neously. Some individuals write excessive letters, e-mails, text messages, and so forth, on many different topics to friends, public figures, or the media.

The increased activity criterion can be difficult to ascertain in children; however, when the child takes on many tasks simultaneously, starts devising elaborate and unrealistic plans for projects, develops previously absent and developmentally inappropriate sexual preoccupations (not accounted for by sexual abuse or exposure to sexually explicit material), then Criterion B might be met based on clinical judgment. It is essential to determine whether the behavior represents a change from the child's baseline behavior; occurs most of the day, nearly every day for the requisite time period; and occurs in temporal association with other symptoms of mania.

The expansive mood, excessive optimism, grandiosity, and poor judgment often lead to reckless involvement in activities such as spending sprees, giving away possessions, reckless driving, foolish business investments, and sexual promiscuity that is unusual for the individual, even though these activities are likely to have catastrophic consequences (Criterion B7). The individual may purchase many unneeded items without the money to pay for them and, in some cases, give them away. Sexual behavior may include infidelity or indiscriminate sexual encounters with strangers, often disregarding the risk of sexually transmitted diseases or interpersonal consequences.

The manic episode must result in marked impairment in social or occupational functioning or require hospitalization to prevent harm to self or others (e.g., financial losses, illegal activities, loss of employment, self-injurious behavior). By definition, the presence of psychotic features during a manic episode also satisfies Criterion C.

Manic symptoms or syndromes that are attributable to the physiological effects of a drug of abuse (e.g., in the context of cocaine or amphetamine intoxication), the side effects of medications or treatments (e.g., steroids, L-dopa, antidepressants, stimulants), or another medical condition do not count toward the diagnosis of bipolar I disorder. However, a fully syndromal manic episode that arises during treatment (e.g., with medications, electroconvulsive therapy, light therapy) or drug use and persists beyond the physiological effect of the inducing agent (i.e., after a medication is fully out of the individual's system or the effects of electroconvulsive therapy would be expected to have dissipated completely) is sufficient evidence for a manic episode diagnosis (Criterion D). 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 manic or hypomanic episode, nor necessarily an indication of a bipolar disorder diathesis. It is necessary to meet criteria for a manic episode to make a diagnosis of bipolar I disorder, but it is not required to have hypomanic or major depressive episodes. However, they may precede or follow a manic episode. Full descriptions of the diagnostic features of a hypomanic episode may be found within the text for bipolar II disorder, and the features of a major depressive episode are described within the text for major depressive disorder.

Associated Features Supporting Diagnosis

During a manic episode, individuals often do not perceive that they are ill or in need of treatment and vehemently resist efforts to be treated. Individuals may change their dress, makeup, or personal appearance to a more sexually suggestive or flamboyant style. Some perceive a sharper sense of smell, hearing, or vision. Gambling and antisocial behaviors may accompany the manic episode. Some individuals may become hostile and physically threatening to others and, when delusional, may become physically assaultive or suicidal. Catastrophic consequences of a manic episode (e.g., involuntary hospitalization, difficulties with the law, serious financial difficulties) often result from poor judgment, loss of insight, and hyperactivity.

Mood may shift very rapidly to anger or depression. Depressive symptoms may occur during a manic episode and, if present, may last moments, hours, or, more rarely, days (see "with mixed features" specifier, pp. 149–150).

Prevalence

The 12-month prevalence estimate in the continental United States was 0.6% for bipolar I disorder as defined in DSM-IV. Twelve-month prevalence of bipolar I disorder across 11 countries ranged from 0.0% to 0.6%. The lifetime male-to-female prevalence ratio is approximately 1.1:1.

Development and Course

Mean age at onset of the first manic, hypomanic, or major depressive episode is approximately 18 years for bipolar I disorder. Special considerations are necessary to detect the diagnosis in children. Since children of the same chronological age may be at different developmental stages, it is difficult to define with precision what is "normal" or "expected" at any given point. Therefore, each child should be judged according to his or her own baseline. Onset occurs throughout the life cycle, including first onsets in the 60s or 70s. Onset of manic symptoms (e.g., sexual or social disinhibition) in late mid-life or late-life should prompt consideration of medical conditions (e.g., frontotemporal neurocognitive disorder) and of substance ingestion or withdrawal.

More than 90% of individuals who have a single manic episode go on to have recurrent mood episodes. Approximately 60% of manic episodes occur immediately before a major depressive episode. Individuals with bipolar I disorder who have multiple (four or more) mood episodes (major depressive, manic, or hypomanic) within 1 year receive the specifier "with rapid cycling."

Risk and Prognostic Factors

Environmental. Bipolar disorder is more common in high-income than in low-income countries (1.4 vs. 0.7%). Separated, divorced, or widowed individuals have higher rates of bipolar I disorder than do individuals who are married or have never been married, but the direction of the association is unclear.

