

Psychopathology of depression and mania: symptoms, phenomena and syndromes

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Summary

The paper gives a phenomenological account of depression and mania in terms of body, space, temporality and intersubjectivity. While the lived body is normally embedded into the world and mediates our relations to others, depression interrupts this embodied contact to the world. Local or general oppression condenses the fluid lived body to a solid, heavy "corporeal body". Instead of expressing the self, the body is now turned into a barrier to all impulses directed to the environment. This impairs the patient's interaction and affective attunement with others, resulting in a general sense of detachment, separation or even segregation. Depression is then further interpreted as the result of a desynchronisation, i.e. an uncoupling in the tem-

poral relation between the patient and his social environment. This concept leads to some suggestions regarding a "resynchronisation therapy" for affective disorders. Conversely, mania is phenomenologically described as a centrifugal dispersion of the lived body, characterised by a general lightness, expansion and disinhibition. In the temporal dimension, the manic desynchronisation from the environment manifests itself in a lack of rhythmicity and constant acceleration of lived time.

Key words

Depression • Mania • Body • Space • Temporality • Intersubjectivity • Desynchronization • Phenomenology

Introduction

Phenomenological psychopathology has a long tradition of describing and analysing the subjective experience of affective disorders, and in particular, melancholic depression. These analyses have mostly focused on dimensions such temporality, spatiality, personality or identity¹⁻⁷. A basic assumption of the phenomenological approach is that the psychopathologist should methodically suspend any assumptions about causal explanations of a disorder, be it psychological or biological, and instead try to grasp the patient's experience as best as possible. The aim of this approach is not just a thorough description, however, but an analysis of the basic structures of experience that are altered in mental illness. This alteration often takes place on a prereflective level and thus may not be immediately accessible to, and verbalised by, the patients themselves.

The following description tries to link these basic structures of experience, i.e. body, space and time with intersubjective aspects in order to give an integrated picture of the depressive and manic condition. To begin with, a few remarks on the general phenomenology of affectivity and the lived body are necessary in order to prepare the ground for the description of affective disorders.

Moods, emotions and the lived body

In contrast to the common cognitivist picture in which mental states and emotions are located within our head, phenomenology regards emotions as embodied relations to the world, and in particular, as residing in-between individuals⁸. Human beings do not have moods or emotions independent of their relations and interactions with others. First, *moods* are not inner states, but permeate and tinge the whole field of experience. Being atmospheric in nature, they radiate through the environment like warmth or cold, and confer corresponding affective qualities on the whole situation⁹. On the other hand, moods also include certain background feelings of the body, such as lightness and freshness in elation or mania, or weariness and heaviness in boredom, sadness, or depression. This background may also consist of what Ratcliffe has termed *existential feelings*: feelings of wideness or restriction, freedom or imprisonment, vulnerability or protection, familiarity or estrangement, feeling alive or feeling dead¹⁰. Similarly, *emotions* are ways of being in the world; they emerge on the basis of a prereflective attunement with others, indicating the current state of our relations, interests and conflicts, and manifest themselves as attitudes and expressions of the body. There is no emotion without bodily sensations, bodily resonance and affectability.

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Of course, when I am moved by an emotion, I may not even be aware of my body; yet being afraid, for instance, is not possible without feeling a bodily tension or trembling, a beating of the heart or a shortness of breath, and a tendency to withdraw. In short, the body is a “resonance body”, a most sensitive sounding board in which interpersonal and other “vibrations” constantly reverberate^{8 11 12}.

Kinaesthesia is an important component of this resonance. Emotions are dynamic forces that motivate and move us in our ongoing interactions with the environment, inducing us to move towards or away from something or someone, or to behave in more specific ways. In this view, emotions are first and foremost embodied motivations to action¹³. As such, they are not only felt from the inside, but also displayed and visible in expression and behavior, often as bodily tokens or rudiments of action. The facial, gestural and postural expression of a feeling is part of the bodily resonance that feeds back into the feeling itself, but also induces processes of *interbodily resonance*¹⁴. Our body is affected by the other’s expression, and we experience the kinetics, intensity and timing of his emotions through our own bodily kinaesthesia and sensation. This results in a continuous interplay of both partners’ expression and impression, mediating a pre-reflective reciprocal understanding which Merleau-Ponty termed “intercorporeality”¹⁵; it may be regarded as the bodily basis of affective attunement with others or empathy.

