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.