

THE BRAIN ON FIRE: A REVIEW OF PATIENT CENTERED CARE FOR WOMEN  
DIAGNOSED WITH BIPOLAR DISORDER

HONORS THESIS

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by

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## **DEDICATION**

This thesis is dedicated to all patients of mental health and in particular women who have struggled to receive adequate care tailored specifically to their needs. Filling the gap in patient-centered care for those diagnosed with mental health disorders is not possible without the participation of patients and for that I am truly appreciative.

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## **ABSTRACT**

Mental health disorders are cited as one of the leading problems of disease worldwide and bipolar disorder in particular affects more than 2.6% of the US adults (National Institute of Mental Health, 2015). Women diagnosed with bipolar disorder experience additional complex issues with concerns to diagnosis and treatment. Although many initiatives are being studied to encourage better treatment of individuals diagnosed with severe mental health illness (SMI), specific focus on improving the application of patient-centered care to women diagnosed with bipolar disorder requires additional consideration. Bipolar disorder in women can be especially challenging to identify and consequently the occurrence of gender-linked delay in suitable diagnosis and treatment is common. Due to the differences in the expression of bipolar disorder, it is crucial that that physicians recognize sex, gender and reproductive influences to help provide optimal treatment and diagnosis for women. This study was conducted by using qualitative methods of historical research via literature review to increase the understanding of the application of patient-centered care of women diagnosed with bipolar disorder. The aim of this study is to identify recommendations to improve treatment. The literature review determined that the quality of care for women diagnosed with bipolar disorder would be improved by creating individualized plans of treatment that are based on patient's preferences and beliefs, delivering sufficient information and education of treatment possibilities through effective communication, and increasing the access to mental health care. The information found in this study provides recommendations for implementation and evaluation.



## **CHAPTER 1**

### **INTRODUCTION TO THE STUDY**

#### **Preface**

Psychiatric conditions including depression, anxiety and bipolar disorder have been determined as one of the leading problems of disease globally and by 2020 are expected to rise from fourth to second, among global burden (8). The cost associated with serious mental illness (SMI) in the United States alone is approximately \$317 billion annually (41). This is broken down into more than \$1000 for everyone in the United States including men, women and children (41). The majority of expense associated with treating psychiatric conditions is a result of the high cost of treatment in an emergency room (ER) setting (41). The purpose of emergency room treatment is for acute situations that need to be controlled in a timely manner when specialists or general practitioners are unavailable. There is a push to get people out of the hospitals quickly to decrease the chance of hospital acquired illness and make room for individuals with acute needs. Individuals with SMI are usually still very ill when discharged from the hospital and are not sure how to receive treatment after (41). Many initiatives are being investigated to encourage improved treatment for those suffering from SMI. A literature review of possible recommendations for both the community and medical professional can help develop the next step in improving outcomes for women diagnosed with bipolar disorder.

## **Statement of Purpose**

The purpose of this research was to provide a detailed account of the history and characteristics of both bipolar disorder and patient centered care to develop recommendations to improve the quality of care for women diagnosed with bipolar disorder.

## **Research Questions**

1. What does traditional care look like for women diagnoses with bipolar disorder?
2. Are there discrepancies in care for women diagnosed with bipolar disorder? If so what are they?
3. How can the care of women diagnosed with bipolar disorder be improved?

## **Research Methodology**

Literature review was the methodology used to develop a detailed account of the history and characteristics of both bipolar disorder and patient centered care. This method enabled the development of recommendations for the improvement of the quality of care for women diagnosed with bipolar disorder. Literature from a broad range of topics including but not limited to the history of bipolar disorder, bipolar disorder in women, current treatment practices for individuals diagnosed with bipolar disorder, the history of patient-centered care, and patient-centered care initiative studies was used to complete the study.

The literature that was reviewed provided answers to research questions concerning the effective application of patient-centered care as applied to the treatment of bipolar women. This method also provided the most applicable mode to investigate the current treatment methods and issues that commonly occur through research that had previously been conducted. From this literature review, a plan to scientifically test developed

recommendations for the improvement of patient-centered treatment of women diagnosed with bipolar disorder may be implemented.

