symptoms of ADHD, such as rapid speech, racing thoughts, distractibility, and less need for sleep, overlap with the symptoms of hypomania. The double counting of symptoms toward both ADHD and bipolar II disorder can be avoided if the clinician clarifies whether the symptoms represent a distinct episode and if the noticeable increase over baseline required for the diagnosis of bipolar II disorder is present.

Personality disorders. The same convention as applies for ADHD also applies when evaluating an individual for a personality disorder such as borderline personality disorder, since mood lability and impulsivity are common in both personality disorders and bipolar II disorder. Symptoms must represent a distinct episode, and the noticeable increase over baseline required for the diagnosis of bipolar II disorder must be present. A diagnosis of a personality disorder should not be made during an untreated mood episode unless the lifetime history supports the presence of a personality disorder.

Other bipolar disorders. Diagnosis of bipolar II disorder should be differentiated from bipolar I disorder by carefully considering whether there have been any past episodes of mania and from other specified and unspecified bipolar and related disorders by confirming the presence of fully syndromal hypomania and depression.

Comorbidity

Bipolar II disorder is more often than not associated with one or more co-occurring mental disorders, with anxiety disorders being the most common. Approximately 60% of individuals with bipolar II disorder have three or more co-occurring mental disorders; 75% have an anxiety disorder; and 37% have a substance use disorder. Children and adolescents with bipolar II disorder have a higher rate of co-occurring anxiety disorders compared with those with bipolar I disorder, and the anxiety disorder most often predates the bipolar disorder. Anxiety and substance use disorders occur in individuals with bipolar II disorder at a higher rate than in the general population. Approximately 14% of individuals with bipolar II disorder have at least one lifetime eating disorder, with binge-eating disorder being more common than bulimia nervosa and anorexia nervosa.

These commonly co-occurring disorders do not seem to follow a course of illness that is truly independent from that of the bipolar disorder, but rather have strong associations with mood states. For example, anxiety and eating disorders tend to associate most with depressive symptoms, and substance use disorders are moderately associated with manic symptoms.

Cyclothymic Disorder

Diagnostic Criteria **301.13 (F34.0)**

A. For at least 2 years (at least 1 year in children and adolescents) there have been numerous periods with hypomanic symptoms that do not meet criteria for a hypomanic episode and numerous periods with depressive symptoms that do not meet criteria for a major depressive episode.

B. During the above 2-year period (1 year in children and adolescents), the hypomanic and depressive periods have been present for at least half the time and the individual has not been without the symptoms for more than 2 months at a time.

C. Criteria for a major depressive, manic, or hypomanic episode have never been met.

D. The symptoms in Criterion A are not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

E. The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).

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

Specify if:

With anxious distress (see p. 149)

Diagnostic Features

The essential feature of cyclothymic disorder is a chronic, fluctuating mood disturbance involving numerous periods of hypomanic symptoms and periods of depressive symptoms that are distinct from each other (Criterion A). The hypomanic symptoms are of insufficient number, severity, pervasiveness, or duration to meet full criteria for a hypomanic episode, and the depressive symptoms are of insufficient number, severity, pervasiveness, or duration to meet full criteria for a major depressive episode. During the initial 2-year period (1 year for children or adolescents), the symptoms must be persistent (present more days than not), and any symptom-free intervals last no longer than 2 months (Criterion B). The diagnosis of cyclothymic disorder is made only if the criteria for a major depressive, manic, or hypomanic episode have never been met (Criterion C).

If an individual with cyclothymic disorder subsequently (i.e., after the initial 2 years in adults or 1 year in children or adolescents) experiences a major depressive, manic, or hypomanic episode, the diagnosis changes to major depressive disorder, bipolar I disorder, or other specified or unspecified bipolar and related disorder (subclassified as hypomanic episode without prior major depressive episode), respectively, and the cyclothymic disorder diagnosis is dropped.

