Rev. Latinoam. Psicopat. Fund., São Paulo, 2024, volume 27, e220954

A historical construction of the phenomenon of mania in the field of psychopathology[1]

Uma construção histórica do fenômeno da mania no campo psicopatológico

Juliana Lima de Araújo*[1]
Virginia Moreira*[2]

This study aims to shed light on the construction of the concept of mania in the field of psychopathology. The article addresses the historical evolution of mania, from manic-depressive illness to the diagnosis of bipolar and schizoaffective disorders. It was observed that the current concept of mania is a product of the second half of the 19th century, although it originates from the classical Greek period, when it was understood as a way of being, and then, throughout history, was reduced to a psychopathological symptom. Currently, mania is again being considered in a broader sense, as manic functioning, but without excluding its symptomatic condition. It is from this position that we situate it as a phenomenon, encompassing the symptom and the lived experience, from the perspective constructed from phenomenological psychopathology, which looks at the manic experience not by reducing it to a natural fact, but by understanding it as a historical-cultural phenomenon, constructed in the world of human relationships.

Keywords: Mania, psychopathology, bipolar disorder, schizoaffective disorder

[1] Este estudo é fruto da tese em andamento da primeira autora e contou com bolsa de pesquisa da Fundação Cearense de Amparo à Pesquisa – FUNCAP.

*[1, 2] Universidade de Fortaleza – UNIFOR (Fortaleza, CE, Brasil).

http://dx.doi.org/10.1590/1415-4714.e220954

Introduction

Since antiquity, mania has been presented as a *modus operandi* of a series of psychopathologies from manic-depressive madness (Kraepelin, 1913/2012) up to contemporary developments in various disorders including mood disorders (depressive disorder; bipolar disorder), anxiety disorders (panic attacks; obsessive-compulsive disorder; generalized anxiety disorder) and schizophrenia and other psychoses (APA, 2014).

The term mania has a Greek origin (Μανία) meaning madness, dementia, eccentricity (Pereira, 1990) or inspiring élan (Wang, 2005) and is understood in the order of moods and affections. The first descriptions of mania were found in the classical era, with four meanings: 1. A reaction of anger or excitement to an event; 2. A biologically defined disease (Aretaeus of Cappadocia, among others); 3. A divine state (Socrates and Plato); and 4. A type of temperament, especially in its mild form (Hippocrates) (Angst & Marneros, 2001).

However, conceptual changes that led to the conditions today referring to mania did not result from this direct association, as it is more appropriate to speak of a "history of pertinent words" (Berrios & Porter, 2012, p. 599), since, in the past, the way in which we looked at and lived the manic experience were different. Successive changes occurred in its meaning, as it is now conceptualized as a clinical syndrome and sometimes as a psychopathological symptom. A different position is maintained (Angst & Marneros, 2001) when affirming that the concept of mania described by the ancient Greeks was not characterized by being different from current concepts, but mania was seen in a broad way, crossing into what is known in the psychopathological field as melancholy, mania, mixed states, schizoaffective disorders and other types of psychosis. In everyday relationships, the term mania can also be associated with weirdness, immoderate desire, bad habits and addiction (Ferreira, 1999). As a suffix — mania — it composes a series of clinical classifications aimed at understanding the ideas of obsession and compulsion, such

as hypomania, kleptomania, toxicomania, trichotillomania, nymphomania, among others (Wang, 2005).

In order to understand how mania has been constructed conceptually, it is important to start from a historical perspective. In the psychopathological field, phenomena are strongly dependent on theoretical assumptions, converging with issues such as the mind-body relationship, intersubjectivity and the dichotomy between subjective and objective methods (Hoff, 2012). There is, therefore, the particularity of research in the field of mental health being epistemologically dependent on research objects built around social, moral and ethical criteria (Berrios, 2015).

This qualitative study starts from the investigation of how the concept of mania was constructed, passing through manic-depressive illness to compose the current diagnoses of bipolar disorder and schizoaffective disorder. We start from the understanding of mania in its beginnings in the classical Greek period, when it was inserted into an individual's way of being to then be reduced throughout history to a condition of symptoms in psychiatric diagnoses. We follow the trail left by Emil Kraepelin in his classification of early dementia and manic-depressive psychosis, which are close to and are at the origin of the current pathological conditions of schizophrenia and bipolar disorder, respectively. In dialogue with the literature, we present and discuss mania from a critical analysis of its restricted understanding of the logic of nosological classification to think of it as a phenomenon, which in the 20th century was organized in the paradigm of the great psychopathological structures, bringing together several psychopathological, historical and cultural references and modes of understanding with phenomenological psychopathology being one of these developments (Lantéri-Laura, 2000). It is from this perspective that we situate it as a phenomenon, encompassing the symptom and the lived, looking at the manic experience as a way of functioning in the world, composing the uniqueness of individuals.

Beginnings of the concept of mania

During the history of mankind, mania has been associated with emotions and these are understood as "passions", commonly related to the darkest aspects of the human being (Berrios, 1996). "Reason", on the other hand, considered since Plato and Aristotle as the characteristic that would constitute the human being, was the instrument for the construction of knowledge and

for the exercise of an ethical freedom. To be seen as being without reason, or to have it in a manner considered insufficient, would be one of the main sources of disturbance and chaos in human relationships (Berrios, 1996; Goodwin & Jamison, 2007).

During the classical period, between the 6th and 4th centuries BC until the end of the 18th century, emotions were considered residues of sensation or elements of the will, but never a phenomenon seen by themselves. Even today, it is difficult to define the difference between behaviors, feelings, emotions, moods, affections and passions. Feelings, emotions and passions are different from moods and affections in regard to the criteria of duration, intensity, and association with objects and bodily sensations, among others. They are described as states of short, intense sensation and related to an identifiable object. Mood and affection, on the other hand, are more enduring states and without defined objects are capable of providing a "tone of profound feeling" to individuals (Berrios, 1996), when going through the most diverse experiences.

What we currently call mania (APA, 2014) is the result of a series of historical conditions that assessed whether manifestations related to feelings, emotions, moods, affections and passions could be used in the psychopathological sphere because they are located in a way that is closer to subjective conditions (Wang, 2005). This scenario started to change with the development of a psychology of the mental faculties and the search for changes in the field of affections (Berrios & Porter, 2012; Wang, 2005), restricting mania to a more objective conception and indicative of the manifestation of a pathological experience.

