We are IntechOpen, the world's leading publisher of Open Access books Built by scientists, for scientists

6,900
Open access books available

185,000
International authors and editors

200M
Downloads

Our authors are among the

154
Countries delivered to

TOP 1%
most cited scientists

12.2%
Contributors from top 500 universities



WEB OF SCIENCE™

Selection of our books indexed in the Book Citation Index in Web of Science™ Core Collection (BKCI)

Interested in publishing with us?
Contact book.department@intechopen.com

Numbers displayed above are based on latest data collected.
For more information visit www.intechopen.com



9

Psychosocial Functioning in Bipolar Disorder from a Social Justice Perspective

Emily Manove, Lauren M. Price and Boaz Levy
Department of Counseling and School Psychology, University of Massachusetts, Boston, USA

1. Introduction

Previous research on psychosocial functioning in bipolar disorder (BD) has uncovered various factors that exacerbate disability over the course of illness, including illness severity (Burdick, Goldberg and Harrow, 2010; Haro et al., 2011; Mur, Portella, Martinez-Aran, Pifarre, & Vieta, 2009), anxiety (Boylan et al., 2004), substance use (Jaworski, Dubertret, Adès, & Gorwood, 2011), and cognitive impairment (Martino, Igoa, Marengo, Scapola, & Strejilevich, 2011). Accordingly, current efforts toward improving functional outcome in BD focus primarily on pharmacological and behavioral interventions that decrease mood symptoms (Fountoulakis & Vieta, 2008; Miklowitz, Goodwin, Bauer, & Geddes, 2008), attenuate anxiety (Rakofsky & Dunlop, 2011), reduce substance use (Weiss et al., 2009), and increase cognitive functioning (Deckersbach et al., 2010; Goldberg & Roy Chengappa, 2009). Whereas this approach addresses the neuro-psychological aspect of functional disability in BD, it largely ignores its social components.

Disability is inherently contextual, and is always defined by the interaction between the person and the environment. In other words, psychosocial functioning varies with the person's abilities, but also with the particular characteristics of the person's social environment. In theory, changes in any given society can shift the functional variability among its members, and therefore carry the potential to decrease the number of people who experience severe forms of psychosocial disability.

Applied to BD, this notion relates to removing social barriers to functioning in mainstream settings such as stigma and discrimination. Currently available therapies can reduce the symptoms of BD to some extent; however, the consequent potential for psychosocial growth remains latent in a social environment that limits the person's opportunities to obtain psychiatric care (Boyd, Linsenmeyer, Woolhandler, Himmelstein, & Nardin, 2011), medical care (Corrigan, 2004) and reputable social standing (Corrigan, Markowitz, & Watson, 2004; Corrigan & Wassel, 2008).

This chapter focuses on the contribution of stigma and discrimination to functional disability in BD. We explore the mechanisms of stigma's effects on functioning, which may involve increasing painful emotions (notably shame) and stress, reducing treatment seeking and adherence, and limiting social and vocational opportunities through both consumer avoidance and public exclusion.

We advance a two-pronged approach to treatment. The first involves therapy directly targeting the negative effects of internalized stigma on the psychological health of people with BD. The second requires providers to publicly align with federal and state governments, advocacy groups and consumers in making the issues of stigma and discrimination visible. These efforts should seek to reduce the ill effects of stigma and discrimination through educational programs, media campaigns, litigation, and reform of service systems.

These two prongs will likely have synergistic effects. With one alleviating internal distress and the other removing external obstacles, they may converge to attenuate the debilitating effects of stigma and discrimination on people with BD. This approach may even shift the functional trajectory of BD from psychosocial decline to growth over the course of illness despite the recurrence of mood symptoms.

2. Functional impairment in BD

Longitudinal, cross-sectional and qualitative studies, now summarized in multiple reviews, have documented substantial levels of social and occupational impairment in BD, even during euthymia (Bonnin et al., 2010; Burdick, Goldberg, & Harrow, 2010; Coryell et al., 1993; Dickerson et al., 2010; Huxley & Baldessarini, 2007; Latalova, Prasko, Diveky, & Velartova, 2011; Martino et al., 2011; McMorris, Downs, Panish, & Dirani, 2010; Michalak, Yatham, Maxwell, Hale, & Lam, 2007; Michalak et al., 2011; Montoya et al., 2010; Pope, Dudley, & Scott, 2007; Rosa et al., 2010). Longitudinal studies show that between 90 to 98% of people receiving treatment for an acute episode of BD achieve syndromal recovery within six months to two years (Bonnin et al., 2010; Dickerson et al., 2010; Huxley & Baldessarini, 2007; Tohen, Waternaux, & Tsuang, 1990; Tohen et al., 2000). However, only 30 to 40% of consumers demonstrate functional recovery after a significant decrease in acute symptoms (Huxley & Baldessarini, 2007; Montoya et al., 2010; Tohen et al., 2000). Even when full syndromal remission is achieved, only about 50% of people with BD recover premorbid functionality (Montoya et al., 2010; Tohen et al., 2000). Disability rates in euthymic BD are similarly high (Gutierrez-Rojas, Jurado, & Gurpegui, 2011; Huxley & Baldessarini, 2007; Montoya et al.; Rosa et al., 2010; Tohen et al., 1990), indicating that acute symptoms are only partially responsible for functional impairment.

This failure to return to premorbid levels of functioning is especially concerning given that while normal psychosocial functioning prior to a first episode is possible (Reichenberg et al., 2002), premorbid functioning in BD tends to be below average (Rietschel et al., 2009; Cannon et al., 1997). A vulnerable premorbid baseline suggests that further decline in functioning after illness onset can result in the type of severe life-long disability often observed in BD.

The effects of disability in BD pervade all areas of functioning (Coryell et al., 1993; Elgie & Morselli, 2007; Pope et al., 2007; Sanchez-Moreno et al., 2009; Sanchez-Moreno et al., 2010). People with BD have more familial conflict and fewer enjoyable social interactions or leisure activities than people without psychiatric diagnoses (Bauwens, Tracy, Pardoen, Vander Elst, & Mendlewicz, 1991; Bauwens, Pardoen, Staner, Dramaix, & Mendlewicz, 1998; Elgie & Morselli, 2007; Sanchez-Moreno et al., 2009; Shapira et al., 1999). In a five-year study following the outcome of an acute mood episode, people with BD were only half as likely as

the general population to be married (Coryell et al., 1993). People suffering from BD report significantly more illness-related obstruction of their social lives, even in comparison to people with chronic medical conditions including rheumatoid arthritis and renal failure (Robb, Cooke, Devins, Young, & Joffe, 1997). These studies further suggest that the disruption to social adjustment and development in BD may extend beyond the direct effects of acute symptoms on social engagement.

Beyond the challenges to social adjustment, limited occupational functioning is also widespread in BD, including during euthymia (Bonnin et al., 2010; Burdick et al., 2010; Dickerson et al., 2010; Zimmerman et al., 2010). Despite studies reporting people with BD to have more years of college and more B.A. degrees than is average in the general population of the U.S. (Kupfer et al., 2002), they demonstrate a much higher degree of unemployment, disability rates, workplace absenteeism, and other occupational impairments (Bowden, 2005; Latalova et al., 2011; Lloyd & Waghorn, 2007; McMorris et al., 2010; Reed, Goetz, Vieta, Bassi, & Haro, 2010; Rosa et al., 2010; Sanchez-Moreno et al., 2009). On average, about 60% of people with BD who are in syndromal remission and have either some college education or a college degree, are unemployed (compared to the average of 6% in the general population), and up to 88% suffer from reduced occupational functioning (Bearden et al., 2011; Elgie & Morselli, 2007; Hirschfeld, Lewis, & Vornick, 2003; Huxley & Baldessarini, 2007; Kessler et al., 2006). These studies indicate that in BD education and competency show much weaker correlations with professional or vocational development than expected in the general population.

Occupational impairment in BD is likely related to the difficulties in maintaining consistent engagement at work. For example, people with BD miss an average of up to 65.5 workdays a year due to absenteeism and presenteeism for illness-related reasons – up to more than one day per week (Gardner et al., 2006; Kessler et al., 2006). These problems can result in placement of people with BD in less skilled, entry-level, poorly paid positions despite superior education and intellectual abilities. Such placement may then lead to greater work dissatisfaction, which has a negative impact on achieving longer-term vocational goals (Baldwin & Marcus, 2011; Tse & Walsh, 2001).

Although work difficulties and underemployment in BD may be attributed to the direct effects of the illness, it is also quite possible that an inhospitable work environment contributes to absenteeism and the tendency to employ people with BD in capacities below their skill level. There is some evidence that despite the therapeutic advancements in BD, psychosocial functioning in this population may be declining. In a 2000 replication (Hirschfeld et al., 2003) of the 1992 National Depressive & Manic-Depressive Association survey (Lish, Dime-Meenan, Whybrow, Price, & Hirschfeld, 1994), people with BD reported that their illness had a more severe impact on their social, occupational and overall functioning than it had in 1992. These studies specifically indicated that rates of unemployment, underemployment and disability in BD had risen (Hirschfeld et al., 2003) during a period in which the stigmatization of people with mental illness (MI) also increased (Corrigan, Roe, & Tsang, 2011; Mehta, Kassam, Leese, Butler, & Thornicroft, 2009). Functional decline in the face of therapeutic progress suggests the presence of potentially important undetected factors that contribute to psychosocial disability in BD. Some of these factors may be external to the treated person, such as those related to social barriers rooted in discrimination.

3. Predictors of psychosocial functioning in BD

A volume of longitudinal studies has identified several predictors of poor psychosocial adjustment in BD. A more severe illness history – including a younger age at onset (Hays, Krishnan, George, & Blazer, 1998) and a greater number of mood episodes (MacQueen et al., 2000) and psychiatric hospitalizations (Altshuler et al., 2007) – yields reduced functioning even during euthymia (Martinez-Aran et al., 2004; Zubieta, Huguelet, O'Neil, & Giordani, 2001). In addition, common comorbidities of BD, such as anxiety (Boylan et al., 2004; Kauer-Sant Anna et al., 2007) and substance use disorders (SUD; Jaworski et al., 2011; Lagerberg et al., 2010), disrupt identity development (Michalak et al., 2011), increase symptoms and social avoidance (Jaworski et al., 2011; Otto et al., 2006), interfere with interpersonal engagement (Elgie & Morselli, 2007), exacerbate cognitive impairment (Latvala et al., 2009; Levy & Weiss, 2009; Silva & Leite, 2000), and generally reduce functioning (Goldstein & Levitt, 2008; Sanchez-Moreno et al., 2009). Finally, emotion dysregulation, sleep disturbances, and an elevated rate of medical comorbidities all predict reduced psychosocial functioning in BD (M.L. Phillips, Ladouceur, & Drevets, 2008 (Deckersbach, T., Hölzel, B. K., Eisner, L. R., Stange, J. P., Peckham, A. D., Dougherty, D. D., Nierenberg, A. A., 2011).

In euthymic BD, two of the strongest predictors of social and occupational functioning are subsyndromal depressive symptoms and cognitive impairment (Bearden et al., 2011; Bonnin et al., 2010; Dickerson et al., 2010; Martínez-Arán et al., 2011; Martino et al., 2009; Tabares-Seisdedos et al., 2008). Even very mild subsyndromal depression leads to reduced functioning including poorer vocational performance (Bearden et al., 2011; Gitlin, Mintz, Sokolski, Hammen, & Altshuler, 2010). Likewise, cognitive deficits (notably in verbal memory, processing speed and executive functioning) are significantly associated with worse social and occupational functioning (Bearden et al., 2011; Dickerson et al., 2010).

