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Treating Bipolar Disorder: Investigation into the Integration of Quality of Life (QOL) in the Treatment Plan

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TREATING BIPOLAR DISORDER: INVESTIGATION INTO THE INTEGRATION
OF QUALITY OF LIFE(QoL) IN THE TREATMENT PLAN

A proposal submitted to the Faculty of Antioch University of
Santa Barbara in partial fulfillment of the requirements for
the Degree of Doctorate of Psychology in Clinical Psychology

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ABSTRACT

This qualitative bounded case study focuses on how the therapist integrates the quality of life into his or her treatment plan when treating a bipolar patient. Quality of life may be defined as an individual's perception of his or her position in life in relation to psychological and physical health, social relationships, goals, expectations, and environment (WHO, 1995). This study specifically explored how therapists treat their bipolar patients and how they integrate QoL into therapy. Two men and seven women were interviewed in Santa Barbara, California. The criterion for participants included licensed psychologists who have treated at least one bipolar patient in the past. Participants were recruited from local agencies as well as through connections through fellow mental health professionals, university professors and colleagues. Using a case study analysis, an integration of quality of life was interpreted to observe common themes. The electronic version of the Dissertation is accessible in the open-access Ohiolink ETD Center. <http://etd.ohiolink.edu/>

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Chapter I

Introduction

Bipolar disorder (BD) is a debilitating, lifelong affective disorder affecting the population worldwide. As the sixth most common cause of disability in the United States, it is a nationwide crisis (Leahy, 2007). A disorder with consequences involving mental and physical health, intimate and social relationships, and the productivity of the bipolar individual's life, it undoubtedly manifests in a toll on the diagnosed individual's quality of life. For the sake of this research, BD will only refer to bipolar I disorder.

It has been noted that while an individual may recover clinically after an episode, he or she may not have recovered functionally (Miklowitz, 2008), creating an upward and sometimes unattainable battle to return to pre-episode routines and lifestyle. While the symptom reduction of a bipolar patient hospitalized for severity of symptoms may permit discharge, the patient may now be faced with returning to a life outside the hospital that has been damaged by the manic or hypomanic event. For example, the patient may have caused damage to important relationships, have created new or exacerbated existing financial or legal troubles, or even have consequential health ramifications such as the acquisition of a sexual transmitted infection or disease.

It has been shown that elevated depressive symptoms have led to actions by patients that have exacerbated the course of the disorder (Rowe & Morris, 2012). Depressive symptoms have, in fact, been a predictor for rehospitalization (Carlson et al., 2012; Lin, Kuo, Liu, Huang, & Chen, 2009). While the patient may appear to have recovered clinically from the episode, the residual effects of the disorder may have future ramifications toward functional recovery, and the success rate after leaving the hospital and attaining a pre-episode routine and lifestyle are impacted, possibly inducing or exacerbating depression.

In a 2009 study analyzing the factors affecting time to re-hospitalization for Chinese patients with bipolar I disorder, 57.8% were readmitted due to depressive episodes, compared to 20% who had been readmitted due to bipolar mania during one year follow up discharge (Lin et al., 2009). It was hypothesized by the authors that depressive episodes are more likely to re-occur than manic episodes.

Additionally, there is variability in the manifestation of the disorder itself, the patient's range of functionality, as well as the patient's picture of recovery. Some patients function well in the context of severe symptoms, while others report significant quality of life decrements in the context of relatively few symptoms (Murry & Michalak, 2012).

Quality of life (QoL) is an individual's perception of his or her position in life in relation to psychological and physical health, social relationships, goals, expectations, and environment (WHO, 1995). Studies show that QoL is significantly reduced for those diagnosed with BD compared to those diagnosed with other psychiatric disorders, as evidenced by recurrence of episodes, mortality, comorbidity, distress in interpersonal relationships, impaired cognitive functioning, and difficulty in many other critical aspects of life (Leahy, 2007; McNamara, Nandagopal, Strakowski, DelBellow, 2010; Perlis, 2009; Michalak, Murray, Young, & Lam, 2008; Baldassano, 2006; Suominen et al., 2007; Rizvi & Zaretsky, 2007).

A full and complete clinical picture of recovery should include a return to an acceptable and realistic quality of life for the individual patient. While traditional recovery outcomes in BD have solely been determined by objective measures based on the pathology of the patient, such as recurrence of episodes, response to medication, or degree of symptom remission on clinician-rated assessment scales (Michalak, Murray, & CREST.BD, 2010), there has been increasing emphasis on the importance of additional, patient centered forms of assessment to measure treatment outcome and recovery, such as QoL of the bipolar individual.

Affecting 5.7 million adult Americans in a given year, Bipolar Disorder (BD) continues to be a nationwide concern (National Institute of Mental Health [NIMH], n.d.). A lifelong disorder impacting the patient's mental, physical, social and emotional state, BD remains a significant and critical concern.

Recent studies showed that there is a concern regarding the predictors of recovery from a manic or hypomanic episode, or success after treatment. Specifically, it has been found that patients who were considered "recovered" were readmitted for hospitalization (Carlson et al., 2012; Lin, Kuo, Liu, Huang, & Chen, 2009, Lin et al., 2009; Lin, C., Chen, M., Chou, L., Lin, C., Chen, C., & Lane, H., 2010). "Reports also indicate that 1-year rehospitalization rates of bipolar I disorder range from 41% to 60%" (Lin, C., Chen, M., Chou, L., Lin, C., Chen, C., & Lane, H., 2010). The recovery that was presumed after the patient was declared ready for discharge, was not constant. It can therefore be deduced that while there is a reduction in the severity of symptoms, there is also a difficulty for the majority of patients to return to their pre-episode routine and lifestyle.

In addition, existing works have shown that the quality of life has not been utilized or effectively integrated by treating clinicians (Baldassano, 2006; Leahy, 2007; McNamara

et al., 2010; Michalak et al., 2008; Perlis, 2009; Rizvi & Zaretsky, 2007; Suominen et al., 2007;). This qualitative case study will attempt to answer questions regarding the therapist's integration and utilization of QoL into the treatment plan for bipolar patients. By examining the therapist's view of his or her individual implementation and utilization of QoL into the treatment of bipolar patients, this current work will contribute to the further exploration of viable treatment of BD.

With the rate of bipolar patients completed suicide at 60 times higher than the general population (Leahy, 2007), the highest association with comorbid substance use disorders (McNamara et al., 2010), and rates of episode relapse resulting in 47% of the patient's life being spent in a symptomatic state (Miklowitz, 2008), it is of great concern both to the clinical world as well as our public health, to contribute to the growing research on those suffering with BD. Quality of Life is a component that can help in the development of a clear clinical picture of the current status of the bipolar patient, help guide the individualized treatment plan, and serve as an indicator of whether or not the treatment is working after implementation. Perhaps it can even enhance the doctor-patient relationship. While a patient may fit criteria for recovery from a manic or depressive

episode, they still may not be functioning at a level that will allow them to cope with the collateral damage caused by the episode or navigate through the necessary steps to prevent episode recurrence (refilling prescriptions, setting up doctor appointments, etc.), which may lead to, exacerbate, or hasten a depressive episode. With research showing depressive symptoms and episodes as the most debilitating aspect of BD, there must be a marriage between the traditional methods of clinical symptom reduction and the nontraditional incorporation of QoL in order to prevent rehospitalization, lessen the recurrence of episodes, and enhance the mental health of the patient.

It is the aim of this study to explore the factors guiding psychologists who treat bipolar patients in their decision of how to integrate QoL into their treatment plans in order to prevent the rehospitalization of their patients. To date, clinicians generally look to traditional methods to assess recovery in a patient, however research is showing that bipolar patients are not doing well regardless of improvement on traditional outcome measures such as rates of relapse, hospitalization, or symptom reduction (Carlson et al., 2012; Lin, Kuo, Liu, Huang, & Chen, 2009, Lin et al., 2009; Lin et al., 2010; Michalak, Murray, & CREST.BD, 2010; Miklowitz, 2008). A working model of "health" or "functionality" exists

for the psychologist to measure progress by determining whether symptoms are under control. However, the question remains of whether the psychologist's methods are actually improving the quality of his or her patient's life.

There has been increased attention to the QoL in depressive disorders, however it has been comparatively slow in BD, in part due to the reservations about the ability of bipolar patients to reliably complete self-report measures when manic (Michalak, Yatham, & Lam, 2005). Gathering data on the factors behind the clinical decisions of psychologists on the integration of QoL into the treatment of bipolar patients may shed light on the success rate of both the therapy as well as the therapeutic relationship. As the QoL in those struggling with BD has been shown to be greatly impaired, investigating ways to integrate it into the clinical picture of recovery will be an important step in the efficacy of bipolar treatment. It will also add to the growing literature on the QoL of those struggling with BD.

Chapter II

Literature Review

The primary purpose of this research is to investigate clinical psychologists' integration of the quality of life (QoL) construct into their treatment of bipolar I patients. In an effort to capture and relate both the essence of bipolar disorder and the concept of QoL, an extensive review of the literature has been completed in both areas.

An intricate and powerful diagnosis, BD has many identifying features and themes. One powerful theme that arose during the review of the literature is the age of onset of the disorder. This not only articulates the course of the disorder, but also underscores the debilitating effects it may have on the afflicted person's development. Continuing with the theme of illustrating the disorder, as well as the impact it has on those diagnosed, this literature review presents information regarding the potential comorbid illnesses, as well as contributing factors to diagnosis.

Currently, the use of medication is the cardinal form of treatment for those experiencing manic/hypomanic and mixed episodes, regardless of the rate of success and the patient's concerns and apprehensions (Miklowitz, 2008; Sajatovic, Jenkins, Cassidy, & Muzina, 2009). The QoL construct

highlights the importance of the whole picture of the patient's wellbeing.