Since ancient Greece, there has been a recognition of a relationship between states of melancholy and mania (Berrios, 1996; Goodwin & Jamison, 2007; Mondimore, 2005). The nosology of these states dates back to the second century AD, in Rome, with the doctor Soranus of Ephedrus, classifying mania and melancholia as separate diseases, with different causes, but also considering melancholy as a manifestation of mania. For Soranus, mania involved a compromise of reason crossed by delusions, fluctuating states of anger and joy, as well as sadness and futility, continuous vigilance, distended veins and a stiff and abnormally strong body, with a tendency to attacks alternating with periods of remission. Melancholy involved dejection and propensity to anger, anguish, discouragement, keeping silent, animosity towards family members and alternating between the desire to live and die (Goodwin & Jamison, 2007; Wang, 2005). We see that a moral tone in the

perception of this living being has been present since its first descriptions, making it challenging to distinguish what would be the order of this particular experience and the exception that characterizes the pathological. This argument leads to the importance of analyzing the decisive role of sociocultural variables in the elaboration of the concept of mania.

Another precursor to studies of mania was Araeteus of Cappadocia, who lived in Alexandria in the first century AD. For Araeteus, mania was a final stage of melancholy, a variant of being melancholy, so mania and melancholy were different dimensions of the same disease (Angst & Marneros, 2001; Del-Porto & Del-Porto, 2005; Goodwin & Jamison, 2007; Wang, 2005). Pinel (1801/2004) describes that

> Araeteus designates mania as a synonym of fury and that when it comes to mania, there are many emotions of an irascible nature, which are the true characteristic of these attacks, rather than the disturbance of ideas or bizarre oddities of judgment. (...) One should only review the too great extension that they gave to this term [mania], since sometimes one observes attacks without rage, but almost never without a kind of alteration or perversion of moral qualities. (p. 118)

According Wang (2005) to Aretaeus, in the classic form of mania, associated with melancholy, the expressions of joy, euphoria and hyperactivity, suddenly have an inclination towards melancholy, with a predominance of sadness, concern for the future and shame of acts while suffering mania. When the depressive phase ends, another cycle begins, with the feeling of joy returning and life being led with less responsibility and more play (Goodwin & Jamison, 2007). Aretaeus was the first to directly associate mania and melancholy and this connection can be considered the first conception of bipolarity (Angst & Marneros, 2001).

In the following centuries, doctors like Paulo de Egina (625-690), Paracelsus (1493-1541), Thomas Willis (1621-1675) and Giovanni Morgagni (1682-1771) defended a close connection between the two states, but others, such as Timothie Bright (1550-1615) and Robert Burton (1557-1640) emphasized melancholic symptoms without referring to manic states (Mondimore, 2005).

Mania has also been associated for a long time with the understanding of madness being its most frequent manifestation (Pessotti, 1996). Since antiquity, changes in behaviors, emotions and rational capacity have been described as the central characteristics of madness (Foucault, 1988). It was with the publication of Philippe Pinel's Medical-Philosophical Treatise

on Mental Alienation or Mania (1801) that there was a change in situating madness as a derangement of mental functions and affections, placing asylums not only as spaces of enclosure, but as institutions that should provide an orderly and rational social life, external removal was justified to deal with internal conflicts (Pessotti, 1996). For Pinel (1801/2004), the madman would not be so different from the healthy man, since anyone could present, at some point in life, imbalances in reason and affections.

It was classified in the 18th century into three main categories: as mania, or universal madness; as melancholy, or partial madness; and as dementia, or weakness of the spirit in the power to judge, so that the perception of the world is compromised (Pessotti, 1996). The definition of madness, and by extension of mania, was modified, causing a revision in the intellectualist nature of psychopathological changes. Among some of the influences in this process of change were: the establishment of affectivity as an autonomous mental function, strongly influenced by the emerging field of scientific psychology; the appreciation of feelings and emotions in the romantic movement, encouraging the development of introspection and psychological notion of consciousness; the clinical limitations of the intellectualist report of madness influencing a redefinition of the traditional concepts of the symptomatology; and the development of a new medical science in the description and etiology of signs and symptoms (Berrios, 1996; 2015).

All these changes impacted the construction of a greater consideration for the field of affections, expanding what we understand by mania today. However, the affective states remain diffused and poorly defined, causing a semiology of poorly developed affectivity compared to intellectual functions. Perhaps, therefore, there is a general preference for a intellectualistic description of psychopathological changes, with the predominance of symptoms such as delusions, hallucinations, obsessions and memory deficit among others, to the detriment of symptoms more related to affective states (Berrios, 1996).

The inclusion of subjective experiences, leaving criteria restricted to the observation of the clinician, contributed to the redefinition of some mental diseases, such as mania, generating a deepening of their understanding from the experiential information about moods and emotions (Berrios, 2015). A better structuring to consider the manic condition was made by Kraepelin, at the end of the nineteenth century, who made a nosological distinction between early dementia (which is approaching the diagnosis of schizophrenia, nowadays), endogenous psychoses and manic-depressive psychosis (Wang,

2005). Empirical research carried out by Kraepelin was a milestone in the construction of a categorical structure in psychopathological nosology and continues to influence contemporary diagnostic constructions (Berrios & Porter, 2012).

With the conception that affections constitute psychic life and with the separation from a condition of melancholy living, mania becomes defined as a primary disorder of affection and action, while melancholy was positioned as a disturbance of intellect (Wang, 2005). However, over the years, mania returns to be looked at from two perspectives: as a condition associated with what was known as depression and as a symptom of other psychopathological diagnoses, influenced by new studies in the field of scientific psychology, the anatomo-clinical model of the disease, and the inclusion of subjective experiences in the symptomatology of mental disorders (Berrios & Porter, 2012).

The mania in manic-depressive disease

The explicit conception of manic-depressive disease as a single disease entity dates from the nineteenth century, while the current notions of mania emerged from the transformation of previous notions and attempts to separate melancholy and mania (Goodwin & Jamison, 2007). The relative unity between these two conditions, for most of the nineteenth century, disappeared after the 1910s due to the increase in the number of people who had access to care and the diversity in the experience of the people who were ill. In addition to people undergoing hospitalization, with chronic and serious diseases, usually in comorbidity with physical illness, there was an increase in outpatient patients and case studies from private practice (Berrios, 1996; Berrios & Porter, 2012), which favored greater contact with multiple expressions of melancholy and mania.

Emil Kraepelin was one of the main scholars of the etymology and symptomatology of psychoses, in which the mania was included (Berrios & Hauser, 2013; Goodwin & Jamison, 2007). His research had as an objective the creation of a stable description and classification of the mental states, seeking to understand how manifestations of illness could be accessed by clinical methods that would clarify signs and symptoms (Berrios & Hauser, 2013). Kraepelin considered the entire tradition of mania and launched the bases for the development of the psychopathological field, going

beyond theory and emphasizing a method based on clinical observation and the importance of the course and phenomenology of the disease in the construction of diagnoses (Mondimore, 2005), while also introducing the concept of prognosis as a methodological criterion (Berrios & Hauser, 2013). His model of disease did not exclude the impact of the psychological and social factors, having been one of the first to point out that psychological stress and the relationship with the medium could trigger pathological episodes (Goodwin & Jamison, 2007).

