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A Phenomenological Study of Mania and Depression

Hannah Mary Bowden

Abstract

In this thesis I develop a cohesive phenomenological account of mania and depression. Whilst phenomenological insights have been applied to a number of psychiatric disorders – most notably schizophrenia – mania, depression, and bipolar disorder have been neglected. In developing my account I challenge the common understanding of mania and depression as opposed. Through an examination of bodily and temporal experiences in mania and depression I unearth deeper structural commonalities. This allows for greater insight into the relationship between the two states and casts light on ‘mixed episodes’, where features of mania and depression co-occur. In my exploration of bodily experience I argue for an understanding of the depressed body as ‘corporealized’. I show how this helps us to understand common descriptions of the body and the world found in first person accounts. I challenge the intuitive distinction between the body as *active and invisible* and *inactive and conspicuous* by showing that the manic body is both conspicuous and active. I argue that we can enhance our understanding of this bodily experience through an appreciation of the associated temporal experience. Turning to the topic of time, I reveal the inadequacies of accounts that suggest that alterations in experiences of time in mania and depression are restricted to changes in temporal velocity. Using the Husserlian concepts of ‘retention’ and ‘protention’ I develop a new model of temporal experience in mania and depression, arguing that in addition to changes in temporal *velocity* we also find changes in temporal *structure*. This account allows us to understand common experiences in mania, including feelings of grandiosity, a loss of reflection, and the active yet conspicuous body. Likewise, it casts light on experiences common in depression, including guilt, a perception of recovery as impossible, and feelings of separation from others.

A Phenomenological Study of Mania and Depression

A thesis submitted for the degree of PhD

By

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2013

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Declaration

I confirm that no part of the material contained in this thesis has previously been submitted for any degree in this or any other university. All the material is the author's own work, except for quotations and paraphrases which have been suitably indicated.

The copyright of this thesis rests with the author. No quotation from it should be published without her prior written consent, and information derived from it should be acknowledged.

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Introduction

The aim of this thesis is to provide a cohesive phenomenological account of mania and depression. Whilst there is a long and productive history of dialogue between phenomenology and psychiatry, mania, depression, and bipolar disorder have been largely neglected.¹ This stands in stark contrast to the rich vein of work undertaken on schizophrenia (e.g. Sass, 2001; Sass and Parnas, 2007; Gallagher, 2006). Recent interest in depression has gone some way towards rectifying the situation (e.g. Fuchs, 2005a; Ratcliffe, 2010; Wyllie, 2005). However, mania remains relatively overlooked and few phenomenological accounts seek to place both states within the same framework. A unified account allows us to unearth otherwise overlooked continuities and disparities in the structures which underlie both states.

In developing this account I focus on two central areas: Experiences of the body and experiences of time. Each of these plays a central role in the structuring of experience and descriptions of alterations in experiences of the body and time are a striking feature of first person accounts of mania and depression. Furthermore, an analysis of these alterations provides us with the means to understand experiences of the world and experiences of other people, thus paving the way for a comprehensive philosophical account of mania and depression.

I aim to challenge the simple opposition between mania and depression that is frequently found in everyday discourse. I offer a new model that reveals deeper commonalities between these two states, thus casting light on their relationship.

¹ For more on the relationship between phenomenology and psychiatry, see Broome et al. (2012).

In the process I make explicit various assumptions made by philosophers, challenging and refining existing accounts of bodily and temporal experience.

Drawing on work by Thomas Fuchs (2003; 2005a), I argue that in cases of depression there is a 'corporealization' of the lived body. By this, I mean that the body loses its everyday transparency and is experienced as distressingly object-like. This account of the body in depression allows us to understand common descriptions found in first person narratives of the body as "heavy" and "tired", as well as evaluative descriptions of the body as "useless" and "disgusting". Throughout this thesis I make use of such first person narrative accounts. However, I take care to reflect on my use of them, remaining alert to potentially problematic features of narratives, including issues of motivation and cultural influence. Despite these concerns, I suggest that the context, focus, and structure of such accounts can help to provide us with access to features of experiences of mania and depression that may not be easily accessible through other means. Used judiciously and in conjunction with other resources these first person narrative accounts can be productively used in phenomenological studies.

When studying these narrative accounts we find frequent reference to increased activity in mania. Whilst philosophers have largely ignored the topic of the body in mania, Fuchs provides a relevant distinction between the *conspicuous and inactive body* and the *invisible and active body* (e.g. 2003). Given this understanding of bodily experience, we might assume that the manic body would fade out of the person's awareness – it would be invisible to the person. However, I argue that this account of the manic body is incorrect. Instead, drawing on first person accounts of mania, I suggest that the manic body is conspicuous *and* active. This challenges Fuchs's distinction and highlights a need for a more nuanced understanding of bodily experience in mania and

depression. I argue that this understanding can be developed partly through an appreciation of the alterations to temporal experience that occur in these states.

Accounts of temporal experience in mania and depression frequently suggest that time is experienced as *slowing down* in cases of depression and *speeding up* in cases of mania (e.g. Fuchs, 2013a). Taking these accounts as my starting point, I explore how a decrease of ‘conation’ (a basic forward-directed drive or momentum) may bring about common features of depressed experience, including feelings of isolation from others. Similarly, I show how an *increase* of conation may feature as part of the manic experience. However, I argue that experiences of time in mania and depression cannot be explained merely by reference to temporal *velocity*; we must also take into account alterations to temporal *structure*.

Husserl proposes a tripartite structure of temporal consciousness (e.g. 1991).² Within the ‘now’ phase we find our awareness of the immediate present, as well as our ‘retention’ of the immediate past and our ‘protention’ of the immediate future. Drawing on work by Matthew Ratcliffe (2012a), I suggest that in cases of depression there is not only a diminishment of conation, there is also an impoverishment of *protention* – the anticipation of the immediate future. I explore the links between protention and retention, arguing that an impoverishment of protention entails an impoverishment of retention. An appreciation of the alterations in temporal structure that occur in depression enriches our understanding of the state, casting light on common experiences of mild fragmentation.

Similarly, I show that mania cannot be understood as merely an increase of conation. I argue that in manic states the person’s *retentional* capacity, his awareness of the immediate past, is weakened. I demonstrate how, in contrast

² The original publication dates for the texts used in this thesis can be found in the reference list.

to accounts that focus merely on temporal velocity, my account of temporal experience in mania provides us with the means of understanding the experiences of fragmentation and loss of reflection that are common in manic states. Furthermore, my account of mania helps us to make sense of the manic experience of the body. I argue that the weakening of retention that we see in mania causes the person to experience an excess of possibilities in the world – the world drawing him in to constant action. Thus, the body is active. However, the weakening of retention also prevents meaningful engagement. I suggest that without this meaningful engagement the body fails to fade out of conscious awareness. Thus, the body is conspicuous. The account of mania that I develop in this thesis therefore grants us greater insight into the seemingly difficult to understand experience of mania, as well as highlighting the intimate relationship between experiences of time and experiences of the body. Throughout my discussion of temporal experience I focus on developing an accurate account of experiences of time in mania and depression, as well aiming to refine descriptions of temporal experience more generally – including revealing the relationship between shorter and longer-term temporal structures, and the connections between experiences of time, the body, the world, and other people.

Superficially, mania and depression appear to be polar opposites – one state characterised by elation, the other by extreme sadness. Given this, it is difficult to understand the existence of ‘mixed episodes’ or ‘states’, where features of mania and depression occur simultaneously. Seeking to address this challenge of mixed states, I provide accounts of mania and depression that accommodate the possibility of this co-occurrence, as well as exploring the relationship between the two states. In doing this I challenge the conception of mania and depression as two ‘pure’ states that directly oppose each other, instead developing accounts that provide insight into a variety of different experiences in bipolar disorder.

Thesis Outline

This is a phenomenological study of mania and depression. As such, we must first be clear on what phenomenology is and on its relationship with psychiatry. I therefore begin chapter one by describing phenomenology and the phenomenological method. Using the work of Husserl (e.g. 1983), I discuss the need to move beyond what he calls the ‘natural attitude’ in order to reveal that which is taken for granted in our everyday experiences. This includes the way in which we are practically embedded in the world – a sense of *belonging* to the world. I highlight how these features of experience may alter in cases of psychiatric disorders and so how the phenomenological method may contribute to our understanding of these disorders, helping us to make sense of seemingly incomprehensible experiences. I draw on work by Parnas and Zahavi (2002) to suggest that we can use phenomenology in order to influence the classification of psychiatric disorders and, following Minkowski (1970), I draw attention to how phenomenology can help us to move beyond superficial presentations of psychiatric disorders. Beyond classification, I argue that phenomenology can play a distinctive role in helping those with psychiatric disorders to understand and articulate their experiences, potentially alleviating some of the feelings of isolation that are commonly reported. I argue that the relationship between phenomenology and psychiatry is a reciprocal one, and review some of the ways in which the study of psychiatric disorders may aid us in improving our phenomenological accounts.

With this account of phenomenology in place, and having explored the mutually beneficial relationship between phenomenology and psychiatry, I turn in chapter two to questions concerning the nature of mania, depression, and bipolar disorder, and ask whether there is a need for phenomenological studies in this area. I begin by providing an overview of the history of these categories, highlighting how the individual categories and the relationship between them has changed. In doing so, I demonstrate the instability of these

categories. I then move on to discuss contemporary classifications of mania, depression, and bipolar disorder, focussing on the criteria given in the fourth and fifth editions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (APA, 2000; 2013). I note the continued instability in even these contemporary classifications, and discuss a number of debates that have arisen from the 2013 publication of the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (APA, 2013). These include the challenge of 'Mixed Episodes', where features of mania and depression co-occur, as well as the difficulties involved in distinguishing between mania, depression, and everyday distress. Such debates, I suggest, highlight the need for greater understanding of these states. I then consider how we can begin to study these experiences, clarifying my use of the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (APA, 2000) and outlining how we can develop an account of mania and depression that moves beyond the complexities of individual experiences without abandoning the aim of describing experiences of these states.

Having established why we might want to develop a phenomenological account of mania and depression, and having outlined how we can go about developing such an account, we must next explore what resources we can draw on to gain access to reliable descriptions of these experiences. In chapter three I therefore focus on narratives of mania and depression, assessing the value and reliability of such accounts. I argue that first person narrative accounts can be a useful resource for phenomenologists, noting the value of the context provided in these accounts, the insight narratives offer into the relationship the person has with his or her disorder, and the extent to which the structure of a narrative can be revealing of the described experience. I go on to outline some of the potential problems with narrative accounts. These include the extent to which the person may compromise the accuracy of the account in order to adapt it to established narrative structures, the role of social and cultural influences, and

the existence of potentially distorting personal or editorial motivations. I take care to note the ways in which narratives of mania and depression may be particularly vulnerable to certain distortions. Following this, I explain how we can corroborate the descriptions found in first person narratives through the use of additional resources, including questionnaire studies. I introduce the Durham Depression Questionnaire, a web-based questionnaire on the experience of depression that I developed with colleagues in the project "Emotional Experience in Depression: A Philosophical Study". I conclude this chapter by outlining the role that narratives of depression and mania can play in phenomenological study, including how we can remain mindful of the limitations of such resources.

First person narratives of mania and depression frequently describe alterations in experiences of the body. In chapter four I therefore turn to bodily experience, seeking to understand these changes and how they impact on the person's wider experiences, including experiences of the world. I begin by outlining the everyday experience of the body, as discussed in the work of Merleau-Ponty (e.g. 2002) and Sartre (e.g. 2003). I particularly note the body's role in structuring our experience of the world, and how it typically takes on a degree of transparency when a person is active in the world. Turning to experiences of the body in depression, I draw on the work of Fuchs (e.g. 2005a) in order to argue for an understanding of the depressed body as 'corporealized'. I note how this account of the depressed body helps us to understand common descriptions of experience in depression. This includes the body feeling "leadened" or "heavy", evaluative claims made about the body and the self as "useless" or "disgusting", as well as accounting for some of the difficulties the depressed person experiences when attempting to act in the world. Having established this account of bodily experience in depression, I turn next to the topic of mania. I begin by highlighting Fuchs's implied distinction between the *inactive and conspicuous body* and the *active and transparent body* (e.g. 2003).

Given the increased activity in states of mania, I suggest that we might initially assume that bodily experience in mania would be characterised by increased transparency. I discuss what an account of this type might look like and consider what some of the advantages of adopting it might be. However, I go on to show that we must ultimately reject accounts of this type. Drawing on first person descriptions of mania I show that far from the body becoming increasingly transparent, it in fact becomes conspicuous during manic states. The active and conspicuous body of mania thus directly challenges Fuchs's distinction. However, it also leaves us with questions regarding how we *should* understand the bodily experiences of mania and depression. How can the manic body be both active in the world and yet not fade from explicit awareness? I suggest that one possible answer lies in the ways that time is experienced in both mania and depression.

In chapter five I therefore turn to the topic of time, exploring how temporal experience is altered in cases of mania and depression. Using the concepts of 'objective' and 'subjective' time, I put forward a basic account of how time may subjectively appear to slow down in cases of depression and speed up in cases of mania. I make use of psychological studies (e.g. Bschor et al, 2004) and first person accounts in order to assess the accuracy of such an account. Whilst I note that this basic account does go some way towards helping us to understand temporal experiences of mania and depression, I argue that it does not adequately capture the full complexities of such experiences. Continuing the chapter, I therefore return to the concept of subjective time. Drawing on work by Fuchs (2013a) and Ratcliffe (2012a) I outline the roles played by 'conation' (a basic forward directed drive) and 'temporal synthesis' (the continuity that we experience through time). I provide a Husserlian account of temporal synthesis, explaining how our 'retention' of the immediate past and 'protention' of the immediate future allows for a unification of temporal experience. With this account of subjective time in place, I go on to discuss how experiences of time

alter in cases of depression. In line with Fuchs (2013a) and Wyllie (2005), I suggest that an appreciation of intersubjective time can enhance our understanding of the temporal experience of depression. I further draw on work by Fuchs (2013a), Ratcliffe (2012a), and Wyllie (2005) to argue that there is a loss of conation in cases of depression, with a resultant desynchronization of intersubjective time. I note how this account of temporal experience can help us to understand common features of depression, including increased experiences of guilt, and a perception of depression as eternal and recovery as impossible.

Turning to cases of mania, I argue that the manic experience of time cannot be adequately understood simply through appeal to alterations in temporal velocity. Instead, I propose that the manic person experiences a weakening of retention – the perception and appreciation of the just-past. I show how this disruption accounts for a number of common features of manic states, including reports of the fragmentation of time, a loss of reflection, a loss of engagement, and a diminished sense of ownership of action. I conclude the chapter by addressing some initial concerns that might be raised against this account of temporal experience in mania.

A full understanding of the experience of time in mania and depression requires an appreciation of alterations in both shorter and longer-term temporal structures. I therefore begin chapter six with a discussion of the ways in which we are situated in time due to our projects, commitments, and self-interpretations. Drawing on work by Matthew Ratcliffe (2012a), I examine the relationship between projects, possibilities that appear as ‘relevant’, and possibilities that appear as ‘enticing’. I explore the ways in which these related features can be affected in cases of depression, and show how the alteration or loss of them can account for experiences that are commonly described in first person accounts. These include experiences of time as cyclical, feelings of separation from the world, and an experience of the world as having lost

meaning. Following this, I examine the relationship between these longer-term temporal structures, and the shorter-term structures of conation and temporal synthesis that I introduced in chapter five. I outline Ratcliffe's (2012a) account of how protention – the anticipation of the immediate future – may be impoverished in cases of depression. Building on this, I argue that an impoverishment of protention necessarily entails an impoverishment of retention, and use first person descriptions of depression to illustrate how this impoverishment may be experienced. In this first section of chapter six I therefore aim to enrich my account of temporal experience in depression as well as reveal the relationships between shorter and longer-term structures of time.

Next, I return to the topic of temporal experience in mania. I argue that the weakening of retention that occurs in manic states prevents the development and maintenance of projects. I suggest that the loss of projects leads to a *decontextualisation* of possibilities, resulting in an excess of relevant and enticing possibilities. This more detailed account of temporal experience in mania helps to develop our understanding of common features of manic states, such as grandiosity, creativity, and a constant re-interpretation of the self and values. I particularly note how these alterations impact on the manic person's relationship with other people. Following this, I return to the questions regarding bodily experience that I raised in chapter four. I note that the excess of possibility experienced by the manic person results in increased activity. However, I argue that the manic body remains conspicuous due to the manic person's inability to meaningfully engage in tasks and projects. Thus, the manic body is both active and conspicuous – just as we find reported in first person accounts. Through this account I examine the relationship between experiences of time and experiences of the body, revealing the intimate connection between the two.

Earlier, I noted the superficial opposition between mania and depression, and the challenge posed by episodes in which features of both states co-occur – so-called “mixed episodes” or “mixed states” (APA, 2000, p365). Through an examination of two forms of mixed state – ‘dysphoric mania’ and ‘agitated depression’ – I demonstrate how my accounts of mania and depression are able to accommodate these theoretically challenging experiences. I then use these accounts of mania, depression, and mixed states to explore potential links between features of these experiences and suicidality.

What emerges from this thesis is a cohesive phenomenological account of mania and depression. Throughout, I refine descriptions of temporal experiences, challenge traditional accounts of bodily experience, and reveal relationships between experiences of the body, time, the world, and other people. In my concluding chapter I discuss the philosophical and clinical implications of this account. I outline how it may be used to provide a principled distinction between bipolar disorder and schizophrenia and suggest fruitful directions for future research.

Chapter 1: Phenomenology and Psychopathology

Introduction

This thesis is a phenomenological study of mania and depression. Before we go any further it is therefore necessary to consider what is meant by 'phenomenology' and to assess what kind of contribution phenomenology can make to the study of psychiatric disorders. This chapter thus has two primary aims: Firstly, to provide a description of phenomenology and the 'phenomenological stance'; and, secondly, to explore the relationship between phenomenology and psychiatry. Through this discussion I will make clear the distinctive role that phenomenology can play in a study of psychiatric disorders.

What is Phenomenology?

Phenomenology may broadly be understood as a field of study concerned with exploring and describing lived experience in all its richness and complexity. Central areas of interest therefore include the ways in which we experience the world, time, our bodies, other people, and so on. At this point we might be led to think that there is nothing particularly distinctive about phenomenology. After all, the question of how we understand and interact with other people is also of interest to other philosophers. Similarly, it might be suggested that a psychologist could carry out explorations into how we perceive the world. We must therefore ask what it is that is distinctive about phenomenological enquiry. Is there anything that unites phenomenological approaches and how do such approaches differ from the methodologies found in other traditions? In the next section I begin to explore these issues, describing what is meant by the *phenomenological method*.

Husserl and the Phenomenological Method

Philosophers working in the phenomenological tradition include Husserl, Heidegger, Merleau-Ponty, and Sartre. Although I draw on insights from each of these philosophers, I will begin by focussing on the work of Husserl in order to introduce the phenomenological method. As we shall see, this method is not unique to Husserl and we can find relevant similarities in the work of other phenomenologists. However, let us start by focussing on Husserl and his account of the phenomenological method.

Husserl argues that in our ordinary, everyday, experiences we take for granted the reality of the world and all that it contains. As Gallagher and Zahavi put it, we assume that reality is “out there, waiting to be discovered and investigated” (2008, p22). This belief in the world does not take what we might think of as the typical form of a belief, demonstrated in statements such as “I believe that London is in England” or “I believe that apples are a type of fruit”. The belief that London is in England or that apples are a type of fruit already presupposes the reality of the world – it takes for granted this acceptance. Our beliefs and doubts operate *within* the world; they are built upon this naïve acceptance – what Husserl refers to as the “natural attitude” (1983, p51). The difference between this belief and beliefs of a more typical structure becomes apparent when we consider Husserl’s description of this attitude – our ordinary acceptance of the world:

I am conscious of a world endlessly spread out in space, endlessly becoming and having endlessly become in time. I am conscious of it: that signifies, above all, that intuitively I find it immediately, that I experience it. By my seeing, touching, hearing, and so forth, and in the different modes of sensuous perception, corporeal physical things with some spatial distribution or other are *simply there for me, “on hand”* in the literal or the figurative sense, whether or not I am particularly heedful of them and busied with them in my considering, thinking, feeling, or willing. Animate beings too – human beings, let us say – are immediately there for me... (1983, p51)

This is not simply a belief in the existence of the world, held in the same way that we may believe London is in England, but rather it is a way of belonging or being in the world. This attitude is taken for granted by people as they go about their day-to-day lives, and it is within this attitude that they explore individual beliefs and doubts. Crucially, we find that it is presupposed even by our scientific methods and endeavours. It is presupposed at every moment, and as such we find that our usual enquires into the world, self, and experience rest on unexamined foundations. As Husserl writes, “No doubt about or rejection of data belonging to the natural world alters in any respect the *general positing which characterizes the natural attitude*” (1983, p57). An accurate and systematic study of world-experience thus requires a radical method in order to move beyond the natural attitude. For Husserl, this is found in the ‘epoché’ and the ‘phenomenological reduction’.

The epoché is a process through which the natural attitude is set aside or ‘put out of action’ in order to allow for a more radical and thus far reaching and thorough study of experience. This is sometimes referred to as a process of ‘bracketing’ the natural attitude. We must make clear here that this is not to advocate a process of denying what is found in the natural attitude, nor even of doubting it. We do not affirm or deny it, instead we suspend, bracket, or set aside our naïve attitude towards the world in order to, as Dan Zahavi puts it, “focus more narrowly and directly on reality just as it is given” (2007, p30). By analogy, I might affirm the truth or falsehood of the sentence “the red mug is next to the blue teapot”. Alternatively, I can set aside questions of the sentence’s truth value and bracket it – (the red mug is next to the blue teapot) – in order to study the *structure* of the sentence. The aim is therefore not to dismiss the world-experience we find in the natural attitude, but rather to set it aside in order to allow these presupposed features of experience to be studied. As Husserl puts it:

[It] is not a transmutation of positing into counter positing, of position into negation...*Rather it is something wholly peculiar. We do not give up the positing we effected, we do not in any respect alter our conviction...Nevertheless the positing undergoes a modification: while it in itself remains what it is, we, so to speak, "put it out of action," we "exclude it," we "parenthesize it".* (1983, p59)¹

It must be stressed that the suggestion is not that we perform the epoché once and then are able to simply return to the natural attitude as we carry out phenomenological enquires. Instead, Husserl suggests that the epoché is the gateway to the 'phenomenological reduction' – a sustained stance that allows us to turn our attention towards the bracketed world-experience, exploring and reflecting on the structure of our experiences. With the natural attitude set aside, we are now able to focus more clearly and fully on the world as it is given to us – on the 'phenomena'. Phenomenological enquiry thus allows for an exploration of the ways in which we experience the world, including the conditions for the possibility of the appearance of objects. Through the epoché and the reduction, phenomenologists are able to explore the contribution consciousness makes in constituting the objects of our experience – in allowing them to appear and giving them meaning – rather than exploring the objects as separate from how they are given. I could, for example, perceive a table, remember a table, imagine a table, or hallucinate a table. The phenomenologist focuses on describing the structures of these different experiences, examining how it is that the object may be given to us in these ways, rather than merely describing the physical features of the table itself (the weight of it, for example, or the colour), or describing the structures of my eye that cause or allow me to see the table. As David Cerbone puts it:

When I perform the reduction, I no longer attend to the worldly objects of my experience, nor do I wonder about the causal

¹ "We "parenthesize it"" (Husserl, 1983, p59) is often translated as we "bracket it" (e.g. Husserl, 1931, p108)

underpinnings of that experience; instead, I focus my attention on the experience of those worldly objects. (2006, p23)

In performing the phenomenological reduction we therefore allow for the possibility of exploring the rich complexities of the structures of our experiences, focussing on that which is taken for granted in the natural attitude. Zahavi sums up the aim of the epoché and the phenomenological reduction, explaining that the purpose is “to liberate us from a natural(istic) dogmatism and to make us aware of our own constitutive (that is, cognitive, meaning-giving) contribution” (2003, p46).

However, this process does not entail cutting-off or turning away from the world. Indeed, what is revealed, amongst other things, is the way in which we find ourselves practically immersed in a world that has meaning for us. In other words, we are not merely detached observers of an inaccessible and external world. Instead, we immediately find that we have a sense of *belonging* to the world. Husserl writes, “this world is there for me not only as a world of mere things, but also with the same immediacy as a *world of objects with values, a world of goods, a practical world*” (1983, p53). Prior to our beliefs, doubts, and perceptions of particular objects in the world we find our implicit understanding that the world is there for us and for others. We are immersed in it, we can act within it, and it holds meaning and significance for us in various ways.

We can therefore see that the epoché and reduction do not lead to the world being excluded or ignored, nor can phenomenology be understood to be a form of introspection.² As Zahavi explains, phenomenology allows for “an *expansion* of our field of research” (2003, p46), rather than a turn inwards, away from the world. Indeed, phenomenologists such as Husserl reject the very distinction

² See Cerbone (2006) and Gallagher and Zahavi (2008) for further discussion of the differences between phenomenology and introspection.

between 'inner' and 'outer' that introspection is reliant upon.³ Gallagher and Zahavi write that to "speak of introspection is to (tacitly) endorse the idea that consciousness is inside the head and the world is outside" (2008, p21). Introspection thus operates within the natural attitude, presupposing the distinction between internal and external and then turning inwards to examine and describe merely the internal. In contrast, phenomenologists reject this distinction, retaining the world as part of their field of enquiry. To offer a description of an internal mental state, even an incredibly rich description of such a state, thus fails to move beyond our natural attitude and so cannot be described as phenomenological.

At this point we may be concerned that such a radical project must be seen as impossible. It seems implausible that we could adopt such an extreme position – disconnecting ourselves from our intuitive and everyday ways of perceiving the world.⁴ If we cannot successfully 'bracket' our natural attitude, does this mean that the entire phenomenological project must be rejected? I think not. Whilst we may doubt whether we can adopt such an extreme position, we *can* aim to turn our attention towards the usually taken-for-granted or presupposed features of experience, commit to uncovering such features, and work towards analysing them. We need not think that the epoché and reduction must be fully completed in order to be valuable. We can adopt a 'phenomenological stance', without committing ourselves to the possibility of completing such a radical turn.

Whilst what I have outlined here is a Husserlian account of the phenomenological method and the world experience that is revealed through that method, we can find relevantly similar commitments and aims within the work of other phenomenologists. For example, Heidegger's (1962) description

³ See Zahavi (2007) for further discussion of this point.

⁴ Indeed, Merleau-Ponty writes that "The most important lesson which the reduction teaches us is the impossibility of a complete reduction" (2002, p xv).

of being-in-the-world similarly stresses the ways in which we are practically immersed in a meaningful world – the world experience that Husserl maintains is overlooked in the natural attitude. Indeed, Merleau-Ponty suggests that *Being and Time* “amounts to no more than an explicit account of the ‘natürlicher Weltbegriff’ or the ‘Lebenswelt’ which Husserl...identified as the central theme of phenomenology” (2002, pviii). Merleau-Ponty himself describes the importance of “reawakening the basic experience of the world” (2002, pix). This turn towards the taken-for-granted world experience thus runs through the work of each of these different philosophers. Whilst significant differences can be found in their broader work, it is in the common acknowledgement of that which is presupposed in the natural attitude and in the aim of studying such structures of experience that we find both what is distinctive about phenomenology and what unifies different phenomenological accounts.

In this study I will be drawing on the collective phenomenological tradition, rather than relying on or seeking to defend any single philosopher’s work. Thus, this thesis ought not be understood to be a purely Husserlian study of mania and depression (or a Sartrean study, or Heideggerian, and so on), but rather a *phenomenological* study of the topic. I therefore employ a phenomenological method while seeking to apply insights from philosophers working within the phenomenological tradition. In doing this, I aim to explore and clarify experiences of mania and depression.

The question that arises at this point is of the relevance of phenomenology for the study of mania and depression, and of psychiatric disorders in general. In the next section I therefore examine the relationship between phenomenology and psychiatry, exploring how phenomenology can aid our understanding of psychiatric disorders.

Phenomenology and Psychiatry

Some features of psychiatric disorders are externally observable to a third person. For example, extremely low weight in cases of anorexia nervosa (APA, 2000, p589) or insomnia/hypersomnia in cases of depression (APA, 2000, p356).⁵ Such features, we might think, can be both described and understood even by those who do not have first person experience of those features.⁶ However, psychiatric disorders also include features that involve alterations in subjective experience. For example, the “excessive anxiety” found in Generalised Anxiety Disorder (APA, 2000, p476) or the racing thoughts found in mania (APA, 2000, p362). These features are often very distressing for the person experiencing them and, as Nassir Ghaemi points out, “If we say nothing or little about subjective states, psychiatry as a field would seem to lose a great deal of relevance to what patients experience and for which they want assistance” (2009). We may be able to observe some of the effects of such experiences – perhaps a person may pace or hyperventilate when anxious, for example – but we cannot directly observe the experience itself. Similarly, we may be able to study the neurobiological processes that may be thought to be responsible for or correlates of the experience. However, we must first have some understanding of what the experience is before we can explore the correlates of that experience or the processes responsible for it. Otherwise, as Matthew Ratcliffe succinctly puts it, “our enquiry would have no subject matter” (2009, p238). Thus, whilst subjective features of psychiatric disorders may be able to be described, to do so accurately requires a developed understanding of the person’s experience. In order to fully understand a psychiatric disorder,

⁵ The examples in this chapter are taken from the *American Psychiatric Association’s Diagnostic and Statistical Manual*, fourth edition, text revision (APA, 2000). However, similar features can be found in other editions of the DSM.

⁶ This is not to say that we can easily provide a causal explanation of such features – merely that we can observe and describe them.

including these features, we must therefore understand the subjective experience of that disorder.

However, when we attempt to describe experiences of a number of psychiatric disorders we immediately run into problems: Many features of the experiences appear to be difficult, if not impossible, to understand. For example, how are we to understand someone who says that she feels like she has been cut off from the world by a glass wall? What does a person mean when he says that time has stopped?⁷ Furthermore, we find that psychiatric disorders do not simply involve alterations in the content of experience – what the experience is *about* – they also frequently involve alterations in the *structures* of experience. First person accounts report profound changes in the structures of temporality, embodiment, self-awareness, interpersonal relations, world-experience, and so on. Consider, for example, the following descriptions, the first taken from a memoir of depression, the second taken from an interview,⁸ and the third taken from a memoir of schizophrenia:

I had, too, a pronounced sense of unreality...It was all so normal, yet everything was different. It looked, to me, like a scene from a play that I was witnessing. (Brampton, 2009, p66)

There were often a lot of confused moments and I would stand still and try to understand how to inhabit the world. Try to find any way at all to breathe, to gesture, to reach, to speak, to do any action in the world that could be me...The world had lost its welcoming quality. It wasn't a habitable earth any longer. It didn't bear the meanings of human life anymore. It wasn't a place where human beings could dwell. It became impossible to know how to relate to it...You've lost the invitation to live that the universe extends to us at every moment.

⁷ As both men and women experience mania and depression, I use both male and female pronouns throughout this thesis.

⁸ It is not clear from the interview what James Melton's precise diagnosis is – though we are told he was in a catatonic state at one stage (Hornstein, 2009, p209). However, his descriptions, whilst more extreme than many, are otherwise similar to accounts of severe depression. Even if we take his experience to be different from most experiences of depression he still appears to be hinting at alterations in features of experience that are frequently involved in a variety of different psychiatric disorders, including depression.

You've lost something that people don't even know is. That's why it's so hard to explain. (Hornstein, pp210-213)

Everything was exact, smooth, artificial, extremely tense; the chairs and tables seemed models placed here and there. Pupils and teachers were puppets revolving without cause, without objective. I recognized nothing, nobody. It was as though reality, attenuated, had slipped away from all these things and these people. (Sechehaye, 1994, p26)

These extracts do not appear to be describing changes in individual beliefs or attitudes, but rather a profound change in world-experience – a change in how the person dwells or is embedded in the world. As the second quotation highlights, these are features of experience of which most people are oblivious. These structures of experience are rarely acknowledged or reflected on, they instead form the presupposed backdrop to our beliefs, doubts, and attitudes. Understanding these experiences is central to understanding psychiatric disorders, but we cannot set about studying these changes in the structure of experience if we continue to maintain the assumptions about world-experience that we hold in the natural attitude. Put simply, we cannot seek to contrast these experiences with everyday experiences if we already assume these structures are the same.

We must, it seems, pull away from these taken-for-granted features so that we can explore the ways in which they may be altered or lost. This is precisely what phenomenology can contribute to the study of psychiatric disorders. Adopting a phenomenological stance grants access to the taken-for-granted structures of experience that are frequently altered in psychiatric disorders. The phenomenological tradition focuses on these structures of experience and thus provides a rich set of resources that we can draw on in order to help us to understand and describe these alterations.

The clarity that phenomenological studies can provide helps to make sense of hard to understand experiences that may occur in the context of psychiatric

disorders. Writing on schizophrenia, Giovanni Stanghellini suggests “there is something incomprehensible and almost inhuman in these experiences, something that makes me feel radically different from the person I am listening to” (2007, p129). He uses a phenomenological approach to enhance our understanding of the experience of schizophrenia, suggesting that we can interpret the experience as a “crisis of commonsense”, where “commonsense” is understood to be “the set of interpretative procedures or ‘account practices’ shared in a tacit and undiscussed manner by everyone belonging to the same cultural context” (2004, p12). It is through phenomenological reflection that he suggests we are able to make the ‘incomprehensible’ experience of schizophrenia comprehensible: “When I listen to my schizophrenic partner, I may have the opportunity to see in front of me what I cannot be aware of when I am turned to the life-world in the so-called ‘natural’ attitude” (2007, p130).

Shaun Gallagher (2006) similarly employs a phenomenological approach in order to enhance our understanding of the experience of schizophrenia. He describes how alterations in temporal experience may help to make sense of the experience of ‘thought insertion’ – where a person believes that thoughts are being inserted into his head from an external source.⁹ Louis Sass and Josef Parnas provide further analysis of the experience of schizophrenia, exploring how disturbances to the person’s sense of self (‘Ipseity’) may account for a number of common features found in schizophrenia, including a sense of alienation from thoughts, the world, and the body (e.g. 2007).¹⁰ They suggest that a phenomenological approach helps to “make sense out of seemingly bizarre actions or beliefs that might otherwise seem completely incomprehensible” (2007, p65).

⁹ See Gallagher (2006, chapter eight) for a discussion of this topic.

¹⁰ They particularly highlight the role that ‘hyper reflexivity’ may play in schizophrenic experience. Hyper-reflexivity may be understood to be “a kind of exaggerated self-consciousness” (Sass and Parnas, 2007, p68).

What these accounts hold in common is the claim that phenomenology can help enhance our understanding of the experience of schizophrenia. They each offer detailed phenomenological analyses that provide accounts of an experience that might otherwise escape our understanding. It should be clear that we do not need to accept the details of each of these accounts in order to appreciate the more general point that phenomenology offers a potential means of clarifying experiences of psychiatric disorders. What these accounts of schizophrenia demonstrate to us is the ways in which phenomenology opens up the possibility of making sense of experiences that might otherwise be labelled as 'incomprehensible'.

In addition to helping us to understand the experiences of psychiatric disorders, phenomenology may also be able to contribute to neuroscientific understanding of those disorders through a process of what Gallagher calls "front-loaded phenomenology" (e.g. 2003). This is a process by which phenomenology can be used to help inform the set-up and interpretation of scientific experiments. Gallagher and Zahavi explain:

The idea is to front-load phenomenological insights into the design of experiments, that is, to allow the insights developed in phenomenological analyses to inform the way experiments are set up (2008, p38).

For example, Gallagher and Brøsted Sørensen describe how phenomenological insights that reveal a distinction between a sense of agency as an immediate first-order experience and as a second-order cognitive attribution have been used to inform fMRI studies seeking to explore the neurological processes that underlie experiences of agency (2006, pp125-6). As disturbances in a sense of agency occur in psychiatric disorders such as schizophrenia, such research has the potential to contribute to our neuroscientific understanding of those experiences. Gallagher and Brøsted Sørensen (2006) also report on how experiments that have been phenomenologically front-loaded have been used

to explore senses of agency and ownership in bulimia nervosa.¹¹ We can therefore see how phenomenological distinctions, and phenomenological insights more generally, may be able to inform experimental studies into psychiatric disorders. In this way phenomenology may aid our understanding of the neuroscience of psychiatric disorders, as well as providing accurate descriptions of the experiences of those disorders.

The recognition that phenomenology can contribute to our understanding of psychiatric disorders is not new. We can find phenomenological approaches in the work of Karl Jaspers, Ludwig Binswanger, Eugene Minkowski, and Erwin Straus, amongst others. Writing in 1946, Binswanger suggested that:

[I]n mental diseases we face modifications of the fundamental or essential structure and of the structural links of being-in-the-world as transcendence. It is one of the tasks of psychiatry to investigate and establish these variations in a scientifically exact way. (2012, p119)

Binswanger employed a phenomenological approach in exploring these structures.¹² Jaspers similarly explains how he made use of phenomenological research:

As a method I adopted and retained Husserl's phenomenology...It turned out to be possible and fruitful to describe the inner experiences of the sick as phenomena of consciousness. By the patient's own self-description, not only hallucinations but delusive experiences, modes of ego-consciousness and types of emotion could be defined well enough for positive recognition in other cases. Phenomenology became a research method. (Quoted in Broome et al. 2012, p87)

Both the historical and the contemporary work in this area highlight the immediate benefit of a phenomenological approach as a means to "further enrich our knowledge of what the psychiatric patient really experiences"

¹¹ See Brøsted Sørensen (2005) for a full discussion of this experimental work.

¹² Binswanger was particularly influenced by the work of Heidegger. See Binswanger (2012) for a detailed description of his approach.

(Jaspers, 2012, p100). However, this phenomenologically informed understanding of psychiatric disorders can also be seen to have further benefits. One such area that has attracted particular attention is the ability for phenomenological research to aid the development of accurate diagnostic categories.

Phenomenology and Classification

We have already seen that many psychiatric disorders involve changes in the structures of experience. Unsurprisingly, changes in subjective experience are frequently referenced in the diagnostic criteria for a number of psychiatric disorders. For example, the diagnostic criteria for anorexia nervosa in DSM-IV refer to an alteration in the person's relationship with her body: "Disturbance in the way in which one's body weight or shape is experienced" (APA, 2000, p589). The criteria for a major depressive episode similarly include alterations in subjective experience - one criterion is a subjective experience of diminished interest in activities,¹³ another mentions a reduced ability to think or concentrate (APA, 2000, p356). It is notable that recent editions of the DSM aim to classify psychiatric disorders on the basis of description rather than by using causal accounts – the American Psychiatric Association has adopted "a descriptive approach that attempt[s] to be neutral with respect to theories of etiology" (APA, 2000, xxvi). If descriptions of experience comprise at least part of the classification of psychiatric disorders, as they do in contemporary classification manuals such as the DSM, it is essential that such descriptions are as accurate as possible. In order to maintain accurate classification of psychiatric disorders we can, therefore, use phenomenological insights in order to explore, challenge, and correct these features.

¹³ "markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)" (APA, 2000, p356).

However, we can go further than this. Parnas and Zahavi argue that whilst the DSM may claim to be atheoretical, a number of terms (such as 'delusion', 'dysfunction', or 'incorrect inference') "are either loaded with metaphysical assumptions...or tainted by references to hypothetical extra-clinical, sub-personal processes" (2002, p140). They also suggest that there is an underemphasis of subjective experience and an overemphasis of behavioural signs and symptoms due to a "lack of a suitable theoretical psychopathological framework to address human *experience*" (2002, p140). Phenomenology, they argue, can provide this framework, allowing for the development of accurate descriptions of the subjective experience of psychiatric disorders whilst avoiding unwanted metaphysical commitments or assumptions. Thus the claim is not simply that phenomenology may inform classification by helping to correct individual criteria within a category, but rather that phenomenology may act as a conceptual framework through which to develop a more accurate classification.

