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The History of Mania

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Abstract

The definition of syndromes in psychiatry has changed over time, although the diseases have been known since antiquity. We review the description of certain syndromes that may be considered similar to the contemporary definition of mania from the ancient period till Kraeplins formulation of manic depressive insanity. Prevailing notions of etiology, and scientific knowledge, guided these earlier classifications. Kraeplin formulated his description on the basis of astute clinical observations in the preceding centuries.

Key words -
History,
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There is always a need for a historical review of diagnostic categories in psychiatry. Prevailing philosophical and psychological theories have had an important influence on the definition of psychiatric syndromes. Symptoms of madness have been known to mankind through the centuries. Social attitudes towards those afflicted has guided their care. There have been attempts made, through the ages, to understand the origins of mental illness [1]. There is a startling similarity between certain symptoms described in antiquity, and as we now know them. This review will include some descriptions of mental illness that could be viewed as fore-runners to the definition of mania as a syndrome. It focusses on the descriptions prior to Kraeplin's description of manic depressive disorder.

The Graeco-Roman period

The classical Greek literature has several references to insanity. Homer (8th century B.C.) viewed human beings as pawns in a social matrix, always at the mercy of the fates, or the Gods, or social forces [2]. He did not differentiate between the mind and the body. Though his works include excellent description of madness, there are no typical syndromes. Plato (5th century B.C.) made the essential difference between the body and the soul. He viewed sanity as the working of the rational mind, and insanity as being irrational. He also distinguished between thinking (reason, understanding, opinions and conjectures) and appetites (lusts, passions). Madness could be viewed as ignorance, or as a split between the rational and irrational (appetitive) functions. He described states of ecstasy and divination.

He describes madness originating in the body, or by the influence of the Gods (Apollo). Divine "mania" could also be caused by wine (Bacchus), love or the muses (in which case the person was inclined to song) [3].

Hippocrates (5th century B.C.) disclaimed the role of demonic possession in causing madness and described states of euphoria and depression [4]. The best descriptions available are those provided by Aretus (2nd century A.D.) and Soranus (100 A.D.). Aretus believed that all "mania" was one in genus. He however, differentiated conditions caused by fever, wine or old age as not being 'true manias'. One description of mania was a remitting but recurrent disorder, most common at a young age. The states of the illness were described. At a milder stage. the individual becomes joyful, dances, wears a crown as if a victor or a King; at a later stage he has a changeable, irritable temper and at the height of illness may act without shame or restraint. After recovery, he would become torpid, dull or sorrowful [3], [4], [5]. Caelius Aurelianus (5th century A.D.) a physician of African origin, translated the work of Soranus and provided a detailed description of mania. He likened it to epilepsy, and stated that it should be unaccompanied by fever, or clearly precede it. Its manifestations were anger, merriment, sadness or futility, or fear of harmless objects. It could be continuous or remittent. Treatment was held to be similar to that for epilepsy. It consisted, among other things of long walks, relaxing massages, dialogue with the patient during which contrary views were expressed, theatre and reading. Restraint was to be used gently, while alcohol, opium and whipping were rejected [3], [4], [5].

The word mania itself was loosely applied. Philologically, it derived from Greek words for anguish, loosening of the mind, defilement, persistence; love for solitude and enduring [4]. States of ecstasy were identified as being unusual. Some, ascribed to certain causes, were identified as being relatively benign. It must be kept in mind that this prediction was based upon the supposed etiology, and not the conglomeration of symptoms. Typical symptoms were identified; illnesses being continuous, recurrent or periodic were so described, and alternation between periods of sadness and euphoria was also identified. They also commented upon the relationship of these symptoms to the temperament. We thus find that many of the cardinal features of manic depression had already been observed in ancient Greece. However, subjective experiences were not incorporated into these descriptions, [6] and thus we cannot accurately judge whether the illness so described was identical to mania as we define it now.

Ancient Indian views

The Atharva Veda [7] is the oldest written record of the medical tradition, and is a compendium of spells, charms and penances to be performed to those afflicted by disease. Insanity is mentioned in passing and is thought to be the effect of demons, drugs, witchcraft, love or fate. There is little account of behaviour of the insane. This is similar to the Homeric descriptions of madness. In post-Vedic period, significant advances are apparent. Growth of various schools of philosophy was accompanied by an attempt to understand the behaviour of the mentally ill. The Charaka-Samhita (600 B.C. - 200 A.D.) [8] is the source book for the Ayurveda. The mind, spirit and body trinity was reflected in the vata (wind), pitta (bile) and kapha (phlegm) [9]. Madness could be caused by each of these individually, or in combination, or by extraneous factors. Charaka offered a classification of insanity (unmada) which relied on humoral and supernatural causes for abnormal behaviour. A so called etiological model, was, as now, considered more valuable. The symptoms of the vata-type madness