Genetic and physiological. A family history of bipolar disorder is one of the strongest and most consistent risk factors for bipolar disorders. There is an average 10-fold increased risk among adult relatives of individuals with bipolar I and bipolar II disorders. Magnitude of risk increases with degree of kinship. Schizophrenia and bipolar disorder likely share a genetic origin, reflected in familial co-aggregation of schizophrenia and bipolar disorder.

Course modifiers. After an individual has a manic episode with psychotic features, subsequent manic episodes are more likely to include psychotic features. Incomplete interepisode recovery is more common when the current episode is accompanied by mood-incongruent psychotic features.

Culture-Related Diagnostic Issues

Little information exists on specific cultural differences in the expression of bipolar I disorder. One possible explanation for this may be that diagnostic instruments are often translated and applied in different cultures with no transcultural validation. In one U.S. study, 12-month prevalence of bipolar I disorder was significantly lower for Afro-Caribbeans than for African Americans or whites.

Gender-Related Diagnostic Issues

Females are more likely to experience rapid cycling and mixed states, and to have patterns of comorbidity that differ from those of males, including higher rates of lifetime eating disorders. Females with bipolar I or II disorder are more likely to experience depressive symptoms than males. They also have a higher lifetime risk of alcohol use disorder than are males and a much greater likelihood of alcohol use disorder than do females in the general population.

Suicide Risk

The lifetime risk of suicide in individuals with bipolar disorder is estimated to be at least 15 times that of the general population. In fact, bipolar disorder may account for one-quarter of all completed suicides. A past history of suicide attempt and percent days spent depressed in the past year are associated with greater risk of suicide attempts or completions.

Functional Consequences of Bipoiar I Disorder

Although many individuals with bipolar disorder return to a fully functional level between episodes, approximately 30% show severe impairment in work role function. Functional recovery lags substantially behind recovery from symptoms, especially with respect to occupational recovery, resulting in lower socioeconomic status despite equivalent levels of education when compared with the general population. Individuals with bipolar I disorder perform more poorly than healthy individuals on cognitive tests. Cognitive impairments may contribute to vocational and interpersonal difficulties and persist through the lifespan, even during euthymic periods.

Differential Diagnosis

Major depressive disorder. Major depressive disorder may also be accompanied by hypomanic or manic symptoms (i.e., fewer symptoms or for a shorter duration than required for mania or hypomania). When the individual presents in an episode of major depression, one must depend on corroborating history regarding past episodes of mania or hypomania. Symptoms of irritability may be associated with either major depressive disorder or bipolar disorder, adding to diagnostic complexity.

Other bipolar disorders. Diagnosis of bipolar I disorder is differentiated from bipolar II disorder by determining whether there have been any past episodes of mania. Other specified and unspecified bipolar and related disorders should be differentiated from bipolar I and II disorders by considering whether either the episodes involving manic or hypomanic symptoms or the episodes of depressive symptoms fail to meet the full criteria for those conditions.

Bipolar disorder due to another medical condition may be distinguished from bipolar I and II disorders by identifying, based on best clinical evidence, a causally related medical condition.

Generalized anxiety disorder, panic disorder, posttraumatic stress disorder, or other anxiety disorders. These disorders need to be considered in the differential diagnosis as either the primary disorder or, in some cases, a comorbid disorder. A careful history of symptoms is needed to differentiate generalized anxiety disorder from bipolar disorder, as anxious ruminations may be mistaken for racing thoughts, and efforts to minimize anxious feelings may be taken as impulsive behavior. Similarly, symptoms of posttraumatic stress disorder need to be differentiated from bipolar disorder. It is helpful to assess the episodic nature of the symptoms described, as well as to consider symptom triggers, in making this differential diagnosis.

Substance/medication-induced bipolar disorder. Substance use disorders may manifest with substance.medication-induced manic symptoms that must be distinguished from bipolar I disorder; response to mood stabilizers during a substance/medication-induced mania may not necessarily be diagnostic for bipolar disorder. There may be substantial overlap in view of the tendency for individuals with bipolar I disorder to overuse substances during an episode. A primary diagnosis of bipolar disorder must be established based on symptoms that remain once substances are no longer being used.

Attention-deficit/hyperactivity disorder. This disorder may be misdiagnosed as bipolar disorder, especially in adolescents and children. Many symptoms overlap with the symp-

toms of mania, such as rapid speech, racing thoughts, distractibility, and less need for sleep. The "double counting" of symptoms toward both ADHD and bipolar disorder can be avoided if the clinician clarifies whether the symptom(s) represents a distinct episode.

Personality disorders. Personality disorders such as borderline personality disorder may have substantial symptomatic overlap with bipolar disorders, since mood lability and impulsivity are common in both conditions. Symptoms must represent a distinct episode, and the noticeable increase over baseline required for the diagnosis of bipolar disorder must be present. A diagnosis of a personality disorder should not be made during an untreated mood episode.

