Reconsidering the affective dimension of depression and mania: towards a phenomenological dissolution of the paradox of mixed states

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Summary

In this paper, I examine recent phenomenological research on both depressive and manic episodes, with the intention of showing how phenomenologically oriented studies can help us overcome the apparently paradoxical nature of mixed states. First, I argue that some of the symptoms included in the diagnostic criteria for depressive and manic episodes in the DSM-5 are not actually essential features of these episodes. Second, I reconsider the category of major depressive disorder (MDD) from the perspective of phenomenological psychopathology, arguing that severe depressive episodes should not be characterized by any particular moods (such as sadness, hopelessness, or guilt), and should instead be characterized by a diminished capacity for finding ourselves situated in and attuned to the world at all. In other words, the affective dimension of depression should be characterized as a change in the way we have moods, not as a change from one kind of mood to another. Third, I turn to mania, arguing that manic episodes, taken as the opposite of depressive episodes, should be characterized not by any particular moods (such as euphoria, grandiosity, or even irritability), but should instead be characterized by an enhanced or heightened capacity for finding ourselves situated in and attuned to the world. In other words, the affective dimension of mania, like the affective dimension of depression, should be understood as a change in the way we have moods, not as a change from one kind of mood to another. Fourth, I return to the phenomenon of mixed states and argue that the affective dimension of depression and mania, when conceived along the phenomenological lines I set forth in the previous sections, dissolves the paradox of mixed states by showing that the essential characteristics of depression and mania cannot and do not coincide. Many cases of mixed states are diagnosed because moods that we take to be essential features of either depression or mania arise within the context of what is considered to be the opposite kind of episode (e.g. dysphoria, typically associated with depression, often arises in what is otherwise considered a manic state). However, if we conceive of the affective dimension of depression as a decrease in the degree to which one is situated in and attune to the world through moods, and the affective dimension of mania as an increase in the degree to which one is situated in and attuned to the world through moods, then the particular mood one finds oneself in is simply irrelevant to the diagnosis of either depression or mania. As a result, the manifestation of any particular moods in what otherwise seems to be a pure manic or depressive episode does not constitute a mixed state.

Key words

Depression • Mania • Mixed state • Phenomenology • Psychopathology

Introduction

Both the general public and professional psychiatrists typically conceive of depression and mania as polar opposites – embodied in the term "bipolar disorder" itself. However, the possibility of mixed states (i.e. states that incorporate symptoms considered essential to both depressive and manic episodes) has a long history. In his book, *Manic Depressive Insanity and Paranoia*, Emil Kraepelin clearly elucidated the possible manifestations of such states [1]. Some authors even point as far back as Hippocrates and Aretaeus of Cappadocia, arguing that these ancient physicians described cases of melancholic symptoms appearing during the course of behaviour that we would today characterise as manic [2-5].

The formal definition of mixed states, given in the DSM-5, consists of either a state meeting full criteria for a manic or hypomanic episode, accompanied by at least three depressive symptoms, or a state meeting full criteria for a depressive episode, accompanied by at least three manic or hypomanic symptoms [6]. This shares some similarities with earlier conceptions of mixed states, but there is one important difference in the DSM. While Kraepelin did not conceive of depression and mania as opposing poles, the DSM conception implies the opposition of the two phenomena, thereby establishing mixed states as a problematic, if not paradoxical, form of human subjectivity. Many of the particular symptoms of each kind of episode are clearly juxtaposed. For example, a major depressive episode is characterised by a depressed mood, while a

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manic episode is characterised by an elevated or expansive mood. Another characteristic of a major depressive episode is loss of interest or pleasure in activities, while a manic episode often includes excessive involvement in activities that have potential for painful consequences. As a result of this characterisation of depressive and manic episodes, mixed states of any sort (whether they be predominantly depressive or manic) present us with a kind of paradox. If depression and mania are, in fact, polar opposites, how can it be that essential features of both disorders manifest simultaneously?