One advantage of a phenomenologically informed classification is the focus given not simply to observable signs and symptoms, but also to the profound structural changes that we have seen occur in psychiatric disorders. As Minkowski points out, superficially similar signs or symptoms may belie significant differences in experiential structures (1970, p224). He illustrates this by contrasting the "hypochondrial preoccupations of a neurotic" with the "hypochondrial preoccupations" seen in schizophrenia (1970, p224). Whilst there may be similarities in an initial description, he suggests that further examination reveals relevant differences between the two cases. That there can be "similarity in the expression of entirely different disorders" (1970, p224) highlights the importance of moving beyond these superficial presentations. A close examination of the structural changes in psychiatric disorders thus allows us to distinguish between those that merely appear similar due to similarity of expression and those that maintain similarities in experiential structures. An

acknowledgement of the potential for difference between the superficial presentation and the experiential structures also allows for the possibility of bringing together seemingly distinct experiences. The phenomenological emphasis on the need to “delve below superficial levels of behavioural description” (Sass, Parnas, and Zahavi, 2011, p3) allows us to explore the possibility of disorders that are relevantly similar at a structural level, but manifest in different ways. Examinations of alterations in the structures of experience thus allow for more accurate classification of psychiatric disorders.

This focus on alterations in the structures of experience can also help to direct and inform the development of effective treatments for psychiatric disorders. As Martin Wyllie writes, “Within the constitution of meaningful experience, one can, on analysis, identify the critical points where the constitution of a meaningful mode of being in the world is exposed and open to distortions that become discernible as psychiatric conditions” (2005, p174). Identifying such critical points provides us with a plausible focus for the development of treatments which focus on the central features of the disorder, rather than dealing with ‘symptoms’ that result *from* these crucial alterations. This may particularly be seen to be the case when we find distinctions that are not apparent at a more superficial level. Significant differences in experience may suggest a need for a difference in treatment or support.¹⁴ Alternatively, the discovery that two seemingly distinct experiences share relevant alterations in structural features may suggest that exploring similar treatments would be of value. Such phenomenological discoveries may, therefore, contribute to research into effective treatments.

We can therefore see that phenomenological approaches to understanding psychiatric disorders may plausibly contribute to contemporary discussions

¹⁴ This is not to suggest that one treatment may not be effective for multiple disorders. However, understanding differences between experiences may still be seen to allow for more *focused* research into possible treatments.

regarding classification and treatment. However, we undersell the importance of interaction between phenomenology and psychiatry if we restrict our discussion to the ways in which phenomenology can inform classification and treatment. In the next section I therefore continue to explore this area, demonstrating how interaction between phenomenology and psychiatry allows for significant benefits in both disciplines.

Beyond Classification

Those with psychiatric disorders often speak of the difficulties they have trying to describe their experiences. Fiona Shaw, for example, writes in her memoir of postnatal depression, “If Hugh asked me how I was, I wept and had no words” (1997, p25). Many use metaphors in the place of description or simply suggest that the experience is impossible for others to understand. Andrew Solomon explains this use of metaphor in his memoir of depression: “Depression is a condition that is almost unimaginable to anyone who has not known it. A sequence of metaphors – vines, trees, cliffs, etc. – is the only way to talk about the experience” (2002, p29). This difficulty in accurately communicating distress may exacerbate already present feelings of loneliness, isolation, irritability, or frustration. William Styron discusses the difficulties with the ‘indescribable’ nature of depression in his memoir of the disorder:

That the word “indescribably” should present itself is not fortuitous, since it has to be emphasized that if the pain were readily describable most of the countless sufferers from this ancient affliction would have been able to confidently depict for their friends and loved ones (and even their physicians) some of the actual dimensions of their torment, and perhaps elicit a comprehension that has been generally lacking.

(2004, p14)

As Styron highlights, the inability to accurately describe the experience of a psychiatric disorder can increase feelings of isolation from others and may prevent other people, including health care professionals, from developing an

empathetic response to those with the disorder. Binswanger stresses that difficulties in communication often come about due to “the fact that the mentally ill live in “worlds” different from ours” (2012, p129). Phenomenological studies of psychiatric disorders can prove beneficial in this regard: By describing these ‘worlds’, these altered structures of experience, phenomenological research can provide those affected with the descriptions needed to accurately communicate their experiences to others. In this way, phenomenology can, as Binswanger puts it, “bridge” these two worlds (2012, p129). This ability to articulate their distress may prove to be beneficial in alleviating some of the feelings of isolation and alienation common in experiences of psychiatric disorders. Improved communication may also aid the building of support networks and facilitate more productive conversation between those who have experienced the disorder and those who have not.¹⁵ If the person is able to accurately articulate his experience, he may more easily be able to highlight to others areas in which support may be beneficial.

Finally, phenomenology may provide the means by which a person can not only articulate her experiences, but also *understand* her experiences. Experiences of psychiatric disorders are often distressing, and this distress may be compounded by a lack of self-understanding. J.P. Whetsell explains this need to understand her own experiences in her account of bipolar disorder: “Because my identity is so bound to my experiences with bipolar disorder...it is important for me to understand my diagnoses in order to understand myself and the story of my life” (2010, p55). Whilst some people may come to understand their experiences through diagnosis, phenomenology offers a means by which a person may gain understanding even if she does not

¹⁵ Matthew Ratcliffe suggests that we can take this one step further and explains that the adoption of a phenomenological stance can aid what he calls “radical empathy”. A recognition of the taken-for-granted structures of experience, and the ways in which these structures can alter in cases of psychiatric disorder can help to develop “a way of engaging with others’ experiences that involves suspending the usual assumption that both parties share the same modal space” (2012b, p483).

interpret her experiences as resulting from or being part of a disease or illness. Furthermore, it allows the person to move beyond the behavioural signs and symptoms found in diagnostic classifications and develop a richer understanding of her experiences.

However, it is not only our understanding of psychiatric disorders that stands to gain from phenomenological studies of psychiatric disorders. The relationship between phenomenology and psychiatry can be seen to be a mutually informative one. Whilst phenomenology can help to clarify our understanding of experiences of psychiatric disorders, in turn aiding classification, directing treatment and improving communication, these same studies can help to improve our broader phenomenological accounts. This is possible in at least two ways:

Firstly, through studying alterations in experience or by exploring atypical experiences, we may have our attention drawn to particular features that would otherwise have been overlooked. An alteration from the everyday can reveal the function or role that a feature typically plays in wider experience. As such, we might discover both the role it occupies in the atypical experience, as well as the role it may more generally occupy in everyday experiences. As Minkowski explains, "Psychopathological research has more than once helped to revise the phenomenological givens, to complete them in calling attention to points which up until then had been disregarded" (1970, p171-2). Through an exploration of psychiatric disorder we may find that it becomes apparent how particular features allow for or contribute to our everyday experiences. An exploration of selfhood in schizophrenia, bodily experience in anorexia nervosa, or world-experience in depression may, therefore, help to refine our phenomenological accounts of everyday experiences of selfhood, the body, and the world.

Secondly, it is important that our phenomenology is not restricted to merely one group or type of person. For example, we find that our phenomenology is enhanced when there is an appreciation of the ways in which female experience may differ from male experience, recognising as we do the importance of accounting for both.¹⁶ Reflecting on these different experiences gives us the opportunity to identify which features may alter in different situations or cases and which may be thought to underlie or unite all experience. The study of psychiatric disorders can contribute to this process, clarifying and correcting our phenomenological accounts, making sure that they are accurate for a variety of different experiences rather than remaining merely abstract theoretical models.¹⁷ Through this dialogue our phenomenological accounts can remain grounded in the reality of experience, improving our understanding of the structures of experience rather than particular instances of experience.

The use of medical insights to enhance and correct phenomenological accounts is well documented. Merleau-Ponty, for example, uses cases of phantom limb syndrome to inform his investigation of bodily experience (2002, pp84-102). Later, he makes use of the case of “Schneider”, explaining that the analysis of this “example of morbid mobility...clearly shows the fundamental relations between body and space” (2002, p117). A contemporary example of a similar methodology can be seen in the work of Shaun Gallagher. Gallagher refers to phantom limb syndrome in order to develop and refine his understanding of body schema (2006, pp86-106). The use of the pathological or non-everyday can

¹⁶ For example, see Iris Young (1980) for an account of female embodiment.

¹⁷ Psychiatric disorders ought not be seen as rare occurrences. A 2007 survey conducted by the National Centre for Social Research and the University of Leicester found that just under a quarter of adults in England met the criteria for at least one psychiatric disorder (McManus et al., 2009). To neglect such experiences in our phenomenology would therefore be to neglect the experiences of a significant percentage of the population. If our phenomenology does not have the potential to account for the experiences of a quarter of the population, we might wonder in what sense it can be said to be accurate.

be an important method of clarifying not only those experiences, but also the related non-pathological or everyday experience.

The relationship between phenomenology and psychiatry ought then to be understood as a process of constant clarification, correction, and re-interpretation. The application of phenomenology to psychiatry is not a one off information exchange but rather a process of dynamic interaction in which advances in each field can provide further challenges and enhanced understanding in the other field.

Phenomenology and the Study of Psychiatric Disorders

What contribution can we then say that phenomenology can make towards the understanding of psychiatric disorders? We have seen that psychiatric disorders often involve alterations in aspects of experience that are taken for granted in the everyday or 'natural attitude'. Adopting a phenomenological stance reveals such features, allowing us to explore and describe the ways in which they may be altered. This allows us greater and more accurate understanding of the lived experience of psychiatric disorders. Such understanding, we have seen, can feed directly into discussions regarding classification as well as helping to direct research into treatment. Phenomenology may even be able to inform research into the neurobiology of psychiatric disorders through a process of 'front-loading' phenomenology. Beyond classification and treatment, phenomenologically informed descriptions may aid those with psychiatric disorders in understanding and articulating their experiences, helping to reduce some of the common feelings of isolation.

Phenomenological research has already been carried out into a number of psychiatric disorders. We have, for example, already seen some of the insightful

phenomenological accounts of schizophrenia that have been developed.¹⁸ We can also find phenomenological accounts of experience of psychiatric disorders as varied as the Capgras delusion (e.g. Ratcliffe, 2008, pp143-163), Obsessive Compulsive Disorder (e.g. Straus, 2012), and Anorexia Nervosa (e.g. Bowden, 2012). In recent years phenomenological research into depression has received increasing attention.¹⁹ However, phenomenologists have remained curiously silent on the topics of mania and bipolar disorder.²⁰ Where these experiences are discussed it is often only to emphasise differences between, for example, bipolar disorder and schizophrenia, rather than with the purpose of developing a phenomenological account of either bipolar disorder or mania.²¹

At this point we might wonder whether the lack of work in this area is actually indicative of a lack of a *need* for work in this area. Are experiences of mania and depression already sufficiently understood? Does the long history of mania and depression suggest that we can already sufficiently describe these states? Is there thus no need for a phenomenological analysis of these experiences? In the next chapter I turn my attention to mania, depression, and bipolar disorder, highlighting the instability of these categories, examining the need for greater understanding, and exploring how best to begin a phenomenological study of these experiences.

¹⁸ For further discussion of phenomenological accounts of schizophrenia see Sass, 2001; Sass and Parnas, 2003; 2007; Stanghellini, 2007.

¹⁹ See, for example, the special issue of the *Journal of Consciousness Studies* 20 (7-8) on depression. See Tellenbach (1980) for one earlier account of melancholy.

²⁰ For one exception see Binswanger (1964).

²¹ For example, see Sass and Pienkos's papers that seek to compare schizophrenia, mania, and depression (2013a; 2013b).

Chapter 2: Changing Conceptions of Mania, Depression, and Bipolar Disorder

Introduction

Frederick Goodwin and Kay Redfield Jamison claim that bipolar disorder has been described with “unvarying language”, writing that, “From ancient times to the present, an extraordinary consistency characterizes descriptions of these conditions” (2007, p3). This long history may be thought to indicate a degree of stability when it comes to the categories of mania, depression, and bipolar disorder. We might assume that the descriptions offered in contemporary diagnostic manuals such as DSM-IV and DSM-5 (APA, 2000; APA, 2013) would therefore be relevantly similar to those that we find in Graeco-Roman texts or in the work of nineteenth century psychiatrists. Furthermore, we might think that such consistency indicates a developed understanding of the disorder, that we are able to accurately describe experiences of these states even if we do not always know what causes these experiences or how best to treat them. Given this, we might wonder what work remains to be done by the phenomenologist. Is there a need for a phenomenological study of mania and depression?

It is this question that I address in this chapter. I do this through an exploration of the categories of mania, depression, and bipolar disorder, examining the extent to which these categories can be seen to be stable and demonstrating the need for greater understanding of experiences of mania and depression. I begin by looking at the history of bipolar disorder, exploring how mania and depression came together in the category of ‘bipolar disorder’. Through this discussion I highlight the instability of these categories, instabilities that caution us against assuming that we can take them to be fixed and easily defined entities. I then turn to contemporary classifications, introducing the DSM-IV

categories of mania, depression, and bipolar disorder. I explore the recent changes to these categories and discuss a number of current debates regarding them. Through this discussion I highlight the continued instability of the categories of mania and depression and demonstrate the importance of understanding the experience of these states. I draw these discussions together in order to clarify the need for phenomenological studies of mania and depression. In the final section I discuss how we can develop a phenomenological account of these states. I explore how we can make use of the DSM categories, explain why I am focussing on experiences of mania and depression rather than the narrower category of bipolar disorder, and identify how 'ideal types' can help to direct our research.

How Mania and Depression became “Bipolar Disorder”

Graeco-Roman Concepts of Mania and Melancholia

The origins of bipolar disorder are often traced back to Graeco-Roman writings on mania and melancholia. Angst and Marenos, for example, write, “The origin of bipolar disorders has its roots in the work and views of the Greek physicians of the classical period” (2001, p3). David Healy notes that it was Hippocrates (c. 460 – c. 370 BC) who was the “first to put mania and melancholia on our cultural radar” (2008, p3), distinguishing between mania, melancholia, and paranoia.¹ The Hippocratic writers understood mania and melancholia as humoral imbalances – melancholia indicating an excess of ‘black bile’, and mania indicating an excess of ‘yellow bile’ (Goodwin and Jamison, 2007, p3). Whilst it is tempting to draw parallels between our modern concepts of mania and depression and these classical accounts, we must be alert to the significant

¹ See Angst and Marenos (2001, pp3-5) for discussion of mania and melancholia in the classical period.

differences that exist.² Angst and Marenos identify four distinct meanings of “mania” used during the classical period³:

1. A reaction to an event with the meaning of rage, anger or excitation.
2. A biologically defined disease.
3. A divine state.
4. A kind of temperament, especially in its mild form.

(2001, p5)

These four categories clearly give us an understanding of mania that is far broader than our current classifications, highlighting the range of different ways the term was understood. However, even if we take only the narrow definition of “a biologically defined disease”, we can still find evidence that this category was quite different from the ones we have today. Healy notes that Hippocrates’s description of manic states included a number of physical symptoms including sweating and fever (2008, pp3-4). Cases of mania in the classical period, he writes, “invariably involved fever and often resulted in death” (2008, p4). As such, at least some of the cases of mania that Hippocrates was discussing may have actually been cases of infection.⁴ At the very least, we can therefore conclude that the mania of the classical period encompassed a far broader range of experiences than our contemporary cases of mania do.

Discussion of the relationship between states of mania and melancholia can be seen as far back as the first and second centuries AD.⁵ Aretaeus of Cappadocia, writing in the first century AD, linked the two states together, suggesting that

² As we shall see, even our contemporary categories of mania and depression are not static.

³ In some cases, thinkers would use the same term to refer to distinct meanings. For example, Hippocrates used mania to refer to both a biologically defined disease as well as a kind of temperament (Angst and Marenos, 2001, p5).

⁴ See Healy (2008, p8) for a discussion of ‘postpartum mania’ and postpartum infection.

⁵ See Goodwin and Jamison (2007, p6) for a timeline of quotations linking mania and depression.

mania was a worsening of the state of melancholia. In 'On the Aetiology and Symptomatology of Chronic Diseases' he writes:

I think that melancholia is the beginning and a part of mania...The development of a mania is really a worsening of the disease (melancholia) rather than a change into another disease...In most of them (melancholics) the sadness became better after various lengths of time and changed into happiness; the patients then developed a mania.

(Quoted in Angst and Marneros, 2001, p6)

However, Erwin Ackerknecht cautions us that this view can "only with some qualifications be regarded as foreshadowing manic-depressive psychosis" (1968, p15). Aretaeus included in his understanding of mania and melancholia concepts that we might now associate with forms of schizophrenia or organic disease (Angst and Marenos, 2001, p6; Goodwin and Jamison, 1990, p57).

This view of mania as being on a continuum with melancholia, rather than an opposite pole, may have been widespread amongst Greek and Roman writers. Healy suggests that, "The usual connection was in terms of melancholia being an earlier stage or mild form of madness with mania being the term used for later and more severe stages" (2008, p11). However, opinion was not uniform in this period. Soranus (fl. 100AD), for example, characterised melancholia and mania as two separate diseases.⁶ He suggested that whilst the two shared similar symptoms (Goodwin and Jamison, 2007, p4), mania "is a disease of the head, while melancholia is a disease of the oesophagus" (Ackerknecht, 1968, p15).

Hence, whilst descriptions of mania and melancholia can be seen in Graeco-Roman writings, the definitions of these terms were not stable and may

⁶ It is worth noting that Soranus excluded cases in which fever is present from his classification of mania (Ackerknecht, 1968, p13). We can, therefore, already see difference in classification and understanding of mania from the understanding of Hippocrates.

seem to bear little resemblance to our modern concepts of mania and depression. Healy writes that “while the terms mania, melancholia, insanity, dysphoria, dysthymia, paranoia, frenzy and lunacy all go back to the Greeks and the Romans, manic depressive disease does not” (2008, p1). In this respect he appears to be correct – the categories used were far broader than our contemporary concepts of mania and depression, and the relationship between the two was not of the two poles of bipolar disorder, but rather mania was understood to be a more severe form of melancholia or part of a distinct disease quite separate from melancholia.

The Nineteenth Century: Falret and Baillarger

Whilst hints of mania and depression can therefore be seen in Greek and Roman writings, it was not until the mid-nineteenth century that the connection between the two states was formally identified and ‘manic depression’ was conceptualised as a distinct entity. First in a lecture in 1850, then published in the *Gazette des Hopitaux* in 1851, Falret devoted a mere twelve lines to the topic of “a special form (of insanity) we call circular” (Falret, 1851, quoted in Pichot, 1995, p4). In a paper published in 1854 he expanded his discussion of “Folie Circulaire” – a circular madness consisting of periods of mania and depression:

In order to be called folie circulaire, depression and excitement must succeed one another for a long time, usually for the whole of the patient’s life, and in a fashion very nearly regular, always in the same order, and with intervals of rationality, which are usually short compared with the length of episodes. (Falret, 1854, quoted in Healy, 2008, p61)

In the same year Jules Baillarger proposed a similar category⁷ – ‘folie à double forme’:

All writers on mania have considered the transformation of mania into melancholia or vice versa to be fairly common. They have also all perceived these facts to be two different disorders, two distinct attacks, which succeed each other more or less within a single patient. This is an opinion which I have sought to combat. Indeed I would like to demonstrate that we have not two diseases but a single one; the two supposed attacks are nothing but two stages of a single attack.

(Baillarger, 1854, quoted in Healy, 2008, p55)

There are obvious similarities between these two accounts. Both can be seen to bring together the concepts of mania and depression into a single entity. However, we also find significant differences. For example, Falret, in contrast to Baillarger, stressed the importance of a period of euthymia (a positive mood appropriate to circumstance), in addition to episodes of mania and depression (Angst and Marenos, 2001, p7). We also find that Falret understood the two phases to be distinct, whereas for Baillarger “the manic period is a “reaction” to the preceding depression and is proportional to it” (Pichot, 1995, p4).

Although mania and depression were first brought together into a distinct entity in the nineteenth century, Goodwin and Jamison suggest “most clinical observers continued to regard mania and melancholia as separate entities” (2007, p7). We also find that later concepts of ‘manic depressive insanity’ differ significantly from the concepts of folie à double forme and folie circulaire. One influential example of these later concepts can be found in the work of Emil Kraepelin.

⁷ There is significant disagreement about whether Baillarger or Falret ought to be credited with first proposing the single entity that became manic depression. For discussion of this topic see Pichot (1995).

Kraepelin and Manic Depressive Insanity

The work of Kraepelin has been influential due to the classifications that he provided and the methodology he employed. Kraepelin classified mental disorders on the basis of “the severity of the disorder...; the identification of groups of symptom-complexes with the same evolutions and outcomes; and the assumption that heredity played a prominent role in the causation of these disorders” (Perris, 1992, p57). He provided detailed descriptions of the symptoms and course of ‘manic depressive insanity’, contrasting this with the concepts of ‘dementia praecox’ and paranoia.⁸ One example of the kind of descriptions he provided can be seen below, where he contrasts the manic and depressed states found in ‘manic depressive insanity’:

On the one hand we meet with distractibility, flight of ideas, exalted ideas, cheerful mood, volitional excitement; on the other sluggishness of attention and of thinking, ideas of sin and of persecution, mournful or anxious mood, volitional inhibition. (Kraepelin, 2010, p64)

Despite linking the concepts of mania and depression, Kraepelin did not hold to the narrow concepts of folie circulaire or folie à double forme. The early editions of Kraepelin’s textbook on psychiatry were perhaps more sympathetic to these concepts, describing Falret’s folie circulaire as “a very well established type of mental disorder” (Quoted in Angst and Marenos, 2001, p8). However, by the eighth edition of his textbook of psychiatry, Kraepelin had broadened the category of ‘manic depressive insanity’ to include “virtually all of melancholia” (Goodwin and Jamison, 1990, p60). Mania and depression therefore remained ‘together’ under Kraepelin, but not as a distinct entity set apart from other forms of affective disorders. Indeed, so broad was Kraepelin’s concept that it has been suggested that “the history of affective disorder after 1910 is no more

⁸ The concept of dementia praecox can be seen to be the forerunner of our modern concept of schizophrenia. Whilst much of the focus at the time was on this category of dementia praecox (Healy, 2008, p74), Kraepelin’s work has been “enormously” influential in bipolar research (Angst and Marenos, 2001, p8).

than the analysis of the fragmentation of the Kraepelinian notion” (Berrios, 1992, p45).

Kraepelin also marked a distinct change in the understanding of mania and depression through his discussion of the possibility of ‘mixed states’: “states which do not exactly correspond either to manic excitement or to depression, but represent a mixture of morbid symptoms of both forms of manic-depressive insanity” (2010, p64). Identifying eight different ways the states may manifest, Kraepelin understood mania and depression not simply as distinct phases of the same disorder, but as states that may also co-occur.⁹ This broad category of ‘manic depressive insanity’ can therefore be seen to differ significantly from the mania and melancholia found in Greek and Roman texts, as well as the folie circulair and folie à double forme of the mid-nineteenth century.

We have already seen how Kraepelin’s thought began to develop and alter, with marked differences between his earlier and later classification of ‘manic depressive insanity’. It is notable that Kraepelin was also open to the possibility that significant changes would be made to his classifications through future research. In this way, we can see that he did not view his categories as rigid or unchanging. For example, he wrote: “What we have formulated here is only a first sketch, which the advance of our science will often have occasion to change and to enlarge in its details, and perhaps even in its principal lines” (Kraepelin, 1913, p345, quoted in Decker, 2007, p356). Whilst Kraepelin brought together mania and depression into the same category, it seems plausible to suggest that he did not view this category as necessarily being static.

⁹ These are: mania, depressive or anxious mania, excited depression, mania with poverty of thought, orthodox depression, manic stupor, depression with flight of ideas, and inhibited mania (Kraepelin, 2010, p66-70). Whilst Kraepelin provides brief descriptions of each of these, he notes that “The doctrine of the mixed states is still too incomplete for a more thorough characterization of the individual forms to be advisable at present” (2010, p70).

Bipolar Disorder, Unipolar Depression, and DSM-III

Bipolar disorder, broadly understood as periods of mania and depression in the same person, did not gain acceptance as a distinct entity separate from other affective disorders (including unipolar depression) until the mid-1960s. Drawing on Karl Leonard's distinction between bipolar and 'monopolar' affective disorders, Angst and Perris independently and simultaneously put forward the claim that bipolar disorder ought to be viewed as a separate disorder distinct from unipolar depression, even if the unipolar depression was recurrent.¹⁰ Interestingly, they based this distinction not simply on differences in clinical description, but also differences they found in terms of "genetics, gender, cause, and premorbid personality" (Angst and Marenos, 2001, p10). The impact these studies had on the general acceptance of bipolar disorder as a distinct entity led Pichot to describe 1966 as the year of the "rebirth" of bipolar disorder (1995, p1). This move away from Kraepelin's broad category of 'manic depressive insanity' towards narrower categories of 'bipolar disorder' and 'unipolar depression' can be seen to be a significant alteration in how the relationship between mania and depression was understood.

The third edition of The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III) (1980) marked the first formal recognition of bipolar disorder as a distinct entity. DSM-III aimed to provide descriptive classifications of mental disorders, "eschewing psychoanalytical aetiologies, stressing that psychiatry was decidedly a part of medicine, and emphasizing the importance of follow-up studies and family histories" (Decker, 2007, p354).¹¹ In this sense, it may be thought to be continuing the legacy of

¹⁰ Angst, Perris, and Leonard were primarily concerned with differentiating between different forms of recurrent affective disorders. See Goodwin and Jamison (2007, pp8-9) for discussion of this point. See Perris (1992) for broader discussion of the bipolar-unipolar distinction. Particularly see pp57-59 for an account of Leonard's work in this area.

¹¹ Earlier editions of DSM were criticised for being overly-influenced by common psychoanalytical theories of the time. See Decker (2007) for discussion of this point.

Kraepelinian descriptive classification. This form of classification occurred against a background of significant criticism regarding what was known as the ‘unreliability’ of diagnosis – a common concern in the 1960s and 1970s that “different psychiatrists would not diagnose the same person with the same symptoms in the same way” (Horwitz and Wakefield, 2007, p7).¹² Thus, one goal of DSM-III was to improve the reliability of diagnosis, producing clear descriptions of psychiatric disorders in order to enable psychiatrists to consistently diagnose in the same way. As the aetiology of psychiatric disorders was unknown, Robert Spitzer, chair of the DSM-III taskforce, had the task of producing a classification manual “that limited itself to the description of the mentally ill and avoided speculation about aetiology” (Decker, 2007, p345). According to Hannah Decker, Spitzer’s hope was that DSM-III would help to improve communication in psychiatry as well as diagnostic reliability (2007, p352).

Whilst the World Health Organisation’s ninth edition of the *International Classification of Diseases* (ICD-9) (WHO, 1977) did not formally incorporate this bipolar-unipolar distinction, the widespread acceptance of bipolar disorder as a distinct entity can be seen through its inclusion in ICD-10 (WHO, 1992), and its continued place in future editions of DSM, including the revised edition of DSM-III (DSM-III-R) (APA, 1987), as well as DSM-IV (APA, 1995), DSM-IV-TR (APA, 2000), and DSM-5 (APA, 2013).¹³

The Category of “Bipolar Disorder”

What this brief historical overview highlights is the varying ways that bipolar disorder, and the broader relationship between mania and depression, has been understood. Far from Goodwin and Jamison’s claim of “unvarying language”,

¹² See Ghaemi (2009) for discussion of the different diagnoses that were made in London vs New York in a study carried out in 1970.

¹³ See Goodwin and Jamison (1990, p62; 1990, pp86-7) for discussion of this point.

we find that mania, depression, and bipolar disorder are not static concepts. Even they concede that “the boundaries that define mania and depression and the relationship between them have changed [over the centuries]” (2007, p3). The understanding of what constitutes an experience of mania or depression has altered significantly – even within the last two centuries.¹⁴ We also find that at different points in history the relationship between the two states has been understood in different ways: Mania as a worsening of melancholia; mania and depression as distinct periods of the same disorder; mania and depression as states that may co-occur, and so on. We cannot, therefore, point to a single, unchanging description of bipolar disorder. As such, it seems implausible to suggest that the long history is indicative of a developed understanding of the experience of mania, depression, or bipolar disorder.

At this point it might be objected that regardless of the historical understanding of bipolar disorder, surely we *now* have clear knowledge of these experiences. We find that a number of questions immediately arise: Are our current classifications any more stable or resistant to change than our historical ones? Are these categories empirically sound? Can we look to the descriptions we find in these classifications for a clear understanding of experiences of mania and depression? It is, therefore, to contemporary classifications that we now turn. I begin this next section by describing how mania, depression, and bipolar disorder are classified and described in DSM-IV. Having established this, I move on to discuss the stability of this category through comparison with DSM-III and DSM-5. Through an examination of contemporary debates and discussions surrounding the diagnosis I highlight the extent to which there is uncertainty in these categories regarding the experience of mania, depression, and bipolar disorder.

¹⁴ See Radden (2000) for further discussion of historical understandings of melancholy.

Bipolar Disorder in DSM-IV

The American Psychiatric Association's Diagnostic and Statistical Manual remains, along with the World Health Organisation's International Classification of Diseases, one of the most influential classification manuals currently in use. As Horwitz and Wakefield explain, "these DSM definitions have become the authoritative arbiter of what is and is not considered mental disorder throughout our society" (2007, p7). The classifications contained in the DSM are used in a number of different contexts, including for research, for the collection of public health statistics, as well as the diagnosis and treatment of service users. The fourth edition of the manual was first published in 1994, with a text revision in 2000.¹⁵

Bipolar disorders are classified in DSM-IV as Mood Disorders – "disorders that have a disturbance in mood as the predominant feature" (APA, 2000, p345). They are distinguished from depressive disorders by the presence of manic, hypomanic, or mixed episodes. The two main types of bipolar disorder that we find described in DSM-IV are Bipolar I Disorder and Bipolar II Disorder. Bipolar I Disorder "is characterized by one or more Manic or Mixed Episodes, usually accompanied by Major Depressive Episodes" (APA, 2000, p345). Bipolar II Disorder, by contrast, "is characterized by one or more Major Depressive Episodes accompanied by at least one Hypomanic Episode" (APA, 2000, p345). In order to understand these categories, and so to assess their stability and value in helping us to understand experiences of bipolar disorder, we must look in greater detail at what is meant by a manic, hypomanic, or major depressive episode. In other words, we must explore the "building blocks" of these diagnoses (APA, 2000, p345).

¹⁵ However, in DSM-IV-TR it is explained that "No substantive changes in the criteria sets were considered, nor were any proposals entertained for new disorders, new subtypes, or changes in the status of the DSM-IV appendix categories" (APA, 2000, pxxix).

Major Depressive Episodes

A major depressive episode must include a period of at least two weeks in which the person experiences a “depressed mood” or “diminished interest or pleasure in all, or almost all, activities” (APA, 2000, p356). At least a further four symptoms are necessary for diagnosis, taken from a list of seven possible symptoms. These include changes in appetite and weight, changes in sleep patterns or ability to sleep, fatigue, feelings of worthlessness or guilt, difficulties in thought or concentration, experiences of agitation or retardation, and thoughts of death or suicide. In order to count towards diagnosis, these experiences must cause significant impairment in the person’s ability to function in social, occupational, or other similar settings. For example, in an extreme case a person may struggle with basic self-care such as showering or preparing food. In milder cases, a person may struggle to complete tasks that he previously found easy to complete, or may experience difficulties interacting with other people. In addition to these symptoms, a major depressive episode may also include psychotic features.

It is noted in DSM-IV that “periods of sadness are inherent aspects of the human experience” (APA, 2000, p355). Seeking to avoid diagnosing everyday sadness as depression, DSM-IV attempts to distinguish between these experiences on the basis of duration (consistent experience for a minimum of two weeks), severity (the presence of five out of the nine possible symptoms), and the presence of the aforementioned clinically significant distress or impairment (APA, 2000, pp355-6). Similarly, there is an attempt to distinguish between a major depressive episode and periods of grief. The criteria includes a bereavement exclusion clause:

The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid

preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation. (APA, 2000, p356)

Manic and Hypomanic Episodes

The defining feature of a manic episode is an “abnormally and persistently elevated, expansive, or irritable mood” (APA, 2000, p357) that lasts for at least one week (or any length of time if hospitalisation is required). At the same time, there must be three additional symptoms present, or four if the mood is irritable. These are taken from a list that includes the following: Grandiosity, decreased need for sleep, a feeling of pressure to keep talking, flight of ideas or racing thoughts, distractibility, increased goal-directed activity, and engagement in high-risk pleasurable activities (APA, 2000, p362). Similarly to the criteria for a major depressive episode, the severity of the mood disturbance must be apparent. In order to be classified as a manic episode there must be either marked impairment in occupational or social functioning or in the person’s relationships with others, a necessitation of hospitalisation in order to prevent harm to self or others, or psychosis must be present. Psychotic experiences in cases of mania may include grandiose delusions (for example, a person’s belief that they have a special relationship to God) or hallucinations. Such experiences are usually mood congruent – “the content of the delusions or hallucinations is consistent with the manic themes” (APA, 2000, p414).

This severity clause distinguishes between manic and hypomanic episodes. Whilst the two have identical lists of symptoms, a hypomanic episode does not cause marked impairment in functioning, necessitate hospitalisation, or allow for the presence of psychosis. As Goodwin and Jamison explain, “there should be no such thing as a hypomanic hospitalized patient; if manic-like symptoms lead to hospitalization, the diagnosis must be mania, not hypomania. The same holds true if psychosis is present” (2007, p95). Instead, DSM-IV requires a *change* in functioning for a diagnosis of hypomania to be made. This change in

functioning may be “a marked increase in efficiency, accomplishments, or creativity” (APA, 2000, p365). Alternatively, there may be a decrease in functioning, with some occupational or social impairment. This change in functioning must not be characteristic of the person’s usual non-hypomanic experience and it must be observable to others. In contrast to the week duration that is required for a diagnosis of mania, a hypomanic episode need only last for a minimum of four days. Manic and hypomanic episodes that come about due to medical treatments, including treatments for depression (such as the use of antidepressants or electroconvulsive therapy) *do not* count towards the diagnosis of bipolar I disorder or bipolar II disorder.

Mixed Episodes

A mixed episode is defined in DSM-IV as a period of at least one week in which a person meets the criteria both for a manic episode and for a major depressive episode (APA, 2000, p365). As in the case of a manic episode, the experience must either cause marked impairment in functioning, or necessitate hospitalisation, or psychotic features must be present. Apart from a clause that excludes symptoms caused by a medical condition or drug induction, these are the only criteria given for the diagnosis of a mixed episode. However, we do find one further description of mixed episodes in DSM-IV under the heading of *Episode Features*:

The individual experiences rapidly alternating moods (sadness, irritability, euphoria) accompanied by symptoms of a manic episode and a major depressive episode. (APA, 2000, p362)

Bipolar I Disorder and Bipolar II Disorder

We are now in a position to understand the distinction between the two types of bipolar disorder given in DSM-IV. Bipolar I Disorder, we have seen, *must* feature at least one manic or mixed episode. Hypomanic or major depressive episodes may also be experienced, but are not necessary for diagnosis. In

contrast, bipolar II disorder *must* feature at least one major depressive episode *and* at least one hypomanic episode. It cannot feature any mixed episodes or manic episodes.

Having established how mania, depression, and bipolar disorder are classified in DSM-IV, we can now return to our earlier questions regarding the stability of the categories and the necessity of understanding these experiences. We have already seen that our historical classifications altered significantly over time. Can the same be said to be true of our contemporary classifications? In the next section I explore this question, noting the continued instability of the categories of mania and depression and highlighting how current debates regarding these categories suggest a need for further understanding of the experiences of these states.

From DSM-III to DSM-IV

DSM-III was first published in 1980, with a text revision in 1987. Even in the short time period between the publication of DSM-III and DSM-IV we find significant alterations in the category of bipolar disorder. Perhaps the most notable change between the editions is the addition of bipolar II disorder as a distinct diagnostic entity in DSM-IV, along with a consequently necessary full criteria set for a hypomanic episode as distinct from a manic episode. We therefore find that an experience that would warrant a DSM-IV diagnosis of ‘bipolar II disorder’ would, using DSM-III-R classification, receive a diagnosis of “Bipolar Disorder Not Otherwise Specified” (APA, 1987, p228).¹⁶ The diagnostic category of bipolar II disorder, we are told, was added “in response to the evidence from the literature review and data reanalysis that suggested its

¹⁶ It is notable that the concept of bipolar II disorder was not present at all in DSM-III and was only included as an example of bipolar NOS in DSM-III-R. This alteration is noted in appendix D of DSM-III-R (1987, p422).

utility and to increase diagnostic coverage” (APA, 1995, p799).¹⁷ It therefore seems that even within the last few decades the category of bipolar disorder has been significantly altered and expanded.

Whilst the addition of the category of bipolar II disorder is the most notable alteration that we find between the editions, alterations within the categories themselves were also made. For example, in DSM-IV we find that, in contrast to DSM-III, antidepressant induced mood alterations do not count towards a diagnosis of bipolar disorder.¹⁸ Additionally, DSM-IV includes explicit criteria for the category of mixed states – something that was again absent in DSM-III and DSM-III-R.

Such changes warn us against assuming that our contemporary classifications are any more stable or resistant to change than our historical ones. ‘Bipolar disorder’ is not a static concept. As Healy writes, “The landscape of bipolar disorder is changing from month to month, never mind decade to decade” (2008, p xv). We can see further evidence of this in the debates and discussions that have surrounded the recent publication of DSM-5.

DSM-5 and Beyond

DSM-5 was published on the 18th May 2013. Whilst it is too soon to assess how the changes that have been made will be interpreted and used in clinical practice, we can look to these alterations as a means of highlighting some of the contemporary discussions regarding bipolar disorder.¹⁹ These discussions, we

¹⁷ See, for example, Dunner et al (1976).

¹⁸ See Goodwin and Jamison (2007, p93) for discussion of this point.

¹⁹ It is notable that the National Institute of Mental Health has announced their intention to abandon the DSM-5 categories and work to replace them with a more biologically informed classification system (NIMH, 29th April, 2013). This demonstrates a notable unease with this new edition of the DSM that suggests we ought be cautious about assuming it will continue to be used in the same way and to the same extent as DSM-IV.

will see, highlight the very real need for further research into experiences of mania, depression, and bipolar disorder.

We saw earlier that DSM-IV defines a mixed episode as a period in which the criteria for both a manic episode and a major depressive episode are met. In DSM-5 we find a move away from this conceptualisation of mixed episodes as both states being wholly present, and towards an understanding of mixed episodes as an episode in which a person is predominantly either depressed or manic, with features of the opposing state.²⁰ The APA explains:

The DSM-IV diagnosis of bipolar I disorder, mixed episode, requiring that the individual simultaneously meet full criteria for both mania and major depressive episode, has been removed. Instead, a new specifier, “with mixed features”, has been added that can be applied to episodes of mania or hypomania when depressive features are present, and to episodes of depression in the context of major depressive disorder or bipolar disorder when features of mania/hypomania are present. (APA, 3rd May 2013, p4)

The mixed features specifier can be used when a person meets the full criteria for mania or hypomania, and experiences at least three features of a major depressive episode, or when a person meets the full criteria for a major depressive episode and experiences at least three features of mania/hypomania (APA, 2013, pp149-50).