Bipolar Disorder

Bipolar Disorder (BD) is a complex, chronic psychiatric condition characterized by the profound effect it has on the individual's moods, experiences of emotion, and affect. True to its moniker, the mood swings in BD are often described as swinging between two poles, with recurring episodes of depression and mania, a period of abnormally elevated, expansive, or irritable mood, and increased energy/activity or hypomania, a subsyndromal counterpart to mania. While BD is usually defined by manic or hypomanic episodes, recent studies show that not only do depressive symptoms predominate over manic symptoms in the majority of patients, but bipolar depression also accounts for much of the comorbidity and mortality associated with the disorder and its significant impact on the quality of central areas in the bipolar individual's life (Michalak et al., 2008).

Between 3 to 5% of the American population is diagnosed with BD at any given time (Leahy, 2007; Rizvi & Zaretsky, 2007), affecting one in every 50 people, or as many as one-in-25 people according to some estimates (Miklowitz, 2011). BD is the sixth most common cause of disability in the United States; globally, it is the fifth leading cause of disability

among 15-44 year olds, as well as the ninth leading cause of years lost to death or disability (Leahy, 2007; Steinkuller & Rheineck, 2009). Those who suffer with this debilitating disorder are at a high lifetime risk for problems in varied critical domains of life, from impairment in family and social relationships, to a substantial impact on physical health and economic security (Steinkuller & Rheineck, 2009). It is estimated that between 25% and 60% of individuals with BD will attempt suicide at least once in their lives and between 4% and 19% will be successful (Novick, Swartz, & Frank, 2010). Compared to the general population, bipolar individuals' lifetime rates for completed suicide are 60 times higher, with a higher rate of success for each attempt (Leahy, 2007). Treating clinicians will find themselves faced with a challenging amalgam requiring skill and competency in many areas including, but not limited to, the identification of the stages inherent in the expression of bipolar disorders (mania, hypomania, mixed states, and depression), pharmacological treatments, dual diagnosis, personality and anxiety disorders, suicidality, and environmental stressors.

A survey by the National Depressive and Manic-Depressive Association found that 60% of patients with BD had previously received a misdiagnosis of unipolar depression, and 26% had been previously misdiagnosed with anxiety disorder

(Hirschfeld, Lewis, &Vormik, 2003). Other common misdiagnoses in the survey included schizophrenia (18%), borderline or antisocial personality disorder (17%), alcohol abuse or dependence (14%), and schizoaffective disorder (11%). Receiving an incorrect diagnosis can lead to an insufficient, ineffective or harmful treatment plan that will not only prolong the suffering of the bipolar individual, but may also deter them from seeking help in the future (Hirschfeld et al., 2003).

Age at Onset

Perlis, Dennehy, Nierenberg, Sachs, et al. (2009) examined prospective outcomes during up to two years of naturalistic treatment among 3,658 adult bipolar I and bipolar II outpatients participating in the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD). Consistent with previous reports in smaller cohorts, adults with retrospectively reported early-onset bipolar disorder appear to be at greater risk for recurrence, chronicity of mood symptoms, and functional impairment during prospective observation (Perlis, 2009). Many bipolar individuals do not seek treatment until adulthood, resulting in the majority of age at onset studies relying heavily upon retroactive patient self-report. Given this observation, the integration of the QoL in the treatment of bipolar disorders will positively

effect the treatment itself when the integration happens at age at onset. While little is known about the course of childhood and adolescent onset BD, these individuals have shown an increased risk for greater life impairment including higher rates of psychotic symptoms, greater comorbidity, and suicidality (McNamara et al., 2010; Perlis, 2009; Baldassano, 2006; Suominen et al., 2007).

Suominen et al. (2007) interviewed 191 bipolar I and bipolar II patients to gather information regarding age at onset of mood symptoms, clinical course, treatment, comorbidity, and functional status. Consistent with previous studies, an early age at onset was related to more psychotic symptoms, rapid cycling, comorbidity, and suicidal ideation. Subjects with earlier onset had more lifetime depressive, manic, and mixed phases. Additionally, age at first hospitalization was lower for early onset subjects compared to adult onset subjects.

Between 15 and 18% of patients suffering from BD have their initial onset before the age of 13 years old, while 50 and 66% experience initial onset before the age of 19 years (Morris, Miklowitz, & Waxmonsky, 2007). These statistics show that age at onset occurs at a particularly critical developmental stage of physical self-sustenance and psychological autonomy, potentially setting the stage for

longstanding damage along the maturational path. A child experiencing symptoms of BD may develop a sense of self characterized by who they are during an episode and between episodes, which may be few and far between due to lack of psychological intervention. The potential consequences this may have on the children's ability to flourish later in life can be great, affecting their perception of what they are capable and deserving of in all areas of their life. Future relationships may be marred by low self-esteem, goals never met, and a QoL below what individuals feel they want but have perhaps resigned to never attaining. Further research is needed to investigate and substantiate this impact.

Comorbidity

The Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD) was funded as part of a National Institute of Mental Health initiative to develop effectiveness information about treatments, illness course, and assessment strategies (Bowden et al., 2011). Enrolling 4,361 participants from 1999 to 2005, the STEP-BD studies were intended to be generalizable to both the research knowledge base for BD and to clinical care of bipolar patients (Bowden et al., 2011). The largest federally funded treatment study to date, along with the provision of extensive knowledge about the treatment of BD, the STEP-BD served as the foundation for many other

studies to expand the pool of knowledge of BD in other areas of research.

Part of the heterogeneous composite of bipolar individuals is the high prevalence of comorbid conditions. Comorbid conditions have been affiliated with complications and poorer outcomes, such as an earlier age of onset, shorter periods of euthymia, and an increase in suicidality and violence (Baldassano, 2006; Rizvi & Zaretsky, 2007). According to data from the STEP-BD, conditions that commonly co-occur with BD are anxiety disorders, attention-deficit/hyperactivity disorder, and substance and alcohol abuse disorder (Nierenberg et al., 2005).

Data from the first 500 participants in the STEP-BD study demonstrated the elevated rate of anxiety disorders in bipolar individuals, revealing that approximately half had experienced some type of anxiety disorder (Simon et al., 2004). When comparing bipolar individuals who had an anxiety disorder with those who did not, STEP-BD data illustrated the comorbid diagnosis increased the risk of suicide attempts. Among patients with any current anxiety disorders, 60.3% of patients had a history of suicide attempts, versus 27.4% of patients without current anxiety disorders (Simon et al., 2004). Additionally, the STEP-BD data showed the average age of onset for bipolar patients without any lifetime anxiety disorder was

19.4 years, opposed to an age of onset of 15.6 for those patients with any lifetime anxiety disorder (Simon et al., 2004; Baldassano, 2006).

Bipolar disorder has been reported as having the highest association with substance use disorder of any DSM-IV Axis I psychiatric disorder (McNamara et al., 2010). Compared with seven other mental disorders, data from the STEP-BD revealed that bipolar I and bipolar II disorders came only second to antisocial personality disorder in rate of alcohol abuse and dependence (Baldassano, 2006). While 16.5% of patients with major depression had received diagnoses of alcohol abuse or dependence, the rate of alcohol abuse and dependence was 46.2% in patients with bipolar I disorder and 39.2% for bipolar II (Baldassano, 2006).

Contributing Factors

While the cause of BD is currently unknown, genetic factors that may influence the development of the disorder are continually being identified and studies that integrate genetics and neuroimaging methods are increasingly being performed (Espie et al., 2012; McNarmara et al., 2010). Familial high-risk research has demonstrated high rates of affective disorders, particularly BD, in the adolescent offspring of bipolar parents (Espie et al., 2012), with the possession of first-degree bipolar relatives substantially

increasing the risk for developing BD. Approximately 55% of the offspring of bipolar parents have a mental health disorder, 30% of which is a mood disorder (McNarmara et al., 2010). Additionally, offspring of bipolar parents have an increased risk of developing early-onset BD. As BD does not only impact the individual, but also the environment in which they live, the poor functioning of a mentally ill parent may impact the illness course of offspring. The offspring must deal with all aspects of the affected parent's disorder, including any impact on the family's social life and economic wellbeing. This means that the environment where patients with bipolar disorder live also affects the disorder itself. This environment, as mentioned above, is not limited to the physical environment. It can actually be the psychological construct by which patients are bound to live. This exemplifies the importance of the integration of QoL into the treatment plan for patients with bipolar disorder as the disorder potentially infiltrates all areas of life.

There is considerable evidence that stressful life events, support systems, as well as the ability to regulate affect with coping skills contribute to the expression of the disorder (Leahy, 2007). A stressful life event may serve as both the catalyst for a depressive or manic episode, as well as the consequence of one (Leahy, 2007). It has been

hypothesized that stressful life events and psychosocial stressors in and of themselves, such as severe trauma or abuse during childhood, have been associated with an increased risk for developing BD independent of familial risk (Steinkuller & Rheineck, 2009). Family attitudes and behaviors have been shown to shape the course of serious mental illness, with bipolar individuals who have strong support systems, such as a healthy and sober spouse who is willing to go to couple's therapy, or relatives that help with errands after hospitalization, faring better (Steinkuller & Rheineck, 2009; Rowe & Morris, 2012). Evidence shows that patients whose parents or spouses express high levels of criticism, hostility, or emotional over-involvement during or immediately after an acute episode are more likely to relapse or have continued severe symptoms in the year following the episode (Steinkuller & Rheineck, 2009). Research shows that partners of individuals with BD are at risk for higher rates of depression compared to partners of people without BD, and when close others have elevated depressive symptoms, they are more likely to behave in maladaptive ways that exacerbate the course of BD (Rowe & Morris, 2012).

