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Hypomania: An Overview

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Description

Hypomania (meaning "less than mania") is a mental and behavioural disease characterised by an apparently non-contextual elevation of mood (euphoria) that leads to continuously disinhibited behaviour. Irritability is a symptom of mania, however it is not always less severe than full-blown mania; In fact, considerable irritability has been reported as a characteristic of hypomanic and mixed episodes in Bipolar type II. Hypomania differs from mania in that there is no major functional impairment; mania, on the other hand, includes considerable functional impairment and may have psychotic symptoms, according to DSM-5 criteria.

A noticeable decrease in the need for sleep, an overall gain in energy, unexpected behaviours and acts, and a strikingly distinctive rise in talkativeness and confidence, usually associated with a flight of creative ideas, are all characteristics of those suffering from hypomania. Grandiosity, distractibility, and hypersexuality are some of the other symptoms associated with this. While hypomanic conduct can be productive and exciting, it can also be problematic if the patient engages in unsafe or otherwise unwise acts, and/or the symptoms present themselves in difficulties with ordinary life events. When manic episodes are divided into stages based on symptomatic severity and associated features, hypomania is the first stage, with the cardinal features (euphoria or heightened irritability, pressure of speech and activity, increased energy, decreased need for sleep, and flight of ideas) most clearly visible. Hypomanic people require less sleep, are highly social and competitive, and have a lot of energy. They're usually completely functional otherwise (unlike individuals suffering from a full manic episode). [1-5]

Hypomania differs from mania in that it lacks psychotic symptoms and has a lower influence on daily functioning. Hypomania is a symptom of bipolar II and cyclothymia, but it can also be a symptom of schizoaffective disorder. Hypomania is a symptom of bipolar I disorder, and it develops in stages as the mood disorder swings between normal mood (euthymia) and mania. Some people with bipolar I disorder experience both hypomanic and manic episodes. Hypomania can also occur when a person's mood shifts from a manic to a normal condition.

Hypomania has been linked to an increase in creative and productive energy. Hypomania has been credited by many people with bipolar disorder with giving them an advantage in the workplace. Hyperthymia, often known as "chronic hypomania," is characterised by the same symptoms as hypomania but occurs over a longer period of time. Cyclothymia is a mood disorder marked by fluctuating bouts of hypomania and depression that do not match the diagnostic criteria for manic or severe depressive episodes. Times of somewhat regular (euthymic) functioning are frequently mixed with these periods. Bipolar II disorder is diagnosed when a patient has had at least one episode of both hypomania and significant depression, both of which match the diagnostic criteria. Depressive episodes are more common in the fall and winter, while hypomanic episodes are more common in the spring and summer. In such circumstances, a "seasonal pattern" is used. Hypomania may progress to mania, which may be psychotic, if left untreated in people who are predisposed, in which case bipolar I disorder is the accurate diagnosis. Prior to the appearance of manic symptoms, many people who have had their first episode of hypomania – usually without psychotic aspects – may have had a long or recent history of depression or a mix of hypomania and depression (known as mixed-state).

This usually appears in the mid-to-late adolescent years. Because adolescence is such an emotionally charged stage of life, mood swings are sometimes misdiagnosed as normal hormonal teen behaviour, and a diagnosis of bipolar illness is not made until there is evidence of a manic or hypomanic phase. In unipolar depressives with drug-induced hypomania, the hypomania can nearly always be resolved by reducing the medication dosage, discontinuing the drug completely, or switching to a different medication if discontinuation of therapy is not possible.

Hypomania is linked to Narcissistic Personality Disorder (NPD). Mania and hypomania are commonly researched as parts of bipolar disorders, and their pathophysiology is considered to be the same. Monoamine hyperactivity ideas have been presented in light of the fact that norepinephrine and dopaminergic medications can cause hypomania. Decreased serotonergic control of other monoamines can result in either depressed or manic symptoms, according to a theory uniting depression and mania in bipolar people. Mania has also been linked to lesions on the right side of the frontal and temporal lobes. Antimanic medicines are used in conjunction with a variety of psychological therapies to control acute attacks and avoid repeated episodes of hypomania. The duration of treatment is indicated to be between 2 and 5 years. Antidepressants may be necessary for existing therapy, but they should be avoided in patients who have recently had hypomania. Sertraline has long been suspected of having hypomania-inducing side effects.

Conflict of Interest

None.

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