The cyclothymic disorder diagnosis is not made if the pattern of mood swings is better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders (Criterion D), in which case the mood symptoms are considered associated features of the psychotic disorder. The mood disturbance must also not be attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism) (Criterion E). Although some individuals may function particularly well during some of the periods of hypomania, over the prolonged course of the disorder, there must be clinically significant distress or impairment in social, occupational, or other important areas of functioning as a result of the mood disturbance (Criterion F). The impairment may develop as a result of prolonged periods of cyclical, often unpredictable mood changes (e.g., the individual may be regarded as temperamental, moody, unpredictable, inconsistent, or unreliable).

Prevalence

The lifetime prevalence of cyclothymic disorder is approximately 0.4%–1%. Prevalence in mood disorders clinics may range from 3% to 5%. In the general population, cyclothymic disorder is apparently equally common in males and females. In clinical settings, females with cyclothymic disorder may be more likely to present for treatment than males.

Development and Course

Cyclothymic disorder usually begins in adolescence or early adult life and is sometimes considered to reflect a temperamental predisposition to other disorders in this chapter. Cyclothymic disorder usually has an insidious onset and a persistent course. There is a 15%–50% risk that an individual with cyclothymic disorder will subsequently develop bipolar I disorder or bipolar II disorder. Onset of persistent, fluctuating hypomanic and depressive symptoms late in adult life needs to be clearly differentiated from bipolar and

related disorder due to another medical condition and depressive disorder due to another medical condition (e.g., multiple sclerosis) before the cyclothymic disorder diagnosis is assigned. Among children with cyclothymic disorder, the mean age at onset of symptoms is 6.5 years of age.

Risk and Prognostic Factors

Genetic and physiological. Major depressive disorder, bipolar I disorder, and bipolar II disorder are more common among first-degree biological relatives of individuals with cyclothymic disorder than in the general population. There may also be an increased familial risk of substance-related disorders. Cyclothymic disorder may be more common in the first-degree biological relatives of individuals with bipolar I disorder than in the general population.

Differential Diagnosis

Bipolar and related disorder due to another medical condition and depressive disorder due to another medical condition. The diagnosis of bipolar and related disorder due to another medical condition or depressive disorder due to another medical condition is made when the mood disturbance is judged to be attributable to the physiological effect of a specific, usually chronic medical condition (e.g., hyperthyroidism). This determination is based on the history, physical examination, or laboratory findings. If it is judged that the hypomanic and depressive symptoms are not the physiological consequence of the medical condition, then the primary mental disorder (i.e., cyclothymic disorder) and the medical condition are coded. For example, this would be the case if the mood symptoms are considered to be the psychological (not the physiological) consequence of having a chronic medical condition, or if there is no etiological relationship between the hypomanic and depressive symptoms and the medical condition.

Substance/medication-induced bipolar and related disorder and substance/medication-induced depressive disorder. Substance/medication-induced bipolar and related disorder and substance/medication-induced depressive disorder are distinguished from cyclothymic disorder by the judgment that a substance/medication (especially stimulants) is etiologically related to the mood disturbance. The frequent mood swings in these disorders that are suggestive of cyclothymic disorder usually resolve following cessation of substance/medication use.

Bipolar I disorder, with rapid cycling, and bipolar II disorder, with rapid cycling. Both disorders may resemble cyclothymic disorder by virtue of the frequent marked shifts in mood. By definition, in cyclothymic disorder the criteria for a major depressive, manic, or hypomanic episode has never been met, whereas the bipolar I disorder and bipolar II disorder specifier "with rapid cycling" requires that full mood episodes be present.

Borderline personality disorder. Borderline personality disorder is associated with marked shifts in mood that may suggest cyclothymic disorder. If the criteria are met for both disorders, both borderline personality disorder and cyclothymic disorder may be diagnosed.