Over time, as bipolar research utilizes the integration of genetics and neuroimaging methods, genetic factors that may influence the development of the disorder are being

identified. Despite many challenges facing the field of neuroimaging researching BD (such as clinical heterogeneity, medication regimes), there is remarkable convergence among findings supporting the view of BD as a neurodevelopmental disorder. An amygdala-anterioparalimbic neural system appears to serve a chief function in BD. Findings in the amygdala and in the ventral prefrontal cortex, as well as in their connections, have been particularly consistent results, with abnormalities reported across mood states of the disorder and in studies employing many different experimental paradigms suggesting that dysfunction in these regions is a trait feature of the disorder (Blond, Fredericks, & Blumberg, 2012). Abnormalities in subcortical components of the amygdala-anterior paralimbic neural system and possibly the olfactocentricparalimbic cortices, as well as connections between these regions, appear to be early features of the disorder, lending support to a neurodevelopmental perspective of BD (Blond et al., 2012). However, further longitudinal studies are needed to gain support for a developmental view of the disorder.

Quality of Life

The World Health Organization has defined Quality of Life (QoL) as individuals' perception of their position in life in context of the culture and value systems in which they live

and in relation to their goals, expectations, standards, and concerns (WHO, 1995). Due to their illness, the quality of life for individuals with BD is characterized by lower wages, higher unemployment, work absenteeism and disability, marked interpersonal relationship instability and higher divorce rates, lower levels of educational attainment, and higher rates of arrest, hospitalization, and premature death compared to the general population (Steinkuller & Rheineck, 2009).

QoL is affected in an intricate and labyrinthine way by both internal and external factors. There is no gold standard as to what constitutes QoL, as it can be highly subjective, therefore qualifying it as a challenging outcome measure to reliably and accurately quantify. However, there is a growing body of evidence that QoL is a unique and compelling indicator of patient wellbeing, sensitive to various and relevant domains of the patient's life (Michalak et al., 2006; Michalak et al, 2007; Rowe & Morris, 2012; Whisman, 2007). Unlike disease-specific measures, QoL measures can take into consideration such factors as the patient who has had significant symptom reduction, but is still not ready to return to work, or the impact the medication's side effects are having on the patient's day-to-day functioning. Per the World Health Organization's definition, individual's goals, expectations, standards, and concerns play a large part in

defining QoL, and these are each idiosyncratic, individualized areas. Highlighting the patient's perception of QoL can allow for a more patient-centered approach, where the patient is no longer at the periphery of assessing the effectiveness of treatment interventions. Interventions can be increasingly successful, and the doctor-patient relationship can be a more collaborative process.

With QoL deriving from a biopsychosocial model and traditional symptom measures deriving from a medical model, it seems the two paradigms would complement each other in the treatment of bipolar patients; however, they have often been in conflict. In some settings, QoL is derided as a sort of secondary measure of the 'real' targets of psychiatric intervention. Conversely, symptom measures have been criticized as ignoring the fact that psychiatric symptoms have little meaning outside the context of the person experiencing them (Murry & Michalak, 2012).

Despite advancements in the pharmacological treatment of BD, most bipolar patients cannot be maintained on drug treatments alone, and the impact of the bipolar patient's symptomatic state on QoL is great. Up to 50% of bipolar I patients do not recover from acute manic episodes within 1 year, and only 25% achieve full recovery of function. Patients spend as much as 47% of their lives in symptomatic states,

specifically depressive states (Miklowitz, 2008). The majority of studies show that, even when euthymic, bipolar individuals have significantly impaired QoL across a variety of domains. It has been suggested that mental disorders are affiliated with considerably more deterioration in health related quality of life (HRQOL) than medical disorders and that there is a patent prototype of impairment linked to numerous mental health disorders. This further underscores the importance of a patient's perception of their QoL in their case conceptualization and treatment plans. Bipolar patients are suffering greatly, and recovery is minimal for many. Clinicians' sole focus on traditional measures of recovery neglects a large piece of what could make the difference between another hospital visit and lasting progress. The clinical recovery that allows discharge from the hospital or that demonstrates the medication is having an impact is significant, however there are other contributing factors.

Depressive episodes of BD have been getting increased attention in the literature, as existing data suggests that for bipolar individuals, QoL is negatively correlated with depression. As previously mentioned, a considerable proportion of the comorbidity and mortality in BD appears to be the result of the depressive phase as opposed to the hypomanic or manic phases (Michalak et al., 2008). For example, an

individual experiencing an acute depressive or mixed episode is at a significantly higher risk of suicide compared with an individual experiencing a purely manic episode (Michalak et al., 2008). Pharmacological treatment for a depressive phase of BD appears to be particularly challenging, and has been considered a highly controversial area of practice and research for clinicians, frequently met with hesitation for fear of increasing the risk of antidepressant-induced cycle acceleration (Bowden et al., 2012; Sajatovic et al., 2009). Additionally, while medication to treat BD can be of great benefit in terms of minimizing or alleviating certain symptoms, it can also be associated with lethargy, sedation, physical morbidity, and increased mortality, decreasing QoL as well as the likelihood for medication compliance (IsHak et al., 2012). This further emphasizes the importance of comprehensive treatment interventions that consider the QoL of the patient when balancing risk-benefit ratios.

In an in-depth qualitative study conducted by Michalak et al. (2006) to describe patients' experiences of how BD has impacted their QoL, 52 interviews were performed with bipolar individuals, their caregivers, and healthcare professionals. Many participants described their experiences to regain their independence within their family due to family members' over-vigilance for recurrence of symptoms. Numerous participants

also mentioned their difficulty in establishing independence from the healthcare system in terms of a lack of ability to be proactive or respected as a participant in their own healthcare decisions. Almost all of the participants described experiences of stigma or marginalization in relation to their disorder, particularly in occupational settings, as well as damage in their relationships created while in a depressive or manic episode. At the end of the interview, participants were asked to produce a list in ranking order of the three things they considered the most important in determining their QoL. An overwhelming 60% ranked social support as number one, mental health in second place, followed by financial status, vocation, and independence (Michalak et al., 2006).

Those with BD may suffer with social impairment due to the behavioral changes born from depressive and manic or hypomanic episodes, a potential consequence of which can lead to occupational dysfunction. Several studies have indicated that BD can have a critical impact on an individual's ability to function in the workplace, impeding their ability to engage in meaningful, satisfying, or goal-related activity, paid or unpaid, consequently impacting their QoL (Castanho de Almeida Rocca et al., 2008). Michalak et al. (2007) interviewed 52 people with BD, their caregivers, and healthcare professionals from a variety of employment situations, ranging from people

with no employment history to highly skilled professionals, to determine the impact BD has on occupational functioning. Five main themes emerged from the data. The first theme was a lack of continuity in work history, where cycles in participants' work lives reflected cycles in participants' moods (that is, depression and mania). The second theme was loss of time due to illness (that is, hospitalizations, having to reduce number of hours worked). The third theme that emerged was illness-management strategies in the workplace; the fourth was stigma and disclosure in the workplace, which usually resulted in participants being held back in some way, or even being fired. The last theme was interpersonal problems at work, usually stemming from social isolation or withdrawal during a depressive episode, or irritability or volatile behavior when hypomanic (Michalak et al, 2007).

Another consequential area of social or interpersonal dysfunction is with romantic partners or spouses. While bipolar individuals with strong support systems and supportive partners experience less depressive symptomology over time, the opposite is also true for hostile or critical partners (Rowe & Morris, 2012). Bipolar individuals are less likely to be in committed relationships or get married than the general population, and those who are in committed relationships or

marriages are more likely to experience relationship distress and ultimately disunion or divorce (Rowe & Morris, 2012).

Rowe and Morris (2012) recruited a sample of 38 bipolar I and bipolar II individuals and their partners for a study of the symptoms of BD and relationship functioning. Results of the study revealed that depressive symptoms of the bipolar individuals were associated with poorer relationship functioning, particularly when the partner without BD also had elevated depressive symptoms (Rowe & Morris, 2012). In a study conducted in 2007, data from the National Comorbidity Survey Replication evaluated the associations between marital distress and Diagnostic and Statistical Manual of Mental Disorders Axis I disorders in 2,213 individuals (Whisman, 2007). Results indicated that marital distress was associated with anxiety, mood, and substance disorders, with the strongest associations obtained between bipolar disorder, alcohol use disorders, and generalized anxiety disorder (Whisman, 2007).

The body of research addressing QoL is growing as researchers and clinicians recognize that QoL outcomes are at least as valuable as clinical outcomes to successful treatment of BD. Patient outcome in BD has traditionally been determined by the assessment of objectively measured clinical information, such as rates of relapse or degree of symptom

reduction. QoL is a new, subjective area of research focusing on patients' perceptions of their position in life in relation to where they want to be. QoL encompasses an individual's psychological, social, and physical wellbeing, along with his or her ability to function in the ordinary daily tasks of living, such as in the workplace or at school.

Treatment

Criteria for the diagnosis of a mental disorder entail both the presence of symptoms as well as functional impairment. Logic follows that remission entails both the resolution of symptoms as well as functional improvement. However, remission has been defined in symptoms terms only (McGlinchey, Posternak, Friedman, Boerescu, & Attiullah, 2006). Conceptually, the return to normal functioning should be as fundamental to the construct of remission as symptom resolution as the contemporary approach of diagnosing depression, as delineated in the DSM-5, requires both the presence of symptoms and impaired functioning (American Psychiatric Association, 2013). Analogously, for a disorder to be in remission, each of the defining features of that disorder should be absent. Yet, in both treatment studies, as well as in the diagnostic manual, remission is defined solely in term of symptom resolution (McGlinchey et al., 2006). This disconnect may steer the direction of the formulation of the

treatment plan. Perhaps, instead of a treatment plan that considers the patient's role as a wife and mother, the therapist will focus and design treatment based upon symptoms such as the patient's insomnia, racing thoughts, or substance abuse.