### **Definition of Terms**

**Anticonvulsant:** This term defines a drug used to prevent or reduce the severity of epileptic attacks, or to prevent dangerous muscle contraction in electroconvulsive therapy. This drug can also be used as a sedative. Examples of anticonvulsant drugs include Phenytoin, Phenobarbitone, Ethosuximide, Carbamazepine, Sodium Valproate, and Clonazepam (3).

**Antidepressant:** This term defines a drug used to manage depression, anxiety, panic disorders that include classes of bicyclics, tricyclics, tetracyclics, monoamine oxidase inhibitors and selective serotonin re-uptake inhibitors (4).

**Antipsychotic:** This term describes any drug that satisfactorily adjusts psychotic symptoms (stabilize mood, reduce anxiety, tension, hyperactivity, help control agitation and aggressiveness, modification of delusions and hallucinations), that include phenothiazines, butyrophenones, thioxanthenes, dibenzodiazepines, diphenylbutylpiperidines, dihydroindolones, and dibenzoxazepines. This class of drugs were formerly called major tranquilizer (5).

**Bipolar I Disorder (BDI):** This term defines a type of bipolar disorder characterized by an occurrence of one or more manic episodes or mixed episodes, along with one or more major depressive episodes in the absence of episodes better accounted for by schizoaffective, delusional, or psychotic disorders (9).

**Bipolar II Disorder (BDII):** This term defines a type of bipolar disorder characterized by recurrent major depressive episodes with hypomanic episodes that may not be accounted for by schizoaffective, delusional, or psychotic disorders (9).

**Bipolar Disorder:** This term describes a mood disorder formerly known as manic depression, that causes radical emotional changes and mood swings, from manic, restless highs to depressive, listless lows (10).

**Bipolar Spectrum:** This is a simple nomenclature system that was introduced in 1978 to more easily classify individuals' affectedness of mood disorders that feature abnormally elevated or depressed mood. These conditions range from bipolar I disorder, presenting full-blown manic episodes, to cyclothymia, presenting less noticeable hypomanic episodes, to "subsyndromal" disorders where only portions of the criteria for mania or hypomania are met. Points on the scale using this nomenclature are symbolized using the following codes: (1)

- ◆ M—severe mania
- ◆ D—severe depression (unipolar depression)
- ◆ m—less severe mania (hypomania)
- ◆ d—less severe depression

**Chronic Care Model:** This is an organizational approach to care for people with chronic diseases in a primary care setting. The scheme is population-based and constructs practical, supportive, evidence-based relations between a knowledgeable, active patient and a prepared, proactive healthcare team (25).

**Cognitive Behavioral Therapy:** This is a therapy method that uses problem solving to help a person comprehend thoughts/feeling and improve strategies to modify behaviors (13).

**Diagnostic and Statistical Manual (DSM):** This is a system of classification, distributed by the American Psychiatric Association, which divides documented mental disorders into distinctly outlined classifications based on sets of impartial criteria (15).

**Electroconvulsive Therapy:** This a term for a therapeutic method that uses the induction of a momentary convulsions by passing an electric current through the brain for the management of affective disorders, particularly in individuals resistant to psychoactive-drug rehabilitation (16).

**Hypomania:** This a term for a mild degree of mania characterized by optimism, excitability, energetic, productive behavior that is marked with hyperactivity and talkativeness with a decreased need for sleep. Individuals with hypomania also present heightened sexual desire, are quick to anger and become irritable. Episodes may be observed before a full-blown manic episode (24).

**International Classification of Disease (ICD):** This is a system used by doctors and other healthcare workers to categorize and code all diagnoses, symptoms and procedures documented in combination with clinic care in the United States (46).

**Mania:** This is a term for an abnormally jubilant mental state, typically characterized by feelings of exhilaration, lack of reserve, speeding thoughts, reduced demand for sleep, talkativeness, increase of risky behaviors, and irritability. In severe incidents, mania can stimulate hallucinations and other psychotic symptoms (27).

**Manic-Depressive Illness:** This is a term that can be used interchangeably with bipolar disorder.

**Melancholia:** This is a term for severe, insistent sadness or hopelessness that is no longer in clinical use and was replaced with the term depression (29).

**Patient-centered Care:** This is a term that describes health and civic services which respectfully suggest an individual's distinctive preferences, beliefs and desires, recognized and decided upon in collaboration with the provider (34).

