ELECTROCONVULSIVE THERAPY

Technique of Electroconvulsive Therapy: Theory & Practice

174

Clinical trials, right unilateral, and left unilateral ECT: Lee, Abrams, and Kohlhaas, 1988; Liston and Sones, 1990. Based on the findings that the outcome of bilateral ECT is better than that of unilaterals, ECT is generally preferred over unilateral ECT. Patients who have previously responded to ECT may show a marked decrease in their response to a second course of ECT.

In my experience, the occurrence of a maniform syndrome during ECT is unusual. Patients who have previously responded to ECT may show a marked decrease in their response to a second course of ECT. Patients who have previously responded to ECT may show a marked decrease in their response to a second course of ECT.

Nausea or vomiting

Nausea or vomiting is common in patients receiving ECT. It can be anticipated that nausea and vomiting will occur during or immediately after the administration of the anesthetic agents. The occurrence of nausea and vomiting is a sign of effective anesthetic administration. Patients who vomit during ECT should be closely monitored for the development of aspiration pneumonia. Patients who vomit during ECT should be closely monitored for the development of aspiration pneumonia.

Aspiration pneumonia

Aspiration pneumonia is a serious complication of ECT. It can be avoided by proper positioning of the patient during the administration of the anesthetic agents. Patients who vomit during ECT should be closely monitored for the development of aspiration pneumonia. Patients who vomit during ECT should be closely monitored for the development of aspiration pneumonia.

Ruptured bladder

Irving and Drayson (1984) reported a case of rupture of the bladder during ECT. The patient was a 74-year-old man with a history of bladder dysfunction. The bladder was found to be distended and the patient was placed on a Foley catheter. The patient was then given a series of shocks and the bladder ruptured. The patient was treated with antibiotics and the bladder was left open. The patient was also given oral fluids and the bladder was allowed to drain spontaneously. The patient made a complete recovery.

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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 if hospitalization is required. 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. If the mood is irritable rather than elevated or expansive, at least four of the above symptoms must be present. 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 1 week. The disturbance must be sufficiently severe to cause marked impairment in social or occupational functioning, or it is characterized by the presence of psychotic features. The episode must not be due to the direct physiological effects of a drug of abuse, a medication, or other treatment for depression, or to a general medical condition, such as multiple sclerosis, brain tumor, or toxin exposure. Manic episodes are frequently seen in patients with bipolar disorder. Infused self-esteem is typically present, ranging from uncritical self-confidence to marked grandiosity, and may reach delusional proportions. Individuals may give advice on matters about which they have no special knowledge, such as running the United Nations. Despite a lack of particular expertise or talent, the individual may embark on writing a novel or composing a symphony or seek publicity for some impractical invention. 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 (Criterion B). Lability of mood, e.g., the alternation between euphoria and irritability, is frequently seen. Infused self-esteem is typically present, ranging from uncritical self-confidence to marked grandiosity, and may reach delusional proportions. Individuals may give advice on matters about which they have no special knowledge, such as running the United Nations. Despite a lack of particular expertise or talent, the individual may embark on writing a novel or composing a symphony or seek publicity for some impractical invention. The elevated mood of a Manic Episode may be described as euphoric, unusually good, cheerful, or high. The episode is typically characterized by a distinct period during which there is an abnormally and persistently elevated, expansive, or irritable mood.
Manic Episode 329

spastic 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 computerchip, the industrial revolution, or applied mathematics. When flight of ideas is severe, speech may be 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 furnishings in the room. There may be a reduced ability to differentiate between thoughts and external events. The individual may become agitated by noise, movement, or change in the environment.

The increase in goal-directed activity often involves excessive planning of and excessive participation in multiple activities e.g., sexual, occupational, political, religious, and social activities. 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. 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. Unusual sexual behavior may include infidelity or indiscriminate sexual encounters with others. The increase in goal-directed activity often involves excessive planning of and excessive participation in multiple activities e.g., social, occupational, religious, and political.

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 coexists with marked impairment in functioning Criterion D.

Symptoms like those seen in a Manic Episode may be due to the direct effects of medication, electroconvulsive therapy, light therapy, or medication prescribed for the general medical condition e.g., corticosteroids. Such presentations are not considered Manic Episodes and do not count toward the diagnosis of a Manic Episode. 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 a diagnosis of 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 or hypomanic episodes that are

manic-like in nature.