Clinical experience suggests that there is sometimes discordance between assessments of symptom severity and functioning. Some patients with minimal or no symptoms of depression fail to return to their normal level of functioning. Consistent with this, some studies have found that recovery in functioning lags behind symptom resolution (McGlinchey et al., 2006). For example, a patient may no longer fit criteria for a manic episode, but may still be an unfit parent. Similarly, a patient may be hypomanic but continue to function normally in his or her role as a student. This sole focus on symptom reduction not only seems flawed, but also effectively removes the patient's QoL from the clinical picture. The primacy of symptoms as outcome measures is a deduction from an organic disease model, which assumes that symptoms have a one-to-one relationship with an underlying pathological entity that is the target of treatment. Measures of QoL, by contrast, are consonant with a biopsychosocial to BD, in that they prioritize patient agency, context, meaning making, and lived experience (Murray & Michalak, 2012).

While guidelines remain varied, pharmacotherapy remains the treatment of choice for the treatment of manic/hypomanic and mixed episodes. First-line treatments such as lithium, valproate, or atypical antipsychotics are generally initiated, while antidepressant medication is discontinued (Niofli et al., 2011). However, antidepressants continue to be widely used, acutely and long term, to treat bipolar depression despite the paucity of evidence to support this strategy (Bowden et al., 2012).

A 2009 study evaluated the perceived treatment effects, concerns, and expectations among 90 individuals with BD (Sajatovic et al., 2009). Results indicated that, while 39% of participants denied medication concerns, nearly 29% feared possible long-term effects, such as consequences to their physical wellbeing. While individuals with BD appreciate the effects of medications, the concerns regarding adverse effects and discrepancy between actual and hoped-for outcomes can be substantial (Sajatovic et al., 2009). It is perhaps not surprising that many patients struggle with medication adherence.

Frank et al. (2000) stated that BD is a disorderly illness. That being said, they observed that it is "characterized by erratic sleep-wake cycles and dramatic symptom fluctuations, the clinical course is unpredictable and

rarely static" (p.594). The main conclusion that could be drawn from this statement is that BD is a moving target, which means that the state is never constant. Because of that, the treatment of this disorderly disorder poses interesting and sometimes problematic challenges (Frank et al., 2000). Sachs et al. (2000) supported this idea when they said that as individuals with bipolar disorder move along the stages of the disorder, the clinicians treat them with a wide range of mood stabilizers in combination with neuroleptics, sedative-hypnotics, and antidepressants. Frank et al. (2000), however, maintained that lithium monotherapy is still the most effective treatment of pharmacotherapy for bipolar disorder.

Summary

Investigation into the literature of BD has painted a clear and conspicuous picture of both the depth and profundity of the disorder, as well as the importance and implication of its treatment. The confrontation of this disorder, both by patient and therapist alike, undoubtedly involves the patient's QoL. The impact of BD on QoL has been researched and validated leaving room for the investigation into how QoL fits into the architecture of the treating psychologist's treatment plan. Currently a dichotomy between the biopsychological mode and traditional symptoms measures exists, leaving much desired

in addition, patient-centered forms of assessment and treatment.

Chapter III

Methodology

The main purpose of this qualitative case study was to investigate clinical psychologists' integration of the quality of life (QoL) construct into their treatment of bipolar patients. Participants were recruited from local agencies i.e., The Santa Barbara County Psychological Association, as well as through connections through fellow mental health professionals, university professors and colleagues who forwarded the Recruitment Letter (Appendix A) on to therapists who fit the criteria outlined in the Recruitment Letter. The primary criteria indicated that a participant must be a licensed psychologist and must have treated at least one bipolar patient in the past.

Seven women and two men, all of whom reside in Santa Barbara, California, were interviewed independently, either in their office or over the phone. As individuals demonstrated interest in the study (via phone call or email), it was communicated that it was the aim of the researcher to make the process as convenient and comfortable as possible for the participant and that the interview would take place at a location of the participant's choice. All participants signed an informed consent form prior to their interview (Appendix C), which included a brief synopsis of the purpose of the

study as well as outlined confidentiality. The participants in this study were not compensated financially for their time.

Each interview took approximately thirty to sixty minutes. At the beginning of each interview, a hard copy of the Consent Form (Appendix C) was briefly taken out, in the case of the face-to-face interviews, or referenced in the case of the phone interviews, and the participant was asked if they had any last questions or concerns. Though it was indicated in the Consent Form that the interview would be audio recorded, the researcher re-confirmed the participant's permission to be recorded. Participants then proceeded to answer a battery of 6 pre-determined, open-ended questions in order to help the researcher identify perceptions and explore the insights and beliefs into the integration of QoL into the participant's treatment of their past or present bipolar patients. Data were collected from this questionnaire, transcribed, categorized for commonalities, and then interpreted.

During reporting, no identifying names were used or recorded. In order to further protect the confidentiality of the participants, pseudonyms have been used in place of names, any identifying information has been altered, and all data has been kept securely in a locked filing cabinet.

This study attempts to understand the process of therapists' treatment of bipolar patients, how QoL is

integrated into the treatment plan and ultimately utilized as an outcome measure. . The interview questions were the following:

1. Where did you learn to treat bipolar disorder?
2. What do you consider to be the three most important factors in treating someone with BD?
3. What has been your experience with bipolar patients and their understanding of their disorder?
4. What are your thoughts on the idea of "clinical" recovery versus "functional" recovery?
5. How do you integrate the quality of life into your treatment?
6. What have you noticed when integrating this construct in your treatment plan?

Procedures for the Study

1. Recruitment of participants was accomplished via professional associations and referral.
2. The location for six interviews took place in the office of the therapist, while the remaining three interviews were conducted over the telephone. All locations guaranteed confidentiality to the extent they were already rooms designated for confidential therapy by the therapist him- or herself, or the phone call was conducted in a closed room with limited access from the outside.

3. Participants were required to sign an informed consent form prior to being interviewed. For the three participants that were interviewed over the phone, two participants were mailed pre-addressed materials in order to mail the consent form back to the researcher's address, and one faxed the consent form via confidential fax.
4. Interviews conducted consisted of 1:1 30-60 minute data collection interview conducted by the researcher with the participant.
5. The data collected was interpreted via standard qualitative data analysis procedures, such as noting similar phrases, patterns, themes and common sequences.

Data Processing Techniques

The study was conducted using a qualitative design, where the participants were asked open-ended questions regarding their goals and experiences of therapy with people who have a diagnosis of BD. "One of the advantages of this approach is the close collaboration between the researcher and the participants, while enabling participants to tell their stories" (Baxter & Jack, 2008). As opposed to quantitative studies that are limited by narrowly defined variables (Berg, 2004), using a qualitative approach was determined to be the

most appropriate for this study. The use of a qualitative approach allows the researcher to collect data specific to a particular context in order to understand an issue (Nakai, 2012). Data was interpreted, as opposed to merely hypothesis testing, with the goal of both arriving at a comprehensive understanding of therapists as well as developing theoretical statements about their treatment of bipolar patients (Marriam, 1998).

As a qualitative method, the bounded case study was determined to be suited for the purpose of the study. "A case study is an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident" (Marriam, 1998). Through careful investigation and research, it was felt that the case itself would reveal much about the integration of QoL and what it represents, as the therapist is on the front line and can accurately provide a holistic illustration of all factors involved in their decisions, such as how they integrated QoL, what happened, and why.

As "an intensive, holistic description and analysis of a single instance, phenomenon, or social unit," a qualitative case study was been determined to be the best method in which

to study psychologists and analyze their treatment of their bipolar patients (Marriam, 1998).

This particular study focused on the process used by clinical psychologists in determining how to integrate QoL into the treatment plan of patients with BD. There are four possible applications of the case study model (a) to explain causal links between the therapist's individual experience and interpretation of the disorder and how current QoL can be integrated into the treatment plan, (b) to describe specific cases wherein QoL was integrated into treatment plans (c) to identify the factors that may necessitate the inclusion of QoL into treatment plans for patients with BD, and (d) to describe the manner by which QoL was integrated into the treatment plan.

A qualitative bounded case study has provided the opportunity to gain as much information about the problem as possible with the intent of analyzing and interpreting the phenomenon, complete with all of the factors that contributed to it. Carefully formulated research questions, informed by the existing literature and a prior appreciation of the theoretical issues and settings were all important in the selection of the population (Crowe, Cresswell, Robertson, Huby, Avery & Sheikh, 20011). The use of open-ended interviews facilitated the exploration of the therapists' integration of

QoL in their treatment by allowing them to describe their views of reality, fostering a clearer understanding of the participants' actions (Baxter & Jack, 2008). A collective case study, using multiple cases, provided a general understanding, as well as a detailed description of each case allowing the researcher to unearth a theme within cases.

Methodological Assumptions and Limitations

As the study population consisted of licensed, clinical psychologists currently practicing in the small community of Santa Barbara, this limited the variability of the participants and the generalization to the larger population. Further research in other locations will further test the hypothesis of this study.

Ethical Assurances

Stringent measures were taken to preserve the privacy of the participants and the confidentiality of the data they provided. Prior to conducting any data collection procedures, the participants were asked to sign an informed consent letter (Appendix C). The informed consent letter clearly reiterated the purpose of the study and indicated the nature of the participation. The participants were informed that all interviews would digitally audio-recorded for data collection and analysis purposes. Procedures to uphold data and

participant confidentiality were similarly explained before the commencement of all the interviews.

