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Time and Space in Manic Episodes

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Temporality and Spatiality have been extensively addressed in philosophy, and their disturbances have been extensively studied in psychopathology (e.g. Wyllie 2005). Mental health patients: (1) describe pathological experiences of Time and Space (Gallagher and Varela 2003); (2) show disturbed timing (Tysk 1984); (3) experience psychopathological phenomena that could be the cause of changes in temporality and spatiality. These topics will be discussed in the case of mood disorders, in particular euphoric and dysphoric mania episodes. Any phenomenological study in mood disorders is delicate as affective disorders are in themselves phenomenologically diverse, because they have obscure meaning, multitude of criteria and inconsistent reference norms. Also, psychoanalytical, colloquial and cognitive psychologies keep instilling comprehensive and epistemological structures onto both mood and time/space notions. Nevertheless, bridging philosophical phenomenology and epistemology on time and temporality with mood psychopathology and taxonomy constitutes an on-going project. Theories by Heidegger, Husserl and Merleau-Ponty as well as by Minkowsky, Binswanger, Fuchs, Parnas, and Sass could help to describe this relation deepened into many other Twentieth-Century philosophical papers. A similar account of space and spatiality will be brought about. We will reason about the concept that they provide evidence to address current conceptualization of "bipolar" disorder and the hierarchical grouping of dysphoric and euphoria mania.

Keywords: mood disorders, time, space, phenomenology, epistemology

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INTRODUCTION TO RELEVANT TIME AND SPACE CONCEPTIONS

Notwithstanding time's frequent use in colloquial, psychological and scientific jargon, St. Augustine was preciously clear on its paradoxical nature: *I know exactly what time is until I try to define it* (Augustine of Hippo 354-430 AD, Ed. 2008). The first difficulties arise inside language as we use the same semantic element for different phenomena. There have been many philosophical enquiries on time and temporality demonstrated to be relevant to psychopathology. As such, we will present pre-noetic time, personal time and interpersonal time as important discussion themes.

In Kant's seminal book we find temporality as an organizer of experience (Kant 1787). In Kant opinion, time was a "form of pure intuition" (one of the *three principles* not derived from experience - categories of pure reason). Furthermore, time importance in intentional activity and perception as well as the microstructure of the self-world relation was stressed in Husserl, Heidegger and Fink when using concepts as *noetic act, horizon, protention and retention*. Personal time can be discussed in different epistemic paradigms:
(1) in St. Augustine, time was addressed as tripartite: the present lacking extension flowing and passing by and tending not to be (opposite to the past and the future that possess extension but lack existence);
(2) in Jaspers, time is divided in these subsets: knowledge, experience and handling of time (Jaspers 1959, Ed.1997).

An interpersonal dimension of time has to be considered in order to provide a comprehensive understanding of psychopathology. Minkowski stresses that we live *syntonically* together with others, alluding to the principle that "*allows us to vibrate in unison with the environment*" (Minkowski 1933, Ed.1973). This dialectical synchronization with others is emphasized in Fuchs, "*the micro-dynamics of everyday contact imply a habitual synchronization […] a basic*

feeling of being in accord with the time of the others" (Fuchs 2001, p.183). Both times induce each other and each moment either resting in a transparent harmony or out of tune it is when the other hassles my experienced time that my awareness of temporal movement is most transformed (adapted from Fuchs 2001). My personal time is contingent not only to objective time (e.g., watches) but also to my interaction with others having different experiences of time.

Spatiality should not be simplistically defined in a physical manner, that is material relation of proximity between two or more human realities. The Heideggerian concept of *Räumlichkeit* clarifies most forms of space that we need to encompass:
(1) Tri-dimensional space - space from geometry (Euclidean);
(2) Homogeneous space - homogeneous emptiness where there are no prominent parts (Newton physics space);
(3) Natural orientation space - sensorial space (visual, acoustic, tactile);
(4) Lived space - where the individual can move, dance, where he is free of directional or situational compromises (Heidegger 1927, Ed.2010).

Concepts as *motor intentionality* (Merleau Ponty 1945, Ed.1962) and *affordances* (Gibson 1977) enriched the relation of spatiality and psychopathology. *Motor intentionality* characterizes habitual actions (Thomson 2007) - the way we primarily relate to things in our everyday life. The concept of *affordance* (and all embodiment literature it assumes) conveys that, permeated in our experience, there is a solicitation to act; the world elicits appropriate actions, bringing suitable motor projects and our physical body is a translator of those solicitations. Examples of these different space experiences are:
(1) the distance of a given path that seems different with the level of our intention to beat it;
(2) the first time we travel a pathway it always looks longer than the next ones;
(3) a chair in the external space is experienced as the universe of interactions available, and the relationship between me and the aspects of the environment depends on the *horizons* or *possibilities* of interaction.
This being, our perceived movement, space and objects in space excel in a physical nature and vary in accordance to embodied and psychic conditions.

