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THE MANIA AND *STIMMUNG*: ON THE PHENOMENOLOGICAL DIFFERENCES OF THE PERCEPTION OF MANIA AND THEIR TRANSFORMATIONS

abstract

Epidemiological studies of the last decade have shown a low prevalence of hypomania and bipolar I disorder in Western societies while pointing to a prevalence of unipolar mania in non-Western societies. This work seeks to investigate the explanatory role of the Stimmung *concept to understand these differences, as much as the increase in the number of cases of mania in the West in the last two decades. It attempts to explore the relationship between the phenomenology of hypomania and its adaptation to the atmosphere of its environment. Our hypothesis is that the experience of hypomania would be in harmony with the narrative of Western societies and with* Stimmung *(in the sense of the term used by Spitzer and Heidegger) of these societies. Finally, we will present a clinical case and analyzes of business leadership manuals that will illustrate the phenomenological relationship of Stimmung and mania, as well as its transformation in the sphere of work.*

keywords

Stimmung*; mania; unipolar mania*

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This work aims to discuss the relevance of the *Stimmung* concept to the clinical and social perception of mania. It is argued that the concept of *Stimmung* may help us to understand the recent epidemiological data that point out a difference in the prevalence of cases of unipolar mania and type I bipolar disorder according to cultural and geographic variables. Thus, according to our hypothesis, the experience of hypomania would be in harmony, for example, with the central narratives of western societies. However, there is at least one point that represents a challenge for the theoretical use of *Stimmung*. This is because, in the case of Western countries, although their *Stimmung* seems to be part of the manic phenomenon, a considerable increase in these cases has been recorded since the beginning of this century. We hypothesized that this increase would be explained by the fact that there has been an internal *Stimmung* rip, which would lead to a transition from the hypomanic adapted functional state to the dysfunctional manic state, resulting in greater visibility of this condition.

The category of *Stimmung* used here comes from the philologist Leo Spitzer and the philosopher Martin Heidegger. Besides being a philosophical concept since the eighteenth century, *Stimmung* also designates a phenomenon that is difficult to circumscribe. It refers to the set of elements present in the environment that give an affective tone and confer a certain sensitive atmosphere that may impact both body and mind. The *Stimmung* means the external atmosphere in which we are immersed in and, at the same time, our inner state. In Spitzer's definition, it is "the unity of feelings experienced by man face to face with his environment (a landscape, nature, one's fellow-man), and would comprehend and weld together the objective (factual) and the subjective (psychological) into one harmonious unity". As a result, it can be said that a landscape has *Stimmung* and that someone has a certain *Stimmung*, as well as a historical era.

Heidegger also emphasizes the meaning of *Stimmung* as an atmosphere capable of determining what he calls being-with-one-another, something in which we are already immersed in and that always goes through us, which has a contagious quality, like "infections germs wander back and forth" (p. 67). Again, the concept does not refer to an epiphenomenon, a state of inner humor, but to the way that our *Dasein* is with another:

> [...] the attunement imposes itself on everything. It is not all inside in some interiority, only to appear in the flash of an eye; but for this reason it is not at all outside either. [...]. Attunement is not some being that appears in the soul as an experience, but the way of our being there with one another. (Heidegger, 2004, p. 67)

This characteristic of continuity between internal and external can be seen in the semantic complex of this German word. According to Spitzer, it has roots close to the Latin *temperamentum* (temperament) and *consonantia* (concord), but also humor, atmosphere. For Spitzer, *Stimmung's* semantic perspective as humor, mood, atmosphere is translatable into other European languages, but the aspect related to the idea of harmonic consonance would not find equivalent expression in those languages. Even so, there is a semantic similarity with the French word *ambiance*.

This second aspect of *Stimmung* played an important role in notions such as Syntony, defined by Minkowski as the ability to "vibrate in unison with ambiance", and in the concept of thymic space (*Der gestimmt Raum*) by Binswanger. And it can be said that was the second aspect of *Stimmung* that most interested these last authors in their writings about the called mood disorders or *Verstimmungen* for German psychiatry. For example, about the manic dysthymia, Binswanger wrote:

> *the term dysthymia refers not only to humor itself, but to the totality of the world of manic constitution*. (p. 125)

In Binswanger's conception, mania does not refer to a mood variation as a primary phenomenon followed by other changes. His conception is that, in these case, the change of the *thymos* involves a wider temporal and spatial shift that impact the way of being with the other. According to Binswanger, unlike the melancholy who would turns himself into his own world, the maniac, "turning away from himself, turns to others, to 'society'" (71). Kimura Bin also points out to the fact that the maniac patient would aspire to a fusional contact with the whole. These elements, Binswanger insist, would lead to an "inability to form a common world" with their fellows.

