

Mania: Understanding the Highs and the Hidden Risks

Authored by
mohammad looti

June 17, 2026

RECOMMENDED CITATION

mohammad looti (2026). *Mania: Understanding the Highs and the Hidden Risks*.
PSYCHOLOGICAL SCALES. Retrieved from <https://scales.arabpsychology.com/?p=38628>

Mania, the presence of which is a criterion for certain psychiatric diagnoses, is a state of abnormally elevated or irritable mood, arousal, and/ or energy levels. In a sense, it is the opposite of depression. The word derives from the Greek "μανία" (mania), "madness, frenzy" and that from the verb "μαίνωμαι" (mainomai), "to be mad, to rage, to be furious".

In addition to mood disorders, individuals may exhibit manic behavior as a result of drug intoxication (notably stimulants such as cocaine or methamphetamine), medication side effects (notably steroids), or malignancy. However, mania is most often associated with bipolar disorder, where episodes of mania may alternate with episodes of major depression. Gelder, Mayou and Geddes (2005) suggests that it is vital that mania is predicted in the early stages because the patient becomes reluctant to comply to the treatment. The criteria for bipolar do not include depressive episodes and the presence of mania in the absence of depressive episodes is sufficient for a diagnosis. Regardless, even those who never experience depression experience cyclical changes in mood. These cycles are often affected by changes in sleep cycle (too much or too little), diurnal rhythms and environmental stressors.

Mania varies in intensity, from mild mania known as hypomania to full-blown mania with psychotic features including hallucinations, delusion of grandeur, suspiciousness, catatonic behavior, aggression, and a preoccupation with thoughts and schemes that may lead to self neglect. Since mania and hypomania have also been associated with creativity and artistic talent, it is not always the case that the clearly manic bipolar person will need or want medical assistance; such people will often either retain sufficient amount of control to function normally or be unaware that they have "gone manic" severely enough to be committed or to commit themselves ('commitment' means admission to a psychiatric facility). Manic individuals can often be mistaken for being on drugs or other mind-altering substances.

Classification

Mixed states

Mania can be experienced at the same time as depression, in a mixed episode. Dysphoric mania is primarily manic and agitated depression is primarily depressed. This has caused speculation amongst doctors that mania and depression are two independent axes in a bipolar spectrum, rather than opposites.

There is an increased probability of suicide in the mixed state, as depressed individuals who are also manic have the energy needed to commit the act and the thoughts of depression that would lead them initially to suicide.

Mania can be the result of using drugs. Quitting drugs can create situations in one's mind similar to the symptoms of mania, such as constant racing of the mind. A diagnosis of mania in these

situations is often temporary.

Hypomania

Hypomania is a lowered state of mania that does little to impair function or decrease quality of life. In hypomania there is less need for sleep, and both goal-motivated behavior and metabolism increase. Though the elevated mood and energy level typical of hypomania could be seen as a benefit, mania itself generally has many undesirable consequences including suicidal tendencies.

Associated disorders

A single manic episode is sufficient to diagnose Bipolar I Disorder. Hypomania may be indicative of Bipolar II Disorder or Cyclothymia. However, if prominent psychotic symptoms are present for a duration significantly longer than the mood episode, a diagnosis of Schizoaffective Disorder is more appropriate. Several types of Mania such as kleptomania and pyromania are related more closely to OCD than to Bipolar Disorder, depending on the seriousness of these disorders. For instance, someone with kleptomania who suffers from impulses to steal things such as pencils, pens, and paperclips is better diagnosed with a form of OCD or Hypomania, but someone with pyromania who receives impulses to commit serious acts of arson (setting fire to large areas of private and/or public property) would be diagnosed with a very serious case of Mania or Bipolar Disorder.

B12 deficiency can also cause characteristics of mania and psychosis.

Signs and symptoms

A manic episode is defined in the American Psychiatric Association's diagnostic manual as a period of seven or more days (or any period if admission to hospital is required) of unusually and continuously effusive and open elated or irritable mood, where the mood is not caused by drugs or a medical illness (e.g., hyperthyroidism), and (a) is causing obvious difficulties at work or in social relationships and activities, or (b) requires admission to hospital to protect the person or others, or (c) the person is suffering psychosis.