The descriptions we find of mixed episodes in DSM-5, and particularly in DSM-IV, provide us with minimal information about exactly how the states of mania and depression may come together.²¹ Understanding these experiences can be seen to be of central importance in bipolar research - how we understand mixed episodes has significant implications for how we understand the related

²⁰ APA publications suggest that this is due to the rarity with which the full DSM-IV mixed episode criteria was met in clinical reality (APA, 1st February 2013).

²¹ We might contrast this with the significantly richer descriptions of different forms of mixed episodes found in the work of Kraepelin (2010).

categories of mania and depression. For example, we cannot simply assume that mania is an 'opposite pole' of depression if we have evidence of the two co-occurring. Alternatively, if we find that mania and depression feature mutually exclusive core features we must conclude that a mixed episode could not manifest as a state in which both mania and depression were fully present. Such an understanding would rule out the possibility of a mixed episode as conceptualised in DSM-IV and place clear limitations on the DSM-5 concept.

In either case, we can find a clear need to understand what the relationship between mania and depression consists of, and whether the two states share any common features. Even if we reject the understanding of a mixed episode as mania and depression simultaneously co-occurring, we still need to consider how mixed episodes *are* experienced and which features of mania and depression may be present in different forms or variations of mixed episodes. At the very least, the category of mixed episodes can be seen to provide us with a clear challenge: How can these seemingly opposed states come together, and what does their co-occurrence tell us about mania and depression as distinct states? The instability of the category of mixed episodes suggests a need for further research in this area. Thus, one central research topic following the publication of DSM-5 must be to explore the experience of mixed episodes. Such research has implications both for the understanding of mixed episodes, as well as the distinct states of mania and depression.

Another much debated alteration from DSM-IV to DSM-5 is the removal of the bereavement exclusion clause for a major depressive episode.²² However, there does remain a cautionary note in the classification:

Responses to a significant loss...may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss...which may resemble a depressive episode. Although

²² For one discussion of this see Parker (2013).

such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss. (APA, 2013, p161)

The APA explains its decision, writing, "By advising clinicians not to diagnose depression in recently bereaved individuals, the DSM-IV bereavement exclusion suggested that grief somehow protected someone from major depression" (APA, 15th February 2013, p1). However, Allen Frances, former chair of the DSM-IV task force warns:

Normal grief will become Major Depressive Disorder, thus medicalizing and trivializing our expectable and necessary emotional reactions to the loss of a loved one and substituting pills and medical rituals for the deep consolations of family, friends, religion, and the resiliency that comes with time and the acceptance of the limitations of life. (2nd December 2012)

This suggestion speaks to broader concerns regarding the extent to which DSM-IV and DSM-5 fail to distinguish between mental disorder and everyday distress.²³ The British Psychological Society, for example, has written:

The Society is concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. (British Psychological Society, 2011, p2)

The dramatic increase in diagnosis of bipolar disorder, what Robert Whitaker refer to as the "bipolar boom" (2010, p172), has meant that the concepts of

²³ See Horwitz and Wakefield (2007) for one detailed discussion of the distinction between depression and everyday sadness or distress.

mania, depression, and bipolar disorder have been at the heart of these discussions.²⁴

Debates regarding the distinction between depression and grief further highlight the need for greater understanding regarding these experiences. In order to answer the question of how, or indeed whether, to distinguish between these two states we must move beyond externally observable signs and symptoms, and develop a nuanced understanding of how each are experienced. Indeed, we can begin to see recognition of this point even within DSM-5. In a footnote to the note on bereavement found in the criteria for a major depressive episode, we find the beginnings of a discussion of the different experiences of grief and depression: “it is useful to consider that in grief the predominant affect is feelings of emptiness and loss, while in MDE it is persistent depressed mood and the inability to anticipate happiness or pleasure” (APA, 2013, p161). We also find here brief discussion of differences in self-esteem, thought content, and attitude towards death. Whilst such descriptions do not amount to detailed or nuanced understanding of these experiences, it does indicate the necessity of such descriptions in order to adequately distinguish between the two states. Greater understanding of the experience of depression can therefore be seen to improve our understanding of both depression and bipolar disorder, as well as helping us to distinguish depression from similar but distinct experiences.

Finally, we find differences between DSM-IV and DSM-5 in the classification of episodes of mania. In DSM-5 there is a move towards emphasising the centrality of changes in energy and activity, rather than focussing on simple changes in mood. Whilst DSM-IV-TR specifies an “elevated, expansive, or irritable mood” as a necessary criterion for a manic state (APA, 2000, p362), DSM-5 additionally requires “persistently increased goal-directed activity or

²⁴ Moreno and colleagues found that between 1994-5 and 2002-3 there was a two-fold increase in the diagnosis of bipolar disorder for adults in the US, and an approximately forty-fold increase in youth (Moreno et al., 2007, p1035).

energy” (APA, 2013, p124).²⁵ Whilst this may seem to be a minor change, it once again highlights the lack of long-term consensus regarding what an experience of mania consists of and what we can take to be the central or defining features of such a state. Furthermore, it raises additional questions regarding our depth of understanding of these states. Can we move beyond these externally observable signs and symptoms in order to access and understand the lived experience?

We began this chapter with the worry that there may be no need for phenomenological studies of mania and depression. By this point it should be clear that this is not the case. Whilst mania, depression, and bipolar disorder can be seen to have a long history, these categories are not static. The constantly changing categories caution us against assuming that we have a robust understanding of these states. Furthermore, the current debates regarding these categories suggest that it is specifically an understanding of the *experiences* of mania and depression that is lacking. Accurately understanding and describing mixed episodes, distinguishing depression from grief and everyday sadness, and determining the central features of mania all require a robust understanding of the experiences of these states. However, even if we assume that the current classifications are stable and reliable in identifying states of mania and depression, we still find that there is phenomenological work to be done. As we saw in the last chapter, our classifications are reliant on descriptions of experiences and the relevant phenomenology is far from clear. As such, even if we set aside current concerns regarding mixed episodes, depression and everyday distress, and the central features of mania, there is still a need for phenomenological studies of mania and depression. Stability of a category does not rule out the need for further phenomenological research, particularly when that categorisation is at least partially based on descriptions

²⁵ Both of these criteria sets require three more symptoms in addition to the changes in mood/activity.

of experience. However, this need for phenomenological enquiry is further highlighted when we consider that these categories are not stable, and that this instability appears to be at least in part due to uncertainty regarding experiences of these states.

A Phenomenological Study of Mania and Depression

We have seen that the way that experiences of mania, depression, and bipolar disorder have been classified has varied significantly. The instability of these categories cannot be seen to be merely a feature of the past: The alterations from DSM-IV to DSM-5, and the on-going discussions regarding the classification of these states even beyond DSM-5,²⁶ caution us against assuming that our contemporary classifications are any more resistant to change than our historical ones. Given this lack of stability, we may be concerned about making use of such categories in our research. Such concerns may be compounded by broader criticisms and discussions regarding the nature of psychiatric classification. Crucial debates have arisen in this area,²⁷ concerning what a psychiatric disorder is,²⁸ what the purpose of the classification of psychiatric disorders is,²⁹ and whether it's possible to develop a truly neutral system of classification.³⁰ We are therefore led to ask how it is possible to explore experiences of mania and depression, given the uncertainty regarding the status of the categories.

²⁶ For example, discussion regarding the broadening of the category of 'bipolar disorder' to include a 'bipolar spectrum' can be found in a special issue of *The Journal of Affective Disorders* 73 (1-2). See also Goodwin and Jamison (2007, pp19-24).

²⁷ See Radden (1994) for an overview of common criticisms and discussions regarding psychiatric classification.

²⁸ See Horwitz and Wakefield (2007) for discussion of mental disorder as "harmful dysfunction". See Zachar (2000) for one argument that psychiatric disorder should be understood as 'practical kinds' rather than 'natural kinds'.

²⁹ See Frances (26th April 2010) and Ghaemi (24th April 2010) for debate about whether the DSM ought to be mindful of the potential uses of classification, as well as descriptive accuracy.

³⁰ See Cooper (2005, pp77-104) for discussion of the problem of theory-ladenness.

However, we can make practical use of the categories provided in DSM-IV in order to identify a set of experiences, without necessarily endorsing these categories as the *best* or most accurate way to classify these experiences. Our use of the categories does not mean that we must adopt an understanding of the experiences identified as disordered or as constituting an 'illness', nor does it entail understanding such experiences as being part of a distinct and unchanging entity. It should also be clear that any use of the DSM does not necessitate thinking that the descriptions offered in the manual exhaust the possible descriptions of the experiences categorised. Instead, we can use these categories as a starting point for our research, helping to identify or mark out a particular set of experiences. However, we can still maintain a critical stance towards those categories, allowing for the possibility of circling back and criticising or evaluating them.

In this study of mania and depression I will therefore be exploring the experiences that fall under the categories of a 'major depressive episode', a 'manic episode', and 'a hypomanic episode' in DSM-IV. Whilst many of those experiences would fall under the categories of 'bipolar I disorder' or 'bipolar II disorder', my focus here is on mania and depression, rather than on bipolar disorder as a distinct category. This broader focus allows for the possibility of exploring the different ways that these states may manifest and interact, not ruling out the possibility that such states could occur independently of one another. As such, I do not restrict my discussion of depression to merely those cases in which the person has also experienced mania, nor my discussion of mania to those that have also experienced depression.³¹ This focus on mania and depression rather than merely bipolar disorder thus allows us to further our understanding of unipolar depression as well as bipolar disorder. As the

³¹ However, as Nassir Ghaemi points out, those that experience episodes of mania will usually also experience episodes of depression (2003, pp31-2). For further discussion of 'unipolar mania' see Goodwin and Jamison (2007, pp13-14).

main criteria for mania and hypomania are identical (the difference being degree of impairment or the presence of psychosis, rather than a difference in the symptoms present), I will not provide separate discussions of these experiences. I will, however, note when the experiences are likely to differ, or when particular features of experience may be more likely to occur in one state rather than the other.

One aim of this study is to explore how the states of mania and depression may come together in forms of mixed episodes. The use of the DSM-IV criteria for a mixed episode – “The criteria are met both for a Manic Episode and for a Major Depressive Episode” (APA, 2000, p365) – would involve presupposing what the experiences of mania and depression are, and what the relationship between the two consists of. For example, the criteria given for a mixed episode already presupposes that none of the central features of manic episodes and major depressive episodes are mutually exclusive. Whilst I therefore make use of the categories for a manic episode and a major depressive episode, I make no assumptions in my definitions regarding how to understand the relationship between the two. Given the changes that have been made to this category in DSM-5, and the particular uncertainty that we have seen exists regarding this category, to restrict the discussion to the DSM-IV category of mixed episodes would be to impose an unnecessary and potentially detrimental limitation on the study. Instead, I will begin with the experiences as described in first person accounts, allowing for an exploration of common ways in which features of the two states may co-occur. Whilst this may include the presentation described in DSM-IV, it does not restrict our discussion to merely this presentation.

Despite the recent publication of DSM-5, I have chosen to direct my research using the earlier categories described in DSM-IV. This is, in part, because the vast majority of this research was carried out before the DSM-5 classifications were published. However, there are additional reasons why we might choose to

continue to use the earlier classifications in the early stages following the publication of DSM-5. Many of the changes made in this new edition have proved controversial, and it is not yet clear how they will influence diagnostic practice. We cannot yet be certain how best to interpret the changed criteria, nor can we know how they will typically or commonly be interpreted. This presents a difficulty in identifying which experiences would fall under the categories of a 'manic episode' and a 'major depressive episode' in the new DSM. Using DSM-IV we can have greater confidence regarding how the criteria is typically interpreted and which experiences could or would be diagnosed under these categories. Until the full implications of the changes made to the DSM have been explored, it would be unwise to rest our research upon it.

Personal experiences of mania and depression are likely to vary significantly, with different individuals experiencing different combinations of signs and 'symptoms'.³² The individual may have further complicating factors, such as an additional diagnosis or a major life event that has impacted on his experience. Even if these kinds of significant complicating factors are not present, the individual's experience will always be affected, at least to some degree, by his individual situation, personality, relationships, and so on. As Schwartz and Wiggins write, "the facts pertaining to any person, when considered in their concrete fullness, are virtually infinite" (1987, p280). We can therefore see that the experience of mania and depression will not be static for the individual, nor is it likely to exactly resemble any other individual's experience of these states.

This complexity of individual experience poses a problem for our research. How are we to develop an understanding of the experience of mania and depression when each individual's experience is unique? Even if we were to

³² By my use of the term 'symptoms' I do not mean to suggest that mania and depression are necessarily illnesses or diseases, nor that the symptoms are manifestations of a disease or illness. Instead, I simply use it as a descriptive term for features of experiences commonly found in cases of mania and depression.

restrict our enquiry to one person's experience of mania and depression, we still find that at different times the experience may have altered, with different features present or absent. One possible solution to this problem, a way to move beyond individual experience, is the use of 'ideal types'.

First developed by sociologist Max Weber and later applied to psychiatry in the work of Jaspers (e.g. 1997), an ideal type can be understood to be a "standard, or simplified version of reality" (Ghaemi, 2009).³³ We develop these types through a process of abstraction, "focusing exclusively on the data that interest us" (Schwartz and Wiggins, 1987, p280). Thus, the types are not an averaging of different individuals' experiences, nor do they represent any one particular person's experience, but rather they are abstract concepts that pick out the salient features of those experiences – that which is *distinctive* of those experiences. As Schwartz and Wiggins explain, "In defining an ideal type we try to set aside this indistinctness, ambiguity, and extreme variation and imagine a pure case in which the relevant features are distinct, unambiguous, and invariant" (1987, p282). This pure case is thus one in which all of the distinctive features of that experience are fully present. However, this 'pure' or 'perfect' case need not correspond directly to any one instance of the type in reality. It is an abstraction, an idealised description of the experiences in question. In reality, many of the cases we identify as instances of that type may lack some of the features present in the ideal type, or those features may present in only a minimal or ambiguous way.

Applied to psychiatry, an ideal type of a particular psychiatric disorder would identify those features that are distinctive of that disorder or experience, rather than providing a comprehensive description of any one individual's experience or an averaging of different experiences. Notably, this does not entail a

³³ See Ghaemi (2009) and Schwartz and Wiggins (1987) for full discussion of Weber's concept of ideal types and how it is applicable to psychiatry.

commitment to that ideal type being a distinct disease entity, nor does it suggest that an instance of that type must possess all of the identified features.³⁴ Clinicians may instead identify “imperfect cases by their resemblance or approximation to the perfect case described by the ideal type” (Schwartz and Wiggins, 1987, p282).³⁵ In this way we can move beyond the individual’s experience and overcome the problem of the infinite complexities that exist in any one person’s experience.

In this thesis I make use of this concept of ideal types, focussing my study on identifying the distinctive features of mania and depression.³⁶ As such, the descriptions I offer may not correspond directly to any one individual’s experience, and I am certainly not suggesting that the features discussed are present in *all* experiences of mania or depression. Instead, I seek to clarify the typical or distinctive features of these states, features that may be more or less present in any one individual’s experience. However, such ideal types may later be used to help clarify an individual’s experience – aiding the understanding of particular features of the experience, even if those features are not fully present or present in a ‘pure’ way. In this way we are able to overcome the problem of the complexities of individual experiences of mania and depression, but still provide valuable descriptions of experiences of these states.

Having established the value of describing these experiences, and having identified ways of constraining and directing our research, we find ourselves led to one final pressing question: How are we to gain access to these experiences? In the next chapter I therefore turn to the topic of narratives,

³⁴ See Ghaemi (2009) for discussion of ideal types, psychiatric nosology, and disease entities.

³⁵ See Schwartz and Wiggins (1987), and particularly pp285-7 for discussion of the clinical application of ideal types and how they can help to guide psychiatric research.

³⁶ I am not, however, claiming that this discussion exhausts description of the distinctive features of mania and depression. It is possible, and indeed likely, that further research in this area would reveal additional distinctive features of manic and depressed experiences.

exploring how these first person accounts can inform our phenomenological research.

Chapter 3: Narratives of Mania and Depression

Introduction

Broadly, a narrative can be understood to be a “representation of a sequence of events” (Goldie, 2009, p98). Peter Goldie clarifies that a narrative must be,

more than just a bare annal or chronicle or list of sequence of events, but a representation of these events, and the people involved in them, from a certain perspective or perspectives, and thereby giving narrative structure – coherence, meaningfulness, and evaluative and emotional import – to what is related. (2012, p2)

In this study I am concerned with publically accessible narratives, rather than what Goldie terms ‘narrative thinking’ (a narrative that is represented simply in thought rather than in a publically accessible form such as text). A narrative, in the sense I use it, might therefore include pieces of writing, drawings,¹ comic strips,² dance, theatre,³ everyday narrations through conversations,⁴ pieces of music, and so on. One of the most common forms of narrative used in phenomenological studies of psychiatric disorders is the published first person account. In this chapter I therefore focus on the value that these accounts have for phenomenologists. Within the category of ‘first-person published account’ I include published book-length memoirs, published diaries, and collections of shorter accounts by multiple authors. I discuss both published and self-published works, though I do not assess the value of internet blogs or other

¹ For an example of a narrative of depression depicted in drawings see Baker (2010).

² For examples of narratives of psychiatric disorders in cartoon strip form see *Hyperbole and a Half: Adventures in Depression* (Brosh, 2011) and *I do not have an Eating Disorder* (McHurst, 2011).

³ See Kane (2006) for an example of a semi-autobiographical play depicting depression.

⁴ See Linde (1993) for a discussion of what she terms ‘life stories’.

narratives that are not formally published.⁵ I begin by outlining some of the advantages of using narrative accounts in phenomenological research, before moving on to examine some of the potential problems. These include the ways in which narrative structure, motivation, and cultural influence may obscure or distort a representation of an experience. I conclude by putting forward an account of how we can use narratives in our enquiries whilst remaining mindful of the problematic aspects of the narrative form.

The Value of Narrative Accounts

The sheer number of available published narratives of mania and depression,⁶ combined with the rich descriptions so often contained within them makes these accounts an attractive resource for the phenomenologist. The extended length of the narrative allows for a degree of depth and context to be seen, albeit always through the lens of how the person himself interprets his experience and broader life story. That the accounts are so subjective need not necessarily be seen as a disadvantage. After all, part of what we are interested in is precisely the subjective nature of the experience.⁷ Our focus is on how events were experienced, rather than merely the events themselves. Through the narrative we can gain access to descriptions of the same person's experiences of mania, depression, and euthymia. Knowledge of how the person acts, what he values, and how he views the world in each of these states helps to bring greater depth of meaning to the changes that occur when the person becomes depressed or manic. Whilst an individual may state that he is punctual when manic, for example, this information is most valuable when put in the context of a person who is usually late for meetings. The reflection on experience commonly found in narrative accounts allows us to appreciate

⁵ However, see Benzon (2008) for a discussion of the use of internet blogs in the study of psychiatric illness.

⁶ See Hornstein (2011) for an extensive list of first person narratives of madness.

⁷ For example, I discuss the subjective experience of time in chapters five and six.

distinctions between the person's typical values and experiences and how these altered when he was manic or depressed.

Narratives also have the advantage of frequently containing descriptions of multiple episodes of both mania and depression. This allows us to explore how the person is affected at different periods of her life, hinting at whether aspects of the disorder are constrained by the individual's particular situation. Hearing that a person overspent during a manic episode both when she was going through a financially secure period as well as when she was not, for example, gives us a more meaningful picture of that particular behaviour. Additionally, narrative accounts give us greater understanding of the sequences of these events. We learn not merely about a person's experience of depression at a particular point in time, but also how that experience progressed and developed. Goldie notes that the meaning that is found in narratives is partly due to the "narrative-historical" (2012, p20) explanations of situations. He explains:

[T]hey locate the motive, the trait, the undue influence on thinking, within a wider nexus, in a way that enables us to understand more deeply why someone did the thing that they did through appeal to aspects of their personal history or circumstances. (2012, p20)

Whilst situating individual events within a wider context cannot be seen to give us access to the full causal story of that event,⁸ it can provide us with a greater degree of insight than we might find in alternative forms of accounts (for example, in medical notes or in a questionnaire). Mania and depression are typically not short-lived, and it is common for a person to experience multiple episodes over the course of a lifetime. As such, narratives that enable longer-term context seem to be a particularly appropriate way to represent the experience of bipolar disorder.

⁸ As Goldie notes, "narratives characteristically leave substantial explanatory gaps to be filled in" (2012, p21).

Finally, as Jennifer Radden and Somogy Varga have argued, narratives of psychiatric disorders can help to demonstrate the relationship that a person holds with her disorder or the symptoms of that disorder (e.g. Radden, 2008; Radden and Varga, 2013). They explain:

Today's identity politics and unprecedented emphasis on personal identity make some description of the relationship between self and illness, or self and symptoms almost *de rigueur* in contemporary first-person accounts. (Radden and Varga, 2013, p105)

Through studying narratives we may be able to access not only a description of what an experience consisted of, but also what the person's relationship to that experience was and is. For example, different accounts of mania and depression may depict the disorder either as an extension of the person's personality, or as an outside or invading force.⁹ In some accounts we may also be able to distinguish between the person's relationship to her symptoms at the time of the experience and how she views her symptoms at the time of writing. As narratives of mania and depression are frequently written after the person has recovered, or during a time of stability, this later reflection can provide valuable insight into how the experience of mania or depression differed from her usual or everyday experience.

However, despite my use of narratives, I recognise that there are significant issues regarding the reliability and usefulness of such accounts. As Paul Atkinson cautions, we cannot "assume that autobiographical accounts or narratives of personal experience grant us untrammelled access to a realm of hyperauthenticity" (1997, p341). Whilst I attempt to show that many of the issues raised against the use of narrative can be largely overcome or mitigated, it is important that any phenomenological account that draws on narratives remains mindful of these potential issues.

⁹ See Radden (2008) for a full discussion of the distinction between 'symptom integrating' and 'symptom alienating' narratives.

Narratives and Phenomenological Study

The value a narrative holds for a phenomenologist is based on the extent to which it reveals an original experience. There is an active debate regarding whether and to what extent we experience life as a narrative. David Carr argues that, “narrative structure pervades our very experience of time and social existence, independently of our contemplating the past” (1991, p9). In contrast, Galen Strawson argues that “There are deeply non-Narrative people and there are good ways to live that are deeply non-Narrative” (2004, p429).¹⁰ The question of whether a written narrative distorts an original experience can be seen to be of particular importance if Strawson’s view is correct. However, even if we accept that our everyday experiences are in some sense narratively structured, this still does not lessen the importance of such questions. The act of placing a narrative experience into a written and published illness narrative may still be thought to potentially distort aspects of that experience. My focus here is therefore not on whether or not experiences are narratively structured. Instead, I look at the related issue of whether placing an original experience into a written and published narrative may be thought to significantly distort or obscure that experience, even if that experience had some form of narrative structure to begin with.

With this in mind, I will discuss features of written narratives that have the potential to obscure, distort, or clarify a representation of an experience of mania or depression. This includes the structure of the narrative, the focus of the narrative, the cultural background of the writer, and the motivation that she has for writing. I take care to note how narratives of mania and depression are particularly vulnerable to certain issues.

¹⁰ See Angela Woods (2011) for one discussion of the implications of Strawson’s paper for the use of narratives in the medical humanities.

Narrative Structure

The structure used in a written narrative can present a particular challenge for the author. A written narrative of illness or disorder is necessarily selective, forcing an experience into a particular structure with a beginning, middle, and end. In contrast, the original experience - even if we grant that it was, to some degree, originally narratively structured - will have been broader, with various features of the person's life being present that are not necessarily relevant to the illness narrative. The same person, for example, could write a narrative about his career that may highlight and neglect very different aspects of experience than a narrative about his depression. This seems to hold even if the two narratives cover the same period. In putting the experience into a narrative structure the person must decide which aspects of the experience are relevant and which are not, as well as highlighting the particular meaning that these experiences hold for him. As Anne Hawkins writes:

The narrative description of illness is both less and more than the actual experience: less, in that remembering and writing are selective processes - certain facts are dropped because they do not fit the author's narrative design; and more, in that the act of committing experience to narrative form inevitably confers upon it a particular sequence of events and endows it with significance that was probably only latent in the original experience. (1999, pp14-15)

The act of putting an experience into narrative form seems to become even more problematic in cases of mania and depression. Whilst we might be able to fit our day to day lives into a simple narrative, it seems harder to fit dramatic and unexpected events into the structure. Sudden life changes seem to resist simple explanations, making a linear, causal, structure insufficient to express the full experience. It may be hard for the person to know what 'caused' the depression, or to fully explore the events and thought processes that lead to and result from a suicide attempt. Elizabeth Wurtzel explains in her memoir of depression the difficulty she had understanding her own suicide attempt: "The

suicide attempt startled even me. It seemed to happen out of context” (1996, p279). Perhaps especially in cases of mania there will be aspects of the experience that may not seem to ‘fit’ into a smooth narrative. Extreme events that may occur in manic states, such as deciding to move countries, leave a partner, or quit a job, may not have the same kind of causal structures that would be expected in a narrative of everyday life. The lack of reflection that forms part of the manic experience,¹¹ along with the memory loss that is commonly reported, would also make it hard for the person to place the events into a simple and communicable narrative structure. Landis quotes one person who describes this difficulty of accurately remembering the manic experience: “I recollect only by fits and starts, with complete gaps” (Graves, 1942, quoted in Landis, 1964, p668). In her memoir of bipolar disorder, Marya Hornbacher explains the difficulties this poses for creating a coherent narrative:

Madness strips you of your memory and leaves you scrabbling around on the floor of your brain for the snatches and snippets of what happened, what was said, and when...This is the best I can do to piece the scattered memories together, to give some semblance of continuous time. (2008, p175)

It is interesting to note that in placing experiences of illness in narrative form writers often make use of the same narrative structures – a journey, for example.¹² Given this, it is worth raising the question of whether, and the extent to which, written descriptions of experiences are altered to fit into familiar structures in order to allow for ease of communication or to aid self-understanding. Particularly in the case of psychiatric disorders, experiences of which we have seen may be hard to articulate and may involve traumatic events, it may be an inviting option to cast the description in familiar terms and structures in order to try to make sense of the experience. The value of

¹¹ See chapter five for a discussion of the loss of reflection in mania.

¹² Hawkins (1999) discusses common ‘myths’ that structure illness narratives (what she terms ‘pathographies’), such as that of rebirth and the journey.

constructing narratives in order to bring meaning to an experience is well documented.¹³ Howard Brody, for example, writes, “both sick persons and physicians make the experience of sickness more meaningful (thereby reducing suffering) by placing it within the context of a meaningful story” (1987, p182). Those that write narratives of mania and depression frequently discuss the value of placing traumatic events into a narrative structure. For example, Fiona Shaw writes the following in her memoir of post-natal depression: “What has been important has been the act of turning blankness and confusion into narrative coherence, however provisional” (1997, p72).

What is of central concern for the phenomenologist, however, is whether the use of familiar narrative structures in published accounts significantly alters or obscures the original experience. Even if we grant that the original experience was at least partly narrative in nature, we might still question whether this narrative was altered in order to fit in with familiar structures found in published accounts. Johanna Shapiro suggests that there is a justified concern that such familiar structures may “prevent other patient voices from emerging” (2011, p69). This may be because those whose experiences do not conform to those structures are reluctant to go against the grain and express those differences. Alternatively, when the majority of accounts conform to common structures, researchers may focus on these at the expense of the atypical examples. However, Shapiro also notes that for some writers of illness narratives these structures may simply “speak their truth” (2011, p70). We might be suspicious of the accuracy of an illness narrative in which the writer suffers great trials through the illness only to emerge having acquired greater self-knowledge from the process, having seen a large number of accounts with the same structure. However, it is possible that the reason why this structure is so popular is because it resonates with the experience of the illness or disorder.

¹³ See, for example, Arthur Frank (1995).

These structures may have emerged *because* they tell us something meaningful about many illness experiences.

It is also possible that the structure a person uses to discuss his experience can be revealing *of* that experience. This might include the overall structure of the narrative, as well as individual life episodes, paragraph structure, and the sense of progression from one section to the next – all may express particular feelings that reveal something about the experience described. This may be because the structure of the experience resists description in certain structural forms, limiting how it can be presented,¹⁴ or it may be a purposeful method taken up by the writer in order to express hard to articulate experiences.

This point might be illuminated by a comparison of the structure of Lizzie Simon's memoir of bipolar disorder *Detour: My Bipolar Road Trip in 4-D* (2003) with that of W. G. Sebald's semi-autobiographical novel *The Rings of Saturn* (2002).

Simon's narrative describing her experience of mania and depression makes use of brief sentences and paragraphs, frequently changing from one time period to another without any sense of smooth progression. For example, one typical section reads:

I'm heading West, no particular destination in mind.

(Use this blank page to color a picture about a time you were freaking out so bad you couldn't even describe it to another person.)

(2003, p167)

¹⁴ For example, Gallagher (2009) discusses the difficulties those with schizophrenia face in constructing coherent narratives.

This single section is all that is written on the page. A second example of this short, almost scattered approach can be seen in the following section:

What started that day after I found out I was accepted to college was an episode so horrific that it would become impossible for me to deny that I had a mental illness for the rest of my life.

Though I had always known that something was wrong with me, what started that day was evidence, concrete evidence.

Yes. True.

(2003, p3)

Again, this single section is all that is on the page. The following page switches to events that took place seventeen years previously. The literal meaning of what is written tells only half the story here. Simon's chosen style of recording her experience teaches us something about the experience she is undergoing. The thoughts often seem scattered, the paragraphs and sections frequently unlinked. The structure of the book allows for the impression of constant and unstructured change, swiftly moving from one topic to the next. What we encounter through the structure of Simon's book is a feeling of constant, sudden, and radical change, a disorientating and often uncomfortable experience that might be thought to highlight elements of the experience of bipolar disorder.

In contrast, Sebald's *The Rings of Saturn* is more complete, with rich descriptions and lengthy paragraphs that frequently loop back upon themselves. Sebald returns to the same themes time and time again, interweaving multiple stories within the one central narrative. This constant returning reminds the reader of the weight of what has gone before and the possibility of history returning and overwhelming the present. The use of this structure is a powerful method of provoking in us some of the feelings of depression the book may be thought to express. The sense of the past being overly present is felt not only through the descriptions themselves, but also through the structure which allows past

aspects of the book to constantly resurface. Sebald's long, circling, paragraphs contrast with Simon's sharp fragments – even were the descriptions to be the same, the structures of the two pieces would represent very different experiences.

Attending to the structure of a narrative in order to gain information about the experience can be particularly useful when studying psychiatric disorders such as bipolar disorder. Those with the disorder often describe the difficulties of accurately articulating their experiences of mania and depression. Andrew Solomon, for example, writes that depression “can be described only in metaphor and allegory” (2002, p16). The use of structure, therefore, is an opportunity to express aspects of the disorder that may be hard to put into words. Indeed, this use of structure to express aspects of experience is sometimes directly mentioned by the writers themselves:

I wanted this book to mirror the disease, to give the reader a visceral experience. That's why I've chosen to tell my life story episodically, rather than in any chronological order. It's truer to the way I think.
(Cheney, 2008, p1)

Cheney has chosen a particular way of structuring her narrative account, in a non-chronological order, in order to give the reader a deeper understanding of the experience of bipolar disorder. As this illustrates, in some cases we not only *can* infer information about the experience from the structure of the book, but we are in fact *meant* to do so.

It seems, therefore, that at the very least the structure used in a narrative of mania or depression cannot be held to be meaningless. Whilst we must be mindful of the potential for distortion when narrative structure is imposed on a broader experience, we must also be aware that the structure of the narrative can be used in order to communicate part of the experience to the reader.

Byron Good (1994) argues that the culture a person is in can influence the structure or form used when constructing an illness narrative. Shapiro agrees, writing that people are “deeply constrained by the power of the dominant narrative conventions and meta-narratives that are most readily available to them as a result of their particular place in time, history, culture and society” (2011, p69). Radden similarly suggests that “rather than being mere phenomenological reports, individual narratives reflect the “framing” ideas and explanations accepted and imagined at their given time and place in history” (2008, p25). We can see that the cultural background of a person may affect the narrative in at least two ways: Firstly, the narrative might have meaning that is only apparent to those familiar with that society or culture. That a person chooses to structure his experience of illness in the form of a journey, for example, may communicate different meanings depending on the culture in which he is writing. Secondly, the narrative structures that the person is familiar with, and therefore we might say are available to him as potential ways to represent his experience, will be dependent upon his culture. For example, the ways in which a person may frame his relationship with the disorder may be, in part, due to the culture in which he lives. Thus the choice of structure made may not be straightforwardly comparable to the structures chosen by those in other cultures.

In order to avoid these complicating factors, I have restricted my use of narratives to those from Western countries. Whilst this may place a limitation on the conclusions that can be drawn, it allows for a more accurate interpretation and use of the narratives. Further studies would have to be done in order to compare the experience of mania and depression, and indeed the narratives of mania and depression, in different cultures.

Narrative Focus and Motivation

The motivation a person has for writing may impact on the narrative that is told. This seems particularly to be the case when the narrative is written with the intent of publication. It must be remembered, after all, that the writer's primary aim is not usually to provide an accurate resource for the purpose of phenomenological study. It is, therefore, not surprising that the focus is not always on providing the most accurate and rich description of an experience as possible, and that sometimes accuracy may be sacrificed for features that are more relevant to the writer's aims. This does not mean that we cannot use such accounts as resources for phenomenological enquiry, but simply that we must be aware of alternative motivations and the impact that they may have on relevant features of the narrative. Motivations that might distort the narrative produced include a desire for monetary gain, to preserve a reputation, to help or offer support to others, or to lend support to a particular account of the causal factors or treatment options for the disorder. The significant amount of time spent completing the narrative, and the decision an individual makes to put her personal life into the public sphere will not have been undertaken without some kind of strong motivation to do so. As such, we should be aware of the motivations that may have influenced the narrative produced.

One of the most worrying motivations for writing that must be considered is the extent to which the narrative is altered in order to create a book that will sell well. There is a danger that passages or, indeed, entire works may be sensationalised in order to 'tell a good story'. Accuracy in reporting the experience may be lost as the writer attempts, either consciously or unconsciously, to provide the reader with an interesting and engaging book. The influence of editors and publishers, who may be particularly concerned with the potential marketability of the book, may compound the issue. In a narrative of mania or depression there is a particular concern that dramatic or unusual experiences will be emphasised. We might expect that events such as

suicide attempts, wild manic behaviour, or sudden recoveries, will be given priority in the narrative over the longer term and less exciting everyday experiences of mania and depression. This may be through exaggeration or by simply focussing on the dramatic events to the exclusion of the non-dramatic. Either of these situations would lead to an inaccurate representation of the experience of mania or depression.

Linked to this is the concern that the narrative may be altered in order to give a more favourable impression of the writer, or of other people or organisations that appear in the narrative. This may be a result of personal desire or specific advice given by a publisher or editor. A person may be reluctant, for example, to discuss the more embarrassing events or experiences that occurred. She may also be unwilling to discuss events that show another person in an unfavourable light. Attempting to paint a positive, or at least neutral, picture of herself and others may result in an unbalanced account with aspects that are dull, embarrassing, or otherwise unsympathetic to the writer being neglected. Aware of this tendency, some writers have specifically set out with the purpose of writing an account that is 'true' to the uncomfortable and often unflattering experience of mania or depression. For example, Elizabeth Wurtzel writes:

I wanted this book to dare to be completely self-indulgent, unhesitant, and forthright in its telling of what clinical depression feels like...I wanted to be completely true to the experience of depression – to the thing itself, and not to the mitigations of translating it. I wanted to portray myself in the midst of this mental crisis precisely as I was: difficult, demanding, impossible, unsatisfiable, self-centered, self-involved, and above all, self-indulgent. (1996, p316)

We cannot, therefore, assume that all narratives of mania and depression have been edited specifically in order to give a favourable impression of the author. However, we must still be aware that this may be an influencing factor for many writers, and some narratives of mania and depression might have been altered in this way.

This kind of external pressure on the writer to conform to a particular narrative in order to produce a successful book is obviously problematic for the study of the resulting narrative. However, writers will also have various internal motivations for publishing a narrative that can put limitations on the extent to which we can take the narrative as offering a reliable insight into the experience described.

Those who publish narratives of illness often cite a desire to help others as a key motivation. Sally Brampton, for example, writes in the introduction to her memoir of depression:

Life is about connection. There is nothing else. Depression is the opposite; it is an illness defined by alienation. So I offer this book by way of connection. I offer it too, as a source of hope. I hope that by sharing what I was like, what happened and what I am like now, that it may bring someone else comfort. (2009, pp1-2)

Jason Pegler, in his memoir of bipolar disorder explains:

When writing this book, I often thought back to how long it took me to accept my own illness. I now know I can help at least one person cope with their illness better than I did. This alone makes the pain of writing it worthwhile. (2003, p7)

Marya Hornbacher, in contrast, offers her memoir of Anorexia and Bulimia Nervosa as a means of a warning:

I would do anything to keep people from going where I went. Writing this book was the only thing I could think of. (1999, p7)

Brampton, Pegler, and Hornbacher, though desiring different outcomes, share the broad motivation of wishing to help others who are undergoing the same experience as they did. This motivation, to warn or to comfort, has the potential to influence the way in which the narrative is framed. If someone wishes to warn against a certain way of living or acting, it is likely that she'll stress the

negatives that result. Someone wishing to offer comfort for others may stress the possibility of recovery. She may highlight the times when she was at her worst, to show others that recovery is possible no matter how severe their situation. Alternatively, she may choose to overlook particularly difficult times, in order to stress to others that the disorder does not have to be as severe as they might expect. When bipolar disorder is so often described as a 'lifelong condition',¹⁵ it seems likely that the desire to comfort and reassure others that it can be 'managed' must inform at least some accounts of the disorder. As Simon writes in her narrative of bipolar disorder and subsequent interviews with others who have the disorder:

I want to demonstrate how it feels to be young and bipolar, and I want to show that people survive this illness and live full lives. I want to figure out what worked in people who are success cases, and shift people's focus away from all the media attention on destructive and violent cases...I want to produce a new image for bipolar people.
(2003, p41)

I previously noted that it has been suggested that the creation of narratives can serve a purpose in helping to reduce the distress associated with illness or traumatic events. Arthur Frank argues that, "becoming seriously ill is a call for stories" (1995, p53). The ill person, he suggests, uses narratives in order to "repair the damage that illness has done to the ill person's sense of where she is in life, and where she may be going" (1995, p53). The narrative is a means of re-orientating the person, helping her to make sense of the past and preparing her for future events. If this view is correct, then this need for narrative coherence may well impact upon the accuracy of the narratives told. We must be aware of the extent to which the writer may be merely attempting to construct *any* coherent narrative that fulfils this purpose of reorientation, rather than necessarily attempting to put forward an *accurate* narrative. This need or

¹⁵ For example, The National Institute of Mental Health describes bipolar disorder as "a lifelong and recurrent illness" (2009, p9).

desire to make sense of the experience may well override the desire to accurately report that experience. Tim Lott, for example, writes in his memoir of his and his mother's depression, "We make it up as we go along, then forget it, and make up something else, because we cannot live without stories" (1997, p132).

A final motivation that must be considered is a desire to lend support to a particular account of the aetiology, understanding of the disorder, or a method of treatment. There is no widespread consensus over the causes of bipolar disorder, and discussions regarding the best course of treatment bring out strongly conflicting views. It's been suggested that certain understandings of psychiatric disorders are more or less likely to reduce stigma. For example, the medical model may be thought to support a view of psychiatric disorders as something that happens *to* a person, separate from the person's character or life choices. In this way it may be thought to be non-judgmental, shifting blame away from the person with the disorder.¹⁶ As Miklowitz writes in his 'survival guide' for those with bipolar disorder, "getting the disorder in the first place is heavily influenced by your genetic makeup...in other words, it isn't your fault" (2002, p83). Alternatively, it might be thought that adopting a view of psychiatric disorders as biologically based illnesses may make recovery seem unlikely or impossible, whilst a disorder caused by difficult life circumstances allows for the possibility of recovery. As Corrigan and Watson write, "Framing mental illness as a brain disorder may resolve onset questions but exacerbate offset issues" (2004, p77).

