Comorbidity

Co-occurring mental disorders are the norm in bipolar I disorder, with the majority of individuals having a history of three or more disorders. The most frequently comorbid disorders are anxiety disorders, alcohol use disorder, other substance use disorder, and attention-deficit/hyperactivity disorder. Sociocultural factors influence the pattern of comorbid conditions in bipolar disorder. For example, countries with cultural prohibitions against alcohol or other substance use may have a lower prevalence of substance use comorbidity. Bipolar I disorder is frequently associated with borderline, schizotypal, and antisocial personality disorder. In particular, although the underlying nature of the relationship between bipolar I disorder and borderline personality disorder is unclear, the substantial comorbidity between the two may reflect similarities in phenomenology (i.e., misdiagnosing the emotional extremes of borderline personality disorder as bipolar I disorder), the influence of borderline personality features on vulnerability to bipolar I disorder, and the impact of early childhood adversity on the development of both bipolar I and borderline personality disorder.

Individuals with bipolar I disorder also have high rates of serious co-occurring and often untreated medical conditions, which largely explain the shortened life expectancy of those with bipolar disorder. Comorbidities appear in multiple organ systems, with cardiovascular and autoimmune diseases, obstructive sleep apnea, metabolic syndrome, and migraine more common among individuals with bipolar disorder than in the general population. Comorbid overweight/obesity is a particular concern for individuals with bipolar disorder and is associated with poor treatment outcomes.

Bipolar II Disorder

Diagnostic Criteria F31.81

For a diagnosis of bipolar II disorder, it is necessary to meet the following criteria for a current or past hypomanic episode *and* the following criteria for a current or past major depressive episode:

Hypomanic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 4 consecutive days and present most of the day, nearly every day.

B. During the period of mood disturbance and increased energy and activity, three (or more) of the following symptoms have persisted (four if the mood is only irritable), represent a noticeable change from usual behavior, and have been present to a significant degree:

1. Inflated self-esteem or grandiosity.
2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
3. More talkative than usual or pressure to keep talking.
4. Flight of ideas or subjective experience that thoughts are racing.

5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.
7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.

D. The disturbance in mood and the change in functioning are observable by others.

E. The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic.

F. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or another medical condition.

Note: A full hypomanic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a hypomanic episode diagnosis. However, caution is indicated so that one or two symptoms (particularly increased irritability, edginess, or agitation following antidepressant use) are not taken as sufficient for diagnosis of a hypomanic episode, nor necessarily indicative of a bipolar diathesis.

Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly attributable to a medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, or hopeless) or observation made by others (e.g., appears tearful). (**Note:** In children and adolescents, can be irritable mood.)
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (**Note:** In children, consider failure to make expected weight

gain.)

4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or another medical condition.

Note: Criteria A–C constitute a major depressive episode.

Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.[1]

Bipolar II Disorder

A. Criteria have been met for at least one hypomanic episode (Criteria A–F under "Hypomanic Episode" above) and at least one major depressive episode (Criteria A–C under "Major Depressive Episode" above).

B. There has never been a manic episode.

C. At least one hypomanic episode and at least one major depressive episode are not better explained by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

D. The symptoms of depression or the unpredictability caused by frequent alternation between periods of depression and hypomania causes clinically significant distress or impairment in social, occupational, or other important

areas of functioning.

Coding and Recording Procedures

Bipolar II disorder has one diagnostic code: F31.81. Its status with respect to current severity, presence of psychotic features, course, and other specifiers cannot be coded but should be indicated in writing (e.g., F31.81 bipolar II disorder, current episode depressed, moderate severity, with mixed features; F31.81 bipolar II disorder, most recent episode depressed, in partial remission).

Specify current or most recent episode:

Hypomanic

Depressed

If current episode is **hypomanic** (or most recent episode if bipolar II disorder is in partial or full remission):

In recording the diagnosis, terms should be listed in the following order: bipolar II disorder, current or most recent episode hypomanic, in partial remission/in full remission (p. 175) (if full criteria for a hypomanic episode are not currently met), plus any of the following hypomanic episode specifiers that are applicable. **Note:** The specifiers “with rapid cycling” and “with seasonal pattern” describe the pattern of mood episodes.

Specify if:

With anxious distress (p. 169–170)

With mixed features (pp. 170–171)

With rapid cycling (p. 171)

With peripartum onset (pp. 173–174)

With seasonal pattern (pp. 174–175)

If current episode is **depressed** (or most recent episode if bipolar II disorder is in partial or full remission):

In recording the diagnosis, terms should be listed in the following order: bipolar II disorder, current or most recent episode depressed, mild/moderate/severe (if full criteria for a major depressive episode are currently met), in partial remission/in full remission (if full criteria for a major depressive episode are not currently met) (p. 175), plus any of the following major depressive episode specifiers that are applicable. **Note:** The specifiers “with rapid cycling” and “with seasonal pattern” describe the pattern of mood episodes.

