



## Research report

# 'Bright side' and 'dark side' hypomania are associated with differences in psychological functioning, sleep and physical activity in a non-clinical sample of young adults

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## ABSTRACT

**Background:** No research has yet focused on hypomanic states in non-clinical early adult populations. The aim of the present study was therefore to assess hypomania in a large non-clinical sample of young adults.

**Methods:** A total of 862 participants (639 females and 223 males; mean age:  $M = 24.67$ ;  $SD = 5.91$ ) took part in the study. They completed a series of validated self-report questionnaires assessing hypomania (HCL-32) and other aspects of psychological functioning, sleep, stress, quality of life, cognitive–emotional elaboration of pain, self-efficacy, and physical activity.

**Results:** Based on the HCL-32, 19% of the participants ( $n = 169$ ) were categorized as currently being in a hypomanic state. Of those, 57.6% were classified as “active/elated” (‘bright side’), whereas 42.4% were classified as “irritable/risk-taking” (‘dark side’). Compared to non-hypomanic participants and the ‘bright side’ group, ‘dark side’ hypomanic participants reported more depressive symptoms, sleep disturbances, somatic complaints, perceived stress, negative coping strategies, and lower self-efficacy. By contrast, ‘bright side’ hypomanic participants had lower stress scores, more positive self-instructions, and higher levels of exploration, self-efficacy, and physical activity.

**Limitations:** A cross-sectional design was adopted, assessing university students, who may not be representative of the stage of early adulthood.

**Conclusions:** The present results underscore the notion of a continuity between a mood state and both favorable (‘bright side’) and unfavorable (‘dark side’) hypomanic states. In early adulthood, ‘bright’ and ‘dark side’ hypomania differs with respect to physical activity, psychological functioning and sleep.

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## 1. Introduction

There is a growing interest in research into hypomanic states because there is a reason to suspect that hypomanic and bipolar disorders may be underdiagnosed (Angst et al.,

2010). In fact, the emerging data from several epidemiologic and clinical studies suggest that bipolar disorders, including hypomania, may in fact be as common as unipolar disorders (Akiskal et al., 2000). This holds both for clinical and non-clinical samples, and for adolescent and adult samples (see below).

The core features of hypomanic stages are: 1) overactivity (DSM-V: American Psychiatric Association, 2009; Benazzi, 2007; Gamma et al., 2008); 2) reduced sleep (DSM-V: APA, 2009; ICD-10: WHO, 2007), and 3) elevated, expansive or irritated mood (DSM-V; APA, 2009; ICD-10: WHO, 2007).

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However, besides, [Hantouche et al. \(2003\)](#) first described that hypomania could be subdivided into so-called “sunny” and “dark” sides of hypomania: Whereas the sunny side of hypomania was related to the socially positive and advantageous facet, the dark side was associated with socially negative aspects. Specifically, the dark side of hypomania was linked with a cyclothymic temperament. Moreover, when hypomania and cyclothymia interacted together, the clinical picture of the patients suffering from unipolar and bipolar disorders ( $N=427$ ) was more complex, severe and recurrent. Thereafter, the publication of [Hantouche et al. \(2003\)](#) has stimulated a wealth of studies in which the subdivision between the so-called sunny and dark sides of hypomania has been further investigated in both clinical and non-clinical samples (see below).

Recent studies of clinical and non-clinical samples ([Brand et al., 2007, 2010a,b,c,d](#); [Dilsaver et al., 2005](#); [Holtmann et al., 2009](#); [Kowatch et al., 2005](#); [Pavuluri et al., 2005](#)) suggest that bipolar II disorders (BP-II) may also be common among children and adolescents. [Raman et al. \(2007\)](#) reported that of 61 outpatients aged about 13.5 years and suffering from major depressive disorders, 12 (20%) were misdiagnosed as having a unipolar disorder. Regarding adolescents, [Holtmann et al. \(2009\)](#) investigated a sample of 294 non-clinical adolescents (mean age: 17.3 years;  $SD=1.1$ ) using the Hypomania Check List 32 (HCL-32; [Angst et al., 2005](#)). The authors observed hypomania in about 11.2% of the participants and distinguished between those who were ‘active-elated’ and those who were ‘disinhibited/stimulation-seeking’ and ‘irritable–erratic’. Importantly, whereas ‘active-elated’ (or ‘bright side’) hypomania was negatively associated with peer problems, ‘disinhibited/stimulation-seeking’ and ‘irritable–erratic’ (or ‘dark side’) hypomania was positively associated with conduct problems, hyperactivity–inattention and peer problems. In sum, both favorable and unfavorable hypomania features could be detected, each having a distinct association with favorable and unfavorable behaviors. Last, in a non-clinical sample of 103 adolescents (mean age: 17.9 years), higher total HCL-32 scores were related to current early-stage intense romantic love ([Brand et al., 2007](#)), to female gender, and to issues related to developmental tasks such as exploring and learning psychosocial and psychosexual behaviors ([Brand et al., 2010a,b,c,d](#)).