It is likely that at least some narratives of mania and depression are written as a means of contributing to these debates. It is common for these narratives to include advice on achieving or maintaining recovery from states of mania or

¹⁶ For discussion of stigma and the medical model see Corrigan and Watson (2004) and Corrigan et al (2002).

depression, or to discuss contributing factors in the development of the disorder. Occasionally these go as far as to have separate sections of the book written by health care professionals explaining what the disorder is, what causes it, and how best to treat it.¹⁷ More commonly, writers will highlight how their narrative fits into debates regarding, for example, the use of psychiatric medication, or the existence of childhood bipolar disorder.

Narratives of mania and depression are written against a background of debate about access to treatment, what the diagnostic criteria ought to be, and how best to confront stigma. Some writers deal explicitly with these themes in their narratives and it is likely that even those who do not will have been at least influenced by the on-going debates. What is included or left out of a narrative may well have been influenced by the writer's desire to lend support to particular theories or viewpoints. As Radden explains, "In reading these works we must be alert to the inevitable reconfigurations imposed on all self-narratives in their retelling, but very often heightened, here, by efforts to explain or excuse states so extreme, unsought, unwelcome, and stigmatized" (2008, p19). This need not mean that what is written is untrue or unreliable, but simply that it may not express the full experience.

However, the narrative account can still provide a starting point through which to focus further research. It seems highly unlikely that any one methodology could give us access to a 'full' or 'pure' experience of mania or depression. Through studying narratives we are able to see what the person with the disorder considers central to her experience, unconstrained by the focus of the researcher. Whilst a person may be able to talk about a particular experience when prompted, for example, the fact that she does not mention it as part of her life narrative is interesting in itself and can provide a focus for potential

¹⁷ For example, see Patty Duke's narrative of bipolar disorder *A Brilliant Madness* (1992), co-written with Gloria Hochman.

enquiries. Equally, without the constraint of fixed questions the narrative may focus on aspects of experience that might otherwise be overlooked by a researcher in an interview. Therefore, whilst the narrative account may not provide a complete representation of the original experience, it is a useful starting point in a phenomenological enquiry. The focus the narrative provides can then be further explored in an interview or questionnaire, where descriptions can be clarified and refined through questioning.

In part to corroborate the descriptions found in narratives, and in part to provide greater focus on phenomenological issues, my colleagues and I constructed a questionnaire on the experience of depression. Matthew Ratcliffe, Benedict Smith and I initially constructed the questionnaire as part of the project 'Emotional Experience in Depression: A Philosophical Study'. We revised it following input from colleagues at the University of Osnabrück and researchers at the UK mental health charity SANE. The Durham Depression Questionnaire was reviewed by the Department of Philosophy Ethics Committee, Durham University, and was placed on the SANE website throughout 2011. The questionnaire included three sections. The first was a description of the questionnaire and a consent form. The second section included basic details, such as age, gender, diagnosis, co-morbidities, treatment received, and asked whether the person was currently depressed. The third section asked thirteen questions, chosen because they represented common themes found in narratives of depression, as well as aspects of the experience that are relevant to current discussions in the Philosophy of Psychiatry (a full copy of the questionnaire can be found in the appendix). Respondents were given open text boxes in which to write as much or as little as they wished. It was also possible for respondents to choose not to respond to a question, and the questions could be answered in any order. The completed responses were stored both as answers to individual questions, as well as each individual's full questionnaire. I initially analysed the results with colleagues in project meetings

at Durham University, and with research associates from the mental health charity SANE. My later individual analysis focussed more directly on responses that were most relevant to this thesis.

The responses from this questionnaire,¹⁸ combined with narrative accounts, give us a fuller picture of the experience. We must resist the urge to assume that questionnaire responses are in some way purer than the narrative accounts – after all, cultural influences may well impact upon questionnaire responses as much as they do narratives of depression. Additionally, the shortened form of the questionnaire response does not allow access to the longer-term information that we find in published memoirs. For example, we would be unlikely to find detailed descriptions of multiple episodes of mania and depression, complete with the relevant life-context for each episode. However, the anonymous nature of the questionnaire does mitigate some of the more worrying potential distortions that may occur in published narratives. There would be, for example, no concern about the distortions caused by motivations associated with monetary gain or popular success. The lack of extensive editing in questionnaire responses may be seen as both an advantage and a disadvantage. The more spontaneous nature of the responses means there is little risk that a third person, such as a publisher, will have exerted undue influence over what is written. However, the lack of extensive reflection may mean that descriptions remain somewhat superficial in contrast to published narratives. Using both types of account, therefore, allows us to have greater confidence that the focus has not been overly influenced either by personal motivations or narrow research aims.

¹⁸ We had 147 responses to the questionnaire, with an age range of between 16 and 76. 82% of the respondents were female. Whilst depression has a higher rate of diagnosis in women than men, this split is still not fully representative of those diagnosed with the disorder.

Societal Influence on Narratives

I have already suggested that culture can play a part in structuring a narrative. However, we must also be aware of the impact that the society a person is in can have upon the descriptions and metaphors used to describe an experience of mania or depression. Those who experience bipolar disorder and write narratives of those experiences do not do so within a vacuum. It is likely that they will be influenced, at least to some extent, by what they have read, seen, and the conversations that they have had. This might be through reading other people's accounts of mania and depression, watching depictions of those with the disorders on television or film, through mental health charity campaigns, or even through conversations had with health care professionals. As such, even if we restrict our use of narratives to only those from the same cultural background, we can still find outside influences on these accounts, of which the phenomenologist must remain aware.

When describing the experience of depression, people consistently use the same or similar metaphors. Many describe depression as a 'black dog',¹⁹ talk of being stuck behind a pane of glass, or describe the body as being 'as heavy as lead'.²⁰ There is a concern that these metaphors might have been taken from other sources, or heavily influenced by those sources, rather than being an accurate description of that person's *own* experience. If a person describes depression as like being stuck in a bell jar, can we be certain that this is anything more than familiarity with Sylvia Plath's *The Bell Jar* (1966)? We might ask whether this is a

¹⁹ The use of the metaphor of depression as 'the black dog' can be seen in a variety of different projects, including SANE's 'black dog campaign' for raising awareness of mental illness (SANE, n.d.) Matthew Johnstone's illustrated guide to depression *I Had a Black Dog* (2007), and Sally Brampton's memoir of depression *Shoot the Damn Dog* (2009). See also Rebecca Hunt's novel *Mr Chartwell* (2011), based on Winston Churchill's 'black dog'.

²⁰ For example, one respondent to the depression questionnaire wrote that "its (sic) like walking around in lead boots" (#34). Respondent #26 described the body as being "as heavy as lead" when depressed.

true representation of the experience of depression, or simply a *familiar* description that falls somewhat short of reality.

We can begin to quell such fears by pointing to the sheer number of narratives of mania and depression that use similar metaphors. These metaphors and descriptions seem to be used regardless of the educational status of the person, whether they're male or female, the class background they come from, what their hobbies and interests are, and the length of time that they have had the disorder. That they still, despite this, describe their experiences in similar ways, using similar metaphors, suggests some degree of accuracy. Whilst some may be overly influenced by common metaphors, it seems unlikely that so many, from such a broad range of backgrounds, would continue to use these metaphors if they didn't capture something important about the experience.

It could, however, be suggested that this widespread use of the same metaphors simply shows the extent to which they have become a part of our everyday culture. Whilst it is unlikely that all those who write narratives are familiar with Plath's *The Bell Jar* (1966), it's possible that they may still be aware of the popular metaphors contained within it – even if they are not aware of the metaphors' origins. As such, we may still wonder if the descriptions are simply familiar rather than accurate, even if the person denies familiarity with the associated popular narratives.

However, we might counter this concern by pointing out that those with depression or bipolar disorder will also occasionally discuss the metaphors that they're using, reflecting on whether they are wholly accurate and pointing out where they fall short of the experience. Brian Adams, for example, writes in his narrative of bipolar disorder, "In manic-depressive imagery the pendulum is often utilized...Yet, I have to say that the image of the pendulum has never really represented the chaotic nature of my manic depression" (2003, p22). Responding to a question in the Durham Depression Questionnaire asking for a

description of moods and emotions during periods of depression, one person wrote, "For me depression is not a black dog as I love dogs and have one myself. For me depression is like a big black blanket" (#228). Another, when asked whether the world looks different when depressed, wrote, "Despite sounding cliched [sic], the colour does drain from the world and everything seems to be tuned to a grey" (#370). There seems to be an evaluation of common metaphors, using them when appropriate to the writer's situation but equally feeling able to reject them when they do not resonate with the experience.

Are Narratives Representative?

One concern with using published narratives in order to inform phenomenological study is the extent to which it is possible to generalise from individual narrative descriptions. Whilst we may be able to find common themes and descriptions throughout different published accounts, it could plausibly be suggested that only a certain type of person writes a narrative of depression or mania. The experience of mania or depression may be quite different for those who would not be inclined to publish an account of their experiences.

Whilst this would be a serious concern if we found that narratives of mania and depression are consistently written by the same kind of person, this does not seem to be the case. A wide range of people write narratives of mania and depression, differing in gender, age, and social background. Many are highly educated professionals, such as Professor Kay Redfield Jamison (1997) or Lawyer Terri Cheney (2008). Some are professional writers (for example, William Styron (2004) or Marya Hornbacher (2008)). However, many narratives are written by those with a different background. John O'Donogue (2009), for example, is homeless and unemployed for much of the period his narrative covers. Suzy Johnston's *When do I get my Shoelaces Back* (2010) is a self-published

copy of diaries kept during a stay in a psychiatric hospital. Whilst there may be a 'type' of person who writes a narrative, this type does not seem to be particularly narrow.

In order to increase confidence we can consider the narrative accounts alongside other sources. Whilst published narratives may favour those who are articulate, confident, and well-connected within the publishing world, other methods of gaining first person accounts do not have this problem. If we find similar descriptions in interview or questionnaire responses to the ones that appear in narrative accounts, then it seems that there is less reason to suspect that the published account is unrepresentative. Put simply, the wider the range of methodologies used, the less likely it is that we are only accessing the experience of one 'type' of person.

The Durham Depression Questionnaire may be a useful tool in this regard. The descriptions given in response to the questionnaire were remarkably similar to descriptions given in narrative accounts of depression.²¹ Similar themes were highlighted as being central to the experience, and the same or similar metaphors were consistently used. The large number of people responding to the questionnaire, some of whom would not be thought to be the 'typical' type of person to publish a narrative,²² gives weight to the position that the descriptions in published narrative accounts *are* representative of the wider experience of depression.

The Value of Narratives

Given the issues discussed, what value should we place on narratives? Despite the potential problems with the use of narrative accounts, I suggest that they

²¹ For example, both narrative accounts and questionnaire respondents describe similar bodily experiences in depression (see chapter four for further discussion of this point).

²² For example, the age range seen in the questionnaire respondents (between ages sixteen and seventy-six) extends beyond those typically seen in published narratives.

can still make a unique contribution to our understanding of an experience. Whilst they may not be able to provide a 'complete' representation of the experience of mania or depression, it is questionable whether any methodology would give us this kind of access. We have already seen some of the limitations on the ability of questionnaire responses to grant us access to experiences of mania and depression. Similar issues regarding societal and cultural influences are found in the use of interviews and clinical reports. In addition, any description that has already been interpreted by, for example, a healthcare professional, must be seen to have drawbacks that are not seen to the same extent in first person accounts. We cannot, therefore, assume that there is any one methodology that would allow us access to a pure or complete representation of the experience.

Given these difficulties, we must value narratives for the access that they *can* provide, whilst remaining aware that we can gain insight into different aspects of the experience through a variety of means. The context, focus, and structure provided by the narrative can, when used in conjunction with other resources, help us to construct a richer account of the experience of mania and depression. We must, however, take care to respect the narrative that is told. This requires taking the narrative as a whole in our studies, rather than merely focussing on short sections or quotations extracted from the original source. This need not mean that entire narratives must be explicitly discussed in a piece of work. It simply requires that, during our initial study, we remain aware of the wider narrative and not treat individual sections as 'data' whilst discarding the context and structure in which they rest. There is a clear epistemic need to treat narratives in this way; by paying attention to the full context of a quotation we can lessen many of the potential problems that have been discussed in this chapter. Knowing the person's social background, her life experiences, and her conscious motivations for writing can allow us to begin to assess the impact

these might have had upon the aspects of the narrative directly relevant to phenomenological enquiry.

In what follows, I therefore make frequent use of narratives, as well as other forms of first person accounts, including questionnaire responses and published interviews. I also use a number of descriptions of the experience of mania and depression that are not written by those with lived first person experience. For example, descriptions written by a partner or carer, or by health care professionals. The value of narrative accounts is strengthened through the bringing together of these different resources, enabling us to develop a more accurate and richer account of the experiences of mania and depression.

With these qualifications in mind, I now want to turn to a subject that is highlighted both in narrative accounts as well as questionnaire responses: Alterations in experiences of the body in cases of depression and mania.

Chapter 4: The Body in Depression and Mania

Introduction

Those with depression often highlight the embodied nature of their experiences. Memoirs of depression frequently describe experiences of the body as “tired”, “leaden” and difficult to move in the usual way. For example, Fiona Shaw writes in her memoir of postnatal depression, “My body became inert, heavy and burdensome. Every gesture was hard” (1997, p26). Andrew Solomon provides a similar description of his experience in depression:

It is like feeling your clothing slowly turning to wood on your body, a stiffness in the elbows and the knees progressing to a terrible weight and an isolating immobility that will atrophy you and in time destroy you. (2002, p50)

In the Durham Depression Questionnaire we asked the question “How does your body feel when you’re depressed?” Of the 136 people who answered the question (eleven who completed the questionnaire did not), only two said that there was no difference from their non-depressed experiences. In addition to these, one person spoke of the effects of medication on her body, and another respondent said that she couldn’t answer the question as other health issues meant she had “no way of knowing what's depression related and what isn't” (#212).

All other respondents noted a change in how the body feels when depressed. Most frequently this was described as feeling tired, lethargic, or lacking in energy. For example, sixty-one respondents used the word “tired” to describe how their body felt when depressed. Almost every other response used a related descriptive term, such as “fatigued”, “lacking in energy”, or “exhausted”:

Tired - really really tired - the stairs in my house seem like a mountain.
(#147)

lethargic is the best word to describe it. It just feels so heavy and worn out and tired all the time, which doesn't [sic] help if you cannot sleep anyway. (#232)

Other common descriptions included feelings of the body as “heavy”, as well as various evaluative claims describing the body as “disgusting” or “useless”:

As heavy as lead. I can't drag it out of bed most of the time. (#26)

Physically low, really really 'heavy', it's like there's a physical weight pulling you down. It makes you really tired so you have no energy. And I hate my body. I look in the mirror and I can't stand what I see, it's disgusting [sic]. (#49)

Huge, an appendage. Grotesque. (#224)

Whilst international studies have noted the centrality of bodily experiences in depression,¹ the diagnostic and treatment focus in Western psychiatry has tended to be almost exclusively on the ‘mental’. Descriptions such as the ones quoted above challenge this view of depression as being largely ‘mental’ in nature. As one respondent explained:

I think a lot of people have this impression that depression is a purely mental illness, and I can't explain it but it totally affects you physically as well and your body just goes into meltdown mode. (#22)

In this chapter I examine these alterations in bodily experience, developing phenomenological accounts of the body in depression and mania. I begin with a discussion of the everyday, non-depressed and non-manic experience of the body, as described by Merleau-Ponty and Sartre. Following a description of the phenomenology of shame, I turn to the topic of depression, exploring Thomas

¹ See, for example, Simon et al. (1999), a study that highlights the frequency with which those with depression report somatic symptoms. See also Kapfhammer (2006) for further discussion of this point.

Fuchs's characterisation of the depressed body as "corporealized" (2003). I follow this with a discussion of the experience of the body in mania, highlighting the somewhat surprising descriptions that we find in first person accounts.

The Lived Body

Whilst our bodies are objects in the sense that they have physical properties such as weight, size, and so on, phenomenologists have argued that they hold a special phenomenological status amongst other objects in the world.² We do not, for example, experience them in the same way we might a table, chair, or coffee cup. In this section I outline the ways in which we experience our bodies, focussing on their status as perceived-perceivers, as well as their transparency in our everyday experiences.

I cannot be without my body, and I cannot change my position in relation to it – it is always present as my opening or perspective onto the world. This is true even if I were to imagine some perspective other than my current actual perspective. In my imagining it can be seen that I still perceive from *some viewpoint*, and that viewpoint is bodily in nature. Describing Husserl's position, Zahavi writes, "there is no pure point of view and there is no view from nowhere, there is only an embodied point of view" (2003, p98). For example, were I to imagine the view of a city from above, this viewpoint would still be the imagining of myself *as an embodied being* viewing from above. As Merleau-Ponty writes, "[I] cannot conceive a perceptible place in which I am not myself present" (1964, p16).

In contrast, other objects are not always present – an object's "presence is such that it entails a possible absence" (Merleau-Ponty, 2002, p103). The table may be in front of me, or it may not be; I can move closer to or further away from it. In

² Whilst I primarily concentrate on Merleau-Ponty's account of bodily experience, relevantly similar discussions can be found in the work of Sartre (e.g. 2003) and Husserl (e.g.1973a).

addition, I always perceive the location of the object in relation to my body. The coffee cup is to the left or right of my body, not 'left' in some meaningless ungrounded way. Indeed, it seems that it is only through my embodied nature that I can understand relations such as 'left', 'right', or 'under' at all. According to Merleau-Ponty:

When I say that an object is *on* a table, I always mentally put myself either in the table or in the object, and I apply to them a category which theoretically fits the relationship of my body to external objects. Stripped of this anthropological association, the word *on* is indistinguishable from the word 'under' or the word 'beside'.

(2002, p116)

I therefore understand the relationships between objects in the way that I do because I am embodied. These relationships are understood either through an imagining of myself in the position of the object, or through the relationship between the two objects and the location of my body. For example, the relationship between a cup and a glass sitting next to each other is of the glass being 'to the left of' the cup or 'behind' the cup depending on where my body is located: "Spatial forms or distances are not so much relations between different points in objective space as they are relations between these points and a central perspective – our body" (Merleau-Ponty, 1964, p5). In being my perspective *onto* the world, therefore, my body acts as a means of framing my experience of objects *in* the world.

It might be asked whether this understanding of the body as a fixed, omnipresent viewpoint necessarily distinguishes it from other objects. After all, I could carry with me at all times some other object – a wedding ring, for example. Objects in the world would then present as closer to or further away from the ring, just as they might a part of my body. Why, then, does the body have a different status from that of the wedding ring?

We might argue that even if I never take off this ring I still retain the *possibility* of taking it off, or could imagine myself taking it off. The ring is not necessary for my interaction with the world, even if it happens to be part of it at a particular time. In contrast, I do not have the possibility of stepping away from my body or even imagining doing so. However, even if we were to say that there was no possibility of taking off the ring, or of imagining taking it off, we would still be able to distinguish between the status of objects and my body. This distinction comes about due to the dual function of the body.

A ring around my finger can be perceived – I can touch it, feel its weight, how smooth it is, and so on. In the same way my body can be perceived – someone could touch my hand, feel how smooth or rough the skin is, what temperature it is, and so on. However, along with this possibility of *being* perceived, my body has the second function of being able *to* perceive. Whilst my hand can be felt, at the same time it can also feel. This can perhaps be best illustrated through the sensation of double touch. When I touch together my left and right hands the dual function of the body becomes apparent – my left hand *is perceiving* my right hand and my right hand *is being perceived*. At the same time, however, my right hand *is perceiving* my left hand and my left hand *is being perceived*. As Merleau-Ponty describes:

When I press my two hands together, it is not a matter of two sensations felt together as one perceives two objects placed side by side, but of an ambiguous set-up in which both hands can alternate the roles of 'touching' and 'being touched'. (2002, p106)

The body, therefore, is neither solely the perceiver nor the perceived. It must be understood in a third way, as a perceived-perceiver. In this way it is different from other objects in the world, those that can only be perceived.

So how should we understand this perceiving role of the body? We ought not think of it as a detached observer of the world, merely taking in details that are

somehow separate from it. Rather, our perception of the world is of a network of practical bodily possibilities; the way we perceive the world is framed by our embodiment. As Gallagher and Zahavi note, “To be situated in the world means not simply to be located someplace in a physical environment, but to be in rapport with circumstances that are bodily meaningful” (2008, p137).

When I perceive an object I perceive more than that which is currently visible. I also perceive the ‘horizons’ of the object – I am aware that I or another person could view the object from other angles, and that there are various practical possibilities associated with that object that I might choose to take up.³ My perception of a water glass, for example, includes in it the possibilities for that glass, not merely acknowledgement of its physical properties. I perceive not only that it is a certain size and shape, but also that it has the possibility of my picking it up, turning it upside down and looking at it from another angle, drinking water out of it, or smashing it against a wall. These possibilities make up the ‘horizontal structure’ of the glass. Merleau-Ponty discusses a piece of leather appearing as “to be cut up”, and lining as “to be sewn” (2002, p122). These possibilities exist for me because of my practical embodied abilities. If I broke both of my arms I would perceive the glass in quite a different way – it would, for example, no longer contain the possibility of my picking it up.

An object’s perceived possibilities are therefore constrained by my embodied nature. My body both highlights and provides limitations on possibilities. I perceive the table as *too heavy* to pick up because I am not strong enough and the top shelf as being *too high* to reach because I am not tall enough. The rickety bridge is experienced as dangerous due to the possibility of my falling off. The way my body is, my height and physical capabilities, the robustness or fragility of my body, along with the projects in which I am engaged, determine a

³ The concept of a ‘horizontal structure’ perhaps most notably appears in the work of Husserl (e.g. 1973b). However, it is also found, for example, in the work of Merleau-Ponty (e.g. 2002).

network of practical possibilities that give the world meaning. This relationship between my embodiment and the way I experience the world highlights the intimate connection between experiences of the body and experiences of the world.

Transparency of the Lived Body

We have established that our bodies occupy a privileged status amongst objects in the world: They are constantly present, act as our point of access onto the world, and structure our perception of the world. However, in order to answer our original query of how we *experience* our bodies, we must further investigate the ways and extent to which we are *aware* of our bodies in everyday experiences.

It is possible to directly focus on our bodies. I can contemplate my hand by stretching it out in front of me: I can study what it looks like, how it feels, or take note of a number of other properties. In a similar way, I could look in a mirror in order to focus on my body, or a doctor could study my body in order to diagnose some condition. In all of these cases my body is at the forefront of my attention and I am explicitly conscious of it.

However, this does not seem to be the primary way of experiencing the body in most situations. My attention is usually focussed not towards the body, but towards the world. As I cross a road I am not explicitly thinking about my body; instead my attention is directed towards my goal of reaching the other side of the road. As Gallagher and Zahavi note, in normal circumstances “I do not observe or contemplate my hand, I reach out with it and grab something” (2008, p136). My body is primarily a means of interacting with the world, something I act *with*, directed towards practical projects in the world.

As I act in the world, therefore, my body gains a degree of transparency. It fades into the background as I focus on the projects and tasks that I am

undertaking. The body, it seems, “tries to stay out of our way so that we can get on with our task” (Gallagher and Zahavi, 2008, p145). However, it would be a mistake to assume that our interaction with the world entirely hides our bodies from us. Whilst I may not be explicitly concentrating on my hand when I reach out for a drink, I still retain a background awareness of it and of the rest of my body in relation to it: “one’s own body is the third term, always tacitly understood, in the figure-background structure” (Merleau-Ponty, 2002, p115). As I walk up a flight of stairs, for example, I have a proprioceptive awareness of the positioning of my body, a ‘body schema’, that allows me to carry out my movement without having to overtly concentrate on my foot’s placement. Everyday actions such as walking, climbing stairs, and picking up small objects, are undertaken without my studying the body in the same way that I might when I look in the mirror or examine a cut on my hand. Instead, I have a background awareness of the body that allows me to focus on the action or task itself. Indeed, if we think too carefully about the exact placement of our body parts, reducing them to a more object-like status, we tend lose the fluidity of our movements. The experience of running down a hill and losing your footing when you start to concentrate on the placement of your feet is a common experience that highlights this relationship that we have with our bodies.

We can see, therefore, that the body in ordinary, everyday, circumstances is experienced as a form of subject-object – that which constantly holds the possibilities of both perceiving and being perceived. We retain an awareness of our bodies, but they fade out of explicit consciousness during our interaction with the world through various tasks and projects. Our bodies set up a network of practical significance, being both the set-point from which we experience the world, as well as allowing for the practical possibilities of objects. In this way our bodies are experienced as more than mere objects.

However, there are times when we do not experience our bodies in this way. In certain situations we lose the transparency of the lived body and find ourselves confronted with the corporeal perceived body. This might occur in cases of fatigue, illness, or when attempting to learn a difficult new skill. This switch between perceiver and perceived is, however, perhaps most strikingly apparent in the case of shame.

Shame and the Body

Sartre puts forward an account of our embodied experience of interpersonal relations, suggesting that in “being-seen-by-another” (2003, p281) our bodies present themselves as object-like.⁴ Whilst, as we have seen, in most situations our bodies present with a degree of transparency, under the gaze of the Other I become aware of the corporeal nature of my body. As the person looks at me I cease to be the centre of my own world, directing my attention outwards towards projects and tasks, becoming instead an object in the world of the Other. As Thomas Fuchs explains,

if this roaming gaze turns on me, I am suddenly caught, as it were, in a forcefield, in a suction that attracts me, or in a stream that floods me. I am torn out of the centrality of my lived-body and become an object inside another world. (2003, p226)

The central perspective is no longer my own, but the other person’s, and I become aware of my body not as that which perceives the world, but as that which is perceived by others.

Sartre illustrates this experience with the example of a person spying on someone else by listening to a conversation through a door and watching through the keyhole. The person is originally absorbed in the activity, the body

⁴ Sartre distinguishes between this experience of being-seen-by-another and other situations in which the body may be experienced as conspicuous (when in pain, for example). See Svenaeus (2009) for an interesting discussion and critique of Sartre’s theory.

fading into the background as he becomes engrossed. Sartre refers to this as “a pure process of relating the instrument (the keyhole) to the end to be attained (the spectacle to be seen), a pure mode of losing myself in the world” (2003, p283) – the person is caught up in his practical activity, his task of listening in on the conversation. However, upon suddenly hearing footsteps behind him, the person’s experience of the body alters. He ceases to be caught up in his project and find his focus thrown back upon his physical body. He becomes aware of himself as an object in the Other’s sight – fragile and vulnerable. The person, in that instant, realises “that I have a body which can be hurt, that I occupy a place and that I can not in any case escape from the space in which I am without defence – in short, that I *am seen*” (Sartre, 2003, p282).

In being seen, the body no longer presents as a locus of possibilities, extending out from the body to the world, but instead appears as *something* that may block possibilities: There is a “solidification and alienation of my own possibilities” (Sartre, 2003, p286) as I see myself through the eyes of the Other. I appear as an object, arranged with other objects around me according to the projects of the Other:

For the Other *I am seated as this inkwell is on the table*; for the Other, *I am leaning over the keyhole as this tree is bent by this wind*. Thus for the Other I have stripped myself of my transcendence.

(Sartre, 2003, p286)

As such, my own network of possibilities is taken over by the Other’s, my projects fading as I am objectified.

Whilst this view must surely be seen as too extreme for a description of ordinary encounters with other people, it does seem to accurately characterise the feeling of ‘being seen’ that occurs in our experiences of shame. In such situations a person feels the judgemental eyes of another person on him - he is revealed as “vulnerable”, “awkward”, “artificial”, or “unseemly”, and

experiences a “corporealization” of the lived body as he internalises the gaze of the Other (Fuchs, 2003, p227). The shamed person experiences his body as obvious or clumsy, seeming to further attract the objectifying gaze of the Other. The familiar ways of responding to shame, such as looking down, socially withdrawing, covering up the body, or putting on an exaggerated act, can all then be seen as attempts to avoid or hide from the Other’s gaze.

The Body in Depression

As we have seen, those with depression often comment on an alteration in their experience of the body. Fuchs suggests that this alteration is best understood as a “corporealization” of the Lived Body (e.g. 2003; 2005a; 2013b), where the body loses its everyday transparency, and instead presents itself as painfully present and object-like. As in the case of shame, the depressed person internalises the gaze of the other, taking on the “devaluating gaze or voice which corporealizes the lived body” (Fuchs, 2003, p240). However, it is suggested that whilst the shamed person may adopt another perspective, a “metaperspective” on the situation in order to overcome the Other’s gaze, the depressed person is incapable of such a move (Fuchs, 2003). The depressed person, therefore, remains in a state of corporealization, an experience characterised by restriction and rigidity. As Fuchs explains, “the lived body loses the lightness, fluidity and mobility of a medium and turns into a heavy, solid body which puts up resistance to all intentions and impulses directed towards the world” (2013b, p226). In contrast with the engaged and transparent body of the everyday, the depressed person loses his engagement with the world as the body becomes conspicuous.

The Corporealization of the Lived Body

“Melancholia” Fuchs writes, “may be regarded as a “stasis”, a freezing or rigidity of the lived-body” (2003, p237). He suggests that as the depressed

person internalises the gaze of the Other the body loses its transparency and becomes object-like – “By the gaze and the voice of the other, primordial bodiliness receives a rupture which never wholly heals again” (2003, p240). The restriction that is experienced causes the body to lose its ease of movement and take on a rigidity that is “clearly visible in the gaze, the face or gestures” (2003, p238). This oppression may be experienced as a slowing down of the body coupled with feelings of pressure, tension, or weight. The body “regain[s] its materiality and turn[s] into an obstacle” (Fuchs, 2005a, p96), thus becoming a painful, dense, and heavy ‘thing’ that the person ‘has’, rather than that which is lived through.

Descriptions of the body as heavy, painful, and object-like are, indeed, exactly what we find in first person accounts of depression. John O’Donogue writes, “I feel like I have become an object, that I have turned to wood, that I’m mired in my own inertia” (2009, p47). Lizzie Simon similarly talks of alterations in bodily experience during a period of depression: “By that point I was a slug, and my dad led my sluggish body to the car” (2003, p14). William Styron, in a quotation that’s strikingly reminiscent of Sartre’s description of the body under the gaze of the Other, explains that he experienced his body as having “an odd fragility – as if my body had actually become frail, hypersensitive and somehow clumsy, lacking normal coordination...Nothing felt quite right with my corporeal self” (2004, p43). Perhaps unsurprisingly, given this description of his body, Styron goes on to discuss the link he experienced between depression and hypochondria. Given that many descriptions of depression contain bodily experiences similar to those in somatic illnesses, this tendency towards hypochondria is understandable. As Fuchs explains, with the body demanding constant focus, the depressed person may “become preoccupied with bodily malfunctions or possible diseases” (2005a, p99). This is also seen in responses to the Durham Depression Questionnaire. For example, one respondent described her bodily experience in the following way: “I notice small aches and pains

more and also feel nauseous and have an undefineable [sic] feeling of being unwell" (#352). Another writes, "it felt as though something 'wasn't quite right' in that I generally felt under the weather. It felt as though I was always coming down with a cold in that I felt 'below par'" (#334).⁵

It may also be possible to interpret some of the more evaluative claims about bodily experience in light of this corporealization. Questionnaire respondents frequently described negative attitudes towards their bodies. For example, one wrote: "You look at youre [sic] body and it looks disgusting, you hate it" (#112). Another wrote, "heavy, slow, big, ugly, hidious [sic], painful" (#326). Many described their bodies as "fat" or "overweight". If the bodily phenomenology outlined in this chapter is correct, then these descriptions are unsurprising. The body has become object-like, a 'thing' to look at and to assess. As such, we would expect a depressed person to evaluate her body – whether positively or negatively – more often than a non-depressed person might. The non-depressed person would, in most situations, have her attention directed outwards towards the world, rather than focusing back upon the body. As such, she would only apprehend the body as a thing-to-be-evaluated in certain circumstances, such as in sickness, when looking in the mirror, or when the body fails to carry out a task in some way.

The depressed person's experience of this object-like body is of something that is too large and heavy; she has a constant feeling of oppression and restriction. Having lost the potential for action, the body appears as corpse-like, with a diminished capacity for a perceiving access onto the world. It causes pain, is clumsy and awkward, and requires constant monitoring. To 'hate' such an object, or to be embarrassed or ashamed of it, seems not to be an unreasonable response to such an alteration. A description of the body as 'fat' or 'ugly' is,

⁵ For discussion of the comparative phenomenology of depression and somatic illness see Ratcliffe et al. (2013).

again, unsurprising, especially given the contemporary Western cultural and societal emphasis put on weight and attractiveness. The prominence of these as evaluative categories means we might expect evaluation on their basis. The descriptive term chosen – ‘fat’ – is, given current cultural norms, an easy way to communicate the experience of the body as ‘too heavy’, ‘object-like’, and something that ‘takes up too much space’.⁶

As we have seen, those with depression also commonly describe their bodies as “disgusting” or “grotesque”. David Lovelace writes, “I stopped bathing. My body disgusted me” (2010, p119). Our propensity to be disgusted by death and decay, or “life turning towards death” (Korsmeyer, 2011, p36), may, in part, be able to explain such a reaction.⁷ The depressed body is corpse-like in its presentation – restricted to its corporeal features, reduced to a mere mass of flesh, providing limited access onto the world. As one questionnaire respondent put it, the body is “really old dead fat” (#199). It does not seem to be much of a stretch to suppose that this corpse-like mass would elicit a disgust reaction in many with depression.⁸

Experiences of the World in Depression

The intimate link between our experiences of the body and our experiences of the world suggest that such a corporealization would impact both areas of experience. Those with depression frequently describe, in combination with an

⁶ For a further discussion of how the experience of the body as object-like may lead to a description of it as ‘fat’ see Bowden (2012).

⁷ The link between death, decay and disgust is far from universally accepted (See chapter one in Korsmeyer, 2011 for a discussion of common theories of disgust). However, even if we do not wish to accept that *all* disgusting things are “pregnant with death” (Kolnai, 1929, quoted in Korsmeyer, 2011, p36), it seems relatively uncontroversial to suggest that in western society a confrontation with a corpse would prove to be disgusting for many.

⁸ This perception of the depressed body as something that is dying or corpse-like can be seen in its most extreme form in cases of Cotard’s delusion. In these cases, it is argued that the severely depressed person comes to interpret alterations in the experience of the body and the world as evidence that he is dead. See, for example, Fuchs (2003; 2013b).

alteration in the experience of the body, an alteration in their experience of the world. This change in world experience includes an increased difficulty interacting with or carrying out tasks within the world. For example, one questionnaire respondent wrote:

Often, the world feels as though it is a very long way away and that it takes an enormous amount of effort to engage with the world and your own life...A feeling of exhaustion often prevented me from being able to interact with the world, adding to the inability to process what was going on around me. (#17)

Another explained:

The most basic tasks can seem insurmountable, as though washing up is suddenly the equivalent of scaling the empire state building. (#118)

Whilst I do not wish to say that these experiences are wholly attributable to alterations in bodily experience, it does seem that the way the body is experienced in depression would have a significant effect on the experience of the world more generally, and may be able to begin to explain some of the descriptions given by those with depression regarding world-experience. As we saw in the case of shame, it has been suggested that when the body shows itself as object-like there is a resultant loss of experienced possibilities. This loss may be characterised in two key ways: Through the resistance to action, and through the loss of the perception of possibilities. In this way we see the person's ability to act within the world altered, as well as his perception of it.

In order to highlight the ways in which the slow, heavy, cumbersome body in depression impacts on the person's interaction with the world, we might draw a comparison with the way the world is experienced during periods of exhaustion or illness. Indeed, one questionnaire respondent does exactly this in order to attempt to describe her experience of carrying out everyday tasks

when depressed: “It's harder because my body feels heavy and I feel tired so it's sort of like trying to do things when you have a bad cold” (#235).⁹

In many cases of illness everyday tasks become more difficult to carry out. The ill body puts up resistance, blocking potential action. The task itself is revealed to the person as challenging, difficult, or impossible; the objects associated with the task stand out not as tools with which to complete it, but rather unconnected objects, or even obstacles, that no longer serve the purposes they once did. There is, therefore, not only an alteration in how the body is perceived – as something that cannot act – but also in how the *world* is perceived – as confusing, troubling, or exhausting. If you think of how a flight of stairs presents itself when you're standing at the bottom of them suffering with a bad cold, your limbs heavy and your balance unsteady, you can begin to see just how much our experiences of our bodies affect our experiences of the world more generally. When healthy (and physically fit and able), the staircase is barely noticed; it is simply a means of getting quickly to another floor. When ill, however, it transforms into a challenge; something that is *preventing* access to the floor above - it looms above, standing out as part of an 'impossible' task. The alteration in bodily experience therefore impacts both on the person's ability to climb the stairs as well as altering the person's experience of the staircase itself.

A similar experience occurs in depression, with the heavy, object-like body preventing ease of interaction with the world, much as the ill body does. Everyday tasks become more difficult as the body has to be consciously observed and moved, rather than the usual experience of acting through the body whilst focusing on the task itself. As Fuchs explains, “Corporealization

⁹ It is interesting to note the frequency with which respondents referred to experiences of the body even in response to questions that were not directly enquiring about bodily experience. The quotation above was responding to the question, “How does depression affect your ability to perform routine tasks and other everyday activities?”

thus means that the body does not give access to the world any more, but stands in the way as an insistent and vexing obstacle" (2003, p238). Objects in the world would, much as in the case of illness, stand out as part of impossible or difficult tasks. Given this difficulty interacting with the world, it seems understandable that many describe their depressed experience of world as a place that is exhausting and more difficult to negotiate, filled with tasks that stand out as being beyond the capabilities of the person. As one questionnaire respondent describes, "Everything seems harder and needs more energy than usual - just having a shower can feel like a huge task" (#147).

However, alterations in the experience of the body may also affect the person's experience of the world in a more fundamental way. Our bodies, we have seen, provide a network of salience through which we interact with the world. It is through our embodiment that we come to experience the practical possibilities an object holds. With an alteration of this embodiment, the body may no longer project meaningful possibilities onto the world, and so the depressed person may begin to not only find interacting with the world more difficult, but may actively perceive the world in a *different* way. Fuchs describes a loss of the "*conative dimension* of the body" (2005a, p99) – that which "opens up the peripersonal space as a realm of possibilities, "affordances", and goals for action" (2005a, p99). We would expect the depressed person to view objects differently, no longer containing the same everyday potential for action. The coffee cup may no longer be perceived as containing the possibility of my holding it, smashing it, filling it with coffee, or drinking out of it. Instead, it may take on a peculiar quality of an object without possibilities, or with diminished possibilities. The depressed person encounters a feeling of absence in the objects and the world more generally, a felt awareness of what has been lost from experience: "It is conspicuous, a very real part of the experience; there is a painful awareness of the loss of feeling" (Ratcliffe, 2009, p230). The body thus becomes not only something that stands in the way of carrying out

everyday tasks, but through its alteration it may contribute to a felt loss of possibilities.