**Perimenopausal:** This term refers to a period of a female's life—age 45 to 55-ish—in which menstrual periods become irregular; perimenopause is immediately before, during and after menopause (35).

**Postpartum:** This is a term referring to the period shortly after childbirth (37).

**Premenstrual:** This is a term relating to the period preceding menstruation (38).

**Project Wellness Enhancement:** This is a project completed by Yale University in collaboration with the Patient-Centered Outcomes Research Institute, aimed at studying health outcomes of individuals with mental illness attending a co-located primary health care center in a mental health center (47).

**Psychotherapy:** This is a Treatment of emotional, behavioral, personality, and psychiatric disorders based primarily on verbal or nonverbal communication and interventions with the patient, in contrast to treatments using chemical and physical measures (39).

**Severe Mental Illness (SMI):** Any person aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet

diagnostic criteria specified within DSM-IV (APA, 1994) that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities” such as maintaining interpersonal relationships, activities of daily living, self-care, employment, and recreation may be diagnosed (7).

**Stigma:** This term can be understood as a suggestion of shame or public disapproval with something, such as an act or condition (42).

**Therapeutic Relationship:** A therapeutic relationship can be described as the continuous relationship between a therapist and a client/patient established to support the client’s/patient’s therapeutic goals (43). Features of a healthy therapeutic relationship include individual mindfulness, understanding, trust, respect, security, dependability, acceptance, empathy, and joint agreement.

## **CHAPTER 2**

### **REVIEW OF LITERATURE**

#### **Bipolar Disorder**

Bipolar disorder is a psychiatric disorder that can be characterized by frequent, interchanging episodes of depression and mania (12). Mania can be expressed as an excessively elevated or irritable mood that cannot be managed by one's own actions ordinarily (12). It is very difficult for those diagnosed with bipolar disorder to prevent severe impairment and function normally (12). An individual's disorder often effects social, educational, and career portions of their lives. There is an increased risk for suicide and although the condition is treatable, many patients experience relapses and therefore a reduced quality of life (12).

Bipolar disorder, or Manic Depressive Illness, is classified as type I (BDI) or type II (BDII). Individuals diagnosed with BD I, exhibit one or more episodes of mania or the existence of varied signs and symptoms of both mania and depression, characterized with one major depressive episode (12). BD II is described as experiencing at least one major depressive episode and one of hypomania (12). A manic episode can be explained as euphoric or irritable mood, hyperactivity, decreased need for sleep, and a sense of invincibility that can cause delusion in regards to individual success and capability (12). Manic episodes often involve reduced judgement that tends to result in dangerous conduct and reckless actions (12).

Bipolar disorder is usually more difficult to treat when compared to major depression due to the extended length and documented higher risk for suicide (12). It can take many years to properly diagnose Bipolar disorder and often individuals can be misdiagnosed with



major depression, substance abuse disorder and reactive depression (12). Those who suffer from bipolar disorder also experience physical issues such as frequent headaches, muscle aches and fatigue (12). The definitive cause of Bipolar Disorder remains unknown, but it is thought that genetic, biochemical, neurophysiologic and environmental factors influence the onset (12).

### **Statistics of Bipolar Disorder in Women**

Bipolar disorder is seen in both men and women, but the frequency, age of onset and severity of the disorder tend to differ (28). Typically, women diagnosed with bipolar disorder suffer more frequent depressive moods and an increased risk of recurrence during fluctuations in hormones typical of postpartum or menopause (28). Due to the prevalence of depressive symptoms women tend to be misdiagnosed with singular depression and usually required on average two additional years of mental health assessment before accurately being diagnosed (28). Because of delayed diagnosis, many women do not start proper treatment for 5 ½ more years (28). The delayed onset of proper treatment can affect many aspects of a woman's life and hinder her ability to maintain her psychological health.

### **History of Bipolar Disorder**

It is commonly cited that the Greeks and Romans recognized bipolar disorder or manic-depressive illness based on visible signs of illness (20). Hippocrates first recognized mania and melancholia but there is no concrete evidence that he was citing bipolar. Throughout ancient times many illnesses resulted in fever and mania due to the lack of antibiotics. It was not until Hippocrates recognized that the postpartum period for women was the highest time of risk for mania, that the categorization of manic episodes began to form (20). Some time later, in the AD times frame, Soranous of Ephesus noticed two poles in

individuals who suffered from an illness that was classified as a melancholia chronic without fever (20).

