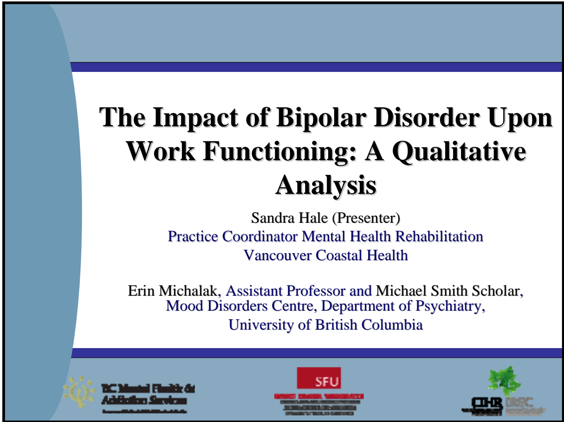
The Impact of Bipolar Disorder Upon Work Functioning: A Qualitative Analysis
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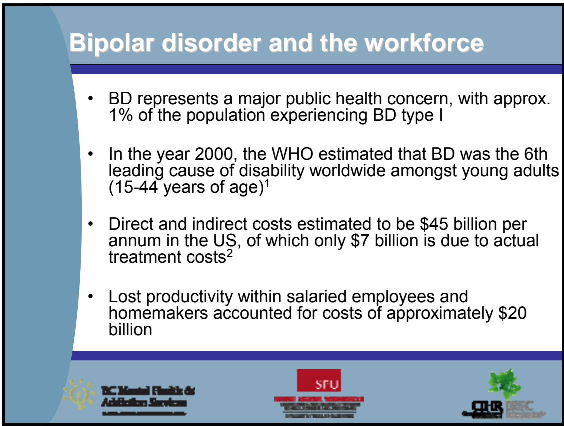
Bipolar disorder and the workforce
• BD represents a major public health concern, with approx. 1% of the population experiencing BD type I
• In the year 2000, the WHO estimated that BD was the 6th leading cause of disability worldwide amongst young adults (15-44 years of age)[1]
• Direct and indirect costs estimated to be $45 billion per annum in the US, of which only $7 billion is due to actual treatment costs[2]
• Lost productivity within salaried employees and homemakers accounted for costs of approximately $20 billion
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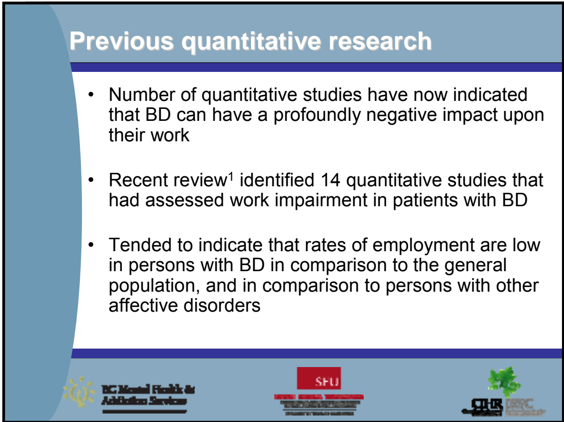
Previous quantitative research
• Number of quantitative studies have now indicated that BD can have a profoundly negative impact upon their work
• Recent review[1] identified 14 quantitative studies that had assessed work impairment in patients with BD
• Tended to indicate that rates of employment are low in persons with BD in comparison to the general population, and in comparison to persons with other affective disorders
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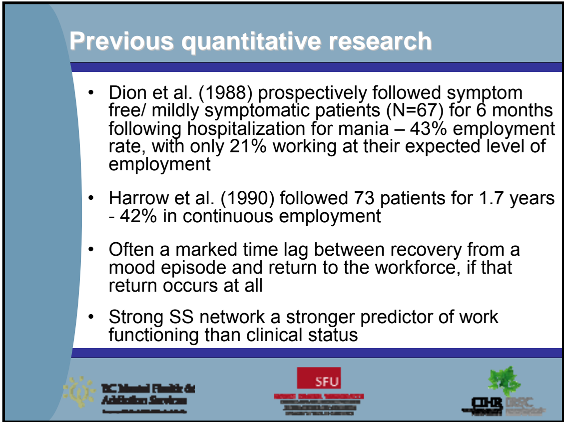
Previous quantitative research
• Dion et al. (1988) prospectively followed symptom free/ mildly symptomatic patients (N=67) for 6 months following hospitalization for mania – 43% employment rate, with only 21% working at their expected level of employment