In this context, it is important to note the distinction of the *subjective* and the *objective body* (also termed “lived” vs. “corporeal” body, or *Leib* vs. *Körper*) as conceptualised by the phenomenologic tradition^{16 17}. The lived body means the body as the medium of all our experience, or in other words, our embodied being-in-the-world: in everyday life, I perceive, act and exist through my body, without explicitly reflecting on it. The body withdraws from my awareness to the same degree as it mediates my relation to the world. The *corporeal body*, on the other hand, is the material, anatomical object of physiology and medicine that can be observed and grasped. It appears in my own experience whenever the lived-body loses its “taken for granted”, mediating role and becomes obstinate or fragile, as for example in the experience of heaviness, fatigue, clumsiness, injury, or illness. The lived-body turns into the objective body whenever I become aware of it in an impeding or embarrassing way. Having been a bodily being without taking notice before,

I now realise that I have a material (clumsy, vulnerable, finite, etc.) body. In the tradition of phenomenology, we can say that the lived body is the body that *I am*, whereas the corporeal body is the body that *I have*¹⁶.

The phenomenology of depression: body, space, time and intersubjectivity

On this background, we may now start to describe the phenomenology of depressive and manic experience. In short, the *depressive state* may be characterised by a general constriction or “congealment” of the lived body, leading to a numbing of emotional resonance and loss of attunement. This alters the patient’s existential feelings of being-with-others, resulting in a general sense of detachment, segregation, or even expulsion. In this way, the lived body also expresses the experiences of loss and separation which usually trigger depressive episodes on a psychosocial level.

Corporealisation

In severe depression, 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. The depressive patient experiences an oppression and constriction that may focus on single areas of the body (e.g. feeling of an armour or tyre around the chest, of a lump in the throat, pressure in the head) or also manifest itself in a diffuse anxiety, an overall bodily rigidity (“anxiety” is derived from the latin “*angustiae*” which means “narrows”, “constriction”). The materiality, density and weight of the body, otherwise suspended and unnoticed in everyday performance, now come to the forefront and are felt painfully. In this respect, depression closely resembles somatic illnesses such as infections that affect one’s overall bodily state. Corresponding reports from patients may well be elicited provided that the interviewer takes their bodily experience serious: they will complain about feelings of fatigue, exhaustion, paralysis, aches, sickness, nausea, numbness, etc.¹⁸. Moreover, in depression the exchange of body and environment is blocked, and drive and impulse are exhausted. In summary, depression may be described as a reification or corporealisation of the lived body^{7 a}: “My body became inert, heavy and burdensome. Every gesture was hard” – “I couldn’t escape the awful confines of my leaden body and downcast eye. I didn’t want to live, but I couldn’t bear to die”¹⁹.

^a This description refers to the most frequent type of severe depression that is characterised by psychomotor inhibition. There is another type with prevailing agitation and anxiety (“agitated depression”) in which the patients experience the same constriction but the loss of drive is less marked, so that they try in vain to escape from their tormenting bodily state by aimless activity.

The constriction and encapsulation of the body corresponds to the psychosocial experiences that typically lead to depression. These are experiences of a disruption of relations and bonds, including the loss of relevant others or of important social roles, further situations of a backlog in one's duties, falling short of one's aspirations, or social defeat^{3,20}. These situations of social separation or defeat are perceived as particularly threatening since the patients feel they do not have the necessary resources for coping ("learned helplessness")²¹. Depression is the consequent psychophysiological reaction: on the biological level, it involves a pattern of neurobiological, metabolic, immunological, biorhythmic and other organismic dysfunctions which are equivalent to a partial decoupling or separation between organism and environment^b. These dysfunctions are subjectively experienced as a loss of drive and interest (anhedonia), psychomotor inhibition, bodily constriction and depressive mood.

Constriction of sensorimotor space

The constriction thus described continues in sensorimotor space. Sense perception and movement are weakened and finally walled in by the general rigidity which is also visible in the patient's gaze, face, or gestures.

Perception is characterised by a loss of alertness and sympathetic sensation: patients may describe a loss of taste, a dullness of colours, or muffled sounds as if heard from afar. Their senses are not able to vividly participate in the environment, their gaze gets tired and empty, their interest and attention weakens. They can only passively receive what comes from outside.

Movement, on the other hand, is marked by psychomotor inhibition: gestures, speech and actions are reduced, only mechanically produced, and lack normal energy. A bowed posture, lowered head and leaden heaviness show the dominance of forces pressing downwards. In order to act, patients have to overcome the inhibition and to push themselves to even minor tasks, compensating by a high effort of will which the body does not have of its own accord any more. Consequently, the external aims and objects withdraw from the patient; using Heidegger's terms, they are not "ready-to-hand" any more, but only "there" (*zuhanden* vs. *vorhanden*).

