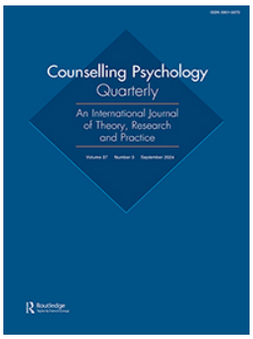

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The experience of mood change over time for people diagnosed with bipolar disorder: a longitudinal interpretative phenomenological analysis

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ABSTRACT

Living with episodes of mania and depression is recognised to instil profound instability in people diagnosed with bipolar disorder, but little is known about how these mood changes arise through a person's trajectory over time. This longitudinal study aimed to investigate the experience of mood change within and between bipolar disorder episodes. Semi-structured interviews were conducted with three women at two time points and were analysed using longitudinal interpretative phenomenological analysis to form idiographic trajectories. Three longitudinal themes illustrated the changing experiences of participants during periods of depression, euthymia (stability) and mania: (i) Extreme changes in activity and agency, (ii) Changes in feelings and connectivity, (iii) Shifting sense of the future disrupts momentum. The findings highlighted trajectories of change in key areas of the participants' lives including activity levels, routine and agency, intensity of feelings and connectivity, and their sense of the future and progression. Changes experienced during episodes were cumulative, impacting participants' ability to reconnect, take control and move forward during euthymia. The clinical value of mapping a client's sense of change across BD phases is indicated, along with the need to build agency, progression and connectivity during euthymic periods. Suggestions for research and practice are discussed.

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Introduction

Bipolar Disorder (BD) is characterised by recurring episodes of mania, hypomania and depression that create profound disruptions to mood, energy and behaviour (Vieta et al., 2018). In diagnostic criteria, BD Type I is characterised by manic symptoms for one week and BD II by hypomania for four days and one major depressive episode (American Psychiatric Association, 2013). BD is estimated to affect 1% of the global population and is associated with substantially shortened life expectancy (Chan et al., 2022). Typically a recurrent illness, it often leads to functional impairment and reduced quality of life that

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can be more severe than unipolar depression and on par with schizophrenia (Brissos et al., 2008; Cotrena et al., 2016).

In the course of BD, a higher number of episodes is associated with a decline in cognition, functioning and quality of life, along with a decrease in response to treatment (IsHak et al., 2012; Scott et al., 2006; Vieta et al., 2013). The relationship between functional and symptomatic recovery during inter-episode periods is also complex, commonly featuring a time lag where people who have become asymptomatic remain functionally impaired (Gitlin & Miklowitz, 2017).

Evidence-based psychotherapy in combination with pharmacotherapy is considered the best option for stabilising manic episodes and preventing recurrences of depression (Cuijpers et al., 2020). An important target of psychological treatment is the prevention of episodes through monitoring of moods and early detection of symptoms (Reinares & Vieta, 2019). BD episodes and their associated symptoms tend to be conceptualised according to the diagnostic criteria whereby depression involves symptoms, such as depressed mood, diminished interest in activities, weight loss, decreased energy, psychomotor agitation, insomnia, feelings of worthlessness, difficulties concentrating and suicidal thoughts, and mania is associated with symptoms including elevated mood and increased activity or energy, inflated self-esteem and flight of ideas (American Psychiatric Association, 2013; World Health Organization, 2019). These symptoms are conceived as discrete, observable and unrelated. Yet this snapshot view of symptoms, perpetuates a conception of BD that overlooks the subjective experience of mood change *between* episodes and how it unfolds within the flow of a person's life.

Quantitative longitudinal work provides indicators on the prevalence and course of BD symptoms. Studies estimate that people experience BD moods and symptoms for approximately half of their time living with the condition (Judd et al., 2002, 2003)., It is suggested that individuals with BD Type I spend 8.9% of their time manic and 31.9% depressed (Judd et al., 2002). Even during inter-episode "stable" periods (euthymia), people report residual symptoms, such as residual depressive and manic mood symptoms, emotional dysregulation, sleep disturbance and impaired concentration (Samalin et al., 2016). Yet no work has focused on how BD mood change unfolds through a person's experience over time. A qualitative longitudinal approach is well-positioned to offer insight.

Qualitative work has attempted to bridge the gap between an objective view of mood symptoms and people's experience of living with them. A small number of cross-sectional studies have explored the retrospective experience of mood states, predominantly focusing on mania. Elevated BD moods are characterised by an intensity experienced in multiple dimensions, encompassing a person's sense of self, their relational experiences and their surroundings (Lobban et al., 2012; Taylor et al., 2015). One study describes heightened perceptual, cognitive and emotional experiences that generate novel ideas and creativity (Taylor et al., 2015). Further work suggests an energy surge that gives rise to non-linear thinking and heightened sensitivity to connections (Rusner Carlssonet et al., 2009).

Some qualitative studies suggest that ecstasy during mania is characterised by feelings of liberation and physical energy, whereas spiritual experiences involve an intensity of meaning and divine connection (Ouwehandet et al., 2018; Russell & Moss, 2013). Other work emphasises the fear generated by a surge of destructive feelings and behaviours (Goldberg, 2019). Mania, therefore, can be viewed as a gift in its ability to extend

experiences beyond the constraints of normal life, but a threat due to its destructive consequences (Lobbanet et al., 2012).