Comorbidity

Substance-related disorders and sleep disorders (i.e., difficulties in initiating and maintaining sleep) may be present in individuals with cyclothymic disorder. Most children with cyclothymic disorder treated in outpatient psychiatric settings have comorbid mental conditions; they are more likely than other pediatric patients with mental disorders to have comorbid attention-deficit/hyperactivity disorder.

Substance/Medication-Induced Bipolar and Related Disorder

Diagnostic Criteria

A. A prominent and persistent disturbance in mood that predominates in the clinical picture and is characterized by elevated, expansive, or irritable mood, with or without depressed mood, or markedly diminished interest or pleasure in all, or almost all, activities.

B. There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):

   1. The symptoms in Criterion A developed during or soon after substance intoxication or withdrawal or after exposure to a medication.
   2. The involved substance/medication is capable of producing the symptoms in Criterion A.

C. The disturbance is not better explained by a bipolar or related disorder that is not substance/medication-induced. Such evidence of an independent bipolar or related disorder could include the following:

   The symptoms precede the onset of the substance/medication use; the symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication; or there is other evidence suggesting the existence of an independent non-substance/medication-induced bipolar and related disorder (e.g., a history of recurrent non-substance/medication-related episodes).

D. The disturbance does not occur exclusively during the course of a delirium.

E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Coding note: The ICD-9-CM and ICD-10-CM codes for the [specific substance/medication]-induced bipolar and related disorders are indicated in the table below. Note that the ICD-10-CM code depends on whether or not there is a comorbid substance use disorder present for the same class of substance. If a mild substance use disorder is comorbid with the substance-induced bipolar and related disorder, the 4th position character is "1," and the clinician should record "mild [substance] use disorder" before the substance-induced bipolar and related disorder (e.g., "mild cocaine use disorder with cocaine-induced bipolar and related disorder"). If a moderate or severe substance use disorder is comorbid with the substance-induced bipolar and related disorder, the 4th position character is "2," and the clinician should record "moderate [substance] use disorder" or "severe [substance] use disorder," depending on the severity of the comorbid substance use disorder. If there is no comorbid substance use disorder (e.g., after a one-time heavy use of the substance), then the 4th position character is "9," and the clinician should record only the substance-induced bipolar and related disorder.

		ICD-10-CM		
	ICD-9-CM	With use disorder, mild	With use disorder, moderate or severe	Without use disorder
Alcohol	291.89	F10.14	F10.24	F10.94
Phencyclidine	292.84	F16.14	F16.24	F16.94
Other hallucinogen	292.84	F16.14	F16.24	F16.94

		ICD-10-CM		
	ICD-9-CM	With use disorder, mild	With use disorder, moderate or severe	Without use disorder
Sedative, hypnotic, or anxiolytic	292.84	F13.14	F13.24	F13.94
Amphetamine (or other stimulant)	292.84	F15.14	F15.24	F15.94
Cocaine	292.84	F14.14	F14.24	F14.94
Other (or unknown) substance	292.84	F19.14	F19.24	F19.94

Specify if (see Table 1 in the chapter "Substance-Related and Addictive Disorders" for diagnoses associated with substance class):

With onset during intoxication: If the criteria are met for intoxication with the substance and the symptoms develop during intoxication.

With onset during withdrawal: If criteria are met for withdrawal from the substance and the symptoms develop during, or shortly after, withdrawal.

Recording Procedures

ICD-9-CM. The name of the substance/medication-induced bipolar and related disorder begins with the specific substance (e.g., cocaine, dexamethasone) that is presumed to be causing the bipolar mood symptoms. The diagnostic code is selected from the table included in the criteria set, which is based on the drug class. For substances that do not fit into any of the classes (e.g., dexamethasone), the code for "other substance" should be used; and in cases in which a substance is judged to be an etiological factor but the specific class of substance is unknown, the category "unknown substance" should be used.