During ancient times, mental illness was considered a humoral issue due to excess bile in the brain or a deficiency of phlegm (20). This systematization of the humoral framework led to treatment of the mentally ill grounded on the prescription model instead of the appearance of the patient (20). Greek remedies originated from a blend of herbs mixed to incite or repress specific biological functions (20). Theriac, a medicinal ointment, was the most prevalent concoction to treat various mental ailments for over 1,500 years (20).

Later during the 15<sup>th</sup> century, several health handbooks were created that proposed acceptable food choices and activities to offset the effects of environmental stimuli that may disturb mental health (20). It was not until the 16<sup>th</sup> century that Paracelsus and his successors began shifting treatment from herbs to metals and other purified elements. This resulted in the initial abandonment from the once accepted humoral framework (20). In 1590 William Thoner from Basel recorded another case of melancholic fits of wakefulness, sleep disturbances, sluggishness and fatigue with an emphasis of no triggers. This episode was labeled as endogenous depression or now known as major depressive disorder sometimes classified as a bipolar spectrum disorder (20).

Thomas Willis in 1664 published *The Anatomy of the Brain*, an influential depiction of the human brain describing the brain as it is known today. This text became influential in neurology and psychology in the centuries to follow. Understanding the anatomy of the brain allowed for better treatment and recognition of disorders such as bipolar. In 1681 Thomas Sydenham described another episode similar to endogenous depression and after he began to classify mental diseases. This was the first attempt made at creating a Diagnostic and

Statistical Manual of Mental Disorders (DSM) and International Classification of Disease (ICD) (20). Psychiatry began to change radically after this initial classification. Diagnosis began shifting from visible-based displays of disorders to using words and accounts of internal emotional conditions (20). By 1682 Sydenham classified hysteria as the most common chronic nerve disease which could possibly have been bipolar.

The introduction of insane asylums in the early 1800's allowed for the observation of patients' illnesses in large numbers (20). After their introduction, it was apparent that not all who suffered from mental ailments, were suffering from the same condition. The common thought of the times was that if a person were insane there was no remedy (20). But the 1800's held many pivotal events that furthered the understanding of bipolar disorder in its elementary stages. For example, King Louis XVIII funded the Royal Academy of Medicine in 1820, that selected the best medical and surgical experts to guide the government on the topic of public health and present the newest breakthroughs of medicine (36). This group of experts allowed for extensive research in many fields and further the advancement of science (36).

Many thoughts, ideas and categories were beginning to form around bipolar disorder and key individuals such as Falret and Baillarger devised terms to describe the syndrome (2). It was not until 1862 that psychiatry was first taught in medical school and became a specialty for physicians (2). Many other terms and observations were formed in the later years of the 1800's, and in 1899 the modern form of bipolar was identified (20).

At the turn of the century, very few individuals were classified and described as having bipolar disorder (20). As time progressed, the incidence of this diagnosis increased and new ideas for treatment began to form. For example, Lithium appeared as a treatment

option in the 1960's and remained the top treatment method for some time (20). In 1972, Karl Leonhard, a professor of psychiatry at East Berlin University convinced the psychiatric professional community of the existence of "poles" that occur in manic-depressive illness (36). This was influential in defining the modern name bipolar disorder. Following his influence, the third edition of the DSM was published in 1980, subdividing manic-depressive psychosis into bipolar disorder and major depression (36).

The introduction of positron emission tomography (PET) scan images in the late 1980's, produced an image of the brain that had never been visualized before (20). It was not until the mid-to-late 1990's that the brain images were utilized in medicine (20). This technology along with the introduction of mood stabilizing drugs enhanced both diagnostic and treatment outcomes (20). As science progresses through the 21<sup>st</sup> century, so too does treatment and diagnostic capability. The understanding of bipolar disorder has advanced through the course of time and although significant developments have been made, the disorder, diagnosis, and treatment can still be improved. This area of research is an important for improvement and has gained popularity in recent years. Many proposals have been created to sponsor the improvement of our understanding of not only the mechanisms but also disorders of the brain. As the incidence of mental health disorders increases, the need for improved diagnosis, treatment, and care becomes even more vital.

