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Embodiment in Patients with Bipolar Disorder: A Dynamic Model

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Qualitative Study

Abstract

Background: Bipolar disorder (BD) is usually studied under the static description and biological etiology, and hence the subjective experience of patients is rarely investigated. This study aimed to investigate the dynamic system of patients with BD through their lived experience in general and their embodiment in specific.

Methods: The current research was qualitative and it was done through the interpretative phenomenological analysis (IPA) method. Semi-structured interviews were conducted with Iranian participants in 2020 through WhatsApp and Skype. 11 participants with BD type I and II were selected through purposive sampling.

Results: The two super-ordinate themes were identified: body in the foreground/background of consciousness and change of power in the body. Themes related to each of them were identified and reported in the phases of depression and mania. The first super-ordinate theme included these themes: hyperembodiment (in depression) and disembodiment (in mania). Painful body (in depression) and heroic body (in mania) were the themes identified in the second super-ordinate theme.

Conclusion: At the psychopathological level, our findings encourage the using of dynamic model for patients with BD in order to extend the possibility of psychotherapy for this group of patients.

Keywords: Psychotherapy; Bipolar disorder; Iran; Humans; Consciousness

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Introduction

Bipolar disorder (BD) is one of the chronic and severe disorders that leads to serious problems in the patient's moods (Carvalho, Firth, & Vieta, 2020). The Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition (DSM-5) specifies BD to entail acute and irregular periods of manic or euphoric, depressive or dysphoric, and mixed states (American Psychiatric Association, 2013). On the other hand, according to Akiskal (2003) and Akiskal and Akiskal (2005), the clinical manifestation of BDs corresponds more than anything to a continuum of these disorders: a spectrum of overlapping BDs that are yet dissociable by objective criteria and mental profiles. Therefore, BD generally is understood through diagnostic categories or dimensional classifications. In both, BD is understood on the basis of biological discourse (Stanghellini, Broome, Fernandez, Fusar-Poli, Raballo, & Rosfort, 2019).

High comorbidity of BD with major depression disorder (MDD), anxiety disorders, and psychotic disorders can reveal that this disorder is not independent of other disorders; this could mean that diagnostic labels for BD are not valid (Spoorthy, Chakrabarti, & Grover, 2019; Sasson, Chopra, Harrari, Amitai, & Zohar, 2003). On the other hand, Shen et al. (2018) found that most of people with BD were initially misdiagnosed. Therefore, the reliability of this diagnostic label is also suspicious.

One of the reasons for these problems can be considered in the static description and biological etiology of this disorder. In recent years, there has been increased focus on dynamics of mental disorders. One way to study the dynamics of disorders is to focus on the lived experience of patients (Nelson, McGorry, Wichers, Wigman, & Hartmann, 2017). The lived experience as a phenomenon can be delimited to 4 microstructures (embodiment, lived time, lived space, and intersubjectivity) (Wyllie, 2005; Van Manen, 2016). Based on this, many researchers studied the schizophrenia spectrum disorders (Torregrossa, et al., 2019; Giersch & Mishara, 2017). But the dynamic of BD is rarely investigated. These researches have usually used quantitative methods and in order to understand the dynamic models of BD, they have proposed a qualitative study of the lived experience of patients with BD to future researches (Curtiss & Klemanski, 2016; Curtiss, Fulford, Hofmann, & Gershon, 2019). Hence, we aimed to study BD based on individual experiences.

Colombetti (2017) in line with Nelson et al. (2017) and other phenomenological psychopathologists as Stanghellini et al. (2019) argued that brain was not the core machinery of moods; in return, he suggested that examining embodiment could be the basis for understanding the changes of moods in BD. In other words, his suggestion was an embodied examination of emotions which can reveal the lived experience of patients and the dynamics of BD.

To better understand embodiment, it is necessary to distinguish it from the body image. Reviewing the literature in this field showed three sometimes conflated concepts of embodiment, body image, and body schema. To scrutinize more, body image (or body as an object) is a combination of perceptions, attitudes, and beliefs around one's own body, i.e., body image is attended when we view our body from a third person's perspective or in vacuity. Conversely, body schema is a system of sensory-motor capacities that do not require conscious awareness or perceptual control to operate. Therefore, objects become meaningful and familiar to us at the level of body schema (or lived body) rather than body image, and it is through the dynamic changes in the structure of body schema that the world is understood (Gallagher, 2001; Tirado, Khatin-Zadeh, Gastelum, Leigh-Jones, & Marmolejo-Ramos, 2018). Gallagher (2001) eventually considered embodiment to enclose body schema

and body image. Nevertheless, Fuchs and Schlimme (2009) regarded embodiment as equivalent to Gallagher's definition of body schema. In the current study, body schema and embodiment are considered the same and are distinguished from the body image.