All this means that the body's space shrinks to the nearest environment, culminating in depressive stupor. The patient cannot *transcend* the body's boundaries any longer – which is what we normally do when we are looking at

and desiring things, reaching for them, walking towards our goals, and thus anticipating the immediate future. As we can see, subjective space and time are interconnected: the extension of space around me and the anticipation of what is possible or what is to come are one and the same thing. For the depressive person, however, space is not embodied any longer; there is a gap between the body and its surroundings. This in turn reinforces the bodily constriction and enclosure mentioned above.

Intercorporality and interaffectivity

The bodily constriction results not only in felt oppression, anxiety, or heaviness, but more subtly, in a loss of the inter-bodily resonance which mediates the empathic understanding in social encounters. The depressive body lacks emotional expression and offers no clue for the other's empathic perception. The continuous synchronisation of bodily gestures and gazes that normally accompanies interaction breaks down. The patients themselves realise this congealment of their expression; moreover, their own empathic perception and resonance with the other's body is lacking²²⁻²⁴. Thus, they feel unable to emotionally communicate their experience and try in vain to compensate for the loss of attunement by stereotyped repetition of their complaints.

The loss of bodily resonance or affectability concerns, more generally, the experience of affective valences and atmospheres in the surroundings. In milder forms this becomes manifest in a loss of interest, pleasure and desire. But the deeper the depression, the more the attractive qualities of the environment faint. Patients are no longer capable of being moved and affected by things, situations, or other persons. This leads to an inability to feel emotions or atmospheres at all, which is all the more painful as it is not caused by mere apathy or indifference (as for example in frontal brain injury), but by the tormenting bodily constriction and rigidity. Kurt Schneider wrote that the "vital disturbances" of bodily feelings in severe depression – anxiety, oppression, heaviness, exhaustion – are so intense that psychic or "higher" feelings can no longer arise²⁵. Patients then complain of a "feeling of not feeling" and of not being able to sympathise with their relatives any more. In his autobiographical account, Solomon describes his depression as "... a loss of feeling, a numbness, [which] had infected all my human relations. I didn't care about love; about my work; about family; about friends ..." ²⁶. Hence, patients lose participation in the shared space of affective attunement.

^b This comes about through a prolonged organismic stress reaction, affecting, above all, the CRH-ACTH-cortisol system, the sympathetic nervous system as well as the serotonin-transmitter regulation in the limbic system, and resulting in a desynchronisation of diurnal hormone and sleep-wake cycles (Wehr & Goodwin 1983, Berger et al. 2003).

Of course, there are emotions that remain despite the loss of affectability, in particular feelings of guilt, anxiety, or despair. However, these emotions show some characteristic features: (1) they do not connect, but rather separate the subject from the world and from the others; (2) their felt bodily quality is characterised by constriction and rigidity, thus corresponding to the overall depressive state of corporealisation; (3) they are embedded in the prevailing depressed mood rather than arising as independent feelings; therefore, their intentional objects are just as ubiquitous as arbitrary. A depressive patient describes what may be called an elementary, bodily experience of guilt:

“It comes from below, from the gut, like a terrible oppression rising to the chest; then a pressure arises, like a crime that I have committed. I feel it like a wound on my chest, that is my tortured conscience ... then this attracts my memories, and I have to think again of all that I have missed or done wrong in my life...”⁶

This shows that an elementary feeling of being guilty can be rooted in bodily experience itself and only secondarily materialises in corresponding, yet arbitrary memories of omissions or failures¹. Similarly, the bodily state of diffuse, vital anxiety finds its concrete objects in all kinds of imagined disaster (financial ruin, lethal disease, etc.), which the patient anticipates as inevitable. The simultaneity of a loss of affectability and the presence of anxiety or guilt feelings, contradictory at first sight, can thus be explained by their mood-congruent, bodily character. In severe or psychotic stages of depression, such constricting emotions turn into continuous states of agony, and it may be doubted whether they could still be called emotions at all.

Derealisation and depersonalisation

Since the affective contact to the environment is also essential for our basic sense of reality and belonging to the world, a loss of body resonance always results in a certain degree of derealisation and depersonalisation. Therefore, affective depersonalisation is a core-feature of severe depressive episodes^{5,27}. Patients do not experience sadness, mourning or grief; they rather feel empty, blunt, dull, or rigid. However, there is a special kind of melancholic depression in which depersonalisation is the prominent symptom; in German psychopathology it is called “Entfremdungsdepression” (depersonalised depression)²⁸. Here the emotional quality of perception is lost completely, objects look blunt or dead, and space seems emptied, as in the following reports:

“Everything around me seems far away, shady and somehow unreal – like in a strange dream” (*own clinic, T.F.*). “I feel detached from all people, like an outcast in a gloomy world. I am unable to participate in life any more” (*own clinic, T.F.*).