To protect the privacy of the participants, the digital audio recordings of the interviews were labeled with initials to avoid revealing the identities of the study participants. They are referred to with pseudonyms in all of the notes and write-ups included in this study. In addition, interviews were conducted individually, and scheduled in a manner that prevented participants from coming into contact with each other. This protected their participation from being discovered by fellow colleagues who may also be participating in the study. A master list of the participants has been locked in a separate location from the data.

All hard copies of the data are stored in a locked filing cabinet inside the researcher's office. Similarly, all electronic data is secured by a password that is known only to the researcher. The back-up copy of the electronic data, which is stored in a password-protected flash drive, is being kept with the rest of the hard files in the filing cabinet. All identifying information will be kept for seven years.

Chapter IV

Results

For this study, two men and seven women were interviewed. All participants are licensed clinical psychologists residing in Santa Barbara who have treated at least one bipolar patient since licensure. The participants were asked six open-ended questions during the interview in order to facilitate an understanding of how therapists treat their bipolar patients, how they integrate QoL into therapy, and what the outcome of this integration is. The subsequent vignettes are accounts derived from the individual interviews.

Dr. Abby

Dr. Abby stated that her training with BD has been a progression. A rare diagnosis in the seventies, her development as a therapist has especially evolved in the 25 years she has spent in private practice. Most of her work now is in private practice, where she does a fair amount of work with patients struggling with severe mental illness, including BD. When asked to detail primary factors in treating bipolar patients, Dr. Abby stated the following three at the top of her list when first treating a bipolar patient: stabilization on medication, exploration of interpersonal relationships, and educating the patient on the long-term nature of their disorder.

She characterizes herself as a psychoanalytic therapist, and will take spend as much time as needed with self-exploration and analysis.

Dr. Crandle

Dr. Crandle stated that he did not receive any formal training on how to treat BD in graduate school. However, he was mentored in differential diagnosis during his post-doctoral training, and it was this hands-on experience with bipolar patients that he considered his first, real adequate training. Dr. Crandle currently has a private practice, as well as leads several groups. He is very active in treating geriatric patients suffering from mental illness. In his private practice, he stated the first step he takes in treating a bipolar patient is to educate him or her about their condition, as he feels a lot of patients do not understand they are bipolar.

Dr. Ender

Most of the information provided from participant Dr. Ender was reflection on a past patient he treated whom he is still in contact with. He treated this patient for several years, until the patient moved away. While Dr. Ender no longer treats this patient, the patient will periodically check in with participant him, and this is a welcomed interaction. Dr.

Ender described this patient as "bipolar in order," stating that the patient has gone on to thrive in his community without medication, is holding down a job, is participating in a healthy relationship, volunteers, and is once again painting, which was a hobby he had previously given up prior to beginning therapy. Dr. Ender described this case as being very inspiring and one that has given him much pride in his career, as well as one that has provided him with much education in the area of BD and the possibility of not taking medication.

As both a professor and a therapist, it is experiences like this one that Dr. Ender credits with "feeding" his career. Although his specialty is hypnosis, Dr. Ender regularly uses what he termed a "kitchen sink approach" to therapy, in which he will pool together all of his tools, skills, and experiences in order to best treat his patients.

Dr. Grant

Dr. Grant reported that she did not have any formal training for bipolar disorder, and all of her experience was gained during her hands-on postdoctoral work. Dr. Grant expressed a lot of discomfort around explaining her diagnostic process, indicating there was a lot that went into determining whether or not a person, indeed, had BD and this could not be hypothetically described. However, Dr. Grant stated that

medication is the primary goal for treatment when treating a bipolar patient. "I always go for the medical thing first," she stated. Most of Dr. Grant's report came from her experience with one patient she is currently seeing, whom she describes as also possibly having a personality disorder as she uses her BD diagnosis to her advantage, manipulating other doctors for medication and resources in the community.

Dr. Ivans

Dr. Ivans received training on BD in graduate school and in her clinical training. She then went on to train in positive psychology. Dr. Ivans described herself as a Monastic. When treating patients with BD, she reported the most important piece in treatment is psychoeducation. She then went on to say that the second most important piece of treatment is self-regulation. Dr. Ivans made it clear that it was very important to her that each patient was evaluated on a case-by-case basis, that due to the individuality of each patient, she proceeds with caution and care, even in her diagnosis and psychoeducation.

Dr. Kelly

Dr. Kelly stated that she did not receive any formal training in BD, and frankly did not receive very much guidance when it came to severe mental illness. When asked about her treatment, Dr. Kelly stated the three most important factors

she focuses on is medication compliance, symptom management, and tracking the patient's level of contentment in order to provide him or her with more of a sense of control. She is not currently treating anyone with BD, however she has treated several patients in the past with BD, many of whom have also struggled with addiction, which is her specialty.

Dr. Mount

Dr. Mount gleaned most of her experience through dually diagnosed patients that had both BD and substance abuse. In her treatment, Dr. Mount stated it was most important to focus on the patient's safety, and to make sure they are "contained." Through her work with dually diagnosed patients, Dr. Mount stated a lot of patients were not aware of their diagnosis and were using substances to self-medicate. Dr. Mount reported it would become very important to educate patients about their disorder in an effort to prevent relapse.

Dr. Perin

Dr. Perin felt very strongly against medication for her patients. She does not take insurance in order to avoid having to diagnose patients, and in the event she does have to formally diagnose she provides the same diagnoses for all as she does not feel that labeling a patient with a disorder is useful.

Dr. Perin stated that she feels the immediate referral to a psychiatrist to get on medication conveys the message to the patients that "I cannot deal with you unless you're drugged." Her primary goal in treatment centers around the formation of a strong therapeutic relationship where the patient feels safe and encouraged to explore what has brought them to therapy.

Dr. Rourke

Dr. Rourke obtained the majority of her experience with bipolar patients from her work conducting emergency room intakes, and during her post-doctoral supervision. When asked what her top priorities are when treating a bipolar patient, Dr. Rourke stated, "establishing rapport, trust, and having an interest in what they're saying is the most important part of my work with patients." Dr. Rourke is not currently treating anyone with BD as she is currently in a phase in her practice where she would like more of a "mutual process" with patients who have more insight into their pathology, have a strong motivation for change, and do not require long-term care.

The Integration of Quality of Life

The objectives of this study were to explore the integration of the quality of life in therapists' treatment of their bipolar patients. The researcher hopes the findings of this study will prove useful to both therapists and patient

alike by illuminating how therapists treat their bipolar patients, how they integrate QoL into therapy, and what the outcome of this integration is.

As the interviews proceeded and themes emerged, categories formed that began to define the construct of the integration of QoL into the treatment. These included: (a) medication; (b) the therapist's perception of the bipolar patient; (c) the importance of the therapeutic relationship; and (d) the integration of QoL into the treatment plan.

Medication

Dr. Abby discussed her experience with bipolar patients, and described her primary goals in treatment as follows:

First I work on getting them connected with a good psychiatrist and helping them to stabilize on medication, because it is a very complicated process to stabilize a patient on medication. Once that stability has been accomplished I think it's very important to look at their interpersonal relationships and see how disruptive they have been. I try to work with them on trying to consistently hold in mind that this is something they will have to work on long term. I work with them on how to accept that this is something more than a transitory depression or a passing manic phase. But without medication ... a true bipolar person, it just won't work.

Dr. Abby posited that beginning her work with a bipolar patient cannot truly begin until they have started medication and, in fact, starts with the process of working with the patient to either begin taking medication or refining medication compliance. Only then can the work develop further into facilitating introspection into interpersonal

relationships, and further understanding the nature of their disorder.

When discussing the bipolar patient's clinical recovery, participant Dr. Crandle described the importance of medication stating, "Clinically, medication is key. We solve the problem of bipolar by placing people on medication. Which is not easy. It doesn't become my job as a psychologist, but I do collaborate with the psychiatrist or the patient's general practitioner."

While Dr. Ender encouraged the patient he reflected on during his interview to speak with a psychiatrist, he also reported "fielding his feedback about his medication" as part of their therapy. This process involved discussing the patient's experience of his medication, as opposed to approaching the situation with a pre-fabricated decision on whether or not he should be medicated. Through this process, Dr. Ender reported that he came to understand that medication was not the best option for this particular individual. This patient was not medication compliant as it was and it became evident to Dr. Ender that it would be more conducive to therapy to focus on other means of treatment, which were successful. "He is what you can call bipolar in order, " Dr. Ender reported, stating that while the patient is still considered bipolar, he is able to hold down employment, have a

satisfying long-term relationship, he is a volunteer in the community, and is partaking in hobbies he had not been when they first met. "He did not like being emasculated from his experience, he did not like the medication because of that," Dr. Ender described.

Dr. Grant described her treatment plan as beginning with a discussion about medication, and "always going for the medical part first." She expressed empathy for patients who do not want to take medication, or do not want to hear that they need medication, and her tactics for getting them to at least try it for a while. "I think somehow there is a stigma in society that is damaging to their egos," She said. "I mean, most people don't want to take a medication at all let alone for the rest of their lives. Diabetics often don't take their medication. So if I can just get them on it for a while so they can see the difference, I think that's an accomplishment."

Dr. Ivans was hesitant to mention medication as a part of her treatment plan. Rather, she stated that she works on "self-regulation" with her patients, which encompasses mind-body skills, planning and activities of wellness. She indicated that medication may be encompassed in the self-regulation piece of therapy. When asked specifically if she supported medication, Dr. Ivan's response was as follows:

My experience with people has to do with finding enough stability to do the work. So I guess the best answer I can give you is maybe. To the degree that the medication is needed, to be able to do the work, to create stability, I would say yes. But across the board, I think that has to do more with the individual.