Disorders with prominent irritability. In individuals with severe irritability, particularly children and adolescents, care must be taken to apply the diagnosis of bipolar disorder only to those who have had a clear episode of mania or hypomania—that is, a distinct time period, of the required duration, during which the irritability was clearly different from the individual's baseline and was accompanied by the onset of Criterion B symptoms. When a child's irritability is persistent and particularly severe, the diagnosis of disruptive mood dysregulation disorder would be more appropriate. Indeed, when any child is being assessed for mania, it is essential that the symptoms represent a clear change from the child's typical behavior.

Comorbidity

Co-occurring mental disorders are common, with the most frequent disorders being any anxiety disorder (e.g., panic attacks, social anxiety disorder [social phobia], specific phobia), occurring in approximately three-fourths of individuals; ADHD, any disruptive, impulse-control, or conduct disorder (e.g., intermittent explosive disorder, oppositional defiant disorder, conduct disorder), and any substance use disorder (e.g., alcohol use disorder) occur in over half of individuals with bipolar I disorder. Adults with bipolar I disorder have high rates of serious and/or untreated co-occurring medical conditions. Metabolic syndrome and migraine are more common among individuals with bipolar disorder than in the general population. More than half of individuals whose symptoms meet criteria for bipolar disorder have an alcohol use disorder, and those with both disorders are at greater risk for suicide attempt.

Bipolar II Disorder

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.

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.

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)

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[1] In 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.

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.

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.

Prevaience

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.

Deveiopment 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

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.

Course modifiers. A rapid-cycling pattern is associated with a poorer prognosis. Return to previous level of social function for individuals with bipolar II disorder is more likely for individuals of younger age and with less severe depression, suggesting adverse effects of prolonged illness on recovery. More education, fewer years of illness, and being married are independently associated with functional recovery in individuals with bipolar disorder, even after diagnostic type (I vs. II), current depressive symptoms, and presence of psychiatric comorbidity are taken into account.

Gender-Related Diagnostic Issues

Whereas the gender ratio for bipolar I disorder is equal, findings on gender differences in bipolar II disorder are mixed, differing by type of sample (i.e., registry, community, or clinical) and country of origin. There is little to no evidence of bipolar gender differences, whereas some, but not all, clinical samples suggest that bipolar II disorder is more common in females than in males, which may reflect gender differences in treatment seeking or other factors.

Patterns of illness and comorbidity, however, seem to differ by gender, with females being more likely than males to report hypomania with mixed depressive features and a rapid-cycling course. Childbirth may be a specific trigger for a hypomanic episode, which can occur in 10%–20% of females in nonclinical populations and most typically in the early postpartum period. Distinguishing hypomania from the elated mood and reduced sleep that normally accompany the birth of a child may be challenging. Postpartum hypomania may foreshadow the onset of a depression that occurs in about half of females who experience postpartum "highs." Accurate detection of bipolar II disorder may help in establishing appropriate treatment of the depression, which may reduce the risk of suicide and infanticide.

Suicide Risk

Suicide risk is high in bipolar II disorder. Approximately one-third of individuals with bipolar II disorder report a lifetime history of suicide attempt. The prevalence rates of lifetime attempted suicide in bipolar II and bipolar I disorder appear to be similar (32.4% and 36.3%, respectively). However, the lethality of attempts, as defined by a lower ratio of attempts to completed suicides, may be higher in individuals with bipolar II disorder compared with individuals with bipolar I disorder. There may be an association between genetic markers and increased risk for suicidal behavior in individuals with bipolar disorder, including a 6.5-fold higher risk of suicide among first-degree relatives of bipolar II probands compared with those with bipolar I disorder.

Functional Consequences of Bipolar II Disorder

Although many individuals with bipolar II disorder return to a fully functional level between mood episodes, at least 15% continue to have some inter-episode dysfunction, and 20% transition directly into another mood episode without inter-episode recovery. Functional recovery lags substantially behind recovery from symptoms of bipolar II disorder, especially in regard to occupational recovery, resulting in lower socioeconomic status despite equivalent levels of education with the general population. Individuals with bipolar II disorder perform more poorly than healthy individuals on cognitive tests and, with the exception of memory and semantic fluency, have similar cognitive impairment as do individuals with bipolar I disorder. Cognitive impairments associated with bipolar II disorder may contribute to vocational difficulties. Prolonged unemployment in individuals with bipolar disorder is associated with more episodes of depression, older age, increased rates of current panic disorder, and lifetime history of alcohol use disorder.

Differential Diagnosis

Major depressive disorder. Perhaps the most challenging differential diagnosis to consider is major depressive disorder, which may be accompanied by hypomanic or manic symptoms that do not meet full criteria (i.e., either fewer symptoms or a shorter duration than required for a hypomanic episode). This is especially true in evaluating individuals with symptoms of irritability, which may be associated with either major depressive disorder or bipolar II disorder.