• Harrow et al. (1990) followed 73 patients for 1.7 years - 42% in continuous employment
• Often a marked time lag between recovery from a mood episode and return to the workforce, if that return occurs at all
• Strong SS network a stronger predictor of work functioning than clinical status
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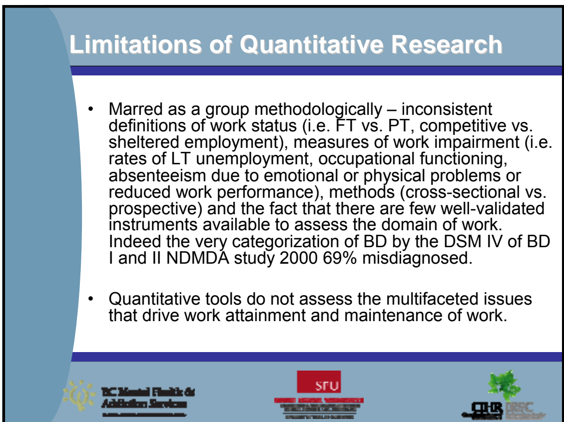
Limitations of Quantitative Research
• Marred as a group methodologically – inconsistent definitions of work status (i.e. FT vs. PT, competitive vs. sheltered employment), measures of work impairment (i.e. rates of LT unemployment, occupational functioning, absenteeism due to emotional or physical problems or reduced work performance), methods (cross-sectional vs. prospective) and the fact that there are few well-validated instruments available to assess the domain of work. Indeed the very categorization of BD by the DSM IV of BD I and II NDMDA study 2000 69% misdiagnosed.
• Quantitative tools do not assess the multifaceted issues that drive work attainment and maintenance of work.
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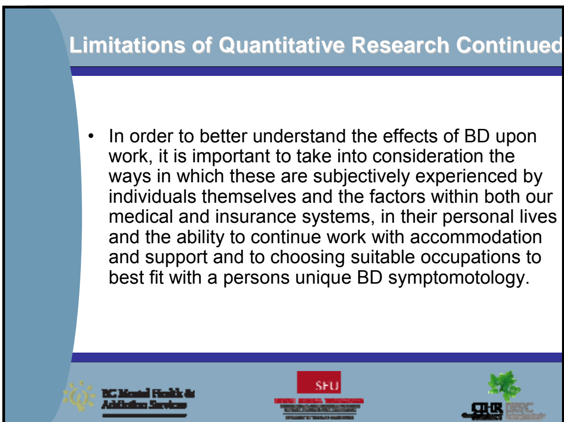
Limitations of Quantitative Research Continued
• In order to better understand the effects of BD upon work, it is important to take into consideration the ways in which these are subjectively experienced by individuals themselves and the factors within both our medical and insurance systems, in their personal lives and the ability to continue work with accommodation and support and to choosing suitable occupations to best fit with a persons unique BD symptomotology.