The individual's thoughts may be organized, coherent, and relevant to the topic.
Clinical considerations that were suggested for Major Depressive Episodes are also

**Specific Culture, Age, and Gender Features**

Cultural considerations that were suggested for Major Depressive Episodes are also

**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 suppression. Abnormalities involving the norepinephrine, serotonin, acetylcholine, dopamine, or gamma-aminobutyric acid neurotransmitter systems have been demonstrated by studies of neurotransmitter metabolites, receptor functioning, pharmacological provocative procedures, and neuroendocrine function.

**Memo**

The mean age of onset for a manic episode is 36.6 years (SD = 12.8), with a range of 10 to 70 years. However, manic episodes in older adults may be associated with a more gradual onset and a lower rate of recurrence compared to younger individuals.

**Differential Diagnosis**

The diagnosis of a manic episode should be considered in individuals with a history of substance use disorder, particularly those with a history of bipolar disorder. However, a manic episode should not be diagnosed if the primary disorder is a substance use disorder, except in cases where the manic episode has been triggered by the use of substances.

**Course**

The course of a manic episode may vary depending on the individual's response to treatment and the presence of comorbid conditions. Some individuals may experience a rapid and sustained recovery, while others may require longer-term treatment and monitoring.

**Associated Descriptive Features and Mood Disorders**

Importantly, consideration in children and adolescents. This may be an especially
Some hypomanic episodes may evolve into full Manic episodes.

Major Depressive Episodes with prominent lifestyle mood may be difficult to
distinguish in children or in other situations where it is not likely to occur. Hypomanic
episodes should be distinguished from hypomanic episodes.

Hypomanic Episodes:

- Hypomanic Mood Disorder: With Manic Features: Electroconvulsive Therapy
- Hypomanic Mood Disorder: Without Manic Features: Electroconvulsive Therapy
- Hypomanic Mood Disorder: With Obscure Mood Disorder: Electroconvulsive Therapy
- Hypomanic Mood Disorder: Without Obscure Mood Disorder: Electroconvulsive Therapy

Features include those seen in a Manic Episode as well as a Depressed Mood Disorder.

Features include those seen in a Manic Episode as well as a Dysthymic Disorder.

Features include those seen in a Manic Episode as well as a Major Depressive Disorder.

Features include those seen in a Manic Episode as well as a Major Depressive Disorder.

A Subsequent Hypomanic Episode is distinguished from Manic Episode. Due to a General

Differential Diagnosis

The diagnosis Hypomanic Episode is applicable for the specifier with pertinent

Course

Information on gender:

For Bipolar I Disorder (p. 360) and Bipolar II Disorder (p. 360) for specifier

Male Episode 331
The diagnosis of Bipolar I Disorder is made when the patient experiences manic episodes. A manic episode is characterized by an abnormally, elevated, expansive, and irritable mood, accompanied by at least three of the following psychological features:

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 interrupts others excessively
4. Increased psychomotor activity or energy
5. Distractibility
6. Increased goal-directed activity (either socially, at work or school, or sexually)
7. Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., pathological gambling)

