

Bipolar II Disorder

A plain-English guide for you and your family

WHAT IS HAPPENING

Bipolar II disorder means a person has had both: at least one episode of major depression (two weeks or more of deep low mood, lost interest, trouble sleeping, guilt, and low energy), and at least one hypomanic episode — four or more days in a row of unusually high or irritable mood with extra energy, less need for sleep, fast talking, big confidence, and racing thoughts, noticeable to others but never bad enough to destroy work, cause a hospital stay, or break from reality. The depressions usually take up most of the time and cause the most suffering. If a full manic episode ever happens, the diagnosis changes to bipolar I. Treating it with antidepressants alone can flip the mood upward or make the cycling faster, so mood-stabilizing medicines (like lithium, valproate, lamotrigine, or certain atypical antipsychotics such as quetiapine or lurasidone) come first, and any antidepressant is added carefully on top if needed.

What you might feel

- Hypomanic episodes lasting at least 4 days — feeling unusually happy, irritable, or 'sped up' with more energy than normal
- Needing much less sleep but still feeling full of energy — maybe only 3 hours instead of 8, with no tiredness the next day
- Talking much more or faster than usual, jumping from topic to topic
- Racing thoughts — ideas flying through the mind so fast it's hard to capture or finish one
- Feeling unusually confident or capable — taking on big projects, making grand plans, or feeling certain about skills you normally doubt
- Major depressive episodes lasting at least 2 weeks — deep sadness or losing interest in nearly everything, plus sleep trouble, appetite changes, fatigue, feelings of worthlessness, trouble concentrating, or thoughts of death
- Suicidal thoughts, plans, or urges — especially dangerous when depressive despair mixes with hypomanic energy (a 'mixed state')
- Hypomanic episodes are noticeable to others but do NOT wreck function, cause psychosis, or require hospitalization

- Between episodes, mood and function often return completely to normal — which can delay recognition and treatment

Call the doctor right away if...

- Any history of a full manic episode (lasting a week or more, causing major problems at work or home, including psychosis, or requiring hospitalization) — if found, the diagnosis is bipolar I, not II, and treatment must adjust accordingly.
- Mixed state: depressive despair (hopelessness, self-blame, thoughts of death) combined with hypomanic energy (restlessness, racing thoughts, little need for sleep) — this is the single highest-risk time for suicide. Assess safety today.
- New trouble sleeping, racing thoughts, or irritability after starting an antidepressant alone (without a mood stabilizer on board) — may signal a switch into hypomania or mania. Contact the prescriber immediately.
- Suicidal thoughts, plans, or urges during any depressive episode — bipolar II depression carries equal or higher suicide risk than bipolar I. Always assess and ensure safety.
- Any new rash while taking lamotrigine — stop the medication immediately and contact the prescriber. A severe, life-threatening skin reaction called Stevens-Johnson syndrome can start as a simple rash.
- Four or more mood episodes in a single year (rapid cycling) — requires a change in treatment strategy and often specialist input, as standard regimens may not control the pattern.

What the care team will do

- Screen EVERY depressed patient for lifetime hypomania before antidepressants start
- Take bipolar II depression as seriously as bipolar I — suicide risk is equal or higher
- Guard sleep rhythm and teach it as medicine
- Teach early-warning plans for BOTH poles, and involve family
- Flag antidepressant-without-stabilizer orders in any bipolar-spectrum chart
- Support adherence through the good stretches

Medicines you may be given — and why

Quetiapine (Seroquel) — for the LOW (depressive) side of bipolar II

Blocks dopamine and serotonin receptors in the brain, and its breakdown product also slows the cleanup of norepinephrine (a wake-up brain chemical). This combo lifts the depression without flipping you into a high energy swing.

Lurasidone (Latuda) — for the LOW (depressive) side of bipolar II

Blocks dopamine D2 and serotonin 5-HT_{2A} receptors (calming overactive circuits), and also tickles the 5-HT₇ receptor (which may help mood and thinking). This lifts bipolar depression without piling on as much weight or sugar trouble as older similar drugs.

Lamotrigine (Lamictal) — maintenance to PREVENT the LOW side from coming back

Blocks voltage-gated sodium channels on nerve cells (stopping them from firing too fast) and dials down glutamate release (glutamate is the brain's main 'go!' signal). This steadies mood from below—it raises the floor so depressive crashes are rarer and shallower. It is the #1 maintenance choice in bipolar II because the LOW side is the biggest enemy.

Lithium (Eskalith, Lithobid) — maintenance for BOTH sides, backbone therapy, and the ONLY drug proven to lower suicide risk

Changes the way nerve cells talk inside themselves by tweaking second-messenger systems (the chemical relay inside cells after a signal lands on the outside). It dials down inositol recycling and inhibits an enzyme called GSK-3 β . This narrows the mood swing in BOTH directions—fewer highs, fewer lows—and directly lowers the risk of suicide, which is critical because bipolar II is so depression-heavy.

Antidepressants (SSRIs like sertraline, fluoxetine; or bupropion) — ONLY as add-on, NEVER alone

Blocks the pump that sucks serotonin (SSRIs) or norepinephrine and dopamine (bupropion) back into nerve endings, leaving more of these mood chemicals in the space between nerves. In a brain wired for bipolar disorder, this boost can tip you into a hypomanic swing or speed up cycling if used without a mood stabilizer underneath.

Where this information comes from

- American Psychiatric Association DSM-5-TR (2022)
- CANMAT and International Society for Bipolar Disorders (ISBD) 2018 guidelines for bipolar disorder management
- FDA prescribing information for quetiapine, lurasidone, and lamotrigine
- Judd et al., Archives of General Psychiatry — longitudinal course and burden of bipolar II disorder

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