Studies on embodiment demonstrated that patients with BD experienced both increase and decrease in the embodiment in the depression phase, where the increased embodiment is the predominant experience. Fuchs (2002, 2005) postulates the body as a medium of experience and a gate for us to experience the world. In presence of hyperembodiment, the body becomes opaque, conspicuous, and too grand to be able to mediate the experience of the world and emotions, and hence becomes all that is remained. From this time forth, the person experiences nothing and becomes motionless and detached from emotions which, in turn, may diminish the possibility of identifying one's own body leading to disembodiment (Bowden, 2013; Bird, 2015; Binswanger, 1963).

Therefore, in the present research, we investigated the lived experience of participants with BD through their embodiment. In this way, we can find a dynamic view of BD that can lead to improvements in the description, etiology, and psychotherapy of this disorder.

Methods

Phenomenological research should be used to study lived experience. In the current research, it was done through interpretative phenomenological analysis (IPA). To conduct this research, a semi-structured interview was designed to explore the lived experience of patients with BD.

This was done through the design pattern of interview (IPA) (Smith, 2004; Smith, Flowers, & Larkin, 2021; Willig, 2013) and interviews of Robinson (2016), Pallesen et al. (2020), and Iacovou (2016). Finally, the final version of the interview was changed based on the pilot interviews run.

The interviews were conducted online via WhatsApp and Skype. First, the volunteers read the form containing the research information and the consent form, and the people who agreed with them were included in the research process. Then their demographic information was collected and finally, the main interview was conducted.

Each participant's interview was recorded and written down; then each interview was analyzed several times by the research team and in this process, sub-level themes, themes, and super-level themes were identified (Smith, 2004; Smith et al., 2021).

Participants: The sample size in an IPA depends on the judgment of the researcher. 6 to 10 participants are recommended for doctoral level research (Smith, 2004; Smith et al., 2021).

Inclusion criteria were: individuals who met the criteria for the diagnostic labels of bipolar I or II disorders at least once in their life (based on the diagnosis of a psychiatrist outside the research group and one of the researchers of the research group), being between 18 and 60 years old, the last period of disorder being at most one year ago, and the minimum educational qualification being a diploma.

And they were excluded if met any of the following criteria: individuals who only had a history of mania, individuals who had a history of diagnosis of schizophrenia and other psychotic disorders or post-traumatic stress disorder (PTSD), individuals who had neurological symptoms or brain damage in their medical records, and individuals whose mania or major depression was active during the research and interfered with the research. A summary of participants' information is presented in table 1.

Table 1. Demographic and psychological data of participants

Code	Age (year)	Gender	Marital status	Type of BD	Last active phase
Khara	32	Woman	Married	II	Hypomania
Aziz	28	Man	Single	II	Depression
Ziba	32	Woman	Single	II	Depression
Shokooh	40	Woman	Married	I	Mania
Baji	28	Woman	Married	II	Depression
Meshki-Jan	30	Woman	Married	I	Depression
Zaher	31	Man	Single	II	Mania
Malihe	20	Woman	Single	II	Hypomania
Ghotame	44	Woman	Married	I	Depression
Mehri	52	Woman	Divorced	II	Depression
Rahim	33	Man	Married	II	Depression

BD: Bipolar disorder

Results

Body in the foreground/background of consciousness

Hyperembodiment: The increased embodiment (hyperembodiment) is followed by the perception of heaviness in the body that sometimes turns the body into a corpse unable to live. "I feel like I am a walking dead, what is the use of living? you neither have someone to like or to be liked by, nor there is any happiness, nor I feel like moving, as I said, a walking dead" (Mehri). Even though the body is still experienced, it is incapable of perceiving different emotions and feelings that constantly remind them of the numbness they feel toward the world. "Like a slice of meat, my body was limp" (Meshki-jan). Participants steadily perceive their body as they feel nothing else in the world and thence, their experience of embodiment increases and turns their body into a burden. "I mean like a burden on my shoulders, it is a burden though it is mine" (Khara). Thus, the body was no more in the background of her awareness and was rather in the foreground, at the center of attention with every little trace of it attended. Hence, it could be inferred that the body is placed in the foreground of consciousness during depression which sometimes begins with the feeling of numbness in the body, proceeds to distrust in the body, and descend to an excruciating embodiment. Figure 1 shows the changes of this theme.