Cyclothymic disorder. In cyclothymic disorder, there are numerous periods of hypomanic symptoms and numerous periods of depressive symptoms that do not meet symptom or duration criteria for a major depressive episode. Bipolar II disorder is distinguished from cyclothymic disorder by the presence of one or more major depressive episodes. If a major depressive episode occurs after the first 2 years of cyclothymic disorder, the additional diagnosis of bipolar II disorder is given.

Schizophrenia spectrum and other related psychotic disorders. Bipolar II disorder must be distinguished from psychotic disorders (e.g., schizoaffective disorder, schizophrenia, and delusional disorder). Schizophrenia, schizoaffective disorder, and delusional disorder are all characterized by periods of psychotic symptoms that occur in the absence of prominent mood symptoms. Other helpful considerations include the accompanying symptoms, previous course, and family history.

Panic disorder or other anxiety disorders. Anxiety disorders need to be considered in the differential diagnosis and may frequently be present as co-occurring disorders.

Substance use disorders. Substance use disorders are included in the differential diagnosis.

Attention-deficit/hyperactivity disorder. Attention-deficit/hyperactivity disorder (ADHD) may be misdiagnosed as bipolar II disorder, especially in adolescents and children. Many

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).

Prevaience

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.

Differentiai 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.

Differentiai 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).

4. Fatigue or loss of energy.
5. Feelings of worthlessness or excessive or inappropriate guilt (not merely self-reproach or guilt about being sick).
6. 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. Mixed symptoms are observable by others and represent a change from the person's usual behavior.
C. For individuals whose symptoms meet full episode criteria for both mania and depression simultaneously, the diagnosis should be manic episode, with mixed features, due to the marked impairment and clinical severity of full mania.
D. The mixed symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment).

Depressive episode, with mixed features:

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

1. Elevated, expansive mood.
2. Inflated self-esteem or grandiosity.
3. More talkative than usual or pressure to keep talking.
4. Flight of ideas or subjective experience that thoughts are racing.
5. Increase in energy or goal-directed activity (either socially, at work or school, or sexually).
6. Increased or 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).
7. Decreased need for sleep (feeling rested despite sleeping less than usual; to be contrasted with insomnia).

B. Mixed symptoms are observable by others and represent a change from the person's usual behavior.
C. For individuals whose symptoms meet full episode criteria for both mania and depression simultaneously, the diagnosis should be manic episode, with mixed features.
D. The mixed symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment).

Note: Mixed features associated with a major depressive episode have been found to be a significant risk factor for the development of bipolar I or bipolar II disorder. As a result, it is clinically useful to note the presence of this specifier for treatment planning and monitoring of response to treatment.

With rapid cycling (can be applied to bipolar I or bipolar II disorder): Presence of at least four mood episodes in the previous 12 months that meet the criteria for manic, hypomanic, or major depressive episode.

Note: Episodes are demarcated by either partial or full remissions of at least 2 months or a switch to an episode of the opposite polarity (e.g., major depressive episode to manic episode).

Note: The essential feature of a rapid-cycling bipolar disorder is the occurrence of at least four mood episodes during the previous 12 months. These episodes can occur in any combination and order. The episodes must meet both the duration and

symptom number criteria for a major depressive, manic, or hypomanic episode and must be demarcated by either a period of full remission or a switch to an episode of the opposite polarity. Manic and hypomanic episodes are counted as being on the same pole. Except for the fact that they occur more frequently, the episodes that occur in a rapid-cycling pattern are no different from those that occur in a non-rapid-cycling pattern. Mood episodes that count toward defining a rapid-cycling pattern exclude those episodes directly caused by a substance (e.g., cocaine, corticosteroids) or another medical condition.

With melancholic features:

A. One of the following is present during the most severe period of the current episode:
   1. Loss of pleasure in all, or almost all, activities.
   2. Lack of reactivity to usually pleasurable stimuli (does not feel much better, even temporarily, when something good happens).

B. Three (or more) of the following:
   1. A distinct quality of depressed mood characterized by profound despondency, despair, and/or moroseness or by so-called empty mood.
   2. Depression that is regularly worse in the morning.
   3. Early-morning awakening (i.e., at least 2 hours before usual awakening).
   4. Marked psychomotor agitation or retardation.
   5. Significant anorexia or weight loss.
   6. Excessive or inappropriate guilt.

Note: The specifier "with melancholic features" is applied if these features are present at the most severe stage of the episode. There is a near-complete absence of the capacity for pleasure, not merely a diminution. A guideline for evaluating the lack of reactivity of mood is that even highly desired events are not associated with marked brightening of mood. Either mood does not brighten at all, or it brightens only partially (e.g., up to 20%–40% of normal for only minutes at a time). The "distinct quality" of mood that is characteristic of the "with melancholic features" specifier is experienced as qualitatively different from that during a nonmelancholic depressive episode. A depressed mood that is described as merely more severe, longer lasting, or present without a reason is not considered distinct in quality. Psychomotor changes are nearly always present and are observable by others.