In 1893, Kraepelin described for the first time the outlines of manic-depressive synthesis, in which he focused his studies on mania. In 1899, the term "manic-depressive madness" appears for the first time (Mondimore, 2005). His defining criteria for the manic-depressive condition were: uniform prognosis and history and presence of excitement or inhibition, this last one, until that moment, had been considered a disorder of psychomotricity, not yet associated with a condition of exaltation in the mania or depressive state (Berrios, 1996).

Kraepelin's work signaled important psychopathological theoretical developments, such as the concept of spectrum, understood as the continuity of manic-depressive symptoms with normal fluctuations of mood, energy and behavior. The Kraepelinian concept of manic-depressive disease, brought together the main mood disorders, providing a model that until today is considered relevant to the understanding of emerging data in clinical, pharmacological and genetic fields (Goodwin & Jamison, 2007) in the research on mania and bipolar depression.

The manic-depressive disease was one of the main clinical conditions in which mania was described. With this diagnosis it was sought to bring together all the manic and acute depressive states, having been structured around the changes of mood, ideation and will, with the growing presence of physical and psychological activity. In the states of excitement there is the predominance of the relaxation of thinking, which can lead to a confusion for escape or gushing of thoughts. Such a movement is not characterized as a wealth of ideas, but on the contrary, through disconnected words and monotonous repetitions (Kraepelin, 1913/2012), produces speech that is not coherent for those who listen. Mood, which suffers changes characteristic of this condition was described in manic and depressive manifestations such as:

> In the midst of exaggerated joy there are not only abrupt fits of anger, but also violent crises of tears and sobs that immediately give over again to exuberant joy (...) The dominant feeling in the states of depression is more often a

> weight, a gloomy despair. The patient has "a hundred pounds on the chest," is devoured by grief, loses all courage, feels abandoned, without a true goal in life. Their heart is like stone, nothing else gives them joy. It seems there is, besides the feeling of sadness, a certain inhibition of sentimental movements that contrasts with the ease of the maniac to be emotional. (pp. 31-32)

The manic-depressive disease was characterized by the broadening in large proportions of human experiences, making it challenging to mark the limit between the particular experience and the general experience, which constitutes the pathology of the disease. This discussion has been a central axis in studies developed in the field of phenomenological psychopathology, prioritizing lived experience (Tatossian, 1979/2006). Initially, Karl Jaspers, with the publication of the work *Psicopathologia Geral* (1913), played a pioneering role by worrying about the scientific nature of the subjective symptom. With his historical-comprehensive model, he inaugurated psychopathology as a field of research and study. Subsequently, Binswanger, considered the "father of phenomenological psychopathology", brings the Being and its relations between the psychopathological phenomenon and existence as a fundamental question (Moreira, 2011), discussing mania in one of the most famous texts of the phenomenological tradition, the work "Melancolia e mania" (1960).

Since Kraepelin, the characteristics attributed to mania are exaggerations of sadness and joy, altered thinking, irritability, anger, and disturbed patterns of energy and sleep. A depressive mood is associated with a "decelerated" person, "dull" or "exhausted", "very slow" and life "loses color," is "without hope," "a burden," and "without meaning". Hypomaniac and manic moods are described as a life that is energetic, "effortless", "full of intensity" and special meanings. The person is seen as "optimistic", "accelerated", "full of energy", and "Flying" (Goodwin & Jamison, 2007).

Kraepelin concluded that all mood disorders comprised a spectrum between manic-depressive illness, depression and mood instability in function of personality — as representatives of disorders of affection, cognition and motivation (Kalk & Young, 2017). Kraepelin conceptualized this spectrum as a continuum between psychotic affective disorders and their less serious manifestations, approaching non-pathological experiences. Through the concept of spectrum, affective disorders were described as: 1. Continuum between bipolar and unipolar disease, known by the manic-depressive spectrum; and 2. Relationship between bipolar and unipolar affective disease with milder states classified as temperaments (Goodwin & Jamison, 2007).

Currently, the manic spectrum has developed from an approach that presents mania in a continuum: hypomania (m), cyclothymia (md), mania (M), mania with mild depression (Md), mania and major depression (MD) and major depression and hypomania (DM). The Md subtype is also often referred to as mania, since pure mania, without symptoms of depression, is practically nonexistent (Marneros & Angst, 2002). Another presentation of the manic spectrum occurs in types: type I (M, MD, Md), type II (m, Dm), type III (drug-induced M or m), type IV (depression with hyperthymic temperament, without characterizing hypomania or mania) and cyclothymia (md) (Lara, 2009). Most psychopathological disorders can be better characterized in spectra by the more wide ranging as well as diversity of possible experiences (Goodwin & Jamison, 2007). However, little discussed regarding clinical concepts could also be the risk in regard to diagnostic excesses.

The main characteristics of manic-depressive illness are dimensional, that is, distributed along a spectrum. While a dimensional approach characterizes each individual according to the various dimensions of the disease experienced, and by placing an emphasis on a cyclical movement in mania, the categorical approach to classifying diseases presents groups of distinct diagnoses or subtypes inserted into a larger diagnosis, placing mania as the pole opposite to depression (Goodwin & Jamison, 2007). In this theoretical-historical study we approach a dimensional understanding of mania, going beyond a categorization, which ends up prevailing in the field of health research due to the statistical and conceptual dimension with which the symptomatological data is handled.

In addition to the bipolar spectrum, the concept of temperament is another dimension that encompasses the manic mode of functioning, being conceptualized as a predominant pattern of mood (Lara, 2009). Kraepelin described manic temperament as a condition marked by thoughts that jump from one to another, incoherent and aimless, with hasty and superficial judgment, restlessness with an exalted and confident mood, although without interfering in a way that substantially changes the lives of individuals (Goodwin & Jamison, 2007). He also classified different mixed states according to disorders presented, for example, distinguishing depressive mania or anxious mania with poverty of thought. Similarly, he made the observation that it was fundamental and practically impossible to consistently separate simple, periodic and circular cases, with persistent gradual transitions (Kalk & Young, 2017).

Despite Kraepelin's influence on the current organization of diagnostic classifications, there is a fundamental distinction in how mania is considered:

Kraepelin views mania as a manifestation of a pathological experience, not as the sign of a separate disorder, as it is considered in the diagnostic practice of North America (and increasingly worldwide) today:

> European and American concepts of manic-depressive illness started to diverge almost immediately after Kraepelin's ideas spread in the early years of the 20th century. The Europeans, adhering to a traditional model of medical illness, emphasized the longitudinal course of the illness (...) the Americans wanted to treat the illness with the available techniques, which at the time were derived from the "moral treatment" movement in psychiatric hospitals and emerging dynamic therapies based on psychoanalytic theory. Research and clinical efforts in the United States, therefore, downplayed clinical and genetic description and turned to the psychological and social contexts in which the symptoms of the disease occurred. The exploration of the links between clinical typology and family history led to the formulation of the bipolar-unipolar distinction, whereby manic-depressive patients were grouped according to the presence or absence of a previous history of mania or hypomania. (Goodwin & Jamison, 2007, p. 20).