The name of the disorder is followed by the specification of onset (i.e., onset during intoxication, onset during withdrawal). Unlike the recording procedures for ICD-10-CM, which combine the substance-induced disorder and substance use disorder into a single code, for ICD-9-CM a separate diagnostic code is given for the substance use disorder. For example, in the case of irritable symptoms occurring during intoxication in a man with a severe cocaine use disorder, the diagnosis is 292.84 cocaine-induced bipolar and related disorder, with onset during intoxication. An additional diagnosis of 304.20 severe cocaine use disorder is also given. When more than one substance is judged to play a significant role in the development of bipolar mood symptoms, each should be listed separately (e.g., 292.84 methylphenidate-induced bipolar and related disorder, with onset during intoxication; 292.84 dexamethasone-induced bipolar and related disorder, with onset during intoxication).

ICD-10-CM. The name of the substance/medication-induced bipolar and related disorder begins with the specific substance (e.g., cocaine, dexamethasone) that is presumed to be causing the bipolar mood symptoms. The diagnostic code is selected from the table included in the criteria set, which is based on the drug class and presence or absence of a comorbid substance use disorder. For substances that do not fit into any of the classes (e.g., dexamethasone), the code for "other substance" should be used; and in cases in which a substance is judged to be an etiological factor but the specific class of substance is unknown, the category "unknown substance" should be used.

When recording the name of the disorder, the comorbid substance use disorder (if any) is listed first, followed by the word "with," followed by the name of the substance-induced

bipolar and related disorder, followed by the specification of onset (i.e., onset during intoxication, onset during withdrawal). For example, in the case of irritable symptoms occurring during intoxication in a man with a severe cocaine use disorder, the diagnosis is F14.24 severe cocaine use disorder with cocaine-induced bipolar and related disorder, with onset during intoxication. A separate diagnosis of the comorbid severe cocaine use disorder is not given. If the substance-induced bipolar and related disorder occurs without a comorbid substance use disorder (e.g., after a one-time heavy use of the substance), no accompanying substance use disorder is noted (e.g., F15.94 amphetamine-induced bipolar and related disorder, with onset during intoxication). When more than one substance is judged to play a significant role in the development of bipolar mood symptoms, each should be listed separately (e.g., F15.24 severe methylphenidate use disorder with methylphenidate-induced bipolar and related disorder, with onset during intoxication; F19.94 dexamethasone-induced bipolar and related disorder, with onset during intoxication).

Diagnostic Features

The diagnostic features of substance/medication-induced bipolar and related disorder are essentially the same as those for mania, hypomania, or depression. A key exception to the diagnosis of substance/medication-induced bipolar and related disorder is the case of hypomania or mania that occurs after antidepressant medication use or other treatments and persists beyond the physiological effects of the medication. This condition is considered an indicator of true bipolar disorder, not substance/medication-induced bipolar and related disorder. Similarly, individuals with apparent electroconvulsive therapy–induced manic or hypomanic episodes that persist beyond the physiological effects of the treatment are diagnosed with bipolar disorder, not substance/medication-induced bipolar and related disorder.

Side effects of some antidepressants and other psychotropic drugs (e.g., edginess, agitation) may resemble the primary symptoms of a manic syndrome, but they are fundamentally distinct from bipolar symptoms and are insufficient for the diagnosis. That is, the criterion symptoms of mania/hypomania have specificity (simple agitation is not the same as excess involvement in purposeful activities), and a sufficient number of symptoms must be present (not just one or two symptoms) to make these diagnoses. In particular, the appearance of one or two nonspecific symptoms—irritability, edginess, or agitation during antidepressant treatment—in the absence of a full manic or hypomanic syndrome should not be taken to support a diagnosis of a bipolar disorder.

Associated Features Supporting Diagnosis

Etiology (causally related to the use of psychotropic medications or substances of abuse based on best clinical evidence) is the key variable in this etiologically specified form of bipolar disorder. Substances/medications that are typically considered to be associated with substance/medication-induced bipolar and related disorder include the stimulant class of drugs, as well as phencyclidine and steroids; however, a number of potential substances continue to emerge as new compounds are synthesized (e.g., so-called bath salts). A history of such substance use may help increase diagnostic certainty.