### **Current Traditional Treatment of Bipolar Disorder**

It is important to treat each face of bipolar disorder and this is usually done with multiple modes (12). A common method includes both antidepressants and antipsychotics for the management and treatment of this disorder (12). Anticonvulsants and mood stabilizers can also be utilized depending on the severity of the case (12). Psychotherapy is typically an

additional requirement for patients and can include but is not limited to cognitive behavioral therapy, family-focused psychoeducation psychotherapy, and in rare cases electroconvulsive therapy (12). It is important when treating bipolar disorder to take into consideration the interactions of mood stabilizing medications with other medications that the individual could be taking (12).

### **Differences in Treating Genders**

It is essential that that providers understand sex, gender and reproductive influences on bipolar disorder to help provide optimal treatment and diagnosis for women (28). Many common expressions of bipolar disorder in women can be difficult to detect and result in a gender-linked delay in proper diagnosis and treatment (28). By addressing the common misunderstood manifestations of bipolar disorder in women, there is a hope for a decrease in the time it takes for proper care (28). This can be achieved by improved efforts to screen girls and women when depressive symptoms, family history or both, are present (28).

An important issue for women concerning treatment is the possible interaction of mood stabilizers with contraceptives (30). Women who use mood stabilizers for the treatment of bipolar disorder may be at a higher risk for accidental pregnancy (28). The interaction that may occur between hormonal contraceptive methods and mood stabilizers has been shown to reduce effectiveness in preventing pregnancy (30). It is important for physicians who are treating women with bipolar disorder to assess the patients' needs and inform them of the possibility of reduced potency of contraceptive hormones (30). In practice, many physicians will prescribe higher doses of contraceptive hormones to compensate for the reduced effectiveness, but this may not always be adequate (30). Physicians should attempt to incorporate family planning and sexuality within the devised

medical treatment strategy to help alleviate unintended stress that can intensify symptoms of the disorder (30).

Another important consideration when treating women with bipolar disorder, is the risk of treatment during pregnancy (28). Both untreated symptoms and treatments have serious risks for women with bipolar disorder who become pregnant. For most women, untreated symptoms serve a greater risk than carefully selected treatment options and monitoring during pregnancy (28). The side-effects of mood stabilizers during pregnancy and breastfeeding are serious in small percentages and physicians should adequately inform their patients (28). Physicians treating pregnant women with bipolar disorder should take special care to properly educate each women of the risks associated with both treatment and untreated symptoms (28).

For health providers who have patients who decide to forgo treatment during pregnancy, it is essential to assess them for patient factors that may reduce the associated risks with discontinuing medication (28). Such factors include ample social support and individual insight on recognizing triggers and warning signs of oncoming episodes (28). It is vital that the physician provides an environment that promotes the patient to seek assistance if an episode occurs (28).

Research findings have provided evidence that circadian rhythms, social interactions, stressors and sociocultural gender roles influence episodes throughout a lifetime (28). Supportive counseling is important to help women with bipolar disorder to cultivate set routines, promote good self-care, harness social encouragement, resolve problems, seek significant roles within society and continue working on the improvement of ones' self-esteem (28).

## **Bipolar Intervention Based on Female Age**

Effective treatment of bipolar disorder in women must be tailored to the specific reproductive stage the patient falls within (30). For young girls going through puberty, physicians should focus on assisting in the identification of triggers for mood events and encourage patients to put an effort into problem-solving rather than rumination to help develop self-coping skills (30). It is also important to educate parents of young girls who have been diagnosed with bipolar disorder on the appropriate way to communicate to prevent triggering an episode (30). The patient-physician relationship should additionally allow for each young woman to begin to accept and understand their diagnosis in the face of a challenged identity (30).

Premenstrual women should be encouraged to maintain a journal or record of symptoms that occur on a regular basis (30). This will allow for symptom patterns to help predict high risk periods for triggered episodes. With the ability to predict high risk periods, physicians should help devise a plan with the patient to proactively decrease the chance of episode occurrence and additionally educate family members about the influence that cyclic mood disorders have on social exchanges (30).