Another important author in the construction of the concept of manic-depressive illness was Eugen Bleuler (1857-1939), who sought to delimit the disorder that generates mental disorders, differently to the descriptive and classificatory emphasis of Kraepelin. He expanded the concept of manic-depressive illness when referring to this condition as an affective illness and as a continuum between schizophrenia and manic-depressive psychosis, with possible oscillations between these two poles (Pereira, 2004). For Bleuler, thinking changes little in less severe forms of mania, though it becomes unstable, jumping from one topic to another, with an involuntary development that can end up producing ideas easily. Due to this rapid flow of ideas, coupled with increased sensitivity and decreased social inhibitions and restraints, artistic activities can be facilitated (Goodwin & Jamison, 2007). From this dimensional, rather than categorical, view of the specifications proposed by Kraepelin, Bleuler also anticipated the current breakdown of the classic manic-depressive diagnosis group, the distinction between bipolar depression and unipolar depression (Del-Porto & Del-Porto, 2005; Goodwin & Jamison, 2007).

In the mainstay of Kraepelin and Bleuler's research, in the 19th century, were six main theoretical notions structured for the formation of the concept of manic-depressive illness: it was seen primarily as a disorder of affection, and not of intellect or cognition; it presented stable psychopathology; with

representation of the brain; it was periodic in nature, based on the concepts of *folie circulaire* and *folie à double forme*, developed by Falret and Baillarger, respectively; it was genetic in origin and tended to appear in individuals with recognizable personality changes (Berrios, 2012).

Jean-Pierre Falret (1794-1870) described *folie circulaire* as being characterized by a continuous cycle of depression, mania and free intervals of varying duration. For Falret, the maniac is the subject of his madness; in mental alienation, narratives crossed by each singularity are produced, from an organic modification that generates delusional states (Ramos, 2010).

Three years later, in 1854, Jules Baillarger (1809-1890) presented *folie à double forme*. Baillarger presented a disease in which mania and melancholy alternate, with the interval being unimportant, while Falret included the interval, even if long, between the manic and the melancholic episodes (Angst & Marneros, 2001). Such emphases on temporal gaps signal the complexity in understanding psychopathological experiences as a coherent unit that form a whole in the description of what is experienced as disturbing and expressed in suffering.

Another presentation of mania came from the research of Karl Leonhard (1904-1988) who presented the distinction between unipolar depression and bipolar depression of affective disorders that gained adherents and was consolidated in the publication of DSM-III and IV (Wang & Demétrio, 2005). Unipolar depression came to encompass all individuals with depression without a history of hypomania or mania — a heterogeneous group that included recurrent and non-recurring depressions, as well as clinical conditions known as neurotic, reactive or atypical. Bipolar depression, on the other hand, was defined as having the presence of depressive and manic phases (Goodwin & Jamison, 2007; Wang & Demétrio, 2005). The DSM system ended up privileging the dimension of polarity, to the detriment of cyclicality, making this characteristic less evident in unipolar depression, which can present itself as a recurrent and bipolar depression, a condition later named bipolar disorder (Goodwin & Jamison, 2007).

Mania in Bipolar Disorder

Currently, bipolar disorder is the diagnosis that is mostly associated with mania (APA, 2014). The concept of bipolar disorder is continually changing, "in a pendular evolution, sometimes adopting mutually exclusive categorical

descriptions, sometimes considering a dimensional nosography with amplifying tendencies" (Wang & Demétrio, 2005, p. 47), which may reflect the conceptual historical movement of mania, sometimes expressed in polarity with melancholy, sometimes in a cyclical movement through a spectral dimension. In addition to the categorical aspects that make up the diagnoses, we understand that the manic experience affects people's lives, marking it in a unique way and that it is only possible to understand it when the symptoms are not seen as an end that identifies the disease, but as expressions of an experience of suffering.

Although much of what has been described about manic-depressive illness overlaps with the current understanding of mood disorders, delimiting their diagnosis and understanding people's experience continues to represent a challenge, both for its identification and treatment and for its reach: major depressive disorders affect nearly 300 million people worldwide and bipolar affective disorder about 60 million (Kalk & Young, 2017). Bipolar disorder is considered a severe and disabling mood disorder, with a relatively unpredictable course that varies greatly between individuals (Koenders et al., 2014).

In the most recent DSM classification, bipolar disorder and its related disorders are situated, in the organization of the manual, between the chapters on schizophrenia spectrum disorders and other psychotic and depressive disorders, which seems to confirm their intermediate place between these two clinical conditions. The current classification of bipolar disorder includes: bipolar disorder type I, bipolar disorder type II, cyclothymic disorder, bipolar disorder and substance / drug-induced disorder, bipolar disorder and related disorder due to another medical condition, specified bipolar disorder and related disorders, and non-specified bipolar disorder and other related disorders (APA, 2014).

The diagnostic condition that comes closest to manic-depressive illness, or affective psychosis, described in the 19th century, is the diagnosis of type I bipolar disorder. The differences are in the non-requirement of the experience of psychosis and the non-experience of a major depressive episode (APA, 2014), despite the fact that, in the course of life, the symptoms that meet the criteria for a manic episode are accompanied by a depressive experience (Hirschfelda, 2014).

Type II bipolar disorder is characterized by one or more major depressive episodes and at least one hypomanic episode during life. In the past, this condition was considered "milder" than type I bipolar disorder, and today

it is considered a clinical condition accompanied by serious impairment in professional and social functioning due to the amount of time that depression is experienced and the frequent instability of mood. An intermediate experience between these conditions is called cyclothymia with at least two years of hypomanic and depressive periods, without meeting the criteria for an episode of mania, hypomania or major depression (APA, 2014).

The manic experience described in bipolar disorder is usually associated with: elevated mood, attitudes and moods that are inconsistent with the situations experienced, being foreign to the environment and with little criticism and empathy for the suffering of others; increased energy that is manifested in less need for sleep, increased frequency of activities for which there was already interest, as well as increased self-esteem and ability to feel pleasure; changes in spontaneous attention, being more distracted with impaired memory capacity for new facts; alteration both in the form and in the content of the thoughts, with accelerated and biased thinking towards the positive, increasing intensity of speech and an increase in impulsive behaviors (Moreno & Tavares, 2019).

Although the symptoms of mania and hypomania are the most recognizable characteristics of bipolar disorder, depression is usually the most frequent clinical presentation (Hirschfelda, 2014). The depressive phase of bipolar disorder represents a very important aspect of bipolarity (Goodwin & Jamison, 2007), the bipolar disorder is experienced in a more depressive manner than mania (Moreno & Tavares, 2019).