Questions of this kind have given rise to a large body of psychological and psychiatric research that attempts to reconceive the essential features of depression and mania with the intention of bestowing some sense on the strange phenomenon of mixed states [7-23]. One account, made popular by Kraepelin, characterises mixed states as the outcome of prolonged periods of transition between depressive and manic episodes, or vice versa. According to this account, the movement from one kind of episode to the other is typically either rapid or includes a transition through a non-episodic state. However, in some cases a person moves from one kind of episode to the other without the typically rapid transition, thereby displaying a mixture of what seem to be two opposing states [1 4]. Another, more radical account claims that depression and mania are not actually two opposing poles. Instead, mania is a severe mental disorder, while depression is a less severe disorder on the same spectrum. According to this conception of depression and mania, the opposing poles, or extremes, are actually mania and a non-episodic state. Because depression stands at a point between these states, it is not unusual to find depressive and manic symptoms arising together [8].

While either of these accounts might explain the possibility of mixed states, in this paper I wish to consider another solution. Rather than *explaining* mixed states, I attempt to *explain them away*. In other words, I argue that mixed states may not actually exist – instead, they are artefacts of inaccurate diagnostic constructs that have been perpetuated in light of misattributions of the essential characteristics of depressive and manic episodes.

This paper is divided into four main sections. First, I argue that some of the symptoms included in the diagnostic criteria for depressive and manic episodes in the DSM-5 are not actually essential features of these episodes. Second, I reconsider the category of major depressive disorder (MDD) from the perspective of phenomenological psychopathology, arguing that severe depressive episodes should not be characterised by any particular moods (such as sadness, hopelessness, or guilt), and should instead be characterised by a diminished capacity for finding ourselves situated in and attuned to the world at all. In other words, the affective dimension of depression should be characterised as a change in the way we have moods, and not as a change from one kind of mood to another. Third, I turn to mania, arguing that manic episodes, taken as the opposite of depressive episodes, should be characterised not by any particular moods (such as euphoria, grandiosity, or even irritability), and should instead be characterised by an enhanced or heightened capacity for finding ourselves situated in and attuned to the world. In other words, the affective dimension of mania, like the affective dimension of depression, should be understood as a change in the way we have moods, and not as a change from one kind of mood to another. Fourth, I return to the phenomenon of mixed states and argue that the affective dimension of depression and mania, when conceived along the phenomenological lines I set forth in the previous sections, dissolves the paradox of mixed states by showing that the essential characteristics of depression and mania *cannot* and *do not* coincide. Many cases of mixed states are diagnosed because moods that we take to be essential features of either depression or mania arise within the context of what is considered to be the opposite kind of episode (e.g. dysphoria, typically associated with depression, often arises in what is otherwise considered a manic state). However, if we conceive of the affective dimension of depression as a decrease in the degree to which one is situated in and attuned to the world through moods, and the affective dimension of mania as an increase in the degree to which one is situated in and attuned to the world through moods, then the particular mood one finds oneself in is simply irrelevant to the diagnosis of either depression or mania. As a result, the manifestation of any particular moods in what otherwise seems to be a pure manic or depressive episode does not constitute a mixed state.

Before I begin, it will help to briefly clarify what I mean by "essential characteristics" and by "phenomenology". Essential characteristics can be defined in a variety of ways. The essence of something can be understood as that which makes something what it is, in the sense that if this characteristic were removed, the being in question would necessarily become something other than what it is. Another way of defining essence is as that essential feature that stands as a ground, or source, of the other features of the phenomenon in question. In philosophical phenomenology, both senses of essence, or essential characteristics, are taken together. Phenomenologists study those characteristics of human subjectivity and existence that must hold for something to count as human subjectivity or existence. And these characteristics are, in turn, conditions for a lived world showing up at all.