Women who are pregnant and near their due date must be informed of the common impractical and excessively perfectionistic anticipations of childbirth and parenthood (29). It is also vital that these women are informed of the postpartum disruptions daily life and social routines. A plan should be devised to help patients cope with the stress and life disturbances after delivery (30). Within this plan, a strong emphasis should be placed on the importance of getting several hours of decent sleep daily and to develop a network of support that can be utilized in times of need when caring for the newborn (30). Educating the family on the

importance of cooperation for both maternal and child care is essential for successful continued treatment after pregnancy (30).

Perimenopausal women often struggle with hormonal fluctuations that cause interruption of sleep due to night sweats and other factors (30). The physician should try to cater treatment options to function properly among hormonal changes (30). Discussion on how to improve sleep quality is important to prevent a trigger of episodes. Also, the transition through aging can negatively affect individuals diagnosed with bipolar disorder (30). This is common when those diagnosed are faced with loss or changes in societal roles. Care providers must try to relieve the stress diagnosed women experience as they transition through life to maintain efficient treatment (30).

### **Coping Strategies and Real World Functioning**

Bipolar disorder is often characterized as affecting those diagnosed, with excessive rumination and self-blame when adversity is present (9). Maladaptive coping negatively impacts treatment commonly caused by denial and non-acceptance (9). When patients struggle to cope with a bipolar diagnosis, medication adherence typically declines. Individuals diagnosed with bipolar disorder must be promoted to give-up self-blame to improve the possibility of functioning above severe depressive symptoms and receive suitable treatment (9). In combination with mood stabilizers, cognitive-behavioral interventions to reduce the occurrence of self-blame and self-critical thoughts can assist in the deterrence of a perpetual descending spiral into severe debilitation (9).



## **Patient-Centered Care**

Numerous studies have been conducted on improving patient centered care of individuals diagnosed with SMI and all share a common theme of providing patient choice in relation to treatment choices. A study by Emory University investigated the CARE program, an initiative designed for focus on shared decision-making between the care givers and patients along with traditional medical model with a recovery-based approach (47). This program and others like it, such as Project Wellness Enhancement (PWE) and Person-Centered Care, highlighted the importance of allowing patients with SMI to have a voice and play an active role in the shared decision of treatment (47).

### **Patient Centered Care History**

Patient-centered care began with the introduction of the term “medical home” in 1967 by the American Academy of Pediatrics (AAP) to define a model of primary care excellence (19). This model includes treatment that is patient-centered, inclusive, easily available and dedicated to the quality and protection of each patient (19). After the initial introduction, some time passed until in 1996 The Institute of Medicine published *Primary Care: America’s Health in a New Era* that redefined primary care by holding physicians responsible for the improvement of continual collaboration with patients and inclusion of the patient’s family and community regarding treatment (19).

In 2002, The Future of Family Medicine was launched with recommendations of changes to be made in the health system including steps to ensure access to patient-centered care (19). Along with this initiative, The Chronic Care Model was introduced to underline the vital function of primary care to prevent, manage and treat chronic illness. A few years later in 2005, further research was conducted on the importance of primary care to the health

systems with several main care tools to improve treatment (19). These guidelines include greater access, better quality, increased focus on prevention, and early management of health problems (19).

For the next eight years, consistent development of the patient-centered care model was encouraged. In 2006, The American College of Physicians (ACP) developed The Advanced Medical Home: A Patient-centered, Physician-guided Model of Health Care that proposed fundamental changes in the way primary care was to be delivered and paid for (19). In the same year, The Patient-centered Primary Care Collaborative (PCPCC) was founded by IBM and four major primary care physician associations. The goal of PCPCC was to build a national movement that promotes the widespread adoption of the patient-centered care model (19).

### **Patient Centered Care in Mental Health**

The application of patient-centered care to mental health has begun to increase in studies. Many researchers have attempted to implement the traditional model to psychiatric treatment and determine recommendations for the improvement of mental health care. In the mental health field, the term patient-centered care has been avoided with the intention of keeping the medical professional in control (21). Patient-centered care has been identified as the best method to implement a recovery-based mental health system, but only recently has it been commonly accepted as a practice in general health care (44).