Mania is the fundamental clinical condition in bipolar disorder, although "pure" affective states are rare, mania is often aggravated by depressive symptoms and bipolar depression is usually accompanied by at least one or more symptoms of mania (Goodwin & Jamison, 2007). The clinical presentation of a person with bipolar disorder, when depressed, may not differ from a depressed non-bipolar person. This seems to signal the way in which people experience mania: the experience is not lived in a "bipolar" way, with clinical states experienced as opposites and totally separate, but by the experience of co-occurrence of mania and depression. Seeking greater clarity between these different experiences reduces the risks of a harmful care action, including the risk of an acceleration of mood cycles, which may precipitate manic or hypomanic episodes (Hirschfelda, 2014).

As for the differences between men and women (Goodwin & Jamison, 2007), it is more frequent that the first manifestation is mania in men and depression in women; that there is more substance abuse, history of

pathological gambling and misbehaviours by men, while women are more likely to experience eating disorders and changes in appetite and weight. Compared to the general population, the suicide rate in the group of bipolar women is higher than among men, although they are generally those who seek more treatment. These characteristics still need to be further investigated both in terms of gender and in relation to the socio-cultural dimension attributed to the manic experience.

The mania described in bipolar disorder does not present itself independently from the events of life (Goodwin & Jamison, 2007; Koendersa et. al., 2014). Stressful events play an important role in its manifestation, and may be associated with a growing risk of increased mood changes and extended time required to return to everyday activities. Such a state manifests in a cyclical way, since the experience of mania and depression, in bipolar disorder, also interfere in the life events experienced by individuals (Koendersa et. al., 2014), generating impacts on their relationship with the world and on the different meanings that are present in the sickness experience.

Life events that are felt as negative seem to be common in the months prior to depressive and manic episodes whereas events that are felt as positive would precede only manic experiences. We understand that such an assessment of a life condition felt as being negative or positive is very subjective, with the risk of being situated in a moralizing/normalizing frame of reference, as this moves through the world of meanings for each person. However, the manic experience often carries with it an urge for addition, to include as many experiences as possible and to an intensity that can be barely sustained in the long run without experiencing this condition. This would bring a "positive" feeling that could hinder self-perception and the search for treatment, precisely because of not wanting to give up that feeling (Koendersa et. al., 2014).

It is important to construct dialogues between the general descriptions and the specifics of each experience to be able to access how mania is constituted as an operation that makes up the entirety of life. Commonly, emphasis is given to narratives that speak "about" and not "with" the other, because it is believed that individuals experiencing a manic condition would have little chance of speaking about themselves:

One reason for this exclusion of experiential information is that first-person reports are subjective and necessarily biased. Thus, patients can clearly remember some aspects of their disorder and forget or ignore others; they can

verbalize what is easier to describe and say little about less easily articulated aspects. They can relate only the most innovative experiences to them, thus giving a disproportionate weight to unusual events, or they can describe what they think the observer wants to hear. In addition, mood can radically alter memory and perception, resulting in distortions depending on their state (Goodwin & Jamison, 2007, p. 29).

Research that seeks to go beyond a symptomatic understanding, while also considering the impacts of life events on the experience of pathological conditions, enables us to reflect on the importance of expanding our gaze beyond the description of the criteria that define the condition of manic existence, today often attributed to bipolar disorder.

Mania in Schizoaffective Disorder

Kraepelin structured the classifications of psychoses from the nosology based on a description of what he used for early dementia and manic-depressive madness (Berrios & Hauser, 2013; Goodwin & Jamison, 2007). Currently, schizophrenia is described as having a complex etiology, involving an interaction between genetic and environmental factors. Due to its strong impacts on quality of life, it is considered one of the most serious psychiatric disorders, with a treatment seen by some clinicians as "palliative" (Gonçalves et al., 2018). It is in the subtype of schizophrenia called schizoaffective disorder, a clinical condition that combines symptoms of schizophrenia and mood disorders (especially the expression of bipolarity), which mania presents itself more prominently.

The very name 'schizoaffective disorder' indicates a hybrid place — between one and the other — at the junction of schizophrenia and mood disorders. Kraepelin, by separating the conditions of early dementia and manic depressive illness, did not eliminate the possibility of "transformational illnesses", in which there would be an overlap of the symptoms of these two clinical conditions (Castle, 2012; Marneros & Angst, 2002). However, it was Kasanin, in 1933, who created the term schizoaffective in the publication of a report of a study with nine patients who had symptoms that approached the diagnostic conditions of schizophrenia and mood disorders (Castle, 2012).

Kasanin's definition of schizoaffective disorder was seen as approaching the concepts of "*buffée délirante*" and "acute and transient psychotic disorder", which described brief, short-lived episodes with affective and

psychotic characteristics, rather than psychotic conditions (Malaspina et al., 2013). A manifestation of schizoaffective disorder tends to come later when compared to schizophrenia, has a predominantly female public, greater social interaction, less severe negative symptoms and better evolution when compared to schizophrenia, but worse in relation to bipolar disorder (Castle, 2012; Cotton et al., 2013). However, it is argued that the limits between these diagnostic conditions are artificial and that psychotic disorders are situated on a continuous spectrum that varies between psychotic mood disorder and schizophrenia (Kotov et al., 2013). In this way, they also signal (Goodwin & Jamison, 2007) several doubts about schizoaffective disorder: whether it is closer to a affective disease or schizophrenia; whether it could be validly diagnosed as a separate disease; whether it is an intermediate form in the continuum of psychosis; whether it acts as a comorbidity of schizophrenia and affective disorders, as well as whether it is a more severe variant of bipolar disorder or less severe variant of schizophrenia.

The experiences of people with schizoaffective disorder show a longer duration of pathological experience, better psychosocial functioning and more severe depressive and negative symptoms than those with schizophrenia (Cheniaux et al., 2008; Mancuso et al., 2015). This characteristic seems to bring schizoaffective disorder closer to schizophrenia than to bipolar disorder. When compared with people diagnosed with schizophrenia, those with schizoaffective disorder most commonly had delusional and manic symptoms, alterations in thinking and a greater presence of depression throughout their life. Compared to bipolar disorder, those diagnosed with schizoaffective disorder were younger, presented more delusional symptoms and alterations in thinking, fewer expressions of mania and had more psychotic symptoms throughout their lives (Mancuso et. al., 2015).

In schizoaffective disorder there are disagreements about which symptoms and what type of temporal relationship (the frequency of its manifestation) should be considered for its definition (Cheniaux et. al., 2008). Schizoaffective disorder is related to a greater number of hospitalizations and a higher frequency of suicidal behavior when compared to schizophrenia and mood disorders. This greater number of hospitalizations may be associated with the degree of severity of symptoms, since, by definition, the psychotic pathological experience is generally more severe than affective episodes. In relation to increased suicidal behavior, the simultaneous presence of psychotic symptoms and mood was correlated as a risk factor (Cheniaux et. al., 2008).

