The Zurich Study

X. Hypomania in a 28- to 30-Year-Old Cohort*

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Summary. Hypomania in a 28- to 30-year-old cohort is described. Data were taken from a prospective longitudinal cohort study from the general population of Zurich, Switzerland. An estimated 1-year prevalence rate of hypomania of 4% was found. Over a period of time hypomania was associated with major depression and dysthymia. We found equal proportions of suicide attempts and equal rates of treated family members among hypomanics and depressives. Furthermore, the previous history of treatment of mild bipolars (hypomania with depression) and unipolar depressives was comparable. The sum of life events, several SCL-90R scores and the scores of distress in relationships were already elevated in hypomanics 7 years before diagnosis of hypomania, indicating an increased activity level, a generalized increase in neuroticism, and a relatively unvarying behaviour pattern in social relationships.

Key words: Hypomania – Epidemiology – Prevalence – Depression – Psychosocial factors

The concept of hypomania

Normal human beings show marked mood fluctuations and obviously there is a continuum from sustained elation to mildly pathological states or traits. This has been frequently maintained in the literature, for instance, by Jung (1904), Schneider (1932), Wertham (1929a, b), and more recently by Kendall (1985). As early as 1910 Reiss had stressed that every distinction between normal and pathological mood is to a certain extent artificial.

The term hypomania in a modern sense was introduced and defined by Mendel (1881) in his monograph on mania in order to designate milder forms of manic disorders. The term was used by Hippocrates, but at that time mania embraced a very broad concept.

During this century a variety of other terms have been used to describe hypomanic states or traits depending on hypothetical aetiologies. In the earlier literature the sanguinic temperament was considered to be an intermediate state between hypomanic and normal personalities (Jung 1904). Jung also stressed that in its original usage the term chronic mania described essentially hypomanic states, a statement confirmed later by Wertham (1929a + b) in his review of chronic mania. In his standard work on chronic mania Nitsche (1910) extensively discussed different terms designating hypomanic states like “sanguinic temperament”, “constitutional mania”, the “constitutional excitement” of Kraepelin and “persisting psychopathic states”. Stransky’s monograph (1911) with a chapter on cyclothymia carefully describes milder forms of hypomania with transition to normal mood states. Cyclothymia was originally conceptualized as a mild subtype of bipolar disorder with constitutional mood changes. This same group was frequently diagnosed as “heboid”, “querulous”, “morally insane” or as “hyperthymic psychopaths” (Blankenburg 1957).

Hypomanic personality traits were extensively described in relatives of manics by Reiss (1910) in his important monograph, and later by Leonhard (1963). The notion of a premorbid “hyperthymic personality” described by Tellenbach (1965) has frequently been used in the context of psychopathy, personality disorder or character descriptions (Buerger-Prinz 1950; Schneider 1932). Recently the “typus manicus” defined as a premorbid character structure of mainly manic bipolars was put forward by von Zerssen (1988). In the terminology of Akiskal et al. (1977) the large group of “subaffective disorders” subsumes cyclothymic and hyperthymic states. Gershon et al. (1975a, b) were the first authors to test the spectrum concept of cyclothymia and bipolar disorder in a genetic model. The spectrum concept of mania and elation was also elaborated by Klerman (1981) for the continuum from normal elation, neurotic elation, hypomania, mania, to delirious mania.

An operational definition for hypomania was not given by DSM-III (American Psychiatric Association 1980),
which allocated this syndrome to a residual category of “atypical bipolar disorder”. DSM-III-R (American Psychiatric Association 1987) defined hypomania in a more precise way. It is important to mention that by definition the disturbance is considered not to be severe enough to cause hospitalization or marked impairment in social or occupational functioning. (These are criteria required for the diagnosis of manic episodes.)

Our own operational definition of hypomania is based on the definition given in the DSM-III-R, but it includes an additional criterion (see section “Diagnostic Assessment: Hypomania”).

Methods

Subjects and Procedure. Our data were derived from four interviews of the longitudinal “Zurich Study”. The Zurich Study began in 1978 with a screening procedure, investigating a representative cohort of 2201 19-year-old men and 2346 20-year-old women from the Canton Zurich in Switzerland. The sample for the prospective study consisted of 591 probands in 1979, with two-thirds of the probands with high scores and one-third with low scores in the SCL-90 (Symptom-Check-List-90-R; Derogatis 1977). These probands were given a semi-structured interview in 1979 and a questionnaire in 1980. They were reinterviewed in 1981, 1986, and in 1988. In 1988, at the third interview, the cohort consisted of 225 males and 232 females who were 27–28 years old. In 1988, when the cohort was 29–30, 197 males and 218 females were reinterviewed. The overall drop-out rate at the third interview in 1986 was 23% and at the fourth interview – 9 years after the first interview – 30%. Sex ratios and ratios of high versus low scorers, according to the screening with the SCL-90, remained stable between 1978 and 1988.