“There is only emptiness around me; it fills the space between me and my husband; instead of conducting it keeps me away”^c.

Patients feel like isolated objects in a world without relationships; there is only an abstract space around them, not a lived, embodied space any more. Perception only shows the naked framework of objects, not their connectedness or their “flesh”. The depersonalisation in severe depression culminates in so-called nihilistic delusion or *Cotard’s syndrome*, formerly called “*melancholia anaesthetica*”²⁹. Patients no longer sense their own body; taste, smell, even the sense of warmth or pain are missing, everything seems dead. Having lost the background feeling of the body that conveys a sense of connectedness and realness to our experience, patients may contend that the whole world is empty or does not exist anymore. This lets them conclude that they have already died and ought to be buried: a 61-year-old patient felt that her inner body, her stomach and bowels had been contracted so that there was no hollow space left. The whole body, she said, was dried out and decayed, nothing inside moved any more. The body felt numb, she sensed neither heat nor cold, meals had lost their taste. The environment seemed strangely altered, too, as if everything had gone dead. Finally, she was convinced that all her relatives had died, that she was alone in the world and had to live in a dead body forever⁶.

Granted, Cotard’s syndrome is a rare phenomenon, yet it illustrates by the extreme how the feeling of reality is dependent on our participation in a shared emotional space. Once the affectability of the body and thus the affective basis of co-experiencing the world is lost, the sense of reality dissolves and gives way to a virtualisation of one’s being-in-the-world.

Delusions of guilt

With Cotard’s syndrome, we have already entered the domain of psychotic depression. In the next section, I want to look at a more typical example of depressive delusions from an intersubjective point of view, namely at delusions of guilt.

As we have already seen above, the depressed patient’s bodily constriction, vital anxiety and loss of interaffective

^c In general, memories are facilitated by the bodily and emotional state that corresponds to the condition in which they were acquired; cf. the research on state-dependent learning and mood-congruent memories (e.g. Bower 1981, Blaney 1986). This is particularly valid for depression (e.g. Barry et al. 2004).

attunement imply a separation from others and thus are particularly suited to reactivate primary feelings of guilt^d. This holds true even more for the “typus melancholicus”, the personality that is particularly prone to fall ill from depression^{3 30 31}. This personality type is characterised by excessive conscientiousness, orderliness, hypernomic adherence to social norms and dependency on stable interpersonal relationships. For these patients, the affective ties to others are essential, even vital, and becoming guilty means to be excluded from the indispensable community with others. In depression, patients experience the bodily constriction as an existential feeling of separation and rejection that activates an archaic, punishing and annihilating conscience³².

The crucial presupposition for depressive delusions, however, concerns the intersubjective constitution of reality. Precisely the social reality of guilt normally does not mean a fixed state or quantity but is negotiated through a shared process of attribution and justification that defines the omissions or faults as well as their degree of severity. Similarly, dealing with guilt (through responsibility, regret, compensation, forgiveness, rehabilitation, etc.) involves an intersubjective agreement and mutual alignment of perspectives. This in turn requires a deeper fundament that is generated by our prereflective affective connectedness with others, and in particular by a basic sense of *mutual trust*. The depressive patient, however, loses this prereflective connection and becomes locked in his bodily constriction and corporealisation. Thus, he is literally deprived of the free scope that is necessary for taking the other's perspective and relativising his own point of view. The others are separated by an abyss and can no longer be reached. Guilt, instead of being an intersubjective *relation* that can be dealt with, becomes a *thing* or an *object* the patient is identified with, as shown by the following case example:

Soon after his retirement, a 64 year-old patient fell ill with severe depression. Coming from a poor background, he had become staff executive of a large company by hard work. He reported that he had only been on sick leave for 10 days in 45 years of work. In contrast, his depression was characterised by a feeling of decay. All his power had vanished, the patient complained, he had no longer command of his arms and legs. He had burnt the candle at both ends, had not taken care of his family, and now he deserved to get his punishment. He accused himself of being responsible for the failure of an important deal of his company two years ago that would inevitably lead

to its bankruptcy. He would never be able to cancel this debt again. Moreover, he complained that he had no more feelings for others. “I am only a burden for them, a millstone around my family's neck ... for me, life is over”. He finally thought that the death sweat already appeared on his forehead, one could even see the cadaveric lividity on his face. He should be driven in the mortuary in the basement and be abandoned there (*own clinic, T.F.*).