Binswanger (1963) described space experience influenced by factual, topological, physical, social and psychological conditions drawing a parallel with Kurt Lewin concept of hodological space. This conceptualization is exemplified in many descriptions as for instance the Portuguese poet Guilherme de Almeida "*Far away from you, everything is a desert, and all distances are one and the same*" (Almeida 1952, p. 212).

TIME EXPERIENCE IN MANIA

In mood disorders there are many examples of psychopathological signs and symptoms that could involve an epistemology including time. A unique one, found in vital depression, is psychomotor slowing or "inhibition" (Schneider 1959). Typical of vital depression, patients limiting engagement with the world lead to slowing the time passing. On the opposite edge we find psychomotor activation or increased "drive" where time is shortened to an "eternal present" and in these extremes - time is conceptualized as been brought to a standstill.

Personal time is altered during mania and Binswanger's description accounts for some of these experiential changes:

> "*these patients live almost entirely in the present and to some degree still in the past, but no longer into the future. Where everything and everyone is "handy" and "present" where distance is missing, there is no future either, but everything is played off 'in the present' in the mere here and now. This also throws light upon the self of such patients. A self that does not live into the future moving around in a merely playful way, in the here and now and, at best, still lives only from the past, is nothing but momentarily "attuned"; it is not steadily advancing, developing or maturing, is not, to borrow a word, an existential self*" (Binswanger 1964, p.131)

The patient has fabled, unreal origin (past), built specifically for current present, a self-sufficient present with an irrelevant and pointless future. An actual and instantaneous exaltation of the Self, without future perspectives, nor constructions of a past archived in his memory.

The most genuine and pathological trace of

euphoric mania in presentification, defined by Minkowsky (1933, Ed.1973), is the *inability to live now*, the inability to live an authentic present (patients experience an *atomization* of time) as a succession of very small 'now'. In this *presentification* patient's existence has vertiginous rhythms, providing a subjective impression of flying in the wings of time, and in euphoric mania there seems to be no true temporal project. The experience of fleeting frustrations and gratification does not change his playful existence.

In less severe mood states, as in hypomania, distortions in time experience are not as absolute or as stable. The present is held as correctly articulated, continuous and with sufficient amplitude, although bearing a shortening of the temporal horizon (reduced influence of the past and future onto the present). The same theoretical account would consider dysphoric episodes, episodes where there is impatience, capacity for holding grudge and vindicating his existential status against others. The frustration that takes hold in a dysphoric mood needs an existential project still being present, or at least the possibility to interpret the present as unable to provide a desirable future. The ability to live now (although a frustrating now) and for the future (impossible to attain and therefore in a frustrating present) draws parallel with hypomania rather than with a condition more disturbed than euphoric mania.

Interpersonal dimension of experience is disturbed in mood disorders, but it is also disturbed in depression with social reclusion, detachment and isolation. In the case of time, Fuchs account on desynchronisation shows that patients experience of measure between objective and intersubjective time provides a reference for interpersonal time experiences in melancholia and mania. He writes "*only in euphoric mania, the asynchrony of individual and social time is not felt unpleasantly by the patient herself, yet all the more so by her environment*" (cited in Wyllie 2005 p.196). Personal time unrivalled by others then becomes immense or even infinite, as one loses his major reference.

In euphoric mania the time of "the same" is never beleaguered, as with his excessive familiarity and proximity, "the same" engages with everything and every other. This engagement could be conceptualized as Levinas notion of travel. The subject travels to the other but in his encounter he is unable to restructure experience, and therefore remaining invulnerable to the experience of *alterity*.

SPACE EXPERIENCE IN MANIA

As emphasised in 3rd person psychiatric reports and in 1st person accounts, spatiality and space experience are altered in mania. Binswanger seminal contribution is impressive in both the phenomenological and the epistemological domain. Firstly, spatiality is used to describe experiential states in mania – "*there is a leaping way of being, an alteration of the humoral spaces, turning homogeneous the distance between lived noetic and noematic factors of reality*" (Binswanger 1964, p.131). Patients experience changes going from leveling, diluting and expanding to leading to a space hunger, "*the world is too small for this being in expansion [...] and distances become smaller*" (Binswanger 1964, p.132). In his study on Flight-of-ideas, Binswanger (1931-1932) goes on describing and analysing the way-of-being of manic patient through movements; this psychopathological sign has four subtypes - ordered, disordered, incoherent, and confused. Through this analysis, and sharing Heidegger's terminology, the manic patient way-of-being in the world was explained by two concepts, "springen" (jumping) and "wirbel" (whirlwind). Therefore he considered two different types of manic episodes - jumper and whirl-winder.