Several comparative studies described (Goodwin & Jamison, 2007) experiences in mania and schizophrenia. In regard to the flow of thoughts, the increased pressure to speak seems to be more characteristic of mania, as well as an increase in the loss of objective and tangentiality in the speech. Those with mania presented more complex speech, but with disordered thinking, with changes from one discourse structure to another with little meaning for the interlocutor. In schizophrenia, the speech content seems to be more disordered, with insufficient elaboration of the discourse structure. Schizoaffective people are closer to mania in terms of the combination of thoughts and intertwining ideas from various points of connection, but they are closer to the characteristics of schizophrenia in terms of idiosyncratic, autistic, fluid and absurd thinking.

This enables us to think about how much mania transits between these pathological experiences, acting as a differential even in the diagnostic framework that is given. However, it is problematic to base the diagnosis only on the symptoms, without seeking to access people's lived experience, as "it is the patient's living that is the object par excellence of the psychiatric experience, which can only be achieved by mediating exterior material aspects considered as the "expression" of this experience" (Tatossian, 1979/2006, p. 38). This is achieved only when we propose to transpose what is given as an external element, considering the expression of mania.

Mania with psychotic characteristics is the experience with the greatest confluence between the diagnoses of bipolar disorder and schizoaffective disorder. Delusions and hallucinations can be congruent with mood when the contents manifest manic themes (such as grandeur, megalomania, power, among others) and would be incongruous with mood when they involve persecutory themes, paranoia, and delusions of influence, among others (Moreno & Tavares, 2019). Characteristics such as irritability, anger, paranoia, thinking disorders and catatonic excitation are not enough to distinguish mania from schizophrenia (Goodwin & Jamison, 2007). However, more than the contents, which are extremely variable, it is the formal aspect, which can indicate a psychopathological condition and which we understand here as being manic, depressive, anxious etc., functioning.

The diagnosis of schizoaffective disorder is still marked by many uncertainties (Castle, 2012; Kotov et. al., 2013; Cheniaux et. al., 2008). The approach taken by the diagnostic manuals to establish such limited criteria does not work for everyone, since the experience lived through psychopathological disorders transcends the mere grouping of symptoms.

As the diagnoses are constructed from clinical exams, there is the primacy of looking at the different sets of symptoms so that they can be evaluated. In this context, the diagnosis of schizoaffective disorder would have two main advantages: it could be a less stigmatizing diagnosis than schizophrenia and would keep clinicians alert to the fact that at least two symptomatic dimensions are operating and requiring treatment (Castle, 2012). In addition to the accurate diagnosis being important for the provision of targeted care, psychopharmacological and psychosocial interventions differ depending on the diagnosis and the implications for the lived experience (Cotton et. al., 2013).

There have always been questions about the classification of Schizoaffective disorder, since its symptoms and clinical course are characteristic of an overlap of diagnostic criteria between schizophrenia and bipolar disorder (Cotton et. al., 2013). In a systematic review (Cheniaux et. al., 2008) with comparative studies of schizoaffective disorder and its relationship with schizophrenia and mood disorders, six possibilities were pointed out as divergences involving schizoaffective disorder: 1. An atypical form of schizophrenia, with affective symptoms; 2. An atypical form of mood disorder, with schizophrenic symptoms; 3. Comorbidity of schizophrenia and mood disorders, in which it presents both manifestations; 4. Independent disorder, distinct from schizophrenia and mood disorders. This possibility of a "third psychosis" finds its roots in Kasanin, the originator of the term schizoaffective; 5. A heterogeneous group, composed of schizophrenia and mood disorder; and 6. Occupying an intermediate position in a continuum between schizophrenia and mood disorder. It is maintained (Cheniaux et. al., 2008) that schizoaffective disorder is formed predominantly by a heterogeneous group that in a continuum would be at a midpoint between schizophrenia and mood disorder.

Schizoaffective disorder can be considered a diagnostic advance by recognizing the co-occurrence of schizophrenia and mood disorders within the same experience. This points to the complexity of limiting the various manifestations that involve mania to a single diagnostic setting. To understand mania (Tatossian, 1979/2006), we need to understand the changes in affectivity, psychomotor behavior, and the experience of time, space and body. However, such complexity is not usually considered in theoretical discussions about mania and, in the case of schizoaffective disorder, being an uncertain diagnosis, it is usually surrounded by discussions about its actual existence as a separate condition from schizophrenia and bipolar disorder.

Currently, schizoaffective disorder is differentiated by the frequency of mood symptoms. The intensity of the manic experience sets the tone for how the clinician seeks to understand the pathological experience (Malaspina et. al., 2013).The most recent psychiatric classification, the DSM-5, remains in the Kraepelin tradition and continues to understand mood disorder separate from disorders on the spectrum of schizophrenia, sustaining the importance of maintaining a diagnosis that deals with the middle ground (APA, 2014).

The lack of specific criteria for the duration of mood disorders in the course of psychosis is problematic and may be the main factor in the low reliability of schizoaffective disorder. We understand that, as the disorders are structured around the symptoms, when there is an overlap between, for example, schizoaffective disorder and bipolar disorder, the diagnosis and consequently the care practices can be reduced to a technicality that does not reach the experience of the one who suffers (Tatossian, 1979/2006).

Final considerations

Bringing together theoretical objects that have been given different names throughout history is a process that requires care, and it is necessary to understand what function, role and social meanings have been attributed to them in each period. In this study, we performed an outline of mania, seeking to understand how its concept was constructed, through three diagnoses — manic-depressive illness, bipolar disorder and schizoaffective disorder. We take these diagnoses not as places in themselves, but by thinking of them as the result of a historical context and placing them in a broader language, which relates the meanings constructed in their conceptual, social and cultural representations.

Currently, mania is closely related to a pathological condition. We ask ourselves if this is the only possible way to think about this phenomenon or if a manic way of being has entered our lives, through the encouragement of a lifestyle guided by the acceleration of experiences, the constant search for energy and self-confidence, and a culture focused on the individual which says that nothing is impossible, it just depends on yourself. Functioning in a manic way seems to have gained, to some extent, social validation. In the psychopathological field, discussions continue about the criteria for defining the frameworks for schizoaffective and bipolar disorders. We understand that

these difficulties exist due to the human experience escaping classifications that delimit these contours in such precise ways.

With this historical review we saw that the phenomenon of mania was built from multiple movements which originated in the classical Greek period as an individual way of being throughout history, to be reduced to a condition of symptom in the diagnosis of the illnesses of manic-depressive disorder, bipolar disorder and schizoaffective disorder, among others. Nowadays, mania is once again considered more broadly, as a manic functioning, but without ruling out its symptomatic condition. It is from this perspective that we situate it as a phenomenon, encompassing the symptom and the lived, from a perspective constructed by phenomenological psychopathology in criticism of a reductionist model of the psychopathological frameworks.