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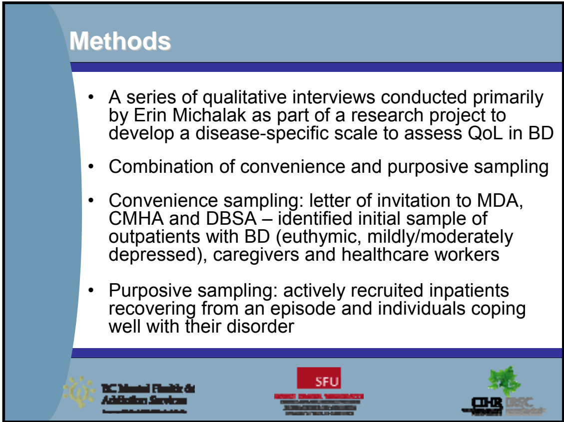
Methods
A series of qualitative interviews conducted primarily by Erin Michalak as part of a research project to develop a disease-specific scale to assess QoL in BD
Combination of convenience and purposive sampling
Convenience sampling: letter of invitation to MDA, CMHA and DBSA – identified initial sample of outpatients with BD (euthymic, mildly/moderately depressed), caregivers and healthcare workers
Purposive sampling: actively recruited inpatients recovering from an episode and individuals coping well with their disorder
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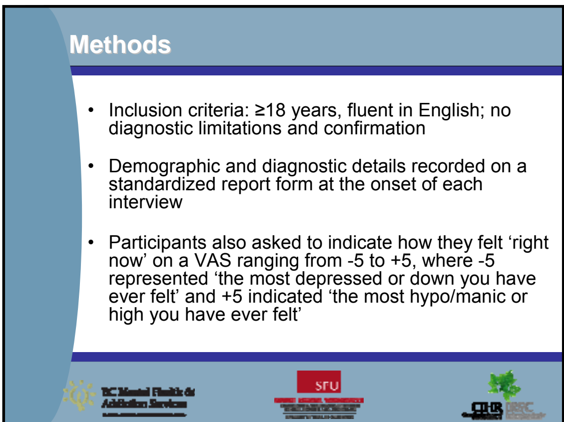
Methods
Inclusion criteria: ≥18 years, fluent in English; no diagnostic limitations and confirmation
Demographic and diagnostic details recorded on a standardized report form at the onset of each interview
Participants also asked to indicate how they felt 'right now' on a VAS ranging from -5 to +5, where -5 represented 'the most depressed or down you have ever felt' and +5 indicated 'the most hypo/manic or high you have ever felt'
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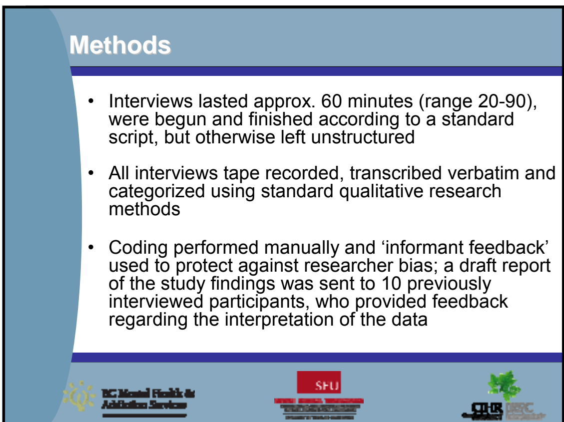
Methods
Interviews lasted approx. 60 minutes (range 20-90), were begun and finished according to a standard script, but otherwise left unstructured
All interviews tape recorded, transcribed verbatim and categorized using standard qualitative research methods
Coding performed manually and 'informant feedback' 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
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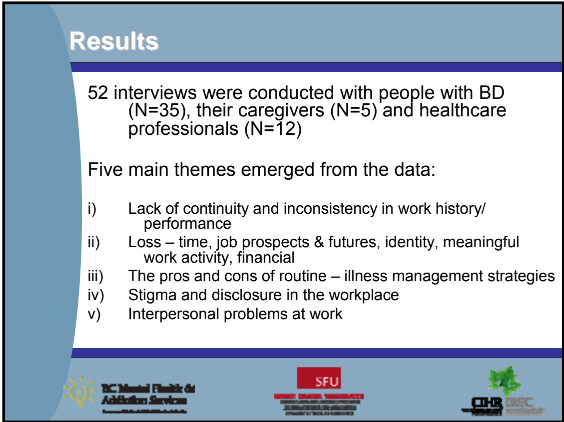
Results
52 interviews were conducted with people with BD (N=35), their caregivers (N=5) and healthcare professionals (N=12)
Five main themes emerged from the data:
i) Lack of continuity and inconsistency in work history/ performance
ii) Loss – time, job prospects & futures, identity, meaningful work activity, financial
iii) The pros and cons of routine – illness management strategies
iv) Stigma and disclosure in the workplace
v) Interpersonal problems at work
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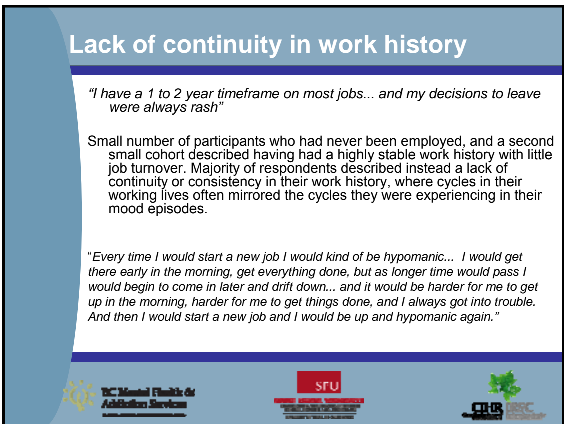
Lack of continuity in work history
"I have a 1 to 2 year timeframe on most jobs... and my decisions to leave were always rash"
Small number of participants who had never been employed, and a second small cohort described having had a highly stable work history with little job turnover. Majority of respondents described instead a lack of continuity or consistency in their work history, where cycles in their working lives often mirrored the cycles they were experiencing in their mood episodes.