Work on the experience of BD depression is scarce. One study suggests that low mood precipitates negative self-perceptions and frightening experiences, including suicidal ideation, loneliness and despair (Fernandezet et al., 2014). The only study to tackle the retrospective experience of both elevated and depressed states examines the cognitive processes and behaviours that mediate moods. Informed by a cognitive model of BD, findings indicate the contributory role of extreme self-appraisals in driving mood escalation, whereby hypomania is seen as a positive aspect of identity and induces ascent behaviours, while depression is negative and intensifies depressive symptoms (Fletcheret al., 2013). The cognitive framing of this study is limited, however, highlighting the need for a holistic and inductive examination of the experience of both low and elevated moods.

Qualitative work in this area has also explored the impact of mood change on the person and their life. Findings indicate that living with BD leads to a loss of control, feelings of confusion, failure and identity loss (Crowe et al., 2012). Helplessness and inconsistency are often accompanied by depleted self-esteem and an inability to meet social norms of self-control (Fernandezet et al., 2014). In turn, confusion and inconsistency can lead to identity disruption (Crowe et al., 2012; Inder et al., 2008, 2011).

These studies provide valuable insight into the profound impact of living with BD, but the way that moods arise and bring about instability is not clear. This study therefore aims to capture the perceived root of people's instability by examining how mood changes are seen to arise and develop during phases of BD.

Longitudinal qualitative enquiry is well-positioned to capture how people experience change between stable periods and different mood states through time. Data are collected from different time-points, enabling an examination of participants' experiences at the time that they occurred. This faciltiates a more immediate view of change than traditional cross-sectional qualitative methods that tend to collect data retrospectively (Neale, 2021). Moreover, the analysis of data across successive time-points can provide insight into the perceived changes *between* different phases. This granular examination shifts the focus away from the retrospective impact of moods and towards the way changes arise and develop.

One unique feature of longitudinal Interpretative Phenomenological Analysis (LIPA) is its idiographic level of analysis (Farr & Nizza, 2019). For each participant, themes are formulated at each time-point before examining change across time-points. A case-by-case approach pinpoints strands of change, offering insight into the complexity of experiential transition as it evolves through a person's subjective sense-making.

The wider literature suggests BD episodes lead to feelings of being out of control, identity challenges and an inability to progress. And yet the experience of how mood change arises within and between episodes, as well as stable (euthymic) periods, is not known. A better understanding of this aspect has potential to bring insight to the self-management and monitoring of BD symptoms, an important focus of clinical provision (Jones et al., 2011). It is also likely to help understand and relate the occurrence of residual symptoms during stability to mood changes across episodes, informing clinical support during inter-episode periods (Samalin et al., 2016). Therefore, this study will examine how people with a diagnosis of BD experience mood change through time in terms of themselves, other people and their environment.

Method

Design and setting

IPA's phenomenological and interpretative orientation is well-positioned to examine the way people experience, make sense of and imbue BD moods with meaning. Used longitudinally, the unique strength of IPA versus other methods is its idiographic level of analysis that can identify each participant's trajectory and their evolving sense-making of change over time. The aim was to interview each participant three times; once during each phase (depression, mania, stability). A key consideration, however, was the feasibility of interviewing people during BD episodes which would be contingent on opportunity and episode severity. Although BD depression is common, episodes of mania tend to be infrequent (Gitlin & Frye, 2012).

Participants

Participants were selected purposively to form a relatively homogenous sample. Inclusion criteria included a diagnosis of BD and sufficient fluency in English to conduct an interview. Three participants were recruited and interviewed during depression and stability. Participants were female, white and aged 35–45. They had received a formal diagnosis of bipolar disorder (ICD-10 criteria) in the last five years from psychiatrists within the community mental health team. All had episodes of mania recorded in their medical notes. See Table 1 below.

Ethical considerations

The study received ethics approval from Camden and Kings Cross National Health Service

Table 1. Participant details and interviews.

Name Pseudonym	Gender	Age	Stable (euthymia) Interview	Depressed Interview	Time between Interviews
Julia	Female	38	Interview 2	Interview 1	6 weeks
Caroline	Female	40	Interview 1	Interview 2	6 months
Karen	Female	45	Interview 2	Interview 1	2 months

(NHS) research ethics committee (Ref: 15/LO/1875). Interview procedures were devised to minimise the risk of upsetting participants. Participants were reminded of their right not to answer questions or to stop the interview, while the researcher monitored their well-being and stopped should they appear distressed. If a participant disclosed a significant risk to themselves or intention to harm others, their clinician would be immediately notified. The terms of breaking confidentiality were outlined in the consent form and, in practice, no issues arose. Interviews were conducted at the service where clinical support was available to both participant and researcher. Recruitment procedures were devised to reduce risk and avoid breaking participant confidentiality. Prior to interviews, clinicians

were approached to check the suitability of individuals, ensuring those who were known to be at risk were not included. In practice, no participants were excluded on this basis.

Procedures

The study was based in the psychology department of a UK NHS adult community mental health service in London. The department works with service users diagnosed with bipolar disorders and other long term mental health conditions. Between 2016 and 2018, recruitment and data collection were conducted. The study analysis was then completed and written up as part of a doctoral thesis.

Clinicians at the service, who were not involved in the study, identified suitable participants and informed them about the study. Potential participants were invited to contact the researcher and told their therapeutic care would not be influenced by their decision to participate or not. The researcher sent an information sheet and consent form to potential participants, who were invited to review and discuss any queries with the researcher or their clinician. If they wished to participate, an interview time was arranged that was convenient for the participant. Interviews were conducted in person. Prior to each interview, study details were reviewed and consent confirmed. Before interviews during depression, participants were screened for depression using the Beck depression inventory self-report questionnaire.

