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Case Study

Understanding the Impact of Bipolar Disorder Experience from an Insiders' Perspective

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ABSTRACT

Introduction: Bipolar disorder is characterized by recurrent episodes of depression and hypomania and is often associated with functional impairment even between mood episodes. A substantial proportion of patients experience inter-episode mood swings, making bipolar disorder a complex psychiatric disorder to manage. Patients' perspectives can enhance clinical practice and research. The present study aimed to explore the impact of the bipolar disorder experience from a patient's perspective to facilitate better understanding in clinical practice and future research.

Method: We conducted a single case study with a key informant living with bipolar disorder (type I) for more than 20 years. The key informant constructed a chart of his mood disorder experiences. Subsequently, he commented on the chart and these comments were noted down by his therapist.

Results: We present a chart of lived experience perception by a person living with bipolar disorder. The main axis was reality perception and it was related with mood, identity, and functioning. The comments on the chart provided a detailed and accurate description of a lived experience of functioning of bipolar disorder and its impact on a person's life.

Discussion: Globally, the experiences described by the key informant are consistent with previous literature. The principal finding was the meaning of the subjective experiences of reality perception, their relation with mood change, and impact on the person's life. The perception of reality seems to be a key factor in the experience of bipolar mood swings. Not only did the disorder affect the self and the functioning, but at its extreme, reality "either did not matter or did not exist." This feeling enhanced the sense of being disconnected from the world and the surroundings and led to the experience of extreme loneliness.

Conclusion: The description in this study cannot be generalized, since it was conducted with only one subject. However, it provided a better insight into the detailed real-life experience that can be useful for clinicians treating persons living with bipolar disorder. Such descriptions obtained from a qualitative procedure can also be combined with quantitative data in patients' assessments and research. This study suggests that the experience of "disconnection" should be investigated further.

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Introduction

Bipolar disorder is characterized by recurrent episodes of depression and hypomania [1]. The two main subtypes are BD-I (manic episodes, often combined with depressive episodes) and BD-II (hypomanic episodes, combined with depressive episodes) [2]. Pallaskorpi *et al.* (2019) conducted a five-year prospective study of predominant polarity in bipolar disorder [3]. Predominant polarity was manic in 16% of the

patients, intermediate in 48%, and depressive in 36%. The depressive group had the highest incidence of suicide attempts. In bipolar disorder, the number of episodes has been found to be associated with poor outcome and patients with long duration of illness and highly recurrent course showed greater impairment of global functioning [4]. Impairment of psychosocial functioning has been demonstrated in 30-60% of the adults with bipolar disorder. Occupational or psychosocial impairment is also present between the mood episodes [5]. These findings have resulted in growing interest in the assessment of functioning in persons

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living with bipolar disorder [6]. The early description of symptom-free euthymia has been reviewed. People with bipolar disorder often experience persistent residual symptoms, cognitive impairment, and poor quality of life [7]. Factors that may influence prognosis, common comorbidities, and chronic and enduring deficits associated with bipolar disorder are being understood in a better way [8].

Mood instability in bipolar disorder is associated with a risk of relapse. Faurholt-Jepsen *et al.* (2019) showed that patients with type II bipolar disorder had higher mood instability during depression than those with type I bipolar disorder [9]. Moreover, inter-episode mood swings are experienced by a substantial proportion of persons living with bipolar disorder. Inter-episode mood instability is associated with impaired functioning and poor prognostic factors such as increased risk of relapse and increased risk of hospitalization. Therefore, it is important for the clinicians and the researchers to identify these inter-episode symptoms. To bridge the gap between research and clinical practice, perspectives of patients living with bipolar disorder have been used in research [10, 11]. The present study aimed to explore the impact of the bipolar disorder experience from a patient's perspective.

Method

I Study and Design

i Case Selection

We conducted a single case study with an information-rich person (BN) who was able to provide a clear account about the related phenomenon of interest (purposeful sampling). He is a euthymic Caucasian male living with bipolar disorder (type I according to DSM 5 criteria) [2]. The course of the disorder experienced by him was not atypical when

compared with cases described in the literature. Therefore, we selected a "most likely" or a "typical case" [9]. This case was intended to represent relevant descriptive features of a broader set of cases.

ii Design

We followed a two-phase design. During the first phase, a conversation between the patient (BN) and his therapist resulted in the drawing depicted in (Figure 1). During the second phase, BN commented on (Figure 1). The comments were recorded in real time with a note-taking process. The researcher conducted the interview and performed the transcription process to avoid misinterpretations [12]. The participant provided his written consent to use the material for this study. There was no need of an ethical approval to conduct this study due to the small sample size (< 5 participants). However, the study was conducted in accordance with the general ethical principles applicable to all research involving individuals, particularly the implementation of the necessary measures to preserve the confidentiality and professional secrecy of the involved person and the anonymity of the participant.

iii Participant

BN is in his forties, living with bipolar disorder since more than 20 years. He experienced the first mood swing in his twenties. He was hospitalized twice (once in his twenties and once in his thirties) for depression with psychotic characteristics. Mania had preceded these depressive episodes and was diagnosed retrospectively (with paranoid delusion). He was initially treated with escitalopram and lithium was introduced recently (6 months ago). After his university studies, he obtained a degree in engineering. He is currently divorced, a father of two children, and works as an independent engineer.

