Individual Planning: A Treatment Plan Overview for Individuals Hypomania and Mania in Bipolar Disorder Control Problems.

Hypomania (literally, below mania) is a mood state characterized by persistent and pervasive elevated or irritable mood, and thoughts and behaviors that are consistent with such a mood state. People experiencing hypomanic symptoms typically have a flight of ideas, a decreased need for sleep and/or rest, are extremely outgoing and daring, and have a great deal of energy. However, unlike full-blown mania, those with hypomanic systems are generally fully functioning. Specifically, it is distinguished from mania by the absence of psychotic symptoms and by its lower degree of impact on functioning. Hypomania is a feature of two mood disorders: bipolar II disorder and cyclothymia, but can also occur in schizoaffective disorder. Hypomania is sometimes credited with increasing creativity and productive energy. A 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.

Mania symptoms below:
- Excessive happiness, hopefulness, and excitement
- Sudden changes from being joyful to being irritable, angry, and hostile
- Restlessness, increased energy, and less need for sleep
- Rapid talk, talkativeness
- Distractibility
- Racing thoughts
- High sex drive
- Tendency to make grand and unattainable plans
- Tendency to show poor judgment, such as deciding to quit a job
- Inflated self-esteem or grandiosity -- unrealistic beliefs in one's ability, intelligence, and powers; may be delusional
- Increased reckless behaviors (such as lavish spending sprees, impulsive sexual indiscretions, abuse of alcohol or drugs, or ill-advised business decisions)

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; rapid talking
- 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 (superficially similar to attention deficit hyperactivity disorder);
- increase in psychomotor agitation; and
- 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, or foolish business investments).

In the hypomanic state, people may feel that they cannot slow their minds down, and that their speeding thoughts are crafted exceptionally well. Some examples are speaking or writing in rhyme or alliteration without planning it first; quick responses to people talking; or the ability to improvise easily.

People in hypomanic episodes do not have delusions or hallucinations. They do not lose touch with reality in the sense that they know who they are and what is real. What can be a problem, however, is that people in a hypomanic state can sometimes overestimate their capabilities and fail to see the risks involved in their ventures. For example, a person may suddenly decide to expand a business in a way that is not really practical or set up schemes for which he or she is ill-prepared.

People experiencing hypomania may also manifest a loss of inhibition, resulting in behavior such as reckless driving, gambling, spending sprees and sexual adventures. They may also report having a host of new ideas, but not following them through. People who are described as hypomanic are often very jolly to be with but may quickly become very impatient or unpleasant if they cannot get what they want.

It is unknown to what degree hypomanic symptoms can occur without a depressive component. Patients may be relatively unlikely to seek psychiatric treatment for hypomania alone. However, many hypomanic patients also experience:

- obsessive behavior, whether mild or severe
- poor judgment
- uncontrolled, or only partially controllable, impulsivity
- excessive sexual activity
- plus other out-of-character behaviors that the person may regret following the conclusion of the mood episode. A more mild form of elevated mood, which has fewer negative behaviors, is hyperthymic temperament.

Hypomania can signal the beginning of a more severe manic episode, and often does result in a more severe manic episode if the hypomanic episode remains untreated. A hypomanic episode can also directly precede a depressive episode.

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. 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.

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 hypomaniac 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.

Treatment
Clinical trials of medications for the non-depressive phases of bipolar illnesses generally treat patients for psychotic mania during the initial, or acute, phase of mania. High doses are justified in the case of mania, in order to remove the patient from immediate danger. Hypomania, however, involves different considerations and almost always requires more in-depth clinical judgment. 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.

Behavioral Definitions for Individuals with Mania or Hypomania Problems:
Reduction attention span and becomes easily distracted.
Impulsive, pleasure oriented behavior without regard for painful consequences, due to loss of normal inhibition
Strange dress and grooming.
Expansive mood that can suddenly turn to impatience and irritable anger if behavior confronted.
Lack of complete projects even though energy is high, but lacks discipline and goal directedness.
Pressed speech or loquaciousness.
Flight of ideas or racing thoughts.
Persecutory or grandiosity beliefs.
Very little need for sleep often with little or no appetite.
Increased motor activity and agitation.

Long Term Goals for Individuals with Mania or Hypomania Problems:
Lower level of psychic energy and return to normal activity levels.
Increase good judgment, stable mood, and goal directed behavior.
Reduce agitation, impulsivity, and pressured speech.
Increase sensitivity to the consequences of behavior and having more realistic expectations.
Explore underlying feelings of guilt, fears of rejection, low self esteem, dependency, and abandonment.
Accomplish controlled behavior, moderated mood, and thought process through psychotherapy and medication.