To be classed as a manic episode, while the disturbed mood is present at least three (or four if only irritability is present) of the following must have been consistently prominent: grand or extravagant style, or expanded self-esteem; reduced need of sleep (e.g. three hours may be sufficient); talks more often and feels the urge to talk longer; ideas flit through the mind in quick succession, or thoughts race and preoccupy the person; over indulgence in enjoyable behaviors with high risk of a negative outcome (e.g., extravagant shopping, sexual adventures or improbable commercial schemes).

If the person is concurrently depressed, they are said to be having a mixed episode.

The World Health Organization's classification system defines a manic episode as one where mood is higher than the person's situation warrants and may vary from relaxed high spirits to barely controllable exuberance, accompanied by hyperactivity, a compulsion to speak, a reduced sleep requirement, difficulty sustaining attention and, often, increased distractibility. Frequently, confidence and self-esteem are excessively enlarged, and grand, extravagant ideas are expressed. Behavior that is out of character and risky, foolish or inappropriate may result from a loss of normal social restraint.

Some people also have physical symptoms, such as sweating, pacing, and weight loss. In full-blown mania, often the manic person will feel as though his or her goal(s) trump all else, that there are no consequences or that negative consequences would be minimal, and that they need not exercise restraint in the pursuit of what they are after. Hypomania is different, as it may cause little or no impairment in function. The hypomanic person's connection with the external world, and its standards of interaction, remain intact, although intensity of moods is heightened. But those who suffer from prolonged unresolved hypomania do run the risk of developing full mania, and indeed may cross that "line" without even realizing they have done so.

One of the most signature symptoms of mania (and to a lesser extent, hypomania) is what many have described as racing thoughts. These are usually instances in which the manic person is excessively distracted by objectively unimportant stimuli. This experience creates an absentmindedness where the manic individual's thoughts totally preoccupy him or her, making him or her unable to keep track of time, or be aware of anything besides the flow of thoughts. Racing thoughts also interfere with the ability to fall asleep.

Mania is always relative to the normal rate of intensity of the person being diagnosed with it; therefore, an easily-angered person may exhibit mania by getting even angrier even more quickly, and an intelligent person may adopt seemingly "genius" characteristics and an ability to perform and to articulate thought beyond what they can do in a normal mood. But perhaps the easiest indicator of mania would be if a noticeably clinically depressed person becomes suddenly cheerful, optimistic, happy, and full of energy. Other elements of mania may include delusions (of grandeur, potential, or otherwise), hypersensitivity, hypersexuality, hyper-religiosity, hyperactivity, impulsiveness, talkativeness, an internal pressure to keep talking (over-explanation) or rapid speech, grandiose ideas and plans, and decreased need for sleep (e.g. feeling rested after 3 or 4 hours of sleep). In manic and hypomanic cases, the afflicted person may engage in out-of-character behavior, such as questionable business transactions, wasteful expenditures of money, risky sexual activity, recreational drug abuse, abnormal social interaction, or highly vocal arguments uncharacteristic of previous behaviors. These behaviors may increase stress in personal relationships, lead to problems at work and increase the risk of altercations with law

enforcement. There is a high risk of impulsively taking part in activities potentially harmful to self and others.

Although "severely elevated mood" sounds somewhat desirable and enjoyable, the experience of mania is ultimately often quite unpleasant and sometimes disturbing, if not frightening, for the person involved and for those close to them, and it may lead to impulsive behavior that may later be regretted. It can also often be complicated by the sufferer's lack of judgment and insight regarding periods of exacerbation of characteristic states. Manic patients are frequently grandiose, obsessive, impulsive, irritable, belligerent, and frequently deny anything is wrong with them. Because mania frequently encourages high energy and decreased perception of need or ability to sleep, within a few days of a manic cycle, sleep-deprived psychosis may appear, further complicating the ability to think clearly. Racing thoughts and misperceptions lead to frustration and decreased ability to communicate with others.

There are different "stages" or "states" of mania. A minor state is essentially hypomania and, like hypomania's characteristics, may involve increased creativity, wit, gregariousness, and ambition. Full-blown mania will make a person feel elated, but perhaps also irritable, frustrated, and even disconnected from reality.

Cause

Mania is a complex neurophysiological phenomenon. Predisposing factors to develop mania are primarily genetic and are no longer considered to be psychological, although stress triggers to a particular manic episode may include significant psychological and social conflicts. The primary trigger for (and the primary symptom of) acute mania is sleep deprivation. Social problems, medications, or illness may initiate manic hyperarousal but genetic predisposition or brain illnesses are most likely to be the main causations for classic and persistent manic symptoms. Some medications, including all stimulants, may mimic manic symptoms but differ substantially in duration and intensity compared with true manic episodes. The primary mediator of all mood disease is the brain's limbic system. A full description of the cause of mania is complex and should be referenced elsewhere.