The same interview schedule was used for all interviews, regardless of phase, offering participants the opportunity to describe their current state in detail but also reflect on the other two states. This more inductive approach enabled participants to describe how they were feeling at the time rather than tailoring the interview schedule to a specific phase and assuming that change had taken place (Farr & Nizza, 2019). During the first part of the interview, questions were asked about the participant's current state. They were then asked to talk about their previous state and, finally, the third state they had not yet discussed. Questions were developed in consultation with the wider literature and the clinician involved with the study (third author).

Interviews were audio recorded and conducted in a private room at the service. After the first interview, participants were asked whether they would be interested in participating in a second interview during a different state. All participants showed interest in continuing and were asked to contact the researcher if they experienced a change in mood. This novel approach to monitoring change in qualitative work meant that participants rather than researchers chose when to initiate second interviews. All interviews lasted 65–100 minutes. Interviews were transcribed verbatim, pseudonymised and all potentially identifying details were changed, including names and locations.

Data analysis

Drawing on a recent review of LIPA analytic strategies (Farr & Nizza, 2019), the analysis was conducted on a case-by-case basis, with longitudinal themes generated for each participant before identifying longitudinal themes for the group. The first step was to analyse the data for each participant at each time point. The analysis of interviews followed the cross-sectional IPA analysis process described by Smith et al., (2021). Notes were made throughout a transcript, translated into experiential statements and

clustered, producing a table of personal experiential themes for that interview. This process was repeated for each interview, producing two tables of personal experiential themes for each participant (depression and stability). The formation of a table of themes at each time-point captured the participant's immediate experience of either depression or stability, along with their retrospective experience of mania.

The two theme tables for each participant were then analysed longitudinally to formulate a table of themes that captured their experience across the three states. This involved looking across themes to identify the changes between depression, stability and mania. To compare the three states, themes relating to each phase were tabled side by side and aspects of change identified (e.g. activity levels, view of the future). Through this process, trajectories of change were established, spanning both episodes and stability. This resulted in a longitudinal table of themes for each participant.

Finally, a cross-case analysis of the three longitudinal table of themes was conducted to formulate a master longitudinal table of themes for the group. Four longitudinal themes were identified, focusing on participants' i) changing sense of activity and agency, ii) feelings and connectivity, iii) perceptions of the future and momentum, and iv) relatedness to other people. The first three themes were closely interrelated, so to allow for sufficient depth, only these will be presented in this paper.

The researcher (first author) who led the interviews and analysis is white, middle-aged and female. She has no lived BD experience but has assisted with BD therapeutic groups and been trained in LIPA. The remaining two researchers are white, middle-aged and male. The second author is an expert in IPA and the third has extensive clinical experience of BD. During analysis, reflexivity supported an awareness of the researcher's position, how this differed from that of participants and how this could influence the formation of analytic interpretations. Though it was not possible to fully grasp differences in position, this process was facilitated by an iterative process during which possible interpretations were repeatedly reflected on by considering the data, the researcher's position and participant's account. A member of the research team (second author) also cross-checked the researcher's interpretations against the data.

Results

Three themes illustrate the changing trajectory of participants during each stage of depression, stability and mania: "Extreme changes in activity and agency", "Changes in feelings and connectivity" and "Shifting sense of the future disrupts momentum". See Table 2 below.

Theme: extreme changes in activity and agency

Participants underwent dramatic changes in activity that impacted their sense of agency over time.

Depression: collapse in activity and agency

During depression, participants experienced a sharp reduction in activity that assaulted their sense of agency.

Table 2. Master table of longitudinal themes for participants.

Depression	Stability	Mania
(1) Extreme changes in activity and agency		
Collapse in activity and agency	Regaining control	Escalating activity and illusory control
(2) Changes in feelings and connectivity		
Numbing disconnection from self and world	Rewakening of feeling and connectivity	Engulfed by intensity of non-stop feeling
(3) Shifting sense of the future disrupts momentum		
Blocked by inaccessible future	Regaining momentum	Unrealistic view of what's possible hinders progress

When Julia first talks about her experiences she has been depressed for several weeks and feels frustrated by her inability to execute basic tasks:

> I'm trying to do things, but I get tired very quickly and crawl back to bed. I'm just doing one-fourth or one-fifth of what I used to do. I kind of live in a mess, I read something, I listen to something, I watch some programmes. Basically, that's it. Actually, nothing. Nothing!

Julia's efforts to do things are frustrated by lapses in energy that force her to "crawl back to bed". Her exhaustion is physically crippling, like a burden that weighs so heavily that it restricts her movement. This is a demeaning experience where she feels depleted by doing only "one-fourth" of what she used to, and what she feels she ought to do. Her admission that she lives "in a mess" not only describes her living conditions, but suggests a deeper sense of chaos that leaves her unable to execute her daily routine and reduces her to "nothing".

Similarly, Karen emphasises that:

> All things just come to a halt. I just don't feel like doing anything. I feel completely lazy, absolutely no interest in doing. I've stopped doing everything, I'm not doing anything and that just reinforces the fact that I'm lazy and I can't do anything.

Karen has been drawn into a cycle of inactivity. Whereas Julia tries to do things, Karen has "absolutely no interest" and capitulates. She does not share Julia's sense of frustration because her inertia simply reinforces the "lazy" person she feels she is. Karen's incapacity to act is not perceived as a transient symptom but an immutable "fact" of her character.

