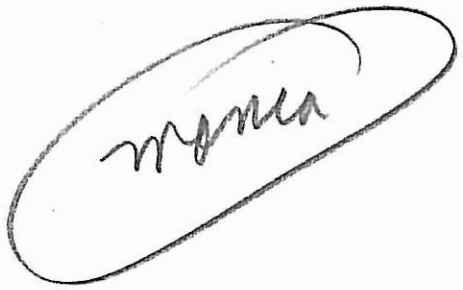
ELECTROCONVULSIVE THERAPY

Second Edition

Richard Abrams, M.D.

UNIVERSITY OF HEALTH SCIENCES
THE CHICAGO MEDICAL SCHOOL



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eral, right unilateral, and left unilateral ECT (Leechuy, Abrams, and Kohlhaas, 1988; Liston and Sones, 1990).

Based on the hypothesis that emergence delirium is a form of lactate-induced panic secondary to seizure-induced skeletal muscle metabolism, Swartz (1990) effectively prevented the syndrome in 5 patients by increasing the succinylcholine dose by about 45%, an intriguing strategy that awaits confirmation in a controlled comparison with placebo.

In the rare patient who fails to respond to benzodiazepine inhibition or prophylaxis, the intravenous line can be left in place following the treatment and a 2% solution of methohexital infused at a rate sufficient to prevent the delirium from emerging. This procedure should be directly supervised by a physician or registered nurse.

MANIA OR ORGANIC EUPHORIA

Years ago, Kalinowsky (1945) described the emergence of organic psychotic states during the course of bilateral ECT—additional ECTs would typically attenuate the syndrome, which might then transiently re-appear during the post-ECT convalescence. As noted elsewhere in this volume, Fink and Kahn (1961) described a euphoric-hypomanic response to ECT that they considered highly favorable. Devanand et al. (1988) described 3 patients who developed maniform states while undergoing right unilateral or bilateral ECT, 2 of whom exhibited no concurrent cognitive impairment and were therefore diagnosed as having true hypomanic or manic syndromes; the third exhibited significant disorientation and impaired cognitive examination scores and was designated to be suffering from an organic-euphoric state. Andrade et al. (1988c) reported that 4 out of 32 endogenous depressives developed transient, nonorganic, self-limited manic syndromes during the course of bilateral ECT, followed by recovery from their depressions. A fifth patient (Andrade et al., 1990) fared similarly at first, but then relapsed and required two additional courses of ECT, with concurrent pharmacotherapy, to achieve a sustained remission.

In my experience, the occurrence of a maniform syndrome during ECT—regardless of the associated cognitive status—is favorable, and an indication to withhold further treatment while closely observing the patient. The majority go on to enjoy full remission of all symptoms, including cognitive impairment; the few who slip back into depression or remain in a maniform state can then be treated either with additional ECT or pharmacotherapy—the rationale for combining the two, however, is obscure.

ASPIRATION PNEUMONITIS

Since the introduction of muscle relaxants, no cases of aspiration pneumonitis were reported until Zibrak, Jensen, and Bloomingdale (1988) described two patients with gastroparesis—one of whom had not eaten for 12 hours—who suffered aspiration of gastric contents during ECT, followed by adult respiratory distress syndrome. (I had a similar case in my practice of a depressed woman in her 70s who had not eaten for over 12 hours prior to ECT, but nevertheless vomited copious amounts of gastric contents immediately following termination of her first seizure and developed aspiration pneumonitis that took almost 2 weeks to resolve.) The authors recommend that ECT candidates with concurrent disorders judged to put them at high risk for gastroparesis (e.g., diabetes mellitus, hypothyroidism, amyloidosis, scleroderma) should have a careful gastrointestinal history taken, followed by a GI series or radionucleotide gastric emptying study, if indicated. The only sure way to prevent vomiting—and aspiration of gastric contents—in patients with documented gastroparesis is to remove the stomach contents by nasogastric tube before induction of anesthesia.

RUPTURED BLADDER

Irving and Drayson (1984) reported rupture of the urinary bladder during the 10th ECT in a 74-year-old man with a history of prostatism. The only other case in the literature is that of O'Brien and Morgan (1991), who described a 55-year-old man on amitriptyline, 150 mg/day, who had failed to void before treatment and who sustained a 3-cm tear in the bladder fundus during the extremely vigorous muscular contractions of an apparently unmodified seizure. These cases amply support the standard recommendation for patients to void their bladder before coming to ECT.

NAUSEA OR VOMITING

These are infrequent after ECT and can be prevented by dimenhydrinate, 50 mg intramuscularly, given at the end of the seizure.