This brings us to the issue of the definition of phenomenology. The term has a variety of meanings, being used in psychological [1], sociological [1], anthropological [1], and philosophical research, among other domains. While

this paper is on phenomenological psychopathology, I use the term phenomenology in the philosophical, rather than the psychological or psychiatric, sense. In psychology, phenomenology is typically understood as a method for the qualitative study of subjective experience. Such data is obtained through avenues such as surveys, first-person reports, and interviews. In psychiatry, the term can have an even broader meaning, being used to refer to any observable symptoms of a disorder – in this sense, even the DSM is phenomenological. Philosophical phenomenology, by contrast, while still concerned with human subjectivity and lived experience, has its roots in the Kantian tradition of transcendental philosophy. What this means is that phenomenology, as a discipline within philosophy, is a research program aimed not at describing particular qualitative differences in experience, but instead at describing the form or structure of subjectivity and experience in general.

In this sense, philosophical phenomenology is still descriptive, but its focus is primarily on what we might broadly construe as "form" – although "structure" [*Struktur*] is the more common coinage, at least among the German phenomenologists. In some cases, phenomenologists speak of the structure of consciousness or human existence as a whole, while at other times they speak of structures in the plural, referring to specific characteristics of consciousness or human existence. Some of the specific characteristics, sometimes referred to as "existentials", include temporality; spatiality; intersubjectivity; selfhood; embodiment; and situatedness or affectivity. In this paper, I focus primarily on the way subjects are situated in, attuned to and affected by their world through moods.

Symptomatology in phenomenology and mainstream psychiatry

The DSM-5 organises and distinguishes its categories of disorder by reference to symptom checklists. The kinds of symptoms listed for each disorder are varied, but there is predominance of behavioural criteria or, at the very least, criteria that can be interpreted behaviourally. A diagnosis of major depressive disorder (MDD), for example, is made when a patient presents with five or more of the following symptoms (with at least one of the symptoms being the first or second on the list) over a period of at least two weeks: (1) depressed mood; (2) diminished interest or pleasure; (3) significant weight loss or weight gain; (4) insomnia or hypersomnia; (5) psychomotor agitation or retardation; (6) fatigue or loss of energy; (7) feelings of worthlessness or excessive guilt; (8) diminished ability to think or concentrate; (9) recurrent thoughts of death, suicidal ideation, or a suicide attempt or plan [6].

Many of these symptoms seem dissimilar and unrelated, especially considering the fact that there does not seem to be any core symptom around which the rest are organised or motivated. In light of this, it is reasonable to ask how such a set of symptoms became *the* symptoms by which MDD is diagnosed.

There are a variety of ways we can formulate such a question, and each formulation will give us a different answer. A historical formulation, for example, would ask about the actual events that led to the selection of the particular criteria in the DSM. A more philosophical formulation, however, might ask why the particular *kinds* of symptoms listed in the DSM have been selected. What is it about these symptoms that made them attractive for use as DSM diagnostic criteria? This is the kind of question I wish to address here.

Many of the symptoms of MDD, including (1), (2), (7), (8) and (9) listed above, seem to be experiential, or subjective. That is to say, they are symptoms that seem to be observable primarily from the perspective of the patient herself. Others, such as (3) and (6), seem physiological, rather than primarily behavioural or experiential. However, nearly all of these symptoms come with some kind of qualification that allows for it to be met, or checked off, as a result of observations made by a clinician, family member, or close acquaintance, rather than the patient herself. For example, depressed mood, diminished interest or pleasure in activities, and diminished ability to think or concentrate are all followed by the qualification that these items can be met by observations made by others. Such a possibility for diagnosis is also implied in the physiological symptom of significant weight loss or weight gain, as this item includes the qualification, "when not dieting", which integrates a behavioural character into the symptom. Out of all the experiential or subjective symptoms that can be used to make a diagnosis, only one – feelings of worthlessness or excessive or inappropriate guilt – does not include the qualification that it can also be confirmed by outside observation, rather than just first-person report.