Prevalence

There are no epidemiological studies of substance/medication-induced mania or bipolar disorder. Each etiological substance may have its own individual risk of inducing a bipolar (manic/hypomanic) disorder.

Development and Course

In phencyclidine-induced mania, the initial presentation may be one of a delirium with affective features, which then becomes an atypically appearing manic or mixed manic state.

This condition follows the ingestion or inhalation quickly, usually within hours or, at the most, a few days. In stimulant-induced manic or hypomanic states, the response is in minutes to 1 hour after one or several ingestions or injections. The episode is very brief and typically resolves over 1–2 days. With corticosteroids and some immunosuppressant medications, the mania (or mixed or depressed state) usually follows several days of ingestion, and the higher doses appear to have a much greater likelihood of producing bipolar symptoms.

Diagnostic Markers

Determination of the substance of use can be made through markers in the blood or urine to corroborate diagnosis.

Differential Diagnosis

Substance/medication-induced bipolar and related disorder should be differentiated from other bipolar disorders, substance intoxication or substance-induced delirium, and medication side effects (as noted earlier). A full manic 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 bipolar I diagnosis. 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 bipolar II diagnosis only if preceded by a major depressive episode.

Comorbidity

Comorbidities are those associated with the use of illicit substances (in the case of illegal stimulants or phencyclidine) or diversion of prescribed stimulants. Comorbidities related to steroid or immunosuppressant medications are those medical indications for these preparations. Delirium can occur before or along with manic symptoms in individuals ingesting phencyclidine or those who are prescribed steroid medications or other immunosuppressant medications.

Bipolar and Related Disorder Due to Another Medical Condition

Diagnostic Criteria

A. A prominent and persistent period of abnormally elevated, expansive, or irritable mood and abnormally increased activity or energy that predominates in the clinical picture.
B. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct pathophysiological consequence of another medical condition.
C. The disturbance is not better explained by another mental disorder.
D. The disturbance does not occur exclusively during the course of a delirium.
E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning, or necessitates hospitalization to prevent harm to self or others, or there are psychotic features.

Coding note: The ICD-9-CM code for bipolar and related disorder due to another medical condition is **293.83,** which is assigned regardless of the specifier. The ICD-10-CM code depends on the specifier (see below).

Specify if:

(F06.33) With manic features: Full criteria are not met for a manic or hypomanic episode.

(F06.33) With manic- or hypomanic-like episode: Full criteria are met except Criterion D for a manic episode or except Criterion F for a hypomanic episode.

(F06.34) With mixed features: Symptoms of depression are also present but do not predominate in the clinical picture.

Coding note: Include the name of the other medical condition in the name of the mental disorder (e.g., 293.83 [F06.33] bipolar disorder due to hyperthyroidism, with manic features). The other medical condition should also be coded and listed separately immediately before the bipolar and related disorder due to the medical condition (e.g., 242.90 [E05.90] hyperthyroidism; 293.83 [F06.33] bipolar disorder due to hyperthyroidism, with manic features).

Diagnostic Features

The essential features of bipolar and related disorder due to another medical condition are presence of a prominent and persistent period of abnormally elevated, expansive, or irritable mood and abnormally increased activity or energy predominating in the clinical picture that is attributable to another medical condition (Criterion B). In most cases the manic or hypomanic picture may appear during the initial presentation of the medical condition (i.e., within 1 month); however, there are exceptions, especially in chronic medical conditions that might worsen or relapse and herald the appearance of the manic or hypomanic picture. Bipolar and related disorder due to another medical condition would not be diagnosed when the manic or hypomanic episodes definitely preceded the medical condition, since the proper diagnosis would be bipolar disorder (except in the unusual circumstance in which all preceding manic or hypomanic episodes—or, when only one such episode has occurred, the preceding manic or hypomanic episode—were associated with ingestion of a substance/medication). The diagnosis of bipolar and related disorder due to another medical condition should not be made during the course of a delirium (Criterion D). The manic or hypomanic episode in bipolar and related disorder due to another medical condition must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning to qualify for this diagnosis (Criterion E).