"Every time I would start a new job I would kind of be hypomanic... 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 hypomanic again."
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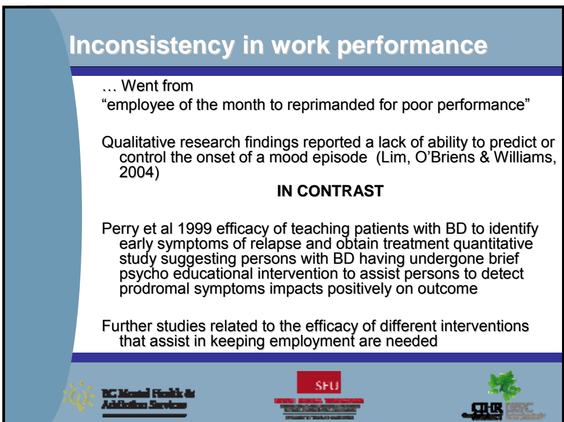
Inconsistency in work performance
… Went from
"employee of the month to reprimanded for poor performance"
Qualitative research findings reported a lack of ability to predict or control the onset of a mood episode (Lim, O'Briens & Williams, 2004)
IN CONTRAST
Perry et al 1999 efficacy of teaching patients with BD to identify early symptoms of relapse and obtain treatment quantitative study suggesting persons with BD having undergone brief psycho educational intervention to assist persons to detect prodromal symptoms impacts positively on outcome
Further studies related to the efficacy of different interventions that assist in keeping employment are needed
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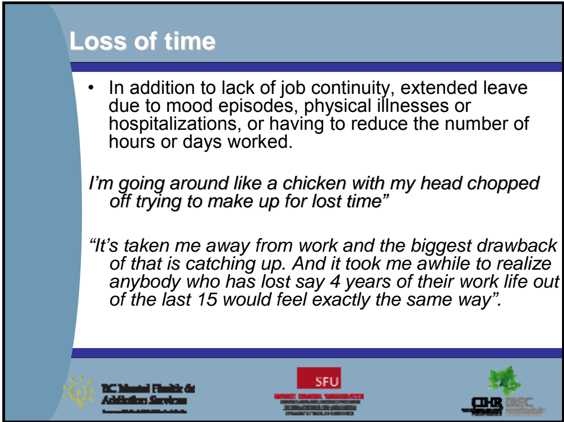

Loss of time
In addition to lack of job continuity, extended leave due to mood episodes, physical illnesses or hospitalizations, or having to reduce the number of hours or days worked.
I'm going around like a chicken with my head chopped off trying to make up for lost time"
"It's taken me away from work and the biggest drawback of that is catching up. And it took me awhile to realize anybody who has lost say 4 years of their work life out of the last 15 would feel exactly the same way".
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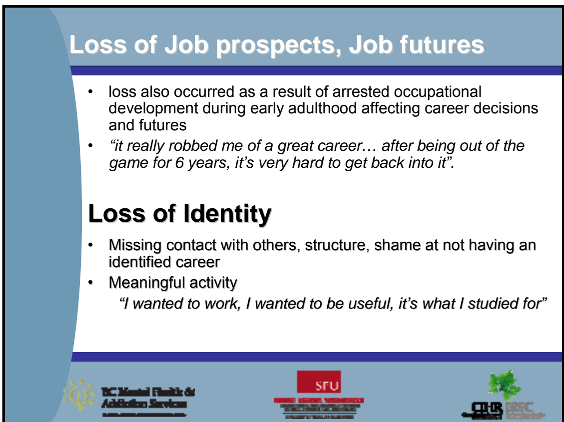

Loss of Job prospects, Job futures
loss also occurred as a result of arrested occupational development during early adulthood affecting career decisions and futures
"it really robbed me of a great career… after being out of the game for 6 years, it's very hard to get back into it".