PERCEPTION OF REALITY					
How it seems	Everything is too real and overwhelming	←	Throughout a blurred sense of truth Dream versus reality	→	Nothing exists except the thought everything which can be thought can be changed
How I feel	Terrified Lonely Depressed	Lack energy But continuing	OK	Absolutely amazing !!	Totally out of control
Who am I ?	Incompetent Unlovable Self-loathing	Self-doubt Shy Low-esteem	Functional Unemotional Judgmental	Everything is possible Hard to stop Full of energy Not thinking about my self-worth	Paranoid Multiple voices Multiple characters Very manipulative versus hate myself
How do I function ? Judgements Decisions Actions, etc	Unable to decide Difficult to act See problems everywhere The universe is pointless Failure is everything	Can focus on tasks Struggle to interact Can make decisions with support Nothing makes sense Feels like I am missing something What does "failure" or "success" mean ?	Can manage multiple ideas together Reluctant to socialize Need rituals Driven by fear of failure and shame	Full access to the matrix I am in control Everything is great Sociable See thoughts, ideas and opportunities Happy coincidences "Failure" is not a concept	Cannot stop Everything must be solved Time is flexible Can be brutal (verbally) with others Every single thoughts must be addressed or I have failed

Figure 1: Experience of bipolar disorder from an insiders' perspective.

Results

BN and his narrative therapy-trained therapist met recently. The subject reported that perception of reality was the most difficult aspect of his relationship with this illness. A conversation between BN and his therapist resulted in the drawing depicted in (Figure 1). He described it as “a consistent and representative figure of his experience.” Figure 1 describes the experience of a person living with bipolar disorder (type I). Perception of reality was the main axis, and it was linked with mood, identity, and functioning. There were 5 identified patterns. During the second phase of the study, BN commented on (Figure 1). His comments related to “different area of functioning”, “transitions”, and “global perception”.

I Different Area of Functioning

BN divided the continuum into 3 areas (extreme left, middle, and extreme right).

“On this continuum, the ‘happiest’ time for me is on the center-right, before the extreme right where it becomes unsustainable, a very high level to operate.” In this extreme phase, his colleagues started to wonder, “How on earth did you do all that? Do you ever sleep?” and to ask him, “Please stop, we cannot keep up with you and we are being judged against you.” It could also be a time of creativity wherein BN was able to design new engines, he painted, and composed music (which he did not do habitually). This “incredibly productive phase” was accompanied by eating less food and inadequate sleep, and the phase was exhausting in the end.

BN reported, “On the left side of the chart, there is a lack of self-confidence, and a lot of self-criticism, with several instances of beating myself up.” The extreme left side of the chart was also described as a phase with “disasters, problems after problems” and the notion that “nothing is going to work.”

These extreme phases used to occur every 2-3 years; time was mostly spending in the middle phase. This inter-episode’s “middle” phase was itself divided into 3 different structured patterns. In the center-right, problems were seen as opportunities along with the feeling of being connected with the self and the world. This was described by responses such as “things make sense,” “I just am,” and “I just live.” Outside this area, the general feeling was that of “being very alone.” Things were either insignificant (on the left side) or not real (on the right side), an oscillation between “nothing matters” and “nothing exists.”

II Transitions

BN said that he could identify features of transition between “the middle” and “the left” sides. He described them as “bursts of anxiety, invasive obsessional thoughts, feeling that things are starting to fall apart, more arguments with friends, and the thought that bad things are because of me.” BN said that he could also identify features of transition between “the middle” and “the right” side. He described them as, “I start seeing connections everywhere, I see something random and I see it everywhere, reality starts to fade away, my mind is extremely fast.”

III Global Perception

BN described his experience with bipolar disorder mainly in terms of the “world looking totally different”; from “having no sense of belonging and feeling disconnected from other people, things being totally pointless and a waste of time” to “belonging, being connected, with a sense of attachment to others”. BN reported that his perceptions changed drastically: “as I move (change in perception of reality), its’ not only the mood that changes, but also the thoughts, the decisions...it’s a constant struggle”. This experience of drastic perception change was globally a very difficult experience on the cognitive level, and it produced the feeling of being “very alone” on the emotional and existential levels. It was a “nothing-nobody, a terrifying, isolating and simultaneously liberating experience.”