It follows from this insight into the preponderance of behavioural, or behaviourally qualified, diagnostic criteria that what makes a particular symptom likely to make the list of characteristic features of a psychiatric disorder is the quality of being easily observable. Each symptom listed in the DSM can be quickly and easily observed by a clinician, patient, family member or close acquaintance, or some combination thereof.

The reason for qualifying symptoms in such a way as to allow for observation or confirmation from multiple sources is clear enough. Easily observable symptoms expedite the process of diagnosis and, in turn, reduce the time it takes to implement targeted interventions – whether these be psychopharmaceuticals or psychotherapies. However, the symptomatology of many of the DSM categories of disorder still leaves one wanting. The most easily observ-

able symptoms are not necessarily the most essential, or characteristic, of the disorder in question. The authors of the DSM, however, do not seem to acknowledge this difference. As they say in the preface to the DSM-5, "… the current diagnostic criteria are the *best available description of how mental disorders are expressed* and can be recognized by trained clinicians" (my emphasis) [6]. And, further, they claim that the DSM is used by researchers and clinicians who "…strive for a common language to communicate the *essential characteristics* of mental disorders presented by their patients" (my emphasis) [6].

While the assumption that the easily observable symptoms listed in the DSM are also essential characteristics of these disorders is problematic, the privileging of easily observable symptoms within the context of a diagnostic manual is not problematic in itself. As said above, there are legitimate practical reasons for the privileging of such symptoms. However, there is another issue that, when combined with the privileging of easily observable symptoms over essential characteristics, problematises the situation. This additional issue is that of validity. While the DSM categories are, for the most part, reliable – in the sense that most clinicians, when presented with the same patient or the same symptom cluster, will make the same diagnosis – they are not necessarily valid. Validity does not have a single definition within the context of psychiatric research and practice, but it is often used to refer to a disorder being "real", which many take to mean that it has a distinct neurobiological cause, or biomarker. Proponents of the DSM have promised time and again that the DSM categories of disorder will be neurobiologically validated in the near future, but this promise has been left unfulfilled for the past few decades.

Another kind of validity, and one that is particularly relevant to philosophical phenomenological investigations of psychiatric disorders, is construct validity. Jablensky and Kendell explain that a category of disorder has construct validity when it "is based on a coherent, explicit set of defining features" [24]. Phenomenological psychopathology can assist in the project of offering coherent features by finding essential characteristics of a disorder that help us make sense of other, less foundational characteristics. And, further, it can assist in the project of offering explicit features by supplying careful and robust descriptions of the essential characteristics.

In the following sections, I consider depression, mania and mixed states, in turn, from a phenomenological perspective. In so doing, I illustrate the way in which phenomenology can assist in the project of discovering and accurately describing essential features of disorder. Finally, I argue that this kind of phenomenological research can help us overcome issues inherent in our conceptualisations of disorders and disordered phenomena, such as mixed states.

The phenomenology of depression

The last decade has seen a renewed interest in the phenomenology of depression. Figures such as Kevin Aho [25], Thomas Fuchs [26-29], Matthew Ratcliffe [30-33], and Giovanni Stanghellini [34] and René Rosfort [35-36] have all contributed to this growing body of literature. Each of these phenomenological psychopathologists has developed a focus on a particular aspect of depressive disorders, but there remains substantial overlap in their work. Some have focused on issues of temporality, or shifts in the way time and the temporal flow manifest in cases of depressive episodes [25 29 32]. Some focus on issues of embodiment, or changes in the way people experience their body or have bodily engagements with the world [25-28]. Others focus on the relationships between depressive episodes and other disorders, such as borderline personality disorder [35 36].