It is not uncommon for healthcare professionals to fear they will be held liable if treatment and care is conducted as a partnership with the patient (44). Yale University School of Medicine completed a study to determine the top ten concerns of health care professionals in the adoption of the patient-centered care model. Many but not all concerns stem from

lessening medical knowledge and proficiency of the professional (44). It was also determined that many practitioners feel that the model is already being implemented, but upon investigation and study, many patients of the mental health system feel differently (44).

Time and money were cited as additional reasons for avoiding the patient-centered care model and this may be a result of the medical infrastructures influence on physicians (44). The economic cost of mental health treatment for both provider and patient is significant and correlates to a lack of care for those who cannot afford it (11). The demand for such health services outweighs the capacity which in turn effects the quality of care within the system (11). An increase in mental health coverage by insurance and decrease in premiums may decrease the burden on both physicians and patients (17). Also, insurance payments to providers have been increased in the case of improved patient-centered care provisions (11). By increasing payment to providers, the burden on both the physician and patient may be decreased.

Patient-centered care provisions emphasize a trusting relationship between the medical professional and both the patient and their family (values and value of patient centered care). These relationships should be based on unique experiences and individualized for each person based on their roles in society (17). A trusting relationship within the patient-centered care protocol should be built on respect with an open-line of communication to provide impartial information and education on the diagnosis and treatment outcomes of mental health disorders (17). Participation of both the patient and family in their treatment plan allows for better adherence and therefore less of a burden on the healthcare professional.

Patient-centered care applied to bipolar disorder is crucial for an improved clinical outlook (33). The management of bipolar disorder can easily be affected by the culture,

gender and social role of the individual seeking mental health treatment (33). Additionally, the method of care delivery may influence treatment outcomes as well (33). Treatment should be catered specifically to each individual to provide patients with care that sponsors recovery (33). It was determined by a study conducted on the sociocultural challenges of managing bipolar, that certain social and cultural factors directly affect the kind and class of care bipolar patients receive (33). Economic, societal and cultural factors all affected the outcome of treatment for individuals diagnosed with bipolar (33). The effect of these factors emphasizes a need for the adequate understanding of such influences on care (33).

### **Hypothetical Patient Case Study**

A hypothetical case study was developed by the American Medical Association Journal of Ethics to help address psychiatric diagnostic uncertainty for practicing physicians. The case study provides a great opportunity to observe challenges to patient-centered care and possible way to address them with ethical consideration.

Sally, a hypothetical patient, is a 20-year-old female and a college freshman. She presented to her university student health center with self-identified symptoms of depression. These symptoms include very low moods, unexplained crying episodes, and an increased lack of energy and motivation (6). She now finds it very difficult to complete daily tasks and is having struggles maintaining her school work (6). The patient revealed to her physician that a friend she went to school with experienced a very similar experience and responded well to “X-drug” with the intention of receiving a prescription for the identical condition (6).

The patient’s history and lab work was completed. Upon discussing the patient’s history, the physician discovered that Sally arrived to school a few months before this episode feeling exceptionally wonderful and needed less sleep than she previously required

(6). It was also discovered that her father and older sister had been diagnosed with bipolar disorder and she made open statements of being different than them (6). Sally did not want to be associated with bipolar illness and stressed to her doctor it was simply depression (6). In this situation, it is essential for physicians to understand the patient's wishes to prevent a diagnosis they do not fully believe they have from being recorded in their health record, but also make sure if the patient meets full criteria, that the diagnosis is applied (6).

The case study created by the AMA provides various examples of common challenges mental healthcare physicians face when attempting to apply patient-centered care principles. Challenges often arise when treating patients with mental health illnesses and a common issue is that delayed diagnosis of mental health disorders often result in high cost prescription medication due to little insurance coverage. Coverage does not apply to the medication due to lack of diagnosis. It is important for the physician to recognize that a one-size-fits-all approach to diagnosis and treatment is ineffective (6). Often, multiple disorder characteristics overlap causing the physician to implement various methods for optimal treatment (6). Classification standards, diagnostic methods and labels for common SMI phenomena allow health care providers to develop beneficial treatment (6). The health care provider should develop a treatment plan with aims at assisting patients in achieving goals by reducing the amount of suffering and pain the individual experiences from their illness (6).