HEADACHE

Headache occurs in about one third of all patients after ECT and usually responds to aspirin or, if severe, ibuprofen. Acting on the

Manic Episode

Episode Features

A Manic Episode is defined by a distinct period during which there is an abnormally and persistently elevated, expansive, or irritable mood. This period of abnormal mood must last at least 1 week (or less if hospitalization is required) (Criterion A). The mood disturbance must be accompanied by at least three additional symptoms from a list that includes inflated self-esteem or grandiosity, decreased need for sleep, pressure of speech, flight of ideas, distractibility, increased involvement in goal-directed activities or psychomotor agitation, and excessive involvement in pleasurable activities with a high potential for painful consequences. If the mood is irritable (rather than elevated or expansive), at least four of the above symptoms must be present (Criterion B). The symptoms do not meet criteria for a Mixed Episode, which is characterized by the symptoms of both a Manic Episode and a Major Depressive Episode occurring nearly every day for at least a 1-week period (Criterion C). The disturbance must be sufficiently severe to cause marked impairment in social or occupational functioning or to require hospitalization, or it is characterized by the presence of psychotic features (Criterion D). The episode must not be due to the direct physiological effects of a drug of abuse, a medication, other somatic treatments for depression (e.g., electroconvulsive therapy or light therapy) or toxin exposure. The episode must also not be due to the direct physiological effects of a general medical condition (e.g., multiple sclerosis, brain tumor) (Criterion E).

The elevated mood of a Manic Episode may be described as euphoric, unusually good, cheerful, or high. Although the person's mood may initially have an infectious quality for the uninvolved observer, it is recognized as excessive by those who know the person well. The expansive quality of the mood is characterized by unceasing and indiscriminate enthusiasm for interpersonal, sexual, or occupational interactions. For example, the person may spontaneously start extensive conversations with strangers in public places, or a salesperson may telephone strangers at home in the early morning hours to initiate sales. Although elevated mood is considered the prototypical symptom, the predominant mood disturbance may be irritability, particularly when the person's wishes are thwarted. Lability of mood (e.g., the alternation between euphoria and irritability) is frequently seen.

Inflated self-esteem is typically present, ranging from uncritical self-confidence to marked grandiosity, and may reach delusional proportions (Criterion B1). Individuals may give advice on matters about which they have no special knowledge (e.g., how to run the United Nations). Despite lack of any particular experience or talent, the individual may embark on writing a novel or composing a symphony or seek publicity for some impractical invention. Grandiose delusions are common (e.g., having a special relationship to God or to some public figure from the political, religious, or entertainment world).

Almost invariably, there is a decreased need for sleep (Criterion B2). The person usually awakens several hours earlier than usual, feeling full of energy. When the sleep disturbance is severe, the person may go for days without sleep and yet not feel tired.

Manic speech is typically pressured, loud, rapid, and difficult to interrupt (Criterion B3). Individuals may talk nonstop, sometimes for hours on end, and without regard for others' wishes to communicate. Speech is sometimes characterized by joking, punning, and amusing irrelevancies. The individual may become theatrical, with dramatic mannerisms and singing. Sounds rather than meaningful conceptual relationships may govern word choice (i.e., clanging). If the person's mood is more irritable than expansive,

speech may be marked by complaints, hostile comments, or angry tirades.

The individual's thoughts may race, often at a rate faster than can be articulated (Criterion B4). Some individuals with Manic Episodes report that this experience resembles watching two or three television programs simultaneously. Frequently there is flight of ideas evidenced by a nearly continuous flow of accelerated speech, with abrupt changes from one topic to another. For example, while talking about a potential business deal to sell computers, a salesperson may shift to discussing in minute detail the history of the computer chip, the industrial revolution, or applied mathematics. When flight of ideas is severe, speech may become disorganized and incoherent.

Distractibility (Criterion B5) is evidenced by an inability to screen out irrelevant external stimuli (e.g., the interviewer's tie, background noises or conversations, or furnishings in the room). There may be a reduced ability to differentiate between thoughts that are germane to the topic and thoughts that are only slightly relevant or clearly irrelevant.

The increase in goal-directed activity often involves excessive planning of, and excessive participation in, multiple activities (e.g., sexual, occupational, political, religious) (Criterion B6). Increased sexual drive, fantasies, and behavior are often present. The person may simultaneously take on multiple new business ventures without regard for the apparent risks or the need to complete each venture satisfactorily. Almost invariably, there is increased sociability (e.g., renewing old acquaintances or calling friends or even strangers at all hours of the day or night), without regard to the intrusive, domineering, and demanding nature of these interactions. Individuals often display psychomotor agitation or restlessness by pacing or by holding multiple conversations simultaneously (e.g., by telephone and in person at the same time). Some individuals write a torrent of letters on many different topics to friends, public figures, or the media.

Expansiveness, unwarranted optimism, grandiosity, and poor judgment often lead to an imprudent involvement in pleasurable activities such as buying sprees, reckless driving, foolish business investments, and sexual behavior unusual for the person, even though these activities are likely to have painful consequences (Criterion B7). The individual may purchase many unneeded items (e.g., 20 pairs of shoes, expensive antiques) without the money to pay for them. Unusual sexual behavior may include infidelity or indiscriminate sexual encounters with strangers.

The impairment resulting from the disturbance must be severe enough to cause marked impairment in functioning or to require hospitalization to protect the individual from the negative consequences of actions that result from poor judgment (e.g., financial losses, illegal activities, loss of employment, assaultive behavior). By definition, the presence of psychotic features during a Manic Episode constitutes marked impairment in functioning (Criterion D).

