

CHAPTER 4

■ Bipolar Disorders

IN THIS CHAPTER:

- Bipolar I Disorder
- **CAUTION:** The Fad of Childhood Bipolar Disorders
- Bipolar II Disorder
- Cyclothymic Disorder
- Substance-Induced Bipolar Disorder
- Bipolar Disorder Due to Another Medical Condition
(Indicate the Medical Condition)
- Unspecified Bipolar Disorder
- Unspecified Mood Disorder

■ 296.XX: BIPOLAR I DISORDER

Fourth-Digit Codes:

- .0x Bipolar I Disorder, Single Manic Episode**
- .40 Bipolar I Disorder, Most Recent Episode Hypomanic**
- .4x Bipolar I Disorder, Most Recent Episode Manic**
- .5x Bipolar I Disorder, Most Recent Episode Depressed**
- .6x Bipolar I Disorder, Most Recent Episode Mixed**
- .7 Bipolar I Disorder, Most Recent Episode Unspecified**

Fifth-Digit Codes:

- .x1 Mild**
- .x2 Moderate**
- .x3 Severe**
- .x4 Severe With Psychotic Features**
- .x5 In Partial Remission**
- .x6 In Full Remission**
- .x0 Unspecified**

Because the ICD-10-CM codes for Bipolar I Disorder are not as easily summarized as the ICD-9-CM codes, they are given in the Crosswalk to ICD-10-CM Codes.

Screening Question

“Do you have mood swings—sometimes way up, other times way down?”

Diagnostic Prototype

The ups in Bipolar I Disorder can be wonderful—at least for a while. The world is the patient’s oyster. Everything feels so smooth, so easy, so great, and so vivid. Colors are brighter, food is more delicious, sex is more intense, jokes are funnier. The patient is flying high with expansive ideas, vaulting ambitions, booming confidence, and dauntless energy. His mind is racing, his speech is pressured and punning, and his body is in perpetual motion. There is nothing he can’t do, and the usual limitations in life no longer apply. There seems no need for sleep or eating, or for the routine drudgery of the everyday. “So much to do and so little time.” Impulses are unleashed—wild shopping sprees, reckless investing, expansive new projects, intense new relationships, fast cars, adventurous drugs, restless travel. “Bring it on.”

Eventually, the euphoria morphs from high spirits into impatient irritability (especially when other people refuse to join the party). Increased energy merges into restless agitation, then dissolves into utter exhaustion; expansive thoughts can become psychotic delusions. At the end of every Manic Episode, there is an inevitable crash with a bruising collapse into depression. Some people have Mixed Episodes from the very start, with rapidly alternating manic and depressive symptoms, and with lots of irritability, agitation, and insomnia. The first episode of Bipolar I Disorder

is usually before age 35, and most people have many lifetime episodes. Some are on a particularly rough roller coaster, with rapid cycling from mania to depression again and again, with few respites of normal functioning. The Depressive Episodes are equivalent to those in Major Depressive Disorder as described in Chapter 3. Depression predominates in most patients with Bipolar I.

Differential Diagnosis: Rule These Conditions Out

- **Major Depressive Disorder.** The person with depressive symptoms has never had Manic or Hypomanic Episodes.
- **Bipolar II Disorder.** The person has had Hypomanic Episodes, but never a full Manic Episode.
- **Cyclothymic Disorder.** Lesser mood swings of alternating depression and hypomania never reach the full register of Major Depressive or Manic Episodes, but they still cause clinically significant distress or impairment.
- **Normal mood swings.** There are alternating periods of sadness and elevated mood, but without clinically significant distress or impairment.
- **Schizoaffective Disorder.** Symptoms resemble Bipolar I Disorder, Severe With Psychotic Features, but psychotic symptoms occur even when mood symptoms are not present.
- **Schizophrenia or Delusional Disorder.** Psychotic symptoms dominate the clinical presentation and occur without prominent mood episodes.
- **Bipolar Disorder Due to Another Medical Condition.** Examples of such conditions include stroke and hyperthyroidism.
- **Substance-Induced Bipolar Disorder.** For example, stimulant drugs can produce bipolar symptoms.
- **Caution: Disruptive Mood Dysregulation Disorder.** DMDD was designed as an alternative to childhood Bipolar Disorders, but I advise against using this diagnosis. See my more extensive caution at the end of Chapter 3.

Diagnostic Tips

- **Mania as a diagnostic emergency.** Manic patients have terrible judgment and get themselves into all sorts of interpersonal, financial, legal, and sexual trouble. The combination of grandiosity, impulsivity, delu-

sions, and heightened energy can lead to fatal car accidents, “flying” off a roof, quick intimacy with dangerous strangers, or lethal drug overdose.