Melancholic features exhibit only a modest tendency to repeat across episodes in the same individual. They are more frequent in inpatients, as opposed to outpatients; are less likely to occur in milder than in more severe major depressive episodes; and are more likely to occur in those with psychotic features.

With atypical features: This specifier can be applied when these features predominate during the majority of days of the current or most recent major depressive episode.

A. Mood reactivity (i.e., mood brightens in response to actual or potential positive events).

B. Two (or more) of the following features:
   1. Significant weight gain or increase in appetite.
   2. Hypersomnia.
   3. Leaden paralysis (i.e., heavy, leaden feelings in arms or legs).
   4. A long-standing pattern of interpersonal rejection sensitivity (not limited to episodes of mood disturbance) that results in significant social or occupational impairment.

C. Criteria are not met for "with melancholic features" or "with catatonia" during the same episode.

Note: "Atypical depression" has historical significance (i.e., atypical in contradistinction to the more classical agitated, "endogenous" presentations of depression that were the norm when depression was rarely diagnosed in outpatients and almost never in adolescents or younger adults) and today does not connote an uncommon or unusual clinical presentation as the term might imply.

Mood reactivity is the capacity to be cheered up when presented with positive events (e.g., a visit from children, compliments from others). Mood may become euthymic (not sad) even for extended periods of time if the external circumstances remain favorable. Increased appetite may be manifested by an obvious increase in food intake or by weight gain. Hypersomnia may include either an extended period of nighttime sleep or daytime napping that totals at least 10 hours of sleep per day (or at least 2 hours more than when not depressed). Leaden paralysis is defined as feeling heavy, leaden, or weighted down, usually in the arms or legs. This sensation is generally present for at least an hour a day but often lasts for many hours at a time. Unlike the other atypical features, pathological sensitivity to perceived interpersonal rejection is a trait that has an early onset and persists throughout most of adult life. Rejection sensitivity occurs both when the person is and is not depressed, though it may be exacerbated during depressive periods.

With psychotic features: Delusions or hallucinations are present at any time in the episode. If psychotic features are present, specify if mood-congruent or mood-incongruent:

With mood-congruent psychotic features: During manic episodes, the content of all delusions and hallucinations is consistent with the typical manic themes of grandiosity, invulnerability, etc., but may also include themes of suspiciousness or paranoia, especially with respect to others' doubts about the individual's capacities, accomplishments, and so forth.

With mood-incongruent psychotic features: The content of delusions and hallucinations is inconsistent with the episode polarity themes as described above, or the content is a mixture of mood-incongruent and mood-congruent themes.

With catatonia: This specifier can apply to an episode of mania or depression if catatonic features are present during most of the episode. See criteria for catatonia associated with a mental disorder in the chapter "Schizophrenia Spectrum and Other Psychotic Disorders."

With peripartum onset: This specifier can be applied to the current or, if the full criteria are not currently met for a mood episode, most recent episode of mania, hypomania, or major depression in bipolar I or bipolar II disorder if onset of mood symptoms occurs during pregnancy or in the 4 weeks following delivery.

Note: Mood episodes can have their onset either during pregnancy or postpartum. Although the estimates differ according to the period of follow-up after delivery, between 3% and 6% of women will experience the onset of a major depressive episode during pregnancy or in the weeks or months following delivery. Fifty percent of "postpartum" major depressive episodes actually begin prior to delivery. Thus, these episodes are referred to collectively as *peripartum* episodes. Women with peripartum major depressive episodes often have severe anxiety and even panic attacks. Prospective studies have demonstrated that mood and anxiety symptoms during pregnancy, as well as the "baby blues," increase the risk for a postpartum major depressive episode.

Peripartum-onset mood episodes can present either with or without psychotic features. Infanticide is most often associated with postpartum psychotic episodes that are characterized by command hallucinations to kill the infant or delusions that the infant is possessed, but psychotic symptoms can also occur in severe postpartum mood episodes without such specific delusions or hallucinations.

Postpartum mood (major depressive or manic) episodes with psychotic features appear to occur in from 1 in 500 to 1 in 1,000 deliveries and may be more common in primiparous women. The risk of postpartum episodes with psychotic features is particularly increased for women with prior postpartum mood episodes but is also elevated for those with a prior history of a depressive or bipolar disorder (especially bipolar I disorder) and those with a family history of bipolar disorders.

Once a woman has had a postpartum episode with psychotic features, the risk of recurrence with each subsequent delivery is between 30% and 50%. Postpartum episodes must be differentiated from delirium occurring in the postpartum period, which is distinguished by a fluctuating level of awareness or attention. The postpartum period is unique with respect to the degree of neuroendocrine alterations and psychosocial adjustments, the potential impact of breast-feeding on treatment planning, and the long-term implications of a history of postpartum mood disorder on subsequent family planning.