Symptoms like those seen in a Manic Episode may be due to the direct effects of antidepressant medication, electroconvulsive therapy, light therapy, or medication prescribed for other general medical conditions (e.g., corticosteroids). Such presentations are not considered Manic Episodes and do not count toward the diagnosis of Bipolar I Disorder. For example, if a person with recurrent Major Depressive Disorder develops manic symptoms following a course of antidepressant medication, the episode is diagnosed as a Substance-Induced Mood Disorder, With Manic Features, and there is no switch from a diagnosis of Major Depressive Disorder to Bipolar I Disorder. Some evidence suggests that there may be a bipolar "diathesis" in individuals who develop manic-like episodes following somatic treatment for depression. Such individuals may have an increased likelihood of future Manic, Mixed, or Hypomanic Episodes that are

not related to substances or somatic treatments for depression. This may be an especially important consideration in children and adolescents.

Associated Features and Disorders

Associated descriptive features and mental disorders. Individuals with a Manic Episode frequently do not recognize that they are ill and resist efforts to be treated. They may travel impulsively to other cities, losing contact with relatives and caretakers. They may change their dress, makeup, or personal appearance to a more sexually suggestive or dramatically flamboyant style that is out of character for them. They may engage in activities that have a disorganized or bizarre quality (e.g., distributing candy, money, or advice to passing strangers). Gambling and antisocial behaviors may accompany the Manic Episode. Ethical concerns may be disregarded even by those who are typically very conscientious (e.g., a stockbroker inappropriately buys and sells stock without the clients' knowledge or permission; a scientist incorporates the findings of others). The person may be hostile and physically threatening to others. Some individuals, especially those with psychotic features, may become physically assaultive or suicidal. Adverse consequences of a Manic Episode (e.g., involuntary hospitalization, difficulties with the law, or serious financial difficulties) often result from poor judgment and hyperactivity. When no longer in the Manic Episode, most individuals are regretful for behaviors engaged in during the Manic Episode. Some individuals describe having a much sharper sense of smell, hearing, or vision (e.g., colors appear very bright). When catatonic symptoms (e.g., stupor, mutism, negativism, and posturing) are present, the specifier With Catatonic Features may be indicated (see p. 382).

Mood may shift rapidly to anger or depression. Depressive symptoms may last moments, hours, or, more rarely, days. Not uncommonly, the depressive symptoms and manic symptoms occur simultaneously. If the criteria for both a Major Depressive Episode and a Manic Episode are prominent every day for at least 1 week, the episode is considered to be a Mixed Episode (see p. 333). As the Manic Episode develops, there is often a substantial increase in the use of alcohol or stimulants, which may exacerbate or prolong the episode.

Associated laboratory findings. No laboratory findings that are diagnostic of a Manic Episode have been identified. However, a variety of laboratory findings have been noted to be abnormal in groups of individuals with Manic Episodes compared with control subjects. Laboratory findings in Manic Episodes include polysomnographic abnormalities, increased cortisol secretion, and absence of dexamethasone nonsuppression. There may be abnormalities involving the norepinephrine, serotonin, acetylcholine, dopamine, or gamma-aminobutyric acid neurotransmitter systems, as demonstrated by studies of neurotransmitter metabolites, receptor functioning, pharmacological provocation, and neuroendocrine function.

Specific Culture, Age, and Gender Features

Cultural considerations that were suggested for Major Depressive Episodes are also relevant to Manic Episodes (see p. 324). Manic Episodes in adolescents are more likely to include psychotic features and may be associated with school truancy, antisocial behavior, school failure, or substance use. A significant minority of adolescents appear

to have a history of long-standing behavior problems that precede the onset of a frank Manic Episode. It is unclear whether these problems represent a prolonged prodrome to Bipolar Disorder or an independent disorder. See the corresponding sections of the texts for Bipolar I Disorder (p. 352) and Bipolar II Disorder (p. 360) for specific information on gender.

Course

The mean age at onset for a first Manic Episode is the early 20s, but some cases start in adolescence and others start after age 50 years. Manic Episodes typically begin suddenly, with a rapid escalation of symptoms over a few days. Frequently, Manic Episodes occur following psychosocial stressors. The episodes usually last from a few weeks to several months and are briefer and end more abruptly than Major Depressive Episodes. In many instances (50%–60%), a Major Depressive Episode immediately precedes or immediately follows a Manic Episode, with no intervening period of euthymia. If the Manic Episode occurs in the postpartum period, there may be an increased risk for recurrence in subsequent postpartum periods and the specifier With Postpartum Onset is applicable (see p. 386).

Differential Diagnosis

A Manic Episode must be distinguished from a **Mood Disorder Due to a General Medical Condition.** The appropriate diagnosis would be Mood Disorder Due to a General Medical Condition if the mood disturbance is judged to be the direct physiological consequence of a specific general medical condition (e.g., multiple sclerosis, brain tumor, Cushing's syndrome) (see p. 366). This determination is based on the history, laboratory findings, or physical examination. If it is judged that the manic symptoms are not the direct physiological consequence of the general medical condition, then the primary Mood Disorder is recorded on Axis I (e.g., Bipolar I Disorder) and the general medical condition is recorded on Axis III (e.g., myocardial infarction). A late onset of a first Manic Episode (e.g., after age 50 years) should alert the clinician to the possibility of an etiological general medical condition or substance.