Associated Features Supporting Diagnosis

Etiology (i.e., a causal relationship to another medical condition based on best clinical evidence) is the key variable in this etiologically specified form of bipolar disorder. The listing of medical conditions that are said to be able to induce mania is never complete, and the clinician's best judgment is the essence of this diagnosis. Among the best known of the medical conditions that can cause a bipolar manic or hypomanic condition are Cushing's disease and multiple sclerosis, as well as stroke and traumatic brain injuries.

Development and Course

Bipolar and related disorder due to another medical condition usually has its onset acutely or subacutely within the first weeks or month of the onset of the associated medical condition. However, this is not always the case, as a worsening or later relapse of the associated medical condition may precede the onset of the manic or hypomanic syndrome. The clinician must make a clinical judgment in these situations about whether the medical condition is causative, based on temporal sequence as well as plausibility of a causal relation-

ship. Finally, the condition may remit before or just after the medical condition remits, particularly when treatment of the manic/hypomanic symptoms is effective.

Culture-Related Diagnostic Issues

Culture-related differences, to the extent that there is any evidence, pertain to those associated with the medical condition (e.g., rates of multiple sclerosis and stroke vary around the world based on dietary, genetic factors, and other environmental factors).

Gender-Related Diagnostic Issues

Gender differences pertain to those associated with the medical condition (e.g., systemic lupus erythematosus is more common in females; stroke is somewhat more common in middle-age males compared with females).

Diagnostic Markers

Diagnostic markers pertain to those associated with the medical condition (e.g., steroid levels in blood or urine to help corroborate the diagnosis of Cushing's disease, which can be associated with manic or depressive syndromes; laboratory tests confirming the diagnosis of multiple sclerosis).

Functional Consequences of Bipolar and Related Disorder Due to Another Medical Condition

Functional consequences of the bipolar symptoms may exacerbate impairments associated with the medical condition and may incur worse outcomes due to interference with medical treatment. In general, it is believed, but not established, that the illness, when induced by Cushing's disease, will not recur if the Cushing's disease is cured or arrested. However, it is also suggested, but not established, that mood syndromes, including depressive and manic/hypomanic ones, may be episodic (i.e., recurring) with static brain injuries and other central nervous system diseases.

Differential Diagnosis

Symptoms of delirium, catatonia, and acute anxiety. It is important to differentiate symptoms of mania from excited or hypervigilant delirious symptoms; from excited catatonic symptoms; and from agitation related to acute anxiety states.

Medication-induced depressive or manic symptoms. An important differential diagnostic observation is that the other medical condition may be treated with medications (e.g., steroids or alpha-interferon) that can induce depressive or manic symptoms. In these cases, clinical judgment using all of the evidence in hand is the best way to try to separate the most likely and/or the most important of two etiological factors (i.e., association with the medical condition vs. a substance/medication-induced syndrome). The differential diagnosis of the associated medical conditions is relevant but largely beyond the scope of the present manual.

Comorbidity

Conditions comorbid with bipolar and related disorder due to another medical condition are those associated with the medical conditions of etiological relevance. Delirium can occur before or along with manic symptoms in individuals with Cushing's disease.

Other Specified Bipolar and Related Disorder

296.89 (F31.89)

This category applies to presentations in which symptoms characteristic of a bipolar and related disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the bipolar and related disorders diagnostic class. The other specified bipolar and related disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific bipolar and related disorder. This is done by recording "other specified bipolar and related disorder" followed by the specific reason (e.g., "short-duration cyclothymia").