A phenomenology of mania has been little explored when compared to an understanding of the melancholic being-in-the-world, according to Tatossian (1979/2006), perhaps because it is a "less pure syndrome" (p. 144), not a "simple deviation from normal organization" (p. 145). Mania is commonly described as an increased liveliness of gestures and agitated arousal, however, much less is said about the subjective perspective of the person experiencing mania (Sass & Pienkos, 2015). In a manic mood, interpersonal relationships can often be colored by strong positive affect, which is less common in melancholia or schizophrenia (Sass & Pienkos, 2015). The euphoria in the manic person feigns affection, but in fact remains a fixed state of empty joy (Fuchs, 2019). Stimulating self-confidence in mania often leads to egocentric or rebellious behavior, functioning in an antagonistic way to melancholia (Sass & Pienkos, 2015). The world is experienced as volatile, fleeting, inconsistent, in a bouncy and sliding existence in contrast to melancholy, in which the world becomes resistant, heavy, an existence that remains in the same place (Binswanger, 1960/2005).

Mania, therefore, cannot fail to be considered for its historical-cultural path. Despite the progress in psychopathological studies, a divided view still prevails between the dimension of the experience and the symptoms. The ability to make distinctions between the different ways of experiencing mania is essential both for clinical follow-up and for research on the manic experience as a way of being-in-the-world. Phenomenological psychopathology has been one of the ways to look at the manic experience as a phenomenon situated on a horizon where, at the same time that it constitutes the world, it is also constituted by it, not by reducing mania to a natural fact

that is shown only as representation, but as a cultural phenomenon as well, as it is built into the world of human relations.

Referências

American Psychiatric Association (APA). (2014). *Manual diagnóstico e estatístico de transtornos mentais* (DSM-5) (5a ed.). Artmed.

Angst, J., & Marneros, A. (2001). Bipolarity from ancient to modern times: conception, birth and rebirth. *Journal of Affective Disorders*, *67*, 3-19.

Berrios, G. (1996). Affect and its disorders In *The history of mental symptoms: descriptive psychopathology since the nineteenth century*. Cambridge University Press.

Berrios, G. (2012). Melancolia e depressão durante o século XIX: uma história conceitual. *Rev. Latinoam. Psicopat. Fund*., *15*(3), 590-608. doi: 10.1590/S1415-47142012000300011.

Berrios, G. (2015). *Rumo a uma nova epistemologia da psiquiatria*. Escuta.

Berrios, G., & Hauser, (2013). O desenvolvimento inicial das ideias de Kraepelin sobre classificação: uma história conceitual. *Rev. Latinoam. Psicopat. Fund*., *16*(1), 126-146. doi: 10.1590/S1415-47142013000100010

Berrios, G., & Porter, R. (2012). *Uma história da psiquiatria clínica: a origem e a história dos transtornos psiquiátricos.* Escuta.

Binswanger, L. (2005). *Mélancolie et manie*. *Etudes phénoménologiques*. Presses Universitaires de France. (Trabalho original publicado em 1960).

Castle, D. (2012). Schizoaffective Disorder. *Advances in psychiatric treatment*, *18*, 32-33. doi: 10.1192/apt.bp.111.008987

Cotton, S., Lambert, M., Schimmelmann, B., Mackinnon, A., Gleeson, J., Berk, M., Hides, L., Chanen, A., Scott, J., Schöttle, D., McGorry, P., & Conus, P. (2013). Differences between first episode schizophrenia and schizoaffective disorder. *Schizophrenia Research, 147*, 169-174. doi: 10.1016/j.schres.2013.02.036

Cheniaux, E., Landeira-Fernandez, J., Telles, L., Lessa, J., Dias, A., Duncan, T., & Versiani, M. (2008). Does schizoaffective disorder really exist? A systematic review of the studies that compared schizoaffective disorder with schizophrenia or mood disorders. *Journal of Affective Disorders*, *106*, 209-217. doi:10.1016/j.jad.2007.07.009

Del-Porto, J. A., & Del-Porto, K. O. (2005). História da caracterização nosológica do transtorno bipolar. *Rev. Psiq. Clín*. *32*(1); 7-14. doi: 10.1590/S0101-60832005000700002.

Ferreira, A. B. H. (1999). *Novo Aurélio século XXI: o dicionário da língua portuguesa* (3ª ed.). Nova Fronteira.

Foucault, M. (1988). *Doença mental e psicologia* (3ª ed.). Tempo Brasileiro.

Fuchs, T. (2019). The life-world of persons with mood disorders. In G. Stanghellini, M. Broome, A. Raballo, A. Fernandez, P. Fusar-Poli, & R. Rosfort (Orgs.), *The Oxford Handbook of Phenomenological Psychology* (pp. 617-633). Oxford University Press. Doi: 10.1093/oxfordhb/9780198803157.001.0001

Gonçalves, A., Dantas, C., Banzato, C., & Oda, A. (2018). A historical account of schizophrenia proneness categories from DSM-I to DSM-5 (1952-2013) *Rev. Latinoam. Psicopat. Fund*., *21*(4), 798-828. http://dx.doi.org/10.1590/1415-4714.2018v21n4p798.7

Goodwin, F. K., & Jamison, K. R. (2007). *Manic-Depressive Illness: Bipolar Disorders and Recurrent Depression* (2ª ed.). Oxford University Press.

Hoff, P. (2012). Eugen Bleuler's concept of Schizophrenia and its relevance to present-day Psychiatry. *Neuropsychobiology*, *66*, 6-13. doi: 10.1159/000337174

Kalk, N. J., & Young, A. H. (2017). Footnotes to Kraepelin: Changes in the classification of mood disorders with DSM-5. *BJPsych Open*, *3*, 1-3. doi: 10.1192/bjpo.bp.117.004739

Koendersa, M. A., Giltayc, E. J., Spijkera, A. T., Hoencampa, E., Spinhovenb, P., & Elzingab, B. M. (2014). Stressful life events in bipolar I and II disorder: Cause or consequence of mood symptoms? *Journal of Affective Disorders, 161*, 55-64. doi: 10.1016 / j.jad.2014.02.036

Kotov, R., Leong, S., Mojtabai, R., Erlanger, A., Fochtmann, L., Constantino, E., Carlson, G., & Bromet, E. (2013). Boundaries of Schizoaffective Disorder: Revisiting Kraepelin. *JAMA Psychiatry*, *70*(12), 1276-1286. doi:10.1001/jamapsychiatry.2013.2350

Kraepelin, E. (2012). *A loucura maníaco-depressiva*. Forense. (Trabalho original publicado em 1913).

Hirschfelda, R. M. (2014). Differential diagnosis of bipolar disorder and major depressive Disorder. *Journal of Affective Disorders, 169*(1), 12-16. doi: 10.1016/S0165-0327(14)70004-7

Lantéri-Laura, G. (2000). *Ensayo sobre los paradigmas de la psiquiatría moderna*. Editorial Triacastela.