A **Substance-Induced Mood Disorder** is distinguished from a Manic Episode by the fact that a substance (e.g., a drug of abuse, a medication, or exposure to a toxin) is judged to be etiologically related to the mood disturbance (see p. 370). Symptoms like those seen in a Manic Episode may be precipitated by a drug of abuse (e.g., manic symptoms that occur only in the context of intoxication with cocaine would be diagnosed as Cocaine-Induced Mood Disorder, With Manic Features, With Onset During Intoxication). Symptoms like those seen in a Manic Episode may also be precipitated by antidepressant treatment such as medication, electroconvulsive therapy, or light therapy. Such episodes are also diagnosed as Substance-Induced Mood Disorders (e.g., Amitriptyline-Induced Mood Disorder, With Manic Features; Electroconvulsive Therapy–Induced Mood Disorder, With Manic Features).

Manic Episodes should be distinguished from **Hypomanic Episodes.** Although Manic Episodes and Hypomanic Episodes have an identical list of characteristic symptoms, the disturbance in Hypomanic Episodes is not sufficiently severe to cause marked impairment in social or occupational functioning or to require hospitalization. Some Hypomanic Episodes may evolve into full Manic Episodes.

Major Depressive Episodes with prominent irritable mood may be difficult to

distinguish from Manic Episodes with irritable mood or from **Mixed Episodes.** This determination requires a careful clinical evaluation of the presence of manic symptoms. If criteria are met for both a Manic Episode and a Major Depressive Episode nearly every day for at least a 1-week period, this would constitute a Mixed Episode.

Attention-Deficit/Hyperactivity Disorder and a Manic Episode are both characterized by excessive activity, impulsive behavior, poor judgment, and denial of problems. Attention-Deficit/Hyperactivity Disorder is distinguished from a Manic Episode by its characteristic early onset (i.e., before age 7 years), chronic rather than episodic course, lack of relatively clear onsets and offsets, and the absence of abnormally expansive or elevated mood or psychotic features.

Criteria for Manic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) 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)
   (6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
   (7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

C. The symptoms do not meet criteria for a Mixed Episode (see p. 335).

D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

Note: Manic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar I Disorder.

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Mixed Episode

Episode Features

A Mixed Episode is characterized by a period of time (lasting at least 1 week) in which the criteria are met both for a Manic Episode and for a Major Depressive Episode nearly every day (Criterion A). The individual experiences rapidly alternating moods (sadness, irritability, euphoria) accompanied by symptoms of a Manic Episode (see p. 328) and a Major Depressive Episode (see p. 320). The symptom presentation frequently includes agitation, insomnia, appetite dysregulation, psychotic features, and suicidal thinking. The disturbance must be sufficiently severe to cause marked impairment in social or occupational functioning or to require hospitalization, or it is characterized by the presence of psychotic features (Criterion B). The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism) (Criterion C). Symptoms like those seen in a Mixed Episode may be due to the direct effects of antidepressant medication, electroconvulsive therapy, light therapy, or medication prescribed for other general medical conditions (e.g., corticosteroids). Such presentations are not considered Mixed Episodes and do not count toward a diagnosis of Bipolar I Disorder. For example, if a person with recurrent Major Depressive Disorder develops a mixed symptom picture during a course of antidepressant medication, the diagnosis of the episode is Substance-Induced Mood Disorder, With Mixed Features, and there is no switch from a diagnosis of Major Depressive Disorder to Bipolar I Disorder. Some evidence suggests that there may be a bipolar "diathesis" in individuals who develop mixed-like episodes following somatic treatment for depression. Such individuals may have an increased likelihood of future Manic, Mixed, or Hypomanic Episodes that are not related to substances or somatic treatments for depression. This may be an especially important consideration in children and adolescents.

Associated Features and Disorders

Associated descriptive features and mental disorders. Associated features of a Mixed Episode are similar to those for Manic Episodes and Major Depressive Episodes. Individuals may be disorganized in their thinking or behavior. Because individuals in Mixed Episodes experience more dysphoria than do those in Manic Episodes, they may be more likely to seek help.

Associated laboratory findings. Laboratory findings for Mixed Episode are not well studied, although evidence to date suggests physiological and endocrine findings that are similar to those found in severe Major Depressive Episodes.

Specific Culture, Age, and Gender Features

Cultural considerations suggested for Major Depressive Episodes are relevant to Mixed Episodes as well (see p. 324). Mixed episodes appear to be more common in younger individuals and in individuals over age 60 years with Bipolar Disorder and may be more common in males than in females.

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Course

Mixed Episodes can evolve from a Manic Episode or from a Major Depressive Episode or may arise de novo. For example, the diagnosis would be changed from Bipolar I Disorder, Most Recent Episode Manic, to Bipolar I Disorder, Most Recent Episode Mixed, for an individual with 3 weeks of manic symptoms followed by 1 week of both manic symptoms and depressive symptoms. Mixed episodes may last weeks to several months and may remit to a period with few or no symptoms or evolve into a Major Depressive Episode. It is far less common for a Mixed Episode to evolve into a Manic Episode.