These findings focused current efforts for improving psychosocial functioning in BD on reducing subsyndromal depressive symptoms (M. Bauer et al., 2009) and cognitive dysfunction (Bearden et al., 2011; Deckersbach et al., 2010; Martínez-Arán et al., 2011), as well as enhancing stress management and interpersonal skills (Frank et al., 2000; Martínez-Arán et al., 2011). The bulk of this research emphasizes pharmacological interventions (Nivoli et al., 2011), followed by psychosocial treatments, such as psychotherapy (Ball et al., 2006; Hollon & Ponniah, 2010; Miklowitz, George, Richards, Simoneau, & Suddath, 2003; Miklowitz et al., 2008) and psychoeducation (Colom et al., 2009), as well as cognitive (Deckersbach et al., 2010) and functional remediation (Martínez-Arán et al., 2011). More broadly, the current overall approach to improving psychosocial adjustment in BD focuses on changing internal factors, with less consideration given to reducing environmental barriers to functioning.

The view that functioning can be fully restored in BD by treating internal factors such as depressive symptoms and cognitive dysfunction may be restrictive. Even if all internal factors that predict lower functioning were identified and successfully treated, people with BD may still not achieve functional recovery due to environmental influences that include level of expressed emotion (i.e., criticism or stigmatization of person with BD) in families (Elgie & Morselli, 2007; McMurrich & Johnson, 2009), stigma (Michalak et al., 2011; Perlick et

al., 2001; Vazquez et al., 2011), discrimination (Corrigan et al., 2004; Elgie & Morselli, 2007; Michalak et al., 2007; Tse & Yeats, 2002), and lack of social support (Elgie & Morselli, 2007; Michalak, Yatham, Kolesar, & Lam, 2006; Michalak et al., 2011).

This notion is consistent with qualitative studies showing people with BD describing stigma, discrimination, reduction in social (especially family) support, shame and identity loss as the greatest challenges they face in dealing with their illness and functional recovery (Elgie & Morselli, 2007; Michalak et al., 2006; Michalak et al., 2007; Michalak et al., 2011; Proudfoot et al., 2009). People with BD describe social validation and support as the most important components that determine their quality of life (QOL; Michalak et al., 2006; Michalak et al., 2007; Michalak et al., 2011). In fact, many people with BD consider social inclusion to be more important than symptom resolution or clinical remission (Michalak et al., 2006).

Given the importance of social inclusion to recovery in BD, as well as the role of stigma in reducing treatment seeking and adherence (Berk et al., 2010; N. Rusch, Corrigan, Wassel, et al., 2009), a more effective investment in treatment may involve a distribution of resources that extends to both sides of the psychosocial equation. Improving functioning in BD may require the simultaneous development and implementation of interventions that target both internal consumer characteristics and external societal barriers to functioning.

4. The stigma of mental illness

"Stigma" comes from a sixteenth-century Greek word meaning a mark that was branded or tattooed onto people to denote a devalued social status – for example, that of a criminal or a slave (Hinshaw, 2007). Likewise, in most countries, MI is associated with harmful social devaluation (Brohan, Gauci, Sartorius, & Thornicroft, 2011). In the U.S., both the Surgeon General and the Department of Defense have identified current stigma against people with MI as one of the most serious barriers to the nation's mental health (Department of Defense Task Force on Mental Health, 2007; Surgeon General, 1999). There is also evidence that stigma against people with MI has grown since 1950, despite greater scientific insights into the phenomenon of MI and the relatively widespread acceptance of these insights by the public (Australian Journal of Pharmacy, 2011; Corrigan & Wassel, 2008; Corrigan et al., 2011; Mehta et al., 2009; Pescosolido, Martin, Lang, & Olafsdottir, 2008; Silton, Flannelly, Milstein, & Vaaler, 2011; Star, 1952, 1955). Recent surveys finding an upward trend in stigmatizing people with MI have inspired large-scale investigations of this stigma and its consequences.

The scientific inquiry into stigma and related constructs, however, is quite complex. While the word "stigma" has grown to be colloquially associated with prejudicial attitudes and discriminatory conduct, it remains a challenging construct to isolate, define and measure for the purpose of scientific research (Corrigan et al., 2011; B. G. Link, Yang, Phelan, & Collins, 2004). Despite these challenges, stigma instruments have been developed and validated for use with people who suffer from depression (Gabriel & Violato, 2010; Interian et al., 2010; Kanter, Rusch, & Brondino, 2008), psychotic disorders (B. G. Link et al., 2004), and SUD (Luoma, O'Hair, Kohlenberg, Hayes, & Fletcher, 2010). In BD, important progress in this area has been made with the development of qualitative literature describing widespread consumer experiences of stigma (Michalak et al., 2006; Michalak et al., 2011; Proudfoot et al., 2009).

Theoretical progress in stigma research has advanced several models that describe its impact on people with MI (Corrigan, 2004; Goffman, 1963; Jones et al., 1984; B. G. Link, Mirotznik, & Cullen, 1991). In the last fifteen years, research has generally converged to support a cognitive-behavioral model of stigma's operation (Corrigan et al., 2011; Crocker, Major, & Steele, 1998; Goffman, 1963; Jones et al., 1984; B. G. Link et al., 1991).

According to the model delineated by Corrigan and colleagues (Corrigan, 2004; Corrigan & Wassel, 2008), stigma is a contextual and relational psychosocial phenomenon whose impact on people suffering from MI can be described using three primary constructs: structural, or institutional, stigma (macro level), public, or enacted, stigma (meso level), and internalized, or self, stigma (micro level) (Corrigan, 2004). This model also describes a fourth construct known as perceived stigma that refers to an individual's perception of structural and public stigma (Corrigan & Watson, 2002).

4.1 Structural stigma

Institutional or structural stigma includes policies and practices of private and governmental institutions that intentionally or unintentionally restrict rights or limit opportunities for people with MI (Corrigan et al., 2004; Corrigan & Wassel, 2008; Michalak et al., 2011). Laws that directly restrict the rights of people with MI are examples of intentional structural discrimination that inhibits functioning (Corrigan et al., 2004; Corrigan, Watson, Heyrman, et al., 2005). In the private sector, lack of equal insurance coverage for mental health treatment (compared to non-psychiatric treatment) and the increasingly negative portrayals of MI in the media are both examples of intentional structural stigma (Corrigan et al., 2004). An example of unintentional structural stigma includes workplace rules that do not allow for scheduling flexibility (even in the absence of a clear need for rigid schedules) such that a person with BD's need for maintenance treatment appointments during business hours is not accommodated (Schultz et al., 2011; Michalak et al., 2007).

In the U.S., private and public institutions play critical roles in perpetuating stigma against people with MI across multiple domains (Krupa, Kirsh, Cockburn, & Gewurtz, 2009; Krupa, 2011a, 2011b). In the legal realm, the Americans with Disabilities Act (Americans with Disabilities Act, 1990) and Fair Housing Act (Fair Housing Amendments Act, 1988) have largely failed to protect people with MI, as indicated by judicial rulings over many years that greatly favored employers (Petrila, 2009) and landlords (Carter, 2010; Swanson, Burris, Moss, Ullman, & Ranney, 2006). In the area of health care, current government policies allow extensive discrimination against people with MI by health insurance companies (Boyd et al., 2011), fail to support deinstitutionalization of psychiatric patients with adequate community alternatives (Corrigan, Watson, Gracia, et al., 2005; Heginbotham, 1998; Phelan & Link, 1998), and provide insufficient funding for effective dissemination of evidence-based psychiatric practices (McHugh, K.R., & Barlow, D.H., 2010). With respect to civil rights, people with MI experience restrictions in obtaining firearms, voting, holding elective office, serving on juries, or gaining full parental rights over their children (Burton, 1990; Corrigan, Watson, Heyrman, et al., 2005; Hemmens, Miller, Burton, & Milner, 2002). People with MI also suffer a great deal of harm from the media (Corrigan, Watson, Gracia, et al., 2005). Currently, the government provides only limited support for anti-MI-discrimination campaigns, and allows the national media to portray people with MI as violent and immoral without penalty (Corrigan, Watson, Gracia, et al., 2005; Corrigan et al., 2011; Heginbotham,

1998; Krupa et al., 2009; Phelan & Link, 1998). Finally, even Social Security Administration (SSA) disability benefits may be structured in a way that incentivizes disability rather than rehabilitation for people who suffer from MI (Drake, Skinner, Bond, & Goldman, 2009; Elinson, Houck, & Pincus, 2007). All of these forms of structural stigma may compromise the psychosocial adjustment of people with MI, beyond the functional limitations imposed by psychiatric symptoms.

4.2 Public stigma

Public stigma operates at the level of interpersonal interactions through a three-part cognitive-behavioral process (Corrigan et al., 2011). First, contextual cues known as "marks" associated with a given person signal to a perceiver (who is in a position of power via the marked person) that a larger group stereotype may be a relevant cognitive response to the marked person. Second, a stereotype is invoked as a cognitive short-cut to allow the perceiver to quickly access a summary of characteristics of that larger group. Finally, the perceiver responds with behavior based on the assumption that these stereotypical group characteristics are true with respect to the marked person (Corrigan, 2004; Corrigan & Wassel, 2008; B. G. Link et al., 2004; Pescosolido et al., 2008).

In this context, the term "prejudice" refers to the adoption of a stereotype as truth with respect to individual members of a stigmatized group, as in step two of the model (Pescosolido et al., 2008). "Discrimination" is defined as a behavior resulting from prejudice that negatively impacts members of the stigmatized group, or step three in the model (Corrigan, 2004 (*American Psychologist*)). The three most common relevant stereotypes found in research literature are that people with MI are dangerous and incompetent, as well as blameworthy with respect to their illness (Corrigan & Wassel, 2008).

The four major categories of cues or "marks" that trigger the use of MI stereotypes are labels, psychiatric symptoms, social skill deficits, and physical appearance (Corrigan, 2004). Several studies demonstrated that a person labeled mentally ill is likely to face prejudiced and discriminatory responses even in the absence of visible psychiatric symptoms or atypical behavior (Link, Cullen, Frank, & Wozniak, 1987; Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999; Martinez at al., 2011). Additional studies have found that even if a potential stigmatizer or stigmatized person does not endorse negative societal stereotypes of people with MI, either party's knowledge of these stereotypes may increase anxiety and discomfort during an interaction (Hinshaw, 2007; B. G. Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001). This discomfort, in turn, may raise anxiety levels and future interactional avoidance for people with MI, even when they are not aware that the other party has knowledge of their illness (Hinshaw, 2007). Thus, the pervasive and harmful nature of public stigma can negatively impact interpersonal relationships even in the absence of individual prejudice.

4.3 Perceived and internalized stigma

Perceived stigma refers to the degree to which a person with MI is aware of structural and public stigma, whether through personal experience, the media, or other means (Corrigan & Wassel, 2008; Livingston & Boyd, 2010). Perceived stigma describes people's awareness that stigma exists, but not their reaction to it, and is thus deemed a separate construct from

internalized stigma (Livingston & Boyd, 2010; N. Rusch, Corrigan, Wassel, et al., 2009; N. Rusch, Todd, Bodenhausen, Olschewski, & Corrigan, 2010). Internalized stigma is broadly defined by feelings of shame, self-criticism, identity changes and maladaptive (most notably avoidant) behavior that may develop in response to perceived stigma (Brohan et al., 2011; Corrigan & Wassel, 2008; Livingston & Boyd, 2010; Manos, Rusch, Kanter, & Clifford, 2009; Michalak et al., 2011; N. Rusch, Lieb, Bohus, & Corrigan, 2006).

5. The impact of stigma on psychosocial functioning in BD

These four forms of stigma – structural, public, perceived and internalized – interact with each other in complex ways to decrease psychosocial functioning in BD. Understanding their individual and combined contributions to these negative outcomes among people with BD is a vital step towards promoting functional adjustment in this population.