In spite of the varied interests of these phenomenological psychopathologists, there is one point of focus that they all share. Every phenomenological psychopathologist who studies depression must, to some extent, consider the affective dimension of depressive episodes. This focus has taken a variety of forms, and a few competing interpretations of the affective dimension of depressive episodes have been offered. However, each phenomenological account of this feature of depression might be understood as an attempt to make sense the central, but rather ambiguous, symptom referred to as "depressed mood". The DSM describes this symptom with the following words: "Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g. feels sad, empty, hopeless) or observation made by others (e.g. appears tearful)" [6]. As is made clear in this brief description, the DSM does not actually include a definition of depressed mood. Instead, it offers the clinician a few examples – sadness, emptiness, and hopelessness – and in so doing leaves open the possibility for other kinds of moods or affective phenomena to fulfil this criterion, while giving very little instruction on how to go about deciding what other affective phenomena or changes in mood actually count as "depressed mood".

This very ambiguity is used by Stanghellini as the starting point for one of his phenomenological investigations of depression and mania. As he says, "In ICD-10, depressed mood is defined quantitatively as 'lowered mood' and it is also assumed that the differentiating criteria between normal and pathological sadness is merely quantitative. Depressed mood is also used as a synonym to 'sadness', assuming that persons affected by major depression feel sad – rather than having no feelings at all" [34]. As he goes on to explain, the ambiguity inherent in the poorly defined symptom of "depressed mood" in both the ICD and DSM create difficulties in drawing boundaries between pathological and non-pathological moods and affective

states. Adequately describing what it is that we are trying to express or point to when we refer to "depressed mood" can, as he says, go a long way towards overcoming controversies over the pathological/non-pathological boundaries, at least in the case of depression.

Much of the recent phenomenological research on describing and defining what exactly we mean by a "depressed mood" has come from the work of Ratcliffe. Two papers in particular – one on deep guilt [31] and one on hopelessness [33] – bring to light the distinct characteristics that these moods take in the context of depressive disorders. In order to adequately characterise these moods, Ratcliffe accounts for them as what he terms "existential feelings". The concept of existential feeling is Ratcliffe's own development, but it is owed in large part to Martin Heidegger's account of moods and ground moods in *Being and Time* [37] and *Fundamental Concepts of Metaphysics* [38]. Existential feelings are understood as all-encompassing, and even world-disclosing, affective phenomena that are pre-intentional (meaning that they are not about, or directed towards, anything in particular), thereby shaping the meaningfulness of our world as a whole. In the case of deep guilt, for example, the person perceives himself as being guilty as such (i.e. not guilty for any distinct reason). Further, this deep guilt, pervading the person's lived world in its entirety, determines the kinds of intentional feelings and emotions (i.e. feelings and emotions that are about, or directed toward, something) that can manifest. Only feelings and emotions that conform to the all-encompassing guiltiness of the person's lived world can arise. Hopelessness, or what Ratcliffe refers to as "radical hopelessness", is a similar phenomenon that is also common in patients diagnosed with MDD. In this case, what is so radical about the hopelessness of depression is that it eliminates the possibility for hoping at all. While most cases of hopelessness are contextual – in the sense that the feeling of hopelessness is linked to the fact that the person finds herself in a hopeless situation – the hopelessness of the person in a depressive episode is not a response to any particular context and a change in context will not cause the hopelessness to subside. This kind of hopelessness can therefore be considered existential. It is the person's very existence, or subjectivity, that has undergone a profound change.

While Ratcliffe's accounts enrich the rather impoverished descriptions of "depressed mood" in the DSM, others have focused on a different feature of the affective dimension of depression that, while historically important, is mostly ignored in the contemporary symptomatology. This is the phenomenon of the loss of feeling, or what is sometimes referred to as the feeling of the loss of feeling. While Ratcliffe's work does touch on this, he characterises it as another kind of existential feeling, arguing that the loss of feeling is, in fact, a *feeling* of the loss of feeling, thereby making it a distinct affective phenomenon in its own right (as opposed to an actual shift in the degree to which we can be affected by the world).

This phenomenon of the loss of feeling is characteristic of the 20th century conception of melancholia, which was further developed by historical phenomenological psychopathologists such as Hubertus Tellenbach [39], but also plays a central role in contemporary works by Stanghellini and Fuchs. Stanghellini refers to a loss of emotional resonance as characteristic of melancholic depression [34], while Fuchs focuses on the ways in which melancholia alters our embodiment, referring instead to a loss of *bodily* resonance that incorporates a diminished capacity for perception (e.g. food tastes bland) [28].