Likewise, Caroline withdraws into inertia:

> I wake up at 4 o'clock or 6 o'clock in the evening and I just (*pause*) whatever happens, happens Order food and the day goes on. I'm very occupied with my thoughts so I don't need TV or anything else.

Caroline's inactive routine exacerbates her disconnection from her surroundings. But while the others express concern over their inertia, Caroline appears indifferent. "Whatever happens" seems to happen without her meaningful participation. Unaware of the significance of her actions, she has become detached from the world and is preoccupied by her own "thoughts".

Stability: regaining control

By the second interview, the participants' mood had stabilised and they felt rejuvenated by an increase in activity and control. Julia embraces a newfound readiness:

> I'm ready to do things, you know, yeah, I'm ready to do things. I kind of make myself breakfast, do the things and then sort things out: cleaning, washing, ironing [. . .] Really, I wake up, you know, I have a plan, want to do things I want to go somewhere. This is the biggest change.

Julia expresses an eagerness to demonstrate volition over her actions, enthusiastically reeling off a list of chores. During depression, Julia lacked ownership, but is now motivated to shape her actions through a regular routine. By executing daily tasks, she gains a sense of order and purpose that reconnect her with her interests and desires.

When Karen begins to feel better, she is surprised at being able to do things:

> "Wow!" Kind of like saying, "I'm back!" so to speak, so I'm kind of like back to normal kind of thing or whatever. I can actually do things. It's kind of like a novelty. I feel well and it helps me tidy up the house or whatever and then before long I'll be down again, so it's not something I can plan.

Karen's revival offers respite from bouts of depression that are so persistent that they make her return to normal activities during stability feel "like a novelty". Unlike Julia, Karen expresses ambivalence over her ability to "do things" which she sees as precarious. Whereas Julia's agency is revived, Karen's prediction that "before long I'll be down again" inhibits her ability to "plan".

Caroline returns to her daily activities:

> I can wake up in the morning and I can take a shower. I can do things and then I can go out. Before, I was so scared of going out, dealing with people, doing things on my own, so I was just paralysed. So, there is a difference now. I can take the transport, I can talk to people a little bit, but I think my communication skills have decreased so much, I'm not as communicative as before.

Whereas before Caroline was "paralysed", she now wakes up within an interactive relationship with her environment. Like Julia, her list of activities expresses a renewed surety in her ability to participate in the world. Now she feels better, her awareness of the physicality of her depressive shut down seems increasingly apparent and brings into focus her accumulated sense of loss – "my communication skills have decreased". Like Karen, Caroline's is not a straightforward recovery, but brings difficulties that are inseparable from her shifts in state over time.

Mania: escalating activity and illusory control

All participants described a dramatic increase in activity levels during mania that overwhelmed their lives, significantly altering daily routines and temporal cycles.

In contrast to depression, Julia emphasised that in mania she works relentlessly:

> I wake up in the morning, go to the gym, work out for 2 hours, then work, you know, but really work so hard, consistently . . . I'd go to work for 8 hours, after 8 hours I'd take it home and work all weekend, non-stop.

Julia attacks her activities with a drive that enables her to work at a ferocious level. But this destabilises her routine, breaking normative temporal cycles and physical limits and,

before long, Julia is aware of a widening disconnect between the intensity of her activities and their productivity:

> That productivity starts to go … like doing things, but not being productive, agitated, you know, and restless.

Though her drive sustains, it fails to result in anything "productive". Julia feels "restless" and "agitated", physical sensations that reflect an inability to confer meaning or direction on her actions.

Karen is similarly energised:

> You feel like you have the energy to go on forever … go on and on and on. You feel full of energy and that's why you have the desire to do all of those things and to carry on doing them.

Karen's boundless energy sparks dramatic increases in activity. Previously she was relieved at just doing *something*, now she feels exhilarated by an extraordinary urge to do *everything*. Like Julia, her activity has a momentum that drives her forward.

Similarly, Caroline experiences a dramatic rise in affectivity and activity:

> It was like a roller coaster to me, a roller coaster … I was very elated, very positive, very aggressive, like everything was possible for me to do, I didn't need to sleep as much as I would normally, I was just full of activities and ideas flowing in my head, doing lots of things

Caroline's mania is driven by extremes of elation and aggression. Like the others, activities that seemed impossible are now open to her, fuelling her sense of invincibility. The change is all-encompassing and occurs at multiple levels, including feelings, activities, and cognitions. Retrospectively, however, she realises that her control is illusory and that nothing meaningful is achieved:

> Not useful things I would do […] I'm just using what comes into my brain rather than having to think about what I have to do, just whatever comes, just comes and I act upon it

Theme: changes in feelings and connectivity

Changes in the participants' feelings during episodes impacted their sense of connection with themselves, others, and their surroundings.

Depression: numbing disconnection from self and world

When depressed, all participants described a sense of numbness.

Julia's arises bodily, blunting her sense of connection:

> It's painful kind of, you know, it's so sad a word, it's painful, yeah, I feel really kind of … that sadness and everything, it makes you like numb, you know, everything, you know paralysing you, yes, paralysing, emotionally painful, very much painful for me.

Julia describes depression as "painful", a word that captures her emotional suffering. Her sadness is "paralysing", making her physically numb and disconnecting her from any sense of a shared affective space.

Karen concurs:

> I'm completely numb, so I've lost kind of all emotion … I don't see myself crying now coz, I don't think I have it in me. And then on the other side of things, I don't get happy either, or I don't experience any actual happiness so it's kind of like I don't have much emotion in me. I don't have much emotion left.