However, if much of the idea of *Stimmung* has been used to understand the psychopathological phenomenon, less attention has been paid to the potential role of *Stimmung* in diagnosis. In the specific literature, it is possible to find some articles that aims to attach institutional ambiance and treatment process, as Chaperot and Altobelli (2014) who discusses the role of psychiatry institution *ambiance* in the therapeutic or iatrogenic response. Another group of articles intent to relate the ambiance with a specific behavior response during the treatment. An example of this is the study of Yao and Algase (2006) that explored relations between environmental ambiance and locomotion behaviors of patients with dementia. But most of them applies the term *Ambiance* in a sense of atmosphere and environment and not in the sense that Spitzer and Heiddegger explores the term *Stimmung*. What we would like to evidence here is the relationship between the *Stimmung* and the diagnosis, this clinical event on the encounter between the therapist and the patient, the moment in which one seeks to understand the experience of the pathological alteration, and sometimes, to name it.

Following the methodological suggestion of Daudet, for whom it is possible to have three levels of approach of *Stimmung*, the individual, interpersonal and the collective level, we would like to focus this last one when combine with the diagnostic problem. Our choice is because the epidemiological studies of the last two decades present different and significant results in the geographical distribution of mania and depression (Aghanwa, 2001; Amamou, 2018; Dakhlaoui, 2007; Douki, 2012; Lee, 2009; Khanna, 1992; Makanjuola, 1982, 1985; Negash, 2005; Osher, 2000; Rangappa, 2016). According to them, there would be a low prevalence of hypomania and mania in Western societies, followed by an expressive number of cases of depression. At the same time, these surveys point to a significant number of cases of unipolar mania in non-Western societies. The results of the comparative study by Douki *et al.* (2010), between clinical cases in France and Tunisia, show that three-quarters of the first episodes in France were diagnosed as depressives

whereas in Tunisia three quarters were manic. In subsequent episodes, the percentage of presentation of mania was three times more extensive in the group of Tunisia. One of the conclusions of the researchers is that the expression of bipolar disorder would be different in the countries of the South, with a higher prevalence of unipolar mania in these countries. Two former articles by Makanjuola (1982, 1985) also show clinical data on the presentation of bipolar disorder in Nigeria that counter the worldwide data according to which depression would be the hegemonic expression of bipolar disorder. In his study, unipolar mania was the rule among patients. The research data of Negash *et al.* (2005) with patients in Ethiopia also present prevalence of manic episodes.

Also, another aspect of the issue is presented in surveys that show the weight of the cultural differences in the team of evaluators, responsible for making the diagnoses, even when using supposedly objective scales. This is demonstrated by the experiment of Mackin *et al.* (2006) to assess the effects of cultural biases on the identification of manic symptoms using the Young Mania Rating Scale, with North American, British, and Indian evaluators, showing that "Indian raters saw the manic behavior of the American patients as significantly iller and inappropriate than did American raters" (p. 380). In another study (Buchmuller and Meyer, 2009) reported by Ghaemi, demonstrated the difficulty of psychologists in diagnosing the manic episode from clinical vignettes. While 95% correctly diagnosed depression, only 38% were able to diagnose mania, based on the DSM-IV criteria (Ghaemi, p. 804). In their article, Kirov and Murray (1999) also discuss the relationship between the quantitative difference of manic presentation and the prejudice of the evaluating physicians.

Without ignoring the many factors involved in epidemiological and in cross-cultural studies, such as hereditary factor, family history, diagnostic instrument differences, seasonality, we would like to emphasize the role that the concept of *Stimmung* and cultural atmosphere may play. In part, a little of this hypothesis, although in other terms, has already been indicated in those studies cited above. For example, Dakhlaoui *et al.* (2007) suppose that in Tunisia "[...] mild to moderate depressive episodes are probably underestimated due to the high tolerance of these symptoms in families". *Stimmung* could help to understand this state of affairs, since it would be the tolerance and imperceptibility factor for manic symptoms, especially in its hypomanic form, in Western countries. Conversely, its low tolerance in other contexts.

It is relevant, in this context, Ghaemi's observation that hypomania would be one of the few diagnoses of Axis I of the DSM that does not have as a criterion for its diagnosis a significant dysfunction: "Hypomania involves little to no subjective distress, no functional impairment, and no apparent loss of freedom. In fact, usually, one's functioning is enhanced. In this sense, hypomania in isolation does not meet DSM definitions of a mental disorder" (p. 810). It is also appropriate to add Caillard's consideration concerning the less rigid boundaries between the hypomanic and the manic state: "The border between the two states remains blurred, even subjective, depending to a large extent on the level of adaptation and tolerance of the environment" (Caillard, p. 25, 1982).

However, along with this solid data on differences in manic perception, there is also a state of affairs that seems to point in the opposite direction. For, according to Yutzy *et al.* (2012), if from the 1970s to the 1990s the rate of prevalence of mania in the western countries remained unchanged between 0.4% and 1.6%, from the 2000s it passed to incredible 5% and 7%. Therefore, an increase of more than 1,000%. Still, this change can also be understood precisely by the way mania is absorbed in what we have called the cultural atmosphere of *Stimmung* of these countries. For not only is there a tolerance for manic cases in Western countries, but there are also discursive and narrative mechanisms that stimulate mania as a factor of productivity in this context. That is what we have seen in many business leadership manuals, for example.