Differential Diagnosis

A Mixed Episode must be distinguished from a **Mood Disorder Due to a General Medical Condition.** The diagnosis is Mood Disorder Due to a General Medical Condition if the mood disturbance is judged to be the direct physiological consequence of a specific general medical condition (e.g., multiple sclerosis, brain tumor, Cushing's syndrome) (see p. 366). This determination is based on the history, laboratory findings, or physical examination. If it is judged that the mixed manic and depressive symptoms are not the direct physiological consequence of the general medical condition, then the primary Mood Disorder is recorded on Axis I (e.g., Bipolar I Disorder) and the general medical condition is recorded on Axis III (e.g., myocardial infarction).

A **Substance-Induced Mood Disorder** is distinguished from a Mixed Episode by the fact that a substance (e.g., a drug of abuse, a medication, or exposure to a toxin) is judged to be etiologically related to the mood disturbance (see p. 370). Symptoms like those seen in a Mixed Episode may be precipitated by use of a drug of abuse (e.g., mixed manic and depressive symptoms that occur only in the context of intoxication with cocaine would be diagnosed as Cocaine-Induced Mood Disorder, With Mixed Features, With Onset During Intoxication). Symptoms like those seen in a Mixed Episode may also be precipitated by antidepressant treatment such as medication, electroconvulsive therapy, or light therapy. Such episodes are also diagnosed as Substance-Induced Mood Disorders (e.g., Amitriptyline-Induced Mood Disorder, With Mixed Features; Electroconvulsive Therapy–Induced Mood Disorder, With Mixed Features).

Major Depressive Episodes with prominent irritable mood and **Manic Episodes with prominent irritable mood** may be difficult to distinguish from Mixed Episodes. This determination requires a careful clinical evaluation of the simultaneous presence of symptoms that are characteristic of both a full Manic Episode and a full Major Depressive Episode (except for duration).

Attention-Deficit/Hyperactivity Disorder and a Mixed Episode are both characterized by excessive activity, impulsive behavior, poor judgment, and denial of problems. Attention-Deficit/Hyperactivity Disorder is distinguished from a Mixed Episode by its characteristic early onset (i.e., before age 7 years), chronic rather than episodic course, lack of relatively clear onsets and offsets, and the absence of abnormally expansive or elevated mood or psychotic features. Children with Attention-Deficit/Hyperactivity Disorder also sometimes show depressive symptoms such as low self-esteem and frustration tolerance. If criteria are met for both, Attention-Deficit/Hyperactivity Disorder may be diagnosed in addition to the Mood Disorder.

Criteria for Mixed Episode

A. The criteria are met both for a Manic Episode (see p. 332) and for a Major Depressive Episode (see p. 327) (except for duration) nearly every day during at least a 1-week period.

B. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

C. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

Note: Mixed-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar I Disorder.

Hypomanic Episode

Episode Features

A Hypomanic Episode is defined as a distinct period during which there is an abnormally and persistently elevated, expansive, or irritable mood that lasts at least 4 days (Criterion A). This period of abnormal mood must be accompanied by at least three additional symptoms from a list that includes inflated self-esteem or grandiosity (nondelusional), decreased need for sleep, pressure of speech, flight of ideas, distractibility, increased involvement in goal-directed activities or psychomotor agitation, and excessive involvement in pleasurable activities that have a high potential for painful consequences (Criterion B). If the mood is irritable rather than elevated or expansive, at least four of the above symptoms must be present. This list of additional symptoms is identical to those that define a Manic Episode (see p. 328) except that delusions or hallucinations cannot be present. The mood during a Hypomanic Episode must be clearly different from the individual's usual nondepressed mood, and there must be a clear change in functioning that is not characteristic of the individual's usual functioning (Criterion C). Because the changes in mood and functioning must be observable by others (Criterion D), the evaluation of this criterion will often require interviewing other informants (e.g., family members). History from other informants is particularly important in the evaluation of adolescents. In contrast to a Manic Episode, a Hypomanic Episode is not severe enough to cause marked impairment in social or occupational functioning or to require hospitalization, and there are no psychotic features (Criterion E). The change in functioning for some individuals may take the form of a marked increase in efficiency, accomplishments, or creativity. However, for others, hypomania can cause some social or occupational impairment.

The mood disturbance and other symptoms must not be due to the direct

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physiological effects of a drug of abuse, a medication, other treatment for depression (electroconvulsive therapy or light therapy), or toxin exposure. The episode must also not be due to the direct physiological effects of a general medical condition (e.g., multiple sclerosis, brain tumor) (Criterion F). Symptoms like those seen in a Hypomanic Episode may be due to the direct effects of antidepressant medication, electroconvulsive therapy, light therapy, or medication prescribed for other general medical conditions (e.g., corticosteroids). Such presentations are not considered Hypomanic Episodes and do not count toward the diagnosis of Bipolar II Disorder. For example, if a person with recurrent Major Depressive Disorder develops symptoms of a hypomanic-like episode during a course of antidepressant medication, the episode is diagnosed as a Substance-Induced Mood Disorder, With Manic Features, and there is no switch from a diagnosis of Major Depressive Disorder to Bipolar II Disorder. Some evidence suggests that there may be a bipolar "diathesis" in individuals who develop manic- or hypomanic-like episodes following somatic treatment for depression. Such individuals may have an increased likelihood of future Manic or Hypomanic Episodes that are not related to substances or somatic treatments for depression.

