuals described having undergone several years of hardship and adjustment before getting themselves ‘back on track’ occupationally.

Illness management strategies in the workplace

Over half of the sample of respondents with BD talked at some point about the illness management strategies they used in the workplace, including: removing themselves from occupational settings when symptomatic, reducing workload, changing work activities, enlisting emotional or practical support from trusted co-workers, seeking help from their healthcare team, and using or avoiding occupational routine. As we did not utilize direct probes during the interviews, we are unable to systematically quantify the number of respondents that used each type of illness management strategy. Furthermore, only a small number of the current sample of respondents were deemed to be ‘functioning well’ (according to subjective interpretation by the interviewer) with their disorder. In order to better understand the self-management strategies utilized by high-functioning individuals with BD, we have begun a more systematic piece of qualitative research focused specifically upon this issue, utilizing a community-based sample of individuals with BD who will undergo thorough quantitative assessment of functioning prior to interview.

One interesting sub-theme that emerged in relation to self-management strategies concerned the role of routine in occupational settings. For several respondents, occupational structure and routine (for example, having to get up for work at a particular time, following a set work schedule) was an important part of maintaining their mental health. Other participants, however, viewed occupational routine as constritive and unhelpful, valuing instead the ability to retain flexibility in their work schedule (for example, being able to work from home occasionally, being able to set their own hours) to respond to fluctuations in their mood. Further examination of the data showed that illness severity (VAS scores, number of previous episodes, whether in a current episode) was not significantly different between these two groups of respondents, although there is other quantitative evidence to suggest that stabilizing circadian rhythms via psychosocial interventions in patients with BD can be of benefit. For example, Interpersonal and Social Rhythm Therapy (40) focuses upon stabilizing both biological (i.e., sleep–wake cycle) and social (i.e., social demands or tasks) circadian zeitgebers and has been associated with reduced depressive symptomatology and prolonged euthymia in patients with BD (41, 42). Qualitative analysis of the factors related to successful employment in people with BD by Tse and Yeats (21) also provided mixed results for the role of routine. Specifically, respondents in their sample cited the importance of having balance between a set routine and room for personal expression, flexibility in work schedules and the value of a set routine during times of depression.

Stigma and disclosure in the workplace

Another common theme that arose in the present study concerned the experience of stigma and disclosure in the workplace. Only a small number of respondents reported that they had not experienced significant stigma in the workplace, and several individuals clearly believed that stigma had resulted in their being dismissed from positions, passed up for promotion, demoted, or had held back their career in other ways. Factors relating to lack of perceived stigma were having worked in one institution for a long period of time, and having developed close relationships with work colleagues and supervisors.

Interestingly, although some qualitative research has begun to examine the impact of stigma upon people with BD (21, 22), few quantitative studies have yet addressed this relationship. Extant quantitative research has indicated that individuals with BD have a strong sense of stigma, and a putative relationship between stigma and self-esteem has been posited (43). Although some psychosocial treatment interventions for BD encourage patients to learn strategies for coping with stigma (e.g., 44), we are not aware of any research that has specifically assessed the efficacy of such techniques in this population yet. Future research is called for in this area, and would benefit from distinguishing between public stigma (what a naïve public does to a stigmatized group when they endorse a prejudice about that group) and self-stigma (what members of a stigmatized group may do to themselves if they internalize the public stigma) (45, 46). Public stigma in the workplace could manifest as people with BD having difficulty finding and keeping jobs and fulfilling their

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potential in the workplace due to stereotyping, prejudice and discrimination. Self-stigma, on the other hand, may be associated with reduced self-esteem and self-efficacy (47, 48), which in turn have been associated with failure to pursue work opportunities (49, 50) and attain employment goals (51).

Discussion of stigma was often interwoven with peoples’ stories about whether or not they disclosed their diagnosis of BD in the workplace. As Tse (52) notes in his practice guidelines for assisting people with BD to obtain their occupational goals, employers’ attitudes, past record and experience of employing people with mental illness, acceptance of work colleagues and management styles can all influence whether or not the outcome following disclosure is positive or negative. Tse goes on to provide some practical advice for helping patients decide when, what and to whom to disclose, including the suggestion that some people may want to wait for a period of time before deciding to disclose, in effect giving them the opportunity to ‘prove themselves’ first, and to develop social support networks within the workplace. In order to address employees’ fears about disclosure, we suggest that organizations should consider developing formal policies and action plans surrounding the disclosure of mental illness in the workplace. Such policies should include clear guidelines addressing how the individual will be protected from discrimination should they choose to disclose. A ‘top–down’ approach, whereby willing senior management or employees are encouraged to disclose prior to more junior employees, could help challenge some of the prevailing stigma surrounding mental illness in occupational settings. For example, some organizations have used in-house newsletters as a medium for senior employees to describe their experiences with mental illness. The stage of illness the individual is at is also likely to have bearing upon their decision-making process about disclosure. Patients who are newly diagnosed or newly established in a job may wish to disclose to as few colleagues as possible, perhaps using a model whereby they disclose to only one trusted mentor or co-worker. People who are in the later stages of the recovery process or well established in their career may choose instead to address stigma or discrimination ‘in the moment’ as an educational tool, and harness disclosure as a way of potentially increasing feelings of self-efficacy and communication in the workplace. Garnering support from a trusted co-worker may, however, be difficult in new job situations or transitions, or where there is a power differential or other disincentives against disclosure.