On a macro level, structural stigma probably affects functioning in BD through the same mechanisms that limit psychosocial adjustment in MI more generally. In the absence of institutional protection, funding and support, structural stigma directly circumscribes the opportunities of people with BD to improve their clinical, social and vocational functioning (Baldwin & Marcus, 2011; Boyd et al., 2011; Corrigan, Watson, Heyrman, et al., 2005; Krupa, 2007; Michalak et al., 2007; Michalak et al., 2011). Thus, people with BD may struggle to function in part because they attempt to negotiate a social environment that is not designed to accommodate their limitations (e.g. cognitive impairment) and special needs (e.g. flexible work schedules and occupational supports), and thus deprives them of opportunities that are available to others.

On the meso level, people with BD encounter functional challenges that emanate from public discrimination. Studies suggest that public stigma against people with BD is prevalent and intense (Australian Journal of Pharmacy, 2011). A 2004 survey of 1200 American adults by the Depression and Bipolar Support Alliance (DBSA) found that a large number of respondents reported serious doubts about the ability of people with BD to keep responsible jobs, hold public office, and maintain positive relationships (Depression and Bipolar Support Alliance, 2008). Employers reported particular concerns as to the potential effects of emotional instability and atypical behavior on clients and co-workers, in addition to absenteeism, poor work performance, and an inability to tolerate stress (Schultz, Milner, Hanson, & Winter, 2011). People with BD therefore appear to suffer unemployment at least partly because employers refuse to hire or retain them (Michalak et al., 2007; Michalak et al., 2011). This notion is consistent with research findings in BD and MI generally indicating that stigma-related constructs are stronger predictors of employment outcomes than diagnosis, employment history or symptoms (Baldwin & Marcus, 2011; Krupa, 2011b; Larson et al., 2011; Michalak et al., 2007; Tse & Walsh, 2001; Tse, 2002; Tse & Yeats, 2002). Unemployment and underemployment in BD therefore may not emanate solely or even primarily from the limiting effects of psychiatric symptoms. Instead, occupational difficulties in BD may be compounded to a considerable degree by social barriers rooted in stigma and discrimination.

Public stigma may also hinder psychosocial adjustment in BD within the close family circle. There is evidence that "expressed emotion" – which consists of emotional over-involvement, as well as hostile, critical, and blaming attitudes of a family toward its members with MI –

is high in families of people with BD (McMurrich & Johnson, 2009). Studies further show that expressed emotion predicts depression and relapse in people with BD (Eisner & Johnson, 2008; McMurrich & Johnson, 2009), which independently correlate with each other and with poor overall functional outcomes (M. Bauer et al., 2009; Bonnin et al., 2010). Conversely, greater social support predicts better social (Perlick et al., 2001) and occupational adjustment in BD (Gutierrez-Rojas et al., 2011). Changes in public stigma within the family therefore may help to improve psychosocial adjustment in BD.

On a micro level, studies consistently show that people with BD suffer from high levels of perceived and internalized stigma (Brohan et al., 2011). Research indicates that many people with BD report experiencing shame about their diagnosis (Michalak et al., 2011) as well as illness-related social and occupational rejection or exclusion (Michalak et al., 2006; Michalak et al., 2007; Michalak et al., 2011; Proudfoot et al., 2009; Ward, 2011).

Both internalized and perceived stigma have been shown to be associated with functional outcome in BD (Brohan et al., 2011; Vasquez et al., 2011). The presence of significant internalized stigma is associated with reduced self-esteem, and lower self-efficacy (Brohan et al., 2011). Internalized stigma is also related to an overall reduction in QOL (Alonso et al., 2009; Brohan et al., 2011), delayed treatment seeking, poor treatment adherence, and greater depressive symptoms (Brohan et al., 2011; Sirey et al., 2001).

Micro-level stigma may play an important role in the mechanisms that decrease psychosocial functioning in BD. As qualitative findings imply, perceived and internalized stigma evoke marked distress in people with a BD diagnosis (Michalak et al., 2006; Michalak et al., 2011; Ward, 2011). More specifically, recent studies found that heightened stress from stigma was associated with increased social anxiety and shame (N. Rusch, Corrigan, Powell, et al., 2009). While anxiety has been shown to predict worse outcomes in BD (Boylan et al., 2004), shame predicts depression, avoidance and psychopathology generally (Andrews, Qian, & Valentine, 2002; Highfield, Markham, Skinner, & Neal, 2010; J.P. Tangney, 1995), which also decrease functional adjustment.

The automatic nature of internalized stigma makes it particularly destructive. There is evidence that the primary response to stigma is an involuntary aversive emotional experience rather than a conscious cognitive reaction (N. Rusch, Corrigan, Powell, et al., 2009). Thus, the impact of internalized stigma on functional adjustment in BD may operate primarily through the mediating factors of shame and social anxiety (Andrews et al., 2002; Brohan et al., 2011; Cheung, Gilbert, & Irons, 2004; B. Link et al., 1987; B. G. Link, 1987; Michalak et al., 2011; Vazquez et al., 2011), rather than through maladaptive cognitions such as endorsed stereotypes (N. Rusch et al., 2010; N. Rusch, Corrigan, Todd, & Bodenhausen, 2011). Shame, avoidance, social isolation and depressive symptoms all contribute to lower QOL in BD and heightened risk of relapse (Cohen et al., 2004; Bonnin et al., 2010; Michalak et al., 2011; Perlick et al., 2001). Collectively, these stigma-related factors probably decrease psychosocial development in BD.

In broader conceptualization, it may be useful to understand the debilitating roles that shame and social anxiety play in stigma's operation across its various levels. More specifically, the different levels of stigma are probably looped together in detrimental ways that exacerbate their individual effects. In this respect, insight into the connection between public and internalized stigma might be particularly informative, with the leading

hypothesis being that public stigma and discrimination often create internalized stigma, which manifests as shame and social anxiety.

In support of this line of reasoning, shame and social anxiety are known as key outcomes of social devaluation by the public (L. C. Rusch, Kanter, Angelone, & Ridley, 2008; N. Rusch, Corrigan, Powell, et al., 2009; N. Rusch et al., 2010). These emotions may be triggered when people perceive themselves to be at risk of social exclusion due to not meeting societal norms or losing social rank (Cheung et al., 2004; Gilbert & Procter, 2006). Further, ongoing criticism or stigmatization of a person may result in the internalization of these devaluations as trait or internal shame, key elements of which are chronic self-invalidation, self-criticism and self-blame (Cheung et al., 2004; Gilbert, 1992, 2002; Gilbert & Procter, 2006; Gilbert et al., 2010; Miklowitz & Johnson, 2009). Trait shame is strongly associated with avoidance (J. P. Tangney & Dearing, 2002) and social anxiety (Gilbert & Irons, 2004), and all three are known as core emotional and behavioral components of internalized stigma (Birchwood et al., 2007; Perlick et al., 2001; N. Rusch et al., 2006; N. Rusch et al., 2010). Internalized stigma therefore may emerge as a function of public stigma (Livingston & Boyd, 2010; Schneider, Beeley, & Repper, 2011) in a manner that compromises psychosocial adjustment (Brohan et al., 2011; Vasquez et al., 2011). Interventions aimed at improving psychosocial functioning in BD thus need to address all levels of stigma to be effective.

6. Implications for care

The conventional approach to improving functional adjustment in BD focuses primarily on pharmacological interventions to decrease symptoms (Balanza-Martinez et al., 2010). These efforts have been traditionally supported by psychosocial treatments that are designed to increase practical knowledge about the illness and its management (e.g., group psychoeducation; Colom et al., 2009), as well as to improve interpersonal and coping skills (Frank et al., 2005). Although studies support the efficacy of these interventions, they are clearly insufficient in fully addressing the problem of psychosocial impairment in BD. Further improvement to functional outcome in BD may therefore come from addressing factors such as stigma and discrimination that originate in the larger social milieu rather than within the individual consumer.

6.1 Bringing about structural changes

On a structural level, treatment providers and mental health care administrators need to advocate for affirmative litigation, proper funding of services, effective dissemination of evidence-based practices, and incentives for work that do not, in the near term, jeopardize the financial support and stability derived from maintaining disability status. These efforts may reduce discrimination in housing and employment. They may also equalize health insurance coverage and access to care for people with BD compared to those with non-psychiatric diagnoses. People with BD need major structural changes in the larger social context to create environments that accommodate their special needs. The absence of these changes currently limits their ability to participate in mainstream social functions.

Accommodations in the workplace should rank high in priorities for reform, due to the pernicious effects of stigma on employment in BD, and the drastic effects of unemployment on mental and physical health generally (Bambra, 2010; Bowden, 2005; Bush, Drake, Xie,

McHugo, & Haslett, 2009 Michalak et al., 2007). Qualitative studies (Michalak et al., 2007; Tse & Yeats, 2002) indicate that augmenting employment in BD requires interventions in four key areas: illness management, social support, and employer-employee relations, as well as in combating broader societal barriers such as stigma and disincentives to working embedded in disability regulations (Elinson et al., 2007; Tse & Yeats, 2002). Evidence-based supported employment (SE) programs that include early intervention after diagnosis, integrated clinical care and vocational services (Cook et al., 2005; Cook et al., 2008), training in goal-setting, cognitive and social skills (Arbesman & Logsdon, 2011; Cook, 2006; Cook et al., 2008; Krupa, 2007; Krupa et al., 2009), a collaborative and individualized approach to rapid employment placement without lengthy pre-placement training, and especially, high-intensity on-the-job support of unlimited duration (G. R. Bond & Kukla, 2011; Cook et al., 2005; Evans & Bond, 2008; McHugo, Drake, & Becker, 1998), address the first three of these areas.

SE programs have been found to be highly effective in improving employment outcomes for people with severe MI, including BD (Arbesman & Logsdon, 2011; Tse & Yeats, 2002). Importantly, as Tse & Yeats (2002) note, the absence of time limits in SE programs is likely critical in helping people with BD achieve their long-term vocational goals. People with BD may need to be guided from working in low-level positions as they initially adjust to employment, towards taking on increasingly challenging work or education over time (Drake et al., 2009; Tse & Yeats, 2002). From a broader structural viewpoint, a widespread implementation of supportive programs and workplace accommodations for people with BD will require affirmative litigation, adequate funding and a change in the social climate.

Beyond the wide-scale implementation of SE, further structural reforms that may increase employment in BD should address the process of shifting consumers from the protective service of disability benefits towards enrollment in SE programs. Even if SE programs were sufficiently funded and disseminated, a remaining obstacle to this shift involves SSA disability benefits recipients' concerns about the loss of income and health insurance benefits in the short and long-term were they to begin working (Drake et al., 2009; Elinson et al., 2007; Tse & Yeats, 2002). In 2011, SSA disability beneficiaries face powerful disincentives to employment as, after a brief trial work period, they risk losing their cash benefits immediately and public health insurance several months thereafter, if they gross over 1000 dollars per month (Drake et al., 2009; Elinson et al., 2007). Not surprisingly, in BD, very few employed people receive disability benefits, and most experience reduced health insurance coverage and access to mental health care compared to those receiving benefits (Elinson et al., 2007).

The vocational reform under discussion is guided by the notion that BD is a form of major mental illness, with recurrent mood and/or psychotic episodes that periodically preclude continuous attendance at work. The instability that inheres in this condition necessitates external supports to assure even minimal long-term financial security. In the absence of such security, the decision to forego the benefits of disability for employment opportunities seems unreasonably risky. For this reason, allowing people with BD to reap the health and economic benefits of employment while reducing the tremendous cost to the nation of lost productivity due to BD, requires a structural mechanism that ensures consumers larger rewards from working without the risk of losing financial security due to relapse.