Karen describes her loss of emotion as a sensation that leaves her empty. Whereas Julia was numbed by the force of her sadness, Karen's numbness reflects a loss of emotional responsiveness and expression. Moreover, she sees this as a personal defect where she doesn't "have it in me" to generate a range of emotions. Her words, "I don't have much emotion left", are tinged with foreboding, expressing the fear that she has little more to give.

Caroline's numbness transports her to another world:

> Numbness, numbness, emotional numbness. With emotional numbness, the numbness comes with the same coming of the isolation into the new world, the fear comes in because you know you're going into that hole again, diving in, like diving into a big sea, and you feel like … you fear it and then you don't wanna talk to anybody.

Caroline sees her "numbness" as severely compromising her affective world. Numbness is inseparable from "the isolation" she feels when entering depression and is synonymous with the fear that comes with "diving into a big sea", huge and with no way out. She emphasises the physicality of her changes in feeling, both sensual and spatial. The crux of her disconnection is the isolation instilled by her emotional numbness. It fills her with dread intensifying her exclusion and preventing any sense of a shared affectivity.

Stability: reawakening of feeling and connectivity

By the second interview, all participants described a revival of feeling that for most evoked a sense of affinity with their environment.

Julia describes her reawakening:

> It's like spring, you know, everything is alive, you know, fresh, you know that freshness! I feel good about things that are happening, I'm excited about my trip, it's like beautiful weather, beautiful people.

Julia's bodily feeling is changed from numbness to "alive" with a "freshness" that instils harmony with her environment. Wellness is "like spring", a reawakening to the world where she can develop again. This instils a sense of hope and goasis:rowth, and the world offers the possibility of being "beautiful" again.

Though Karen's well periods are short, she is relieved to feel responsive again:

> I feel happy, whereas when I'm depressed I feel very, very, numb so I feel that I can't really feel anything. We had a passing away in the family; my aunt died in March and I couldn't cry cos I didn't think I could. So now I just feel happy, feeling content with life and feeling like I'm coping with everything and I know what I want to do and I know what I want in life, yeah all of those feelings.

Karen's emotional world is transformed from feeling "numb" to "content with life". Where Julia's rejuvenated feelings instilled vitality and goasis:rowth, Karen's bring relief at being able to express a normal range of emotions. When she highlights that she "couldn't cry" after her aunt died, we realise how the ability to feel not only brings a sense of connection with others but also control and normalcy.

When Caroline becomes well, she struggles to reconnect:

> I feel now. There is a sense, like the sensations, the sense of smell and the sense of . . . There was moments in my life where I was happy and I can sometimes, during the day, touch that point and come back from it but, at least, there is a sense where I can relate to myself and I felt that satisfaction so I tap, tap into it.

Caroline's reconnection is intermittent and confined to "sensations" that she "taps" into from remembered "moments". These "sensations" lack physical immediacy, are fleeting and only experienced through memory. Moreover, they are inconstant and lack intensity, reflecting a "point" in her past she can "touch". Yet, however precarious, they provide at least some sense of how she can connect with herself.

Mania: engulfed by intensity of non-stop feeling

Participants were overwhelmed by an intensity of feeling during mania that had no apparent cause, but sustained for significant periods of time. At the height of episodes, participants were captivated by a force of feeling that brought a palpable sense of purpose, but retrospectively was seen as incoherent.

When manic, Julia is propelled by an enduring high:

> You feel so good, you know, kind of I would say the same, like you would on drugs, you know, like cocaine, like cocaine, but all day long, every day, non-stop. [. . .] I'm very confident. [. . .] When I'm high I don't care what they [other people] think [. . .] I'll wear shiny dresses, high heels [. . .] [But afterwards] I thought how the hell could I wear this dress? [. . .] I can't believe, you know.

Julia's description of her feelings as a "drug-fuelled high" expresses the intensity of the high, but also its persistence. For Julia, this euphoria is without source and seemingly self-supporting, creating an artificial over-confidence that disconnects her from her environment and contrasts to her harmonising feelings during stability. The views of other people no longer matter, and she incongruously wears "shiny dresses" that afterwards she finds incomprehensible.

In contrast, Karen expresses an anger that she is usually too inhibited to reveal.

> I started shouting and crying and screaming or whatever – "This person's done this to me!". I go out actually looking for places where I can confront people cos I have the confidence to do it, so that's something I was lacking before [. . .] I wasn't scared of speaking my mind anymore.

Karen recalls being filled with an anger that drives her to confront others and release her inner rage. No longer inhibited, she explodes in self-righteous fury. This is not the euphoric high Julia experienced, but an outpouring of indignation. And yet Karen's state empowers her, and she no longer feels "hesitant" or "scared".

When manic, Caroline struggles to express how she feels and is far more conscious of her actions than emotions.

> Happy, I'm really happy! (*pause*). To be honest, it's not a feeling, it's a behaviour rather than a feeling, there wasn't any feeling to it, no, I wouldn't understand how I felt. [When well], I can feel things, but when I'm at the manic episode I don't feel because I'm just following my instincts it's just actions, yeah, I'm very detached, distorted, damaged.

Caroline sees mania as predominantly a behaviour, rather than a feeling. She realises that "I'm just following my instincts" and is propelled by the confidence of "just actions". Whereas during depression, Caroline was isolated, during mania she is disconnected, acting in a way that, retrospectively, is bereft of feeling or meaning. For Caroline, mania brings a "happy" high but she is "very detached, distorted, damaged". Whereas Julia stressed the artificiality of mania, Caroline points out the absence of feeling which she sees as a significant part of her humanity. This detachment from herself and her environment leaves her feeling damaged.