Interpersonal problems at work

A final theme that emerged from the data related to interpersonal problems in the workplace. Specifically, respondents talked about interpersonal problems arising because of perceived lack of education about BD (e.g., co-workers not understanding their need for different work schedules or misunderstandings regarding inconsistency in work productivity) and problems associated with work colleagues being over-vigilant for symptoms of BD. A range of strategies are available for increasing awareness of mental illness in the workplace, for example, by thoroughly assessing an organization’s specific educational needs, and then tapping into appropriate services such as awareness training or mental health education initiatives offered by regional mental health organizations and charities. We suggest setting up a ‘mental illness awareness committee’ within larger organizations to target system or policy level changes, the provision of in-house mental health forums or workshops and close liaison and partnership between the individual, their employer, human resources departments, their Employee Assistance Program and their mental health team. For employees concerned about co-workers being over-vigilant for symptoms, a model incorporating judicial disclosure paired with the development of a contract with a trusted work colleague may be effective for some individuals. ‘Treatment contracts’, whereby the patient identifies their pro-dromes, and informs trusted individuals of guidelines for their desired course of care should they have a relapse, are now being used quite widely in clinical practice. We propose developing similar contracts for the workplace, whereby individuals with BD would identify a trusted co-worker with whom they could disclose their diagnosis and set up a contract specifically dealing with symptoms in the workplace according to their individual wishes. Such an approach could help increase feelings of self-efficacy, individual accountability and self-management and hopefully bolster social support, a key influence on vocational outcome in people with BD (9, 21, 53).

Limitations of the current study

There are some limitations to this study. The qualitative interviews described here were conducted as part of the item-generation phase for a disease-specific measure of QoL. As such, they were relatively unstructured, used a broad QoL
frame, and were not focused specifically upon the work domain. Although the majority of our sample (94% of those affected by BD and the entirety of the health professional and caregiver samples) discussed the relationship between work and BD at some point, the depth to which they did so varied, with some interviewees spending the majority of the interview period discussing the subject, others <5 min. Although we used purposeful sampling to identify people who were functioning poorly with their disorder as well as those who were functioning exceptionally well, we did not assess level of functioning quantitatively, and we did not sample on the basis of work functioning specifically. We may not, therefore, have explored the range of experiences in this area exhaustively. Furthermore, had we used a more structured interview schedule, we could have more accurately determined the proportion of participants who had experienced a certain phenomenon, such as stigma in the workplace.

There was also some selection bias in our methodology. Participants who responded to our recruitment campaign would likely be those who were most interested in (and able to) talk about work and BD. This self-selected sample would not be representative of all patients with BD. In particular, the sample we obtained may have been under-representative of patients with poorer self-management strategies in the workplace. Although we attempted to interview people from a wide geographic spread across North America, we were unable to interview people who were not English speakers, so our results may have little generalizability to other cultures. All of the caregivers we interviewed were caring for males, which may have introduced some bias to our results (although the prevalence of BD appears to be equal amongst males and females, other factors, such as presentation and course of the condition, may vary by gender (54). Although the inpatient and outpatient group we interviewed had a confirmed diagnosis of BD, we did not verify diagnoses in other participants via structured interview. Some of this self-reported sample may not have had a diagnosis of BD, or may have had other unmeasured comorbid psychiatric conditions that affected the results we obtained. Our description of the clinical characteristics of our sample would also have been more robust had we systematically assessed depressive and hypomanic symptoms at the time of the interview. In summary, the data presented here is clearly exploratory in nature, and requires further exploration both qualitatively and quantitatively.

**Conclusions**

Although qualitative research does not have the statistical power of quantitative research, it can be particularly useful for helping to elucidate complex relationships or for shedding light on emerging areas of research. In the present study, exploratory qualitative techniques were used to produce some detailed, contextual data about the complex, multi-layered and variable relationship between BD and occupational functioning. Historically, we have relied upon measures of symptomatology to assess how well patients with this disorder are faring. Although it is encouraging to see that increasing awareness is now being paid to the assessment of other forms of outcome such as occupational functioning, it is not sufficient to simply measure whether or not an individual is working. The qualitative data obtained here indicates that a wide range of factors (some of which, like the experience of stigma and the meaning derived from a job, are quite nebulous) can contribute to an individual’s ability to function in the workplace. It is important to attempt to capture these factors by using measures that reflect the experiences and concerns of the individuals with BD themselves. This will require the development of more sophisticated and precise measures of occupational functioning for this population. More broadly, there is also an urgent need for well-designed, longitudinal studies on vocational rehabilitation for patients with BD to help identify effective solutions to some of the issues identified in this and other research. Although a strong body of data now exists concerning the efficacy of ‘supported employment’ as a model for assisting individuals with psychiatric conditions in the workplace (e.g., 55–57), much of this work has been performed in individuals with severe mental illnesses such as schizophrenia. More data is needed about the efficacy of such interventions in bipolar populations, particularly BD type II. Finally, there is clearly also need for more well-designed research, both qualitative and quantitative, into the apparently wide range of coping strategies individuals with BD use to fulfill their work and career goals. People with BD can be highly valued employees, bringing creativity, energy, passion and productivity to the workplace. It is in the best interests, therefore, of both the individual and society to identify the most effective ways of supporting people with the disorder in their quest for appropriate, meaningful and rewarding work.
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