Dr. Kelly reported that one of the most important factors she focuses on when beginning treatment with a bipolar patient is medication compliance. She expressed much support for medication, stating, "I'm not entirely sure that when you meet full criteria, un-medicated, a rich and juicy life is possible. Even with quite a bit of insight."

Most of participant Dr. Mount's work with bipolar patients came from her time at a substance abuse center, and as such a lot of her responses reflected experiences with patients who were dually diagnosed. She spoke of medicated patients who, thinking they were now cured, would suddenly stop taking their medication without the support of their doctor(s). She saw this leading to eventual relapse as a lot of her patients would consequently reach for other substances to self-medicate when the depression or mania would inevitably strike.

Dr. Perin felt very strongly against medication. In fact, she does not accept insurance in an effort to avoid the formal diagnoses process. In the event diagnosis is ever required, she provides all patients with the same diagnosis. She indicated she has noticed, experienced, and been told about a

great deal of corruption both with the pharmaceutical companies and psychiatrists, but it was mostly her experience with patients that drugs hampered the recovery process. It created new problems for patients, such as anxiety surrounding whether or not it would be possible to stop the medication or the copious amount of side effects, and impacted the therapeutic relationship by sending the message to the patient that work could not begin until they were drugged. Dr. Perin's strong feelings surrounding medication has led to her involvement in groups that help spread the word that medication is not the only way to treat severe mental illness.

Dr. Rourke stated that she does not work from a medical model and, while she does feel the medication may be necessary in some instances, she is more interested in her patients' every-day lives.

The Therapist's Perception of the Bipolar Patient

Dr. Abby recalled when she first revealed her diagnosis to her patients and how difficult that can be for some, which can result in resistance to accept their bipolar diagnosis as accurate.

With the informational resources available to most people today via the Internet, they can easily start researching their diagnosis, and most people don't like what they read. Of course it's not wonderful news, and there is a degree of resistance in that they don't want to think about 'this is something that has manifested in me, I always got by fine in the past.' In general, yes it is resistance.

Dr. Abby expressed the importance of the consideration that this may be a big blow to a person's perception of who they are and what the rest of their life may now look like. Dr. Abby's expression of concern translates into her practice, where she works with her patients' resistance.

Dr. Crandle stated that he does not feel that most patients have a clear understanding that they are bipolar. Additionally, Dr. Crandle realized and that admitting to a bipolar diagnosis can be "a tough pill to swallow," and may require "some easing into." He therefore feels it extremely important to support his diagnosis to his patient's with evidence.

And it's really important for me to have clear evidence of identification, and then to use the behavioral material to educate the client that they are indeed bipolar. I have a three rule: I have to notice something three times in order to be able to provide an interpretation that carries some strength. So when I see a pattern three times, so then I feel I am in a position to say I see a bipolar process.

Through his long-term therapy with the bipolar patient he referenced in his interview, Dr. Ender mentioned in particular the amount of inner strength it took for him to remain patient in the face of the many "unreasonable" things his patient did during the course of a manic episode. "There were some times when I actually got pretty firm with him in therapy and had to draw a line and say this is not okay, and it's not acceptable

and I'm very disappointed. Almost like a parent," Dr. Ender recalled. "And I look back on that and think, how could he still like me? But it's been a success."

Dr. Grant reported diagnosis and assessment being very integral to her process as her treatment immediately with treating the medical aspect of the disorder. "They have to understand they have a biochemical illness," she explained. Dr. Grant expressed confusion as to why some people are successful with medication and therapy, and some people are not.

Dr. Ivan's described herself as a very spiritual person at heart, which in turn shaped her view of her patients.

My fundamental lens is that people have a way of flowering, just like plants do, and some are going to flower well and some are not going to flower well, and it's all according to the care they're given. And sometimes plants that don't flower well we can resuscitate and sometimes we can't. Now I'm speaking to that at a psychic level. So I very clearly see a differentiation between functional and medical recovery. And I think that's where the art of psychotherapy, and really good therapy comes in. Because that's built on so many nuances.

Dr. Ivans attributed her same nature for her hesitation to clinically diagnose patients. She reports noticing a lot of stigma surrounding BD and has not noticed benefits in labeling her patients. Instead, she "stays with the feeling of what is going on" rather than a "blanket statement."

Some people very much want the black and white answer, and they'll come in and give me the laundry list, and they'll give me all the things they think they are. And

of course they're grasping to cognitively understand. But I'm very careful. I'm not real big on labels. Monastics on not real big on clinical diagnosis. Some people will unravel; they will go down the Internet hole, catastrophizing and then we'll have even more of a mess.

Dr. Kelly described her bipolar patients as being completely overcome by their disorder, many turning to drugs and alcohol to mimic the mania they do not want to give up. Additionally, diagnosis could be especially difficult for some to accept:

I remember at times people being somewhat relieved, that things made more sense to them, that their behavior made more sense to them. I remember responses from people that they were quite enraged to think that they were "mentally ill," and that's actually what detrimental to treatment. Some people became quite angry.

Dr. Mount expressed that bipolar patients needed constant monitoring as, in addition to not fully comprehending their disorder, they were easily seduced by false recovery. Dr. Mount reported being enlightened, however, at the role trauma played in the lives of many of her patients.

I've come to understand to role trauma has played in the origin of BD. A fight or flight state may have become hard-wired in due to a traumatic experience and correlates to the manic state, and how that manic state may have served a function for them. And then helping them to realize this.

Dr. Perin feels that a lot of bipolar patients are not recovering, making progress or are even resisting therapy due to the messages they are being fed by labels and stigmas. She does not incorporate medication into her practice in order to avoid sending the message to her patients that they need to be

drugged in order for her to work with them, and she does not feel that a mental health diagnosis is useful, especially for patients who are not ready to hear it.

Dr. Rourke reported being at a state in her career where she is currently not taking on any more bipolar patients because, as she stated, she "does not want to work with people any longer that do not want to change." While she recalls many past bipolar patients as being intelligent, and some as being very insightful, the amount of work and patience it took to make progress was something she had the energy for in the past, and does not currently desire as she winds down her practice.

The Importance of the Therapeutic Relationship

Dr. Abby spoke about the importance of her relationship with her patients and how, due to the nature of her therapeutic orientation, she was able to convey to them that she was always available.

Because I mostly do long-term therapy, that means that I am consistently there for people. Even after the first significant period of work that we do together. We usually taper down therapy, but even after we taper off they know I'm still around. So there are some people I'm at the point I see once a month, once every two months. Some people will come back a year later for a couple of sessions. But it builds then on the work we've done before, sort of like a tune up to try to help them deal with a current issue or get back on track. And I think that's where therapeutic relationship is so important bc they know I'm here. They know I'm here if anything starts to happen they know I'm here and they don't have to start

from the beginning. I know who they are and I can step in to work with them again.

Dr. Crandle spoke considerably about the importance of the therapeutic relationship to his treatment of those with mental illness, stating that it in fact formed the basis of his practice. He indicated that progress was not possible without first developing the bond between the therapist and the patient:

To me, everything comes from the relationship. So, my work involves creating the therapeutic relationship, an empathic tie between myself and the individual. I'm not doing anything to them or for them, we are doing something here together. So, through my understanding and their recognition that I really do care and I want to help and I am available to them, I am developing a therapeutic relationship. And through that therapeutic relationship I can begin to provide some information and some perspective and ask them to look at that and hopefully buy into that so that we can look at it together.

Dr. Ender spoke mostly about the rapport he developed with his patient. He described a situation where he had to develop empathy and patience in order to both be able to weather the storm of his patient's manic episodes, as well as genuinely communicate understanding and set boundaries. Dr. Ender described his role as an advocate in the community for his patient, helping him to obtain resources necessary for survival and success, as what cemented their bond and showed his patient how much he cared. This created a sense of trust and security, which facilitated therapy. Dr. Ender described his perspective as follows:

The relationship is everything. They've known since Norcross did his stuff, that they could not distill from different types of therapy. The only thing that they could distill out of comparing different kinds of therapies was that the perception on the part of the client on the empathy coming from the clinician was a predictor of success. That's it. So all of the rest of the stuff, it's like a medium in which you supply empathy.

While Dr. Grant expressed much preference for immediate and prolonged attention towards medication compliance, she stated there is a great deal of importance in the relationship between the therapist and the patient. "Sometimes you need a psychologist to get you to take your meds and do it right so that you can take the next step in your life," she explained. "There must be a relationship there that is based on trust, understanding and respect in order for your patient to believe that you know what you're talking about and to follow any advice you're giving."

Dr. Ivans described the importance of "meeting patients where they are" in terms their ability to accept and process information on multiple levels of consciousness. She described the patient-doctor relationship as one that requires sensitivity, attention to detail, and years of experience to develop.

I have had so many people come to me and tell me they have felt the therapists judge them. Now that may have been the therapist's discernment, but I know what they mean. And yet you can be too tender and empathetic and blow the treatment up at the same time. So meeting them where they are is a

nuance skill, something we learn over a lifetime in this career.

Dr. Kelly spoke extensively about the importance of having a regulatory figure in a bipolar patient's life. She referred to the re-parenting process in therapy, and how the capability of providing boundaries and safety for a person to process their thoughts and feelings plays a large part in the success of the patient.

I think people do much better if you are with a regulatory figure. In other words, you can be total crazy when you're working with one person and completely sane when you're working with another. I'm not entirely sure what that's all about. I think an awful lot has to do with the therapist. I realize bipolar disorder is chemical in nature, but it also is, to some degree, attunement. And if there's nobody stable to attune to, how do you do manage this disease? A feeling of yes, I belong someplace and it's safe, will make all of the difference. That hour should be from diagnosis to death.