Disembodiment: In contrast to depression, a decrease in embodiment during mania is the common experience among participants. It seems that participants experience a feeling of being out of their body as it becomes lucid. "I feel like I am not limited to my body at all, I kind of don't feel it at all, I leave my body shell, actually it (body) is the only thing I don't even think about or have contact with" (Shokooh). In other words, in the manic phase, the body is no longer in the center of attention and is placed in the background of consciousness. Figure 2 shows the dynamic model of the changes in disembodiment.

Change of power in the body

Painful body: With the body at the center of attention, even the smallest pain is experienced leading to a permanently agonizing experience of embodiment in depression and manifold experience of pain compared to normal.

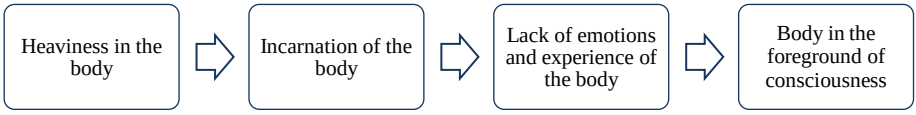

Figure 1. The process of hyperembodiment in the participants

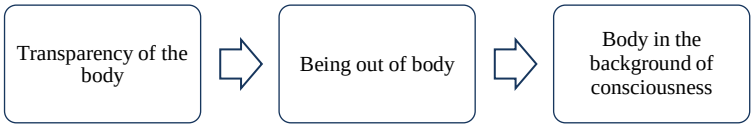

Figure 2. The process of disembodiment in the participants

"A tiny injection needle is nothing, right? I was scared of its pain during depression and the pain was multiplied for me" (Shokooh). The heaviness and painfulness of the body together can make every little movement exhausting. "My body is very heavy and moving is really difficult for me … I am too heavy, moving is extremely bothersome for me" (Zaher); insofar as the participant may feel exhausted even without any movement. "The constant feeling of exhaustion and boredom, as if I have done some herculean task. Extreme tiredness even right after sleep" (Zaher). Accordingly, Baji, Malihe, and Ziba delayed appeasing their physiological needs in order to move less. "Even going to the restroom is problematic in depression. I try to eat less to have fewer visits to the restroom, I can't sit on my knees well, might suddenly stumble and hit my head" (Ziba). Thereby, her body weakens gradually during depression, becomes less tolerant against pain, and experiences pain more profoundly. Namely, the process that began with the heaviness and proceeded to reduced activity and tiredness due to lowered pain tolerance leads to a weaker and more vulnerable body, a detrimental cycle for the body that seems endless during the depression. "Anxiety, stress, because I feel impuissant, and I don't want to feel that way, so I am always struggling to add something to this to change it and this aimless wandering makes me anxious and stressed because I know after all it is futile" (Aziz). Figure 3 shows the dynamic model of the changes in this theme.

Heroic body: In manic phase, pain tolerance is increased and painful incidents are less felt. "I feel my pain less, my fibromyalgia becomes less severe, I don't feel pain" (Mehri). Furthermore, managing the body and consonance with specific physical features is promoted in mania and helps decrease the pain felt. "In that period, I hold the fruits I bought in a way that the pressure was on my legs and not my back, which is why nothing worsened my backache then" (Rahim).

Participants viewed themselves as more powerful and reported more freedom in their embodied experiences. "In mania, I was like wow, this is my body, how good it is, how capable I am, now I can lift that rock or I can push that person to the wall if I want" (Aziz). Unlike depression, they perceive their body symmetric and do not experience any defects, abnormalities, or constraints about it.