6.2 Reducing public stigma

Attenuating the detrimental effects of public stigma may also be important for improving functional adjustment in BD. In this regard, there is evidence that family-focused therapy (FFT; Miklowitz et al., 2003), which aims to mitigate expressed emotion and augment social support from family members, can be highly beneficial. Studies suggest that FFT improves clinical outcomes in BD even over long periods of time (Rea et al., 2003), including by delaying time to relapse and lessening residual symptoms (Miklowitz et al., 2003), which are highly correlated with functional adjustment (M. Bauer et al., 2009).

While the focus on family members is essential, the efforts to reduce the ill effects of public stigma should also include larger social circles. In this realm, advocates have traditionally supported the use of protests (Corrigan et al., 2011), anti-stigma mass media campaigns (Schneider et al., 2011), and educational programs that contradict negative stereotypes (Corrigan et al., 2011). However, there is no evidence that these interventions lead to lasting reductions in stigma, and they sometimes may have opposite effects (Corrigan & Wassel, 2008; Masuda, Hayes, et al., 2009). As with internalized stigma, the stigmatization of people with MI by others appears to be an automatic emotional process occurring outside awareness, which then triggers stereotypical cognitions (N. Rusch et al., 2011). Further efforts to alter or suppress these unwanted cognitions often paradoxically result in reinforcing them (Masuda, Hayes, et al., 2009). Thus, educational interventions that aim to decrease the frequency of stereotypical cognitions without addressing the underlying emotional process that produces stigma, may in fact trigger an intensified emotional reaction of heightened stigma. This reaction may then unintentionally increase the occurrence of stereotypical thoughts (Masuda, Hayes, et al., 2009; Masuda, Price, Anderson, Schmertz, & Calamaras, 2009). The same type of resistance to change was observed in educational interventions aimed at altering racial prejudice (McKown, 2005; Paluck & Green, 2009). At the same time, extensive research in social psychology has developed models and programs involving advocacy and education to combat public stigmatization of historically oppressed groups that have had some success (Buhin & Vera, 2009). These models may inform the development of interventions to reduce public stigma in BD.

Models that come from the field of clinical psychology may also be helpful in reducing public stigma. There is some evidence that mindfulness-based interventions can decrease the stigmatizing of people with MI by college students (Masuda, Hayes, et al., 2009). In this study, after an acceptance and commitment therapy (ACT) intervention of only 2.5 hours, stigmatization of MI was reduced even at a one-month follow-up, compared to an educational control intervention. Mindfulness-based interventions may be practical to implement in educational settings, as part of a curriculum that aims to promote social justice.

6.3 Individual counseling

Addressing the broader social context of stigma, with its structural and public components, should be accompanied by counseling methods that reduce the effects of stigma at an individual level. One potentially useful approach to alleviating the shame, social anxiety and avoidance that result from stigma in BD may be based on mindfulness- (Luoma, Kohlenberg, Hayes, Bunting, & Rye, 2008) and compassion-focused (Gilbert & Procter, 2006) therapies. Mindfulness-based interventions increase nonjudgmental awareness and acceptance of thoughts and feelings, which allow people to better regulate these internal

experiences (Luoma et al., 2008). Thus, these therapies may be suitable for decreasing the chronic, automatic self-criticism that emanates from internalized stigma and impedes functioning (Gilbert et al., 2010). Some studies show that mindfulness-based cognitive therapy (MBCT; Weber et al., 2010; Williams et al., 2008) raised levels of treatment adherence while diminishing stress, anxiety, depression and relapse in BD, all of which improved functioning (Bonvalot et al., 2010; Miklowitz & Johnson, 2009; Richardson, 2010). ACT has been found to diminish internalized stigma in SUD, a common comorbidity of BD (Luoma et al., 2008), warranting research to examine the effects of this intervention on stigma-related thoughts and feelings in BD.

Recent research also points to the potential usefulness of compassion-focused therapy (CFT; Gilbert & Procter, 2006; Highfield et al., 2010) in improving functioning in BD. CFT trains people in countering chronic self-criticism by practicing self-compassion (Gilbert & Procter, 2006). Studies show that CFT can promote self-soothing and decrease shame, social anxiety, depression and self-criticism in personality as well as mood disorders (Gilbert & Procter, 2006; Pauley & McPherson, 2010; Van Dam, Sheppard, Forsyth, & Earleywine, 2010). In BD, it may also promote affect regulation (Galvez et al., 2011; Gruber et al., 2009; Lowens, 2010). Given CFT's potential to diminish shame and self-criticism, future research may therefore wish to examine the effects of CFT on internalized stigma in BD.

Use of empowerment-based interventions to counter internalized stigma also deserves consideration (Brohan et al., 2011; Corrigan et al., 2011). Broadly defined, empowerment refers to perceived and actual control over the central domains of life, such as personal security, financial stability, social networks, employment and health (Corrigan et al., 2011). To empower people with BD in the face of heavy internal and public stigma, treatment providers and researchers need to give greater weight and attention to consumer experiences including self-management strategies (Ilic et al., 2011), as well as to the potential use of consumer-led support services (Repper & Carter, 2011) and a strengths-based collaborative care treatment model (M. S. Bauer et al., 2006). While research on empowerment in BD remains scarce, Brohan et al. (2011) found that empowerment was negatively correlated with internalized stigma in BD. Empowerment interventions may therefore carry the potential to decrease the ill effects of stigma and improve functioning in BD.

Finally, psychoeducation for consumers with BD that explicitly acknowledges the realities of stigma and discrimination and helps consumers share experiences and improve strategies for navigating and coping with stigma, may serve a three-part function. First, such psychoeducation may reduce individual shame with respect to stigma by naming it as part of unjust systemic inequalities. Second, helping people with BD learn strategies for negotiating stigma may be of practical value to them. Third, such psychoeducational programs could provide a mechanism for people with BD who are managing their illness and related stigma successfully to impart their experiences to others with BD, in a way that empowers the community of people with BD as a whole. Such consumer-led psychoeducation and empowerment is taking place in some psychiatric rehabilitation programs, as well as in consumer support centers known as "recovery learning centers," that are being created in growing numbers. However, significantly increased resources must be devoted to the peer-led recovery movement if it going to play a dominant role in combating stigma and improving functioning in BD.

In sum, diminishing the effects of stigma on functioning in BD requires efforts on multiple levels. Treatment providers, researchers and mental health care administrators need to join with consumers and others in advocating for equality, support and accommodation in employment, housing and social opportunities, as well as in health insurance coverage for people with BD. To reduce public and internalized stigma, mindfulness- and compassion-based therapies might be considered along with more traditional empirically validated psychosocial interventions.

7. Conclusions

Tremendous advances in pharmacological and psychosocial treatments now allow many people with BD to achieve syndromal remission within two years of an acute episode, and sometimes much sooner (Huxley & Baldessarini, 2007; Tohen et al., 2000). However, the reduction in symptoms is often not accompanied by functional recovery (Montoya et al., 2010; Tohen et al., 2000). Given the limited ability of identified predictors of functioning in euthymic BD to account for the variance in functional outcomes, researchers have begun to look more closely at contextual factors that may restrict functioning. Stigma and discrimination have been identified as important contextual factors that contribute to psychosocial disability in BD (Vazquez et al., 2011).

Different forms of stigma interact with each other and the illness in a series of vicious cycles that push people with BD towards social and vocational marginalization (Brohan et al., 2011; Michalak et al., 2006, 2011; Vasquez et al., 2011). Reversing the impact of stigma on functioning in BD will likely require simultaneous interventions on multiple fronts. First, advocacy is needed to reform laws and regulations that restrict the rights and opportunities of people with BD. Second, funding is required for supported employment and social programs that empower them. Third, a major effort at reducing public stigma and discrimination against BD, both in the family and society at large, is required for developing the necessary social support and employment opportunities for psychosocial adjustment. Finally, counseling in BD needs to include methods for addressing stigma-related shame, self-criticism, social anxiety and avoidance, which carry detrimental clinical and psychosocial effects.

From a broad-based perspective, the presence of powerful societal barriers to functioning limits current efforts to improve functional outcomes in BD, which mostly focus on interventions that address internal factors. An inhospitable social climate hampers psychosocial development in ways that are unaffected by psychopharmacology or psychotherapy. For this reason, significant improvement to functioning in BD requires balancing investment into interventions aimed at removing societal barriers to functional adjustment and alleviating the ill effects of these barriers on the individual, with more traditional forms of treatment.

8. References

Alonso, J., Buron, A., Rojas-Farreras, S., de Graaf, R., Haro, J. M., de Girolamo, G., Vilagut, G. (2009). Perceived stigma among individuals with common mental disorders. *Journal of Affective Disorders, 118*(1-3), 180-186.

Altshuler, L., Tekell, J., Biswas, K., Kilbourne, A. M., Evans, D., Tang, D., & Bauer, M. S. (2007). Executive function and employment status among veterans with bipolar disorder. *Psychiatric Services, 58*(11), 1441.

Americans with Disabilities Act of 1990, 42 U.S.C.A. §§ 12101 (1990) *et seq.* (West 1993).

Andrews, B., Qian, M., & Valentine, J. D. (2002). Predicting depressive symptoms with a new measure of shame: The Experience of Shame Scale. *British Journal of Clinical Psychology, 41*(Pt 1), 29-42.

Arbesman, M., & Logsdon, D. W. (2011). Occupational therapy interventions for employment and education for adults with serious mental illness: A systematic review. *American Journal of Occupational Therapy, 65*, 238-246.

Australian Journal of Pharmacy. (2011). Practice updates: Rising misconceptions about mental illness. *AJP: The Australian Journal of Pharmacy, 92*(1091), 29.

Balanza-Martinez, V., Selva, G., Martinez-Aran, A., Prickaerts, J., Salazar, J., Gonzalez-Pinto, A., Tabares-Seisdedos, R. (2010). Neurocognition in bipolar disorders -- A closer look at comorbidities and medications. *European Journal of Pharmacology, 626*(1), 87-96.

Baldwin, M. L., & Marcus, S. C. (2011). Stigma, discrimination, and employment outcomes among persons with mental health disabilities. In I. Z. Schultz & E. S. Rogers (Eds.), *Work accommodation and retention in mental health* (pp. 53-69). New York: Springer Science+Business Media.

Ball, J. R., Mitchell, P. B., Corry, J. C., Skillecorn, A., Smith, M., & Malhi, G. S. (2006). A randomized controlled trial of cognitive therapy for bipolar disorder: Focus on long-term change. *Journal of Clinical Psychiatry, 67*(2), 277-286.

Bambra, C. (2010) 'Yesterday once more? unemployment and health in the 21st century.', *Journal of epidemiology and community health, 64*, 213-215.

Bauer, M., Glenn, T., Grof, P., Rasgon, N. L., Marsh, W., Sagduyu, K., Whybrow, P. C. (2009). Frequency of subsyndromal symptoms and employment status in patients with bipolar disorder. *Social Psychiatry and Psychiatric Epidemiology, 44*(7), 515-522.

Bauer, M. S., McBride, L., Williford, W. O., Glick, H., Kinosian, B., Altshuler, L., Sajatovic, M. (2006). Collaborative care for bipolar disorder: Part I. Intervention and implementation in a randomized effectiveness trial. *Psychiatric Services, 57*(7), 927-936.

Bauwens, F., Tracy, A., Pardoen, D., Vander Elst, M., & Mendlewicz, J. (1991). Social adjustment of remitted bipolar and unipolar out-patients. A comparison with age- and sex-matched controls. *The British Journal of Psychiatry, 159*(2), 239.

Bauwens, F., Pardoen, D., Staner, L., Dramaix, M., & Mendlewicz, J. (1998). Social adjustment and the course of affective illness: A one year controlled longitudinal study involving bipolar and unipolar outpatients. *Depression and Anxiety, 8*(2), 50-57.