With seasonal pattern: This specifier applies to the lifetime pattern of mood episodes. The essential feature is a regular seasonal pattern of at least one type of episode (i.e., mania, hypomania, or depression). The other types of episodes may not follow this pattern. For example, an individual may have seasonal manias, but his or her depressions do not regularly occur at a specific time of year.

A. There has been a regular temporal relationship between the onset of manic, hypomanic, or major depressive episodes and a particular time of the year (e.g., in the fall or winter) in bipolar I or bipolar II disorder.

   Note: Do not include cases in which there is an obvious effect of seasonally related psychosocial stressors (e.g., regularly being unemployed every winter).

B. Full remissions (or a change from major depression to mania or hypomania or vice versa) also occur at a characteristic time of the year (e.g., depression disappears in the spring).

C. In the last 2 years, the individual's manic, hypomanic, or major depressive episodes have demonstrated a temporal seasonal relationship, as defined above, and no non-seasonal episodes of that polarity have occurred during that 2-year period.

D. Seasonal manias, hypomanias, or depressions (as described above) substantially outnumber any nonseasonal manias, hypomanias, or depressions that may have occurred over the individual's lifetime.

   Note: This specifier can be applied to the pattern of major depressive episodes in bipolar I disorder, bipolar II disorder, or major depressive disorder, recurrent. The essential feature is the onset and remission of major depressive episodes at characteristic times of the year. In most cases, the episodes begin in fall or winter and remit in spring. Less commonly, there may be recurrent summer depressive episodes. This pattern of onset and remission of episodes must have occurred during at least a 2-year period, without any nonseasonal episodes occurring during this period. In addition, the seasonal depressive episodes must substantially outnumber any nonseasonal depressive episodes over the individual's lifetime.

   This specifier does not apply to those situations in which the pattern is better explained by seasonally linked psychosocial stressors (e.g., seasonal unemployment or school schedule). Major depressive episodes that occur in a seasonal pattern

are often characterized by prominent energy, hypersomnia, overeating, weight gain, and a craving for carbohydrates. It is unclear whether a seasonal pattern is more likely in recurrent major depressive disorder or in bipolar disorders. However, within the bipolar disorders group, a seasonal pattern appears to be more likely in bipolar II disorder than in bipolar I disorder. In some individuals, the onset of manic or hypomanic episodes may also be linked to a particular season.

The prevalence of winter-type seasonal pattern appears to vary with latitude, age, and sex. Prevalence increases with higher latitudes. Age is also a strong predictor of seasonality, with younger persons at higher risk for winter depressive episodes.

Specify if:

In partial remission: Symptoms of the immediately previous manic, hypomanic, or depressive episode are present, but full criteria are not met, or there is a period lasting less than 2 months without any significant symptoms of a manic, hypomanic, or major depressive episode following the end of such an episode.

In full remission: During the past 2 months, no significant signs or symptoms of the disturbance were present.

Specify current severity:

Severity is based on the number of criterion symptoms, the severity of those symptoms, and the degree of functional disability.

Mild: Few, if any, symptoms in excess of those required to meet the diagnostic criteria are present, the intensity of the symptoms is distressing but manageable, and the symptoms result in minor impairment in social or occupational functioning.

Moderate: The number of symptoms, intensity of symptoms, and/or functional impairment are between those specified for "mild" and "severe."

Severe: The number of symptoms is substantially in excess of those required to make the diagnosis, the intensity of the symptoms is seriously distressing and unmanageable, and the symptoms markedly interfere with social and occupational functioning.

Depressive Disorders

Depressive disorders include disruptive mood dysregulation disorder, major depressive disorder (including major depressive episode), persistent depressive disorder (dysthymia), premenstrual dysphoric disorder, substance/medication-induced depressive disorder, depressive disorder due to another medical condition, other specified depressive disorder, and unspecified depressive disorder. Unlike in DSM-IV, this chapter "Depressive Disorders" has been separated from the previous chapter "Bipolar and Related Disorders." The common feature of all of these disorders is the presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function. What differs among them are issues of duration, timing, or presumed etiology.

In order to address concerns about the potential for the overdiagnosis of and treatment for bipolar disorder in children, a new diagnosis, disruptive mood dysregulation disorder, referring to the presentation of children with persistent irritability and frequent episodes of extreme behavioral dyscontrol, is added to the depressive disorders for children up to 12 years of age. Its placement in this chapter reflects the finding that children with this symptom pattern typically develop unipolar depressive disorders or anxiety disorders, rather than bipolar disorders, as they mature into adolescence and adulthood.

Major depressive disorder represents the classic condition in this group of disorders. It is characterized by discrete episodes of at least 2 weeks' duration (although most episodes last considerably longer) involving clear-cut changes in affect, cognition, and neurovegetative functions and inter-episode remissions. A diagnosis based on a single episode is possible, although the disorder is a recurrent one in the majority of cases. Careful consideration is given to the delineation of normal sadness and grief from a major depressive episode. Bereavement may induce great suffering, but it does not typically induce an episode of major depressive disorder. When they do occur together, the depressive symptoms and functional impairment tend to be more severe and the prognosis is worse compared with bereavement that is not accompanied by major depressive disorder. Bereavement-related depression tends to occur in persons with other vulnerabilities to depressive disorders, and recovery may be facilitated by antidepressant treatment.