- **Noncompliance.** Unfortunately, manic patients also resent being reined in, are quick to travel to distant places, deny the need for treatment, and barely notice that you exist. The odds that such a patient will show up for a second visit are not great. Assume you have to do something right now.
- **Hospitalization.** Admission to a hospital is often necessary for clearer diagnosis, for beginning the treatment, and (most important) for safety.
- **Informants.** People close to the patient can supply important information and can help keep the patient involved in treatment rather than taking the next plane to anywhere.
- **Unipolar Manic Episodes.** A very small percentage of patients with Bipolar I have had only Manic, never Depressive, Episodes. They are usually men, and most do go on later to have Major Depressive Episodes.
- **Mixed Episodes.** Mixed Episodes (which are no longer included in DSM-5, but which are retained here because they are diagnostically useful) count toward a diagnosis of Bipolar I, but can be very difficult to distinguish from unipolar agitated depression. When in doubt, stick to the diagnosis of Major Depression unless there is a family history of Bipolar Disorders.
- **Role of substances.** Medications and other substances sometimes cause Manic Episodes in patients previously diagnosed with Depressive Disorders. Whether their diagnostic status is best considered unipolar or bipolar is controversial. Factors that tip the diagnosis toward Bipolar I include a family history of Bipolar Disorders; previous equivocal Mixed or Hypomanic Episodes; a previous substance-induced mania; and/or disproportionately severe or enduring manic symptoms.
- **Late onset.** Whenever there is a first Manic Episode after age 35, always consider the possible role of a medical illness, an antidepressant medication, or other substances.
- **Schizoaffective Disorder.** As noted above, this is often very difficult to distinguish from Bipolar I Disorder, Severe With Psychotic Features. At the boundary, the distinction is probably without a difference. Go ahead and diagnose Unspecified Psychotic Disorder.
- **Avoiding overdiagnosis of childhood Bipolar Disorders.** Most irrita-

bility and temper tantrums in childhood are either normal or associated with ADHD, Conduct Disorder, or ODD, and are not related to Bipolar Disorders. Don't join the fad. (See the Caution box below.)

CAUTION: **The Fad of Childhood Bipolar Disorders**

The rate of diagnosis for childhood Bipolar Disorders has increased 40-fold in the last 20 years, with consequent massive overusage of antipsychotic and mood-stabilizing medication. Most kids who now get the diagnosis have nonepisodic temper outbursts and irritability—not classic swings between Manic or Hypomanic Episodes and Depressive Episodes. The idea that Bipolar Disorders present very differently in children is largely untested.

“Leading” researchers, heavily sponsored by drug companies, encouraged child clinicians, educators, and parents to ignore the standard Bipolar Disorder definitions and instead to entertain the diagnosis of childhood Bipolar Disorders in a free-form, overinclusive way.

The “epidemic” of childhood Bipolar Disorders fed off the engaging story line that (1) they are extremely common; (2) they were previously greatly underdiagnosed; (3) they present differently in children because of developmental factors; (4) they can explain the variety of childhood emotional dysregulation; and (5) they have diverse presenting symptoms (e.g., irritability, anger, agitation, aggression, distractibility, hyperactivity, and conduct problems).

Problems with the Diagnosis

The boundaries of childhood Bipolar Disorders have pushed far into unfamiliar territory to label kids who previously received other diagnoses (e.g., ADHD, Conduct Disorder, ODD, or Anxiety Disorders) or no diagnosis at all (“temperamental” but normal kids). The other more specific causes of irritability may be missed. For example, ADHD often presents with an irritability that responds best to stimulants, but these may be withheld in the face of an incorrect Bipolar Disorder diagnosis. Normal development should always be the first thought for irritable teenagers, and Substance Abuse for severely irritable teens.

A Lifetime Diagnosis

The diagnosis of a Bipolar Disorder carries the connotation that it will last a lifetime and require continuous medication treatment. It is unwise to base such a consequential judgment on such a short track record in children and teenagers. Many causes of temper outbursts are much shorter-lived and amenable to time-limited treatment.

Inappropriate and Excessive Medication Use

Teenagers, children, and even infants have been overmedicated with antipsychotics and mood-stabilizing drugs that can promote obesity, diabetes, and heart disease, and possibly reduce lifespan.

Stigma and Risk

The label of a Bipolar Disorder can distort a person's life narrative and cut off hopes of otherwise achievable ambitions. Those labeled worry about getting married and having children, or about taking on stressful ambitions, jobs, or work challenges. It may become more difficult to get insurance. An incorrect diagnosis of a Bipolar Disorder may reduce one's sense of personal responsibility for, and control over, undesirable behavior. People sometimes use the diagnosis as an excuse for interpersonal or legal problems.

I recommend that the diagnosis of childhood Bipolar Disorders should go back to being rarely used, and that the widespread, inappropriate use of antipsychotics for children and teenagers should be curtailed.

■ 296.89 / F31.81 BIPOLAR II DISORDER

Screening Question

"Do you have mood swings—sometimes going up, other times going down?"

Diagnostic Prototype

Three conditions must be met before Bipolar II Disorder can be diagnosed. First, the person must have Major Depressive Episodes that are fully equivalent to those described in Chapter 3 for unipolar Major Depressive Disorder. Second, she must have at least one clear-cut Hypomanic Episode. Third, the person must never have had a full-blown Manic Episode (if she has had one, that would make the diagnosis Bipolar I, not Bipolar II).