Bearden, C. E., Shih, V. H., Green, M. F., Gitlin, M., Sokolski, K. N., Levander, E., Altshuler, L. L. (2011). The impact of neurocognitive impairment on occupational recovery of clinically stable patients with bipolar disorder: A prospective study. *Bipolar Disorders, 13*(4), 323-333.

Berk, L., Hallam, K. T., Colom, F., Vieta, E., Hasty, M., Macneil, C., & Berk, M. (2010). Enhancing medication adherence in patients with bipolar disorder. *Human Psychopharmacology, 25*(1), 1-16.

Birchwood, M., Trower, P., Brunet, K., Gilbert, P., Iqbal, Z., & Jackson, C. (2007). Social anxiety and the shame of psychosis: A study in first episode psychosis. *Behaviour Research and Therapy, 45*(5), 1025-1037.

Bond, G. R., Xie, H., & Drake, R. E. (2007). Can SSDI and SSI beneficiaries with mental illness benefit from evidence-based supported employment? *Psychiatric Services, 58*(11), 1412.

Bond, G. R., & Kukla, M. (2011). Impact of follow-along support on job tenure in the individual placement and support model. *Journal of Nervous and Mental Disorders, 199*(3), 150-155.

Bonnin, C. M., Martinez-Aran, A., Torrent, C., Pacchiarotti, I., Rosa, A. R., Franco, C., Vieta, E. (2010). Clinical and neurocognitive predictors of functional outcome in bipolar euthymic patients: A long-term, follow-up study. *Journal of Affective Disorders, 121*(1-2), 156-160.

Bonvalot, T., Placines, B., Bouché, C., Le Moigne, L., Boldi, I., Millet, B., & Thym, B. (2010). P01-13 - The bipolar patients observance and participation in cognitive behavioral therapy groups tend to be improved through mindfulness meditation. *European Psychiatry, 25*(Suppl 1), 232-233.

Bowden, C. L. (2005). Bipolar disorder and work loss. *The American Journal of Managed Care, 11*(3 Suppl), S91-94.

Boyd, J. W., Linsenmeyer, A., Woolhandler, S., Himmelstein, D. U., & Nardin, R. (2011). The crisis in mental health care: A preliminary study of access to psychiatric care in Boston. *Annals of Emergency Medicine, 58*(2), 218.

Boylan, K. R., Bieling, P. J., Marriott, M., Begin, H., Young, L. T., & MacQueen, G. M. (2004). Impact of comorbid anxiety disorders on outcome in a cohort of patients with bipolar disorder. *Journal of Clinical Psychiatry, 65*(8), 1106-1113.

Brohan, E., Gauci, D., Sartorius, N., & Thornicroft, G. (2011). Self-stigma, empowerment and perceived discrimination among people with bipolar disorder or depression in 13 European countries: The GAMIAN-Europe study. *Journal of Affective Disorders, 129*(1-3), 56-63.

Buhin, L., & Vera, E. M. (2009). Preventing racism and promoting social justice: Person-centered and environment-centered interventions. *Journal of Primary Prevention, 30*, 43-59.

Burdick, K. E., Goldberg, J. F., & Harrow, M. (2010). Neurocognitive dysfunction and psychosocial outcome in patients with bipolar I disorder at 15-year follow-up. *Acta Psychiatrica Scandinavica, 122*(6), 499-506.

Burton, V. S., Jr. (1990). The consequences of official labels: A research note on rights lost by the mentally ill, mentally incompetent, and convicted felons. *Community Mental Health Journal, 26*(3), 267-276.

Bush, P. W., Drake, R. E., Xie, H., McHugo, G. J., & Haslett, W. R. (2009). The long-term impact of employment on mental health service use and costs for persons with severe mental illness. *Psychiatric Services, 60*(8), 1024-1031.

Cannon, M., Jones, P., Gilvarry, C., Rifkin, L., McKenzie, K., Foerster, A., & Murray, R. (1997). Premorbid social functioning in schizophrenia and bipolar disorder: Similarities and differences. *American Journal of Psychiatry, 154*(11), 1544-1550.

Carter, M. P. (2010). How evictions from subsidized housing routinely violate the rights of persons with mental illness. *Northwestern Journal of Law and Social Policy, 5*, 118-148.

Caspi, A., Sugden, K., Moffitt, T. E., Taylor, A., Craig, I. W., Harrington, H., Poulton, R. (2003). Influence of life stress on depression: Moderation by a polymorphism in the 5-HTT gene. *Science, 301*(5631), 386-389.

Cheung, M., Gilbert, P., & Irons, C. (2004). An exploration of shame, social rank and rumination in relation to depression. *Personality and Individual Differences, 36*(5), 1143-1153.

Cohen, A. N., Hammen, C., Henry, R. M., & Daley, S. E. (2004). Effects of stress and social support on recurrence in bipolar disorder. *Journal of Affective Disorders, 82*(1), 143-147.

Colom, F., Vieta, E., Sanchez-Moreno, J., Palomino-Otiniano, R., Reinares, M., Goikolea, J. M., . . . Martinez-Aran, A. (2009). Group psychoeducation for stabilised bipolar disorders: 5-year outcome of a randomised clinical trial. *British Journal of Psychiatry, 194*(3), 260-265.

Cook, J. A., Lehman, A. F., Drake, R., McFarlane, W. R., Gold, P. B., Leff, H. S., Grey, D. D. (2005). Integration of psychiatric and vocational services: A multisite randomized, controlled trial of supported employment. *American Journal of Psychiatry, 162*, 1948-1956.

Cook, J. A. (2006). Employment barriers for persons with psychiatric disabilities: A report for the President's New Freedom Commission. *Psychiatric Services, 57*(10), 1391-1405.

Cook, J. A., Blyler, C. R., Leff, H. S., McFarlane, W. R., Goldberg, R. W., Gold, P. B., Razzano, L. A. (2008). The Employment Intervention Demonstration Program: Major findings and policy implications. *Psychiatric Rehabilitation Journal, 31*(4), 291-295.

Corrigan, P. W., & Watson, A. C. (2002). The paradox of self-stigma and mental illness. *Clinical Psychology: Science and Practice, 9*(1), 35-53.

Corrigan, P. W. (2004). How stigma interferes with mental health care. *American Psychologist, 59*(7), 614-625.

Corrigan, P. W., Markowitz, F. E., & Watson, A. C. (2004). Structural levels of mental illness stigma and discrimination. *Schizophrenia Bulletin, 30*(3), 481-491.

Corrigan, P. W., Watson, A. C., Gracia, G., Slopen, N., Rasinski, K., & Hall, L. L. (2005). Newspaper stories as measures of structural stigma. *Psychiatric Services, 56*(5), 551-556.

Corrigan, P. W., Watson, A. C., Heyrman, M. L., Warpinski, A., Gracia, G., Slopen, N., & Hall, L. L. (2005). Structural stigma in state legislation. *Psychiatric Services, 56*(5), 557-563.

Corrigan, P. W., & Wassel, A. (2008). Understanding and influencing the stigma of mental illness. *Journal of Psychosocial Nursing and Mental Health Services, 46*(1), 42-48.

Corrigan, P. W., Roe, D., & Tsang, H. W. (2011). *Challenging the stigma of mental illness: Lessons for therapists and advocates*. West Sussex, UK: John Wiley & Sons Ltd.

Coryell, W., Scheftner, W., Keller, M., Endicott, J., Maser, J., & Klerman, G. L. (1993). The enduring psychosocial consequences of mania and depression. *American Journal of Psychiatry, 150*(5), 720.

Crocker, J., Major, B., & Steele, C. (1998). Social stigma. In D. T. Gilbert, S. T. Fiske & G. Lindzey (Eds.), *Handbook of social psychology* (4th ed., pp. 504-553). Boston & New York: McGraw-Hill; Distributed exclusively by Oxford University Press.

Deckersbach, T., Hölzel, B. K., Eisner, L. R., Stange, J. P., Peckham, A. D., Dougherty, D. D., Nierenberg, A. A. (2011). Mindfulness-based cognitive therapy for non-remitted patients with bipolar isorder. *CNS Neuroscience & Therapeutics*, doi: 10.1111/j.1755-5949.2011.00236.x

Deckersbach, T., Nierenberg, A. A., Kessler, R., Lund, H. G., Ametrano, R. M., Sachs, G., Dougherty, D. (2010). RESEARCH: Cognitive rehabilitation for bipolar disorder: An open trial for employed patients with residual depressive symptoms. *CNS Neuroscience and Therapeutics, 16*(5), 298-307.

Denicoff, K. D., Ali, S. O., Mirsky, A. F., Smith-Jackson, E. E., Leverich, G. S., Duncan, C. C., Post, R. M. (1999). Relationship between prior course of illness and neuropsychological functioning in patients with bipolar disorder. *Journal of Affective Disorders, 56*(1), 67-73.

Department of Defense Task Force on Mental Health. (2007). *An achievable vision: Report of the Department of Defense Task Force on Mental Health*. Falls Church, VA: Defense Health Board.

Depression and Bipolar Support Alliance. (2008). Workplace Stigma & Bipolar Disorder: DBSA Speaks to ABC News Retrieved 5 September 2011, from http://www.dbsalliance.org/site/PageServer?pagename=media_eupdate0308_complete

Dickerson, F. B., Origoni, A., Stallings, C., Khushalani, S., Dickinson, D., & Medoff, D. (2010). Occupational status and social adjustment six months after hospitalization early in the course of bipolar disorder: A prospective study. *Bipolar Disorders, 12*(1), 10-20.

Drake, R. E., Skinner, J. S., Bond, G. R., & Goldman, H. H. (2009). Social security and mental illness: Reducing disability with supported employment. *Health Affairs, 28*(3), 761.

Eisner, L. R., & Johnson, S. L. (2008). An acceptance-based psychoeducation intervention to reduce expressed emotion in relatives of bipolar patients. *Behavior Therapy, 39*(4), 375-385.

Elgie, R., & Morselli, P. L. (2007). Social functioning in bipolar patients: The perception and perspective of patients, relatives and advocacy organizations - A review. *Bipolar Disorders, 9*(1-2), 144-157.

Elinson, L., Houck, P., & Pincus, H. A. (2007). Working, receiving disability benefits, and access to mental health care in individuals with bipolar disorder. *Bipolar Disorders, 9*(1-2), 158-165.

Evans, L. J., & Bond, G. R. (2008). Expert ratings on the critical ingredients of supported employment for people with severe mental illness. *Psychiatric Rehabilitation Journal, 31*(4), 318-331.

Fair Housing Amendments Act of 1988, 42 U.S.C.A. §§ 3601-3619 *et seq.* (West 1988).

Fountoulakis, K. N., & Vieta, E. (2008). Treatment of bipolar disorder: A systematic review of available data and clinical perspectives. *International Journal of Neuropsychopharmacology, 11*(7), 999-1029.

Frank, E., Hlastala, S., Ritenour, A., Houck, P., Tu, X. M., Monk, T. H., Kupfer, D. J. (1997). Inducing lifestyle regularity in recovering bipolar disorder patients: Results from the Maintenance Therapies in Bipolar Disorder protocol. *Biological Psychiatry, 1997*(41).

Frank, E., Swartz, H. A., & Kupfer, D. J. (2000). Interpersonal and social rhythm therapy: Managing the chaos of bipolar disorder. *Biological Psychiatry, 48*(6), 593-604.

Frank, E., Kupfer, D. J., Thase, M. E., Mallinger, A. G., Swartz, H. A., Fagiolini, A. M., Monk, T. (2005). Two-year outcomes for interpersonal and social rhythm therapy in individuals with bipolar I disorder. *Archives of General Psychiatry, 62*, 996-1004.