The elevated mood in a Hypomanic Episode is described as euphoric, unusually good, cheerful, or high. Although the person's mood may have an infectious quality for the uninvolved observer, it is recognized as a distinct change from the usual self by those who know the person well. The expansive quality of the mood disturbance is characterized by enthusiasm for social, interpersonal, or occupational interactions. Although elevated mood is considered prototypical, the mood disturbance may be irritable or may alternate between euphoria and irritability. Characteristically, inflated self-esteem, usually at the level of uncritical self-confidence rather than marked grandiosity, is present (Criterion B1). There is very often a decreased need for sleep (Criterion B2); the person awakens before the usual time with increased energy. The speech of a person with a Hypomanic Episode is often somewhat louder and more rapid than usual, but is not typically difficult to interrupt. It may be full of jokes, puns, plays on words, and irrelevancies (Criterion B3). Flight of ideas is uncommon and, if present, lasts for very brief periods (Criterion B4).

Distractibility is often present, as evidenced by rapid changes in speech or activity as a result of responding to various irrelevant external stimuli (Criterion B5). The increase in goal-directed activity may involve planning of, and participation in, multiple activities (Criterion B6). These activities are often creative and productive (e.g., writing a letter to the editor, clearing up paperwork). Sociability is usually increased, and there may be an increase in sexual activity. There may be impulsive activity such as buying sprees, reckless driving, or foolish business investments (Criterion B7). However, such activities are usually organized, are not bizarre, and do not result in the level of impairment that is characteristic of a Manic Episode.

Specific Culture and Age Features

Cultural considerations that were suggested for Major Depressive Episodes are relevant to Hypomanic Episodes as well (see p. 324). In younger (e.g., adolescent) persons, Hypomanic Episodes may be associated with school truancy, antisocial behavior, school failure, or substance use.

Course

A Hypomanic Episode typically begins suddenly, with a rapid escalation of symptoms within a day or two. Episodes may last for several weeks to months and are usually more abrupt in onset and briefer than Major Depressive Episodes. In many cases, the Hypomanic Episode may be preceded or followed by a Major Depressive Episode. Studies suggest that 5%–15% of individuals with hypomania will ultimately develop a Manic Episode.

Differential Diagnosis

A Hypomanic Episode must be distinguished from a **Mood Disorder Due to a General Medical Condition.** The diagnosis is Mood Disorder Due to a General Medical Condition if the mood disturbance is judged to be the direct physiological consequence of a specific general medical condition (e.g., multiple sclerosis, brain tumor, Cushing's syndrome) (see p. 366). This determination is based on the history, laboratory findings, or physical examination. If it is judged that the hypomanic symptoms are not the direct physiological consequence of the general medical condition, then the primary Mood Disorder is recorded on Axis I (e.g., Bipolar II Disorder) and the general medical condition is recorded on Axis III (e.g., myocardial infarction).

A **Substance-Induced Mood Disorder** is distinguished from a Hypomanic Episode by the fact that a substance (e.g., a drug of abuse, a medication, or exposure to a toxin) is judged to be etiologically related to the mood disturbance (see p. 370). Symptoms like those seen in a Hypomanic Episode may be precipitated by a drug of abuse (e.g., hypomanic symptoms that occur only in the context of intoxication with cocaine would be diagnosed as Cocaine-Induced Mood Disorder, With Manic Features, With Onset During Intoxication). Symptoms like those seen in a Hypomanic Episode may also be precipitated by antidepressant treatment such as medication, electroconvulsive therapy, or light therapy. Such episodes are also diagnosed as Substance-Induced Mood Disorders (e.g., Amitriptyline-Induced Mood Disorder, With Manic Features; Electroconvulsive Therapy–Induced Mood Disorder, With Manic Features).

Manic Episodes should be distinguished from Hypomanic Episodes. Although Manic Episodes and Hypomanic Episodes have identical lists of characteristic symptoms, the mood disturbance in Hypomanic Episodes is not sufficiently severe to cause marked impairment in social or occupational functioning or to require hospitalization. Some Hypomanic Episodes may evolve into full Manic Episodes.

Attention-Deficit/Hyperactivity Disorder and a Hypomanic Episode are both characterized by excessive activity, impulsive behavior, poor judgment, and denial of problems. Attention-Deficit/Hyperactivity Disorder is distinguished from a Hypomanic Episode by its characteristic early onset (i.e., before age 7 years), chronic rather than episodic course, lack of relatively clear onsets and offsets, and the absence of abnormally expansive or elevated mood.