Examples of presentations that can be specified using the "other specified" designation include the following:

1. **Short-duration hypomanic episodes (2–3 days) and major depressive episodes:** A lifetime history of one or more major depressive episodes in individuals whose presentation has never met full criteria for a manic or hypomanic episode but who have experienced two or more episodes of short-duration hypomania that meet the full symptomatic criteria for a hypomanic episode but that only last for 2–3 days. The episodes of hypomanic symptoms do not overlap in time with the major depressive episodes, so the disturbance does not meet criteria for major depressive episode, with mixed features.
2. **Hypomanic episodes with insufficient symptoms and major depressive episodes:** A lifetime history of one or more major depressive episodes in individuals whose presentation has never met full criteria for a manic or hypomanic episode but who have experienced one or more episodes of hypomania that do not meet full symptomatic criteria (i.e., at least 4 consecutive days of elevated mood and one or two of the other symptoms of a hypomanic episode, or irritable mood and two or three of the other symptoms of a hypomanic episode). The episodes of hypomanic symptoms do not overlap in time with the major depressive episodes, so the disturbance does not meet criteria for major depressive episode, with mixed features.
3. **Hypomanic episode without prior major depressive episode:** One or more hypomanic episodes in an individual whose presentation has never met full criteria for a major depressive episode or a manic episode. If this occurs in an individual with an established diagnosis of persistent depressive disorder (dysthymia), both diagnoses can be concurrently applied during the periods when the full criteria for a hypomanic episode are met.
4. **Short-duration cyclothymia (less than 24 months):** Multiple episodes of hypomanic symptoms that do not meet criteria for a hypomanic episode and multiple episodes of depressive symptoms that do not meet criteria for a major depressive episode that persist over a period of less than 24 months (less than 12 months for children or adolescents) in an individual whose presentation has never met full criteria for a major depressive, manic, or hypomanic episode and does not meet criteria for any psychotic disorder. During the course of the disorder, the hypomanic or depressive symptoms are present for more days than not, the individual has not been without symptoms for more than 2 months at a time, and the symptoms cause clinically significant distress or impairment.

Unspecified Bipolar and Related Disorder

296.80 (F31.9)

This category applies to presentations in which symptoms characteristic of a bipolar and related disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the bipolar and related disorders diagnostic class. The unspecified bipolar and related disorder category is used in situations in which the clinician chooses *not* to specify the reason that the criteria are not met for a specific bipolar and related disorder, and includes presentations in which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings).

Specifiers for Bipolar and Related Disorders

Specify if:

With anxious distress: The presence of at least two of the following symptoms during the majority of days of the current or most recent episode of mania, hypomania, or depression:

1. Feeling keyed up or tense.
2. Feeling unusually restless.
3. Difficulty concentrating because of worry.
4. Fear that something awful may happen.
5. Feeling that the individual might lose control of himself or herself.

Specify current severity:

Mild: Two symptoms.

Moderate: Three symptoms.

Moderate-severe: Four or five symptoms.

Severe: Four or five symptoms with motor agitation.

Note: Anxious distress has been noted as a prominent feature of both bipolar and major depressive disorder in both primary care and specialty mental health settings. High levels of anxiety have been associated with higher suicide risk, longer duration of illness, and greater likelihood of treatment nonresponse. As a result, it is clinically useful to specify accurately the presence and severity levels of anxious distress for treatment planning and monitoring of response to treatment.

With mixed features: The mixed features specifier can apply to the current manic, hypomanic, or depressive episode in bipolar I or bipolar II disorder:

Manic or hypomanic episode, with mixed features:

A. Full criteria are met for a manic episode or hypomanic episode, and at least three of the following symptoms are present during the majority of days of the current or most recent episode of mania or hypomania:

   1. Prominent dysphoria or depressed mood as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful).
   2. Diminished interest or pleasure in all, or almost all, activities (as indicated by either subjective account or observation made by others).
   3. Psychomotor retardation nearly every day (observable by others; not merely subjective feelings of being slowed down).