The capacity of taking the perspective of others is not only a cognitive feat but depends on a common inter-affective sphere that is part of the “bedrock of unquestioned certainties”^{33 34}. It provides a foundational, non-representational structure of mutual understanding that underpins our shared view of reality. In delusional depression, however, the loss of the pre-predicative relation to others makes it impossible to take their perspective and to gain distance from oneself, thus forcing the patient *to completely equate his self with his current depressed state*. This present state means being thrown back upon oneself, feeling rejected and expelled. The delusional patient, as shown in the case example, is identified with his existential feeling of guilt to the extent that he is *guilty as such*. There is no remorse, recompensation, or forgiveness, for the guilt is not embedded in a common sphere which would allow for that. Delusions of guilt result from a disruption of intersubjective relations on the basic level of interaffectivity⁸.

This is characteristic of depressive delusion in general: corporealisation and loss of attunement to others prevent the patient from taking their perspective. As a result, a state of self beyond the present one becomes unimaginable. It has always been like this, and it will stay like this forever – to remember or hope for anything different is deception. The patient is inevitably identified with his present state of bodily constriction and decay, with his state of feeling guilty as such, or, in nihilistic delusion, with his state of feeling dead. Hypochondriacal or nihilistic delusions, delusions of guilt or impoverishment are all just different manifestations of a complete objectivation or reification of the self that can no longer be transcended. Depressive delusion is therefore rooted in the loss of the shared interaffective space and in the utter isolation of the self that results from it.

Temporality and desynchronisation

As pointed out earlier, there is a narrow connection between the lived body, lived space and temporality. In the last analysis, the possibility of bodily movement, the ac-

^d This is in line with recent research on the embodiment of emotions, showing that bodily postures, expressions, sensations and interoceptive states influence one's emotional state in various ways, “bottom-up”, so to speak (Damasio 1999, Niedenthal 2007, Craig 2008).

cessibility and openness of space, and the movement of life towards the future are one and the same thing. So if the body is isolated from the surroundings by constriction, then space will appear to be inaccessible, unreachable and detached from the potentiality of the body. But what is more, the temporal movement of life will also cease and come to a standstill.

Thus, an inhibition of lived time is the hallmark of depression, as Straus, von Gebattel and Tellenbach have pointed out¹⁻³. Following Straus, in melancholic depression the “ego-time” of the movement of life gets stuck, whereas the “world-time” goes on and passes by. The inhibition of inner time does not allow the patient to progress towards the future, nor is he able to close up and leave behind his past experiences. “The more the inhibition increases and the speed of inner time slows down, the more the determining power of the past is experienced”¹. What has happened remains conscious as a fault or failure, as ever-growing guilt. Such analyses are still fundamental for a psychopathology of temporality. Modifying this approach, however, I will consider the depressive pathology of time not only as an individual inhibition but as a disturbance of a synchronised relation, or a *desynchronisation*. Depression then means an uncoupling in the temporal relation of organism and environment, as well as with the individual and society³⁵. The concept of synchronisation is derived from chronobiology, referring to the order of rhythms such as the sleep-wake-cycle or the diurnal period of hormone levels. There is a continuous attunement between organismic or endogenous with cosmic or exogenous rhythms, such as daily, lunar and solar periods. On the social level, however, we find many forms of synchronisation as well. Since birth, the rhythms of the organism (eating, sleeping, excretion times, etc.) are shaped by socialisation. More subtly, the everyday contact with others implies a continuous fine-tuning of emotional and bodily communication, an intercorporeal resonance. Moreover, social synchronisation is conspicuous in the manifold ways of “timing”, of day- and week-time regulation, date scheduling, as well as in all mutual commitments and agreements which are bound to certain time frames. These various temporal coordinations engender a basic feeling of being in accord with the time of the others, and to live with them in the same, intersubjective time.

All these biological and social synchronisations, however, are not constant. The homeostasis of the organism in relation to its environment is only preserved through recurring deviations or *desynchronisations*. On the social level, too, we periodically experience asynchronies, i.e. situations that require us to re-adapt to external changes, to compensate for disturbances and backlogs. Uncompleted tasks, unresolved conflicts, strain and distress accumulate, thus inhibiting our progress toward the future.

Even more in serious experiences of trauma, in guilt, loss, or separation, the person temporarily loses the lived synchrony with others.