Short Term Goals for Individuals with Mania or Hypomania Problems:
Explore feelings and thoughts about self, his or her own abilities, and future plans.
Explore mood state, level of energy, level of control over thoughts, and sleeping pattern.
Refer for psychiatric evaluation for medication need, and to assess hospitalization need to stabilize mood and energy.
Monitor taking of psychotropic medications as directed.
Encourage trust in the therapy relationship by sharing fears about dependency, loss, and abandonment.
Accomplish mood stability, having slower reaction with anger, less expansive, and being more socially appropriate and sensitive.
Encourage expression of grief, fear, and anger regarding real or imagined losses in life.
Differ between real and imagined losses, rejections, and abandonment.
Accept the level of low self esteem and fear of rejection that underlies the behavior. Identify and list the causes for the low self esteem and abandonment fears. Stop or reduce self destructive behaviors such as promiscuity, substance abuse, and the expression of overt hostility or aggression. Learn to speak more slowly and be more subject oriented. Learn to dress and groom in a less attention grabbing manner. Express the acceptance of dependency needs. Identify and list positive traits and behaviors that help build genuine self esteem. Lower grandiose statements and learn to express self more realistically. Learn to be less agitated and distracted, and be able to sit quietly and calmly for 30 minutes. Agree to sleep about 5 hours or more per night. Increase control over thoughts and a slower thinking process. Increase ability to stay focused on a single activity to completion. Increase an understanding that behavior and judgment are under poor control during manic phase or episode. Increase acceptance of the need for ongoing supportive treatment and medication to reduce or eliminate destructive, manic swings. Allow the family of the patient express in therapy their feelings regarding patient’s behavior and mental illness. Allow the family of patient increase the understanding of the serious nature illness, its behavioral manifestations, and the need for continuing treatment.

Interventions or Strategies for Individuals with Mania or Hypomania Problems:

Explore for classic signs of mania: pressured speech, impulsive behavior, euphoric mood, reduced need for sleep, flight of ideas, inflated self esteem, and high energy. Evaluate stage of elation: hypo manic, manic, or psychotic. Prepare patient for or continue hospitalization if patient is potentially harmful to self or others, or unable to care for own basic needs. Refer for psychiatric evaluation for pharmacotherapy (such as, lithium carbonate). Measure the patient's reaction to the medication (such as, side effects and effectiveness). Assure patient to be there consistently to help, listen to, and support. Explore fears of abandonment. Explore real or perceived losses in the patient's life. Explore the roots for low self esteem and abandonment fears in the family history. Gradually and firmly confront feelings or ideation of grandiosity and demandingness. Assess the manner to best replace the losses and put them in perspective. Assist the patient differ between real and imagined, actual and exaggerated losses. Measure any stressors that precipitate manic behavior (such as, school failure, social rejection, or family trauma). Continuously focus on consequences of behavior to reduce thoughtless and impulsivity. Reinforce impulse control by using role playing, behavioral rehearsal, or role reversal to increase sensitivity to negative consequences of behavior. Listen carefully for expressions of hostility while setting limits on aggressive or impulsive behavior. Place limits on any manipulation or acting out behavior, by making clear rules and establishing clear consequences for breaking rules. Allow for structure to focus the patient's thoughts and actions, and, by regulating the direction of conversation and setting plans for behavior. Reinforce slower speech and more careful focused thought process. Encourage and reinforce better appropriate dress and grooming habits. Help patient develop reasonable limits on behavior. Assess the fear and insecurity underlying the patient's ideations, and hostility, and denial of
dependency.
Help identify strengths and assets to build self esteem and confidence.
Allow and encourage the share feelings at a deeper level to facilitate openness and intimacy in relationships, counteracting denial and superficiality.
Increase control over hyperactivity and help patient set goals and limits on agitation.
Assess sleep patterns and encourage 5 or more hours sleep per night.
Assess energy level and reinforce increased control over behavior, pressured speech, and verbalization of ideas.
Encourage reports of behavior that is focused on goal attainments and less unfocused.
Assess patient's understanding of his or her illness and elicit a realistic appraisal of loss of judgment and impulsivity.
Instruct patient that a usually chronic nature and often misleads a patient into thinking there is no need for medication or therapy.
Provide family joint therapy with family to allow ventilation of their feelings of guilt, shame, fear, concern, confusion, or anger regarding patient's behavior.
Educate family regarding the illness and emphasize the need for ongoing treatment.