Lara, D. (2009). Temperamento forte e bipolaridade: dominando os altos e baixos do humor (10ª ed.). Saraiva.

Malaspina, D., Owen, M., Heckers, S., Tandon, R., Bustillo, J., Schultz, S., Barch, D., Gaebel, W., Gur, R., Tsuang, M., Os, J., & Carpenter, W. (2013). Schizoaffective Disorder in the DSM-5. *Schizophrenia Research, 150*, 21-25. http://dx.doi.org/10.1016/j.schres.2013.04.026

Mancuso, S., Morgan, V., Mitchell, P., Berk, M., Young, A., & Castle, D. (2015). A comparison of schizophrenia, schizoaffective disorder, and bipolar disorder: Results from the Second Australian national psychosis survey. *Journal of Affective Disorders*, *172*, 30-37 http://dx.doi.org/10.1016/j.jad.2014.09.035

Marneros, A., & Angst, J. (2002). Bipolar disorders: roots and evolutio. In *Bipolar Disorders: 100 Years After Manic-Depressive Insanity*. Kluwer Academic Publishers.

Mondimore, F. M. (2005). Kraepelin and manic-depressive insanity: An historical perspective. *International Review of Psychiatry*, *17*(1), 49-52. doi: 10.1080/09540260500080534

Moreira, V. (2011). A contribuição de Jaspers, Binswanger, Boss e Tatossian para a psicopatologia fenomenológica. *Revista da Abordagem Gestáltica*, *XVII*(2), 172-184.

Moreno, R., & Tavares, D. (2019). *Depressão e Transtorno Bipolar: a complexidade das doenças afetivas*. Segmento Farma.

Pessotti, I. (1996). *O século dos manicômio*s. Ed. 34.

Pereira, S. (1990). *Dicionário grego-português e português-grego* (7ª ed.). Ed. Livraria Apostolado da imprensa.

Pereira, M. E. (2004). A perda do contato vital com a realidade na esquizofrenia, segundo Eugène Minkowski. *Rev. Latinoam. Psicopat. Fund*., *II*(2), 125-129. doi:10.1590/1415-47142004002008.

Pinel, P. (2004). Tratado médico-filosófico sobre a alienação mental ou a mania — Sinais precursores dos acessos de mania. *Rev. Latinoam. Psicopat. Fund*., *VII*(3), 117-127. (Trabalho original publicado em 1801).

Ramos, F. (2010). Jean-Pierre Falret e a definição do método clínico em psiquiatria. *Rev. Latinoam. Psicopat. Fund*., *13*(2), 296-306.

Sass, L., & Pienkos, E. (2015). Faces of intersubjectivity – A phenomenological study of interpersonal experience in melancholia, mania, and schizophrenia. *Journal of Phenomenological Psychology*, *46*, 1-32. doi: 10.1163/15691624-12341283

Tatossian, J. (2006). *Fenomenologia das psicoses*. Escuta. (Trabalho original em 1979).

Wang, Y. (2005). Aspectos históricos da doença maníaco-depressiva. In R. Moreno, D. Moreno (Orgs.), *Da psicose maníaco-depressiva ao espectro bipolar*. Segmento.

Wang, Y., & Demétrio, F. (2005). Evolução da dicotomia unipolar/bipolar. In R. Moreno, D. Moreno (Orgs.), *Da psicose maníaco-depressiva ao espectro bipolar*. Segmento.

Resumos

(Uma construção histórica do fenômeno da mania no campo psicopatológico)

Esta pesquisa teve como objetivo compreender a construção do conceito de mania no campo psicopatológico. Aborda-se a evolução histórica da mania, desde a doença maníaco-depressiva até o diagnóstico de transtornos bipolares e esquizoafetivos. Observou-se que o atual conceito de mania é um produto da segunda metade do século XIX, embora oriundo do período clássico grego quando era entendido como um modo de ser, e depois, ao longo da história, foi reduzido a um sintoma psicopatológico. Atualmente, a mania volta a ser considerada de forma mais ampla, como um funcionamento maníaco, mas sem descartar sua condição sintomática. É a partir dessa posição que a situamos como fenômeno, englobando o sintoma e o vivido, a partir da perspectiva construída a partir da psicopatologia fenomenológica que olha a experiência maníaca não reduzindo-a a um fato natural, mas como fenômeno histórico-cultural, construída no mundo das relações humanas.

Palavras-chave: Mania, psicopatologia, transtorno bipolar, transtorno esquizoafetivo

(Une construction historique du phénomène de la manie dans le champ psychopathologique)

Cette recherche vise à comprendre la construction du concept de manie dans le champ psychopathologique. L'évolution historique de la manie, de la maladie maniaco-dépressive aux diagnostics de troubles bipolaires et schizo-affectifs, est abordée. Il a été observé que le concept actuel de manie est un produit de la seconde moitié du XIXe siècle, bien qu'originaire de la période grecque classique où il était compris comme une manière d'être, puis réduit à un symptôme psychopathologique tout au long de l'histoire. Actuellement, la manie est à nouveau considérée au sens large comme un fonctionnement maniaque, mais sans exclure sa condition symptomatique. C'est à partir de cette position que nous la situons comme un phénomène, englobant le symptôme et le vécu, dans la perspective construite par la psychopathologie phénoménologique qui envisage l'expérience maniaque en ne la réduisant pas à un fait naturel, mais comme un phénomène historico-culturel construit dans le monde des relations humaines.

Mots-clés: Manie, psychopathologie, trouble bipolaire, trouble schizo-affectif

(Una construcción histórica del fenómeno de la mania en el campo psicopatológico)

Esta investigación tuvo como objetivo comprender la construcción del concepto de manía en el campo psicopatológico. Se aborda la evolución histórica de la manía desde la enfermedad maníaco-depresiva hasta los diagnósticos de trastorno bipolar y esquizoafectivo. Se observó que el concepto actual de manía proviene de la segunda

mitad del siglo XIX, aunque tuvo su origen en la época clásica griega cuando la entendía como una forma de ser y luego, a lo largo de la historia, se redujo a un síntoma psicopatológico. Actualmente, la manía vuelve a considerarse de forma más amplia como un funcionamiento maníaco, sin descartar su condición sintomática. En esta posición se constituye un fenómeno que abarca el síntoma y lo vivido desde la perspectiva construida en la psicopatología fenomenológica que no mira la experiencia maníaca como un hecho natural, sino como un fenómeno histórico-cultural construido en el mundo de las relaciones humanas.

Palabras clave: Manía, psicopatología, trastorno bipolar, trastorno esquizoafectivo

Artigo submetido em 27.09.2022
Artigo revisado em 25.07.2023
Artigo aceito em 30.04.2024

julianalima@unifor.br
https://orcid.org/0000-0002-5174-4398

virginia_moreira@fulbrightmail.org
https://orcid.org/0000-0003-2740-0023