A prolonged desynchronisation between the individual and the environment is characteristic of melancholic depression. The typical constellation triggering the illness has already been characterised by Tellenbach as a situation of “*remanence*” which means falling short of one’s own rigid demands concerning social duties and orderliness³. According to Tellenbach, remanence is the risk inherent in the personality structure of the melancholic type. Patients do not feel equal to the pace of changes or cannot cope with increasing obligations. Often they surrender in the face of painful processes of detachment or grief, or they refrain from necessary role changes.

This corresponds to the premonitory striving of the melancholic type to avoid discrepancies in relation to the environment by all means. The “*hypernomia*” which Alfred Kraus has characterised as the hallmark of the melancholic person’s social identity, is a “*hypersynchrony*” as well⁴. Down to the microdynamics of everyday behaviour, the melancholic type seeks continuous resonance by social attunement, compliance, friendliness, punctuality and timely completion of tasks. The capitulation before an inescapable task of coping or development now leads exactly to what the melancholic fears most of all: the breakdown of coherence with his social environment in depressive illness.

Depressive psychopathology may then be viewed as the result of a general desynchronisation, as a psychophysical slowdown or *stasis*. On the physiological level, this manifests itself in disturbances of neuroendocrine and temperature periods, of the sleep-wake-rhythm, in a loss of drive, appetite and libido. One may also think of the seasonal depressions as desynchronisations in relation to the annual period. The uncoupling of organism and environment also manifests itself in the experience of *corporealisation* described above. The body loses its embedding in, and resonance with, the environment, and turns into an obstacle that falls short of its tasks.

Let us now consider the desynchronisation concerning intersubjective time. Depressed patients avoid the environment with its social or physical timekeepers. They do not get up in time, withdraw from social obligations, and their tasks are taken over by others. Painfully, the patient experiences his inhibition and rigidity in contrast to the movement of life going on in his environment. The desynchronisation also becomes manifest in a failure to achieve forgetting and elimination of the past. “Everything goes through my head again and again, and I always have to wonder if I did things right”, as a patient described it. It is the torture of not being able to forget, of being constantly forced to remember and therefore not arriving at the present any more.

With increasing inhibition the basic movement of life comes to a standstill. The depressive has fallen out of common time, usually expressed in the complaint that time has slowed down or stopped. He literally lives in another, sluggish time, and the external, intersubjective time passes him by⁸³⁶. This disturbance of temporalisation can be experimentally verified: depressive persons experience a time dilation, i.e. they estimate given time intervals to be longer than the actual, objectively measured time³⁷.

"My inner clock seems to stand still, while the clocks of the others run on. In everything I do I am unable to get ahead, as if I am paralysed. I lag behind my duties. I am stealing time" (*own clinic, T.F.*).

"I have to keep on thinking that time is continuously passing away. As I speak to you now, I think 'gone, gone, gone' with every word I say to you. This state is unbearable and makes me feel driven. (...) Dripping water is unbearable and infuriates me because I have to keep on thinking: another second has gone, now another second. It is the same when I hear the clock ticking – again and again: gone, gone"².

This patient perceives time in fragments because she cannot experience it in the flow of spontaneous becoming but as something remaining outside her. She must subsequently go back to everything that she was not able to live through in perceiving and acting, however, only to notice that the impression or the movement is already "gone".

With uncoupling from external time, the future is blocked, which means that *the past is fixed once and for all*; it may no more be changed or compensated by future living. Now all past guilt and all omissions are actualised: "What has happened can never be undone again. Not only the things go by, but also possibilities pass by unused. If one does not accomplish something in time, it is never done any more ... The real essence of time is indelible guilt"³⁸. Thus, in melancholic depression, time is continuously transformed, as it were, into guilt which cannot be discharged any more.

Complete desynchronisation is marked by the transition to melancholic delusion. Now the return to a common intersubjective time has become unimaginable, the determination by the past total. A state of self outside the present one seems impossible. The patient is forced to identify with his present state of bodily inhibition and decay, with his state of feeling guilty as such, or, in nihilistic delusion, with his state of not feeling alive any more. He is no longer able to keep his situation in perspective, and to relativise his convictions. It has always been like this, and it will stay the same forever – all reminiscence or hope different from that is deception.

Now if for the patient there is no state of self outside the present one, he loses the capacity to change his perspec-

tive and to transcend his present experience towards an intersubjective view. Depressive delusion is therefore rooted in the total constriction of self-experience: Corporealisation and desynchronisation, i.e. bodily and temporal separation from the shared world, prevent the patient from taking the perspective of others. He loses the freedom of self-distancing, of considering other possibilities of self-being. Delusions of guilt or impoverishment, nihilistic and hypochondriacal delusions are all just different expressions of the same state of the self: a state of total objectivation or "reification" that can no longer be transcended.