The symptoms must cause significant impairment in social, occupational, or other important areas of functioning. A manic episode lasts for at least 1 week or results in hospitalization. If the mood disturbance is not fully defined by the manic episode, a Mixed Episode is diagnosed. This is characterized by symptoms that include both manic and depressive features. The mixed state is a diagnosis reserved for cases where the manic and depressive symptoms are both severe and present.
A Mixed Episode is characterized by a period of time lasting at least 1 week in which the criteria for both a Manic Episode and a Major Depressive Episode are 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 a general medical condition (e.g., hyperthyroidism). Symptoms like those seen in a Mixed Episode may be due to 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 Disorder. For example, if a person with recurrent Major Depressive Disorder develops a mixed symptom picture, a diagnosis of Bipolar Disorder is not made unless there is evidence of a prior manic, mixed, or hypomanic episode that is not related to substances or somatic treatments for depression. Some evidence suggests that there may be a bipolar diathesis in individuals who develop mixed-episode disorders following treatment for depression, similar to the cases of apparent Bipolar Disorder that occur following antidepressant treatment in individuals with recurrent Major Depressive Disorder. With Mixed Episodes, the course of the episode is substance-induced and the diagnosis is Substance-Induced Mood Disorder, Mixed features (see p. 323). Associated descriptive features and mental disorders are considered on p. 324. As for other types of Major Depressive Episode, the acute nature of the disturbance is not due to the direct effects of another mental disorder (e.g., a generalized anxiety disorder). Associated descriptive features and mental disorders include an increased likelihood of a manic, mixed, or hypomanic episode that is not related to substances or somatic treatments for depression. Some individuals experience more dysphoria than do those in Manic Episodes, they may be more likely to seek help. Mixed Episodes often follow the course of antidepressant medications, and mixed symptom presentation is often seen during or at the end of a course of antidepressant medication. The disruption of the episode is substance-induced and the diagnosis is Substance-Induced Mood Disorder, Mixed features (see p. 323).
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 a specific general medical condition, then 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 toxic substance 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 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 distinguished from 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 symptomatology of these episodes. The presence of symptoms that are characteristic of both a full Manic Episode and a full Major Depressive Episode may be difficult to distinguish from Mixed Episodes. A careful clinical evaluation of the symptomatology of these episodes is required to make this determination. Mixed Episodes with prominent irritable mood may be distinguished from a Mixed Episode by the presence of symptoms that are characteristic of both a full Manic Episode and a full Major Depressive Episode. A careful clinical evaluation of the symptomatology of these episodes is required to make this determination.

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 onset and offset, and the absence of abnormally expanded orrestricted by excessive activity, Capillary punished, poor judgment, and denial of problems. Mixed Episodes can only occur from a Mood Disorder or from a Major Depressive Episode. Mixed Episodes are both characterized by excessive activity, impulsive behavior, poor judgment, and denial of problems.
The mood disturbance and other symptoms must not be due to the direct effect of a general medical condition (e.g., hypothyroidism), substance (e.g., alcohol or other mood-altering substance) or treatment (e.g., the use of a medication of other treatment) of a physical condition. The symptoms are not due to the direct physiological effects of a general medical condition, substance (e.g., alcohol or other mood-altering substance) or treatment (e.g., the use of a medication or other treatment) of a physical condition. The mood disturbance is sufficiently severe to cause marked impairment in social functioning or occupational functioning. If the criteria are met for a major depressive episode (see p. 332), episode of major depression begins at least 1 week earlier.

Mixed Episodes

**Criteria for Mixed Episode**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood disturbance</td>
<td>At least 1 week</td>
</tr>
<tr>
<td>Psychomotor agitation</td>
<td>At least 1 week</td>
</tr>
<tr>
<td>Marked psychological stress</td>
<td>At least 1 week</td>
</tr>
</tbody>
</table>

**Psychomotor Agitation**

- Increased physical activity
- Feelings of restlessness
- Difficulty sitting still

**Marked Psychological Stress**

- Anxiety
- Irritability
- Difficulty concentrating

**Psychomotor Retardation**

- Decreased physical activity
- Feelings of inertia
- Difficulty starting tasks

**Mood Disturbance**

- Depressed mood
- Manic mood

**Psychomotor Agitation or Retardation**

- Increased or decreased physical activity
- Feelings of restlessness or inertia

**Marked Psychological Stress**

- Anxiety
- Irritability
- Difficulty concentrating
Specific Culture and Age Features

Hyponomic Episodes may be associated with school trends, unusual behavior, school factors, or psychological disturbances. However, such activities in children and adolescents may not be associated with school trends, unusual behavior, or psychological disturbances. The episodes may be associated with school trends, unusual behavior, or psychological disturbances.

Defining Specific Culture and Age Features

Although depressed mood is considered prototypical, the mood disturbance may be observed as an expression of non-mood experiences. This mood disturbance is considered prototypical, although non-mood experiences may be expressed as an expression of non-mood experiences. This mood disturbance is considered prototypical, although non-mood experiences may be expressed as an expression of non-mood experiences.