Physicians may often mislabel phenomena or symptoms resulting in a misdiagnosis (6). When an individual is misdiagnosed and labeled with a particular disorder it is very difficult to fix the stigma and associated consequences (6). This is a common issue when providers use classification systems to assign diagnostic labels to patients who do not fully meet diagnostic criteria. The doctor should take special care to address Sally's concerns with

being labeled as bipolar and understand the effect the disorder has had on her family (6). The best way to address her concerns is to provide ample education and support networks to help Sally gain a better understanding of mental health (6).

Health care providers must not allow patients' fears and demands dictate the designation of a diagnosis and should always recognize that each psychiatric diagnosis has unique needs (6). "Who the patient "is", is under constant modification and whichever mental disorder the person "has" is revised in concert with the self (6)." With the ever-changing face of bipolar disorder, physicians must excel at providing continuous and comprehensive treatment with proper modifications when necessary (6). This is possible through fostering a therapeutic relationship between care provider and patient that is especially important when the individual is wary of their diagnostic label (6).

A therapeutic relationship can be defined as a relationship that allows the patient to feel relaxed enough to be open and honest with the health care provider (36). Sally and her physician must work to build their therapeutic relationship and develop a system of honest discussion (6). Sally's physician may apply a provisional diagnosis to effectively treat her illness and further build a therapeutic relationship by emphasizing that each bipolar diagnosis is different and provides individualized circumstances (6). A successful physician will be sure to stress that a diagnosis does not define the patient (6). It is also important to ethically consider Sally's concerns with a bipolar diagnosis, but her physician should base his/her diagnosis and care plan on medical training and professional honesty instead of his/her patient's desires (6).

## **CHAPTER 3**

### **DISCUSSION AND RECOMMENDATIONS**

#### **Summary of Findings**

Statistics show that the influence of mental health, specifically bipolar disorder, on the population is continuing to grow. This fact alone is sufficient evidence for the increased demand to improve the care of those who suffer from mental health disorders such as bipolar. The central problem many individuals experience within the mental healthcare system is the ineffective application of patient-centered care. For example, patient-centered care is not effectively being applied to the treatment of women who have been diagnosed with bipolar disorder.

Common themes discovered in research studies conducted on improving patient-centered care included patient's struggling with lack of access, decline in quality of care, lack of involvement of family in care plan, poor therapeutic relationships between care providers and patients, and little or no resources available for the individuals to develop coping skills on their own. Another key problem seen in mental health treatment was a decrease in understanding each patient's condition as an experience of their own. Doctors are trained to treat an illness and not an individual. This creates a relationship that does not sponsor healing and tends to decrease the ability for the patient to manage their disorder.

#### **Recommendations**

Based on the research conducted through the literature review, the following recommendations can be made and applied for improved patient centered care of women diagnosed with bipolar disorder:

1. Individualized Treatment
  - a. Make a conscious effort to construct personalized strategies of treatment that are built on patient's feelings and beliefs.
2. Communication, Education and Information
  - a. Provide neutral, comprehensive information about treatment options by maintaining open lines of communication and educating patients on the data and projected outcomes of each treatment.
3. Accessibility of Care
  - a. Access to suitable and affordable options in locations where the clients feel at ease.

### **Questions for Future Research**

The need for increased research and focus on improving patient-centered is evident. Institutions and organizations interested in further investigating methods to improve the application of patient-centered care in mental health may ask:

1. Do these recommendations pertain to men as they do to women?
2. Is the difference in treating women and men a common theme seen in other mental illnesses?
3. How can treatment be further specialized for each gender?
4. Do these same recommendations apply to other mental health illnesses?
5. Are there other discrepancies present in general mental health, and if so what are they?



## **Future Application**

From the information gathered in this study, it would be useful to develop a plan to test recommendations to determine if implementation would be valuable. The hope for developing a plan for implementation is to determine the effectiveness of the developed recommendations for producing better outcomes and perceptions of patient-centered care for women diagnosed with bipolar disorder. Institutions and organizations focused on improving patient-centered care for those diagnosed with mental health disorders are the prime candidates for this type of study. Additional research would be valuable to establish if the developed recommendations are applicable to men diagnosed with bipolar disorder or to the treatment plans of other mental illnesses to improve care of mental health overall.

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