Bipolar II Disorder

Code: 296.89 (F31.81)

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Diagnostic Criteria 296.89 (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.
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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 or other treatment).
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, 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.
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Note: Criteria A–C above 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. The occurrence of the hypomanic episode(s) and major depressive episode(s) is not better explained by schizoaffective disorder, 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: 296.89 (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., 296.89 [F31.81] bipolar II disorder, current episode depressed, moderate severity, with mixed features; 296.89 [F31.81] bipolar II disorder, most recent episode depressed, in partial remission).
Specify current or most recent episode:
Hypomanic
Depressed
Specify if:
With anxious distress (p. 149)
With mixed features (pp. 149–150)
1In distinguishing grief from a major depressive episode (MDE), it is useful to consider that in grief the predominant affect is feelings of emptiness and loss, while in a MDE it is persistent depressed mood and the inability to anticipate happiness or pleasure. The dysphoria in grief is likely to decrease in intensity over days to weeks and occurs in waves, the so-called pangs of grief. These waves tend to be associated with thoughts or reminders of the deceased. The depressed mood of a MDE is more persistent and not tied to specific thoughts or preoccupations. The pain of grief may be accompanied by positive emotions and humor that are uncharacteristic of the pervasive unhappiness and misery characteristic of a MDE. The thought content associated with grief generally features a preoccupation with thoughts and memories of the deceased, rather than the self-critical or pessimistic ruminations seen in a MDE. In grief, self-esteem is generally preserved, whereas in a MDE feelings of worthlessness and self-loathing are common. If self-derogatory ideation is present in grief, it typically involves perceived failings vis-à-vis the deceased (e.g., not visiting frequently enough, not telling the deceased how much he or she was loved). If a bereaved individual thinks about death and dying, such thoughts are generally focused on the deceased and possibly about "joining" the deceased, whereas in a MDE such thoughts are focused on ending one's own life because of feeling worthless, undeserving of life, or unable to cope with the pain of depression.
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With rapid cycling (pp. 150–151)
With mood-congruent psychotic features (p. 152)
With mood-incongruent psychotic features (p. 152)
With catatonia (p. 152). Coding note: Use additional code 293.89 (F06.1).
With peripartum onset (pp. 152–153)
With seasonal pattern (pp. 153–154): Applies only to the pattern of major depressive episodes.
Specify course if full criteria for a mood episode are not currently met:
In partial remission (p. 154)
In full remission (p. 154)
Specify severity if full criteria for a mood episode are currently met:
Mild (p. 154)
Moderate (p. 154)
Severe (p. 154)

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"). The major depressive episode must last at least 2 weeks, and the hypomanic episode must last at least 4 days, to meet the diagnostic criteria. During the mood episode(s), the requisite number of symptoms must be present most of the day, nearly every day, and represent a noticeable change from usual behavior and functioning. The presence of a manic episode during the course of illness precludes the diagnosis of bipolar II disorder (Criterion B under "Bipolar II Disorder"). Episodes of substance/medication-induced depressive disorder or substance/medication-induced bipolar and related disorder (representing the physiological effects of a medication, other somatic treatments for depression, drugs of abuse, or toxin exposure) or of depressive and related disorder due to another medical condition or bipolar and related disorder due to another medical condition do not count toward a diagnosis of bipolar II disorder unless they persist beyond the physiological effects of the treatment or substance and then meet duration criteria for an episode. In addition, the episodes must not be better accounted for by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum or other psychotic disorders (Criterion C under "Bipolar II Disorder"). The depressive episodes or hypomanic fluctuations must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion D under "Bipolar II Disorder"); however, for hypomanic episodes, this requirement does not have to be met. A hypomanic episode that causes significant impairment would likely qualify for the diagnosis of manic episode and, therefore, for a lifetime diagnosis of bipolar I 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 and are unlikely to complain initially of hypomania. Typically, the hypomanic episodes themselves do not cause 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.
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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 with 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. 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 Supporting Diagnosis