A Hypomanic Episode must be distinguished from **euthymia**, particularly in individuals who have been chronically depressed and are unaccustomed to the experience of a nondepressed mood state.

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311 Depressive Disorder Not Otherwise Specified

The Depressive Disorder Not Otherwise Specified category includes disorders with depressive features that do not meet the criteria for Major Depressive Disorder, Dysthymic Disorder, Adjustment Disorder With Depressed Mood (see p. 623), or Adjustment Disorder With Mixed Anxiety and Depressed Mood (see p. 624). Sometimes depressive symptoms can present as part of an Anxiety Disorder Not Otherwise Specified (see p. 444). Examples of Depressive Disorder Not Otherwise Specified include

1. Premenstrual dysphoric disorder: in most menstrual cycles during the past year, symptoms (e.g., markedly depressed mood, marked anxiety, marked affective lability, decreased interest in activities) regularly occurred during the last week of the luteal phase (and remitted within a few days of the onset of menses). These symptoms must be severe enough to markedly interfere with work, school, or usual activities and be entirely absent for at least 1 week postmenses (see p. 715 for suggested research criteria).
2. Minor depressive disorder: episodes of at least 2 weeks of depressive symptoms but with fewer than the five items required for Major Depressive Disorder (see p. 719 for suggested research criteria).
3. Recurrent brief depressive disorder: depressive episodes lasting from 2 days up to 2 weeks, occurring at least once a month for 12 months (not associated with the menstrual cycle) (see p. 721 for suggested research criteria).
4. Postpsychotic depressive disorder of Schizophrenia: a Major Depressive Episode that occurs during the residual phase of Schizophrenia (see p. 711 for suggested research criteria).
5. A Major Depressive Episode superimposed on Delusional Disorder, Psychotic Disorder Not Otherwise Specified, or the active phase of Schizophrenia.
6. Situations in which the clinician has concluded that a depressive disorder is present but is unable to determine whether it is primary, due to a general medical condition, or substance induced.

Bipolar Disorders

This section includes Bipolar I Disorder, Bipolar II Disorder, Cyclothymia, and Bipolar Disorder Not Otherwise Specified. There are six separate criteria sets for Bipolar I Disorder: Single Manic Episode, Most Recent Episode Hypomanic, Most Recent Episode Manic, Most Recent Episode Mixed, Most Recent Episode Depressed, and Most Recent Episode Unspecified. Bipolar I Disorder, Single Manic Episode, is used to describe individuals who are having a first episode of mania. The remaining criteria sets are used to specify the nature of the current (or most recent) episode in individuals who have had recurrent mood episodes.

Bipolar I Disorder

Diagnostic Features

The essential feature of Bipolar I Disorder is a clinical course that is characterized by the occurrence of one or more Manic Episodes (see p. 328) or Mixed Episodes (see

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p. 333). Often individuals have also had one or more Major Depressive Episodes (see p. 320). Episodes of Substance-Induced-Mood Disorder (due to the direct effects of a medication, other somatic treatments for depression, a drug of abuse, or toxin exposure) or of Mood Disorder Due to a General Medical Condition do not count toward a diagnosis of Bipolar I Disorder. In addition, the episodes are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified. Bipolar I Disorder is subclassified in the fourth digit of the code according to whether the individual is experiencing a first episode (i.e., Single-Manic Episode) or whether the disorder is recurrent. Recurrence is indicated by either a shift in the polarity of the episode or an interval between episodes of at least 2 months without manic symptoms. A shift in polarity is defined as a clinical course in which a Major Depressive Episode evolves into a Manic Episode or a Mixed Episode or in which a Manic Episode or a Mixed Episode evolves into a Major Depressive Episode. In contrast, a Hypomanic Episode that evolves into a Manic Episode or a Mixed Episode, or a Manic Episode that evolves into a Mixed Episode (or vice versa), is considered to be only a single episode. For recurrent Bipolar I Disorders, the nature of the current (or most recent) episode can be specified (Most Recent Episode Hypomanic, Most Recent Episode Manic, Most Recent Episode Mixed, Most Recent Episode Depressed, Most Recent Episode Unspecified).

"Somatic treatments" refers to ECT (see p 371)

Specifiers

The following specifiers for Bipolar I Disorder can be used to describe the current Manic, Mixed, or Major Depressive Episode (or, if criteria are not currently met for a Manic, Mixed, or Major Depressive Episode, the most recent Manic, Mixed, or Major Depressive Episode):

Mild, Moderate, Severe Without Psychotic Features, Severe With Psychotic Features, In Partial Remission, In Full Remission (see p. 376)
With Catatonic Features (see p. 382)
With Postpartum Onset (see p. 386)

The following specifiers apply only to the current (or most recent) Major Depressive Episode only if it is the most recent type of mood episode:

Chronic (see p. 382)
With Melancholic Features (see p. 383)
With Atypical Features (see p. 384)

The following specifiers can be used to indicate the pattern of episodes:

Longitudinal Course Specifiers (With or Without Full Interepisode Recovery) (see p. 387)
With Seasonal Pattern (applies only to the pattern of Major Depressive Episodes) (see p. 389)
With Rapid Cycling (see p. 390)

Recording Procedures

The diagnostic codes for Bipolar I Disorder are selected as follows:

1. The first three digits are 296.

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☐ **Diagnostic criteria for 293.83 Mood Disorder Due to . . . [*Indicate the General Medical Condition*]** (*continued*)

C. The disturbance is not better accounted for by another mental disorder (e.g., Adjustment Disorder With Depressed Mood in response to the stress of having a general medical condition).