Discussion

The experience of bipolar disorder was described on a continuum divided into three areas (depression, mania, and inter-episode phase). These areas were linked with experiences that were radically different and there were two identifiable turning points (one from euthymia to depression and one from euthymia to mania). These descriptions are compatible with the current knowledge on bipolar disorder. The subject’s description of the inter-episode phase was the “center-right area,” the only area on the chart that denoted well-being. It could be considered as mild hypomania. It did not represent a substantial percentage of time on the continuum. The subject also tended to experience a smaller number of inter-episode phases with time. The clinical and the functional impact of inter-episode mood instability has been suggested as a target for treatment and may be a more sensitive outcome measure in randomized controlled trials than relapse or recurrence of the affective episodes [9].

Contrary to the findings in the literature, the subject did not report cognitive impairments or impulsivity during the inter-episode phase or the mood episodes. Two meta-analyses have shown that cognitive impairment is frequently observed among individuals with bipolar disorder during acute and euthymic phases of the illness [13, 14]. In bipolar disorder, cognitive impairments (attention/processing speed, episodic memory, and executive functioning) cannot be fully attributed to symptoms of depression and mania. In euthymic bipolar disorder, generalized cognitive impairment may be moderated by age, duration of the illness, education, and clinical course. Moreover, self-report impulsivity scores showed evidence of persistent self-perceived impulsivity by patients during euthymia [15]. Thus, impulsivity may be a trait of patients with bipolar disorder.

The main axis of the continuum was not mood, as could be expected, but “perception of reality.” The reported experience for most of the period was that the reality “either did not matter or did not exist.” This was observed especially during mood episodes, which produced a feeling of “extreme loneliness” that was mostly unbearable. These experiences could be linked to delusion. In addition, research regarding “theory of mind,” which is the ability to make sense of information on the potential intentions and dispositions of others, showed that people with bipolar disorder have difficulties in understanding the mental state of others, which can result in the misreading of social cues and consequently, a reduced ability to accurately comprehend social interactions [16]. This

finding could also partially explain the feeling of being “disconnected” that was reported by the subject in the present study.

The reported changes in the experience of the self by the subject matched Moskalewicz and Schwartz's (2018) description of the manic self [17]. They showed how manic temporality and the manic self were intertwined. Mania impinges on the ordinary temporal structure of lived experience, as it involves radical acceleration and radical asynchronicity, which result in an instantaneous existence. The manic self is immersed in the now and lacks a reflective distance toward time. There is little or no consideration for the consequences of actions.

The reported experiences of discontinuity by the subject can partially be linked with the global experience of bipolar disorder, but also with the description of people in manic states. People in manic states remain in contact with reality, even if they are unable to penetrate it. Contact becomes a mere play between the instants of time, and not a lived duration. Manic persons not only are more impulsive but also have unrealistic goals and grandiose visions of what is possible. Even though people suffering from mania may remain in touch with the clock time, they do not establish a meaningful relationship with it. Therefore, the clock time categories are detached from lived experience and operate in a depersonalized form.

In clinical practice and in research, measures have been used to analyze mood fluctuations in bipolar disorders. For example, “measurement-based care” and “mood instability factor” have been used to quantify bipolar disorder illness. Measurement-based care is a clinical strategy involving regular measurement of symptom frequency and severity, side effects, and treatment adherence and the use of these findings to inform clinical decision making. However, its utilization for bipolar disorders is limited, in part due to the uncertainty regarding the utility of available measures [18].

Faurholt-Jepsen *et al.* (2019) described a mood instability factor calculated as the number of mood changes divided by the number of weeks followed [9]. A mood instability factor for depression was calculated as the number of mood changes of depressive polarity divided by the number of weeks followed. A mood instability factor for mania was calculated as the number of mood changes of manic polarity divided by the number of weeks followed. The qualitative data of this single case study cannot be generalized, but they may help provide better insight into experiences and describe clinical landmarks that can be combined with the quantitative measures [19, 20].

Conclusion

The results of the present study are consistent with those in previous literature, namely the description of the three phases in bipolar disorder, the different impacts of each phase, and the switches on the continuum. However, from an insider's perspective, the switches in the perception of reality are most important, and their impact is apparent on the relation with self, the world, and others. These results may open newer fields of investigation for the clinicians and the researchers. Especially, the experience of “disconnection” should be investigated further.

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Conflicts of Interest

None.

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