A common feature of bipolar II disorder is impulsivity, which can contribute to suicide attempts and substance use disorders. Impulsivity may also stem from a concurrent personality disorder, substance use disorder, anxiety disorder, another mental disorder, or a medical condition. There may be heightened levels of creativity in some individuals with a bipolar disorder. However, that relationship may be nonlinear; that is, greater lifetime creative accomplishments have been associated with milder forms of bipolar disorder, and higher creativity has been found in unaffected family members. The individual's attachment to heightened creativity during hypomanic episodes may contribute to ambivalence about seeking treatment or undermine adherence to treatment.

Prevalence

The 12-month prevalence of bipolar II disorder, internationally, is 0.3%. In the United States, 12-month prevalence is 0.8%. The prevalence rate of pediatric bipolar II disorder is difficult to establish. DSM-IV bipolar I, bipolar II, and bipolar disorder not otherwise specified yield a combined prevalence rate of 1.8% in U.S. and non-U.S. community samples, with higher rates (2.7% inclusive) in youths age 12 years or older.

Development and Course

Although bipolar II disorder can begin in late adolescence and throughout adulthood, average age at onset is the mid-20s, which is slightly later than for bipolar I disorder but earlier than for major depressive disorder. The illness most often begins with a depressive episode and is not recognized as bipolar II disorder until a hypomanic episode occurs; this happens in about 12% of individuals with the initial diagnosis of major depressive disorder. Anxiety, substance use, or eating disorders may also precede the diagnosis, complicating its detection. Many individuals experience several episodes of major depression prior to the first recognized hypomanic episode.
The number of lifetime episodes (both hypomanic and major depressive episodes) tends to be higher for bipolar II disorder than for major depressive disorder or bipolar I disorder. However, individuals with bipolar I disorder are actually more likely to experience hypomanic symptoms than are individuals with bipolar II disorder.The interval between mood episodes in the course of bipolar II disorder tends to decrease as the individual ages. While the hypomanic episode is the feature that defines bipolar II disorder, depressive episodes are more enduring and disabling over time. Despite the predominance of depression, once a hypomanic episode has occurred, the diagnosis becomes bipolar II disorder and never reverts to major depressive disorder.
Approximately 5%–15% of individuals with bipolar II disorder have multiple (four or more) mood episodes (hypomanic or major depressive) within the previous 12 months. If
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this pattern is present, it is noted by the specifier "with rapid cycling." 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. Switching from a depressive episode to a manic or hypomanic episode (with or without mixed features) may occur, both spontaneously and during treatment for depression. About 5%–15% of individuals with bipolar II disorder will ultimately develop a manic episode, which changes the diagnosis to bipolar I disorder, regardless of subsequent course. Making the diagnosis in children is often a challenge, especially in those with irritability and hyperarousal that is nonepisodic (i.e., lacks the well-demarcated periods of altered mood). Nonepisodic irritability in youth is associated with an elevated risk for anxiety disorders and major depressive disorder, but not bipolar disorder, in adulthood. Persistently irritable youths have lower familial rates of bipolar disorder than do youths who have bipolar disorder. For a hypomanic episode to be diagnosed, the child's symptoms must exceed what is expected in a given environment and culture for the child's developmental stage. Compared with adult onset of bipolar II disorder, childhood or adolescent onset of the disorder may be associated with a more severe lifetime course. The 3-year incidence rate of first-onset bipolar II disorder in adults older than 60 years is 0.34%. However, distinguishing individuals older than 60 years with bipolar II disorder by late versus early age at onset does not appear to have any clinical utility.

Risk and Prognostic Factors

Genetic and physiological. The risk of bipolar II disorder tends to be highest among relatives of individuals with bipolar II disorder, as opposed to individuals with bipolar I disorder or major depressive disorder. There may be genetic factors influencing the age at onset for bipolar disorders.