Loss of Identity
Missing contact with others, structure, shame at not having an identified career
Meaningful activity
"I wanted to work, I wanted to be useful, it's what I studied for"
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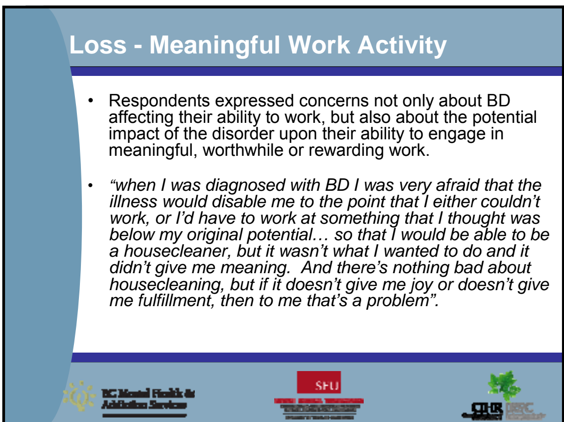

Loss - Meaningful Work Activity
Respondents expressed concerns not only about BD affecting their ability to work, but also about the potential impact of the disorder upon their ability to engage in meaningful, worthwhile or rewarding work.
"when I was diagnosed with BD I was very afraid that the illness 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".
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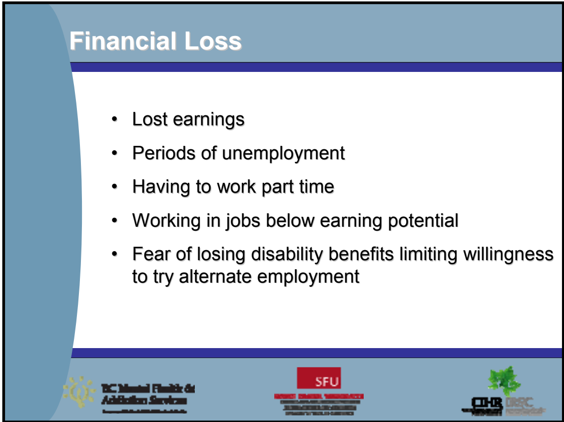
Financial Loss
Lost earnings
Periods of unemployment
Having to work part time
Working in jobs below earning potential
Fear of losing disability benefits limiting willingness to try alternate employment
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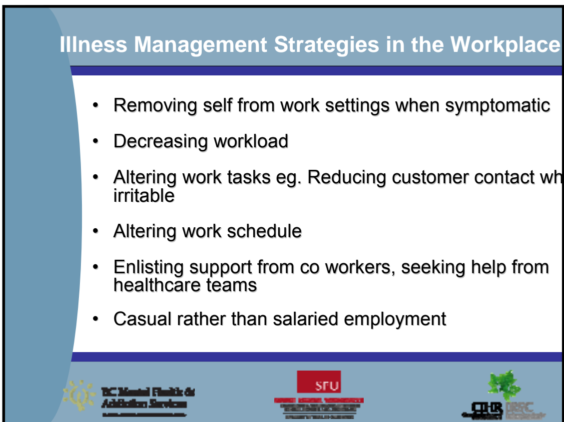
Illness Management Strategies in the Workplace
Removing self from work settings when symptomatic
Decreasing workload
Altering work tasks eg. Reducing customer contact wh irritable
Altering work schedule
Enlisting support from co workers, seeking help from healthcare teams
Casual rather than salaried employment
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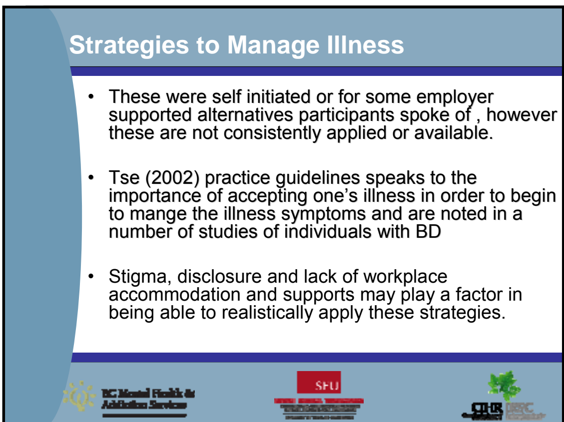
Strategies to Manage Illness
These were self initiated or for some employer supported alternatives participants spoke of , however these are not consistently applied or available.