This deeper loss of possibilities is, indeed, described as occurring in severe cases of depression. In such situations it is not that carrying out everyday tasks simply becomes harder or more exhausting, we can see instead that the very possibility of the task is no longer available to the person. As 'James' describes in his interview with Gail Hornstein:

It was as if the whatness of each thing – I'm no good at philosophical vocabulary – but the essence of each thing in the sense of the tableness of the table or the chairness of the chair or the flooriness of the floor was gone. There was a mute and indifferent object in that place. Its availability to human living, to human dwelling in the world was drained out of it...It became impossible to reach anything. Like, how do I get up and walk to that chair if the essential thing that we mean by chair, something that lets us sit down and rest or upholds us as we read a book, something that shares our life in that way, has lost the quality of being able to do that? (Hornstein, 2009, p213)

Evaluative comments may, again, be better understood in light of our understanding of the impact of alterations in bodily experience. Along with descriptions of the body as fat and grotesque, we equally find frequent reference to the body as "pointless" or "useless": "It feels fat and useless" (#110), one questionnaire respondent writes. Another describes the body as "Heavy, tired, useless" (#311). Such evaluative comments seem un-mysterious when considered in the context of a body that both puts up resistance to the carrying out of tasks, as well as one that fails to highlight meaningful practical possibilities in the world. A body that does not allow the person to carry out potential actions, and one that no longer fulfills the role of highlighting possibilities in the world does, indeed, seem not to be as 'useful' as the non-depressed body. The frustration felt by those with depression towards their bodies seems to be an understandable response to this alteration in experience.

This alteration may also be thought to contribute to the experience of separation or distancing that many with depression report. A world which offers no opportunities for interaction, with little highlighted as salient or indeed possible, may indeed be experienced as 'far away' or 'inaccessible'. Descriptions common in memoirs of depression describing a separation from the world – such as looking at it through a glass window, or through a bubble, may be thought to be describing this kind of experience. As the person cannot act in the world in his usual way, he does not feel that he is 'in' the world in the same way. When this is coupled with an experience of the body as something that puts up constant resistance, blocking possibilities, this experience of separation may be heightened. A loss of connection with the world seems somewhat inevitable if the world no longer offers possibilities for interaction.¹⁰

We can, therefore, see the centrality of the body in experiences of depression. Some form of alteration in bodily experience appears to occur in almost all depressive episodes. This alteration may be described as a 'corporealization' or 'reification' of the lived body, in which the body ceases to be that which is lived through, and instead becomes painfully object-like, putting up resistance and blocking activity. This corporealization, we have seen, also impacts on the depressed person's experience of the world. Everyday tasks appear as more difficult, and in severe cases the person may experience a diminishment or even loss of possibilities. These changes may help to account for evaluative comments made about the body, including descriptions of the body as "fat", "disgusting", and "useless". Finally, we have seen how this range of alterations in experiences of the body and the world may lead to feelings of distance and separation.

¹⁰ Thomas Fuchs (2013b) also suggests that the corporealization of the body can negatively affect the person's interaction with other people. If Fuchs is correct, it seems likely that this social separation would contribute to feelings of distance and separation more generally.

The Body in Mania

The manic person, unlike the depressed person, is very active within the world. During an episode of mania it is common for the person to find herself with endless energy, a reduced need for sleep, and increased productivity. Those in manic states will often take on ambitious tasks, or a large number of projects. Whilst the depressed person's experience may be characterised by feelings of impossibility, the manic person's experience is one of endless *possibility*. As Patty Duke writes in her memoir of bipolar disorder, "When I'm manic, I just don't think rationally. Anything I want to do is possible" (Duke and Hochman, 1992, p37). Kay Redfield Jamison provides a strikingly similar description, "I felt I could do anything, that no task was too difficult" (1997, p36). The manic person perceives objects as containing a wealth of possibilities that in many cases are highlighted not only as containing the *potential* for action, but as *demanding* action or use. Everyday objects may seem not to be restricted to their usual uses, but rather are open to a range of imaginative possibilities. Whilst there may be a neglect of everyday tasks, we find that this has less to do with the sense of impossibility and exhaustion that the depressed person experiences, and more due to a feeling of the relative unimportance of such mundane activities. Marya Hornbacher recalls the following exchange between herself, her husband, and her psychiatrist:

"...How much is she working?" Lentz asks Jeff.

"All the time. She even works when someone's talking to her. She won't change her clothes because she says it would interrupt her 'things.'"

"I wrote fifty pages yesterday," I tell him, quite smug.

"Good for you. Are you eating?" Lentz asks.

"She's not eating," Jeff says. (2008, p263)

The manic person still experiences a world in which everyday tasks can be carried out with ease, though often she may choose not to complete them.

This degree of energy and activity within the world contrasts with the depressed person's experience of restriction, distance, and impossibility. We might, therefore, initially assume that the manic person's experience of the body would be markedly different from the depressed person's experience. Fuchs describes an opposition between the inactive object-like body that we see in depression, and the active, inconspicuous body. He explains:

Primordial or lived bodiliness is a constant outward movement, directed to the environment from a hidden center, and participating in the world. Corporeality appears whenever this movement is paralysed or stopped, when the lived body is thrown back on itself, reified or "corporealized". (2003, p225)

Motivated by such a distinction, we might expect that in opposition to the heavy and object-like body of depression, the manic body would take on an increased degree of transparency, fading further into the background as a 'hidden centre' as the person is caught up in the completion of tasks. The more active the person becomes, the more we would expect the body to fade out of conscious awareness.

There are hints of this kind of understanding in some first person accounts: John O'Donoghue describes feeling "loose, disconnected, as if I'm made of mercury, of quicksilver" (2009, p47). The manic body, we might expect, would be light and unnoticeable, allowing access onto the world, but not forming part of the person's conscious awareness. The constant activity, the ease of movement and the increased perception of possibilities may be thought to point to an invisible body that never 'stands in the way' of activity.

Such an understanding of the manic body might be thought to explain the increase in possibilities that occur in mania. With the body losing its experienced materiality, it may no longer provide limitations on possible action. As such, the manic person would experience all practical activities as possible.

I judge a hill as 'too steep to climb' because of my awareness of my body and its inability to climb steep hills. However, if the manic person does not have this awareness of the limitations of his body – if his focus is always on the world and the potential for action, rather than the body itself – then the hill may not be seen to hold that same restriction. The transparency of the body, therefore, may be thought to result in an increase in the amount of activities that are experienced as possible for the manic person.

Such a diminished awareness of the body may also be thought to account for the apparent loss of fear or concern for consequences that occurs during episodes of mania. The manic person may engage in high-risk activities without worrying about the potential negative outcomes that may occur. Examples of these activities include driving very fast or walking down a street known to be dangerous. Terri Cheney describes, during one episode of mania, climbing past a sign reading "Do Not Enter. Danger. Riptide" in order to go for a midnight swim in the ocean (2008, p108). Using the understanding of the manic body proposed above, we might suggest that the manic person engages in these kinds of activities because he has lost the awareness of the fragility of the body. Without the awareness that he *is* a body, that his body can be harmed or damaged, activities that carry a high risk of bodily injury would not necessarily stand out as dangerous. With the focus entirely on the activity or final aim of the task, the potential consequences to the body may seem to fade away. The manic person, therefore, would not necessarily perceive the danger in what are objectively dangerous situations.

Whilst such an understanding is an intuitively plausible description of the body in mania, we must reject it as false. The consequences we would wish to draw from such an understanding, such as the increase in possibilities and decrease in awareness of threat and danger, do not hold up to philosophical examination. Just as crucially, however, we find that first person accounts of the

bodily experience of mania contradict this understanding of the body as fading out of conscious awareness.

Firstly, it does not seem obvious that it is possible for the body to lose sufficient materiality in order to no longer pose a limitation on possibilities, whilst still retaining enough materiality to open up practical possibilities in the world. Whilst it is true that the body provides a degree of limitation on possibilities – I perceive certain actions as impossible because of my awareness of the way my body is – the body is also that through which things first appear as possible. A cup only contains the practical possibility of my picking it up because I am aware that I have arms and hands and fingers that can carry out the requisite actions. In most everyday situations the body takes on a degree of transparency, but retains enough materiality to structure practical possibilities in the world – the body is not wholly invisible. If there were to be a greater degree of transparency, as might be suggested occurs in the case of mania, then it is questionable as to whether the body would still be able to provide this necessary structuring. As such, we might expect there to be a *contraction* in experienced possibilities, rather than an increase.

The same criticism can be levelled at the suggestion that an overly-transparent body would lead to a loss of the perception of activities as dangerous. Whilst such an experience may lessen the perceived danger of the activity, it seems likely that the decrease in the experienced materiality of the body would equally prevent some actions as being highlighted as possible at all. It can also be seen that an understanding of the manic person undertaking activities that pose a high degree of risk to the body is too narrow an understanding of the types of high-risk activities that are common in mania. Whilst some manic people do drive too quickly, walk down streets known to be dangerous, or swim in risky areas of the ocean, others spend large amounts of money or engage in unwise business transactions. As one person describes, “I had six

hundred dollars in overdraft charges, in *overdraft* charges – that’s not counting the amount that the check was for” (Simon, 2003, p106). As we can see, not all high-risk activities undertaken whilst manic involve physical risk – gambling large amounts of money on the stock market is certainly risky, but it is not obvious that it poses any direct risk to the person’s physical wellbeing. As such, this picture of involvement in high-risk activities resulting from an increased degree of bodily transparency must, at the very least, be seen to be incomplete.

However, even if valid responses to these criticisms can be found,¹¹ we must still reject this understanding of the body in mania. The clearest indication that this view is inaccurate is that it does not match the descriptions given by those with bipolar disorder. Far from the transparent body described above, first person accounts describe the manic body as overly-present, hyper-sensitive, and as standing out as something that is ‘seen’ by others. Cheney describes her experience of her body as she took a bath whilst manic: “the pressure of the warm, soapy water against my skin was unbearable” (2008, p204). Later, she again describes this overly-sensitive, present, body – “The satin sheets felt like sandpaper against my flesh” (2008, p205). Not only is Cheney aware of her body, she is *excessively* aware of it. In situations where the body would normally fade into the background, we see that in mania the person’s focus and attention is *still* drawn to the body. The manic person remains acutely aware of how the world may affect or be experienced by the body: “Everything is tactile, the taste of wine, the feel of the excellent fabric, the heel of the fabulous shoe, the thrum of the road under the wheels of the car” (Hornbacher, 2008, p99).

The manic person is not only aware of how the body feels or how it can act, but also how it looks. The body is, much as in the case of depression, ‘seen’. However, in contrast to the experience of the body in depression, in mania this

¹¹ We might, for example, suggest that the body does not become more transparent, but is simply transparent in more situations.

process of being seen is not always unpleasant. Whilst the experience of the manic body is frequently distressing – reports of being overwhelmed by sensations are common – the manic person is not normally ashamed or disgusted by the body, rather flaunting it, seeking out the gaze of the Other. This awareness of the object-like status of the body can be seen through the attention-grabbing manner of dressing that is common during episodes of mania. Kay Redfield Jamison describes dressing in a “remarkably provocative way” (1997, p71) when manic. She explains, “My normal Brooks Brothers conservatism would go by the board; my hemlines would go up, my neckline down, and I would enjoy the sensuality of my youth” (1997, p42). The manic person is aware of her body as an object for both her and others. It has not faded away or become transparent, but rather stands at the forefront of the person’s attention, as a conspicuous object to be ‘seen’.

Despite this retention of materiality, the manic person does not appear to experience the rigidity or weight that is common in depressed experiences. Whilst the body is conspicuous, the world, for the manic person, still contains a wealth of practical possibilities. The body does not ‘stand in the way’ of tasks as an obstacle to be overcome, as the depressed body does. The manic body may be insistent in its materiality, but it does not lose its fluidity of movement, nor its ability to carry out tasks.

This engaged but still conspicuous body provides a challenge to Fuchs’s implied distinction between the active and invisible body, and the inactive and conspicuous body. “The body”, Fuchs writes, “oscillates in the polarity of being unnoticed or conspicuous, of automatic performance or interfering resistance, of being subject or object, being lived or being had” (2003, p225). This link between action in the world and the invisibility of the body would lead us to expect the manic body to take on a greater degree of transparency. Our thinking might go as follows: If the manic body were to be object-like, we would expect

it to block potential action. As it does not block action, it must be 'hidden'. However, as I have shown, this understanding of the manic body is not accurate. The manic body *is* conspicuous, often to a distressing degree, and yet it is still active in the world – it still highlights potential action. That this could be the case suggests that the link between activity and invisibility is not as close as Fuchs seems to suggest.

The manic body, therefore, can be seen to raise an interesting challenge for the phenomenologist. How are we to understand this overly obvious, 'seen', body that does not result in an experience of restriction or rigidity, but rather is experienced as "loose" and "disconnected"? Why is the manic body so conspicuous when our intuitions suggest that it ought to be hidden? Furthermore, how are we to understand the restriction in depression, given that the experience of the body as conspicuous does not always result in a contraction of experienced possibilities? We can summarise these concerns in two key questions regarding the bodily experience of mania and depression:

1. How can the manic body be active in the world and yet not fade from explicit awareness?
2. Why is the depressed body both conspicuous and inactive, when we have a clear example of a conspicuous body that does not prevent action in the case of mania?

One potential answer, I suggest, lies in the way in which time is experienced during episodes of mania and depression. It is, therefore, to the issue of time that we should now turn our attention. Through this discussion I show how we can deepen our understanding of both mania and depression, building a richer account of the bodily experiences of the two states.

Chapter 5: Experiences of Time in Mania and Depression

Introduction

First person accounts of mania and depression frequently highlight the occurrence of alterations in temporal experience during both states. When respondents to the Durham Depression Questionnaire were asked the question, “When you are depressed, does time seem different to you? If so, how?”, they described a variety of different experiences of time. Although a few stated that they experienced no change – by answering, for example, “No it doesn’t” (#105) and “I personally don’t feel that time seems different to me, when I am depressed” (#20) – most described changes in both shorter and longer-term experiences of time.

One of the most common descriptions was of time seeming to slow down when depressed. For example:

It goes slower, it drags. Occasionally [sic] I just loose [sic] chunks of time. (#8)

Time slows down and I feel like that bad feelings will last forever. (#147)

Time seems to go very slowly. (#292)

Others described the loss of the significance of time, or an inability to keep track of time:

Time is immaterial to me during a depressional [sic] episode. I loose [sic] track of time. I wonder what I’ve done all day when the children suddenly burst through the door from school. Time has gone by, but I

have done nothing, even to think one thought seems to have taken all day.... (#117)

I don't tend to have any track of time when I'm depressed. My wife writes me lists so I remember to do things at certain times. When not depressed I am very punctual, and always know what needs doing and when. (#157)

When I am depressed I don't seem to notice time, it just doesn't matter to me, it all seems to blend in to a mass of nothing. I always wear a watch, to try when things are bad to try and regulate my days into some sort of order, but i [sic] never seem able to manage it. Time loses significance. (#54)

In cases of mania, we can also see an alteration in temporal experience. Terri Cheney, for example, describes how "Tomorrow meant nothing to me" (2008, p179). Marya Hornbacher writes, "We walk in circles for weeks, or minutes, or years. Time has escaped me" (2008, p119). In contrast to the descriptions we see in cases of depression, she also describes "rac[ing] through the hours" (2008, p100). Kay Redfield Jamison describes a similar experience, writing that her "life and mind were going at an ever faster and faster clip" (1997, p68).

From these descriptions it seems clear that alterations in temporal experience occur during episodes of mania and depression. These changes are described as involving the speed of time, the relevance of time, fragmentation of time, and the existence of time. In this chapter I begin to explore these various temporal experiences. I look at both the experience of time itself, as well as how these alterations in temporal experience can impact upon other aspects of experience, thus aiding our understanding of common features of mania and depression.

I begin by discussing the distinction between objective and subjective time, before moving on to discuss subjective time in more detail. I show how basic accounts of the temporal experience of mania and depression can be enhanced by an appreciation of the distinction between implicit and explicit time, as well as the role of the intersubjective. Through this I explore common experiences in

depression, such as a loss of the appreciation of the possibility of recovery and intense feelings of irrevocable guilt. I argue that an understanding of the temporal experience of mania as 'time speeding up' is inadequate, and provide an alternative account using the work of Husserl to suggest that there is a disruption in temporal synthesis during manic episodes. This account allows us to understand a wide variety of experiences that are common in manic states, including an inability to reflect upon the self and action, a lack of engagement with the world, a fragmentation of time, and a diminished sense of ownership of actions.

Objective and Subjective Time

Recent literature has focussed on the distinction between objective time, and subjective or 'lived' time. Objective time can be defined as 'clock' time, the time it takes in seconds, minutes, or hours for something to happen. Subjective time is time as it is experienced by the person. For example, if you're in a boring meeting, time may appear to go slowly relative to the actual rate of objective time. When spending time with a loved one, it might seem to go quickly in comparison.

This distinction allows us to construct a basic account of the temporal experience of mania and depression. It has been suggested that in cases of depression time appears subjectively to slow down in contrast to objective time (e.g. Kitamura and Kumar, 1982) and that in mania it is experienced as speeding up. Vogeley and Kupke state that "Non-psychotic affective disorders seem to present a systematic change of velocity: acceleration (mania) or deceleration (depression) of time experience, with the basic temporal structure being preserved" (2007, p162). This understanding of the temporal experience of mania and depression seems to be supported by psychological studies showing that people who are depressed report a slowed experience of time, and those who are manic report an accelerated experience (Bschor et al., 2004).

When asked to estimate elapsed time periods, people with depression will tend to over-estimate both long and short intervals (Bschor et al., 2004; Kitamura and Kumar, 1982).

This alteration in temporal experience is also backed up by first person accounts. Andrew Solomon, for example, writes, "Depression minutes are like dog years, based on some artificial notion of time" (Solomon, 2002, p52). Respondents to the Durham Depression Questionnaire also reported similar experiences of a slowing of subjective time during depressed episodes:

'Time seems to drag. A day feels like a year.' (#26)

'Time goes so slowly when I'm depressed. Painfully slow.' (#14)

In cases of mania, first person accounts also seem to suggest an alteration in subjective temporal velocity. Emma Forrest writes in her memoir of bipolar disorder that "Mania flows like a river approaching a waterfall. Depression is a stagnant lake" (2011, p29). Hornbacher also describes experiences of time seeming to speed up during manic episodes: "I can't deal with it...It's too much. It's going too fast." (2008, p109). Responses to the Durham Depression Questionnaire again support this understanding of temporal experience. One respondent who had been diagnosed with bipolar disorder described her experience in the following way: "the hours seem to drag on...but sleep cures that. total reverse in mania...no sleep at all and ti[m]e flies" (#269).

These first person accounts, combined with the psychological studies, suggest that some kind of change in temporal experience occurs during episodes of mania and depression. However, describing these experiences as a simple 'speeding up' or 'slowing down' of subjective time does not adequately account for the full range of temporal experiences that occur within these states. First person accounts of mania do not simply describe experiences of time speeding up. We also find descriptions of altered experiences of the past, present and

future; and of time becoming irrelevant, fragmented, or losing meaning. Jamison, for example, writes of a manic episode: "Of course, I had no notion of time" (1997, p83). Cheney, similarly, describes alterations in temporal experience: "When I'm manic, all I remember is the moment" (2008, p2).

The psychological studies, similarly, do not provide clear support for the view that time is simply experienced as passing more quickly in cases of mania. Although people do describe time as seeming to speed up during manic episodes, time-estimation tests suggest a more complex experience. Whilst we would expect people who are manic to under-estimate elapsed periods of time – estimating that a shorter period of time had passed in contrast to the actual period - this is not seen in all or even a majority of results. Like those with depression and schizophrenia, those in manic states also tend to over-estimate elapsed periods of time (Bschor et al., 2004; Tysk, 1984). These psychological studies seem not to point towards a simple 'speeding up' of time, but something richer and more complex.

Equally, we see that a description of the temporal experience of depression as being a simple 'slowing down' of subjective time fails to take into account the variety of experiences commonly described in first person accounts. Along with descriptions of time slowing down, there are also reports of time losing meaning or becoming irrelevant, of it seeming to stop altogether, and of alterations in how the person relates to the past and future.

Whilst the distinction between subjective and objective time therefore allows us to construct a very basic account of the temporal experiences in mania and depression, we can see that a richer account is needed in order to provide a full description of the experience. In order to develop such an account, we first need to look more closely at the structure of the subjective experience of time.

Subjective Time

Subjective time is time as the person himself experiences it. Thomas Fuchs introduces the helpful distinction in experiences of subjective time between “Explicit Time” and “Implicit Time” (e.g. 2005b; 2013a). Explicit time is the flow of time as it is consciously experienced. For example, we might point to the awareness of time when running late for a meeting, or when waiting for a delayed bus to arrive. Fuchs suggests that time becomes explicit when “a gap arises between need and satisfaction, desire and fulfillment, or plan and execution” (2005b, p195).

In contrast, we do not consciously observe implicit time – it instead passes as we are engaged in activities; it “runs with the movement of life” (Fuchs, 2005b, p195). Fuchs uses the example of a child playing with toys, but any time we’re wholly engaged in carrying out a task would equally demonstrate the experience. Time unfolds, but the child is not explicitly concentrating on the passage of time. Instead, time is “pre-reflectively lived” (Fuchs, 2013a, p77). Fuchs points to two preconditions for this implicit, lived, time: *Conation* and *temporal synthesis*.

Conation may be described as the “basic “energetic” momentum of mental life...expressed by concepts such as drive, striving, urge or affection” (Fuchs, 2013a, p78).¹ It is the orientation towards the future, drawing us in to meaningful action and giving energy and forward movement to our temporal experiences. Matthew Ratcliffe suggests that this conative drive “does not have a purely internal phenomenology; it manifests itself as a subset of the world’s possibilities” (2012a, p119). Through conation there is a form of practical allure – we find possibilities within the world to be enticing in various ways. The world, it seems, draws us in towards both perceptual and practical possibilities.

¹ Matthew Ratcliffe (2012a) notes similarities between this concept and Eugene Minkowski’s (1970) “elan vital” and Erwin Straus’s (1947) state of “becoming”.

We might, therefore define conation as a future-directed drive that draws us in to possible action.

This conative drive is combined with a basic synthesis of temporality. Here Fuchs appeals to the Husserlian analysis of the continuity of inner time consciousness.

Husserl on Time

It is often thought that we experience time as a series of moments – a constant progression of ‘Nows’. Instant a, b, and c following on from each other, separate from that which has gone before. Husserl sought to understand how it is that we can experience continuity through time, through these moments. This refers both to the continuity of objects and of the self. He suggests that our feelings of continuity do not make sense when we think of time as being merely a series of Nows. Instead, he proposes a tripartite structure of temporal consciousness that allows us to experience this sense of continuity and unification (e.g. Husserl, 1991).

Husserl terms our initial consciousness of the present Now the ‘primal impression’. Within the current temporal phase – that which we are currently experiencing – we do not only have awareness of the Now, but also experience the ‘retention’ of the just-past and the ‘protention’ of what will immediately follow. Husserl describes this as “the living horizon of the now” (1991, p45). As such, moving through time we experience a degree of continuity, through our retention and protention. We are aware of the current Now being after the prior Now and before the next, due to our retention of that prior Now – and our

protention of the Now-to-come.² The popular example of a melody may help to illustrate this: When we hear the note 'E' in the tune, we also have an experience of the note 'D' that came before it – experiencing it *as* past. Husserl writes, “it is actually present itself (but not an actually present tone), it is a retention *of* the tone that has been” (1991, p31). Similarly, we have an experience of the note that will come next – 'F'. Our protention need not be as specific as 'F' follows 'E', but rather merely that *something* will follow 'E'. If we consider our surprise when a melody suddenly stops short, we can begin to understand how intuitive this tripartite understanding is. In this way, we hear a unified melody, rather than merely a series of individual notes. We can therefore see how our retention of the immediate past and the protention of the immediate future allows for a unification of our temporal experiences.

The retentional-protentional structure underlies our feeling of continuity in our pre-reflective experience of time. The conative drive adds momentum to this structure, resulting in an implicit, pre-reflective experience of time as future-directed and unified.

Intersubjective Time

Philosophers such as Fuchs (2013a) and Martin Wyllie (2005) have stressed the importance of the intersubjective in implicit and explicit experiences of subjective time. We find that our experience of time is synchronized with those around us, a “lived synchronization” as Minkowski puts it (1970, p65, quoted in Wyllie, 2005, p177). This can be seen not only in our shared methods of measuring periods of time, becoming attuned with one another through the passage of a day, a calendar month, or the celebration of annual holidays, but

² It is important that we note that the retention and protention occur at the same time as the primal impression – retention is a *present* experience of the immediately past as past, rather than being part of that past. This does not, however, mean that the person experiences the events as occurring concurrently – what is retained is the immediate past *as* past, rather than the past *as* present.

also through a more basic sense of being ““in tune” with the time of others” (Wyllie, 2005, p177). This feeling of being “in tune” with others is experienced through our “simultaneous referral to the world” (Fuchs, 2013a, p82) – through shared attention, projects, and actions.

The importance of intersubjective time is particularly highlighted when there is a *desynchronization* between the subjective and the intersubjective. A somewhat everyday example is the experience of boredom, where one finds a “stagnation of one’s personal lived time against the dynamic background of intersubjective time” (Wyllie, 2005, p178). This intersubjective domain becomes apparent if we imagine the experience of waiting for a delayed bus, wherein the individual experiences a subjective slowing of time as everyone around him hurries on with their tasks. Equally, we might point to the uncomfortable feeling of trying to catch up in a meeting when arriving late – highlighting the often distressing feeling of being out of synch with other people’s experiences of time.

This disruption to the lived synchronization of intersubjective time results in an experience of time as explicit. Whilst the person may previously have not been aware of the passing of time, when there is a desynchronization of the subjective and the intersubjective she will begin to be aware of, and focus on, the passing of time. Again, we might think of the experience of waiting for a delayed bus. We become more aware of the time that passes, feeling frustrated that we are not able to get on with our tasks or frequently checking a watch or clock.

Temporal Experiences in Depression

This more detailed description of subjective time allows us to construct a richer account of the experience of time in depression. It is suggested that during episodes of depression there are alterations in both subjective and intersubjective time (e.g. Fuchs, 2013a; Wyllie, 2005).

In cases of depression Fuchs suggests that there is a loss of conation whilst temporal synthesis – the underlying retentional-protentional structure – remains unaffected.³ This disruption of the future directed momentum manifests “in psychomotor inhibition, thought inhibition, and in a slow-down or standstill of lived time” (Fuchs, 2013a, p96). The depressed person therefore experiences difficulties in both thought and action, along with direct alterations to the experience of temporal progression. The playwright Sarah Kane describes this experience of thought inhibition in her play *4.48 Psychosis*, which is based on her experience of depression:⁴

tongue out
thought stalled

the piecemeal crumple of my mind. (2006, p23)

The individual experiences time as moving much more slowly, or even stopping altogether. This description is consistent with what we find in first person accounts. For example, one respondent to the questionnaire wrote of his temporal experience:

Time stops. Days last forever, especially evenings when tired but victim to insomnia. (#180)

This slowing of lived time results in a loss of synchrony between subjective and intersubjective experiences of time. The person not only experiences time as slowing down or stopping, he also experiences a feeling of ‘lagging behind’

³ This is often contrasted with the breakdown of temporal synthesis that is thought to occur in cases of schizophrenia (see, for example, Fuchs, 2013a). Sass and Pienkos summarise this position: “In schizophrenia, a mode of temporality (perhaps better, of *a*-temporality) that, together with collapse of protention and retention, loses all organization and meaning; in melancholia, a foundering of drive and associated projection of the self into the future, that leaves one dominated by the past, futility, and fatigue” (2013b, p141).

⁴ Kane committed suicide shortly after completing the play and before its publication or performance. I have retained Kane’s original formatting. We might wonder whether the fragmented structure similarly hints at this experience of thought having stalled.

others or of being out of synch with other people's temporal experiences. For example, one person described how she felt that she was "experiencing time much slower than others" (#169). These feelings of desynchronization contribute to more general feelings of distance or separation, both from individuals as well as from the shared world that we generally inhabit. It becomes increasingly difficult for the person to interact or engage with other people, the feeling of being 'out of step' with others heightening an already present experience of isolation. When asked whether other people seem different during periods of depression, one person wrote, "they seem far away hard to relate to them" (#80). Another wrote that she "feel[s] detached from them" (#228). Sally Brampton similarly writes in her memoir: "Depression feels like the most isolated place on earth. No wonder they call it a disease of loneliness" (2009, p1). H. Rachele Graham provides the following description of this experience of isolation:

I am at the bottom of a dark ocean with a hundred pounds of concrete on top of my body. My friends and family are snorkeling nearby. I can hear them call out to me, but I cannot see them. (2010, p3)

The frequency with which such descriptions appear both in narratives of depression as well as the questionnaire results highlights how common these alterations of interpersonal relations are in cases of depression. Changes in temporal experience contribute to and thus help us to understand such experiences.

Similarly to the case of boredom, this desynchronization of subjective and intersubjective time results in a reification of time. For the depressed person, time is explicit, heavy, or 'dead'. As Fuchs writes, "explicit time is experienced as a painful burden" (2013a, p97). The depressed person no longer implicitly lives time – like the child playing with her toys – but rather is explicitly aware of the progression of time or, more accurately, the lack of progression. Von

Gebattel quotes a depressed girl who can be seen to be having an extreme experience of time becoming explicit. She describes her experience in the following way:

As I am speaking to you, with every word I'm thinking 'past', 'past', 'past'...Water dripping is unbearable and it drives me mad, because I always have to think: Now another second has gone past, now another. (2012, p215)

As von Gebattel writes, this is a girl who "is compulsively, constantly, preoccupied with time" (2012, p216). Whilst most temporal experiences in depression are not this severe, we do find that there is a more general experience of time becoming explicit. This loss of the usual implicit temporal experience is felt painfully, the loss of synchrony and conative dynamism impacting not only on the person's experiences of the progression of time, but also her ability to relate and interact with others. In addition, we find that these alterations have implications for the person's experience of the past and future.

The experience of the future as open, a field of potential possibilities, requires an ability to project into that future. If we accept the account put forward by Fuchs we can see that the depressed person still has an intact experience of temporal synthesis and so maintains her protentional capacity – she can still anticipate the immediate future and so may be able to follow a piece of music or a conversation. However, with the loss of conation, we find that the depressed person no longer experiences a draw towards the future, and so can no longer project into it or experience it as open. Straus explains, "With a standstill of becoming, future is rendered inaccessible. We do not proceed anymore towards the future" (1947, p257). For the depressed person, the future no longer holds the possibility of progression or change. Instead, the future is blocked – there are no new possibilities available, only a static, unchanging, present that the person has no control over. One person described her experience in the

following way: “There is no hope for a better future. Everything feels inevitable, out of control and all attempts at anything are pointless” (#280).

The loss of conation prevents the person from being drawn into the future, and the future is therefore experienced as closed or blocked. The depressed person thus experiences an unchanging and eternal present over which she has minimal control – she cannot change things in the future. This account of temporal experience helps us to understand a common complaint in descriptions of depression – the loss of the belief that it is possible to ever recover from a depressive episode.

This feeling of the impossibility of recovery arises in most depression narratives. Brampton, for example, writes, “Nobody thinks they’ll ever get better. They think they’ll cry until eternity” (2009, p80). Solomon describes a similar experience in his memoir of depression:

When you are depressed, the past and future are absorbed entirely by the present moment, as in the world of a three year old. You cannot remember a time when you felt better, at least not clearly; and you certainly cannot imagine a future time when you will feel better.

(2002, p55)

Similar themes are echoed in responses to the Durham Depression Questionnaire. For example, one person wrote, “When depressed I feel I have no future and lose any hope in things improving in my life. I just feel generally hopeless” (#158). Another wrote, “There seemed to be no future, no possibility that I could ever be happy again or that life was worth living” (#160).

In light of our understanding of the depressed person’s loss of conation and subsequent disruption to the synchronization of intersubjective time, these descriptions ought not to surprise us. If the person no longer experiences the future as containing the possibility of meaningful change, then this would suggest that she could not envisage the possibility that she might not be

depressed in the future. As Wyllie explains, “The sufferer cannot project themselves into a future of events and there is therefore no sense of “things getting better”” (2005, p182). The closed future blocks off any possibility of recovery, and the depressed person instead experiences her depression as eternal.

The experience of a blocked future can be seen to have even further consequences for the depressed person. With this alteration of the experience of the future, we find that the person’s experiences of the past and the present are equally affected. One area in which we can see this change is in the increased frequency and intensity of feelings of guilt that occur in depression.

Depression and Guilt

Heightened feelings of guilt are common during episodes of depression.⁵ Ratcliffe (2010) notes that whilst these experiences of guilt are superficially similar to everyday experiences of guilt, we find that in severe depression there is often no specific object or incident to which the guilt refers. Instead, there is a generalised feeling of guilt – the person feels that he himself *is* guilty, rather than merely having performed a specific immoral act, “Whereas object-directed guilt is one of many emotional attitudes that one might adopt towards one’s various deeds, guilt in severe depression envelops all experience” (Ratcliffe, 2010, p612). As one person with depression describes, “The sense of sin...in depression is dominating and all pervading” (Custance, 1952, p79, quoted in Landis, 1964, p262). Ratcliffe identifies at least four distinct qualities common to the guilt experience of both everyday and depressed circumstances:

⁵ It should be noted that not all people with depression experience an increase of feelings of guilt, nor are experiences of guilt in any way unique to depression. The diagnosis of depression encompasses a wide range of different experiences, and it is possible that feelings of guilt are more commonly associated with only a particular ‘type’ or ‘form’ of depression. Such concerns point more broadly to the issue of the heterogeneity of depression, reminding us that our descriptions of depression cannot be taken to be representative of all depression experiences.

1. A focus upon past deeds.
2. Recognition of the effects of those past deeds as unchangeable.
3. Estrangement from others, in whose eyes one has done wrong.
4. Anticipation of being harmed or punished (2010, p612).

Each of these, we shall see, may in part come about due to alterations in temporal experience.

Gallagher notes that in depression “there is a reorientation away from the future towards present and especially past dimensions” (2012, p128). Straus similarly writes, “the more firmly the future is closed off to the depressive, the more strongly he feels overcome by and tied to the past” (2012, p212). This is backed up by first person accounts. One respondent to the Durham Depression Questionnaire, for example, wrote that when depressed “time is backwards all i [sic] can think about is the past all the horrible things that happened - but when i'm [sic] happy i [sic] don't think about those things at all” (#199). Whilst the everyday is directed towards the future, the loss of conation prevents access to this possible future, forcing attention to towards the past. With the desynchronization of interpersonal time and subsequent reification of time, “mistakes made long ago are experienced as if they had just been committed” (Fuchs, 2013a, p98). Sarah Kane describes this experience in her play: “a wound from two years ago opens like a cadaver and a long buried shame roars its foul decaying grief” (2006, p7).

Whilst the non-depressed person has some distance from his past, and can eventually forget regretted deeds, for the depressed person the past begins to overwhelm the static present – he cannot escape his mistakes or shameful experiences. Fuchs remarks that, for the depressed person, “the past is not actually over, it can no longer *be forgotten* and becomes a facticity accumulated in the present” (2013a, p98). There is, therefore, not only a focus on past deeds, but also an inescapability of those deeds.

The feeling of guilt that may arise from this focus on past events is heightened by the experience of a blocked future. Without the possibility of a meaningfully different future, the depressed person finds himself with no way to overcome or make amends for his perceived wrongdoings – he cannot rebuild broken relationships, atone for immoral acts, or gain any distance from the past events. As Wyllie explains, “The past itself becomes fixed once and for all because it cannot be abolished by any future living” (2005, p183).⁶ In this way the depressed person experiences not only an increase in feelings of guilt, but also a transformation of that guilt into constant and irrevocable guilt. With the past and future fixed, the depressed person cannot overcome or forget any mistakes or wrongdoings. The person cannot gain distance from the perceived wrongdoings, and the effects of these acts cannot be undone, compensated for, or in any way altered.

Desynchronization between the person’s subjective experience of time and the time of others exacerbates already present feelings of distance and alienation from others. In severe depression emotional connection appears to the person not just as altered, but as impossible.⁷ As David Karp explains:

Much of depression’s pain arises out of the recognition that what might make me feel better – human connection – seems impossible in the midst of a paralyzing episode of depression. It is rather like dying from thirst while looking at a glass of water, just beyond one’s reach. (1996, p16)

Brampton describes the loss of connection to others in the following way: “Everybody feels that way sometimes. It is just that in depression, that feeling is magnified to become a supreme, unsplendid isolation” (2009, p101). Similarly, Solomon writes, “I saw friends and tried and failed to connect” (2002, p45).

⁶ See also Fuchs (2001) for further discussion of this point.

⁷ For further discussion of the role of the intersubjective in depression see: Fuchs (2013b) and Taylor Aiken (2011).

This social estrangement heightens the inescapable feelings of guilt experienced by the depressed person. The distancing and alienation prevent the person from overcoming guilt experiences through establishing a connection with others. Firstly, we find that the person straightforwardly cannot be reassured by others, the distancing prevents such emotional connection. However, we also find that without the connection usually present in interpersonal relations, the depressed person may begin to experience other people as cold, distant, or judgmental. One questionnaire respondent wrote, "I feel very separate from people, fearing that if I talk about how I'm feeling they'll reject or disapprove of me" (#21). Another response stated that "[other people] seem more distant and harder to hold a simple conversation with. I begin to feel very alone" (#369). This experience of isolation fulfills Ratcliffe's third criterion of estrangement from others.

Finally, we see that in depression the world is often experienced as taking on a threatening quality. As one respondent to the Durham Depression Questionnaire put it, "The world appears to be a frightening place full of people who are bad and threatening" (#66). This feeling of anxiety is often particularly related to the future; people with depression frequently describe a dangerous future seeming to rush towards them. Another respondent described this experience as feeling like "I - or anyone else- has hardly any time to live at all. It feels as if time is running out" (#45). Such an experience is understandable within the context of the altered temporal experience. The loss or retardation of the conative drive, coupled with the general feelings of impossibility that are present in depression, unite to create an experience in which the person is passive before a future that holds no possibility of improvement. Ratcliffe notes that such an experience can incorporate a "feeling of impending death" (2012a, p127). Solomon describes this experience in his memoir of depression: "Among other things, you feel you are about to die. The dying would not be so bad, but the living at the brink of dying, the not-quite-over the-geographical-edge

condition, is horrible" (2002, p28).

Without the forward directed momentum and feeling of progression that is usually found in the everyday experience, the depressed person experiences death as imminent. There is no distance from death, because "there is no longer an organized sequence of significant events in which to situate it and distance it from the present" (Ratcliffe, 2012a, p127). Von Gebattel quotes a girl with depression who illustrates this experience with a sketch:

[A -> death]

She explains:

Everything I do makes the line that separates me from death shorter.
That's why I am anxious of everything. (von Gebattel, 2012, p215)

Passive before a future that holds no meaningful possibilities apart from inevitable and imminent death, the depressed person experiences the future as seeming to rush toward him, threatening and overwhelming him.

Collectively, these temporal alterations amount to an experience of deep, irrevocable, groundless guilt. This is a guilt that cannot be overcome through future deeds or nullified through human connection. The fixed past encroaches upon the present, and the threatening future, promising harm or even death, bears down upon the person. This encroaching past, blocked but threatening future, and separation from other people, leads to the person experiencing not just an *instance* of guilt, but rather *all* experience taking on the form of guilt.

We can therefore see the ways in which alterations in temporal experience can account for a number of distressing experiences common to depression. This includes the slowing or stopping of lived time, the failure to grasp the possibility of recovering, and increased feelings of guilt. The depressed person

experiences changes in both subjective and intersubjective time, resulting in an experience of isolation or distance from those around him. This account of temporal experience in depression helps us to understand some of the common descriptions we find in first person accounts. For example, at the start of this chapter I quoted a number of respondents to the depression questionnaire. One wrote: "Time loses significance" (#54). Another explained: "I don't tend to have any track of time when I'm depressed" (#157). With alterations in both subjective and intersubjective time it seems likely that time would lose its usual significance or meaning for the person, just as the first quotation describes as occurring. It is a strange and distressing experience, holding little in common with his usual temporal experience. The desynchronization with the time of others means that the significance or meaning of time would be profoundly altered. The descriptions of losing track of time or becoming confused about how much time has passed also seem to be unsurprising given the alterations in temporal experience. The depressed person experiences a loss of the usual temporal relationship that he has with others, alongside a significantly altered experience of the past and future. This seems to constitute a form of temporal disorientation, a confusing and often distressing change in the way the person lives through time. Given this, we might expect the depressed person to find it harder to accurately keep track of time, particularly when attempting to co-ordinate with others.