Dr. Mount spoke extensively about her personal discovery while working with bipolar patients, and how only through hands-on work did she truly see the pain and trauma bipolar patients had endured in order to present with the symptomology they were exhibiting.

Dr. Perin's work centers all around the therapeutic relationship. As the diagnosis and medication is not a part of her clinical picture, she focuses solely on the formulation of a relationship. She does not consider herself to be a directive therapist, and therefore takes more of an

"encouragement role," in order to support her patient's in their journey of self-exploration.

Dr. Rourke stated that establishing rapport and trust with her patients are the most important factors in her treatment. She treats therapy as a mutual process where the goal is to help people to change. However, she is realistic about this process, understanding that people are only capable of what they are capable of, and she takes this into consideration during the therapeutic process. "I give people a good sense of what it would be like to work with me," Dr. Rourke reported. "I don't take every client I see, and not all of them take me. It's important for there to be a good fit."

Progress

Dr. Abby spoke extensively about the importance of focusing on the quality of a patient's functional recovery. "There is difficulty in learning how to live with certain considerations that other people don't," she explained. "In how to be in the world, how to be in relationships, how to take care of one's self. And that's the functional part." Dr. Abby explained that once she was able to stabilize her patient, usually with medication, she was then able to "focus on the quality of that function." This included asking the patient questions such as what they would like more of in their life, what they would like to be different, and what

they would like to sustain. And once they were able to make progress in those areas, Dr. Abby stated she was then able to move into more esoteric QoL questions that included exploration in areas such as spiritual development, career goals, and personal values.

Dr. Abby explained that this process was a continual one, where she and her patient came to an acknowledgement that QoL will always need to be reevaluated. She explained further:

The QOL of one's life and what one chooses at 22 is not going to be the same at 52. Along with whatever bipolar issues may be present, there is still the social, cultural, developmental progression. And I think this is where patient's realization hits that I am around for a long time, I've been in practice for a long time, once they're my patient they're always my patient, and they know that "okay I've got someone to do this with! If I reach I point in my life where I'm re-thinking things and what's important to me, I can do that with Dr. Abby!" I think that's very grounding for them.

Dr. Crandle spoke about how his work also involves processing what the client capable of doing during the stages of their progression of treatment to together. After his patient has been stabilized on medication, Dr. Crandle then reevaluates to see their capability to function in day-to-day aspects as well as major functions of their life.

I will talk spend time evaluating my patients in order to determine if they are now able to handle the major aspects of their life. How is it going in their relationships at home, with their child, with their family, how are they doing at work. And equally important, how are they doing recreationally and socially? Are they able to find fulfillment?

When discussing his patient, Dr. Ender spoke a lot about the impact BD had on this man's life, such trauma, the substance abuse, and the aftermath of his manic episodes, which regularly involved depression, guilt, shame and embarrassment. Dr. Ender described his role as this patient's therapist as doing whatever it took to help improve his daily functioning. Employing his "kitchen sink" method of integrating hypnosis, meditation, neurofeedback, and fielding his feedback about medication, Dr. Ender focused on helping his patient to "get his bipolar in order" in a way that worked for this individual. While Dr. Ender knew that it was against the advice of the patient's psychiatrist to discontinue medication, he realized the side effects, both physical and psychological, were detracting from his patient's QoL and decided against contending with his patient on that matter. He instead worked with him to develop alternative methods of treatment, and "was ultimately successful."

Dr. Grant feels that medication is imperative in bipolar treatment. Without medication, she feels progress cannot be made in other areas. She focuses first on medication compliance or helping her patient to get started on the right medication, and only after improvement will then move into the next phase of treatment.

I always go for the medical thing first. Once the mood is even enough, then I move into the QOL stuff. I mean,

that's the point really. To me, that's the work of the psychologist.

Dr. Ivans communicated the most important aspect of her treatment with patients is to assure she is meeting them where they are in order to assure that she is not only treating their BD, but treating their pain and offering relief. It is her belief that with the relief comes relaxation, providing the foundation for their work together.

I've got to find out at the heart of their matter what they want. Again it comes back to meeting them where they are, what's working, what's not working. One of the things that I ask, at least the first time and often thereafter, is what's pressing against them the most. Because that's the 'pain piece' that needs to be dealt with straight away. People come into therapy because they're in pain. Something is pushing them from the inside out in their experience. So I tried to find out what the most pressing piece is first so I can bring close and immediate relief. And when we bring close and pretty immediate relief, there is a trust that begins, and they start to feel better and they can start to relax a little bit more. And everything builds on that.

Dr. Kelly asserted her belief in the necessity for long-term psychotherapy in order to improve the QoL of her patients. She stated her belief that having a stable, supportive regulatory figure in the patient's life to regularly attend to symptomology will dramatically improve their QoL. "I ask them to tell me about what's been hard this week," she explained, "and what can we try that might be different. I ask them where they are in this process, what's one thing that made them grateful or happy this week." Dr.

Kelly wonders what the impact of having a stable, dependable regulatory figure in the life of bipolar patient from day one could do in terms of the presentation, as she feels that almost all disorders, including BD, can be boiled down to complications in the patient's development and adjustment formations.

There was no parenting, no self-regulating, for many of these patients, and it is not the fault of the individual if no one ever said to them, 'sometimes we're up, sometimes we're down, but when we're down what do we have to do today to make things brighter?' Or 'I promise you that this feeling will go away, because feelings do go away.' They are the most un-parented people imaginable.

Dr. Mount expressed that safety is a primary concern for the bipolar patients in her current milieu. When discussing treatment, she stated that almost all of her bipolar patients did lack awareness into their disorder. Rather, they enjoy the feelings that come with their mania and will do what they can to preserve it. Her treatment goals encompass individual and group therapy to provide education, tools for exploration and behavior modification in order to prevent self-medication, depression following manic and hypomanic episodes, and improve the lives of her patients. In her words, it all focuses on the quality of her patients' lives as their self-containment and sobriety will determine their next step.

Dr. Perin described a patient who could get through a day without feeling suicidal, however she could not get through an

hour without having to pop a pill in her mouth. "What kind of life is that?" she asked. "She doesn't want to kill herself, but her family is afraid for her safety, she is afraid of everything and she has an extremely low QoL." Dr. Perin's treatment sometimes centers around helping patients deal with the anxiety and fear they feel about stopping medication, and then how to cope with their disorder without it. Her focus is then put into letting her patient drive the therapy by telling her what they want and need in order to live a happy life. She attunes to resistance, and will process what the patient can handle as they can handle it. Her modality is not about forcing treatment, but rather paying attention to what her patients' needs are.

Dr. Rourke stated that she pays close attention to her patients and listens attentively in order to provide a solid base for treatment. According to Dr. Rourke, this enhances rapport and promotes honesty in the therapeutic relationship, which in turn assists her in her development of a treatment plan that is tailored to providing the best standard of care for her patients.

Chapter V

Discussion

Overview

Seven women and two men residing in Santa Barbara, California described their experience treating bipolar patients from a variety of perspectives in response to six open-ended questions posed by this researcher. Questions aimed to identify how therapists treat their bipolar patients, the integration of QoL into the treatment plan and what the outcome of this integration is. Through the course of analysis, four major themes emerged: medication, the therapist's perception of the bipolar patient, the importance of the therapeutic relationship, and progress throughout treatment.

The Common Themes

Medication

Dr. Abby, Dr. Crandle, Dr. Grant, Dr. Kelly, and Dr. Mount all support medication as their first line of treatment, delineating it as an imperative first step needed before further progress in treatment, such as self-exploration or reparation of social relationships, can be made. The remaining participants, Dr. Ender, Dr. Ivans, Dr. Rourke and Dr. Perin, described their approach as "meeting [their] patients where they are" in order to focus more on other aspects of treatment

such as resistance, self-regulation, self-exploration, or even medication cessation as opposed to prescription. The latter participants described medication being either less a part of or not a part of the treatment plan, with their focus more towards the patient's presentation.

The Therapist's Perception of the Bipolar Patient

The participants all agreed that their patients lacked a comprehensive understanding or clear insight into their disorder. Participants described manifestations of resistance in therapy that stemmed from the patient's difficulty to accept the magnitude of conceptualizing their disorder. Some participants felt it better not to use labels, such as BD, or chose to hold off on diagnosis until it was determined the patient was stable enough to develop the necessary coping skills to handle the news of their diagnosis. The therapists all agreed that bipolar patients are a very challenging population to work with and one that takes a special degree of care.

The Importance of the Therapeutic Relationship

All participants mentioned the importance of developing the therapeutic relationship or developing rapport with their patients in order to proceed successfully in therapy. Dr. Abby, Dr. Ender, Dr. Grant, Dr. Kelly and Dr. Rourke all mentioned the importance of developing trust with their

patients, which was accomplished by providing a safe and stable environment, in which it was effectively conveyed the therapist intended to become a part of the patient's support network. In other words, the participants indicated they expressed to their patients that the relationship they were developing was not transitory, and even if therapy ended and they did not see one another for years, they would always consider themselves to be the patient's therapist and would be always be available if the patient needed them. As one participant stated, "I am there for my patients from diagnosis to death."

Progress

As mentioned, most participants mentioned that progress began with first stabilizing their patients on medication. Participants then could move on to focusing on other aspects of therapy such as improving the daily functioning of their patient, such as self-exploration or social relationships. In other words, once the patient had been stabilized, they could then move on to focus on aspects, which they qualified as areas of QoL.

