

Hypomania: Understanding the Highs and Creative Energy

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Hypomania (literally, "below mania") is a mood state characterized by persistent and pervasive elevated (euphoric) or irritable mood, as well as thoughts and behaviors that are consistent with such a mood state.

Presentation

Individuals in a hypomanic state have a decreased need for sleep, are extremely outgoing and competitive, and have a great deal of energy. However, unlike with full mania, those with hypomanic systems are fully functioning, and are often actually more productive than usual.

Distinctive markers

Specifically, hypomania is distinguished from mania by the absence of psychotic symptoms and grandiosity, and by its lesser degree of impact on functioning. Hypomania is a feature of bipolar II disorder and cyclothymia, but can also occur in schizoaffective disorder. Hypomania is also a feature of bipolar I disorder as it arises in sequential procession as the mood disorder fluctuates between normal mood and mania. Hypomania can occur when moods progress downwards from a manic mood state to a normal mood. Hypomania is sometimes credited with increasing creativity and productive energy. A significant number of people with creative talents have reportedly experienced hypomania or other symptoms of bipolar disorder and attribute their success to it. Classic symptoms of hypomania include mild euphoria, a flood of ideas, endless energy, and a desire and drive for success. A lesser form of hypomania is called hyperthymia.

Definitions

Hypomania is also a side effect of numerous medications, often--though not always--those used in psychopharmacotherapy. Patients suffering from severe depression who experience hypomania as a side effect of (for example) antidepressants, may prove to have a form of bipolar disorder that has previously gone unrecognized. However, drug-induced hypomania is not invariably indicative of bipolar affective disorders. The difference between uni- and bi-polar disorders is essential for analysis of switches (mood changes). Consequently, it is important for researchers and mental health professionals to distinguish drug-induced hypomania in bipolar patients from drug-induced hypomania in unipolar (non-bipolar) depressives. Nevertheless if antidepressants trigger the first episode of hypomania, it is strongly suggestive of an underlying diagnosis of Bipolar Disorder, particularly if the manic symptoms (mild, moderate or severe) last for a lengthy period of time after they start. In cases of true drug-induced hypomania, cessation of the antidepressant or whichever drug has triggered this mood state - for example steroid therapy or stimulants such as amphetamine - usually causes a fairly swift return to normal mood. It is far less likely to be a side effect in those with pure Clinical Unipolar Depression, unless for example tricyclic antidepressants

are given in very high doses. SSRIs are less likely to trigger manic symptoms except in those individuals where there is an underlying Bipolar Disorder, particularly if administered without a mood stabilizer.

Occurrence

Often in those who have experienced their first episode of hypomania (which is a level of mild to moderate mania) - generally without psychotic features - there will have been a long or recent history of depression prior to the emergence of manic symptoms, and commonly this surfaces in the mid to late teens. Due to this being an emotionally charged time, it is not unusual for mood swings to be passed off as hormonal or teenage ups and downs and for a diagnosis of Bipolar Disorder to be missed until there is evidence of an obvious manic/hypomanic phase.

Hypomania may also occur as a side effect of pharmaceuticals prescribed for conditions/diseases other than psychological states or mood disorders. In those instances, as in cases of drug-induced hypomanic episodes in unipolar depressives, the hypomania can almost invariably be eliminated by lowering medication dosage, withdrawing the drug entirely, or changing to a different medication if discontinuation of treatment is not possible.

Some, such as Johns Hopkins psychologist John Gartner, argue that hypomania is better understood as a stable non-pathological temperament rather than an episode of mental illness. The DSM however clearly defines hypomania as an aberrant state, not a stable trait.

Symptomatic recognition

The DSM-IV-TR defines a hypomanic episode as including, over the course of at least four days, elevated mood plus three of the following symptoms OR irritable mood plus four of the following symptoms:

pressured speech

inflated self-esteem or grandiosity

decreased need for sleep

flight of ideas or the subjective experience that thoughts are racing

easy distractibility and attention-deficit similar to attention deficit hyperactivity disorder

increase in psychomotor agitation

involvement in pleasurable activities that may have a high potential for negative psycho-social or physical consequences (e.g., the person engages in unrestrained buying sprees, sexual indiscretions, reckless driving, or foolish business investments).

Possible benefits

Some commentators believe that hypomania actually has an evolutionary advantage. People with hypomania are generally perceived as being energetic, euphoric, visionary, overflowing with new ideas, and sometimes over-confident and very charismatic, yet--unlike those with full-blown mania--are sufficiently capable of coherent thought and action to participate in everyday activities. Like mania, there seems to be a significant correlation between hypomania and creativity. A person in the state of hypomania might be immune to fear and doubt and have little social and sexual inhibition. People experiencing hypomania are often the "life of the party." They may talk to strangers easily, offer solutions to problems, and find pleasure in small activities. Such advantages may render them unwilling to submit to treatment, especially when disadvantages are minimal.

Relationship with disorders

Cyclothymia is a condition of continued mood fluctuations between hypomania and depressive symptoms that do not meet the criteria for a major depressive episode. These are often interspersed with periods of normal moods.

When a patient presents with a history of one or more hypomanic episodes and one or more depressive episodes that meet the criteria for a major depressive episode, bipolar II disorder is diagnosed.

If left untreated, hypomania can transition into mania and sometimes psychosis, in which case, bipolar I disorder is often diagnosed. (See also, Kindling model)

Treatment

Medications typically prescribed for hypomania include mood stabilizers such as valproic acid and lithium carbonate as well as atypical antipsychotics such as olanzapine and quetiapine.

Notable individuals with hypomanic symptoms

John Gartner's book *The Hypomanic Edge* claims notable people including Christopher Columbus, Alexander Hamilton, Andrew Carnegie, Howard Zinn and Louis B. Mayer owe their innovation and drive, as well as their eccentricities, to hypomanic temperaments. Gartner suggests that the constructive behaviors associated with hypomania may contribute to bipolar disorder's evolutionary survival. Critics charge that Gartner vastly overstates his case, however.