Resynchronising therapy

I have described depression by two main alterations that are closely interconnected: *corporealisation* and *desynchronisation*. The loss of goal-oriented capacities of the body, of drive, appetite and desire, are equivalent to a slowing-down and finally a standstill of lived time. Thus the past, the guilt, losses and failures gain dominance over the future and its possibilities. Melancholic delusion is the utter manifestation of this uncoupling from common time.

From this point of view, the treatment of depression should have the aim to restore and support the missing processes of synchronisation. Apart from biological approaches, a psychosocial "*resynchronising therapy*" should take into account the following guidelines:

1) The first requirement would be a spatial and temporal frame that creates a legitimate recovery period for the patient, a "time-out" so-to-speak, during which he can gradually readapt to the common social course of time with as little pressure as possible. In this phase of treatment, the aim is to loosen the rigidity of bodily restriction and anxiety, which is mainly achieved by psychotropic medication, but also by the relief of everyday tasks that overburden the patient's capacities.

(2) Secondly, it is important to give rhythm to everyday life, i.e. to emphasise repetition and regularity in the structure of the day and week. This helps the patient to gain a stand against fleeting time and to support the resynchronisation of internal and external rhythms.

(3) Careful activation therapy may support the patient's orientation toward future goals, however modest. This may be stressful at first, since the patient's own, appetitive motivation is still missing and each action is in immediate danger of not satisfying his high demands on achievement. It is therefore important to explain to the patient that the intentional arc alone, which he draws in planning and execution, is enough to extend his sensorimotor space again and to re-establish his directedness towards the future.

(4) From this follows the principle of "optimal resynchro-

nisation”: the patient should experience a degree of activation and stimulation appropriate to his present state, so that the empty time is filled again, without however, causing a relapse into uncoupled time by forced rehabilitation. The image of a gear-change suggests itself here, where different levels of synchronisation are chosen according to the present capacity.

(5) After the remission of acute depression, it becomes important to further the psychological and social processes of resynchronisation whose failure has contributed to the onset of illness, above all, processes of grief and role change.

The phenomenology of mania: body, space, time and intersubjectivity

Mania is obviously the antithesis of depression. The depressive heaviness, inhibition and retardation is replaced by lightness, disinhibition and acceleration. The lived body, instead of its constriction in depression, is characterised by a *centrifugal expansion*, connected with a general sense of omnipotence and appropriation. Therefore, the manic mood is not so much a state of happiness and cheerfulness, but rather a state of superficial elation, often experienced with feelings of flying or floating. One may speak of a “vital euphoria”, since the manic state of mood is not due to a narcissistic grandiosity, but mainly to an excess of drive, energy and disinhibition. The body seems to have lost all inner resistance that normally hinders us from acting out every impulse immediately.

However, manic euphoria may turn into *dysphoria* and irritability, especially when others question the manic person’s omnipotent attitude or confront his expansion. *Dysphoria* (from the Greek *dysphoros* = hard to bear) denotes a condition of disagreeable, nervous tension, hostile emotional reactivity and propensity for aggressive acting out. It becomes the dominant mood in so-called *mixed states* of bipolar disorders, characterised by rapidly shifting affects, agitation, accelerated thoughts, lack of concentration and memory, and sudden attacks of depression which may even cause suicidal thoughts and actions^{39 40}. *Dysphoric* mood should thus be considered as a particular type of mood that is qualitatively distinct from anger, sadness, anxiety, or euphoria.

As a result of the excess of drive and the expansivity of the body, the *space* of the manic person changes into an unlimited, homogeneous medium of projects and activities. The patient’s self is exteriorised and extended in his environment, trespassing on others’ territories regardless of barriers of decency or respect. “The world is too small for this being in expansion [...] and distances become smaller”⁴¹. Space is lived as if it were vast, open and lacking resistance. Attractive qualities or opportunities abound,

all objects seem equally close, available and ready-to-hand⁴², leading to the notorious excessive consumption. Thus, the relation of person and space is characterised by *centrifugal dispersion* and *dedifferentiation*, overriding the gradations of proximity and distance that normally structure the peripersonal environment. In the symbolic realm of thinking, the “flight of ideas” corresponds to the dispersed mode of existence that is conspicuous in the patient’s lived space.

