

Hypomania

Same circuit as mania, turned up halfway: the person keeps working and stays out of the hospital, but the mood, sleep, and spending have clearly changed.

THE ONE-LINE TRUTH

Hypomania is a lasting 'too-high' mood that doesn't wreck daily life — and it's the clue that unmasks Bipolar II.

The chain — how it unfolds

1. Elevated dopamine and norepinephrine tone raises drive, confidence, and speech speed — why: The ventral striatum (the reward circuit deep in the brain) fires more easily, so every idea feels excellent and worth starting right now. Norepinephrine cranks up alertness, so thoughts race and words tumble out fast.
2. Sleep need drops for 4 or more days in a row — why: The suprachiasmatic nucleus (the brain's sleep-wake timer in the hypothalamus) is destabilized by the high norepinephrine and dopamine — and every short night pushes the mood a step higher, because sleep loss itself boosts arousal.
3. Spending, plans, and social contact increase — why: Warm reward circuit plus softened (not absent) prefrontal braking bends judgment toward optimism and risk. The person sees opportunity everywhere, says yes to invitations, buys things on impulse, and starts projects without weighing the cost.
4. The episode resolves — or escalates — why: Left alone it usually settles within days to weeks as neurotransmitter tone drifts back to baseline. But stimulants (caffeine, ADHD meds, cocaine), alcohol, shift work, or an antidepressant taken alone (without a mood stabilizer) can push the same circuit into full mania.
5. Depression follows — why: Bipolar II depression is where most of the illness — and most of the suicide risk — actually lives. After the high burns out, dopamine and norepinephrine tone often crash below baseline, and the person sinks into weeks or months of low mood, no energy, and dark thoughts. The hypomanic episode is the diagnostic key that tells the doctor this isn't simple depression — it's Bipolar II, and antidepressants alone can make it worse.

Spot it — what you see, and why

- Sleeping much less but not feeling tired: Norepinephrine (a brain chemical that keeps you alert and awake) is running higher than usual, so it blocks the normal signal that tells your body it needs rest. The brain feels charged and ready even after only four or five hours of sleep, like a battery that thinks it is still full when it should be halfway drained.
- Talking much more and much faster than usual: The brain is making thoughts faster than normal, and the prefrontal cortex (the front part of the brain that usually slows you down and helps you take turns in conversation) is not putting the brakes on as strongly. Words spill out quickly because the thinking engine is revved up.
- Feeling unusually confident and optimistic: Dopamine (the brain's reward messenger) is more active, so it stamps more ideas and plans with a 'this is great' feeling than it normally would. The person feels certain that things will work out, even plans that might seem risky or unrealistic. This confidence stays short of the fixed, unshakeable grandiose beliefs you see in full mania.
- Starting many new projects, spending more money, reaching out to more people: The brain's reward circuit—centered in the nucleus accumbens and ventral tegmental area (deep centers that drive motivation and pleasure)—is turned up, so every goal feels exciting and urgent. The person throws energy into new hobbies, shopping, travel plans, or social events because the brain is tagging all of them as high-priority and rewarding.
- Getting irritated or snappy when things do not go as planned: The sped-up system does not tolerate waiting or obstacles well. Some people feel euphoric during hypomania, but others run irritable instead—short-tempered, impatient, easily frustrated. This irritable mood is just as real a sign of hypomania as the happy, energized mood, and it is often mistaken for stress or anxiety instead of recognized as part of the mood episode.
- Racing thoughts or jumping quickly from idea to idea: The flow of thoughts speeds up because dopamine and norepinephrine are both elevated. Ideas arrive faster than the person can finish one, so the mind feels crowded and jumpy. This is different from the distractibility of ADHD because it comes in clear episodes and pairs with the other mood and energy changes of hypomania.

Red flags — act now

- Psychotic symptoms—seeing, hearing, or believing things that are not real—mean this is mania, not hypomania, and the person needs same-day psychiatric evaluation and medication adjustment
- Mood climbing higher despite efforts to protect sleep, or sleep dropping below three hours a night—the episode is escalating toward full mania

- Any suicidal thoughts or plans—people with Bipolar II face their highest suicide risk during depressive episodes and the switches between moods, so any suicidal thinking requires immediate safety assessment
- The person is taking an antidepressant without a mood stabilizer—antidepressants alone can flip a person with bipolar disorder into hypomania or mania, so the medication plan needs urgent review
- Reckless behavior the person cannot undo—spending large amounts of money they do not have, dangerous driving, risky sexual decisions—that causes real harm and cannot be walked back means the episode has crossed into impairing mania

Treat it — in this order

1. Stop any antidepressant the person is taking without a mood stabilizer → Antidepressants (like sertraline, escitalopram, bupropion) alone can shove the mood upward in someone with bipolar wiring. Stopping it removes the push and prevents hypomania from climbing into full mania.
2. Start a mood stabilizer: lithium (if the course is classic highs and lows), or lamotrigine (if depression is the bigger problem) → Lithium calms the manic circuit and is the only mood medicine proven to lower suicide risk. Lamotrigine stops the slide into depression and prevents future lows, though it does little for active highs. Both keep the mood from swinging too far in either direction.
3. Use quetiapine when the episode needs faster control, sleep is broken, or depression and hypomania mix → Quetiapine blocks dopamine (a brain chemical that revs up pleasure and energy) and histamine (a wake signal), so it calms hypomanic symptoms, treats bipolar depression, and restores sleep within days. Sleep is the brake pedal—once it is back, the mood usually stops climbing.
4. Protect sleep with a fixed sleep and wake time every day (social rhythm therapy) → The brain's circadian clock (the internal 24-hour timer run by the suprachiasmatic nucleus in the hypothalamus) sets mood stability. When sleep shifts—staying up late, sleeping in, or skipping nights—the clock loses its rhythm and the mood circuit destabilizes. A steady schedule is not just advice; it is a real treatment that prevents future episodes.
5. Teach the person and their family the early warning signs to catch the next episode early → Most people have a personal pattern—sleeping less (down to 4 or 5 hours without feeling tired), talking faster, spending money in new ways, starting big projects, or feeling 'amazing' after weeks of being low. Writing these signs down while well creates a smoke alarm. When two or three signs show up, the person or family calls early, before the episode is full-blown.

Your top priorities at the bedside

1. Screen every 'depression' patient for past hypomanic episodes before antidepressants start — why: One missed 4-day episode rewrites the diagnosis to Bipolar II and makes antidepressant monotherapy unsafe.
2. Anchor and protect sleep — document actual hours, not just 'slept well' — why: Sleep is both the earliest warning sign and the most powerful non-drug treatment lever.
3. Bring family or collateral into the history whenever possible — why: The person often feels great and under-reports; observers supply the diagnostic evidence DSM requires.