Stanghellini, in investigating the loss of feeling associated with depressive episodes, points out that the DSM does in fact refer to such a phenomenon, but immediately downplays its importance, or even eliminates it as a legitimate expression of "depressed mood", by allowing for the clinician's observations of the patient's behaviour to override the patient's descriptions of his own experience. This comes to light in the DSM-5 in the line, "In some cases, sadness may be denied at first but may subsequently be elicited by interview (e.g. by pointing out that the individual looks as if he or she is about to cry). In some individuals who complain of feeling 'blah', having no feelings, or feeling anxious, the presence of a depressed mood can be inferred from the person's facial expressions and demeanour" [34]. In other words, even if a patient does in fact undergo an existential shift in which his capacity for being affected by his world is diminished, and he subsequently expresses this shift in a psychiatric interview, the clinician's "expert" interpretation of the patient's facial expressions supplies overriding evidence for the fact that the patient is actually sad (thereby having what the DSM considers to be a "depressed mood"). Such lapses into behaviourism undercut the very possibility of alternative interpretations of the existential changes occurring on the side of the patient's subjectivity.

Continuing in the vein of research opened up by Fuchs, Stanghellini and others, I have developed an account of the affective dimension of depressive episodes that is similar to their accounts of the loss of emotional and bodily resonance, but focuses more heavily on the distinction between this kind of change and a change in mood [40]. I argue that one of the essential features of a major depressive episode is – contrary to the popular account of depression as a kind of mood – a degradation or erosion of the capacity for having moods at all. In this sense, the fundamental affective shift in depressive episodes is in what Heidegger refers to as *Befindlichkeit* – commonly translated as "situatedness" or "affectivity" – rather than *Stimmung* – commonly translated as mood, atmosphere, or even tune, in the sense of tuning an instrument. Ac-

cording to Heidegger, *Befindlichkeit*, which refers to the fact that at any time we find ourselves always already situated in and attuned to the world, is a categorial characteristic of human existence. That is to say, it refers to an essential feature of human existence that is itself a category that encompasses a certain group of phenomena. The phenomena that fall into the category of *Befindlichkeit* are *Stimmungen*, or moods. Moods, according to Heidegger, are particular ways of finding ourselves in the world, and determine the ways we can be affected by this world. The relationship between these terms is, then, that *Befindlichkeit* refers to the category of moods as a whole, while a *Stimmung* is a particular mood, and thus a particular way of being situated in and attuned to the world. By following this distinction, we can see that the affective changes expressed in the DSM, as well as in the work of Ratcliffe, are of a fundamentally different kind from the affective changes I have discussed in my own account. If we understand "depressed mood" as a *kind of mood*, then it is a shift in what Heidegger refers to as *Stimmung*. Depression, characterised in this way, should be understood as a distinctive mode of being situated in and attuned to the world. However, if we understand "depressed mood" as a *diminished capacity to have moods*, then it is a shift in what Heidegger refers to as *Befindlichkeit*. Depression, characterised in this way, should be understood as a diminishing of the intensity of moods as a whole. (It should also be noted that the shift I am proposing here is in some ways alien to Heidegger's own account. Heidegger does not seem to allow for the possibility of changes in the degree to which one is situated in and attuned to the world. Rather, he only allows for changes from one mood to another.)

Of course, these two accounts are not mutually exclusive. Moods with diminished intensity are still moods. It is possible for a depressed person to be situated and attuned through a dulled or blunted mood of guilt, hopelessness, or sadness. However, this does not imply that any of these moods should be considered an essential characteristic of depression. Rather, the fact that all moods are, for the depressed person, dulled or blunted, is an essential characteristic. In light of this, if "depressed mood" is to remain an essential characteristic of depression, it should be redefined as a decrease in the intensity of moods as a whole – not as an ambiguous set of moods that includes sadness, hopelessness and guilt.