Some medications may cause symptoms that mimic mania. Some medications may trigger a manic episode through hyperarousal of the limbic system and subsequent sleep deprivation. These may include: amphetamines and other stimulants (Provigil, Nuvigil, Adipex), caffeine (caffeine/taurine energy drinks), cocaine and various illegal drugs, serotonin reuptake inhibitors (SSRI, SNRI), tricyclic compounds (TCA, excluding carbamazepine), steroid medications (Prednisone, oral cortisone), serotonin agonists, dopamine agonists (Mirapex, Sinemet), and several other groups of medicines. One common over the counter medication group that can be stimulating in large doses is cough and cold medications that contain agents meant to stimulate

blood vessels which shrink nasal mucosa thereby enlarging space for nasal air flow (decongestants).

For example, Phenylpropanolamine (PPA) is a sympathomimetic drug similar in structure to amphetamine which was formerly present in over 130 medications, primarily decongestants, cough/cold remedies, and anorectic agents.

A report on PPA, from the Dept. of Psychiatry, F. Edward Hebert School of Medicine, Uniformed Services University of the Health Sciences, Bethesda, Maryland. *Pharmacopsychiatry* 1988 stated:

We have reviewed 37 cases (published in North America and Europe since 1960) that received diagnoses of acute mania, paranoid schizophrenia, and organic psychosis and that were attributed to PPA product ingestion. Of the 27 North American case reports, more reactions followed the ingestion of combination products than preparations containing PPA alone; more occurred after ingestion of over-the-counter products than those obtained by prescription or on-the-street; and more of the cases followed ingestion of recommended doses rather than overdoses.

Failure to recognize PPA as an etiological agent in the onset of symptoms usually led to a diagnosis of schizophrenia or mania, lengthy hospitalization, and treatment with substantial doses of neuroleptics or lithium.

PPA is no longer available in any medication in the United States as of the year 2000.

Treatment

Before beginning treatment for mania, careful differential diagnosis must be performed to rule out non-psychiatric causes.

Acute mania in bipolar disorder is typically treated with mood stabilizers and/or antipsychotic medication. Note that these treatments need to be prescribed and monitored carefully to avoid harmful side-effects such as neuroleptic malignant syndrome with the antipsychotic medications. It may be necessary to temporarily admit the patient involuntarily until the patient is stabilized. Antipsychotics and mood stabilizers help stabilize mood of those with mania or depression. They work by blocking the receptor for the neurotransmitter dopamine and allowing serotonin to still work, but in diminished capacity.

When the manic behaviours have gone, long-term treatment then focuses on prophylactic treatment to try to stabilize the patient's mood, typically through a combination of pharmacotherapy and psychotherapy.

Lithium is the classic mood stabilizer to prevent further manic and depressive episodes. Anticonvulsants such as valproic acid and carbamazepine are also used for prophylaxis. More

recent drug solutions include lamotrigine. Clonazepam (Rivotril, Ravotril or Rivatril) is also used.

Verapamil, a calcium-channel blocker, is useful in the treatment of hypomania and in those cases where lithium and mood stabilizers are contraindicated or ineffective.. Verapamil is effective for both short-term and long-term treatment.

Medications

The biological mechanism by which mania occurs is not yet known. One hypothesised cause of mania (among others), is that the amount of the neurotransmitter serotonin in the temporal lobe may be excessively high. Dopamine, norepinephrine, glutamate and gamma-aminobutyric acid also appear to play important roles. Imaging studies have shown that the left amygdala is more active in women who are manic and the orbitofrontal cortex is less active.

Antidepressant monotherapy is not recommended for the treatment of depression in patients with bipolar disorders I or II, and no benefit has been demonstrated by combining antidepressants with mood stabilizers in these patients.

Society and culture

In *Electroboy: A Memoir of Mania* by Andy Behrman, he describes his experience of mania as "the most perfect prescription glasses with which to see the world...life appears in front of you like an oversized movie screen" . Behrman indicates early in his memoir that he sees himself not as a person suffering from an uncontrollable disabling illness, but as a director of the movie that is his vivid and emotionally alive life. When I'm manic, I'm so awake and alert, that my eyelashes fluttering on the pillow sound like thunder" .