Tse (2002) practice guidelines speaks to the importance of accepting one's illness in order to begin to mange the illness symptoms and are noted in a number of studies of individuals with BD
Stigma, disclosure and lack of workplace accommodation and supports may play a factor in being able to realistically apply these strategies.
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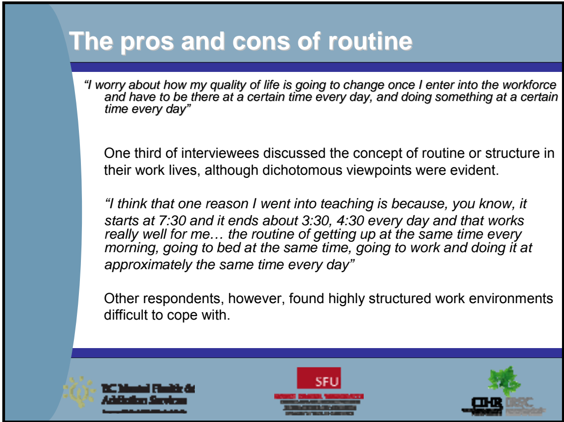
The pros and cons of routine
"I worry about how my quality of life is going to change once I enter into the workforce and have to be there at a certain time every day, and doing something at a certain time every day"
One third of interviewees discussed the concept of routine or structure in their work lives, although dichotomous viewpoints were evident.
"I think that one reason I went into teaching is because, you know, 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"
Other respondents, however, found highly structured work environments difficult to cope with.
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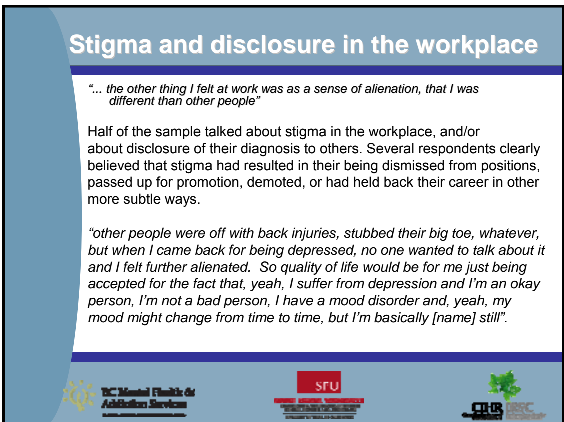
Stigma and disclosure in the workplace
"… the other thing I felt at work was as a sense of alienation, that I was different than other people"
Half of the sample talked about stigma in the workplace, and/or about disclosure of their diagnosis to others. Several respondents clearly believed that stigma had resulted in their being dismissed from positions, passed up for promotion, demoted, or had held back their career in other more subtle ways.
"other people were off with back injuries, stubbed their big toe, whatever, but when I came back for being depressed, no one wanted to talk about it and I felt further alienated. So quality of life would be for me just being accepted for the fact that, yeah, I suffer from depression and I'm an okay person, I'm not a bad person, I have a mood disorder and, yeah, my mood might change from time to time, but I'm basically [name] still".