Having seen the ways in which alterations in temporal experience help us to understand a range of common experiences in depression, I will now turn to the experience of time in mania.

Temporal Experiences in Mania

Fuchs suggests that in mania there is an increase of conation, causing the manic person to 'surge ahead' – "an acceleration of one's own time in relation to social processes" (2013a, p82). As in depression, this consists of alterations in both the

subjective and intersubjective experiences of time. I previously acknowledged the common descriptions of time seeming to speed up in mania, seen in first person memoirs, questionnaire results, and psychological studies. These descriptions are enriched by an appreciation of the intersubjective temporal experience – the manic person constantly feeling ‘held back’ by others as her own personal time races ahead of the intersubjective. Such a loss of synchrony may well help us to understand the feelings of frustration with others that are common in mania. Hornbacher, for example, writes:

Nothing is going fast enough. At school, the teachers are talking as if their mouths are full of molasses. Their limbs move in slow motion. Pointing to call on someone the teacher lifts her arm as if it is filled with wet sand. (2008, p23)

Whilst the depressed person finds it hard to interact with or relate to others when ‘left behind’, the manic person may well become irritated or frustrated by the apparent inactivity of others.

Although such an account does seem informative, and is richer than the one we originally proposed, it still appears to be incomplete. Alterations to conation, even taking into account the intersubjective experience, still fail to account for the range of temporal experiences common in mania. For example, an increase of conation still provides us with no means of understanding the fragmentation that is described as occurring in mania. Nor do we gain any extra understanding of the alterations reported in the person’s relationship to the past, present, and future – including, for example, the swift abandonment of previously made plans, or the loss of regard for the consequences of actions. I suggest that in addition to the understanding of manic temporal experience involving a change in conative dynamism, we also must look at the underlying temporal synthesis. In looking at the ways in which temporal synthesis is affected in mania, we can build up a more complete account of the manic experience of time. Such an account allows us to understand several common

features of mania, including loss of engagement, reflection, and ownership of actions.

However, in order to allow for accurate discussion of the features of a manic temporal experience, we first need to return to the Husserlian description of temporal synthesis, focusing on the role that retention plays in our experiences.

Husserl and Time Revisited

We've established that our sense of continuity and synthesis through time comes about due to the tripartite structure of retention (perception of the just-past as past), the Now, and protention (anticipation of the immediate future). This can be compared with the experience of reading a sentence – when we read a particular word we also perceive the word that has come before, and the word which will come afterwards (or, at least, the expectation that *some* word will come afterwards). In this way, the sentence becomes more than merely a series of words, and our experience of time is of a unified process, not a merely disconnected series of Nows. Recent literature has been illuminating on the role that disruptions to protention may play in schizophrenia (e.g. Fuchs, 2013a; Gallagher, 2006). However, my focus in this section is not on *protention*, but instead on the related *retention*.

It is important that retention is not thought of as part of the past or as a memory of the past. It is a *present* experience of the *immediate* past as past – part of the horizon of the present moment. There are a number of ways we can distinguish between retention and recollection: Firstly, in retention we are dealing with a present experience of the immediate past, whereas in recollection we are concerned with memories of the more distant past.⁸ Whilst I can, for example,

⁸ By suggesting that recollection is concerned with the 'distant' past I do not mean to suggest that we can only have memories of events that occurred years or decades ago. In contrast with the immediate past, events that occurred only a matter of hours previously would still be 'distant'. It is in this latter sense that I use the word 'distant'.

recollect what I said five minutes ago, this is still significantly further in the past than my retention of the immediately prior moment. More importantly, we find that when we recall the past we are aware of the structure of that past – it maintains the retentional-protentional structure of that time. Returning to the example of a melody, if I have a memory of hearing the tone ‘E’, I experience in that memory the retention of the ‘D’ and the protention of the ‘F’. As Husserl writes, “In the re-presentation we once again have the tone or the tonal formation together with its whole temporal extension” (1991, p48). Retention, and the retentional-protentional structure more generally, is therefore not simply part of the past, but rather underlies and allows for our usual experience of recollecting memories of the past. As Zahavi writes, recollection “presuppose[s] the work of the retention and the protention” (2003, p83).

Secondly, recollection and retention can be distinguished with regards to the passive nature of the retentional-protentional structure. When we experience the present moment, and in that moment have the retention of the just-past and the protention of the immediate future, this is a passive process – we do not need to be actively focused on the past in order to experience it. In contrast, in many cases of recollection we *are* actively focusing on the past. Whilst some memories do not have this active component – we might involuntarily recall some past experience – this still shows a notable difference between recollection and retention. Recollection may be active or passive; we can focus on the past in order to bring about a memory or that memory may come to our attention without our explicit focus. In contrast, retention is always part of a passive process.

Our sense of retention includes in it not only a sense of our just-past, but also an ownership of that just-past. When I utter a sentence, I retain not only the previous word, but also my consciousness that *I* spoke the previous word, establishing continuity of self. This consciousness is prereflective and passive. I

do not have to focus on my past utterances in order to know that it was I who spoke them. However, retention is an essential part not only of prereflective consciousness, but also of *reflective* consciousness. To reflect on something requires some level of awareness of it to begin with – we can only reflect on that which we have experienced. As such, reflection presumes an intact inner time consciousness – a prereflective consciousness.

However, reflection also requires retention in a more direct way. When I reflect on myself and my current acts, I reflect not only upon the present, but also upon the just-past. As Zahavi states, that which I am reflecting on did not, “commence the moment I started paying attention to it” (2003, p89). There must have been a motivating element prior to my reflection. This motivation must be retained in order to be reflected on. When I reflect, therefore, I am reflecting on the just-past – that which is retained. This is particularly apparent with regards to the initial motivating factor, but my ongoing reflection would also necessitate a retentional aspect to inner time consciousness.

We can, therefore, see the essential role that retention plays not only in the continuity of temporal experiences, but also the sense of ownership of actions and the ability to reflect on the self and action.

Mania and Retention

What I wish to propose is that rather than there merely being an alteration to conation in cases of mania, the manic person also has a disruption to the basic structure of temporal synthesis. Specifically, I am suggesting that there is a weakening of the process of retention – the perception and appreciation of the just-past – in addition to an increase in conative dynamism. Importantly, I am not stating that it is entirely disrupted or broken, but rather that there is *some* level of disruption that prevents the normal process of synthesis.

In order to explore how such a disruption would be experienced, I will highlight three key areas of alteration: The fragmentation of experience, loss of reflection, and diminished feelings of ownership of action. Whilst parts of this experience may be able to be explained by appealing to longer-term temporal structures, collectively they provide us with good reason to think that temporal synthesis is disrupted in cases of mania.

Fragmentation

It seems clear that a weakening of temporal synthesis would involve a fragmentation of experience. The manic person would begin to experience life as a series of snapshots, rather than as a united whole. Time would no longer seem to flow smoothly, like a melody, but rather as fragmented, individual experiences separated from each other like pearls on a necklace. To put this in the context of an overarching narrative, it seems likely that the manic person would perceive experiences as discrete episodes, which would not necessarily be connected to and therefore inform current and future action, or allow for focused and long term projects. This is, indeed, exactly what those in manic states report. Landis quotes one person who describes the manic experience in the following way:

Everything is absolutely new, every minute is as if everything has just started. (Anderson, 1938, p85, quoted in Landis, 1964, p290)

Leonard Woolf describes his wife, Virginia Woolf, in a manic state:

For about a day what she said was coherent; the sentences meant something, though it was nearly all wildly insane. Then gradually it became completely incoherent, a mere jumble of disassociated words.
(quoted in Jamison, 1994, pp29-30)

Simon describes a similar difficulty with language, writing in her journal that "It's hard to remember the beginning of my sentence now that I'm all the way

at the end” (2003, p11). Simon also describes some of the difficulties she had putting together a coherent narrative of her experience of bipolar disorder:

The history of my head is the hardest to tell, because it is nonlinear, because it is fractured, because there are so many subplots, and because I have spent so much of my energy...hiding that history from the outside world. (2003, p13)

Simon structures her memoir non-chronologically – a common decision in memoirs of bipolar disorder.⁹ Cheney provides an explanation of her own decision to structure her memoir non-chronologically, writing the following in her introduction:

Manic depression is not a safe ride. It doesn't go from point A to point B in a familiar, friendly pattern...That's why I've chosen to tell my life story episodically, rather than in any chronological order. It's truer to the way I think. (Cheney, 2008, p1)

In contrast to the smooth narratives we find in first person accounts of depression, accounts of bipolar disorder are frequently disjointed, lacking a sense of progression (here we might recall the contrasting structures of Simon (2003) and Sebald (2002) that we saw in chapter three). Individual life episodes are often presented in isolation from longer-term goals or interpretative frameworks. Given the fragmentation of temporal experience, this disruption in the progression of bipolar narratives is not unexpected, potentially giving the reader a richer and more accurate account of the experience itself. Landis explains that when those who have been manic attempt to recollect the experience they find that “Memories are fragmented and so disconnected that much of the episode seems senseless” (1964, p293). Thus, an accurate account of mania may well also be disconnected and fragmented in a manner markedly different from what we might think of as a typical or smooth narrative

⁹ This is potentially unsurprising, given that she later writes of a manic episode, “I don't remember anything chronologically” (Simon, 2003, p15).

structure. This difficulty of placing the manic experience into a typical narrative structure may also help to us to understand why memoirs of mania are comparatively rare and often contain less experiential detail than those of depression. Whilst depression is undoubtedly a more common diagnosis, and as such we would expect a greater number of depression narratives than bipolar disorder narratives, the focus on depression at the expense of mania even in memoirs of bipolar disorder is striking. However, if the temporal experience of mania prevents ease of narrative coherence, then this is unsurprising. In her descriptive account of temporal experience following the death of her child Denise Riley writes: “it seems that the possibilities for describing, and the kinds of temporality that you inhabit, may be intimately allied” (2012). She notes that her own radical alteration in temporal experience prohibited narrative description, writing, “To struggle to narrate becomes not only an unenticing prospect, but structurally impossible” (2012).¹⁰ Whilst the temporal experiences of grief and mania are undoubtedly different, it seems reasonable to suggest that the radical alteration in temporal experience that occurs in mania may equally result in a resistance to description in narrative form. A fragmented experience may well be difficult to articulate in a standard narrative structure. In contrast, in cases of depression it may be difficult for the person to structure a narrative when depressed – the loss of conation making a sense of progression difficult – but after recovery the person can reflect on experiences that are less fragmented, and therefore more amenable to standard narrative forms than in cases of mania.¹¹ As such, we should expect memoirs of mania to be less developed than memoirs of depression, and potentially for there to be fewer in number.

¹⁰ Riley describes time as having halted following the death of her son. She suggests that it is impossible to describe this experience whilst it is occurring because “Describing would involve some notion of the passage of time. Narrating would imply at least a hint of ‘and then’ and ‘after that’” (2012).

¹¹ We may, however, expect that narratives of depression would largely be written following recovery rather than whilst the person is actually depressed.

This fragmentation would also lead to a large degree of distractibility. If the person experienced life without a sense of continuity, it makes sense that she would alter plans and that the progression of thoughts would change on the basis of the current moment. If the immediate past was, to a certain degree, disconnected from the present Now then it seems likely that the person would restructure her life on the basis of the immediate present, rather than by looking to longer-term plans and structures, which necessarily involve a perception and appreciation of the immediate past. This restructuring on the basis of the present moment can frequently be seen in first person accounts. Hornbacher, for example, writes, “This plan has just occurred to me in the last three minutes but now it is essential, imperative, that I go” (2008, p38). Jamison provides a similar description: “I spent several hundreds of pounds on books that somehow caught my fancy: books on natural history of the mole, twenty sundry Penguin books because I thought it could be nice if the penguins could form a colony” (1997, p74).

The disruption to the synthesis between the immediate past and the present Now means that the manic person would not base actions on the tasks previously held to be important, but rather on that which is available in the immediate moment. This is demonstrated in the distractibility of those in a manic state, where their attention is grasped by whatever is presented to them, often abandoning prior responsibilities.

This form of distractibility may also help us to understand the experience of the “flight of ideas” (APA, 2000, p362), a common feature of manic states. First person accounts frequently describe trains of thought rapidly altering, often switching to seemingly unrelated topics. For example, one person writes: “Fragments of ideas, images, sentences, raced around and around in my mind like the tigers in a children’s story...a million other thoughts – magnificent and morbid, wove in and raced by” (Jamison, 1997, pp82-3). Landis quotes a

remarkable excerpt from one person in a manic state that clearly illustrates the experience of the flight of ideas:

I have to choose my words very carefully. For what I am doing is, I believe, something which has not very often been attempted (BEEZLEBUB ON BED in form of blue fly). It is to think at precisely the same point in the space-time continuum by both methods of thought (coughing, running at the nose, bottom of feet wet) (blue check handkerchief) – inductive and deductive (so hot, have to remove coat and purple pullover query CASESAR’S) artistic and rational (itching), negative and positive – in the terminology expounded [previously]...

First of all it seems to be (had to open window owing to extreme sense of heat query “real”?) essential to fix my exact position (fly on pipe) in the space-time continuum, at any rate by what the sailors call D.R. (dead reckoning query alive or dead?)... (Custance, 1952, pp138-9, quoted in Landis, 1964, p294)

In this last quotation we can see how the person is distracted by what is currently in front of him, the progression of thoughts switching from topic to topic with little to unify them. Just as we saw occurs with the person’s actions and tasks – the person constantly switching to carry out what is immediately in front of him rather than by looking to longer term plans or structures – the manic person equally finds his thoughts constantly distracted and diverted. When coupled with the increased conative dynamism that we have seen occurs in cases of mania, these flighty ideas may seem to “race”.

Engagement

However, it would not just be the feeling of continuity that would be affected by such a disruption. As previously noted, the intact tripartite structure is essential for the ability to meaningfully reflect on the self. With the manic person’s retention weakened, it seems unlikely that she would be able to reflect on herself and her current actions in any meaningful way. This would mean that the manic person would lose the ability to engage meaningfully with the world, leaving her with only a superficial level of engagement. Any type of

meaningful engagement, whether it is with others, with the self, or various projects within the world, presupposes an ability to reflect upon those features. Such reflection requires intact temporal consciousness and, as such, engagement with the world ought to be diminished during manic states. This is, again, exactly what is seen in cases of mania. One of the most striking features of the manic state is how, despite being very active within the world, the person is in fact only superficially engaged. As Binswanger comments:

...this heightened facility in communication is only apparent; it remains superficial. If a second or third party appears, the patient loses you from sight just as quickly as he first laid eyes on you...you quickly get the impression that the patient is not close to himself, but lives, as it were, away from himself. (1964, p129)

Discussing the manic person's grasp of ideas, Binswanger comments that the individual "superficially apprehends every germ of idea as soon as it comes to consciousness", but notes that this is done "without reaching into the depths" (1964, p138).

Minkowski draws similar conclusions, stating that, "a person in a state of manic excitement lives only in the now, and this is a now which limits his contact with the environment" (1970, p291). Likewise, Kraepelin describes how manic patients "usually perceive only in a fugitive and imprecise manner, seeming scarcely to care very much about what goes on around them" (quoted in Minkowski, 1970, p295).

If the temporal structure was disrupted at a retentional level this loss of reflective engagement is precisely what we would expect to see. The manic person lives in a world in which only the immediate Now is relevant, her temporal synthesis having been disrupted. However, she also lacks the ability to reflect upon that Now, leaving her to skip along the surface of a constant series of unrelated moments – flightly and detached from reality. Andy

Behrman provides a description of this experience in his memoir of bipolar disorder, writing “In truth, I am removed from reality and have no way to connect to it” (2003, pxxi). Hornbacher similarly writes: “Manic, made further manic by the wrong meds, I simply do it, unaware in the instant that there will be any consequence at all” (2008, p7).

This inability to meaningfully reflect on herself and her actions prevents the manic person both from fully engaging with the world, and also means that she has only a superficial understanding of the consequences of her actions. Stephanie Merrit, for example, describes this loss of the perception of the consequences of her actions during manic states: “No consequences: this was how it always felt in these taut, vibrant moods” (2009, p94). This may also aid our understanding of the manic person’s engagement in high-risk pleasurable activities. Caught in a series of unrelated Nows, incapable of meaningful reflection, it’s easy to understand why the person may act in ways she would not were she not manic. Being unable to grasp the potential consequences of her actions, the manic person seems just as likely to engage in high-risk activities as low-risk ones, unable to sufficiently differentiate between the two. We therefore find that a person in a manic state may engage both in physically dangerous tasks, such as swimming in an unsafe area, as well as tasks that may risk her financial safety or the state of her relationships – for example, by spending large amounts of money on unnecessary items or cheating on a partner. The consequences of these actions are not apparent to her, nor is she able to sufficiently reflect on the actions.

Diminished Ownership of Action

I previously discussed the ways in which an intact temporal synthesis is necessary for a continuity of the self and a sense of ownership of that self. It is through the retentional structure that I gain a sense not only of a word having

just been spoken, or an action completed, but also of *my* having spoken that word or completed that action.

With retention disrupted it seems possible, and indeed likely, that feelings of ownership would be diminished. The manic person may, in milder cases (such as in states of hypomania), have a strange feeling of separation from his actions. In more severe cases, including those in which psychosis is present, this separation may extend to an experience of a complete loss of ownership of action, which may incorporate a misattribution of the source of that action – a loss of agency.¹² Again, this can be seen in reports of people with bipolar disorder. One person describes being manic as being “a seemingly helpless passenger in my own body” (Zanoni 2010. p139). Jamison describes her confusion regarding whether she actually performed certain actions: “Once I think I shoplifted a blouse...Or maybe I just thought about shoplifting” (1997, p74). She seems to maintain a sense that she willed the action, or was the source of that action, but has lost the sense that she actually *did* perform the action. Landis discusses one person’s experience of mania in which “she seemed convinced that she had come under the control of some outside power” (1964, p50). Hornbacher similarly describes her experience of mania in the following way:

The rages always come at night. They control my voice, my hands, I scream and throw myself against the walls...It slides under my skin, borrowing my body without asking; my hands are its hands, and its hands are filled with an other worldly strength. (2008, p56)

¹² Whilst a sense of agency and an ownership of action are intimately linked, it does seem possible to draw them apart. I have agency of an action if I experience myself as having being the *source* of that action. In contrast, I experience ownership of an action if I experience that action as having occurred to me – I am the *subject* of the action. For more on this see Gallagher (2006, chapter eight). Particularly see pp. 173-4 for discussion of the distinction between ownership of action and agency. Whilst Gallagher goes on in this chapter to explore the connection between protention and agency, it is notable that he suggests that “The function of *retention*...is, in part, to provide a sense of ownership for thought” (2006, p193).

It seems that in this case the sense that *she* willed the action is not experienced – she knows that she performed the action, but does not feel a sense of control over her performance. As such, when Hornbacher looks back at the actions performed she does not see the continuity of her conceiving of an action, willing it, and then performing it.

The manic person seems not only to have a superficial engagement with the world and a diminished understanding of the consequences of his actions, he also struggles to retain ownership of those actions, and even a reduced ability to recognise such actions and events as having taken place. This is consistent with a disrupted inner time consciousness, which includes a disrupted retention of ownership of the immediate past.

The manic experience, as described in first person accounts, seems to point to a flighty, distractible, unengaged and unreflective way of being. Those in manic states appear to skip along the surface of experience, without ever fully engaging, or grasping, matters in the world or their own actions. They seem to have little concept of the consequences of their actions, and swiftly abandon previously held beliefs and plans as soon as something new catches the eye. They engage in high-risk activities, appearing to understand only superficially the possible consequences of such acts. Experiences of time, whilst described as seeming to ‘speed up’, are also described as fragmented. This experience seems not to be able to be explained by a mere speeding up of subjective time, or even by the loss of synchrony with intersubjective time. However, this is exactly what we would expect were the manic person’s retentional structure weakened.

The Manic Experience of Time

This account of experiences of time in mania helps us to understand some of the first person descriptions highlighted at the beginning of this chapter. Descriptions of temporal experience discussed how time seemed to lose

meaning during episodes of mania. For example, I quoted Hornbacher who writes, "We walk in circles for weeks, or minutes, or years. Time has escaped me" (2008, p119). This and other similar descriptions seem unsurprising in light of the radical alteration in temporal experience that I have described. If time is experienced by the manic person as fragmented and out of synch with both objective and intersubjective time, then it seems likely that it would lose its usual meaning or significance and that the individual would find it difficult to keep track of it in the usual ways.

It also now seems possible to explain the seemingly unusual responses to the time estimation tests – where those who are manic tended to overestimate the duration of an elapsed period of time. We originally predicted that the manic person would tend to underestimate an interval of time, as his subjective experience is that time speeds up. However, we can point to two reasons why such a result may not occur: Firstly, we find that the manic person is very active within the world. He may accomplish more tasks within a shorter period of time, or at least be involved with more tasks than a non-manic person would be. Equally, racing thoughts are common during episodes of mania. Jamison describes the experience in her memoir of bipolar disorder: "the fast ideas are far too fast, and there are far too many" (1997, p67). Behrman provides a similar description in his account bipolar disorder: "My manic mind teems with rapidly changing ideas and needs; my head is cluttered with vibrant colors, wild images, bizarre thoughts, sharp details, secret codes, symbols, and foreign languages" (2003, pxix). The combination of racing thoughts and increased activity leads the manic person to overestimate the duration of an elapsed period of time because so much seems to have happened to and for him.

Secondly, I have shown how the experience of time for the manic person is fragmented, with a diminished retention of the immediate past. If I am correct, we might expect the manic person to struggle to accurately keep track of time,

as this seems to involve an appreciation of time that has just-been. We would, therefore, expect the manic person to be less accurate in his time estimation, perhaps having to overly rely on more easily observable features – such as how much has happened during the time period – rather than on his subjective experience of time.

There are, however, two potential objections to the account of temporal experience in mania that I have outlined. We might worry that a disruption of temporal synthesis produces unwanted consequences that are not part of the usual manic experience; and, furthermore, that such a disruption is unnecessary in order to explain the alterations that we do see in mania.

Firstly, it may be thought that there are some experiences that we would expect to result from a disruption in the protentional-retentional structure that do not seem to occur during episodes of mania. Those in manic states, for example, do not encounter difficulties in carrying out a basic task to completion – they are still able to cook basic meals, or go shopping, or choose and put on an outfit. We might contrast this with the impact that the disruption to protention is thought to have on those with schizophrenia. Shaun Gallagher, amongst others, has outlined the ways in which “protentional mechanism malfunctions” (2006, p197) may account for a number of symptoms common in schizophrenia, including difficulties planning and carrying out actions, and the experience of thought-insertion.¹³ If temporal synthesis has been disrupted in both cases, we might wonder why we do not see such extreme experiences in cases of mania.

However, this objection mischaracterises the extent to which the process of temporal synthesis has been disrupted. Whilst we would expect significant implications for the carrying out of everyday tasks were there to be a complete breakdown of temporal synthesis, it is not obvious that it is necessitated by a

¹³ For a discussion of protention and schizophrenia see chapter eight in Gallagher (2006).

mere disruption or weakening of the process. I have suggested that in mania there is a *weakening* of the retentional-protentional structure rather than a complete breakdown and, therefore, we would not necessarily expect there to be such severe effects upon the ability to carry out basic everyday tasks.¹⁴ It might also be suggested that habitual tasks, such as making a cup of tea or getting dressed, are more stable than non-habitual tasks and would therefore be less vulnerable to disruption from alteration in temporal experience. It is the tasks or projects that require reflection and engagement that are most disrupted in cases of mania. As most everyday habitual tasks, like making a cup of tea, require minimal reflection and engagement they would be largely unaffected by the temporal changes. In contrast, non-habitual or novel tasks would become difficult for the manic person. We would, therefore, expect the manic person to have difficulties following conversations in the usual way (a task that requires both reflection and engagement, and cannot be completed merely by relying on habit), but would not expect her to encounter difficulties walking or getting dressed.

The second concern suggests that the manic experience can be adequately explained without the need to posit any alterations in temporal synthesis. The disruption to narrative structures, without the loss of the ability to carry out everyday tasks, may be thought to point to problems with longer-term experiences of the past, present, and future, rather than disruption to the shorter-term retentional-protentional structures that I have focused on. We might think that the difficulties in progressing or unifying life narratives can be explained simply by a changed relationship with the past and present, rather than necessitating the kind of fragmentation that I have outlined.

¹⁴ This is, however, not to discount the possibility that in severe episodes of mania there may be significant impairment of everyday functioning.

Studying the longer-term structures of the past, present, and future is vital if we wish to fully understand the temporal experience in mania,¹⁵ and it is likely that the ways in which narrative accounts of mania are structured is affected by those longer-term temporal experiences. However, even if the lack of narrative progression can be explained without discussion of temporal synthesis, it does not seem clear that certain other aspects of the manic experience could be explained simply through altered experiences of the past or future. Reflection, engagement, and ownership of action are all intimately bound up with our experiences of temporal synthesis. A disruption at this level, therefore, helps us to understand why each of these experiences may occur. It is not in any way obvious that the longer-term temporal structures can do this crucial explanatory work. As such, I suggest that the disruption to retention is necessary in order to explain the range of temporal experiences in mania. As I argue that there is a weakening of retention rather than an entire breakdown of the process, the concern that unwanted effects would occur appears to be without weight.

Time, Depression, and Mania

In this chapter I have provided an account of the ways in which temporal experience is altered during episodes of depression and mania. This includes a desynchronization of intersubjective time, as well as changes to both the conative drive and the process of temporal synthesis. I've begun to outline some of the potential consequences of these alterations in temporal experience. In the case of depression this includes the experience of time slowing down, an inability to perceive the possibility of recovery, and increased feelings of guilt. Turning to the experience of time in mania, I have shown how a weakening of retention results in experiences of fragmentation, a loss of reflection, loss of engagement with the world, and a diminished feeling of ownership of action.

¹⁵ I discuss alterations in these longer-term temporal structures in chapter six.

Having established this account of temporal experience in mania and depression, I now want to look further at the ways in which shorter and longer-term temporal structures relate to and affect one another, and the ways in which alterations in these structures impact on experiences of the self and the world.

Chapter 6: Time, Projects, and Possibilities

Introduction

In the last chapter I discussed a number of different aspects that constitute a person's experience of time. I explored concepts of objective, subjective, and intersubjective time, expanding particularly on the role that alterations in conation and temporal synthesis play in experiences of mania and depression. As well as looking at these short-term experiences of time, I noted how these alterations were linked to longer-term temporal experiences. In depression, this includes an experience of a closed future and an overwhelming past. In mania, this is seen in the inability to reflect on the past or consider future consequences.

In this chapter I look more closely at these longer-term structures of past, present, and future – focussing on the ways in which we are meaningfully situated in time due to our projects and our self-interpretations. I draw on recent work by Matthew Ratcliffe (2012a) in order to highlight some of the ways in which these structures are altered in cases of depression. I then turn to cases of mania, showing how an appreciation of the alterations that occur in these longer-term structures can help us to understand a number of experiences common in episodes of mania. In particular, I note the contrasting responses to the loss of projects that are found in experiences of depression and mania. I then discuss how alterations in temporal experience can impact on bodily experiences, particularly noting how this helps us to understand the unintuitive descriptions of bodily experience that we find in the case of mania. With these accounts of mania and depression in place, I consider how we can best understand the relationship between mania and depression, and how the states can come together in experiences of mixed states.

Projects and Possibilities

The meaning that objects in the world hold for us is partly constituted by the projects in which we are engaged. Objects are highlighted to us and take on varying degrees of enticement or calls-to-action in relation to our on-going projects – both short and long-term. Possibilities are contextualised or brought to life within broader projects, some of which we may be explicitly aware of, others only implicitly. Certain possibilities appear as salient because we are seeking to achieve some further purpose – for example, the possibility of typing on the computer is highlighted to me because I am concerned with possibilities relating to my project of writing this chapter. This short-term project of my immediate writing is then given further meaning within longer-term projects – I write this chapter for the sake of completing a PhD, which rests within the even longer-term project of being a philosopher. Sartre uses the example of a man's experience of a crag in order to highlight the role our projects play in structuring our experiences. He writes:

Here I am at the foot of this crag which appears to me as “not scalable”. This means that the rock appears to me in the light of a projected scaling – a secondary project which finds its meaning in terms of an initial project which is my being-in-the-world. (2003, p509)

We find similar discussion in the work of Heidegger. In *Being and Time* he provides the following description:

Being-in-the-world...amounts to a non-thematic circumspective absorption in references or assignments constitutive for the readiness-to-hand of a totality of equipment. (1962, p107)

We understand the world, it is suggested, because we are absorbed in various projects that give practical significance to the objects that we encounter. The possibilities we perceive in the world are disclosed to us in networks of

significance – an individual possibility does not stand alone, but rather forms a web of interrelated possibilities providing structure to the world as a whole.

As well as forming an understanding of world, these project-contextualised possibilities also constitute a form of understanding of the self. To understand myself as a philosopher, for example, is to say that I am concerned with possibilities relating to philosophising. Actions relating to this longer-term project will be highlighted to me as salient or enticing. In contrast, were I to understand myself as a farmer this would amount to a very different way of being in the world – different actions in the world would appear as possible, enticing, or relevant. As Heidegger explains, “Dasein always has understood itself and always will understand itself in terms of possibilities” (1962, p185).¹ It is in this sense that Heidegger is able to describe Dasein as “always ‘beyond itself’” (1962, p236) – a person *is*, in a sense, the very set of possibilities that she projects into the future.

Ratcliffe describes how “a sense of the ongoing projects and commitments that render things significant to us” (2012a, p122) is included in our experience of implicit time, in addition to temporal synthesis and conation. Such projects provide a framework of meaning to the world we encounter that constitutes a long-term future directed orientation – a “teleological time” (2012a, p122). This teleological time includes both short and long-term projects, providing a “sense of working towards something, a teleological direction” (2012a, p122). This gives stability to our experiences of time – a sense of long-term ordered progression. We can therefore see how the projects to which a person is committed provide a meaningful structure to the world as well as forming part of the person’s temporal experience.

¹ Heidegger uses the term ‘Dasein’ (meaning ‘Being-there’) to refer to man – beings like us. For a clear description of the meaning of the term and Heidegger’s reasons for using it rather than the more common ‘human beings’ or ‘people’ see Polt, 1999, pp29-30.

Depression and the Loss of Projects

In many cases of depression there appears to be a loss of the networks of projects that usually structure the person's experiences. The depressed person no longer perceives the world through the context of meaning-making projects and so the world as a whole takes on the characteristic of being grey, lifeless, or flat. One possible outcome of the loss of the projects and commitments that usually provide structure to the world is that relevant possibilities are no longer highlighted. Descriptions of the world losing meaning, relevance, and significance are common in first person accounts of depression. For example:

Everything is "flatter" – there's no depth, no intricacy, no potential for anything good or positive. Quite literally every sense is more muted.
(#307)

It seems more dull. I don't notice anything so much. Nothing stands out. (#235)

However, we need to take care when interpreting these kinds of descriptive statements, making sure to tease apart related but distinct experiences. Ratcliffe (2012a) distinguishes two different ways in which projects and possibilities may be disrupted in cases of depression. In what follows I draw on his distinction, discussing these two forms of depression.

In some instances of depression we find that there is a loss of a particular project or group of projects. This might be through the loss of a job, the death of a loved one, or a breakdown of a relationship. In these kinds of situations the person loses a collection of ongoing projects and commitments that previously made salient things in the world, determining relevant actions. The world has therefore lost its usual meaning for the person – the usual possibilities may not stand out or call the person to action – there is a loss of practical significance. As Ratcliffe explains, "projects that were central to a life have been lost. Consequently, things that used to appear significant no longer do" (2012a,

p125-6). We can find descriptions of this kind of experience in first person accounts of depression. Sally Brampton, for example, provides the following description in her memoir of depression: "Everything was strange. My life was strange. There were no fixed points left" (2009, p58). One respondent to the Durham Depression Questionnaire offered a concise description of this experience, writing, "When I am depressed life loses its meaning" (#54). The depressed person has not lost the *capacity* for action, but rather particular *possibilities* for action no longer stand out as being relevant or salient, having been decontextualised through the loss of projects. We might experience this loss of salience to a lesser extent when we finish a large project. In his semi-autobiographical novel *The Rings of Saturn* Sebald describes an "emptiness that takes hold of me whenever I have completed a long stint of work" (2002, p3). It is not that we cannot act in these situations, but rather actions that previously appeared as relevant or salient are no longer highlighted.

Without projects to highlight relevant practical possibilities in the world the depressed person may begin to experience actions as 'pointless'. As one questionnaire respondent described:

I lose interest in everyday activities and seem to lose track of what needs doing at home. I find myself sitting alone more and feel slightly removed from what's going on at home. Nothing seems to interest me.
(#195)

The actions of the depressed person are no longer contextualised within longer-term structures, and so no longer appear as relevant or meaningful. We therefore find descriptions in first person accounts of people 'going through the motions' or behaving mechanistically. Elizabeth Wurtzel, for example, writes, "I just kept walking quick and straight, an automaton following a program" (1996, p101). One questionnaire respondent explained, "I become like a robot. It's like I'm on auto-pilot" (#51). The depressed person may lose his usual motivation to act, his everyday activities no longer given meaning through

longer-term projects and commitments. However, he still retains the ability to act, and so can still complete basic tasks. These actions, whilst possible, will have lost their usual meaning, motivation, and context, and so the person experiences them as 'pointless' and may only carry them out in a mechanistic manner.

In these cases we can see that there is a loss of the usual meaning-giving projects, and so a loss of significant practical possibilities in the world. However, the possibility of practical significance remains, because new or replacement projects may be developed. As Ratcliffe puts it, "there is an intact sense that things *could* be practically significant – the problem is that they are not" (2012a, p125). Ratcliffe contrasts this with a deeper loss of significance in which there is a loss of the very *capacity* to find things significant. This is not simply a loss of an individual project or collection of projects, or even the loss of all projects, but rather the loss of the possibility that there could be any possibilities. The loss of the possibility of practical significance precludes the possibility of the development of meaningful projects.

We might think that this deeper loss comes about as a consequence of the earlier loss of projects and practical significance. It seems plausible to suggest that were a person to live for an extended time without experiencing practical significance, his *capacity* for practical significance itself may begin to be eroded. Alternatively, we might think that the two experiences have entirely separate causal routes – that those who experience the loss of the possibility of practical significance do not have to have previously experienced a collapse of projects. It is likely that in some cases the loss of significance is prior to the loss of projects, whilst for others the loss of projects is the starting point for the more severe experience. What is important, however, is that we note the distinction between the two experiences, despite superficial similarities. In the first case there is a loss of projects and so a loss of practical significance. In the second, the loss of

the possibility of practical significance prevents the development of new or replacement projects.

In this second case there is a profound alteration in the experience of time. Along with the loss of the capacity for practical significance we find that there is a “collapse of all the projects that shape experience and regulate activity, a loss of teleological time” (Ratcliffe, 2012a, p123). The loss of the capacity for meaning-giving projects would be the loss of a kind of future directed orientation, distinct from conation but nonetheless acting so as to provide a long-term sense of direction for the person.² Without current projects, and having lost the capacity to develop replacement projects, the depressed person finds that this long-term orientation is lost. Ratcliffe suggests that this loss of teleological time may amount to an experience of time as cyclical. He explains that for some people with depression diagnoses “nothing matters and there is thus no way of individuating days or putting them in a linear order” (2012a, p123). Without projects and commitments, “there is nothing to distinguish one day from the next – nothing stands out and nothing makes a difference” (2012a, p123). Although the days may differ in certain ways, the person may wear different clothes or eat different meals, there is no sense in which any day is *meaningfully* different from those that have gone before. This account of temporal experience is supported by descriptions found in first person accounts. One respondent to the depression questionnaire explained, “I have to re read my memoirs to remind myself that things can and will change” (#117). Another wrote, “What is the point of any of it anyway? nothing changes” (#253). Such an experience clearly relates to our earlier discussion of guilt and the experience of depression as “eternal”. Whilst I earlier described how a loss of conation could bring about such experiences, it seems clear that a loss of

² Whilst we might suggest that a similar experience may occur in some cases where projects are lost but the capacity for practical significance is not, the fact that the possibility for new or replacement projects remains would guard against more severe experiences of the loss of teleological time.

teleological time would compound the experience of change being impossible. If nothing can change, then the depressed person can hold no hope of recovery, nor can he perceive the possibility of making amends for perceived wrongdoing and thus overcoming guilt experiences.

Minkowski's discussion of the development of obsessive rituals in response to depressive experiences of time seems particularly relevant in light of this form of temporal alteration. Minkowski suggests that behaviours such as obsessive counting and checking can have a "compensatory character" (1970, p299), making up for the loss of progression that may occur in depression. He illustrates this using an example originally given by Straus (2012) of a woman who said that "she felt time advancing only when she was knitting" (Minkowski, 1970, p299).³ Minkowski writes:

All of them – like counting, for example, or a constant recording of events – can give rise to the idea of a progression – a mechanical progression, that is – of time. This progression, or rather this illusion of progression, comes to fill in for the weakening dynamism. (1970, p299)

The depressed person no longer experiences meaningful change – nothing is relevantly different from one day to the next. Such an experience is distressing for the individual, and so in some cases ritualistic behaviour may develop as an attempt to replace this lost sense of progression and change.

We can therefore see that the loss of projects and commitments can have a significant impact on the depressed person's experience of the world and of time. I distinguished between two different ways in which this loss may be experienced. In the first case there is a loss of the usual world-structuring projects that may involve a loss of practical significance in the present moment. Whilst this leads to an experience of action as pointless or unmotivated, we

³ Straus suggests that these obsessive actions are partly an attempt to "drive stalling time onwards" (2012, p212).

crucially discover that the person retains the *capacity* for practical significance and so may replace past projects with new projects. In the second case, which I suggest may either develop from the first or by a separate causal route, there is a loss of the capacity for practical significance that incorporates the loss of projects. In this case there is not only a loss of current projects, but also the loss of the possibility of future or replacement projects. The person in the second case experiences a profound alteration in temporal experience including a disruption to long-term future directed orientation or teleological time.

In both of these cases there is a loss of practical significance. However, in addition to this, in some cases of depression we may also find that there is a loss of what Ratcliffe, drawing on Husserl, calls “enticing possibilities” (2012a). These can be understood to be possibilities that “elicit various kinds of response from us” (Ratcliffe, 2012a, p119), drawing a person in to action. With the loss of projects these enticing possibilities would certainly become *unstructured*. The depressed person would no longer experience any draw to act in order to further longer-term goals and commitments and so there may be no sense of *relevantly* enticing possibilities. However, he might retain the enticement to non-project contextualised action – the draw to watch bad films, for example, or to play mindless computer games.⁴ However, in many cases of depression enticing possibilities are entirely, or almost entirely, lost. The depressed person loses a sense of draw into the world – not only for the purpose of furthering particular projects, but also more general non-project-specific actions. Whilst we cannot rule out the possibility that enticing possibilities are lost through a

⁴ We might, however, question the extent to which such activities really ‘entice’ the depressed person, rather than simply being possible actions that require little energy. With the distressing bodily alterations that occur in depression, the person may default to such activities rather than ones that require significant bodily movement.

separate causal route,⁵ it seems plausible to suggest that the decontextualisation of possibilities through the loss of projects may in some cases contribute to this loss. The collapse of the usual networks of meaning and relevance, without any replacement system of significance, may lead to a loss of enticing possibilities more generally. If nothing is highlighted as relevant, we might expect that little, if anything, would appear as 'enticing'. It is likely that the extent to which enticing possibilities are lost is in part due to differences in temperament as well as the degree to which the person has robust habitual actions that may continue to entice despite the loss of projects. It is notable that many of the enticing possibilities that remain in cases of depression are habit-based, rather than novel or goal-directed.