A similar account of depression has arisen from psychological research on what is referred to as emotion context insensitivity [41 42]. As Jonathan Rottenberg explains, "depression flattens the emotional landscape, greatly constricting the range of emotional reactions to differing emotional contexts" [41]. This account, however, differs from my own in one important respect. According to Rottenberg and colleagues, depression is still a distinctive mood. What makes it distinctive is that, rather than causing the depressed person to be more easily affected by negative events – thereby becoming more susceptible to sadness, despair and related emotions – it instead causes the depressed person to be less emotionally affected by their context in general. In other words, depression, as a mood, reduces the degree to which one is affected by, and has emotional responses to, one's world. My own account, by contrast, appeals to the same phenomenon – low emotional sensitivity to context – but does not explain this reduction in sensitivity by appealing to the distinctiveness of a particular mood. Rather, I argue that it is the capacity to be situated in and attuned to the world through a mood in general that is an essential characteristic of depression, which explains the low emotional sensitivity to context.

To return to the above discussion of the easily observable versus the essential characteristics of depression, the account I offer here portrays a degradation of *Befindlichkeit*, or a diminished capacity for being situated in and attuned through moods, as an essential characteristic of depression. The particular kinds of moods that may often manifest in depression, such as sadness, hopelessness, or guilt, are considered non-essential because their manifestation is not a necessary feature of a depressive episode (this is, of course, in contrast to the DSM characterisation). "Depressed mood", then, should be redefined as a lowering or diminishing of the intensity of moods as a whole, and not as a particular kind of mood.

The phenomenology of mania

Continuing from the account of depression I have sketched here, we can reconsider the phenomenon of mania from a phenomenological perspective. In reviewing the criteria for a manic episode listed in the DSM-5, it seems that particular kinds of moods are considered essential characteristics of a manic episode. While the depressed person is said to feel sad, empty, or guilty, the manic person is described as displaying an elevated, expansive, or irritable mood (although the latter clearly holds a secondary status, as is evidenced by the qualification that the person must present with four, rather than three, additional symptoms if her mood is only irritable, rather than elevated or expansive).

If we reconsider mania in light of the phenomenological account of depression given above, we can bring into question to what an elevated or expansive mood actually refers. Are these *kinds* of moods, in the way that sadness and guilt are kinds of moods? Or is the reference to elevated and expansive moods similar to my reinterpretation of "depressed mood"? If it is the latter, this forces us to rethink our conception of the essential characteristics of mania as portrayed in both popular culture and professional psychiatry.

The further descriptions of a manic episode offered in the DSM-5 refer to the manic mood as "euphoric, excessively cheerful, high, or 'feeling on top of the world'" [6]. However, while these constitute the popular conception of the affective dimension of mania, the DSM-5 also states, "Rapid shifts in mood over brief periods of time may occur and are referred to as lability (i.e. the alternation among euphoria, dysphoria, and irritability)" [6]. In other words, the DSM-5 describes mania as characterised both by a certain kind of mood (e.g. euphoria, or excessive cheerfulness) and by increased lability, or the ease and frequency with which moods change over.

This is again similar to the DSM's characterisation of the affective dimension of depression. Depression, according to the DSM, is characterised by particular moods, but may also be characterised by a loss of feeling. The DSM's characterisation of mania, by comparison, includes references to particular moods, but also to the fact that these moods may change rapidly.

To clarify this characterisation, we can reconceive mania along the same lines as that of depression. If depression is a diminishment of *Befindlichkeit*, or a decrease in the degree to which we find ourselves situated in and attuned to the world, then we might understand mania as an amplification or intensification of *Befindlichkeit*. What would follow from such an existential shift? One thing that would be likely to follow is that a person in the midst of a manic episode will be profoundly affected by the world around them. Persons, events and even objects appear as more meaningful (whether positively or negatively), affecting the person to a greater degree. In the psychological and psychiatric literature, this is referred to as emotional reactivity. At least two psychiatric studies have shown that a fundamental characteristic of both manic and mixed manic states is emotional hyper-reactivity, rather than a distinctive mood tonality [15 17]. This account is similar to the one I am proposing here, although it focuses on a narrower dimension of manic affectivity.