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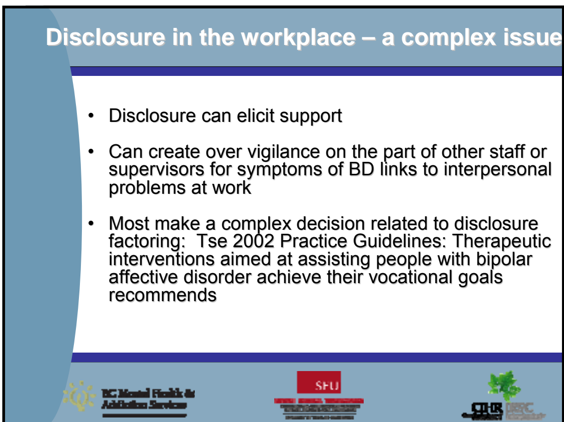
Disclosure in the workplace – a complex issue
• Disclosure can elicit support
• Can create over vigilance on the part of other staff or supervisors for symptoms of BD links to interpersonal problems at work
• Most make a complex decision related to disclosure factoring: Tse 2002 Practice Guidelines: Therapeutic interventions aimed at assisting people with bipolar affective disorder achieve their vocational goals recommends
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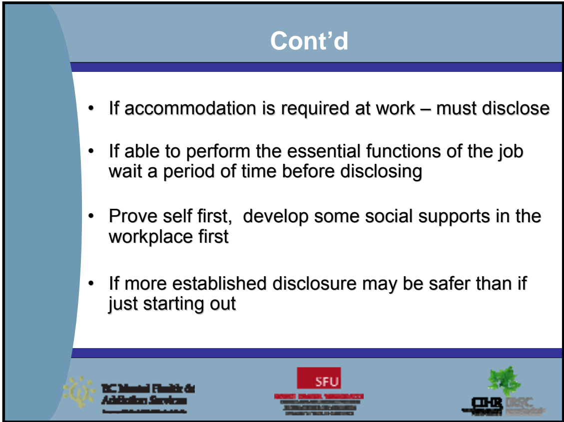
Cont'd
If accommodation is required at work – must disclose
If able to perform the essential functions of the job wait a period of time before disclosing
Prove self first, develop some social supports in the workplace first
If more established disclosure may be safer than if just starting out
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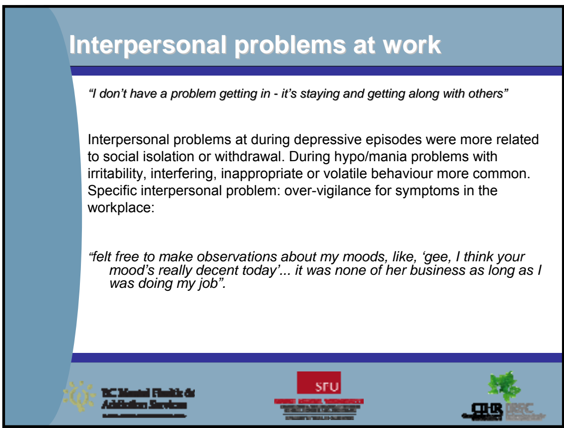
Interpersonal problems at work
"I don't have a problem getting in - it's staying and getting along with others"
Interpersonal problems at during depressive episodes were more related to social isolation or withdrawal. During hypo/mania problems with irritability, interfering, inappropriate or volatile behaviour more common. Specific interpersonal problem: over-vigilance for symptoms in the workplace:
"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".
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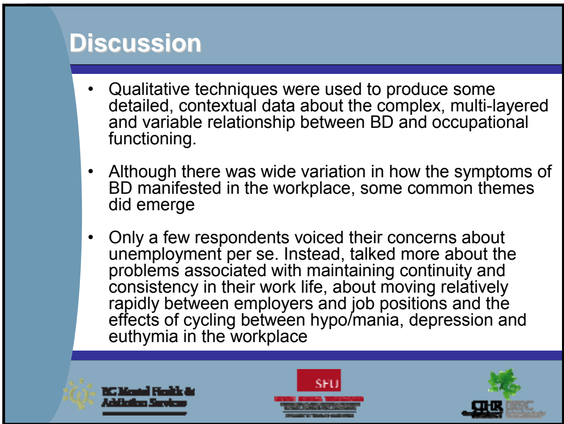
Discussion
Qualitative techniques were used to produce some detailed, contextual data about the complex, multi-layered and variable relationship between BD and occupational functioning.
Although there was wide variation in how the symptoms of BD manifested in the workplace, some common themes did emerge
Only a few respondents voiced their concerns about unemployment per se. Instead, talked more about the problems associated with maintaining continuity and consistency in their work life, about moving relatively rapidly between employers and job positions and the effects of cycling between hypo/mania, depression and euthymia in the workplace
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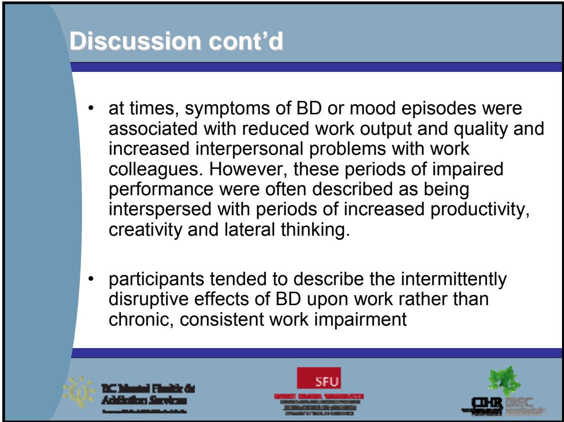
Discussion cont'd
• at times, symptoms of BD or mood episodes were associated with reduced work output and quality and increased interpersonal problems with work colleagues. However, these periods of impaired performance were often described as being interspersed with periods of increased productivity, creativity and lateral thinking.