This loss of enticing possibilities would not be experienced merely as a loss of motivation or desire to act. In addition, the person may also experience a feeling of separation from the world. As Ratcliffe explains, "A world drained of the relevant kinds of affective import would appear somehow detached" (2012a, p124). Descriptions of these kinds of feelings of distance or separation are common in accounts of depression. Elizabeth Wurtzel, for example, provides the following description in her memoir of depression: "The Yard seemed like a phantom. I moved through it in the plastic bubble that separated my fogworld from everything around me" (1996, p101). Sally Brampton similarly describes how she "cannot connect with life" instead writing that she is "doomed, for ever, to have my face pressed against the window watching it pass me by" (2009, p244). Similar descriptions can also be found in responses to the depression questionnaire. One person wrote, "it seems like there is a barrier between me and the outside world, as if everything is more distant" (#129).

⁵ The existence of projects does not necessarily equate to the existence of enticing possibilities. For example, a person may have an important project and yet experience no enticement to act, instead merely feeling an unpleasant sensation that she 'ought' to be acting. It is, however, clear that in many cases there is a relationship between the two, at least in determining *which* enticing possibilities are experienced as relevant or salient.

These kinds of metaphors point to an experience of recognising the world and the possible actions that can be carried out within it, but feeling unable to participate in the world – to *actually* reach the world. It seems plausible to suggest that the loss of enticing possibilities would contribute to this kind of experience. Without the draw to the world and the enticement to act the depressed person will feel cut off or disconnected. He may still recognise that objects hold certain possibilities, but none of these would draw him in to action or be highlighted to him in any way.

We can therefore see that in depression there may be a loss of projects, practical significance, and enticing possibilities. Whilst closely associated, we can draw apart these related experiences in order to better understand the range of experiences associated with depression. In what follows I will explore further consequences of the loss of projects, practical significance, and enticing possibilities, including a destabilisation of the conative drive and a resultant impoverishment of both protention and retention.

Conation, Possibilities, and Protention

I previously discussed how commitments and projects underpin a form of teleological time. With the loss of the possibility of practical significance and so the prevention of projects, we saw how teleological time is disrupted in cases of depression. However, it seems plausible to suggest that the loss of projects also destabilises *conation*. I previously defined conation as a “future-directed drive that draws us in to possible action”, noting that it manifests both as an internal drive as well as a form of practical allure in the world – we are drawn in to action by enticing possibilities within the world.

We have seen that the loss of projects contributes to a loss of practical significance and an unstructuring of enticing possibilities, including a complete loss of enticing possibilities in some cases of depression. Without enticing

possibilities in the world, or with a significant loss of enticing possibilities, conation would be diminished or lost. There would be no pull towards future action, as the enticing possibilities for that action have been lost or eroded. If practical allure is one manifestation of conation, then the loss of this allure must at the same time be an impoverishment or diminishment of conation itself. I previously suggested that the loss of teleological time would exacerbate distressing experiences brought about through the loss of conation, such as experiences of guilt. However, we are now in a position to put forward the much stronger claim that the loss of teleological time and the loss of conation may, in some cases, come about not by two distinct means, or by coincidence, but as a joint consequence of the loss of projects and possibilities.

Through this we can begin to see the importance that projects and commitments hold for a stable conative drive. Projects provide context and structure that make meaningful possibilities in the world. It is through projects and commitments that we encounter most possibilities as salient or enticing. We can therefore see that if either the capacity to develop projects is lost, or the possibility of practical significance is lost, then conation will also be destabilised. This connection highlights once more the intimate link between experiences of time and experiences of the world.

Having established the relationship between projects, possibilities, and conation, I now want to explore how the alterations in these features of temporal experience impact on the shorter-term retentional-protentional structure of temporal synthesis.

Temporal Synthesis

Ratcliffe (2012a) argues that enticing possibilities and practical significance both form an integral part of temporal synthesis. Our protentional capacity is reliant on an appreciation and anticipation of the changing perception and fulfilment

of practical and enticing possibilities. Husserl is clear that a sense of striving directedness is *part of* protention. Kortooms, describing Husserl's position, explains that there is a "directedness that intrinsically belongs to protention" (2002, p183). Such directedness is passive, not requiring active thought or reflection. It is still possible to have an *active* directedness towards the past – perhaps in the case of reflection or recollection. However, this kind of active directedness would be against the flow of the still present passive *striving directedness* which, Kortooms notes, is always "directed toward what is to come" (2002, p183).

What alteration to temporal synthesis, and in particular protention, can we say occurs in cases of depression where there may be a loss of practical or enticing possibilities, and the loss of conation?

Conation, we have seen, may be understood as a form of "drive, striving, urge or affection" (Fuchs, 2013a, p78). It is a future directed momentum, helping to provide a form of orientation or directedness. It can therefore be seen that a loss of conation would also be an impoverishment of the sense of striving directedness that Husserl says is integral to protention. This passive directedness is necessary to allow for the anticipatory role that protention provides. Without a drive towards "what comes next", there can be only a limited sense of anticipating that next moment. What is therefore lost from protention when conation is diminished is a sense of a grasping anticipation of the immediate future.

Closely associated with the loss of conation is the loss of enticing possibilities – the world no longer drawing the person in. We have already seen how the loss of enticing possibilities may lead the depressed person to experience a feeling of separation from the world. However, we can also see that such a loss may entail an impoverishment of protention. As noted in our discussion of conation, enticing possibilities in the world are one aspect of our future-directed striving.

The loss of this enticement would, therefore, be an impoverishment of the protentional anticipatory grasp towards the immediate future. The anticipation and fulfillment of enticing possibilities would also be straightforwardly lost. As protention involves the perception and anticipation of possibilities and the fulfillment of possibilities, the loss of a class of possibilities and their potential fulfillment must surely be seen as an impoverishment of protention.

Ratcliffe (2012a) argues that the loss of practical significance causes an even greater alteration to protention. We have seen how the loss of practical significance may lead to an experience of time as cyclical – the depressed person no longer experiencing the future as holding the potential of being meaningfully different from the present. Without significance, there can be no sense of things being meaningfully different. As Ratcliffe writes:

In so far as our experience incorporates significant possibilities, it also incorporates a sense of its own contingency – a sense that this is not all there is or ever could be. In their absence, the potential for significant change is gone from one's world. (2012a, p121)

What does this mean for protention? Without the potential for meaningful change or difference, a sense of *anticipation* of that change is also missing from the depressed person's experiences. There can be no anticipation of alterations in significant possibilities, or of the fulfillment of these possibilities, as those very possibilities are lost. Protention involves this anticipation and so it is impoverished if practical significance is lost.

It must here be clarified that protention is not lost or destroyed; the depressed person may still possess an appreciation and perception of the immediate future. There is still *some* sense of anticipation of the next moment. What occurs when practical and enticing possibilities are lost is an *impoverishment* of this anticipation. The grasp towards the immediate future is diminished, following the loss of enticing possibilities, and the anticipation of possibilities and the

fulfillment of possibilities is similarly stripped away. Can one anticipate an immediate future that holds no significance or enticement? I think so, the general structure of anticipation remains, but it must be seen to be markedly different from our usual experience of both anticipation and fulfillment.

From Protention to Retention

However, the impact of the loss of enticing possibilities and practical significance on temporal synthesis is not limited to an impoverishment of protention. In what follows I argue that if we accept that protention is impoverished in cases of depression, we also need to acknowledge a necessary impoverishment of the content of retention as well. A fully developed protentional phase, we shall see, is essential for a fully developed *retentional* phase.

Protention involves an anticipation of the immediate future. This anticipation is then fulfilled in the present moment. Husserl explains, “the merely expected object is identified with the actually arriving object, as fulfilling the expectation” (2001, p122). The anticipation that belongs to the protentional phase at time t_1 is therefore fulfilled in the primal impression of time t_2 (where t_2 occurs immediately after t_1). The present moment thus “functions as a fulfillment of a preceding protentional intentionality” (Kortooms, 2002, p178). Although Husserl is unclear on this point, it seems plausible to suggest that in order to act as a fulfillment of this protentional anticipation, the anticipation must also be *retained*.⁶ This anticipation would be modified through retention, and as such would be experienced as a past-anticipation, or a fulfilled-anticipation, rather than the open-anticipation we find in the original protentional phase. Husserl writes, “The representation belonging to the

⁶ Husserl’s views on temporal consciousness were not static. As Kortooms notes, Husserl’s work in this area “is not so much the result of a thought process, but rather the process itself, in all its versatility and restlessness” (2002, pxiv).

fulfilled expectation necessarily “includes” the representation that the expectation itself is past” (1991, p160). Without the retention of the prior anticipation, the primal impression cannot be experienced as a *fulfillment* of anything – it would merely be noted as occurring after the previous moment. Thus, we can say that every retention includes the fulfilled-anticipation that was a part of the past protentional phase. Kortooms explains that retention includes, “the protentional directedness toward fulfillment that belonged to the preceding phase of consciousness” (2002, p162).

We only ever experience the primal impression in isolation from the temporal horizon in which it rests through a process of abstraction. Husserl is clear that in retaining a past Now we also retain the retentional phase that belonged to that Now – we do not just retain the prior primal impression. As Gallagher explains, “In the now-phase there is a retentioning...of the previous phase of consciousness. Of course the just-past phase includes its own retentioning of the prior phase. This means that there is retentional continuum...that stretches back over past experience” (2006, p191). Husserl is therefore able to speak of a “comet’s tail of retentions” (1991, p32). Our retention of a Now therefore includes the primal impression and the horizon in which it rests. I see no reason why this would include retentions and not protentions.

Indeed, Rodemeyer suggests that it is this protentional content of a retention that provides direction “from one “moment” or “phase” to the next “moment”, linking the retentions to one another” (2003, p132). The smooth progression of the “comet’s tail” is reliant on the interplay between retained-anticipation and fulfillment. DeRoo similarly argues that it is this structure that ““tie[s]” retentions to the present of the stream of consciousness” (2010, p105). The fulfillment of a past anticipatory directedness connects the immediate present moment to that past phase. The loss or impoverishment of this anticipation in protention, therefore, would equally be a form of impoverishment of *retention*,

impacting on the relationship between the retained phase and the current primal impression. This is not a complete loss of retention, nor is it as severe a breakdown as we have seen occurs in mania. The *structure* of retention has not been destroyed. Instead, retention is damaged in a very particular way – the grasp of the immediate past towards the present moment is lost and so the connection between the two is undermined. The person would, therefore, still have an awareness of what occurred in the immediate past, and indeed a sense of ownership of that past. The ordering of temporal events would be maintained. She would, however, experience a sense of disconnection that would make following action, speech, or thought across an extended period of time more difficult.

This kind of mild fragmentation is exactly what we see in some cases of depression. Descriptions of difficulties following trains of thought are common in first person accounts of depression. One respondent to the depression questionnaire, for example, wrote that “Thoughts become muddled and erratic” (#269). Another explained that she “Frequently lost trail of thought” (#218). One person described how “Everything is jumbled up like for someone with dyslexia who can’t read the letters on the page” (#303). Another respondent wrote:

My concentration reduces to the point where I cannot read and retain pieces of writing/information: I have never been able to "study" and it is only recently, after ~4years of medication, that I am able to read novels again although in Primary school (age 5-11) I was near infamous for my consumption of books. I'm not at that level again but better. At its worst I was able to look up from what I was doing and completely forget what it is I was doing or that I even had something to occupy my time at all. I have, at my worst, forgotten to breathe and have to inspire suddenly at the pain in my chest/realisation then focus on it for a few breaths until it gets back into rhythm. (#166)

We find descriptions of similar difficulties with speech and action. For example:

I have trouble concentrating and more often than not drift off topic. I often forget what I'm talking about mid-sentence [sic]. (#20)

Concentration and processing e.g...Forgetting what I was talking about midway through a conversation. (#350)

I find it hard to concentrate on every task I try and do. I give up put everything off. I wont [sic] go to the shops, I wont [sic] do housework. I cant [sic] do my Job / lose my Job. I can watch TV and not have a clue what is happening. I get confused and I find my memory really suffers. (#157)

I lose track of what I am saying mid sentence. My mind goes blank and I cant [sic] access information. (#280)

Part of what is going on here is a loss of a sense of connection between temporal moments. This loss makes it more difficult for the depressed person to follow trains of thought, speech, and action. The person is not confused as to the direction or order of time, nor does she experience a loss of ownership of her thoughts or speech, as we might expect were there to be a *breakdown* of the temporal structure. However, there is clearly still something lacking from the experience that means she no longer experiences a smooth sense of temporal progression. I suggest that this is partly due to the impoverishment of the anticipatory directedness in the protentional phase, leading to a loss of connection between the retentional phase and the primal impression.

We can therefore see how projects, possibilities, conation, and temporal synthesis are all intimately linked. Disruptions in one aspect of temporal experience may bring about disruptions in other areas. Having outlined how these changes may be linked in the case of depression I now want to turn to the experience of mania, developing the account I put forward in the last chapter through consideration of how longer and shorter-term temporal structures may relate in the case of manic experiences.

Mania, Projects, and Possibilities

In my discussion of the temporal experience in mania I have so far concentrated on the shorter-term alterations that occur in the retentional-protentional structure and conative drive. I have argued that there is a weakening of retention during manic episodes in addition to an increase in conative dynamism. However, along with alterations to drive and temporal synthesis, I will show that there are also alterations in the longer-term structures of projects and related possibilities.

Similarly to cases of depression, in mania there is often a loss of the projects in which the person was previously engaged. It is notable that manic episodes are often preceded by times of great upheaval or change, such as the birth of a child or a change in career.⁷ Whilst the stress of such events is undoubtedly causally significant, it seems plausible to suggest that the loss of past structures and projects also plays a significant role. The loss of projects would lead to a decontextualised present – past projects no longer providing structure to present experiences.

In addition to an initial loss of projects, the weakening of retention prevents the building of new or replacement projects, as well as preventing the maintenance of current projects. The manic person's confinement to an unengaged and unreflective Now precludes the possibility of any form of structured project. As one person with bipolar disorder explained, "To destroy myself or to escape often occurred to me, but my mind could not hold on to one subject long enough to formulate any definite plan" (Reiss, 1910, cited in Goodwin and Jamison, 1990, p27). Kraepelin provides a similar description of acute mania: "The patient is unable to carry out any plan at all involved, because new

⁷ See (Johnson 2005) for full discussion of the role of life events in episodes of mania. Of particular note is the relationship between the achievement of goals and the development of mania. The achievement of a goal may partly be seen to be a loss of a former project.

impulses continually intervene, which turn him aside from his original aim” (2010, p21). There are at least two implications of such a loss: Firstly, the manic person may no longer act in order to further goals or promote values previously held to be important. A manic person may quit a job, leave a partner, or spend all of his life savings in part because working at a job, maintaining a relationship, or putting money into savings would no longer be given value through longer-term projects or commitments. The manic person will have lost the for-the-sake-of-which that gives meaning to his tasks and shorter-term goals.

It also seems likely that this loss of projects would amount to a loss of a form of understanding or interpretation of the self. I previously noted the extent to which we understand ourselves through our commitment to certain relevant possibilities. The manic person, however, would no longer be able to interpret himself through longer-term commitments and projects that usually contextualise and give meaning to possibilities within the world. For example, a man who previously committed himself to the role of being a father may, when manic, lose this self-interpretation. Possibilities and shorter-term projects related to his longer-term project of being a father would fall away, as he is no longer able to maintain this long-term commitment. As such, the loss of the projects may also be a loss of a way in which the person understands himself.

Our projects provide a form of structure or context for possibilities in the world. It is partly through our projects that we encounter various possibilities as more or less enticing and relevant. The loss of these projects may, therefore, result in no possibilities appearing as relevant or enticing. This, we have seen, is what occurs in many cases of depression. However, the loss of possibilities is not a necessary outcome of the loss of projects. It is also possible that the loss of projects may result in *all* possibilities appearing as enticing and relevant. Whilst projects help us to determine what *is* relevant, they also, crucially, help us to

determine what *is not* relevant. This second scenario, I suggest, is what occurs in cases of mania. Far from the grey and meaningless experience of the world that we find in cases of depression, in mania the world is experienced as being full of unstructured meaning and colour. The loss of projects has not resulted in a contraction or loss of possibilities, it has instead resulted in a *decontextualisation* of possibilities. Such a decontextualisation means that all possibilities are experienced as equally relevant and enticing.

Whilst the depressed person loses practical significance and enticing possibilities, the manic person experiences an excess of significance and enticement. All possibilities are meaningful, and all possibilities draw the manic person in to action. The manic person therefore retains the will to act as well as experiencing an increase of practical significance in the world. In contrast to the non-manic person, however, these possibilities are not structured by longer-term goals or projects – all possibilities are at each moment ‘new’, unconstrained by longer-term projects or meanings. We would, therefore, expect the manic person to be overwhelmed with possibility. There is a ‘flattening’ in the sense that particular objects do not stand out more than others, but this is not because everything has lost its significance, but rather because all things have significance for the manic person.⁸ Everything is enticing, ‘new’, and relevant. Without the constraints of a project the manic person no longer meaningfully differentiates between different possibilities in the way that the non-manic person does.⁹ In some cases this may even extend to possibilities that may appear to the non-manic person as unattractive or

⁸ We can contrast this with the ‘flattening’ that occurs in depression where, as one person with depression describes it, “There is little or no discrimination” (Custance, 1952, pp76-77, quoted in Landis, 1964, p262).

⁹ Sass and Pienkos suggest that one way we can distinguish between cases of mania and schizophrenia is precisely in this topic of “*how things matter*”. They write: “Whereas for the individual with mania...there are too many things that matter, and that come to matter too quickly and fleetingly, for the individual with schizophrenia, it is rather that nothing may matter, or at least matter in a normal fashion” (2013a, p115).

repulsive. As one person writes, “In the manic phase repulsion gives place to attraction” (Custance, 1952, p42, quoted in Landis, 1964, p291).¹⁰

Conation, Obsessions, and Grandiosity

Just as we saw that a loss of enticing possibilities is a retardation of conation, we can equally see that an increase in practical and enticing possibilities would be an *increase* of conation. With all possibilities being experienced as enticing possibilities, the manic person will experience a greater sense of being drawn in to action. The world, for the manic person, has an increased allure, a pull towards short-term future possible action. This allure or enticement to action is *part of* conation. An increase in enticing possibilities is, therefore, an increase of conation.

The loss of projects, we can therefore conclude, destabilises the conative drive. However, this destabilisation may either take the form of a loss of conative dynamism, or of an increase in that same drive. The former is what we have seen occurs in cases of depression. The latter, we can now see, is what occurs in cases of mania.

As the conative drive is preserved, the manic person retains some ability to anticipate or project into the future. As such, we find that through the loss of projects he does not simply lose his current interpretation of the self. Instead, he begins a process of constant radical reinterpretation. Andy Behrman, for example, writes of a manic episode: “I want to be a chef, a model, an architect, a surgeon, and an astronaut” (2003, pxx). The manic person may no longer be able to maintain a commitment to his role of being a father, for example, but rather would reinterpret himself on the basis of whatever he sees or is involved with in the present moment. Brian Adams describes this process in his memoir

¹⁰ Custance contrasts this with his experiences in depression, where he was disgusted by many things and continually washed his hands (quoted in Landis, 1964, p291).

of bipolar disorder, explaining how he came to interpret himself and his possibilities entirely in relation to Lego:

Lego, I was sure, was what I was meant to be, what I was created for. I'll get a job with Lego now and build Lego houses and Lego spaceships for a living. With my talent for Lego I'll make a fortune. I'll get a letter off to Lego today to tell them all about me. I need to buy more Lego.

(2003, p14)

Adams has lost all prior interpretations of himself, thus allowing for this radical reinterpretation purely in terms of his relationship to the currently present Lego. He no longer structures the world in relation to prior longer-term projects, instead developing meaning-structures based on his current involvement in tasks. As Lego-related tasks dominate his present, so they structure his experience as a whole. He would, therefore, begin to neglect past commitments that do not involve Lego, such as jobs, family commitments, or relationships. Adams recalls another short-lived manic obsession with cleaning a byre:

I had used that byre as a workshop of nine contented years without ever thinking in that time that the place needed a special doing, but suddenly, all this, the pursuit of perfection, had to be followed to the exclusion of everything else in my life. (2003, p17)

Anything that is not immediately present to the manic person would not feature as part of his understanding of himself, and so we see a development of structures based only in the present. The manic person may therefore develop deep obsessions on the basis of what is immediately available, and may well build long-term plans on the basis of these obsessions. Without the distraction of past projects or plans the manic person is able to build a structure based around possibilities currently available to him, and so those possibilities encompass and define all of his tasks. One person describes this all-encompassing focus in the following way:

The immediate stimulus to action or expression, whether that stimulus comes from external circumstances or from the chance flow of thought, is momentarily brought to represent the total of pressure. (Graves, 1942, pp671-672, quoted in Landis, 1964, p294)

This ability to focus entirely on one thing without the distraction of past projects or commitments may contribute to the creativity and productivity that is commonly reported in episodes of hypomania.¹¹ The manic person is able to think in new or unique ways, unconstrained by past associations or projects. Without the usual context for possibilities, the person's creative attempts may well be more original than those developed when non-manic.¹² This experience may be enhanced by the flight of ideas allowed by the weakening of retention. It is, however, unlikely that any long-term plans would be able to be carried out in a structured manner, unless relevant features of that project were always available in the present. This would be particularly true in more severe cases of mania – suggesting that creative pursuits may become increasingly difficult to develop the more severe the manic state (thus, such creativity may be restricted to cases of hypomania or milder cases of mania). The manic person therefore experiences deep but short-lived obsessions, constantly developing new tasks and interpretations of the self based on that which is currently available.

Terri Cheney writes in her memoir that “the danger of mania is always its grandiosity” (2008, p123), and grandiosity even appears as part of the diagnostic criteria for mania in DSM-IV (APA, 2000, p362). Goodwin and Jamison note that manic delusions “are usually grandiose and expansive in nature” (2007, p57). The account I have offered of temporal experience in mania may help us to understand manic grandiosity. Without the context given by longer-term projects the possibilities the manic person perceives are

¹¹ See Jamison (1994) for a discussion of creativity in affective disorders. However, see also Sass (2000-2001a), Jamison (2000-2001), and Sass (2000-2001b) for a useful discussion of the concept of creativity and diagnostic issues.

¹² See Jamison (1994, p106-7) for discussion of mania and ‘divergent’ thinking.

unconstrained. This lack of constraint is combined with a loss of reflection, owing to the weakening of retention – the manic person therefore losing the ability to realistically predict or envisage consequences of actions. What the person wishes the outcome to be, therefore, she would envisage as being the likely outcome. Indeed, Goodwin and Jamison suggest that manic delusions “generally can be differentiated from schizophrenic delusions by their tendency to be wish-fulfilling in nature” (2007, p57). The unconstrained possibilities allow the manic person to develop an understanding of the self as someone who can do or be anything she wishes. It’s easy to see how such an experience may be grandiose in nature.

Delusions in manic states are frequently grandiose, but they are also notable for being remarkably fleeting and unstructured. Winokur et al. state that “They are often evanescent, appearing or disappearing during the course of a day, or even during an interview” (1969, p70, quoted in Jamison and Goodwin, 1990, p265). Kraepelin puts forward a similar claim, explaining that they “change frequently, emerge as creations of the moment and again disappear” (2010, pp17-18). We also find that in “mania the delusions tend not to be as fixed and persistent as in schizophrenia” (Silverstone and Hunt, 1992, p18),¹³ and Goodwin and Jamison note that these delusions “tend not to be systematized” (1990, p265). We can therefore describe manic delusions as largely grandiose, fleeting, and unstructured. This understanding of manic delusions is also backed up by first person accounts. Landis quotes one person who described his experience of grandiose delusions in manic states in the following way: “To be sure such houses of cards almost immediately superseded each other, but the vanishing of one could not disturb a mind which had ever another interesting bauble to take its place” (Beers, 1908, p193, quoted in Landis, 1964, p286).

¹³ Similarly, Straus notes that delusions in manic states tend to be “more changeable” (2012, p213) than delusions in states of depression.

This form of delusion is what we would expect given the loss of the capacity to develop structured projects alongside the inability to meaningfully reflect or appreciate likely consequences. The excess of possibility experienced by the manic person allows for the development of wish-fulfilling grandiose delusions. However, the loss of the capacity to maintain structured projects means that such delusions are not fixed or structured.

Finally, we can see how the decontextualisation of possibilities may lead to the manic person performing excessive or unnecessary acts. For example, both Hornbacher and Cheney describe continuing to buy large quantities of particular items despite already owning those items and having no need for them. Hornbacher writes, "I buy nine Coach purses, twelve Coach scarves, and six identical Coach hats, items I obviously need immediately, *urgently*" (2008, p258). Cheney similarly describes buying a large number of kites as presents, "High as a Kite. Perfect, perfect! They have every style of kite imaginable...all so colorful, so silly, so just what I wanted! I bought a dozen plus two more for luck"(2008, p167).

We can immediately suggest that the lack of the contextualisation of possibilities serves to make relevant these otherwise unnecessary or irrelevant actions. The manic person sees these possibilities as salient because the loss of projects and commitments allows *all* possibilities to become salient and enticing. Therefore, whilst Hornbacher may have no relevant reason to buy a hat, the possibility is still highlighted to her and appears as enticing. Additionally, we can see why she might continue to buy hats, despite already having fulfilled her desire to buy one; without the contextualisation of projects and commitments, the possibility may remain 'relevant' and enticing even after it has been completed. In the non-manic experience, a person may find the possibility of buying a hat becomes salient to her because she is preparing for an event that requires a hat. As such, once she has bought the hat, the

possibility of buying a hat no longer appears as salient or enticing. For the manic person, however, all possibilities are salient and enticing, not because there is some further for-the-sake-of-which, but because they have been decontextualised. As such, the hat-buying remains a salient possibility, even after one hat has been bought.

We can, however, find another potential contributing factor for this experience. We earlier noted the intimate link between protention, fulfilment, and retention and saw how an intact retentional capacity is necessary for the fulfilment of protentional anticipation. It is this retentional capacity that is weakened in cases of mania. As such, we find that the capacity for fulfilment is undermined. Whilst the manic person is able to perform the anticipated action, there would be no retention of the anticipation and therefore no experience of 'fulfilled-anticipation'. For example: The manic person may perceive the possibility of buying a hat. She then acts to buy that hat – to fulfil that possibility. However, because the anticipation of buying the hat has not been retained, there would be only a limited sense in which the person could experience the action as being a fulfilment of the prior possibility. Even if we grant that there is a limited experience of fulfilment, this would not be retained in the next temporal moment. As such, the hat-buying possibility may still appear to the manic person as being un-fulfilled. We therefore find that a person in a manic state may buy large quantities of the same or similar items without perceiving such acts as excessive.

We must take care here to distinguish between this loss of fulfilment, and the everyday experience of *failing* to fulfil a possibility – an experience that may result in frustration or disappointment. In this everyday experience, there is a retention of the anticipation of the possibility combined with the experience of it not being fulfilled. In contrast, the manic person does not retain the prior anticipation, and so there is no experience of the fulfilment having been

frustrated. The manic person is simply left in the same experiential state as before she bought the hat – still perceiving the hat-buying possibilities, and with no experience of having already fulfilled that possibility. Thus, the manic person may continue to buy multiple hats despite already having carried out this possibility.

We can therefore see that an understanding of a person's capacity to have and maintain projects can help to cast light on several aspects of experience in both mania and depression. In cases of depression we can see that the loss of practical significance in the world prevents the building of meaningful projects. The resultant loss of enticing possibilities is a loss or diminishment of conation. The depressed person therefore begins to experience time cyclically, and the world as a whole takes on the appearance of being grey, flat, and meaningless. In contrast, we find that in mania the weakening of retention prevents the maintenance of long-term projects. The decontextualisation of possibilities leads to an experience of all possibilities as enticing possibilities. This increase in enticement to action is an increase of conation. Without the constraint of projects the manic person perceives significance in the world, but it is unstructured and so unstable from moment to moment. This allows for a constant re-interpretation of the self, with the neglect of prior responsibilities and values, and may foster the development of grandiose delusions.

Mania and Interpersonal Relationships

In chapter five I highlighted the sense of frustration that a person in a manic state may feel towards other people. I noted that the desynchronization of interpersonal time contributes to this experience, the manic person feeling 'held back' by others. Having further developed our account of temporal experience in mania, we can now return to this topic of interpersonal relationships, exploring the ways in which the manic person's altered experiences of time and the world may affect his relationship with others.

I have explored how the weakening of retention that occurs in states of mania prevents meaningful engagement. The manic person not only experiences a diminished engagement with the world, he also experiences a loss of meaningful engagement with other people. Recall, for example, the following description from Ludwig Binswanger:

They answer you easily and quickly, even breaking in, giving you undivided attention, admiring your mustache or your dress, your intelligence or your manner...But this heightened facility in communication is only apparent; it remains superficial. If a second or third party appears, the patient loses you from sight just as quickly as he first laid eyes on you.... (1964, p129)

Whilst the manic person is active and talkative, and so may initially appear as highly sociable, the connection with others remains superficial due to the high distractibility and loss of reflection that is experienced in manic states. The manic person is frequently distracted from the conversations he is having with others, and his inability to meaningfully reflect means that what he says may be inappropriate or irrelevant to the situation. As such, the manic person may find his ability to connect with others undermined, despite his increased activity.

The manic person's relationship with others may be further damaged through his inability to maintain projects and commitments that were previously held to be important. We have seen that the weakening of retention prevents the development and maintenance of projects. This may bring the manic person into conflict with friends, family, or work colleagues that still view these projects as important or valuable. Those around the manic person may become frustrated or angry with him as he no longer acts to further goals related to the previously held project. We also find that the loss of long-term projects and commitments, combined with a diminished capacity for meaningful reflection, may cause radical changes in behaviour, such as a person quitting his job or leaving his partner. These kinds of extreme actions may make it difficult for

close relationships to be maintained. As Goodwin and Jamison note, “Bipolar illness...inevitably has powerful and often painful effects on relationships” (2007, p337).

Earlier in this chapter I discussed how short-lived obsessions may develop in cases of mania, due to the manic person’s experience being structured by what is available in the present moment rather than by longer-term projects. During periods in which these obsessions are present, prior responsibilities may be neglected. A man who, in a manic state, becomes obsessed with writing a book may, for example, continue to write instead of looking after his children or carrying out tasks necessary for his job. This neglect of responsibilities may prove to be frustrating for those who are close to the person. Although he may still be highly talkative, social and productive, the manic person’s ability to maintain longer-term relationships may therefore still be undermined.

The points discussed above highlight why another person might find interacting or forming a relationship with a manic person difficult or frustrating. However, the alterations that occur in temporal experience during episodes of mania may also lead to the manic person becoming frustrated or irritated with others. We have already seen that the desynchronization of temporal experience that occurs in mania may contribute to this frustration. We can, however, find a further reason why a person in a manic state may become irritated or angry with other people.

During a manic episode, the person experiences an excess of possibility, these possibilities appearing as both relevant and enticing. The person is constantly drawn in to action and, with her capacity for reflection diminished through the weakening of retention, these actions may not always be appropriate or safe. As such, the manic person may come into conflict with other people, who may be reluctant to pursue the same actions or may be trying to prevent the manic person from carrying out actions that are dangerous. That other people do not

share her experience of unstructured possibility may become frustrating for the manic person. Although she may continue to interact with others, irritation or even anger is likely when the other person refuses to acknowledge or act on what the manic person sees as possibilities that are relevant and enticing. This frustration or anger may be even more pronounced when the person is trying to *stop* the manic person from carrying out a particular action, rather than merely failing to 'join in'. As Binswanger notes, "...there is one thing they will not tolerate: contradiction and restriction of their freedom of movement" (1964, p132). Kraepelin similarly writes that the manic person may become "impertinent and even rough, when he comes up against opposition to his wishes and inclinations" (2010, p36). The radically different ways in which the manic and non-manic person experience the world may bring them into conflict with one another, resulting in the manic person becoming annoyed or even angry at the other person.

We can therefore see that whilst a person may become more active, talkative, or sociable whilst manic, her relationship with other people will not necessarily be improved. Her conversations are likely to remain superficial, undermined by her increased distractibility. She may neglect prior responsibilities and commitments, or radically change her behaviour in ways that are damaging for family, friends, or colleagues. She may become frustrated with other people, both due to the feeling of being out of synch with others, as well as due to others failing to 'join in' or recognise the possibilities that she perceives as being enticing. Her ability to interact or connect with others is therefore undermined both due to her actions, which may be damaging to others, and due to the radical difference between the possibilities she perceives and the possibilities that are perceived by others.

Having examined the temporal experience of mania and depression and noted some of the common implications of these experiences, we are now finally in a

position to explore our earlier questions regarding bodily experience in mania and depression.

Time and the Body

In chapter three I highlighted the unintuitive experience of the body that is described in states of mania. The manic body is active, but in contrast to our everyday non-manic experiences it fails to fade into the background through its activity. Instead, the body remains conspicuous to the manic person – she is explicitly aware of it. I suggested that two key questions arise from this description of bodily experience:

1. How can the manic body be active in the world and yet not fade from explicit awareness?
2. Why is the depressed body both conspicuous and inactive, when we have a clear example of a conspicuous body that does not prevent action in the case of mania?

I suggest that both questions can be answered with reference to the contrasting temporal experiences that occur in mania and depression.

In cases of mania we have seen how a weakening of retention leads to a decontextualisation of possibilities. The manic person is no longer constrained by past projects or self-interpretations and so experiences a wealth of possibilities in the world – all possibilities standing out to her as relevant, salient, and enticing. Given this increase in possibilities it is therefore not surprising that the body in mania is active. Why it is conspicuous, however, requires further examination.

The body becomes transparent when a person is engaged in a task. When I cross a road, or drink from a mug, or climb a flight of stairs, I am focussed towards the world as I carry out the activity. As such, my bodily awareness

fades in order to allow me to get on with the task – I am directed towards the world, not the body. However, in mania the person is only ever superficially engaged in the tasks that she carries out. Whilst she is active, this activity is flighty and detached from the longer-term purposes and projects that enable meaningful engagement. The manic person, in contrast with the non-manic person, is constantly re-structuring on the basis of each moment. In everyday situations the tasks I carry out are situated in a longer-term context. For example, I cross the road in order to reach the library, in order to collect a book that I need in order to complete some piece of research, and so on. With the loss of this context the manic person can no longer meaningfully engage in the task itself, and without this deeper engagement we find that the body does not fade away. It is the engagement in projects that allows the body to fade into the background, not merely activity. The manic body therefore remains conspicuous to the person.

However, we find that the manic person can still act in the world – there is still salience, there are still possibilities, and she can still project into the future. It is this wealth of possibility that allows the manic person to describe the bodily experience as “loose, disconnected, as if I’m made of mercury, of quicksilver” (O’Donoghue, 2009, p47). The conspicuous body of mania does not *block* action; it is not *objectified* as it is in cases of shame or depression. Instead, the inability to meaningfully engage in tasks that rest within a wider context prevents the person from fully directing her attention towards the world. This prevents the body from ever fully fading out of explicit awareness. The manic experience of the body would therefore be comparable to that of the non-manic person at the moment of initially motivating a task. The person can perceive the relevant practical possibilities for the object and she can act to perform them. However, in cases of mania the person will not be able to get beyond this initial motivation – each action remains for the sake of itself, rather than for a

longer-term purpose. As such, the manic person never fully engages in the task, and so the body never fully fades away.

We can therefore see that the conspicuous body and the inactive body do not necessarily have to coincide. The manic experience includes practical and enticing possibilities, and preservation of the conative drive. The manic person is still capable of projecting forward into the future, and so can still act in the world. The body becomes conspicuous due to the decontextualisation of the actions performed, the resultant loss of engagement preventing the body from fading into the background. The body is therefore both active and conspicuous.

We can also enrich our account of bodily experience in depression by taking into account the impact of alterations in temporal experience. Whilst the manic person maintains the perception of enticing possibilities in the world, the depressed person loses the capacity for practical and enticing possibilities and experiences a loss of conation. This loss of the forward directed momentum manifests in a *restricted* experience of the body. As Fuchs explains, “the patient’s imagination, the sense of the possible, fails to generate future goals and plans, leaving the self confined to the present state of pure bodily restriction” (2005a, p99). Without this capacity for practical significance the body loses a central element of its perceiving role, and so the person experiences it as object-like – “the person affected by melancholia collapses into the spatial boundaries of her own solid, material body” (Fuchs, 2005a, p100). The body in depression is therefore not merely *conspicuous*, as the manic body is, but rather *corporealized*. It is reduced to its corporeal form in part due to the loss of conation – an inability to transcend the body’s materiality. As we saw in chapter four, this corporealized body results in an altered experience of the world as well as the body itself. Thus, we find a mutually reinforcing relationship between depressed experiences of time, the world, and the body.

We can therefore see how alteration in temporal experience impacts on the bodily experiences of both mania and depression. This change in embodiment results in an altered experience of the world as well as the body. We therefore see a dynamic relationship between experiences of time, the body, and the world. Each aspect of experience further influences and reinforces the way that the other aspects are experienced. A change in temporality would at the same time be a change in world experience and embodiment, just as a change in world experience would incorporate altered bodily and temporal experiences.

Mixed States

What I have provided in this study so far is a discussion of 'pure' forms of mania and depression. Whilst such ideal types are useful in order to allow us to understand the extremes of bipolar disorder, it is important that we acknowledge the multitude of different ways that mania and depression may be experienced. We have already seen a number of different possible manifestations of depression and mania within these 'pure' types. However, it is also important that our account allows for the possibility of 'Mixed Episodes' or 'Mixed States'. As we saw in chapter two, the diagnostic criteria for a mixed episode – where a person with bipolar disorder experiences features of both mania and depression at the same time – provide us with little detail regarding how to recognise or understand such states. The vague and constantly changing criteria makes measuring exact rates of mixed states difficult. However, studies do confirm that such states are common.¹⁴ Nassir Ghaemi writes, "Any discussion of the phenomenology of mania and depression has to cope with the topic of mixed states" (2007, p123).

¹⁴ Goodwin and Jamison provide a summary of 18 studies measuring rates of mixed states. In these studies there was an average rate of 28 percent in affectively ill patients, though the rates in individual studies ranged between 67 percent and 10 percent. They conclude, "By any standard, mixed states are not as rare as they once were reputed to be" (2007, p78). See Goodwin and Jamison (2007, pp78-82) for full discussion.

Mixed states are difficult to understand if we conceive of depression as being nothing more than extreme unhappiness and mania nothing more than extreme elation. Indeed, the existence of such states appears to be unthinkable if we understand mania and depression to be opposite poles – how could two opposite extremes exist in the same person simultaneously? As Swann et. al. explain:

The occurrence of simultaneous depressive and manic states is counterintuitive. The term ‘bipolar’ may not be an accurate description of patients with manic or depressive states, implying as it does that manic and depressive syndromes must be polar opposites. (1993, p87)

In what follows I show how the accounts I have provided of mania and depression allow us to accommodate mixed ‘states’ or ‘episodes’, providing a framework that helps us to make sense of experiences that might otherwise be difficult to understand.