Gabriel, A., & Violato, C. (2010). The development and psychometric assessment of an instrument to measure attitudes towards depression and its treatments in patients suffering from non-psychotic depression. *Journal of Affective Disorders, 124*(3), 241-249.

Galvez, J. F., Thommi, S., & Ghaemi, S. N. (2011). Positive aspects of mental illness: A review in bipolar disorder. *Journal of Affective Disorders, 128*(3), 185-190.

Gardner, H. H., Kleinman, N. L., Brook, R. A., Rajagopalan, K., Brizee, T. J., & Smeeding, J. E. (2006). The economic impact of bipolar disorder in an employed population from an employer perspective. *Journal of Clinical Psychiatry, 67*(8), 1209-1218.

Gilbert, P. (1992). *Depression: The evolution of powerlessness*. Hove, U.K.: Erlbaum.

Gilbert, P. (2002). Body shame: A biopsychosocial conceptualisation and overview, with treatment implications. In P. Gilbert & J. Miles (Eds.), *Body shame: Conceptualisation, research and treatment* (pp. 3-54). London: Brunner-Routledge.

Gilbert, P., & Irons, C. (2004). A pilot exploration of the use of compassionate images in a group of self-critical people. *Memory, 2004*(12), 4.

Gilbert, P., & Procter, S. (2006). Compassionate mind training for people with high shame and self-criticism: Overview and pilot study of a group therapy approach. *Clinical Psychology & Psychotherapy, 13*(6), 353-379.

Gilbert, P., McEwan, K., Irons, C., Bhundia, R., Christie, R., Broomhead, C., & Rockliff, H. (2010). Self-harm in a mixed clinical population: The roles of self-criticism, shame, and social rank. *British Journal of Clinical Psychology, 49*(Pt 4), 563-576.

Gitlin, M., Mintz, J., Sokolski, K., Hammen, C., & Altshuler, L. (2010). Subsyndromal depressive symptoms after symptomatic recovery from mania are associated with delayed functional recovery. *Journal of Clinical Psychiatry*.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs, N.J.,: Prentice-Hall.

Goldberg, J. F., & Chengappa, K.N.R. (2009). Identifying and treating cognitive impairment in bipolar disorder. *Bipolar Disorders, 11*, 123-137.

Goldstein, B. I., & Levitt, A. J. (2008). The specific burden of comorbid anxiety disorders and of substance use disorders in bipolar I disorder. *Bipolar Disorders, 10*(1), 67-78.

Gruber, J., Culver, J. L., Johnson, S. L., Nam, J. Y., Keller, K. L., & Ketter, T. A. (2009). Do positive emotions predict symptomatic change in bipolar disorder? *Bipolar Disorders, 11*(3), 330-336.

Gutierrez-Rojas, L., Jurado, D., & Gurpegui, M. (2011). Factors associated with work, social life and family life disability in bipolar disorder patients. *Psychiatry Research, 186*(2-3), 254-260.

Haro, J. M., Reed, C., Gonzalez-Pinto, A., Novick, D., Bertsch, J., & Vieta, E. (2011). 2-Year course of bipolar disorder type I patients in outpatient care: Factors associated with remission and functional recovery. *European Neuropsychopharmacology, 21*(4), 287-293.

Harvey, A. G., Schmidt, D. A., Scarna, A., Semler, C. N., & Goodwin, G. M. (2005). Sleep-related functioning in euthymic patients with bipolar disorder, patients with insomnia, and subjects without sleep problems. *American Journal of Psychiatry, 162*(1), 50.

Hays, J. C., Krishnan, K. R., George, L. K., & Blazer, D. G. (1998). Age of first onset of bipolar disorder: Demographic, family history, and psychosocial correlates. *Depression and Anxiety, 7*(2), 76-82.

Heginbotham, C. (1998). U.K. mental health policy can alter the stigma of mental illness. *Lancet, 352*(9133), 1052-1053.

Hemmens, C., Miller, M., Burton, V. S., Jr., & Milner, S. (2002). The consequences of official labels: An examination of the rights lost by the mentally ill and mentally incompetent ten years later. *Community Mental Health Journal, 38*(2), 129-140.

Highfield, J., Markham, D., Skinner, M., & Neal, A. (2010). An investigation into the experience of self-conscious emotions in individuals with bipolar disorder, unipolar depression and non-psychiatric controls. *Clinical Psychology & Psychotherapy, 17*(5), 395-405.

Hinshaw, S. P. (2007). *The mark of shame: Stigma of mental Illness and an agenda for change*. New York: Oxford University Press.

Hirschfeld, R. M., Lewis, L., & Vornick, L. A. (2003). Perception and impact of bipolar disorder: How far have we really come? Results of the National Depressive and Manic-Depressive Association 2000 Survey of individuals with BD. *Journal of Clinical Psychiatry, 64*(161-174).

Hollon, S. D., & Ponniah, K. (2010). A review of empirically supported psychological therapies for mood disorders in adults. *Depression and Anxiety, 27*(10), 891-932.

Huxley, N., & Baldessarini, R. (2007). Disability and its treatment in bipolar disorder patients. *Bipolar Disorders, 9*(1-2), 183-196.

Ilic, M., Reinecke, J., Bohner, G., Rottgers, H. O., Beblo, T., Driessen, M., Corrigan, P. W. (2011). Protecting self-esteem from stigma: A test of different strategies for coping with the stigma of mental illness. *International Journal of Social Psychiatry*, 1-12.

Interian, A., Ang, A., Gara, M. A., Link, B. G., Rodriguez, M. A., & Vega, W. A. (2010). Stigma and depression treatment utilization among Latinos: Utility of four stigma measures. *Psychiatric Services, 61*(4), 373-379.

Jaworski, F., Dubertret, C., Adès, J., & Gorwood, P. (2011). Presence of co-morbid substance use disorder in bipolar patients worsens their social functioning to the level observed in patients with schizophrenia. *Psychiatry Research, 185*(1-2), 129-134.

Johnson, S. L., Meyer, B., Winett, C., & Small, J. (2000). Social support and self-esteem predict changes in bipolar depression but not mania. *Journal of Affective Disorders, 58*(1), 79-86.

Jones, E., Farina, A., Hastorf, A., Markus, H., Miller, D., & Scott, R. (1984). *Social stigma: The psychology of marked relationships*. New York: W. H. Freeman.

Kanter, J. W., Rusch, L. C., & Brondino, M. J. (2008). Depression self-stigma: A new measure and preliminary findings. *Journal of Nervous and Mental Disorders, 196*(9), 663-670.

Kauer-Sant Anna, M., Frey, B. N., Andreazza, A. C., Cereser, K. M., Gazalle, F. K., Tramontina, J., . . . Kapczinski, F. (2007). Anxiety comorbidity and quality of life in bipolar disorder patients. *Canadian Journal of Psychiatry, 52*(3), 175.

Kessler, R. C., Akiskal, H. S., Ames, M., Birnbaum, H., Greenberg, P., Hirschfeld, R. M., Wang, P. S. (2006). Prevalence and effects of mood disorders on work performance in a nationally representative sample of U.S. workers. *American Journal of Psychiatry, 163*(9), 1561-1568.

Krishnan, K. R. R. (2005). Psychiatric and medical comorbidities of bipolar disorder. *Psychosomatic Medicine, 67*, 1-8.

Krupa, T. (2007). Interventions to improve employment outcomes for workers who experience mental illness. *Canadian Journal of Psychiatry, 52*(6), 339.

Krupa, T., Kirsh, B., Cockburn, L., & Gewurtz, R. (2009). Understanding the stigma of mental illness in employment. *Work, 33*(4), 413-425.

Krupa, T. (2011a). Approaches to improving employment outcomes for people with serious mental illness. In I. Z. Schultz & E. S. Rogers (Eds.), *Work accommodation and retention in mental health* (pp. 219-231). New York: Springer Science+Business Media.

Krupa, T. (2011b). Employment and serious mental health disabilities. In I. Z. Schultz & E. S. Rogers (Eds.), *Work accommodation and retention in mental health* (pp. 91-101). New York: Springer Science+Business Media.

Kupfer, D. J., Frank, E., Grochocinski, V. J., Cluss, P. A., Houck, P. R., & Stapf, D. A. (2002). Demographic and clinical characteristics of individuals in a bipolar disorder case registry. *Journal of Clinical Psychiatry, 63*(2), 120-125.

Lagerberg, T. V., Andreassen, O. A., Ringen, P. A., Berg, A. O., Larsson, S., Agartz, I., Melle, I. (2010). Excessive substance use in bipolar disorder is associated with impaired functioning rather than clinical characteristics, a descriptive study. *BMC Psychiatry, 10*, 9.

Larson, J. E., Ryan, C. B., Wassel, A. K., Kaszynski, K. L., Ibara, L., Glenn, T. L., & Boyle, M. G. (2011). Analyses of employment incentives and barriers for individuals with psychiatric disabilities. *Rehabilitation Psychology, 56*(2), 145-149.

Latalova, K., Prasko, J., Diveky, T., & Velartova, H. (2011). Cognitive impairment in bipolar disorder. *Biomedical Papers, 155*(1).

Latvala, A., Castaneda, A. E., Perälä, J., Saarni, S. I., Aalto Setälä, T., Lönnqvist, J., . . . Tuulio Henriksson, A. (2009). Cognitive functioning in substance abuse and dependence: A population based study of young adults. *Addiction, 104*(9), 1558-1568.

Levy, B., & Weiss, R. D. (2009). Cognitive functioning in bipolar and co-occurring substance use disorders: A missing piece of the puzzle. *Harvard Review of Psychiatry, 17*(3), 226-230.

Lim, L., Nathan, P., O'Brien-Malone, A., & Williams, S. (2004). A qualitative approach to identifying psychosocial issues faced by bipolar patients. *Journal of Nervous and Mental Disorders, 192*(12), 810-817.

Link, B., Cullen, F. T., Frank, J., & Wozniak, J. F. (1987). The social rejection of former mental patients: Understanding why labels matter. *American Journal of Sociology, 92*, 1461-1500.

Link, B. G. (1987). Understanding labeling effects in the area of mental disorders: An assessment of the effects of expectations of rejection. *American Sociological Review*, 96-112.

Link, B. G., Mirotznik, J., & Cullen, F. T. (1991). The effectiveness of stigma coping orientations: Can negative consequences of mental illness labeling be avoided? *Journal of Health and Social Behavior, 32*(3), 302-320.

Link, B. G., Phelan, J. C., Bresnahan, M., Stueve, A., & Pescosolido, B. A. (1999). Public conceptions of mental illness: Labels, causes, dangerousness, and social distance. *American Journal of Public Health, 89*(9), 1328-1333.

Link, B. G., Struening, E. L., Neese-Todd, S., Asmussen, S., & Phelan, J. C. (2001). Stigma as a barrier to recovery: The consequences of stigma for the self-esteem of people with mental illnesses. *Psychiatric Services, 52*(12), 1621.

Link, B. G., Yang, L. H., Phelan, J. C., & Collins, P. Y. (2004). Measuring mental illness stigma. *Schizophrenia Bulletin, 30*(3), 511-541.

Lish, J. D., Dime-Meenan, S., Whybrow, P. C., Price, R. A., & Hirschfeld, R. M. (1994). The National Depressive and Manic-depressive Association (DMDA) survey of bipolar members. *Journal of Affective Disorders, 31*(4), 281-294.

Livingston, J. D., & Boyd, J. E. (2010). Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis. *Social Science & Medicine, 71*(12), 2150-2161.

Lloyd, C., & Waghorn, G. (2007). The importance of vocation in recovery for young people with psychiatric disabilities. *British Journal of Occupational Therapy, 70*(2), 50-59.