Theme: shifting sense of the future disrupts momentum

Participants' changing experience of the future significantly influenced their sense of progression and opportunity.

Depression: blocked by inaccessible future

At T1, participants emphasised a disconnection with the future where their way forward was blocked.

Julia's future is foreshadowed by feelings of dread:

> I'm so scared of what's happening tomoroasis:row and actually, oh, I think a lot of bad things could happen to me. I'm, you know, really stressed and anxious, extremely anxious, all the time. I'm just generally [when well], a bit, always a bit scared of the future, but when I'm depressed then I think I'm gonna be one of those people who lives in a horrible place in social housing with, you know, all those crazies … when I'm depressed I don't have any option.

Julia feels she is facing a bleak future that is laid out with such certainty that she is acutely anxious. Her fear of the future is ever-present, but during depression it escalates as she envisages definitive negative outcomes: "I'm gonna be one of those people". Her stress is exacerbated by the fact that she feels it is "happening tomoroasis:row". This vision of a desperate future has a clarity that seems to rob Julia of any choice: she is "with all those crazies" and has no other option.

Like Julia, Karen's perceived future fills her with anxiety:

> I just feel I'm not coping – "Ah no! I've got to do this! I don't know how I'm gonna do it." The natural thing is just going to sleep or lying in bed, because I don't know what needs to be done. I go to sleep hoping that I won't be here tomoroasis:row and that I won't have to wake up and address the [problem], […] cos it's just so scary.

Karen is oppressed by uncertainty. Unlike Julia, who is overwhelmed by negative visions of her future, Karen is weighed down by indecision. She has a sense of what has to be done – "I've got to do this" – but feels incapable of doing it, leaving her paralysed. Her anxiety leaves her feeling unable to move forward and face tomoroasis:row. She craves an escape from her daily struggle and welcomes the possibility of an endless sleep where she has nothing more to address.

Caroline also cannot see a way forward:

> I don't see a path, I don't see a path at all … I don't want to end my life because as I said nothing matters to me, the days pass and it's going on. Mostly it's a comfort for me to be honest (laughs), I never thought that I would be able to speak again … I just felt life is all finished, the isolation, the death.

Caroline's sense of detachment from the passing of time leaves her stuck in a cyclical present. While the others were blocked by uncertainty or negative predictions, Caroline's "days pass" without meaning. Without a grasp of what "matters", she has no framework from which to anticipate, act or differentiate one day from another, leaving her static. Time has become a process that she watches "going on" from the outside, a persistent reminder of her irrelevance. In contrast to the others, Caroline's inaccessible future is "mostly a comfort", a temporal void perhaps, where she feels protected from the past. With bitter irony, she laughingly admits the "comfort" of detachment where she doesn't 'want to end my life because "nothing matters".

Stability: regaining momentum

By the time the participants have stabilised, they notice a change in their sense of momentum and can conceive a way forward. Julia's depression lifts, revealing a new sense of possibility:

> I felt, that's it [during depression], I'd lost all opportunities and I'm gonna live like a vegetable. So now I do believe that things are gonna get better, you know, sort it all out . . . What can I do? I have to move forward, move forward, you know, do something.

Released from her dark vision of the future, Julia perceives scope for change, but remains unsure over how to proceed. She sees an opportunity to "sort it all out", yet this is contingent on her ability to "move forward". Her path remains precarious and she desperately insists she has to "do something".

Like Julia, Karen's view is transformed:

> It feels like you're going somewhere, you're able to see some kind of future . . . you feel a lot more capable, and it makes you feel positive as well that things are moving in the right direction, so you remind yourself you're getting better.

Karen sees stability as a physical, temporal and perceptual reconnection, during which she is "moving in the right direction" and can "see some kind of future". Like Julia, she has no plans, but perceives an open future that draws her forward, making her feel capable.

Similarly, Caroline says;

> I'm hoping things will change for the better, it needs to for me. The more I put into it the more result I find so I feel there is . . . I'm not as hopeless, even though nothing excites me anymore or hurts me anymore, but I'm not hopeless and I wanna learn, I'm open to learning.

Caroline's reconnection with her daily concerns springs from a renewed sense of temporality.

This change is apparent in the way she talks. During depression, her words indicated a detachment from time. At this point, she neither anticipated or considered consequences because "nothing matters to me, the days pass and it's going on". When stable her language suggests that she is reconnected – "the more I put into it, the more result I find". Time is no longer extraneous but shapes her life and confers meaning and direction. Her words suggests her sense of progression is shaped by the coherency of her engagement. Like Julia, she has an awareness of her part in activating change. That brings a sense of impetus, yet she remains emotionally indifferent – "nothing excites me anymore or hurts me anymore".

Mania: unrealistic view of what's possible hinders progress

During mania, the participants foresee a future where everything is possible and within their reach.

Julia's plans appear immediately achievable:

> You're really confident, over-confident. A guy came and said, "Can you do a [building] project?" I say, "Of course." It was like a five-storey building! I took it and really believed it, like I will easily do it, like one, two, three, four. I never did it myself, of course.

No longer a solid obstacle, Julia's future seems unrestricted by obligations or limitations. Projects are pursued with confidence, yet they are unrealistic. At first, they appear instantly achievable but she is locked within an ever-active present, without any sense of anticipation or reflection to guide it. Julia's admission that she "never did it myself, of course" expresses a sense of resignation. In retrospect, her reckless manic self feels disconnected from who she wants to be.