A number of different forms of mixed states have been identified – Kraepelin notably proposed eight distinct types of states (2010, p66-70). However, my focus here is not on providing an account of a particular diagnostic category, but rather on exploring the more general question of how features of mania and features of depression may present simultaneously. For the following discussion I will therefore focus on two of the more commonly described states in which these features co-occur: ‘Dysphoric Mania’ and ‘Agitated Depression’.¹⁵ Each of these demonstrates a way in which mania and depression may come together in a single experience. Once we have grasped how this is possible in these accounts we can use this insight in order to understand the variety of different experiences common in bipolar disorder; and how, in contrast to the understandable intuition of the two as opposites, it is possible to reconcile mania and depression in a single experience.

¹⁵ Goodwin and Jamison note that research into mixed states has largely focused on forms of dysphoric mania (2007, p81).

Dysphoric Mania and Agitated Depression

There is nothing in my account of mania that restricts the mood to that of elation. Certainly, a positive or even euphoric mood is likely given the unconstrained possibilities and the restricted ability to consider consequences. The manic person feels that she can do or be anything she wishes, and she has no concern for possible negative consequences. Without this concern for future negative experiences, and without the experience of things being difficult or impossible it's easy to see why a person's mood may be joyful or euphoric. However, this need not be the case. I have already shown how the experience of intersubjective temporal desynchronization may be experienced as negative or distressing. The manic person may find being out of synch with other people as upsetting or frustrating, potentially even developing into anger at the other person. As such, whilst euphoria is likely when a person is manic, it is also possible that the person's mood may be one of irritation and frustration. Whilst a feeling of time speeding up, being drawn into the world with unconstrained possibilities, may be a positive experience for many, this excess of possibility may be experienced by some as unwanted pressure or an excess of demand. This might be experienced as an uncomfortable sensation of the world being 'too much' or of the person feeling out of control. Patty Duke describes how during manic episodes she experienced irritation and anger:

My manias took the form of irritability and unpredictable flashes of rage...I would start screaming ugly foul epithets either at a particular kid or at John or at the group in general, or at the world. And if the words weren't enough and I would feel physically on fire, I would start throwing things – the food, the plates, the glasses.

(Duke and Hochman, 1992, pp199-200)

We can therefore see how symptoms that we usually associate with a depressed state may occur during a manic state. The account I have offered does not limit mania to being pleasurable or desirable – it also allows for the possibility of features of depression such as frustration, anger, or a general negative mood.

Similarly, it is possible for a depressed state to contain features of mania. One way in which this may occur is if enticing possibilities are lost, but some projects and commitments remain.¹⁶ We have seen that projects and commitments provide a form of long-term temporal orientation for the person – a teleological time. This teleological time allows for an experience of the progression of time, including a sense of being drawn into the long-term future. As such, we see that with the maintenance of projects there remains what we might characterise as a form of drive towards the long-term future. However, without enticing possibilities the person finds her ability to act in the world restricted – she experiences a sense of separation or distance from the world. Whilst possibilities may appear as relevant – she *could* or indeed *ought* to act in that way – she does not experience them with varying degrees of enticement. Such an experience may bring about agitation or provoke anxiety in at least two ways:

Firstly, without enticing possibilities the person has lost a crucial ability to distinguish which possibilities are necessary for her particular course of action. Whilst possibilities may be highlighted as relevant, this is not backed up by a feeling of being drawn to fulfil them. The person may therefore find herself conflicted as to whether that particular possibility is *actually* the relevant one – she does not experience the usual draw to the world that allows her to commit to actions. This experience of tension between the possibility being revealed as relevant but not enticing may prove to be anxiety-provoking or distressing.

Secondly, we find that due to the maintenance of projects and commitments the person still perceives possibilities that show how she ought to act. Various possibilities are shown as relevant within the context of furthering a project. We also find that, as teleological time is maintained, she is still drawn into the

¹⁶ See Ratcliffe (2012a) for a similar proposal that suggests one form of mixed state may come about due to the loss of enticing possibilities combined with an intact conative drive.

long-term future. As such, she not only finds relevant possibilities highlighted, she also experiences a sense of pressure or drive. However, with the loss of enticing possibilities she does not experience a draw into the *world* that entices her to act. She recognises the need to act, and still experiences a draw towards the future, but remains disconnected from the world, feeling blocked or unable to act. The resultant pressure thus manifests as a form of bodily agitation rather than an enticement to productive action. This is a distressing but still active state distinct from the rigid and inactive state commonly associated with a 'pure' depression. Hornbacher describes her experience of one mixed episode:

I'm agitated, constantly anxious, gripped by random, sudden fears, and I whip around aimlessly, compulsively making lists, worried that I will forget something, that I'll lose something, that I'll fail at something important, that I won't get something done. (2008, p169)

The loss of enticing possibilities cuts the person off from the world, preventing productive action that might alleviate the pressure experienced due to the maintenance of projects and commitments. She also experiences anxiety due to the tension between possibilities appearing as relevant but not enticing. Her recognition that she ought to be carrying out certain actions for the sake of furthering a particular project, combined with her feeling blocked from actually carrying out such actions, may result in her beginning to evaluate herself as 'useless' or 'worthless'. It is therefore unsurprising that the person becomes concerned that she might 'fail at something important' or 'forget something'.

We can therefore see how the agitation and pressure usually associated with mania may occur in a state of depression, producing a form of 'agitated' or 'anxious' depression. This type of state is perhaps more closely related to 'pure' presentations of depression than to states of mania, with only a few manic

features being present.¹⁷ However, what is key for our purposes here is that this form of depression can be seen to be distinct from the forms of depression we have previously discussed, and that it combines features of depression with features of mania. The accounts of mania and depression that I have offered allow us to bring together these features, revealing states in which they are mixed to be non-mysterious.

Kraepelin notes that mixed states commonly occur during “periods of transition between states of depression and mania” (2010, p19). This fits with our understanding of mania and depression not as two extremes on opposite poles, but rather two manifestations of alterations to similar structural elements. A loss of projects, for example, may lead to either a manic, a depressed or, as we have just seen, a dysphoric manic state. Disturbances in temporal and bodily experience are central to both states. Common features of mania and depression need not be seen as unique to those states, and some ‘symptoms’ typically associated with depression may also occur during manic states, and vice versa. This complexity suggests that transition periods are unlikely to consist of sharp switches between a ‘pure’ state of depression and a ‘pure’ state of mania.

As similar structural features are altered or lost to produce both states of mania and depression, a person may easily switch between the two. This allows for the possibility of a *rapid cycling* bipolar disorder. According to DSM-IV, this type of bipolar disorder – where four or more distinct mood episodes are experienced within a twelve-month period – occurs in “approximately 10%-20% of individuals with Bipolar Disorder seen in Mood Disorders clinics” (APA, 2000, p427). The relatively high rate of rapid cycling bipolar disorder is understandable given the similar structures that underlie both mania and depression. This relationship between the two states also allows for the

¹⁷ See Akiskal et al. (2005) for discussion of whether forms of agitated depression ought to be conceptualised as types of mixed state.

possibility of a type of mixed episode characterised by constant short-term switching between the two states, rather than the co-occurrence of features of both states. Indeed, this is how a mixed episode is initially characterised in DSM-IV: “the individual experiences rapidly alternating moods” (APA, 2000, p362). Thus, the accounts I have outlined of mania and depression help us to make sense of episodes in which features of mania and depression occur simultaneously, as well as episodes in which the person experiences rapid switching between the two states.

The accounts of mixed episodes that I have offered here ought not be thought to exhaust the possible ways in which mania and depression may come together. Instead, they illustrate the more general point that states that appear as mysterious when we conceive of mania and depression as polar opposites, are rendered non-mysterious when we recognise that the two states rest on similar structural alterations. This acknowledgement that the experiential structure of mania allows for the development of features we might commonly associate with depression (and vice versa) reveals the possibility of understanding a broader range of experiences common in bipolar disorder. It is notable that this conception of mixed episodes is closer to the descriptions provided in DSM-5 (APA, 2013, pp149-50) than those provided in DSM-IV (APA, 2000, p365). In line with DSM-5, these accounts of mania and depression support an understanding of mixed episodes as involving features typically associated with the other state, rather than the full co-occurrence of two opposing states. This understanding allows us to better account for a broader range of experiences that occur in bipolar disorder.

It can therefore be seen that the accounts I have offered of mania and depression help us to better understand the ‘pure’ states as well as experiences with mixed features.

Depression, Mixed States, and Suicide

Suicide, suicide attempts, and suicidal thoughts and feelings are common in bipolar disorder – about half of those with bipolar disorder attempt suicide (Lönnqvist, 2002).¹⁸ Indeed, such features form part of the diagnostic criteria for a major depressive episode (APA, 2000, p356). We find written in DSM-IV that “These thoughts range from a belief that others would be better off if the person were dead, to transient but recurrent thoughts of committing suicide, to actual specific plans of how to commit suicide” (APA, 2000, pp350-351). Understanding the experience of feeling suicidal is a complex topic, and one that I will touch on only briefly in this thesis.¹⁹ It must be remembered that we cannot straightforwardly assume suicidal thoughts are evidence of depression, nor are thoughts of suicide a necessary symptom of a depressed state. It is also likely that there are numerous different experiences of feeling suicidal (for example, the distinction between wishing that one was dead versus having an active wish to kill oneself).²⁰ There are also difficulties with accessing first person accounts of suicidal thoughts and behaviours – we cannot assume that the experience leading to an ‘attempted’ suicide is the same as the experience leading to a ‘completed’ suicide, and first person descriptions of the latter are rare for obvious reasons.²¹

That said, there are features of the accounts I have put forward of mania and depression that cast light on some aspects of the experience of suicidality. In

¹⁸ See Lönnqvist (2002) for a discussion of the risks of suicide in depressive disorders. However, see also Goodwin and Jamison (1990, pp227-228) for a discussion of the difficulties of accurately measuring the rate of suicide and suicidal thoughts in bipolar disorder.

¹⁹ For one in depth discussion of suicide and the relationship between bipolar disorder, depression, and suicidality see Jamison (2001).

²⁰ See Benson et al (2013) for a discussion of the distinction between suicidal thoughts and suicidal feelings.

²¹ We can, however, draw on diary and journal accounts for descriptions of this type. See, for example, Keith Vaughan’s journals (Vaughan, 2010), which include a journal entry written after he’d taken a fatal overdose.

what follows I will focus on four common features of the experience of depression, showing how each may contribute to thoughts of suicide. These are alterations in experiences of the body and world, isolation from the world and others, hopelessness, and experiences of a 'threatening' future. Following this, I discuss how common features of mixed states may contribute to suicidal thoughts. Exploring these features will not amount to full account of the experience of feeling suicidal, nor will it provide a full explanation of the reasons why a person may become suicidal. Instead, I aim simply to make a modest contribution to our understanding of the relationship between mania, depression, and suicidality.

Firstly, we have seen how alterations in bodily experience that occur in many cases of depression can lead to difficulties interacting with the world. The corporealized body is experienced as an obstacle when the person attempts to act, seemingly confining and restricting the person to his 'corporeal' self. This leads some to evaluate their bodies and themselves as 'useless'. Further to this, we have seen how the depressed body may fail to highlight potential practical actions within the world. The usual bodily structures that reveal and highlight practical possibilities are eroded, leading to feelings of restriction, frustration, and isolation. These feelings of being unable to act within the world, combined with the experience of being trapped in an exhausted, painful body may plausibly be thought to contribute to experiences of suicidality. For example, one person described her experience shortly before a suicide attempt, explaining, "my body is uninhabitable" (Goodwin and Jamison, 1990, p236). Another person, diagnosed with bipolar disorder, writes, "I hated my body. When I went out in public I thought everyone was staring at me with disgust. I believed I would only feel better if I were dead. So I overdosed again" (Graham, 2010, p4). This is not simply an experience of 'hating' or strongly disliking the body – the bodily experience is also one of extreme and distressing restriction.

William Styron describes the connection between this feeling of restriction and suicidal thoughts:

The gray drizzle of horror induced by depression takes on the quality of physical pain...[D]esperair...comes to resemble the diabolical discomfort of being imprisoned in a fiercely overheated room. And because no breeze stirs this caldron, because there is no escape from this smothering confinement, it is entirely natural that the victim begins to think ceaselessly of oblivion. (2004, pp49-50)

However, this relationship between bodily experience and suicidal feelings is not straightforward. First person accounts describe how the experience of the body being slow, heavy, and difficult to move, in many cases helped to prevent the person from attempting suicide. Terri Cheney, for example, explains:

I just lay there – unwashed, uncombed, and drowning in inertia, struggling with the need to breathe in and out...the paralysis is no doubt what kept me alive. Had I been able to move the least little bit, I would surely have seized the first chance to die. (2008, p199)

Alterations in bodily and thus world experience may therefore be thought to contribute to a person feeling suicidal, but the physical restriction experienced may prevent the person from actually carrying out such plans.

Isolation from the world and others is a consistent theme in first person accounts of depression. I have shown how alterations in both bodily experience and temporal experience may contribute to this experience of alienation. The depressed body, we have seen, blocks access onto the world, appearing to the person as a heavy and difficult to move 'object'. Combined with its failure to highlight relevant possibilities for action, an experience of distance or separation from the world is likely to result. We have also seen how altered experiences of time may contribute to this kind of experience. The loss of the capacity for practical significance and enticing possibilities contributes to this feeling of separation. Similarly, desynchronization of the depressed person's

subjective time with the time of others can result in a feeling of separation from other people as well as leading to difficulties in interaction. In severe depression we have seen how this may be experienced as a sense of emotional connection being 'impossible'. First person accounts of experiences of suicidal thoughts often stress how this feeling of being irreconcilably separate from others contributes to thoughts of suicide. For example, one person described her experience of feeling suicidal in the following way:

I have prayed to God to kill me – isn't there some pill they can give me to take my life?...I dread to wake up in the morning and face another day of emptiness. I'm tired of feeling as though I'm standing in the foyer of mankind and can't go in. (Quoted in Goodwin and Jamison 1990, p236)

Sally Brampton provides a similar description in her memoir of depression:

At times like that suicide, or death, presses heavy on my mind. If I cannot live, cannot connect with life but am doomed, for ever, to have my face pressed against the window watching it pass me by, then why not die? What is that already, if not a living death? (2009, p244)

Feelings of isolation from the world and others, we might plausibly suggest, contribute to a person feeling suicidal. It is perhaps not surprising that a person who feels that she cannot interact with either other people or the world more generally may begin to feel that her life is 'pointless' or a form of 'living death'.

Another feature of temporal experience in depression that I have highlighted is the experience of depression as eternal. We have seen that the retardation of conation may lead to an experience of the future as blocked or inaccessible. The depressed person therefore experiences the present as eternal and unchanging – there is no sense of things altering or improving in the future. I demonstrated in this chapter how the loss of practical and enticing possibilities might exacerbate such an experience. The depressed person can no longer perceive the possibility of the future being meaningfully different from the present, and so the current

state of depression is felt to be both eternal and impossible to recover from. This experience of recovery as impossible may be thought to contribute to a person becoming suicidal. Without the possibility of 'escaping' the depression in the future, death may begin to seem to be the only way out of the current state. As Andrew Solomon writes in his memoir of depression, "If I had truly believed when I was ill that my situation was permanent, I would have killed myself" (2002, p274). The temporal structure that we encounter in many cases of depression may cause a person to believe that her situation *is* permanent, that she will always be depressed. Hopelessness has been identified as an important risk factor for the development of suicidal thoughts and behaviours (Mann et al, 1999; Goodwin and Jamison, 2007, pp261-2), and this form of temporal structure appears to cause the person to lose hope of recovery. Mark Williams writes, "People seem able to bear depression so long as they are able to think the future might improve, but if they begin to feel hopeless, the risk of suicidal behaviour rises" (2001, p91). We might suggest, therefore, that this temporal structure increases the likelihood of the person developing thoughts of suicide. As one person with bipolar disorder explains:

...in my most desperate moments I believe I would do, will do, anything to stop the suffocating, all consuming excruciating misery and panic. And In those moments/hours/days/weeks I cannot fathom the possibility that it might stop on its own. (Garey, 2010, p8)

Finally, I noted how temporal structures common in depression not only lead to an experience of depression as eternal; they also create an experience of the future as threatening and death as imminent. With the loss of the possibility of meaningful change in the future, the person experiences no distance between her and death – there are no meaningful activities or possibilities that provide this necessary separation. As such, the depressed person's experience is characterised by a sense of passivity before a future that holds no possibility of improvement as well as a feeling that death is bearing down on her. The feeling

that she is about to die is both distressing and exhausting for the person. Given this, it is perhaps not surprising that many in this situation begin to think about suicide.²² If all she perceives her life to consist of is a painful present and a threatening future, taking control of her own death may begin to appear to be an attractive alternative – the exhaustion of constantly perceiving death to be imminent may contribute to a person becoming suicidal.²³ Solomon writes, “Though suicide assuages present suffering, in most instances it is undertaken to avoid future suffering” (2002, p260). Von Gebattel quotes a girl with depression who makes this link between suicidality and a threatening future:

when I am crocheting, too, the emphasis isn't on the fact that the cover I'm crocheting is getting bigger, but on the fact that as the cover gets bigger the lifeline is getting shorter and shorter. I find that terrible. That is why I always want to take my life, to escape from this thought.... (2012, p215)

Given these alterations in temporal experience, it is possible that some people with depression will experience their future as consisting of nothing but suffering. Thoughts of suicide may, in such situations, arise as a potential way of avoiding seemingly inevitable suffering in the future.

Whilst the link between depressed states and suicidality may appear to be clear, the link between forms of mixed episodes and suicidality is perhaps less obvious. Suicide attempts are uncommon in manic states (Goodwin and Jamison, 1990, pp240-241). In contrast, suicidal thoughts and attempts

²² Benson et al. suggest that in some cases suicide attempts may be seen as a case of “letting nature take its course” (2013, p77) – bringing about a situation that appears to the person to be inevitable.

²³ Benson et al. note that “an integral part of the feeling of being suicidal is a sense of overwhelming demand on one’s mental resources” (2013, p66). This feeling of being near death might plausibly be thought to contribute to this overwhelming mental demand.

frequently occur in mixed states (APA, 2000, p362).²⁴ This heightened risk may, in part, be due to increased energy that is seen in many mixed states (Goodwin and Jamison, 1990, p241). The person in a mixed state has both the desire to commit suicide, and the energy to carry out such a task. However, the account I have offered of the possibility of mixed states helps to cast light on other potential contributing factors.

Earlier in this chapter I provided an outline of how we might understand cases of dysphoric mania – a form of mixed state. I noted how the account I have offered of mania is not reliant on the person being in a particular mood state – the temporal and bodily experiences may underlie a dysphoric experience, as well as the more classical euphoric. A dysphoric manic state, therefore, would contain many of the same features of experience that I suggested occur in states of euphoric mania. These, crucially for our current discussion, include a reduced ability to reflect on thought or action and the loss of previously held projects and commitments.

The manic person, we have seen, loses the long-term projects and commitments that previously provided structure to her life. Instead, she begins to develop tasks and interpretations of herself that are entirely based on what she experiences in the present moment. She is flighty, detached, and highly distractible. The reduced ability to reflect means she is no longer able to perceive likely consequences to her actions. This kind of experience, when combined with a dysphoric mood, may make the person more likely to carry out impulsive suicidal acts.²⁵ If the thought of suicide occurs to her, or she finds herself in a situation in which suicide is a possibility, she may act on that

²⁴ See Jamison (2001, pp111-113) for one discussion of the relationship between mixed states and suicidality. See also Goodwin and Jamison (2007, pp263) for discussion of the rate of suicidality in mixed states.

²⁵ We might note that “impulsivity is associated with suicide risk” (Williams and Pollock, 2002, p81). See also Mann et al (1999).

thought without the reflection or regard to consequence that we might usually expect. Hornbacher, for example, recalls an incident during a mixed state in which she impulsively slit her wrists:

Mania triggers wildly impulsive behaviours...Who knows, really, what leads to my sudden, uncontrollable desire to cut myself? I don't know...I simply do it, unaware in the instant that there will be any consequence at all. I watch my right hand put the razor in my left arm.
(2008, pp6-7)

It is therefore not simply that the person in a dysphoric manic state has the energy to carry out suicidal acts, she may also have lost the ability to meaningfully reflect on her current situation and the consequences of her actions. Thus, if she feels suicidal in that particular moment, or if the thought of suicide occurs to her, she may act without fully reflecting on the experience in a way that she might in a non-mixed state.

The loss of the person's previously held projects and commitments may also contribute to this impulsive act – the person would not, for example, be able to maintain the same commitment to life goals or family responsibilities. Jamison notes that “Often only a sense of responsibility to other family members or concerns about the effects of suicide on their children keep some people alive who otherwise have a strong desire to commit suicide” (2001, p93). As this ability to maintain long-term commitments is eroded in some forms of mixed state, these responsibilities may no longer dissuade the person from carrying out suicidal acts. Whilst the reduced ability to maintain projects may lessen the likelihood of a person in a mixed state carrying out a *planned* suicide, the risk of impulsively carrying out suicidal acts must therefore be seen to be higher than in the non-mixed state.

We can therefore see how common features of experience in depression and mixed states may contribute to suicidal thoughts and behaviours. We can also

see how the experience of suicidality in cases of depression and in dysphoric manic states may differ significantly, and how certain features of the depressed experience – such as the heavy, object-like body – may in fact prevent or make it less likely that the person will carry out suicidal acts. Whilst we cannot make any necessary causal links between experiences of depression and mixed states and suicidal thoughts and feelings, we might plausibly suggest that certain common features of these states play some role in the development of such thoughts and feelings.

Experiences of Time in Mania, Depression, and Mixed States

In this chapter I have explored the role that projects play in structuring our experiences of the world and the way in which they constitute a long-term sense of temporal direction. I discussed the different ways that these projects may be lost or altered in cases of mania and depression, and the impact that this loss may have on world-experience. I highlighted the relationship between possibilities and conation, and noted how these structures can help us to understand why the loss of projects is experienced differently in manic versus depressed states. I returned to our earlier questions concerning bodily experience, showing how different temporal experiences can impact on the way in which the body itself is experienced. I particularly noted how the loss of projects in mania, combined with the continued capacity to act, allows us to understand the initially unintuitive descriptions we find of bodily experience in manic episodes. Next, I showed how this account of mania and depression can help us to understand mixed states, where features of mania and depression co-occur. I demonstrated how we can account for these states through descriptions of two varieties of mixed state: Dysphoric mania and agitated depression. This discussion highlights the central role that temporality plays in bipolar disorder, helping to enrich our understanding of both the manic and the depressed state. I ended with a brief exploration of the ways key temporal and bodily alterations in depression and mixed states may contribute to experiences

of suicidality. This final discussion highlights the importance of considering the ways in which phenomenological research may be developed for practical application. In my concluding chapter I therefore turn to the clinical and philosophical implications of this thesis as well as considering potential directions for further research.

Conclusion

The aim of this thesis was to develop a cohesive phenomenological account of mania and depression. In contrast to the rich philosophical work that has been developed on a number of psychiatric disorders, most notably schizophrenia, mania, depression, and bipolar disorder have been neglected. This is despite a marked uncertainty regarding how to understand experiences of these states, as evidenced in contemporary debates in bipolar disorder research. Drawing on narrative accounts and questionnaire responses I have sought to correct this imbalance. In developing my account I have addressed alterations in experiences of time, the body, the world, and other people.

Accounts of temporal experience in mania typically suggest that in manic states the person experiences an increase in subjective temporal velocity (e.g. Fuchs, 2013a). In contrast, I have argued that in cases of mania there is a weakening of retention and an increase of conation. This leads to experiences of fragmentation, loss of reflection, loss of engagement, and a diminished sense of ownership of actions. I demonstrated how the weakening of retention prevents the maintenance and development of projects, as well as allowing for a constant re-interpretation of the self and values. In manic states, the loss of projects decontextualises possibilities, leading to an excess of possibility. This helps us to understand manic grandiosity, short-lived obsessions, and increased creativity.

I also explored the effect of the loss of projects in depression. In contrast to the manic experience, I argued that in depression the loss of projects can lead to a loss of practical significance and enticing possibilities. Drawing on work by Thomas Fuchs (2013a) and Matthew Ratcliffe (2012a), I suggested that the depressed person experiences a loss of conation. This helps us to understand

the commonly reported experiences of depression seeming to be eternal as well as the development of excessive guilt. I demonstrated how protention is impoverished in depressed states and argued that an impoverishment of protention necessitates an impoverishment of retention. A recognition of this alteration to temporal structure in depression casts light on the descriptions of mild fragmentation that we find in first person accounts.

An appreciation of temporal experience in mania and depression can enrich our understanding of bodily experience in these states. I have argued that in the case of mania the weakening of retention prevents the engagement that would allow the body to fade out of conscious awareness. It therefore remains conspicuous. However, it also remains active due to the experienced excess of possibilities. In cases of depression the body is also conspicuous, albeit in a markedly different way. Following Fuchs (2003; 2005a), I have argued that the depressed body is 'corporealized'.

These accounts of bodily and temporal experience also help us to better understand depressed and manic experiences of the world and other people. A corporealized body, we have seen, both stands in the way of interaction with the world and contributes to a felt loss of possibilities. The weakening of retention in mania leads to an excess of enticing possibilities – the world drawing the person in to action. Desynchronization of interpersonal time in both mania *and* depression can undermine interpersonal relations. The accounts of mania and depression that I have developed therefore address each of these central features of time, the body, the world, and other people.

I have also shown how my account allows us to go beyond the 'pure' states of mania and depression, helping us to develop an understanding of how features of both states may co-occur. I demonstrated this through two forms of mixed episode: 'Dysphoric mania' and 'agitated depression'. However, once we appreciate that mania and depression do not stand in opposition, but rather

exist as two manifestations of similar alterations to experiential structures, we may allow for the possibility of the development of accounts for the full variety of different states experienced in bipolar disorder.

Philosophical Implications

Although my primary aim was to develop a phenomenological account of mania and depression, I have also endeavoured to *do phenomenology*. As I argued in chapter one, the relationship between phenomenology and psychiatry is mutually informative and we can use the study of psychiatric disorders to inform our phenomenology. This thesis contains significant implications for our phenomenological understanding of bodily experience and temporal experience.

We can see that recognising that the manic body is both conspicuous and active provides a direct challenge to an implicit distinction found in the work of Fuchs (e.g. 2003) between the body as *conspicuous and inactive* and the body as *invisible and active*. This recognition emphasises the variety of ways in which the body may be or become conspicuous. Furthermore, I have shown how temporal experience can impact on bodily experience, thus helping us to understand this variety. This further demonstrates the intimate links between these experiential structures, highlighting the difficulties that result from considering them in isolation. A full understanding of bodily experience requires an acknowledgment of the associated temporal experience.

Throughout my study on the experiences of mania and depression I have also drawn out the complexities of temporal experience. I have refined the Husserlian account of temporal synthesis, highlighting the relationship between protention and retention. Further to this, I have demonstrated the relationship between shorter and longer-term temporal structures: Firstly, I have revealed and examined links between projects and possibilities. Secondly,

I have demonstrated how conation is stabilised by projects and commitments. Thirdly, I have highlighted the relationship between conation and temporal synthesis. Finally, I have shown the necessity of an intact retentional capacity for the development and maintenance of projects. In doing this I have further demonstrated the critical role that experiences of time play in structuring our everyday experiences.

One further welcome outcome of this thesis is that it provides a means of developing a phenomenological distinction between bipolar disorder and schizophrenia. Debates regarding whether and how schizophrenia and affective disorders can be distinguished have existed for at least the last hundred years.¹ Differentiating bipolar disorder from schizophrenia remains a diagnostic challenge in contemporary clinical settings. As Goodwin and Jamison note, “presenting symptoms can be similar in mania and schizophrenia” (2007, p103). Phenomenological accounts move beyond these superficial presentations and thus allow for the possibility of unearthing structural differences.

Experiences of time have been an important feature of recent phenomenological accounts of schizophrenia (e.g. Fuchs, 2013a; Gallagher, 2006). Shaun Gallagher (2006) argues that temporal synthesis is disrupted in cases of schizophrenia. Specifically, he suggests that there is a loss of what Husserl calls *protention*, the anticipation of the immediate future. This is a view that is also developed by Thomas Fuchs (e.g. 2013a). Fuchs argues that there is a “fragmentation of the intentional arc” (2013a, p85), due to an impairment of protention. The person with schizophrenia thus experiences a fragmentation of experience, alongside difficulties anticipating the future.² Gallagher further suggests that “the

¹ See Goodwin and Jamison for an overview of the historical debate (2007, pp100-102).

² Fuchs (2013a) notes that this account is compatible with accounts that suggest there is a disturbance to “ipseity” or a minimal sense of self. See Sass and Parnas (2007) for one account of this type. The link between these two accounts is also acknowledged by Sass and Pienkos (2013b).

protentional mechanism underlies the sense of agency for thought” (2006, p193). Thus, with the loss of protention the person with schizophrenia also loses this agency of thought. He therefore may not experience his thoughts as originating from himself. In this way, Gallagher suggests that the loss of protention can account for the experience of “thought insertion”, in which a person believes that an outsider has inserted thoughts into his head.³

If these accounts are correct, we can provide a principled phenomenological distinction between temporal experience in mania and schizophrenia, thus helping us to move beyond the similar presenting symptoms. In schizophrenia, we have seen, protention may be lost. In contrast, I have proposed that in cases of mania it is *retention* that is damaged. Although both mania and schizophrenia may therefore be seen to involve disruption to temporal synthesis, it is different aspects of temporal synthesis that are damaged. Whilst we see similarities between the presenting symptoms of the two cases (after all, both involve significant disruptions to temporal synthesis), we can still find a principled way of distinguishing between the two.

Clinical Implications

Although the focus in this thesis has been on developing an account of mania and depression, rather than on exploring how best to treat mania, depression, or bipolar disorder, we may still consider some initial implications for treatment. The account that I have put forward highlights how the loss of projects and commitments may contribute to distressing experiences in both mania and depression. Considering how projects may be maintained or rebuilt therefore appears to be a potentially beneficial focus for the development of treatments. In some cases the maintenance of projects or commitments may help to guard against the development of depression. Learning how to rebuild

³ See Gallagher (2006, pp194-7) for a full discussion of thought insertion.

projects may, in cases where the possibility of practical significance has not been entirely eroded, help the person to restore his usual experience of time, thus preventing the depression from becoming more severe.

In some cases of depression, and during most manic states, the possibility of developing new projects is lost. In these cases we can focus on preventative regimens. We have seen that although projects and commitments are frequently lost in manic and depressed states, habits are often maintained. It is the novel tasks and structures that are most vulnerable to erosion in these states. As such, the prior development of robust habitual structures may help to minimise the distressing effects of the loss of projects. The maintenance of these habitual tasks may help to contextualise and highlight relevant possibilities, thus helping to stabilise conation. A possible focus of treatment, therefore, may be the development of habitual tasks and structures. Indeed, the importance of maintaining daily routines is highlighted in literature on bipolar treatment (e.g. Frank et al. 2000).

I have also highlighted the distressing experience of alienation or distance from others, common in both mania and depression (albeit in notably different forms, as frustration in mania and isolation in depression). I particularly stressed the role that intersubjective time plays in this experience, where a person in a manic or depressed state finds himself out of synch with the time of others. A possible focus for treatment may, therefore, be on the development of a sense of intersubjective time. Engagement in projects with others that focus on shared attention and the acknowledgement of objective temporal markers – calendar based celebrations or occasions, or certain tasks occurring at the same time each day – may plausibly help to minimise the distressing experience of desynchronization.

There are a number of different forms these projects might take.⁴ One interesting possibility is the use of 'Arts in Health'. These services aim to provide opportunities for those with health difficulties to engage in artistic projects, often group based and community rooted. Such projects may be thought to provide distraction and give "participants a sense of individual achievement at having made something which has some value within their community" (Macnaughton et al., 2005, p335). However, we might plausibly suggest that arts in health offers one means of both developing projects and re-synchronizing intersubjective temporal experiences. Encouraging this kind of engagement in projects may be beneficial for those with bipolar disorder. Forms of 'Interpersonal and Social Rhythm Therapy' may similarly prove beneficial.⁵ The focus in this form of therapy is on stabilising daily routines and "social rhythms", as well as helping the person to manage interpersonal problems (Frank et al. 1999; Frank et al. 2000).⁶ Re-establishing these habits and routines, along with the focus on maintaining *interpersonal* routines and relationships, may plausibly help to stabilise the person's experience of time.

These suggestions, it must be stressed, are made only tentatively. What this thesis provides is a sense of the possible direction of research into potential treatments, rather than an account of the exact form that such treatments would take. What is revealed here are the points at which experience is altered, suggesting potential targets for effective treatment. It may be, however, that it is not possible to artificially develop effective responses to these structural changes. Extensive empirical research would be needed in order to discover the

⁴ See Fuchs (2001) for a list of guidelines for a possible resynchronization therapy.

⁵ See Goodwin and Jamison (2007, pp900-2) for an overview of Interpersonal and Social Rhythm Therapy.

⁶ Frank et al. (2000) discuss an interesting link between these daily routines and social rhythms and circadian rhythms, which are often disrupted in cases of bipolar disorder. See Goodwin and Jamison, (2007, pp659-688) for a full discussion of bipolar disorder and circadian rhythms.

form of effective treatments and the extent to which they may be beneficial for individuals.

Further Research

The focus in this thesis has been on experiences of mania and depression in English-speaking western countries. An obvious direction for the development of this account would be to perform a cross-cultural phenomenological study, exploring the extent to which similar structures underlie experiences of mania and depression in a variety of different countries. Colleagues of mine at the University of Osnabrück have already begun research in this area, translating the Durham Depression Questionnaire into Spanish, German, and Bulgarian. They have placed a translated version of the questionnaire on the website of a Bulgarian mental health organisation and have received sixty-six responses so far.⁷ Further studies may focus on obtaining results from Spanish and German speaking countries in the hope that similarly rich descriptions can be gathered. Comparison of the responses to these questionnaires, along with the study of relevant first person narratives, may yield valuable results. Further studies in this area could explore whether differences seen in the experience of depression in different countries are a result of structural differences, or whether differences at a superficial level belie structural similarities. The extent to which the experience of mania or depression is consistent across different cultures has clear relevance for the diagnosis and treatment of bipolar disorder.

A second area of potential further study would be to explore the distinction between unipolar and bipolar *depression*. It has been claimed that depression as experienced by a person with bipolar disorder is markedly different from depression as experienced by someone with a purely unipolar depression. Goodwin and Jamison, for example, write:

⁷ <http://psihichnozdrave.com/links/на-български/>. Accessed: 18th September 2013.

Compared with unipolar patients, depressed bipolar patients...appear clinically to be less physically active and more likely to sleep excessively. Other reported differences include lower ratings of anxiety, anger, and physical complaints, more psychomotor retardation, and a greater likelihood of experiencing depressive delusions or hallucinations.

(1990, p43)

Phenomenological analysis of the bipolar and unipolar experiences of depression may prove enlightening, helping to clarify whether and the extent to which there are meaningful differences between the states. There are, however, significant concerns about misdiagnosis that may present difficulties for any such analysis.⁸ A person who currently appears to have only a unipolar depression may in the future experience a manic episode. The question of how to determine what is a case of unipolar depression without making pre-judgements or assumptions about the differences between the experiences may, therefore, prove to be extremely difficult. However, determining potential differences between cases of unipolar and bipolar depression would be extremely valuable. Not only might this help us to predict whether a person is likely to experience a manic episode in the future, there may also be differences in appropriate treatment for these potentially different types of depression.⁹

I noted in chapter two the difficulty of distinguishing depression from grief, a topic that has received considerable attention following the publication of DSM-5 (APA, 2013). Having developed a phenomenological account of depression, a valuable further study would be to develop a phenomenological account of grief and to explore the similarities and differences between these two experiences. For example, the account of temporal experience in

⁸ See Goodwin and Jamison (2007, pp104-106) for a discussion of the misdiagnosis of bipolar disorder as unipolar depression.

⁹ See Goodwin and Jamison (2007, pp771-778) for discussion of the topic of those with bipolar disorder 'switching' from states of depression to states of mania following the use of antidepressants.

depression that I have developed in this thesis may be contrasted with the temporal experience in cases of grief in order to determine whether and how the states differ in this regard. A phenomenologically informed discussion that compares depression and grief would, therefore, be an interesting and informative development and application of this thesis.

As diagnosis of bipolar disorder in children has dramatically increased in recent years,¹⁰ it would be valuable to extend this study to include the experiences of mania and depression in children, allowing us to explore whether their experience of these states is different from those of adults. We might, for example, investigate whether temporal structures and bodily experiences are comparable in adults and children with bipolar disorder. However, there is an additional difficulty in researching cases of childhood bipolar disorder. We should not assume that typical structures of experience in adults are the same as the typical structures found in children's experiences – what may be an alteration from the everyday in the case of the adult may not be an alteration in the case of the child. It would first be necessary, for example, to determine what an everyday experience of time *is* for a child, before we could investigate whether and to what extent such an experience is altered in childhood bipolar disorder. This is not to say that such a research project would be impossible. However, we must acknowledge the additional difficulties that come with any phenomenological discussion of childhood experience – a straightforward comparative study of typical experiences of mania and depression in adults and in children would not be sufficient.

A final development that may prove to be informative would be to examine the links between mania, depression and other psychiatric disorders. For example, we have seen that experiences of the body are significantly altered in cases of

¹⁰ Moreno et al. (2007) found a forty-fold increase in youth diagnosis of bipolar disorder between 1994-5 and 2002-3.

depression. Given this, it would be interesting to explore whether we can uncover any plausible links between these experiences and experiences of the body in eating disorders, such as anorexia nervosa and bulimia nervosa.¹¹ We might additionally explore whether the presence of depression significantly alters the bodily experiences of eating disorders, or if the bodily experience remains the same regardless of whether or not the person is depressed. This direction of research may also be valuable in the exploration of other psychiatric disorders that are commonly comorbid with depression, such as Body Dysmorphic Disorder (APA, 2000, p509) or Obsessive Compulsive Disorder (APA, 2000, p458). In this way, the accounts of mania and depression I have put forward can be developed in order to contribute to our understanding of a number of psychiatric disorders. More broadly, these suggestions for further research highlight some of the ways in which this thesis may be developed, forming a foundation for further philosophical and clinical work.

¹¹ It is notable that depressive symptoms and mood disorders more generally are common in those that have eating disorders (APA, 2000, p585; p591).

Appendix

Durham Depression Questionnaire

Section A: Background information

Age	
Gender	
Country of residence	
Medical diagnosis of depression	
Year of diagnosis	
Specifics of diagnosis	
Forms of treatment	
Other psychiatric diagnoses	
Specifics of other diagnoses	
Currently depressed?	

Section B: Your Experience of Depression

1. Describe your emotions and moods during those periods when you are depressed. In what ways are they different from when you are not depressed?
2. Does the world look different when you're depressed? If so, how?
3. Do other people, including family and friends, seem different when you're depressed? If so, how?
4. How does your body feel when you're depressed?
5. How does depression affect your ability to perform routine tasks and other everyday activities?
6. When you are depressed, does time seem different to you? If so, how?

7. How, if at all, does depression affect your ability to think?
8. In what ways, if any, does depression make you think differently about life compared to when you are not depressed?
9. If you have taken medication for depression, what effect did it have?
10. Are there aspects of depression that you find particularly difficult to convey to others? If so, could you try as best you can to indicate what they are and why they are so hard to express.
11. What do you think depression is and what, in your view, caused your depression?
12. Who and/or what have you consulted in order to try to understand your depression? (E.g., medical practitioners, friends, books, internet sources, etc.).
13. If there are important aspects of your experience of depression not covered by this questionnaire please describe them here.

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