This relationship appears not only in business magazines but also in scientific articles since the 1990s, in which the relationships between bipolarity and creativity have been investigated, claiming that music geniuses, political leaders, painters, writers would have been bipolar patients. In the following decade, another thesis arose that bipolar disorder would help a business career. The manic phase comes to be known as the *CEO's disease*, and a look at the management manuals and leadership is enough to understand why: the clinical signs that characterize manic behavior appear in those books as the ideal characteristics for market participation and productivity in times of high levels of competitiveness. Thus, these manuals recommend, however paradoxical it may sound, a leader should prefer the crisis to stability, have self-confidence, have a holistic understanding of the context, have energy and energize employees, be euphoric, feel well-being, communicate and promote changes. The leader must look for opportunities and take risks, ignoring any danger. He must be the one who revolutionizes, experiments and creates (Hickmann, 1990). Although more emphasized in leadership management literature, these characteristics are sometimes appreciated for every individual who wants to intensify their performance and self-manage. So no wonder a hypomanic patient, an businessman hospitalized by his family in the psychiatric emergency room, said: "I am not going to take too much mood stabilizer because my clients do not like it when I am out of the manic phase". What can be more self-confident than someone who says, "When in mania, I became more powerful than God"; or "I felt the whole sea, not just a drop in the ocean", or "I am the chosen one. I am universal"?

Strengthening this state of affairs, the manuals for extracting the best performance from the leader diagnosed with bipolar disorder have appeared as well. For example, one of the titles is "Managing a Hypomanic", which states that it is possible to control the disease avoiding its negative aspects - such as irritation, intolerance, depression, risks of aggression and suicide - and thus avoiding "business catastrophe".

However, this management capacity seems to have reached its point of exhaustion, revealing it counterproductive aspect. Recent studies have begun to question this link between entrepreneurship and mania. The article "Career effects of mental health" (2015) brings the results of research carried out by three universities with significant sampling. The main results: 1) individuals at higher risk of bipolar disorder are more likely to be self-employed or executives (25%) in new and small companies because these enterprises would be more risk tolerant; 2) these individuals are significantly less likely to assume administrative places (13%), including chief executive officer, chief operating officer or chief financial officer; 3) as for wages, they earn 43% less on average.

In order to illustrate this relationship between mania and its instrumental administration for higher productivity in the work environment, we will present a clinical report, which was treated in a psychiatric emergency department in a large metropolis in Brazil. This case allows us to raise a hypothesis about the contemporary condition of *Stimmung* and the intensification of the perception of mania even in Western countries.

The case refers a patient, 28 years old, brought by relatives to the psychiatric emergency, where he was hospitalized. On the day of first attendance, he walks around the infirmary, talks to all patients, attaches meaning to all the colors and objects around him. He said he worked in a company of development and commercialization of hardware and software. For the last three months, he worked 18 hours a day. He was a trainee and, in the company hierarchy, he "was below the line of misery". He claimed he worked harder than his boss's boss, but earned more than twenty times less. According to him, in this company, the employees "do not have to punch the time card, have to hit its targets". So he came to sleep three hours a day with small moments of naps during the day. After a few days, so he continued his speech, "I did not need to sleep anymore. I wanted to do something great. That activated areas of my brain and

connected it with the universe and the cosmos. I started to have many ideas to improve the company. I started thinking about thinking, and I went up, up, up to other spheres. It's bad because I lost contact with me, I did not know where I was anymore. It's like an astronaut who does not have oxygen to return to Earth". A few days later, he stated: "The day I came to this clinic, I had presented my hiring document to go up a post in the hierarchy. The document was with the boss to be signed. On that day, the (president of Brazil) Dilma fell. I thought I had conquered everything I wanted. I began to think I was seeing the glory of God. I was so tired. It was only with this nervous breakdown that I managed to relax, to feel good".

This case is a concrete example of what we might call the internal rip of *Stimmung*, which is taken to its extreme and finds no narrative able to contain the experience anymore.

Thus, from a situation in which it absorbed the mania and rendered it someway tolerable, maybe imperceptible, even scientific and clinical contexts, and it passed into a condition of acceleration and stimulation of its internal logic in such a way that it is impossible to signify anymore.

In conclusion, we may say that *Stimmung*, as a concept that reveals the aspect of the interaction between subject and object crossed by an affective tonality of experience, may allow the access to a fundamental and less explored dimension of the human suffering experience. Mainly in the process of diagnosis, the inclusion of the *Stimmung* dimension could help to refine it and not to reduce it to a simple act of categorize. Certainly, the subliminal and evanescent character of the *Stimmung* phenomenon may be factors that hinder its apply and its formal conceptualization. But we still maintain that it may enrich our clinic sensibility and help us to understand the complex process of human *pathos*.

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