In contrast, Karen feels that she can become a better person:

> It feels like a better version of me … I feel very capable and I know what I want to do and I know what I want out of life and then, on the other hand [when depressed], you feel completely lost and you feel hopeless and you don't make any decisions.

Karen feels released from the "hopeless" indecision of depression. Unlike Julia, she feels that her decisive manic self is a "better version of me" who knows "what I want to do".

Similarly, Caroline's future appears accessible:

> I'm having lots of ideas about the future: energetic, doing lots of things, going shopping, coming back, not, not useful things … working like a machine, you just set the machine on and the machine just works, you give it instructions and it just follows the instructions, without having a sense of, oh wait this might be dangerous for you. I lose my direction so when I have to start from the beginning, I have to find ways of where to direct myself again.

Caroline feels energised by myriad possibilities. In retrospect, Caroline is troubled by her directionless activity where – "like a machine"- she blindly follows instructions. Like Julia, Caroline perceives this automated manic self as detached from her values that ordinarily provide a framework through which to progress. She acknowledges – "I lose my direction" - a telling admission that reflects the chaos of mania and suggests a deeper disruption that endures during recovery and leaves her struggling to "direct" herself again.

Discussion

The analysis shows that participants experienced instability characterised by dramatic changes in their sense of connection with themselves and the world. Three core change trajectories were emphasised: "Extreme changes in activity and agency", "Changes in feelings and connectivity" and "Shifting sense of the future disrupts momentum".

Changes in activity levels are highlighted in BD diagnostic criteria, with increased activity a necessary symptom for a diagnosis of mania and hypomania (American Psychiatric Association, 2013). Although studies suggest that activity levels are lower during depressive states and higher in mania, no work has examined how this is subjectively experienced (Cassano et al., 2009; Scott et al., 2017). In our study, findings

indicated that changes in activity levels were interrelated to, and profoundly disrupted, the participants' sense of agency.

Agency is commonly understood to reflect a person's capacity to act independently and is related to autonomy and control (Moore, 2016). Living with BD is recognised to create feelings of being out of control and an inability to predict behaviours and mood symptoms (Crowe et al., 2012; Fernandezet et al., 2014). Loss of control diminishes self-esteem and destabilises future goals (Inder et al., 2008). Building on this, our study reveals that feeling out of control is closely related to changes in activity levels between mood episodes.

Writers argue that agency arises during action through a person's embodied experience of that action and their intention to act (Gallagher & Zahavi, 2012). Together these instil the experience of being the source of an action and in control of it. Reflecting this, participants in our study underwent a collapse in activity, accompanied by a loss of volition. During mania, sharply increased activity was accompanied by feelings of being able to do anything. The wider qualitative literature suggests that mania coincides with intense productivity, giving rise to a sense of control (Crowe et al., 2012; Russell & Moss, 2013). In our study, however, participants' activities increased, but they had no sense of discrimination, leaving them engaged in multiple projects that were disconnected from practical significance. Retrospectively, they viewed themselves during mania as highly active but without agency. While agency is rooted in intentional, embodied action, it is also generated through seeing our actions as attributable to, and following from, our beliefs or desires (Gallagher & Zahavi, 2012). Accordingly, our study's participants were unable to explain their manic actions in terms of their goals and underwent a loss of self-control.

Moreover, although all participants returned to former activity levels during well periods, two of the group struggled to regain agency. An inability to manage emotions and behaviours during BD euthymia has been linked to low self-efficacy (Bandura, 1977). Our study further suggests that successive changes in agency during episodes can impact sense of control even during stability. Some participants could not regain agency when activity levels returned, pointing to the cumulative impact of changes over multiple episodes.

A further dimension highlighted was the change in participants' feelings and connection with the world. During depression, all participants described a "numbness" that left them paralysed, empty and disconnected. A feeling of emptiness is commonly described across depressive disorders and is associated with bodily numbness and loss of purpose (D'Agostinoet et al., 2020). For two participants in our study, however, numbness seemed to act as a defence from painful feelings.

Elevated or irritable mood have long been identified in diagnostic criteria as defining characteristics of mania. In the present study, participants were overwhelmed by emotions during mania that ranged from happiness to anger. All felt emboldened to express their feelings, were freed from social constraints and the needs of others. Other studies suggest that manic ecstasy is inseparable from being disinhibited and self-confident (Lobban et al., 2012). The present study underlines this, but also highlights a consequential emotional unresponsiveness to others and the environment that, ordinarily, would shape actions. Julia and Karen became indifferent to others and Caroline

described acting without feeling. BD models suggest a persistence of positive emotion during mania that reflects a lack of flexibility in shifting emotional response to context (Urosevićet et al., 2008). Our study extends this view by indicating that a rigid emotional range is experienced during depression and mania and is related to disrupted emotional resonance.

During stability, the participants' affectivity and connection with others and the world was partially restored. Julia and Karen's emotional responsiveness rooted them in their environment. Caroline continued to feel disconnected, pointing to the cumulative impact on stable periods of successive changes in feeling across multiple episodes.

Across phases, participants' sense of the future dramatically changed, coinciding with a shifting sense of momentum. One dimension of subjective temporality highlighted in studies involves the speed of time, which slows during depression (Thönes & Oberfeld, 2015) and accelerates during mania (Bschor et al., 2004). However, this does not account for the experience of "lived time" which unfolds within a temporal structure that stretches into past and future (Cavaletti & Heimann, 2020). In this study, participants shifted from being trapped by an inaccessible future during depression to an overwhelming sense of possibilities and momentum during mania.