• participants tended to describe the intermittently disruptive effects of BD upon work rather than chronic, consistent work impairment
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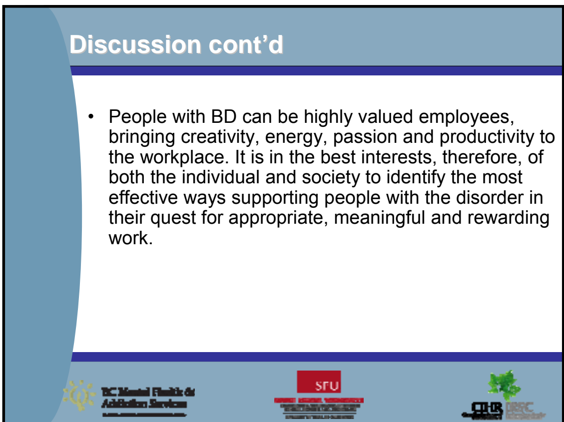
Discussion cont'd
• People with BD can be highly valued employees, bringing creativity, energy, passion and productivity to the workplace. It is in the best interests, therefore, of both the individual and society to identify the most effective ways supporting people with the disorder in their quest for appropriate, meaningful and rewarding work.
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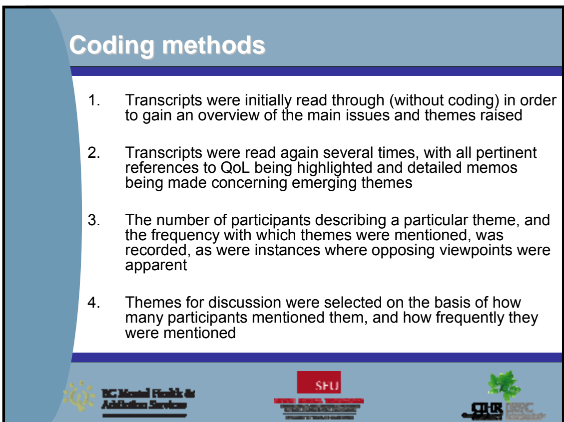
Coding methods
1. Transcripts were initially read through (without coding) in order to gain an overview of the main issues and themes raised
2. Transcripts were read again several times, with all pertinent references to QoL being highlighted and detailed memos being made concerning emerging themes
3. The number of participants describing a particular theme, and the frequency with which themes were mentioned, was recorded, as were instances where opposing viewpoints were apparent
4. Themes for discussion were selected on the basis of how many participants mentioned them, and how frequently they were mentioned
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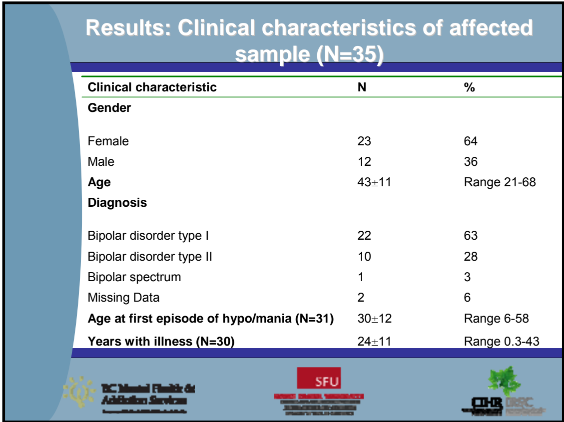

Results: Clinical characteristics of affected sample (N=35)

Clinical characteristic	N	%
Gender		
Female	23	64
Male	12	36
Age	43±11	Range 21-68
Diagnosis		
Bipolar disorder type I	22	63
Bipolar disorder type II	10	28
Bipolar spectrum	1	3
Missing Data	2	6
Age at first episode of hypo/mania (N=31)	30±12	Range 6-58
Years with illness (N=30)	24±11	Range 0.3-43