Specify if:

With anxious distress (pp. 169–170)

With mixed features (pp. 170–171)

With rapid cycling (p. 171)

With melancholic features (pp. 171–172)

With atypical features (pp. 172–173)
With mood-congruent psychotic features (p. 173)
With mood-incongruent psychotic features (p. 173)
With catatonia (p. 173). **Coding note:** Use additional code F06.1.
With peripartum onset (pp. 172–174)
With seasonal pattern (pp. 174–175)
Specify course if full criteria for a mood episode are not currently met:
In partial remission (p. 175)
In full remission (p. 175)
Specify severity if full criteria for a major depressive episode are currently met:
Mild (p. 175)
Moderate (p. 175)
Severe (p. 175)

Diagnostic Features

Bipolar II disorder is characterized by a clinical course of recurring mood episodes consisting of one or more major depressive episodes (Criteria A–C under "Major Depressive Episode") and at least one hypomanic episode (Criteria A–F under "Hypomanic Episode"). A diagnosis of a major depressive episode requires that there be a period of depressed mood, or as an alternative, marked diminished interest or pleasure, for most of the day nearly every day, lasting for a minimum of 2 weeks. The depressed mood or loss of interest must be accompanied by additional symptoms occurring nearly every day (e.g., sleep disturbance, psychomotor agitation or retardation) for a total of at least five symptoms. The diagnosis of a hypomanic episode requires that there be a distinct period of

abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy for most of the day, nearly every day, for at least 4 consecutive days accompanied by three (or four if mood is only irritable) additional symptoms (e.g., inflated self-esteem, decreased need for sleep, distractibility) that persist and represent a noticeable change from usual behavior and functioning. By definition, psychotic symptoms do not occur in hypomanic episodes, and they appear to be less frequent in the major depressive episodes in bipolar II disorder than in those of bipolar I disorder. The presence of a manic episode during the course of illness precludes the diagnosis of bipolar II disorder (Criterion B under "Bipolar II Disorder"). Moreover, for depressive and hypomanic episodes to count toward the diagnosis of bipolar II disorder, at least one of the depressive episodes and at least one of the hypomanic episodes must not be attributable to the physiological effects of a substance (i.e., medication, drug of abuse, or toxin exposure) or another medical condition. Note that hypomanic episodes that emerge during antidepressant treatment and persist for at least 4 days at a fully syndromal level beyond the physiological effects of the treatment are not considered to be

substance-induced and do count toward the diagnosis of bipolar II disorder. In addition, at least one hypomanic episode and at least one major depressive episode are not explained by a diagnosis of schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum or other psychotic disorder (Criterion C under "Bipolar II Disorder"). The depressive episodes or the pattern of unpredictable mood changes must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion D under "Bipolar II Disorder"). The recurrent major depressive episodes are often more frequent and lengthier than those occurring in bipolar I disorder.

Individuals with bipolar II disorder typically present to a clinician during a major depressive episode. They are unlikely to complain initially of hypomania, because either they do not recognize the symptoms of hypomania or they consider hypomania desirable. Hypomanic episodes by definition do not cause significant impairment. Instead, the impairment results from the major depressive episodes or from a persistent pattern of unpredictable mood changes and fluctuating, unreliable interpersonal or occupational functioning. Individuals with bipolar II disorder may not view the hypomanic episodes as pathological or disadvantageous, although others may be troubled by the individual's erratic behavior. Clinical information from other informants, such as close friends or relatives, is often useful in establishing the diagnosis of bipolar II disorder.

A hypomanic episode should not be confused with the several days of euthymia and restored energy or activity that may follow remission of a major depressive episode. Despite the substantial differences in duration and severity between a manic and hypomanic episode, bipolar II disorder is not a "milder form" of bipolar I disorder. Compared to individuals with bipolar I disorder, individuals with bipolar II disorder have greater chronicity of illness and spend, on average, more time in the depressive phase of their illness, which can be severe and/or disabling.

Although the diagnostic requirements for major depressive episodes are identical whether they occur in the context of bipolar II disorder or major depressive disorder, certain clinical features of the episodes may hint at possible differential diagnosis. For instance, the coexistence of both insomnia and hypersomnia is not uncommon in major depressive episodes in both bipolar II disorder and major depressive disorder; however, both insomnia and hypersomnia are overrepresented among women with bipolar II disorder. Similarly, atypical depressive symptoms (hypersomnia, hyperphagia) are common in both disorders, but more so in those with bipolar II disorder.

Depressive symptoms co-occurring with a hypomanic episode or hypomanic symptoms co-occurring with a depressive episode are common in individuals with bipolar II disorder and are overrepresented in females, particularly hypomania with mixed features.

Individuals experiencing hypomania with mixed features may not label their symptoms as hypomania, but instead experience them as depression with increased energy or irritability.

Associated Features

A common feature of bipolar II disorder is impulsivity, which can contribute to suicide attempts