were wandering, talking too much, laughing, dancing and playing of instruments, imitating musical instruments, adorning oneself, contempt of those who actually possess valuables (!) and continuous jerking of various body parts. Exogenous causes were demons goblins, Gods and in general any transgression of the prevailing social rules. 'Psychogenic' factors do find mention here. Some attempt is made to describe syndromes. Spirit possession is marked by super-human speech, valour, prowess, knowledge of science and strength. Gandharvas, Gods, Yaksas, and Brahma-rakshasas, influence was apparent in those who sang and danced, wore bright clothes, were rude and restless. These 'psychic seizures' were differentiated in addition by relapsing on different days of the lunar cycle, and afflicted people with varying temperament. Behaviours that may be considered 'manic' were thus recognised clearly. The relationship to melancholy was not elaborated, but relapses were described. Personality and the pattern of relapse played a role in the diagnosis. Treatment consisted of various herbal preparations, diet and drugs. In addition, the mentally ill were to be sympathised with, given good advice or shocked out of their insanity by contrary experiences (including the use of lions and elephants !). Seasonal influences were important in deciding the treatment as were a host of other factors. Treatment in general was consonant with that recommended for epilepsy, as the two were considered similar. The descriptions, and treatment show an eclectic approach to the understanding of insanity [8], [9]. However, it is quite apparent that the advances made in metaphysics and introspective psychology did not have a significant influence on the description of the psychopathology of insanity.

This is quite in contrast to the psychology of emotions. Tantric theories were diametrically oppositional to the Vedic insistence on austerity and penance [10]. They extolled the physical and psychological experience of sensuality as an equally valid basis for understanding the divine. Emotions were also defined as being of three pure kinds: sattvic (psychological), rajasic (physiological) and tamasic (physical) of which various combinations could be made [9], [10], [11]. The Natyashastra differentiated between the bhava (the pure emotion), vibhava (the cause) and anubhava (the conscious experience of the particular emotion). Natyashastra (the semiotics of theatre) also described the portrayal of those afflicted by madness caused by sorrow or love [11]. It described nine pure emotions that could be consciously experienced and described. Of these, eight could vary between extremes, but one was invariant (a state of 'shanti' or quitetude). A fairly elaborate theory of emotions (including subjective states and objective description) was evolved. Its application to understanding madness was however inadequate. It must be remembered that Brahmins and the high born were advised not to look at insane persons, as they were considered impure [12]. It may be conjectured that this created a lacuna in applying these theories to the behaviour of the mentally ill. The subjective experience of the psychotic patient was left out of the discourse. Indian philosophies, in any case, were not rigid in differentiating the inner world of the mind from wider outside influences. The latter were always considered important in causing inner turmoil.

The Renaissance period and beyond

The modern interest in description of mania began during the renaissance, after the intellectual gloom of the medieval period. Arab medicine synthesized the existing schools of knowledge. They also described a group of syndromes, but detailed descriptions of these are not available [13]. An urge for humane treatment of the mentally ill had already begun after the Inquisition. Asylums were built all

over Europe. Paracelsus (1492-1541) described some conditions of madness as a state of restlessness, mischievousness and frantic unreasonable behaviour that would remit, only to recurr in some individuals. A lunar cycle of relapses was also noted. He also differentiated madness caused by external agents. All this was part of a muddled theory of etiology and magicoreligious treatment [3]. but, he did lay the base for describing abnormal behaviour. Willis (1680, of the Circle of Willis fame) commented that melancholia and madness often change from one to the other, joy, audaciousness and fury were seen in the latter, in contrast to fear and sadness in the former. Theophile Bonet (1679) was the first to use the term melancholiae mania, indicating some awareness of a link between the two [4].

The eighteenth century saw significant advances. Cartesian dualism, the total rejection of superstition and dogma, a more humane social policy and specialised care in asylums were all contributory factors. Boerhaave (1709) believed that melancholia and madness (described as a state of great strength, decreased sleep, decreased appetite and furious behaviour) are produced from the same causes [4]. Arnold (1782) felt that mania could precede or alternate with periods of melancholy [4]. Mead (1755) also described the link between mania and melancholy, and believed the two different only in degree. Allen (1791) provided a very detailed description. A "hurry of mind", thoughts running in a train from one to the other, false perception and judgement, irritability and violent behaviour if restrained are the various symptoms of mania [5].