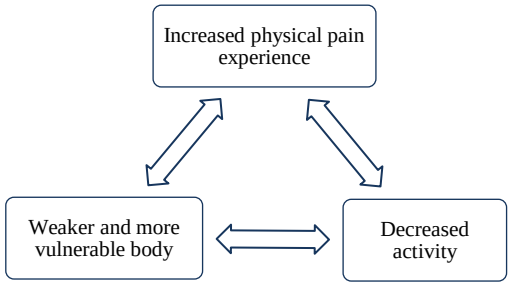

Figure 3. The process of painful body in the participants

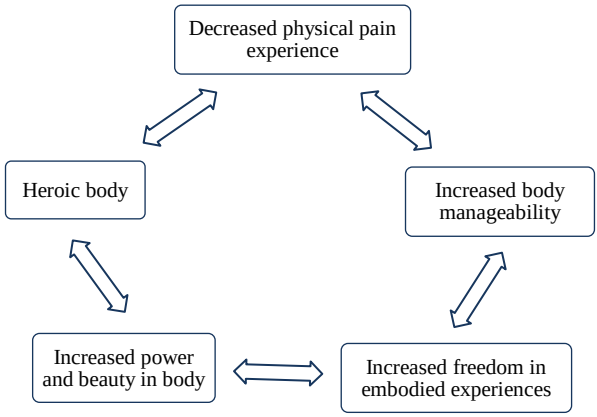

Figure 4. The process of heroic body in the participants

"Completely symmetric, totally balanced … I feel my body is expanded, my chest is patulous, my back is patulous" (Aziz). Ghotame and Meshki-Jan overall experience their bodies as "an extraordinary body, a superhero body" (Meshki-Jan). Dynamic model of heroic body is presented in figure 4.

Discussion

Our findings indicate that embodiment changes in patients with BD. In other words, a dynamic model of BD can be identified based on the patient's embodied mood. This shows that the theoretical proposal of Nelson et al. (2017) for the future of psychopathological research can be realized in practice. This model briefly shows the change in the active phase of BD in 2 levels: body in the foreground/background of consciousness and change of power in the body. When the body is in the foreground of consciousness, hyperembodiment occurs and depression is experienced. In contrast, when the body is in the background of consciousness, a disembodiment occurs and the patients experience mania. The changes experienced in the first level lead to a change in change of power in the body, the second level. Thus, examining the embodied mood presented in this model can be a suggestion to increase the reliability of the diagnostic label of BD (Shen, Zhang, Xu, Zhu, Chen, & Fang, 2018) and by providing a strategy for a more accurate understanding of BD, it can be differentiated from other comorbid disorders (Spoorthy et al., 2019; Sasson et al., 2003). This finding is generally consistent with the results of research by Curtiss and Klemanski (2016), Curtiss et al. (2019), and Manfro et al. (2021).

Fuchs (2002, 2005) reported diverse findings of the experience of embodiment in depression including both inclined and declined embodiment, whereas in first super-ordinate theme of current study, all participants experienced increased embodiment in depression. This inconsistency could stem from the fact that with the increased embodiment, prominence of body, and its placement at the center of attention during depression, participants experience as though there is nothing else but their bodies. Participants in this study believed that their experience was attributed to the placement of body at the focus of their perception and did not report decreased embodiment in depression. Decreased embodied presence in-the-world transforms the experience of the body into an experience akin to that of a corpse;

being a corpse is a state of body where there is solely the body and nothing else. Sensing the world is impossible in the corpse state which is why participants do not experience emotions that itself can decrease one's experience of his/her own body in-the-world or embodiment.

This experience is accompanied by the emergence of the second super-ordinate theme in depression phase (painful body). This finding is consistent with Michaelides and Zis (2019) and Maletic and Raison (2017). According to this super-ordinate theme, pain tolerance is reduced since every movement can be painful when the body is fully attended to with no attention to the external world. Hence, movements are gradually reduced to cease this pain.

On the other hand, second theme of first super-ordinate theme in this study in line with the findings of Bird (2015), Bowden (2013), and Binswanger (1963) showed that the embodiment in mania was reduced. This leads to transparency of the body. As the mania intensifies, the patient's body becomes more faded to him to the point that he experiences himself outside his body. In this way, the patient will no longer be conscious of her/his body.

The mentioned experience leads to the emergence of second super-ordinate theme in the manic phase. In other words, the patients experience the heroic body. This finding is consistent with Bird (2015) and Bowden (2013). In this phase, perceived bodily constraints such as pain are no more in the center of attention and the amount of activity is also increased. Due to the unique experience of the body, activities that seem dangerous to others might be perceived as completely normal and within the range of the person's physical capabilities.

One limitation of the present study was the examination of patients with BD type I or II as the research sample, while the participants had different experiences of these two disorders. Therefore, we suggest future research to separately investigate the dynamic system in these two types of BD in order to separate them from each other and adopt the type and manner of receiving services suitable for the patients.

Conclusion

Finally, in order to solve the shortcomings in the dominant paradigm of psychopathology which is based on modern psychiatry, or to have another point of view about mental disorders and to expand the scope of understanding of mental disorders by specialists in the field of psychology, the current research suggests phenomenological psychopathology. Specifically, this was done in this research about BD and it was shown that this disorder could be investigated and understood based on the dynamic systems like subjective experience of patients. This possibility can create a new way that increases the possibility of psychotherapy.

Conflict of Interests

Authors have no conflict of interests.

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