Instruments and Measurements. The semi-structured interviews of 1979 to 1988 included the structured psychopathological interview of the social consequences of mental disorders for epidemiology (SPIKE) (Angst et al. 1984), the SCL-90-R, a modified life event inventory based on Tennant and Andrews (1976, 1977) with additional items from Holmes and Rahe (1967) and various sociological and psychological measures.

In 1988 the Freiburg Personality Inventory (FPI; Fahrenberg et al. 1978) was also used. Data concerning the history of childhood up to the age of 16 years were obtained retrospectively from the interview of 1986. School phobia, behavioural problems, psychiatric treatment, referrals to a school psychologist, and problems with and of parents were assessed.

Conflicts and distress in relationships with parents, partner, friends, and at work were recorded with the help of different direct questions based on items of the Scales of Social Adjustment (SSIAM) by Gurland et al. (1972) and of the Social Adjustment Scale (SAS) by Weissman and Paykel (1974). Conflicts and distress in relationships were assessed at all interviews except in 1988. For the measurements of self-esteem and locus of control, two scales developed by Pearlin and Schooler (1978) were used in 1979, 1981 and 1986.

The subjects’ education and their fathers’ social class were assessed by means of the questionnaire in 1978.

In 1988 the SPIKE interview collected information on 23 clinical syndromes and detailed data on consumption habits. The usual range of psychiatric syndromes was assessed (such as depression, anxiety, panic, phobia, hypomania, suicidal behaviour, obsessive-compulsive or hypochondriacal syndromes), as well as a variety of somatic and psychosomatic syndromes of stomach, intestinal tract, respiratory system, heart and circulation. Additionally, backache, allergies, menstrual and sexual problems were assessed. While most of the syndromes were assessed at all interviews, hypomania was included in the interviews only in 1986 and in 1988.

Diagnostic Assessment of Mood Disorders, Insomnia and Neurasthenia. Mood disorders, insomnia and neurasthenia were assessed in 1979, 1981 and 1988. The diagnoses of DSM-III major depression (MDD) and dysthymia are based on the reported number of depressive symptoms, and on the duration and frequency of episodes during the last 12 months. The diagnosis of recurrent brief depression (RBD) also includes work impairment (Angst et al. 1990).

The diagnoses of panic and general anxiety were also based upon the criteria of the DSM-III (American Psychiatric Association 1980). Additionally, we developed empirical definitions concerning insomnia (Angst et al. 1989), neurasthenia (Angst and Koch, in press) and sporadic panic (Vollrath et al. 1990).

Statistical Analysis. All analyses were conducted using SAS procedures (SAS 1985). For the purpose of the analysis of categorical data chi-squared statistics were computed. As a measure of association between diagnosis we calculated odds ratios and their confidence limits. Continuous data were subjected to the non-parametric Wilcoxon two-sample test. Because of the high number of statistical tests, any significant results should be interpreted with caution.

Diagnostic Assessment of Hypomania. The items concerning hypomania were situated in the middle of the interview after the section on depression. The interviewer started with the three probe questions shown in Table 1. The proband had to assent to the first question and additionally to the second or to the third probe question in order to meet our additional criterion for hypomania. Proband who did not assent to either the second or to the third probe question were excluded from further examination and were thus not considered to be “hypomanic cases”. This criterion was introduced because of the lack of information from external sources to corroborate the occurrence of the hypomanic episode. (The same procedure was used in epidemiological studies to assess alcoholism.) Thus, subjects with the diagnosis of hypomania not only had to experience symptoms of elation, but these symptoms had to be

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<th>Table 1. Hypomania assessment: probe questions</th>
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<td>Role</td>
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<td>1. Were you, during the past 12 months, much more energetic, active, less easily tired, needing less sleep than usual (i.e. talking more, travelling more)?</td>
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<td>2. Was this to the extent that it created difficulties (i.e. for yourself, with others or financially)?</td>
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<td>3. Did others (i.e. family members, partner) observe that something wasn’t as usual so that they thought something might be wrong with you?</td>
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1 By reason of this sampling procedure we weighted the prevalence rates back to the normal population (see Table 3).

2 Further details on methodology and results have previously been described by Angst et al. (1984) and Angst and Dobler-Mikola (1984).

3 The RBD diagnosis requires the same symptoms as major depression (DSM-III). In contrast to MDD, the depressive episodes in RBD last less than 2 weeks, but they recur at least monthly over 1 year and include work impairment.