Another Binswanger spatial concept, *extravagance*, fits in manic patients existential status – "*to climb so high one is not able to return, to lose one's self among precipitous mountain peaks, to fly high, to go too far*" (Binswanger 1963, p.342, translator's note). He uses the Latin root extra "beyond"; vagari "wander" to understand patients usual "*wandering beyond the limit*". He continues on saying that:

> "*to feel the full sense of the word, imagine a mountain climber trapped on a narrow ledge such that he can neither descend nor ascend, and from which he must be rescued by others*" (Binswanger 1963, p.342)

Here Binswanger also calls for an understanding of human existence as thrusting itself in breadth and in height:

> "*it not only strides forth, but also mounts upward […] existential height and breadth signify, ultimately, two different spatial schemata of one temporal direction of finite human existence*" (Binswanger 1963, pp.342-349)

Manic patients endure "*a certain disharmony in the relation between rising upward and striding forth"* (Binswanger, 1963 pp.342-343).

Binswanger considers spatiality disproportion to be fundamental for an inauthentic existence "*this height-breadth disproportion is rooted in an "excessive" expansion of the manic's pervasively volatile world; excessive, that is not authentic, undergoing simultaneous processes of levelling*" (Binswanger 1963, p.346). This inauthentic way of being in the world implies the impossibility to obtain a genuine foothold on the ladder of human problems (in this respect it also signifies the impossibility of authentic decision, action, and maturation). This concept is giftedly clarified by him:

> "*detached from loving communion and authentic communication, all too far and hastily carried upward, the manic hovers in fraudulent heights in which he cannot take a stand or make a self-sufficient decision. Love and friendship have, in these airy heights, lost their power*" (Binswanger 1963, p.347)

Binswanger descriptions of one of his patients (Ellen West: Binswanger 1958) were particularly insightful for the dialogical relation of mood and space experience: she used space jargons to describe three different types of existential attitudes during her mood episodes: "Flying, floating over the clouds in relation with periods of hope and joy"; "Walking, straight and stiff over the earth in the world of praxis, activities and concrete realizations"; and "Crawling like a worm in a final phase of desperation and soreness, until we deepen into our grave and plunge into the darkness of a swamp". Space experience attachment to mood experience is therefore suggested, allowing for patients to relate to them and to communicate with them.

Alonso Fernandez (1965) enhanced this contribution by providing, through the model for endogenous mania, striking differences in the experience of space during euphoric and dysphoric episodes. He separates the humoral space in four divisions:

(1) pre-empted space
(2) action space
(3) mood space
(4) intersubjective space

Using these partitions he described patients' space experience during euphoric episodes as wide and cosy, moving as through a volatile world, clear and full of light, being inter-subjectively open and prosperous. Opposite to this, there is another experience found in dysphoric episodes: patients were incited to fight and absorb new objects, they moved through tumultuous environments filled with heteroclites with pointy edges, a blood-red world shut-closed to others. Alonso Fernandez goes on designating a type of domination during each of these episodes: the euphoric episode dominated by "the other" (patient living in a totemic Orgy) and the dysphoric episode dominated by "the self" (patient living in a fortress). While spatiality is reformed in manic episodes, patient's reports in dysphoric and euphoric episodes bear important differences.

CONCLUDING REMARKS

The breadth of bipolarity is still under debate as there are epidemiological and phenomenological distinct patterns underlying bipolar-I and bipolar-II disorders, mixed affective episodes and schizoaffective disorder. The phenomenological differences between them are defiant (e.g., the only thing currently distinguishing mania from hypomania is the level of social and occupational functioning). Patients meeting full criteria for mania are heterogeneous as a group and dysphoric episodes seem more likely associated with suicide, younger onset, longer duration of illness, higher rates of personal and familial depression, frequent sedative-hypnotic abuse, neuropsychiatric abnormalities or poorer outcome. Disturbed experiences of Space and Time in these episodes (hypomania, dysphoric and euphoric mania) show deeper phenomenological and epistemological differences.

In case there is a bipolarity and ostensive hierarchy, a theoretical utter dissolution of time should only occur in euphoric mania.

Also, an absolute *presentification* would also be exclusive of euphoric mania and therefore frustration, grudge and dysphoric mood can only be conceptualized in earlier stages where a temporal project is still possible. Accordingly, hypomania and dysphoric episodes bear lesser changes of time and temporality disturbances. The distinctions in patient's lived space during these episodes are striking as well, as provided by Alonso Fernandez's remarks of dysphoric and euphoric episodes. In his opinion patient's experience of space in euphoric episodes is the immersion in a world permanently available as in orgiastic relation with others, whereas in dysphoric episodes patients describe the others and the world as markedly separated from them.

The provided data on time and space experience is clearly inconsistent with clinical severity. Not only it suggests these episodes could be much more apart than currently theorized, but also stresses why euphoria should not be considered less disordered than dysphoria. This inquiry over manic episodes shows how unrested is the psychopathology and nosology of euphoria and dysphoria and why current conceptualization needs a sturdier phenomenological or epistemological inquiry.

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