Regarding *temporality*, we find the opposite type of desynchronisation compared to depression, namely an *acceleration* and finally uncoupling of the individual from the world time. Manic action is characterised by restless hustle and agitation. The present is not enough, it is virtually marked by what is still missing or what would be possible. Whereas the depressive patient keeps lamenting over missed opportunities of the past, the manic person is constantly ahead of himself, addicted to the seemingly unlimited scope of possibilities. Interest in the present is always distracted in favour of the next-to-come. The future cannot be awaited and expected, but must be assailed and seized immediately. Impatience leaves no ease for pursuing long-term goals. The past, on the other hand, is forgotten as soon as new alluring options and possibilities emerge; commitments are betrayed in favour of a more enticing future.

All this leads to a momentary life, consisting of isolated “nows”, not allowing for a sustained development and conclusion of projects. The manic mode of existence is volatile, playful and provisional; both the past and the future lose their influence on the present⁴³. If one project fails, then a dozen of other plans take its place at once, resulting in a spinning round on the spot without actual efficacy. In so doing, the manic person neglects the natural rhythms that oppose his acceleration: he represses the cyclic time of the body in favour of homogeneous, linearly accelerated time. He disregards the needs of his body, denies it the necessary sleep and ignores the signs of beginning exhaustion. The body is exploited recklessly, as a mere vehicle of the expansive drives.

In summary, in mania the movement of life is accelerated and overtakes external, social, or world time. Only in fleeting transition does the patient come in contact with the world and the others, unable to dwell in the present and instead always turning to the next-to-come. Here too, the disturbance of temporality may be experimentally verified: in studies on time estimation, hypomanic and manic patients experience a shortening of time periods⁴⁴.

If we finally turn to *intersubjectivity*, we find patients bustling around in dispersed attention, without being able to take a specific interest in others. Though the manic person constantly approaches and seizes them, he soon loses his interest once they do not participate, and no deeper affective connection results. The patient’s euphoria feigns

affection, but actually remains a “frozen”, fixed state of empty cheerfulness. Since the component of *receptivity* in contact is lacking, encounters cannot establish contentment and fulfillment. Lack of distance and disinhibition, often a sexualised behaviour to the point of promiscuity, may have a destructive effect on personal relationships. Frequently the manic episode leaves behind a mess of job loss, debts, or divorce. Manic patients thus live over their means and exhaust their biological and social resources to the point of depletion and breakdown. Even though they may not realize this immediately for lack of self-criticism, the disillusionment after the manic episode is all the more profound and may often contribute to a sudden fall from mania into depression.

Conclusion

From a phenomenological point of view, depression and mania are not just “inner”, psychological, or mental disorders, but disturbances of the bodily, affective and intersubjective space in which the patients live, behave and act. In depression, the corporealised, constricted body loses its affectability and emotional resonance; this undermines the patient’s existential feelings of being-with-others, resulting in a general sense of detachment, separation, or even expulsion. The typical cognitive symptoms of depression – negative thoughts about self and future, delusional ideation – are a result of this basic bodily and affective alteration.

The constriction and encapsulation of the lived body also corresponds to the typical triggering situations of depression. These are mostly experiences of a disruption of relations and bonds: a loss of relevant others or of important social roles, experiences of backlog or defeat, resulting in a desynchronisation from others and in a blocked movement of life. To these situations of threatening or actual separation, the depressive patient reacts as a psychophysiological unity. Without doubt, depression is a bodily illness even in the biological sense, implying functional disturbances on different levels and a partial decoupling of organism and environment. But at the same time, the biological dysfunctions that result in the felt bodily constriction are the meaningful expression of a disorder of intercorporality and interaffectivity on the psychosocial level. Our participation in interaffective space is mediated by a fundamental bodily resonance. In depression, this attunement fails, and the lived body, as it were, shrinks to the boundaries of the material body.

In mania, the depressive heaviness, inhibition and retardation find their counterparts in lightness, disinhibition and acceleration. The centrifugal expansion of lived body and lived space is connected with a compression of experienced time and a dispersion of activities rendering the patient incapable of pursuing his goals in a sustain-

able and productive way. Moreover, the overstimulated and expansive body is inadequate for establishing the fine-tuned and reciprocal interactions with others that are necessary for emotional resonance and interaffectivity. Though the manic person’s behaviour may convey a different impression, his rapport with others is no less disturbed than in depression; his contacts remain fleeting and superficial. In summary, both disorders are only fully described as disorders of intersubjectivity, which means, as a failure to participate in the interaffective space that is mediated by bodily resonance.

Conflict of interest

None.

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