Another feature that would be likely to follow from an intensification of the existential structure of *Befindlichkeit* is the lability of mood, or the ease with which moods change over. This feature of manic states, as mentioned above, is discussed in the DSM-5 (however, it does not actually make it into the diagnostic criteria, so the authors of the DSM-5 may not consider it to be an essential feature). And it is also proposed as an important characteristic of mania in a number of psychiatric and psychological studies [14 17 20 22].

These reformulations of the essential characteristics of both depression and mania, while perhaps of interest in their own right, may be able to be applied in the context of other issues is psychopathology and psychiatric classification. In the following section, I address the paradox of mixed states in light of the phenomenological account of depression and mania offered here.

Dissolving the paradox of mixed states

To reiterate, mixed states are defined as cases in which one meets the full criteria for a depressive episode while exhibiting manic symptoms, or cases in which one meets the full criteria for a manic episode while exhibiting depressive symptoms. The paradox, then, arises in light of the fact that depression and mania are conceived of as polar opposites. The possibility of having symptoms, not to mention essential characteristics, of one kind of episode manifesting in the midst of the other seems, on the face of it, paradoxical. My solution to this apparent contradiction, unlike the solutions discussed at the beginning of this paper, is neither that depression and mania are polar opposites that may nevertheless overlap in cases of prolonged transition, nor that depression and mania are not, in fact, polar opposites. Rather, I argue that depression and mania *should* be understood as polar opposites, and that *they do not, in fact, manifest at the same time*. The belief that mixed states are possible stems from a misunderstanding of the essential features of depression and mania.

As I have argued, the affective dimensions of both depression and mania should not be characterised as particular moods, or even as general kinds of moods, such as dysphoric or euphoric moods. Instead, the affective dimensions of these states should be characterised as changes in what Heidegger refers to as *Befindlichkeit*, which refers to the fact that we always already find ourselves situated in and attuned to the world through a mood. Depression, under this account, is characterised by a diminished or eroded intensity of moods. This results in low emotional reactivity – as evidenced by the fact that people in depressive episodes are largely unaffected by the world around them. Mania, by contrast, is characterised by an intensification of moods. This results in emotional hyper-reactivity – as evidenced by the fact that people in manic episodes can be profoundly affected by the world around them.

It follows from this recharacterisation of the essential features of depression and mania that many of the symptoms we considered constitutive of mixed episodes should not be understood as playing any such role. Because no particular moods, or even kinds of moods, constitute essential features of depression or mania, they cannot be used as evidence of mixed episodes. In other words, sadness, guilt and related moods and emotions should not be considered legitimate symptoms of depression. Euphoria and excessive cheerfulness, in turn, should not be considered legitimate symptoms of mania. It follows from this that these symptoms should not only be abolished from discussions of the classification of mixed states, but should

also be removed from the symptomatology of pure manic and depressive states.

Conclusion

In summary, I have considered the paradox of mixed manic and depressive states from the perspective of contemporary phenomenological psychopathology. I argued that contemporary psychiatric classification in the DSM-5 privileges easily observable symptoms while neglecting essential features of disorders. Furthermore, the authors of the DSM-5 seem to portray their symptomatology as capturing the essential features of disorders, thereby sedimenting the problematic nature of their system of classification. I followed this discussion with an illustration of how philosophical phenomenology can assist in the project of separating essential from non-essential features of a disorder by offering more accurate descriptions of disordered subjectivity that can, in turn, be used to draw more accurate boundaries between categories of disorder. Finally, I argued that the phenomenological accounts of the affective dimensions of depression and mania I offered in this paper help us overcome the apparent paradox of mixed states.

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Conflict of interest

None.

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