Some Random Observations on Depression

While mood disturbances were observed in children, adolescents, and adults, they were more frequent in children and adolescents. Some evidence suggests that these may be symptoms of depression, and depression is diagnosed as a diagnosis of Major Depressive Disorder. Some evidence suggests that these may be symptoms of depression, and depression is diagnosed as a diagnosis of Major Depressive Disorder. Some evidence suggests that these may be symptoms of depression, and depression is diagnosed as a diagnosis of Major Depressive Disorder. Some evidence suggests that these may be symptoms of depression, and depression is diagnosed as a diagnosis of Major Depressive Disorder.
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.

Hypomanic Episodes must be distinguished from Mood Disorders 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. 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 Hypomanic Episode must be distinguished from a Mood Disorder Due to Substance Abuse. 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. 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.

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 Manic Episodes and Hypomanic Episodes are, however, not distinguishable by clinical criteria alone. The presence or absence of sleep disturbance, changes in appetite, and problems with impulse control can help distinguish between the two. Manic Episodes are typically accompanied by a more rapid speech, more distractibility, and a more expansive and less realistic thinking.

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, the absence 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. A Hypomanic Episode may be preceded or followed by a Major Depressive Episode. Hypomanic Episodes may also be distinguished from a Major Depressive Episode by the presence of mania or hypomania. A Hypomanic Episode may also be distinguished from a Major Depressive Episode by the absence of a depressed mood.

Differential Diagnoses

Hypomanic Episodes may be preceded or followed by a Major Depressive Episode. 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 Manic Episodes and Hypomanic Episodes are, however, not distinguishable by clinical criteria alone. The presence or absence of sleep disturbance, changes in appetite, and problems with impulse control can help distinguish between the two. Manic Episodes are typically accompanied by a more rapid speech, more distractibility, and a more expansive and less realistic thinking.
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 individuals who are having a first episode of mania/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 postmenstrual (see p. 714). Examples of depressive disorders not otherwise specified include Dysthymic Disorder, Adjustment Disorder With Mixed Anxiety and Depressed Mood (see p. 624). Sometimes Diagnostic Criteria: Dysthymic Disorder, Adjustment Disorder With Mixed Anxiety and Depressed Mood (see p. 624). Sometimes Depressive Disorders Not Otherwise Specified - other depressive disorders which are not major depressive disorders.

This section includes Bipolar Disorder, Bipolar II Disorder, Cyclothymia, and Bipolar Disorder Not Otherwise Specified. There are six separate criteria sets for Bipolar I Disorder, Bipolar II Disorder, Cyclothymia, and Bipolar Disorder Not Otherwise Specified.
Bipolar I Disorder

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, or drug of abuse as in the case of MDD, with a generic class of drug do not count towards a diagnosis of Bipolar I Disorder. In addition, the episodes are not better accounted for by or in 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 a single episode. For recurrent Bipolar I Disorders, the nature of the current or most recent episode can be specified: Most Recent Episode Manic, Most Recent Episode Mixed, Most Recent Episode Depressed, Most Recent Episode Unspecified.

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
- 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: Chronic, With Melancholic Features, With Atypical Features.

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

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

The above specifiers can be used to indicate the pattern of episodes.

Diagnosis

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

1. The first three digits are 296.  
2. The diagnostic codes for Bipolar I Disorder are specified as follows:

- 296.50, 296.51, 296.52, 296.53, 296.54, 296.55, 296.56
- 296.57

Recording Procedures

I. The first three digits are 296.
Substance-Induced Mood Disorder

**Diagnostic Features**

The essential feature of substance-induced Mood Disorder is a prominent and persistent

<table>
<thead>
<tr>
<th>Subtype</th>
<th>Description</th>
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<tbody>
<tr>
<td>With Major Depressive Episode (Criteria C)</td>
<td>The Mood Disorder is rapid or recurrent.</td>
</tr>
<tr>
<td>With Mixed Features</td>
<td>The Mood Disorder is rapid or recurrent.</td>
</tr>
<tr>
<td>With Depression-Induced Psychotic Episode</td>
<td>The Mood Disorder is rapid or recurrent.</td>
</tr>
<tr>
<td>With Depression-Induced Psychotic Episode</td>
<td>The Mood Disorder is rapid or recurrent.</td>
</tr>
</tbody>
</table>

**Coding Note:**
- Include the name of the general medical condition on axis I, e.g., " Alcohol Dependence (Axis I), Depression (Axis II)."
expressed depression features. This subject is used if the predominant mood is...