Lowens, I. (2010). Compassion-focused therapy for people with bipolar disorder. *International Journal of Cognitive Therapy, 3*(2), 172-185.

Luoma, J. B., Kohlenberg, B. S., Hayes, S. C., Bunting, K., & Rye, A. K. (2008). Reducing self-stigma in substance abuse through acceptance and commitment therapy: Model manual development, and pilot outcomes. *Addiction Research and Theory, 16*, 149-165.

Luoma, J. B., O'Hair, A. K., Kohlenberg, B. S., Hayes, S. C., & Fletcher, L. (2010). The development and psychometric properties of a new measure of perceived stigma toward substance users. *Substance Use & Misuse, 45*(1-2), 47-57.

MacQueen, G. M., Young, L. T., Robb, J. C., Marriott, M., Cooke, R. G., & Joffe, R. T. (2000). Effect of number of episodes on wellbeing and functioning of patients with bipolar disorder. *Acta Psychiatrica Scandinavica, 101*(5), 374-381.

Manos, R. C., Rusch, L. C., Kanter, J. W., & Clifford, L. M. (2009). Depression self-stigma as a mediator of the relationship between depression severity and avoidance. *Journal of Social and Clinical Psychology, 28*(9), 1128-1143.

Martinez, A. G., Piff, P. K., Mendoza-Denton, R., & Hinshaw, S. P. (2011). The power of a label: Mental illness diagnoses, ascribed humanity, and social rejection. *Journal of Social and Clinical Psychology, 30*(1), 1-23.

Martinez-Aran, A., Vieta, E., Reinares, M., Colom, F., Torrent, C., Sanchez-Moreno, J., Salamero, M. (2004). Cognitive function across manic or hypomanic, depressed, and euthymic states in bipolar disorder. *American Journal of Psychiatry, 161*(2), 262.

Martínez-Arán, A., Torrent, C., Solé, B., Bonnín, C. M., Rosa, A. R., Sánchez-Moreno, J., & Vieta, E. (2011). Functional remediation for bipolar disorder. *Clinical Practice and Epidemiology in Mental Health: CP & EMH, 7*, 112.

Martino, D. J., Marengo, E., Igoa, A., Scápola, M., Ais, E. D., Perinot, L., & Strejilevich, S. A. (2009). Neurocognitive and symptomatic predictors of functional outcome in bipolar disorders: A prospective 1 year follow-up study. *Journal of Affective Disorders, 116*(1-2), 37-42.

Martino, D. J., Igoa, A., Marengo, E., Scapola, M., & Strejilevich, S. A. (2011). Neurocognitive impairments and their relationship with psychosocial functioning in euthymic bipolar II disorder. *Journal of Nervous and Mental Disorders, 199*(7), 459-464.

Masuda, A., Hayes, S. C., Lillis, J., Bunting, K., Herbst, S. A., & Fletcher, L. B. (2009). The relation between psychological flexibility and mental health stigma in acceptance and commitment therapy: A preliminary process investigation. *Behavior and Social Issues, 18*, 25-40.

Masuda, A., Price, M., Anderson, P. L., Schmertz, S. K., & Calamaras, M. R. (2009). The role of psychological flexibility in mental health stigma and psychological disress for the stigmatizer. *Journal of Social and Clinical Psychology, 28*(10), 1244-1262.

McHugh, K.R., & Barlow, D.H. (2010). The dissemination and implementation of evidence-based psychological treatments. *American Psychologist, 65(2),* 73-84. DOI: 10.1037/a0018121

McHugo, G. J., Drake, R. E., & Becker, D. R. (1998). The durability of supported employment effects. *Psychiatric Rehabilitation Journal, 22*, 55-61.

McKown, C. (2005). Applying ecological theory to advance the science and practice of school-based prejudice reduction interventions. *Educational Psychology, 40*, 177-189.

McMorris, B. J., Downs, K. E., Panish, J. M., & Dirani, R. (2010). Workplace productivity, employment issues, and resource utilization in patients with bipolar I disorder. *Journal of Medical Economics, 13*(1), 23-32.

McMurrich, S. L., & Johnson, S. L. (2009). The role of depression, shame-proneness, and guilt-proneness in predicting criticism of relatives towards people with bipolar disorder. *Behavior Therapy, 40*(4), 315-324.

Mehta, N., Kassam, A., Leese, M., Butler, G., & Thornicroft, G. (2009). Public attitudes towards people with mental illness in England and Scotland, 1994-2003. *British Journal of Psychiatry, 194*(3), 278-284.

Michalak, E. E., Yatham, L. N., Kolesar, S., & Lam, R. W. (2006). Bipolar disorder and quality of life: A patient-centered perspective. *Quality of Life Research, 15*(1), 25-37.

Michalak, E. E., Yatham, L. N., Maxwell, V., Hale, S., & Lam, R. W. (2007). The impact of bipolar disorder upon work functioning: A qualitative analysis. *Bipolar Disorders, 9*(1-2), 126-143.

Michalak, E. E., Livingston, J. D., Hole, R., Suto, M., Hale, S., & Haddock, C. (2011). 'It's something that I manage but it is not who I am': Reflections on internalized stigma in individuals with bipolar disorder. *Chronic Illness, 0*(0), 1-16.

Miklowitz, D. J., George, E. L., Richards, J. A., Simoneau, T. L., & Suddath, R. L. (2003). A randomized study of family-focused psychoeducation and pharmacotherapy in the outpatient management of bipolar disorder. *Archives of General Psychiatry, 60*(9), 904-912.

Miklowitz, D. J., Goodwin, G. M., Bauer, M. S., & Geddes, J. R. (2008). Common and specific elements of psychosocial treatments for bipolar disorder: A survey of clinicians participating in randomized trials. *Journal of Psychiatric Practice, 14*(2), 77-85.

Miklowitz, D. J., & Johnson, S. L. (2009). Social and familial factors in the course of bipolar disorder: Basic processes and relevant interventions. *Clinical Psychology, 16*(2), 281-296.

Montoya, A., Tohen, M., Vieta, E., Casillas, M., Chacon, F., Polavieja, P., & Gilaberte, I. (2010). Functioning and symptomatic outcomes in patients with bipolar I disorder in syndromal remission: A 1-year, prospective, observational cohort study. *Journal of Affective Disorders, 127*(1-3), 50-57.

Mur, M., Portella, M. J., Martinez-Aran, A., Pifarre, J., & Vieta, E. (2009). Influence of clinical and neuropsychological variables on the psychosocial and occupational outcome of remitted bipolar patients. *Psychopathology, 42*(3), 148-156.

Nivoli, A. M., Colom, F., Murru, A., Pacchiarotti, I., Castro-Loli, P., Gonzalez-Pinto, A., Vieta, E. (2011). New treatment guidelines for acute bipolar depression: A systematic review. *Journal of Affective Disorders, 129*(1-3), 14-26.

Otto, M. W., Simon, N. M., Wisniewski, S. R., MIklowitz, D. J., Kogan, J. N., Reilly-Harrington, N. A., Pollack, M. H. (2006). Prospective 12-month course of bipolar disorder in out-patients with and without comorbid anxiety disorders. *British Journal of Psychiatry, 189*, 20-25.

Paluck, E. L., & Green, D. P. (2009). Prejudice reduction: What works? A critical look at evidence from the field and the laboratory. *Annual Review of Psychology, 60*, 339-367.

Pauley, G., & McPherson, S. (2010). The experience and meaning of compassion and self compassion for individuals with depression or anxiety. *Psychology and Psychotherapy: Theory, Research and Practice, 83*(2), 129-143.

Perlick, D. A., Rosenheck, R. A., Clarkin, J. F., Sirey, J. A., Salahi, J., Struening, E. L., & Link, B. G. (2001). Stigma as a barrier to recovery: Adverse effects of perceived stigma on social adaptation of persons diagnosed with bipolar affective disorder. *Psychiatric Services, 52*(12), 1627.

Perlick, D. A., Miklowitz, D. J., Link, B. G., Struening, E., Kaczynski, R., Gonzalez, J., Rosenheck, R. A. (2007). Perceived stigma and depression among caregivers of patients with bipolar disorder. *British Journal of Psychiatry, 190*, 535-536.

Pescosolido, B. A., Martin, J. K., Lang, A., & Olafsdottir, S. (2008). Rethinking theoretical approaches to stigma: A Framework Integrating Normative Influences on Stigma (FINIS). *Social Science & Medicine, 67*(3), 431-440.

Petrila, J. (2009). Congress restores the Americans with Disabilities Act to its original intent. *Psychiatric Services, 60*, 878-879.

Phelan, J. C., & Link, B. G. (1998). The growing belief that people with mental illnesses are violent: The role of the dangerousness criterion for civil commitment. *Social Psychiatry and Psychiatric Epidemiology, 33*(Suppl 1), S7-S12.

Pope, M., Dudley, R., & Scott, J. (2007). Determinants of social functioning in bipolar disorder. *Bipolar Disorders, 9*(1-2), 38-44.

Proudfoot, J. G., Parker, G. B., Benoit, M., Manicavasagar, V., Smith, M., & Gayed, A. (2009). What happens after diagnosis? Understanding the experiences of patients with newly-diagnosed bipolar disorder. *Health Expectations, 12*(2), 120-129.

Rakofsky, J. J., & Dunlop, B. W. (2011). Treating nonspecific anxiety and anxiety disorders in patients with bipolar disorder: A review. *Journal of Clinical Psychiatry, 72*(1), 81-90.

Raune, D., Kuipers, E., & Bebbington, P. E. (2004). Expressed emotion at first-episode psychosis: Investigating a carer-appraisal model. *British Journal of Psychiatry, 184*, 321-326.

Rea, M. M., Tompson, M. C., Miklowitz, D. J., Goldstein, M. J., Hwang, S., & Mintz, J. (2003). Family-focused treatment versus individual treatment for bipolar disorder: Results of a randomized clinical trial. *Journal of Consulting and Clinical Psychology, 71*(3), 482-492.

Reed, C., Goetz, I., Vieta, E., Bassi, M., & Haro, J. M. (2010). Work impairment in bipolar disorder patients -- Results from a two-year observational study (EMBLEM). *European Psychiatry, 25*(6), 338-344.

Reichenberg, A., Weiser, M., Rabinowitz, J., Caspi, A., Schmeidler, J., Mark, M., & Kaplan, Z. (2002). A population-based cohort study of premorbid intellectual, language, and behavioral functioning in patients with schizophrenia, schizoaffective disorder, and nonpsychotic bipolar disorder. *American Journal of Psychiatry, 159*(12), 2027-2035.

Repper, J., & Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal of Mental Health, 20,* 392-411.

Richardson, T. H. (2010). Psychosocial interventions for bipolar disorder: A review of recent research. *Journal of Medical Science, 10*(6), 143-152.

Rietschel, M., Georgi, A., Schmael, C., Schirmbeck, F., Strohmaier, J., Boesshenz, K. V.,. Schulze, T. G. (2009). Premorbid adjustment: A phenotype highlighting a distinction rather than an overlap between schizophrenia and bipolar disorder. *Schizophrenia Research, 110*(1-3), 33-39.

Robb, J. C., Cooke, R. G., Devins, G. M., Young, L. T., & Joffe, R. T. (1997). Quality of life and lifestyle disruption in euthymic bipolar disorder. *Journal of Psychiatric Research, 31*(5), 509-517.

Rosa, A. R., Bonnin, C. M., Vazquez, G. H., Reinares, M., Sole, B., Tabares-Seisdedos, R., . Vieta, E. (2010). Functional impairment in bipolar II disorder: Is it as disabling as bipolar I? *Journal of Affective Disorders, 127*(1-3), 71-76.