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

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

Specify type:

With Depressive Features: if the predominant mood is depressed but the full criteria are not met for a Major Depressive Episode

With Major Depressive-Like Episode: if the full criteria are met (except Criterion D) for a Major Depressive Episode (see p. 327)

With Manic Features: if the predominant mood is elevated, euphoric, or irritable

With Mixed Features: if the symptoms of both mania and depression are present but neither predominates

Coding note: Include the name of the general medical condition on Axis I, e.g., 293.83 Mood Disorder Due to Hypothyroidism, With Depressive Features; also code the general medical condition on Axis III (see Appendix G for codes).

Coding note: If depressive symptoms occur as part of a preexisting dementia, indicate the depressive symptoms by coding the appropriate subtype of the dementia if one is available, e.g., 290.21 Dementia of the Alzheimer's Type, With Late Onset, With Depressed Mood.

Substance-Induced Mood Disorder

Diagnostic Features

The essential feature of Substance-Induced Mood Disorder is a prominent and persistent disturbance in mood (Criterion A) that is judged to be due to the direct physiological effects of a substance (i.e., a drug of abuse, a medication, other somatic treatment for depression, or toxin exposure) (Criterion B). Depending on the nature of the substance and the context in which the symptoms occur (i.e., during intoxication or withdrawal), the disturbance may involve depressed mood or markedly diminished interest or pleasure or elevated, expansive, or irritable mood. Although the clinical presentation of the mood disturbance may resemble that of a Major Depressive, Manic, Mixed, or Hypomanic Episode, the full criteria for one of these episodes need not be met. The predominant symptom type may be indicated by using one of the following subtypes: With Depressive Features, With Manic Features, With Mixed Features. The disturbance must not be better accounted for by a Mood Disorder that is not substance induced

important full criteria NOT needed

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(Criterion C). The diagnosis is not made if the mood disturbance occurs only during the course of a delirium (Criterion D). The symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion E). In some cases, the individual may still be able to function, but only with markedly increased effort. This diagnosis should be made instead of a diagnosis of Substance Intoxication or Substance Withdrawal only when the mood symptoms are in excess of those usually associated with the intoxication or withdrawal syndrome and when the mood symptoms are sufficiently severe to warrant independent clinical attention.

A Substance-Induced Mood Disorder is distinguished from a primary Mood Disorder by considering the onset, course, and other factors. For drugs of abuse, there must be evidence from the history, physical examination, or laboratory findings of intoxication or withdrawal. Substance-Induced Mood Disorders arise only in association with intoxication or withdrawal states, whereas primary Mood Disorders may precede the onset of substance use or may occur during times of sustained abstinence. Because the withdrawal state for some substances can be relatively protracted, the onset of the mood symptoms can occur up to 4 weeks after the cessation of substance use. Another consideration is the presence of features that are atypical of primary Mood Disorders (e.g., atypical age at onset or course). For example, the onset of a Manic Episode after age 45 years may suggest a substance-induced etiology. In contrast, factors that suggest that the mood symptoms are better accounted for by a primary Mood Disorder include persistence of mood symptoms for a substantial period of time (i.e., about a month) after the end of Substance Intoxication or acute Substance Withdrawal; the development of mood symptoms that are substantially in excess of what would be expected given the type or amount of the substance used or the duration of use; or a history of prior recurrent primary episodes of Mood Disorder.

Some medications (e.g., stimulants, steroids, L-dopa, antidepressants) or other somatic treatments for depression (e.g., electroconvulsive therapy or light therapy) can induce manic-like mood disturbances. Clinical judgment is essential to determine whether the treatment is truly causal or whether a primary Mood Disorder happened to have its onset while the person was receiving the treatment. For example, manic symptoms that develop in a person while he or she is taking lithium would not be diagnosed as Substance-Induced Mood Disorder because lithium is not likely to induce manic-like episodes. On the other hand, a depressive episode that developed within the first several weeks of beginning alpha-methyldopa (an antihypertensive agent) in a person with no history of Mood Disorder would qualify for the diagnosis of alpha-Methyldopa–Induced Mood Disorder, With Depressive Features. In some cases, a previously established condition (e.g., Major Depressive Disorder, Recurrent) can recur while the person is coincidentally taking a medication that has the capacity to cause depressive symptoms (e.g., L-dopa, birth-control pills). In such cases, the clinician must make a judgment as to whether the medication is causative in this particular situation. For a more detailed discussion of Substance-Related Disorders, see p. 175.

Subtypes and Specifiers

One of the following subtypes may be used to indicate which of the following symptom presentations predominates:

With Depressive Features. This subtype is used if the predominant mood is depressed.