Among adults, hypomania and bipolar II disorders (BP II) have been observed in both clinical (cf. [Angst et al., 2005, 2010](#); [Meyer et al., in press](#)) and non-clinical samples ([Angst et al., 2003](#); [Gamma et al., 2008](#); [Meyer et al., 2007](#)). With respect to non-clinical samples, [Gamma et al. \(2008\)](#) showed that about 13% of the cohort (mean age: 40 years) presented a very mild expression of bipolarity between a bipolar disorder and normality. Compared to controls, these ‘pure’ hypomanics did not substantially differ with respect to quality of life or distress, though they earned more money and were more likely to be married. These observations were interpreted both as being related to hypomanic features and as favorable expressions of increased efforts with respect to vocational and social issues.

[Meyer et al. \(2007\)](#) investigated two different non-clinical samples. The first sample consisted of 695 German adults (mean age: 29.22 years; range: 17–67 years; predominantly academic staff members), the second sample consisted of 408

Swedish adults (mean age: 55.50 years; range: 35–65 years). Both samples completed the HCL-32. Results showed that, even with these non-clinical samples, the HCL-32 items could be divided between two distinct factors, the first describing ‘active/elated’ and the second ‘irritable/risk-taking’ hypomania. The two-factor solution was identical to that based on data from clinical samples.

To summarize, 1) there is evidence that hypomania is common both in the clinical and non-clinical population of children, adolescents, and adults; 2) the HCL-32 has proved to be an easily and readily applied self-report tool for assessing hypomania; 3) based on the seminal work of [Hantouche et al. \(2003\)](#), international and cross-cultural comparisons of the HCL-32 scores have revealed a robust two factor solution, distinguishing between ‘active/elated’ (‘bright side’) and ‘irritable/risk-taking’ (‘dark side’) hypomania (cf. [Angst et al., 2010](#)).

However, surprisingly, little is known about the relations between hypomanic states, psychological functioning, sleep, and physical activity in the non-clinical population of young adults. Nonetheless, we hold that, at least for four reasons, trying to fill this gap in knowledge may be important. First, early adulthood is a period of transition between adolescence and more stable periods of adulthood; this period of transition may be particularly critical for longer lasting decisions related to peer interaction, romantic relationships, family planning, vocational career and life style choices. As a result, some decisions may be accompanied by increased emotional turmoil and mood changes (cf. [Arnett, 2007](#); [Arnett, et al., in press](#)). Second, findings from research focusing on cerebral development suggest that complete myelination comes to its end at the age of about 24 years (cf. [Giedd et al., 1999](#); [Higgins and George, 2007](#)). Thus, from the point of view of cerebral development, adolescence seems to reach its end during early adulthood. Third, following [Steinberg \(1996\)](#), late adolescence may last until the age of 21 and to early adulthood, although, in most European countries, 18 year-olds have full adult rights and from the view-point of criminal law are fully responsible for their behavior. Fourth, it is conceivable that general practitioners and counselors have to deal with young adults’ issues related to hypomanic states and mood changes. Against this background, the present study may shed more light on the topic of hypomania and mood change during early adulthood within the non-clinical population of young adults.

Five hypotheses were formulated. First, following [Gamma et al. \(2008\)](#) and [Brand et al. \(2007\)](#), we expected better psychological functioning<sup>1</sup> among participants reporting ‘active/elated’ hypomania, compared to those reporting ‘irritable/risk-taking’ hypomania or no hypomania. Second, and complementary to the first hypothesis, we anticipated poorer psychological functioning among participants reporting ‘irritable/risk-taking’ hypomania, compared to those reporting ‘active/elated’ hypomania or no hypomania. Third, as reduced sleep is a further core symptom of hypomania, and

<sup>1</sup> In the present paper, ‘psychological functioning’ is intended to embrace psychological domains such as depressive symptoms, perceived stress, coping with stress, perception of pain, sleep-related cognitions and emotions, quality of life, curiosity and exploration, self-efficacy and externality.

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