Clinical phenomenologists argue that episodes of mania and depression involve a disturbance in the formal structure of temporal experience. Mania coincides with a shift towards an overly optimistic future orientation, resulting in a present that is disconnected from the past (Binswanger, 1964). In our study, participants' projects during mania were seen as immediately accessible and no longer limited by past events. Similarly, a recent study of BD mania found that participants described a positive, yet unspecific, orientation towards the future that altered their activities in the present and affected their relationship with risk (Martinet et al., 2019). Building on these insights, this study highlights that perceptions of the future dramatically change during a person's mood trajectory. Participants saw an array of possibilities during mania, whereas during depression their future became fundamentally blocked.

When stable, all participants became able to envisage a future, but their capacity to engage with it differed. Julia felt motivated to direct herself forward, but Caroline underwent an enduring emotional detachment, perhaps because the loss of significance she experienced during depression was so profound that her relationship with time was more permanently undermined.

Limitations and strengths

Study findings should be considered within the following limitations. First, given the homogenous sampling and small sample size, the claims made are specific to a group and further research is required to investigate their potential transferability to other contexts. This study is an account of the female experience of mood change. Some studies show gender differences in the clinical course of BD, including higher incidence of depression and higher frequency of attempted or completed suicide in women (Clements et al., 2013; Nivoli et al., 2011). It is unclear whether gender impacted this study's findings, but it is possible that the experience of change is different for men and the transferability of findings should be treated with caution. The data were collected within a defined period

of months and may not reflect the experience of change across longer time scales. The data reported for mania were not drawn from the participants' experience during this state and therefore may fall short of expressing certain aspects of a person's real-time experience.

Study strengths are also apparent. Findings highlight the utility of LIPA in understanding BD moods as changing trajectories rather than discrete symptoms. The ability to pinpoint distinct trajectories of change, such as shifting activity and agency, is contingent on its idiographic approach where the experience at one time-point can be compared to what has come before. The results adhere to important facets of IPA quality criteria (Nizza et al., 2021) such as the detailed analysis of participants' quotes and the comparison of experiences, highlighting convergence and divergence.

Clinical implications

Findings point to the clinical value of gaining insight into patterns of mood change experienced by clients rather than focusing only on detection of symptoms. This could help clinicians understand how BD episodes shape their client's ongoing sense of change and the resulting challenges over time. For example, in our study, changes in activity levels – a recognised symptom of mania and depression – were found to disrupt agency during episodes and euthymic periods. Gaining insight into a client's trajectory across BD phases can reveal changes that underpin the challenges of living with BD, enabling clinicians and their clients to address them.

The novel finding that patterns of change often endured during euthymia highlights the difficulties associated with residual symptoms and instability during inter-episode periods (Samalin et al., 2016), something that warrants further therapeutic attention. For example, participants struggled to reconnect with bodily feelings during stability, pointing to the need to focus on building physical self-awareness (Röhricht et al., 2011).

The heterogenous course of BD can create treatment challenges. Examining a client's subjective experience of mood change over time provides insight into the individualised impact of symptom patterns, supporting a more individualised approach to therapy. The shifting sense of the future and momentum revealed in our study is not highlighted in prevailing criteria but was fundamental to the participants' ability to progress. This finding highlights the clinical value of understanding how time is lived by clients during different phases and how this interrelates with feelings, energy and activity levels.

The extreme and enduring changes expressed by participants point to the possible utility of narrative interventions in developing a person's sense of continuity through states which may promote self-control and connectivity (Rhodes, 2014). Although limited research has assessed narrative-based interventions for BD (Hawkeet et al., 2023), the literature highlights their relevance to addressing difficulties associated with mood change, such as identity disruption and incoherent self-narrative (Inder et al., 2011). Facilitating the formation of clients' narratives, where mood change is understood in the context of life, has the potential to build self-understanding, self-trust and identity coherence (Potter, 2013).

Findings also indicate the potential benefit of going beyond the assessment of residual mood symptoms during euthymia (Samalinet et al., 2016) to focus on the recovery of key connections between self and world, including agency, feelings and temporality. Mindfulness may improve awareness of experiences in the present and during inter-

episode periods, helping to connect with feelings, activities and future wants, while moderating anxiety around risk of relapse (Murray et al., 2017).

Research implications

Future studies could explore the male experience of mood change which is currently not known. Idiographic longitudinal work is likely to offer insight into the way interventions are experienced and influence a person's trajectory. Future research could focus on the development of key interventions, particularly those that help individuals understand their relationship with mood change and manage disruptions to agency, connectivity and progression.

Conclusions

This study demonstrates new insights into how BD mood change is experienced over time. Recognised features of BD episodes, such as activity levels, changes in feelings and instability, have novel significance when construed through time. The three trajectories highlighted suggest that changing activity levels disrupted agency, fluctuating feelings shaped connectivity and shifting perceptions of the future disrupted temporality and momentum. Participants' capacity to recover during stable periods varied, pointing to the impact of successive episodic changes on their ability to regain agency, felt connection and temporal engagement during inter-episode periods. The clinical benefit of exploring clients' trajectories of change within and between BD phases is suggested along with its relevance to building self-coherence, client insight and connection with key aspects of their life and self during therapy.

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No potential conflict of interest was reported by the author(s).

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Data availability statement

The full dataset is not available due to ethical and privacy restrictions.

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