Rusch, L. C., Kanter, J. W., Angelone, A. F., & Ridley, R. C. (2008). The impact of In Our Own Voice on stigma. *American Journal of Psychiatric Rehabilitation, 11*(4), 373-389.

Rusch, N., Lieb, K., Bohus, M., & Corrigan, P. W. (2006). Self-stigma, empowerment, and perceived legitimacy of discrimination among women with mental illness. *Psychiatric Services, 57*(3), 399-402.

Rusch, N., Corrigan, P. W., Powell, K., Rajah, A., Olschewski, M., Wilkniss, S., & Batia, K. (2009). A stress-coping model of mental illness stigma: II. Emotional stress responses, coping behavior and outcome. *Schizophrenia Research, 110*(1-3), 65-71.

Rusch, N., Corrigan, P. W., Wassel, A., Michaels, P., Larson, J. E., Olschewski, M., Batia, K. (2009). Self-stigma, group identification, perceived legitimacy of discrimination and mental health service use. *British Journal of Psychiatry, 195*(6), 551-552.

Rusch, N., Todd, A. R., Bodenhausen, G. V., Olschewski, M., & Corrigan, P. W. (2010). Automatically activated shame reactions and perceived legitimacy of discrimination: A longitudinal study among people with mental illness. *Journal of Behavior Therapy and Experimental Psychiatry, 41*(1), 60-63.

Rusch, N., Corrigan, P. W., Todd, A. R., & Bodenhausen, G. V. (2011). Automatic stereotyping against people with schizophrenia, schizoaffective and affective disorders. *Psychiatry Research, 186*(1), 34-39.

Sajatovic, M., Smith, D., Singer, E., Meyer, W. J., Cassidy, K. A., & Jenkins, J. H. (2009). Subjective experience of bipolar disorder, treatment adherence and stigma. In D. Roth & W. J. Lutz (Eds.), New research in mental health, 2006-2007 (Vol. 18, pp. 47-51). Columbus, OH: Ohio Department of Mental Health.

Sanchez-Moreno, J., Martinez-Aran, A., Tabarés-Seisdedos, R., Torrent, C., Vieta, E., & Ayuso-Mateos, J. (2009). Functioning and disability in bipolar disorder: An extensive review. *Psychotherapy and Psychosomatics, 78*(5), 285-297.

Sanchez-Moreno, J., Martinez-Aran, A., Gadelrab, H. F., Cabello, M., Torrent, C., Bonnin Cdel, M., Vieta, E. (2010). The role and impact of contextual factors on functioning in patients with bipolar disorder. *Disability and Rehabilitation, 32*(Suppl 1), S94-S104.

Schneider, J., Beeley, C., & Repper, J. (2011). Campaign appears to influence subjective experience of stigma. *Journal of Mental Health, 20*(1), 89-97.

Schultz, I. Z., Milner, R. A., Hanson, D. B., & Winter, A. (2011). Employer attitudes towards accommodations in mental health disability. In I. Z. Schultz & E. S. Rogers (Eds.), *Work accommondation and retention in mental health* (pp. 325-340). New York: Springer Science+Business Media.

Shapira, B., Zislin, J., Gelfin, Y., Osher, Y., Gorfine, M., Souery, D., Lerer, B. (1999). Social adjustment and self-esteem in remitted patients with unipolar and bipolar affective disorder: A case-control study. *Comprehensive Psychiatry, 40*(1), 24-30.

Silton, N. R., Flannelly, K. J., Milstein, G., & Vaaler, M. L. (2011). Stigma in America: Has anything changed? Impact of perceptions of mental illness and dangerousness on the desire for social distance: 1996 and 2006. *Journal of Nervous and Mental Disorders, 199*(6), 361-366.

Silva, F. T., & Leite, J. R. (2000). Physiological modifications and increase in state anxiety in volunteers submitted to the Stroop Color-Word Interference Test: A preliminary study. *Physiology & Behavior, 70*(1-2), 113-118.

Sirey, J. A., Bruce, M. L., Alexopoulos, G. S., Perlick, D. A., Friedman, S. J., & Meyers, B. S. (2001). Stigma as a barrier to recovery: Perceived stigma and patient-rated severity of illness as predictors of antidepressant drug adherence. *Psychiatric Services, 52*(12), 1615.

Star, S. A. (1952). *What the public thinks about mental health and mental illness*. Paper presented at the Annual Meeting of the National Association for Mental Health.

Star, S. A. (1955). *The public's ideas about mental illness*. Paper presented at the Annual Meeting of the National Association for Mental Health.

Surgeon General, U. S. (1999). Mental health: A report of the Surgeon General. Retrieved August 26, 2011, from http://www.surgeongeneral.gov/library/mentalhealth/home.html

Swanson, J., Burris, S., Moss, K., Ullman, M., & Ranney, L. M. (2006). Justice disparities: Does the ADA enforcement system treat people with psychiatric disabilities fairly? *Maryland Law Review, 66*(94), 94-139.

Tabares-Seisdedos, R., Balanza-Martinez, V., Sanchez-Moreno, J., Martinez-Aran, A., Salazar-Fraile, J., Selva-Vera, G., Vieta, E. (2008). Neurocognitive and clinical predictors of functional outcome in patients with schizophrenia and bipolar I disorder at one-year follow-up. *Journal of Affective Disorders, 109*(3), 286-299.

Tangney, J. P. (1995). Recent advances in the empirical study of shame and guilt. *American Behavioral Scientist, 38*(8), 1132.

Tangney, J. P., & Dearing, R. L. (2002). *Shame and guilt*. New York: Guilford.

Tohen, M., Waternaux, C. M., & Tsuang, M. T. (1990). Outcome in mania. A 4-year prospective follow-up of 75 patients utilizing survival analysis. *Archives of General Psychiatry, 47*(12), 1106-1111.

Tohen, M., Hennen, J., Zarate Jr, C. M., Baldessarini, R. J., Strakowski, S. M., Stoll, A. L., Cohen, B. M. (2000). Two-year syndromal and functional recovery in 219 cases of first-episode major affective disorder with psychotic features. *American Journal of Psychiatry, 157*(2), 220.

Tse, S. S., & Walsh, A. E. S. (2001). How does work work for people with bipolar affective disorder? *Occupational Therapy International, 8*(3), 210-225.

Tse, S. S. (2002). Practice guidelines: Therapeutic interventions aimed at assisting people with bipolar affective disorder achieve their vocational goals. *Work, 19*(2), 167-179.

Tse, S. S., & Yeats, M. (2002). What helps people with bipolar affective disorder to succeed in employment: A grounded theory approach. *Work, 19*(1), 47–62.

Uzelac, S., Jaeger, J., Berns, S., & Gonzales, C. (2006). Premorbid adjustment in bipolar disorder: Comparison with schizophrenia. *Journal of Nervous and Mental Disorders, 194*(9), 654-658.

Van Dam, N. T., Sheppard, S. C., Forsyth, J. P., & Earleywine, M. (2010). Self-compassion is a better predictor than mindfulness of symptom severity and quality of life in mixed anxiety and depression. *Journal of Anxiety Disorders, 25*(1), 123-130.

Vazquez, G. H., Kapczinski, F., Magalhaes, P. V., Cordoba, R., Lopez Jaramillo, C., Rosa, A. R., Tohen, M. (2011). Stigma and functioning in patients with bipolar disorder. *Journal of Affective Disorders, 130*(1-2), 323-327.

Ward, T. D. (2011). The lived experience of adults with bipolar disorder and comorbid substance use disorder. *Issues in Mental Health Nursing, 32*(1), 20-27.

Weber, B., Jermann, F., Gex-Fabry, M., Nallet, A., Bondolfi, G., & Aubry, J. M. (2010). Mindfulness-based cognitive therapy for bipolar disorder: A feasibility trial. *European Psychiatry, 25*(6), 334-337.

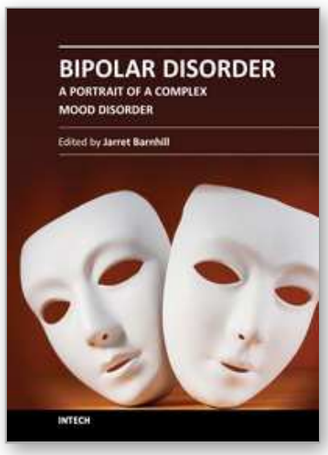
Weiss, R. D., Griffin, M. L., Jaffee, W. B., Bender, R. E., Graff, F. S., Gallop, R. J., & Fitzmaurice, G. M. (2009). A "community-friendly" version of integrated group therapy for patients with bipolar disorder and substance dependence: A randomized controlled trial. *Drug and Alcohol Dependence, 104*(3), 212-219.

Williams, J. M., Alatiq, Y., Crane, C., Barnhofer, T., Fennell, M. J., Duggan, D. S., Goodwin, G. M. (2008). Mindfulness-based cognitive therapy (MBCT) in bipolar disorder: Preliminary evaluation of immediate effects on between-episode functioning. *Journal of Affective Disorders, 107*(1-3), 275-279.

Zimmerman, M., Galione, J., Chelminski, I., Young, D., Dalrymple, K., & Ruggero, C. (2010). Sustained unemployment in psychiatric outpatients with bipolar disorder: Frequency and association with demographic variables and comorbid disorders. *Bipolar Disorders, 12*(7), 720-726.

Zubieta, J. K., Huguelet, P., O'Neil, R. L., & Giordani, B. J. (2001). Cognitive function in euthymic bipolar I disorder. *Psychiatry Research, 102*(1), 9-20.

IntechOpen



Bipolar Disorder - A Portrait of a Complex Mood Disorder
Edited by Dr. Jarrett Barnhill

ISBN 978-953-51-0002-7
Hard cover, 236 pages
Publisher InTech
Published online 24, February, 2012
Published in print edition February, 2012

Bipolar Disorder: Portrait of a Complex Mood Disorder is a step towards integrating many diverse perspectives on BD. As we shall see, such diversity makes it difficult to clearly define the boundaries of BD. It is helpful to view BD from this perspective, as a final common pathway arises from multiple frames of reference. The integration of epigenetics, molecular pharmacology, and neurophysiology is essential. One solution involves using this diverse data to search for endophenotypes to aid researchers, even though most clinicians prefer broader groupings of symptoms and clinical variables. Our challenge is to consolidate this new information with existing clinical practice in a usable fashion. This need for convergent thinkers who can integrate the findings in this book remains a critical need. This book is a small step in that direction and hopefully guides researchers and clinicians towards a new synthesis of basic neurosciences and clinical psychiatry

How to reference
In order to correctly reference this scholarly work, feel free to copy and paste the following:

Emily Manove, Lauren M. Price and Boaz Levy (2012). Psychosocial Functioning in Bipolar Disorder from a Social Justice Perspective, Bipolar Disorder - A Portrait of a Complex Mood Disorder, Dr. Jarrett Barnhill (Ed.), ISBN: 978-953-51-0002-7, InTech, Available from: http://www.intechopen.com/books/bipolar-disorder-a-portrait-of-a-complex-mood-disorder/psychosocial-functioning-in-bipolar-disorder-from-a-social-justice-perspective

INTECH
open science | open minds

InTech Europe
University Campus STeP Ri
Slavka Krautzeka 83/A
51000 Rijeka, Croatia
Phone: +385 (51) 770 447
Fax: +385 (51) 686 166
www.intechopen.com

InTech China
Unit 405, Office Block, Hotel Equatorial Shanghai
No.65, Yan An Road (West), Shanghai, 200040, China
中国上海市延安西路65号上海国际贵都大饭店办公楼405单元
Phone: +86-21-62489820
Fax: +86-21-62489821

© 2012 The Author(s). Licensee IntechOpen. This is an open access article distributed under the terms of the Creative Commons Attribution 3.0 License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

IntechOpen

IntechOpen