Haslam (1809) felt that mania and melancholy were caused by different passions. During mania, the persons become more talkative, express their opinions vehemently, do not tolerate criticism, behave without restraint, behave as if inebriated and may also develop suspicions, and finally due to too many rapid thoughts, confusion ensues. Burrows (1828) added other details. Impulsivity, increased interest in poetry, music, declamation, painting, "many things begun, but few are finished", marked overactivity, impaired judgment are described. These symptoms, he says, may occur in a mild form for days or weeks before a full blown attack, or a rapid change from a melancholic condition may cause this. Pritchard (1837) also agreed. He described an illness characterised by gloom and despondency which sometimes changed into a state of excitement, extravagant conduct, loquaciousness and general high sprits. The two were implicity understood to be similar in nature [3], [4].

Griesinger [3], [4], [5], [14] laid the foundation for the pre-eminence of German psychiatry in subsequent years. He firmly believed that psychological diseases were diseases of the brain. His approach was eclectic and he suggested that "anatomical, physiological, psychological and clinical" points of view were valuable in understanding insanity. Mania, according to him, was characterised by persistent excitement of the will, an increase in self sensation and of self confidence. He describes the transition from melancholia to mania, prodomal symptoms and the ability of patients to predict a relapse. The behaviour described was similar to earlier reports. In addition, he describes fixed alternate cycle, a regular annual (seasonal) relapse (in which case melancholic symptoms were somewhat prolonged), or irregular but recurrent relapses with a poorer prognosis [4]. The latter half of the 19th century saw a proliferation of astute clinical observations. "Primary" insanity was separated from mania and melancholia which were till then considered primary. This "primary" insanity was to later develop into paranoia, and yet later into the concept of schizophrenia itself. Jacquelin - Dubuisson (1816) had suggested that affective faculties alone were at fault in mania, without an impairment of understanding. Falret (1854) had also described folic-circularie as a disease of young people, alternating symptoms and a remitting but recurrent course [15].

It remained for Kraeplin to synthesise all these existing descriptions, and the vast experiences already

gathered in the institutions for the mentally ill. His emphasis on clinical disease patterns, and definitions of manic depression were to guide the entire development of psychiatry and are familiar to most readers. The importance give to "psychological" data in the 19th century helped in this crystallisation. Overt behaviour of the individual had been the important factor prior to this. As we have seen, behavioural symptoms akin to the modern syndrome were recognised. The subjective mood state, the essential symptom in modern usage, was not commented upon specifically [16]. Even then, rather than rely on the symptoms themselves Kraeplin [17] added the longitudinal course to the process of diagnosis. Subsequent validation of this came rapidly, and the concept of manic depression was widely used.

1.Berrios G E, Descriptive psychopathology: conceptual and historical aspects
Psychological Medicine Page: 14: 303-313, 1984
2.Ducey C & Simon B, Ancient Greece and Rome
In: Howells J G (Ed) World History of Psychiatry. NY, Brunner-Mazel Page: 1-38, 1975
3.Goshen C E, *Documentary History of Psychiatry, London, Vision Press* 1967
4.Altschule M D, *The development of Traditional Psychopathology, Washington. Hemisphere* 1976
5.Ackernecht E H, *A Short History of Psychiatry, NY, Hafner* 1959
6.Berrios G E, The psychopathology of affectivity: conceptual and historical aspects
Psychological Medicine Page: 15: 745-755, 1985
7.*Atharva Veda. Translated by W D Whitney, Motilal Banarsidass, Varanasi* 1962
8.*Charaka-Samhita. Vol. 5, Jamnagar, Shree Gulabkunverba Ayurvedic Society* 1949
9.Venkoba Rao, *In: Howells J G (Ed) World History of Psychiatry, NY, Brunner - Mazel* Page: 624-649, 1975
10.Chakravarty M, *Current Psychological Concepts in Tantras, Bangalore University* 1978
11.Keith A B, *A History of Sanskrit Literature, Oxford Univ. Press, London* 1920
12.Weiss M, History of psychiatry in India: toward a culturally and historically informed study of indigenous tradition
Samiksa Page: 40 (2): 31-45, 1986
13.Baasher T, The Arab countries
In: Howells J G (Ed) The World History of Psychiatry. Brunner-Mazel, NY Page: 547-578, 1975
14.Hoff H & Arnold O H, Germany and Austria
In: Bellack L (Ed) Contemporary European Psychiatry Grove Press, NY 1961
15.Pichot P, France
In: Bellak L (Ed) Contemporary European Psychiatry Grove Press, NY 1961
16.Berrios G E, Historical background to abnormal psychology
In: Miller E & Cooper P J (Eds) Adult Abnormal Psychology, Churchill Livingtone, Edinburgh 1988
17.Kraeplin E, *Manic Depressive Insanity and Paranoia. E & S. Livingtone, Edinburgh* 1921