Implications

Implications from this study suggest that while most participants indicate a desire to develop a strong rapport and relationship with their patients, progress is dependent on

first stabilizing the patient on medication. As all participants are psychologists, and not psychiatrists or in possession of a medical degree, this indicates that treatment at this critical and initial part of treatment is immediately dependent on the intervention of another, separate doctor, which can involve independent referrals, new appointments and the delay of therapy. The significance of what the interruption to treatment could be, perhaps in terms of the patient's motivation or to the therapeutic relationship, remains unmeasured. However, in considering how this may impact the therapeutic relationship, as Dr. Perin put it, "it sends the message, I can't deal with you unless you're drugged."

Additionally, almost all participants indicated their patients did not tend to have insight into their disorder, expressed some element of resistance, or needed a significant amount of support and monitoring. So while these characteristics were accepted attributes of the bipolar patient for most of the participants, providing support and facilitating insight came secondary to symptom reduction.

All participants expressed empathy for the struggle their patients were enduring, a desire to develop the therapeutic relationship, and revelation that their primary goal of patient stabilization on medication is fueled by hopes of

significant work together in the future. Bipolar disorder is a challenging, complex disorder for both the patient and the therapist, posing various obstacles in treatment that do not always have a clear-cut answer or plan of action. However, as a formal diagnosis requires both the presence of symptoms as well as functional impairment, reason would follow that remission or recovery would entail the resolution of both symptomology as well functional improvement. A primary focus on symptom reduction not only neglects a large portion of what constitutes the disorder itself, it also ignores the embodiment of recovery and this continues to be a dilemma in mental health treatment, as further evidenced by the narratives from the interviews in this study.

In the present study, while the participants faithfully and genuinely showed concern and care for their patients, and demonstrated the utmost professionalism in the face of one of the most challenging of mental illnesses, the reduction of symptoms was prioritized over patient agency in an effort to be consistent with what is typically considered to be responsible and in attunement with ethical guidelines. As QoL has been defined as an individual's perception of his or her position in life in relation to psychological and physical health, social relationships, goals, expectations, and environment (WHO, 1995), it therefore can be deduced that,

regardless of intentions, it was uncertain as to whether or not QoL was effectively integrated into the treatment plan by the participants in this study.

Participants who indicated they avoided labels or diagnosis in favor of protecting their patients from the potentially damaging effect of stigma, "worthless blanket statements," did not provide much in terms of offering an alternative explanation to the patient for what they were experiencing. For the confused bipolar patient looking for an explanation for his or her thoughts, feelings and behavior, clinicians are often at a loss as to how to balance a fear of stigmatization with an authentically caring encounter. As indicated earlier in this study, QoL encompasses an individual's perception of his or her position in life in relation to psychological health (Who, 1995). The patient's lack of understanding, perpetuated confusion, or even the therapist's countertransference regarding diagnosis, can influence recovery and consequently impact QoL.

Based on the conclusion on these findings, five out of nine participants prioritized medication. While participants all agreed their patients tended to lack insight into their disorder, many decided against providing a clear picture of what BD is in favor of steering clear of blanket statements, or overwhelming their patients with traumatic information they

may not be ready for. Participants credited the next step in therapy with the development of the therapeutic relationship. In reflecting on the dilemma between addressing the immediate crisis presentation that often accompanies BD, particularly Bipolar I, and balancing authentic listening and engaging, rapport may be compromised if the therapist is not fully considering the patient's view or reaction(s) to medication, and then even being honest about the patient's diagnosis.

Future studies could address the question of how psychologists and others in the mental health community would have a better understanding of the importance of integrating the patient's QoL into the treatment plan by not only focusing on symptom reduction, but rather taking a biopsychosocial approach that prioritizes patient agency, context, meaning making, and lived experience. Focusing on the patient's QoL will incorporate an individual's psychological, social, and physical wellbeing, along with his or her ability to function in the ordinary daily tasks of living. For example, this can be accomplished by working on specific ways to reintegrate the patient back into school or work after a hospitalization, learning relationship skills, or how to cope with emotions.

As stated, all participants in this study showed great care and concern for their patients, which was evident in their ability to ethically and responsibly assist first and

foremost in anything that posed a risk to their safety. The goal is to find a marriage between the traditional methods of clinical symptom reduction and the nontraditional incorporation of QoL in order to prevent rehospitalization, lessen the recurrence of episodes, and enhance the mental health of the patient.

Strengths and Weaknesses of the Study

All of the participants in this study were from a small city in southern California, which narrowed the scope of this research. Additionally, there were a small number of participants involved. This suggests avenues for future study in other areas of the state and or country.

Strengths of this study were the openness and honesty of the therapists sharing their experiences with current and past patients. All therapists involved understood the concept of this project, had many years of experience, and expressed a desire to share their knowledge for the purpose of helping further bipolar research.

Recommendations for Future Studies

Recommendations for future study include a study with a larger sample size and, as mentioned, populations in other areas of California and the United States.

Another area recommended for further research is in age of onset and how it impacts QoL. As mentioned, statistics show that age at onset occurs at a particularly critical developmental stage and a child experiencing symptoms of BD may develop a sense of self characterized by who they are during an episode and between episodes. Further research is needed to investigate the extent of this impact. This can be a particularly important area of interest as an integration of QoL into the treatment plan from the beginning can possibly set the stage for a more realistic picture of the future, acceptance of the disorder, and a more integrative treatment plan that incorporates the goals and expectations of the child.

A third area suggested for further research is the impact to the patient when treatment is interrupted by a referral to an outside doctor, and the work is not done in tandem. For example, is the relationship with the patient's psychologist impaired when the psychologist immediately refers the patient to a psychiatrist?

Conclusion

Bipolar disorder is an acute, lifelong disorder that, particularly with the Bipolar I diagnostic distinction, often causes grave and debilitating consequences for its sufferers.

Consequently, providing adequate and successful treatment for this population is imperative.

Traditional recovery outcomes in BD have been determined by objective measures based on the pathology of the patient, such as recurrence of episodes, response to medication, or degree of symptom remission on clinician-rated assessment scales. This does not always take into full account the patient-centered, biopsychosocial approach to BD, prioritizing patient agency, context, meaning making, and lived experience. In other words, the patient's QoL in the formulation of the treatment plan is neglected in favor of traditional and perhaps more concrete forms of recovery. Participants showed deep concern for the stability of their patients, a strong desire for rapport through the development of trust and conveyance of constancy, and an innate passion for progress. However, the majority of participants' treatment plans were not tailored around the individual's perception of his or her position in life.

As QoL has already been shown to be significantly reduced in bipolar patients, and elevated depression tied to recurrence of episodes and rehospitalization, it follows that a clinical picture of recovery could benefit by including a return to an acceptable or realistic QoL for the individual patient.

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Appendix A: Recruitment Letter

Date:

To Whom It May Concern:

I am a graduate student at Antioch University in Santa Barbara conducting research on therapist's integration of quality of life (QoL) into the treatment of their bipolar patients. I am looking for licensed psychologists who have treated at least one bipolar patient. I will travel to you or conduct the interview over the telephone or via Skype.

Participation in this study is strictly confidential, and action will be employed to ensure interviewing methods and materials are kept confidential. I will be happy to discuss these methods with you at any time.

If you are interested in participating in this study, please contact me at (805) 453-1866 or send an email to CarolynnShor@gmail.com.

Thank you for your interest in this study!

Sincerely,
Carolynn Shor, M.A.
Doctoral Candidate
Antioch University, Santa Barbara

Appendix B: Dissertation Questionnaire

Preface: I will be asking you a series of questions about your treatment and therapeutic interaction with your bipolar patient(s). All of these questions relate to the integration of quality of life in the treatment plan.

7. Where did you learn to treat bipolar disorder?
8. What do you consider to be the three most important factors in treating someone with BD?
9. What has been your experience with bipolar patients and their understanding of their disorder?
10. What are your thoughts on the idea of "clinical" recovery versus "functional" recovery?
11. How do you integrate the quality of life into your treatment?
12. What have you noticed when integrating this construct in your treatment plan?

Appendix C: Consent Form

Project Title: Treating Bipolar Disorder: Investigation into the Integration of Quality of Life in the Treatment Plan

Project Investigator:Carolynn Shor, M.A.

Dissertation Chair: Juliet Rohde-Brown, Ph.D.

About this consent form

Please read this form carefully. It tells you important information about this research study. If you have any questions about the research or about this form, please ask. If you decide to take part in this research study, you must sign this form to show that you want to take part. You will be given a copy of this form.

1. You understand that this study is of a research nature. It may offer no direct benefit to me.
2. Participation in this study is voluntary. You may refuse to enter it or withdraw at any time without creating any harmful consequences to myself.
 - a. If you withdraw your permission, you will not be able to take back information that has already been used.
3. The main purpose of this study is to investigate how psychologists incorporate Quality of Life (QoL) into their treatment of bipolar patients, as well as their personal experiences, concerns, and assumptions. Participation in this study will further the understanding of the treatment of bipolar patients and possibly enhance the ability of therapists to work more effectively with their patients.
4. As a participant in this study, you will be asked to take part in the following procedures:
 - a. Reviewing and completing this consent form.
 - b. Participating in an interview that will last approximately 30 minutes.
 - c. Completing a brief demographic questionnaire.
 - d. Participation will take place in my office or over the telephone.
5. There are no known risks, discomforts or inconveniences associated with participation in this study.
6. The possible benefits of the procedure might be:

- a. Direct benefit to you: Discussing issues related to QoL may increase your awareness of additional factors involved in complete recovery.
 - b. Benefits to others: further the understanding of the treatment of bipolar patients and possibly enhance the ability of therapists to work more effectively with their patients.
7. Data will be identified with a random number and all personal information (name, address, phone number) will be stored on a password protected computer file. Only the researcher and dissertation chair will have access to this information.
8. Information about the study was discussed with you with Carolynn Shor.
If you have further questions you can call her at (805) 453-1866

Date: _____

Signed: _____