A more chronic form of depression, persistent depressive disorder (dysthymia), can be diagnosed when the mood disturbance continues for at least 2 years in adults or 1 year in children. This diagnosis, new in DSM-5, includes both the DSM-IV diagnostic categories of chronic major depression and dysthymia.

After careful scientific review of the evidence, premenstrual dysphoric disorder has been moved from an appendix of DSM-IV ("Criteria Sets and Axes Provided for Further Study") to Section II of DSM-5. Almost 20 years of additional of research on this condition has confirmed a specific and treatment-responsive form of depressive disorder that begins sometime following ovulation and remits within a few days of menses and has a marked impact on functioning.

A large number of substances of abuse, some prescribed medications, and several medical conditions can be associated with depression-like phenomena. This fact is recognized in the diagnoses of substance/medication-induced depressive disorder and depressive disorder due to another medical condition.

Disruptive Mood Dysregulation Disorder

Diagnostic Criteria **296.99 (F34.8)**

A. Severe recurrent temper outbursts manifested verbally (e.g., verbal rages) and/or behaviorally (e.g., physical aggression toward people or property) that are grossly out of proportion in intensity or duration to the situation or provocation.
B. The temper outbursts are inconsistent with developmental level.
C. The temper outbursts occur, on average, three or more times per week.
D. The mood between temper outbursts is persistently irritable or angry most of the day, nearly every day, and is observable by others (e.g., parents, teachers, peers).
E. Criteria A–D have been present for 12 or more months. Throughout that time, the individual has not had a period lasting 3 or more consecutive months without all of the symptoms in Criteria A–D.
F. Criteria A and D are present in at least two of three settings (i.e., at home, at school, with peers) and are severe in at least one of these.
G. The diagnosis should not be made for the first time before age 6 years or after age 18 years.
H. By history or observation, the age at onset of Criteria A–E is before 10 years.
I. There has never been a distinct period lasting more than 1 day during which the full symptom criteria, except duration, for a manic or hypomanic episode have been met.
Note: Developmentally appropriate mood elevation, such as occurs in the context of a highly positive event or its anticipation, should not be considered as a symptom of mania or hypomania.
J. The behaviors do not occur exclusively during an episode of major depressive disorder and are not better explained by another mental disorder (e.g., autism spectrum disorder, posttraumatic stress disorder, separation anxiety disorder, persistent depressive disorder [dysthymia]).
Note: This diagnosis cannot coexist with oppositional defiant disorder, intermittent explosive disorder, or bipolar disorder, though it can coexist with others, including major depressive disorder, attention-deficit/hyperactivity disorder, conduct disorder, and substance use disorders. Individuals whose symptoms meet criteria for both disruptive mood dysregulation disorder and oppositional defiant disorder should only be given the diagnosis of disruptive mood dysregulation disorder. If an individual has ever experienced a manic or hypomanic episode, the diagnosis of disruptive mood dysregulation disorder should not be assigned.
K. The symptoms are not attributable to the physiological effects of a substance or to another medical or neurological condition.

Diagnostic Features

The core feature of disruptive mood dysregulation disorder is chronic, severe persistent irritability. This severe irritability has two prominent clinical manifestations, the first of which is frequent temper outbursts. These outbursts typically occur in response to frustration and can be verbal or behavioral (the latter in the form of aggression against property, self, or others). They must occur frequently (i.e., on average, three or more times per week) (Criterion C) over at least 1 year in at least two settings (Criteria E and F), such as in the home and at school, and they must be developmentally inappropriate (Criterion B). The second manifestation of severe irritability consists of chronic, persistently irritable or angry mood that is present between the severe temper outbursts. This irritable or angry mood must be characteristic of the child, being present most of the day, nearly every day, and noticeable by others in the child's environment (Criterion D).

The clinical presentation of disruptive mood dysregulation disorder must be carefully distinguished from presentations of other, related conditions, particularly pediatric bipolar disorder. In fact, disruptive mood dysregulation disorder was added to DSM-5 to address the considerable concern about the appropriate classification and treatment of children who present with chronic, persistent irritability relative to children who present with classic (i.e., episodic) bipolar disorder.

Some researchers view severe, non-episodic irritability as characteristic of bipolar disorder in children, although both DSM-IV and DSM-5 require that both children and adults have distinct episodes of mania or hypomania to qualify for the diagnosis of bipolar I disorder. During the latter decades of the 20th century, this contention by researchers that severe, nonepisodic irritability is a manifestation of pediatric mania coincided with an upsurge in the rates at which clinicians assigned the diagnosis of bipolar disorder to their pediatric patients. This sharp increase in rates appears to be attributable to clinicians combining at least two clinical presentations into a single category. That is, both classic, episodic presentations of mania and non-episodic presentations of severe irritability have been labeled as bipolar disorder in children. In DSM-5, the term *bipolar disorder* is explicitly reserved for episodic presentations of bipolar symptoms. DSM-IV did not include a diagnosis designed to capture youths whose hallmark symptoms consisted of very severe, nonepisodic irritability, whereas DSM-5, with the inclusion of disruptive mood dysregulation disorder, provides a distinct category for such presentations.

Prevalence

Disruptive mood dysregulation disorder is common among children presenting to pediatric mental health clinics. Prevalence estimates of the disorder in the community are unclear. Based on rates of chronic and severe persistent irritability, which is the core feature of the disorder, the overall 6-month to 1-year period-prevalence of disruptive mood dysregulation disorder among children and adolescents probably falls in the 2%–5% range. However, rates are expected to be higher in males and school-age children than in females and adolescents.

Development and Course

The onset of disruptive mood dysregulation disorder must be before age 10 years, and the diagnosis should not be applied to children with a developmental age of less than 6 years. It is unknown whether the condition presents only in this age-delimited fashion. Because the symptoms of disruptive mood dysregulation disorder are likely to change as children mature, use of the diagnosis should be restricted to age groups similar to those in which validity has been established (7–18 years). Approximately half of children with severe, chronic irritability will have a presentation that continues to meet criteria for the condition 1 year later. Rates of conversion from severe, nonepisodic irritability to bipolar disorder are very low. Instead, children with chronic irritability are at risk to develop unipolar depressive and/or anxiety disorders in adulthood.

Age-related variations also differentiate classic bipolar disorder and disruptive mood dysregulation disorder. Rates of bipolar disorder generally are very low prior to adolescence (<1%), with a steady increase into early adulthood (1%–2% prevalence). Disruptive mood dysregulation disorder is more common than bipolar disorder prior to adolescence, and symptoms of the condition generally become less common as children transition into adulthood.

Risk and Prognostic Factors

Temperamental. Children with chronic irritability typically exhibit complicated psychiatric histories. In such children, a relatively extensive history of chronic irritability is

common, typically manifesting before full criteria for the syndrome are met. Such prediagnostic presentations may have qualified for a diagnosis of oppositional defiant disorder. Many children with disruptive mood dysregulation disorder have symptoms that also meet criteria for attention-deficit/hyperactivity disorder (ADHD) and for an anxiety disorder, with such diagnoses often being present from a relatively early age. For some children, the criteria for major depressive disorder may also be met.

Genetic and physiological. In terms of familial aggregation and genetics, it has been suggested that children presenting with chronic, non-episodic irritability can be differentiated from children with bipolar disorder in their family-based risk. However, these two groups do not differ in familial rates of anxiety disorders, unipolar depressive disorders, or substance abuse. Compared with children with pediatric bipolar disorder or other mental illnesses, those with disruptive mood dysregulation disorder exhibit both commonalities and differences in information-processing deficits. For example, face-emotion labeling deficits, as well as perturbed decision making and cognitive control, are present in children with bipolar disorder and chronically irritable children, as well as in children with some other psychiatric conditions. There is also evidence for disorder-specific dysfunction, such as during tasks assessing attention deployment in response to emotional stimuli, which has demonstrated unique signs of dysfunction in children with chronic irritability.

Gender-Related Diagnostic Issues

Children presenting to clinics with features of disruptive mood dysregulation disorder are predominantly male. Among community samples, a male preponderance appears to be supported. This difference in prevalence between males and females differentiates disruptive mood dysregulation disorder from bipolar disorder, in which there is an equal gender prevalence.

Suicide Risk

In general, evidence documenting suicidal behavior and aggression, as well as other severe functional consequences, in disruptive mood dysregulation disorder should be noted when evaluating children with chronic irritability.

Functionai Consequences of Disruptive Mood Dysregulation Disorder

Chronic, severe irritability, such as is seen in disruptive mood dysregulation disorder, is associated with marked disruption in a child's family and peer relationships, as well as in school performance. Because of their extremely low frustration tolerance, such children generally have difficulty succeeding in school; they are often unable to participate in the activities typically enjoyed by healthy children; their family life is severely disrupted by their outbursts and irritability; and they have trouble initiating or sustaining friendships. Levels of dysfunction in children with bipolar disorder and disruptive mood dysregulation disorder are generally comparable. Both conditions cause severe disruption in the lives of the affected individual and their families. In both disruptive mood dysregulation disorder and pediatric bipolar disorder, dangerous behavior, suicidal ideation or suicide attempts, severe aggression, and psychiatric hospitalization are common.

Dlfferential Diagnosis

Because chronically irritable children and adolescents typically present with complex histories, the diagnosis of disruptive mood dysregulation disorder must be made while considering the presence or absence of multiple other conditions. Despite the need to consider