The word "hypomanic" is just a fancy way of saying "less than manic." A Hypomanic Episode is indeed less severe than a Manic Episode, but it has the same symptoms of elevated mood, expansive self-confidence, infectious joking, increased energy, intrusive sociability, and less need for

sleep and rest. The mood swing has to be a distinct shift upward from the person's usual gear. The unique thing about a Hypomanic Episode is that it does not usually by itself cause clinically significant impairment or distress.

Differential Diagnosis: Rule These Conditions Out

- **Major Depressive Disorder.** There is no history of Hypomanic Episodes.
- **Bipolar I Disorder.** There has been at least one clear-cut Manic Episode.
- **Cyclothymic Disorder.** Mood swings from hypomania to mild depression cause clinically significant distress or impairment, and there is no history of any Major Depressive Episodes.
- **Normal mood swings.** The person alternately feels a bit high and a bit low, but with no clinically significant distress or impairment.
- **Bipolar Disorder Due to Another Medical Condition.** Examples of such conditions include stroke and hyperthyroidism.
- **Substance-Induced Bipolar Disorder.** The Hypomanic Episode was caused by antidepressant medication or cocaine.
- **ADHD.** ADHD has distractibility, hyperactivity, and impulsivity in common with Bipolar II, but ADHD onset is in early childhood, its course is chronic rather than episodic, and it does not include features of elevated mood.

Diagnostic Tips

- **A difficult decision.** Because it sits on the fuzzy boundary between unipolar Major Depressive Disorder and Bipolar I Disorder, Bipolar II is one of the very toughest diagnostic decisions in all of psychiatry. The diagnosis rests on whether or not the patient has ever had a Hypomanic Episode. Hypomania is difficult to distinguish, particularly if there have been only few and brief episodes and if drugs or medication are a part of the clinical presentation. Always be sure to ask about substance use and prescribed medications.
- **Deciding what's normal.** Hypomanic Episodes are also difficult to distinguish from a normal mood, particularly in someone who has been depressed so much that it feels strange when the depression lifts and mood returns to normal. For this person, being normal is easily confused with being high.

- **Clues from age of onset.** Bipolar II Disorder usually shows itself before age 35. Whenever there is a late onset, always consider the possibility that a medical illness or substance is causing the symptoms.
- **Family history.** When you are in doubt, a family history of Bipolar Disorders is a useful clue that the patient has underlying Bipolar II Disorder.
- **Other clues.** Rapid cycling in a patient with unipolar Major Depressive Disorder may be a hint of masked Bipolar II Disorder. Agitation or irritability in response to antidepressant medication doesn't clinch the diagnosis but should alert you to it.
- **A high-stakes risk-benefit analysis.** In doubtful boundary cases, it is crucial that this difficult diagnosis be made carefully and correctly. Always do an individualized risk-benefit analysis to decide what will be worse: missing Bipolar II Disorder (and treating with antidepressants alone, which may risk promoting a switch to hypomania, agitation, or rapid cycling) or mistakenly diagnosing Bipolar II Disorder (and giving unnecessary mood stabilizers, which can cause dangerous weight gain with the added risks of diabetes and heart disease). It is often a tough call with no obvious right answer.
- **Unipolar Major Depression first.** When in doubt, diagnose unipolar Major Depressive Disorder. Once the diagnosis of Bipolar II is made, the patient is probably committed to a lifetime course of antipsychotics or mood stabilizers. These should be risked only when really necessary. Withhold the diagnosis of Bipolar II Disorder until there are clear, repeated, or enduring Hypomanic Episodes.
- **Joint decision making.** Educate the patient and family about the risks and benefits on both sides of the unipolar-bipolar divide, and include them in decision making.
- **Severity.** Don't assume that Bipolar II is a milder form of Bipolar I. Although there is no frank Manic Episode in Bipolar II, the Depressive Episodes can be absolutely devastating, and suicide risk can be relatively high.
- **Avoiding overdiagnosis of Bipolar II Disorder.** Rates of Bipolar Disorder diagnoses have doubled since Bipolar II became an official diagnosis in DSM-IV. Some of this resulted from better diagnosis of Bipolar Disorders, but there has also been a tendency to overdiagnose Hypomanic Episodes (stimulated in part by aggressive drug company marketing suggesting that Bipolar Disorders are underdiagnosed and that medication for them is underutilized).

■ 301.13 / F34.0 CYCLOTHYMIC DISORDER

Screening Question

“Do you have constant mood swings, alternating from high to low?”

Diagnostic Prototype

The person has alternating hypomanic and depressive symptoms that cause clinically significant distress and impairment, but never severe enough to qualify for Bipolar I or Bipolar II Disorder. These are among the most temperamental, mercurial, unpredictable of people. Catch them on an upswing, and you are their best friend. The conversation is light and breezy; the jokes fly; and soon you are planning an exciting vacation next week. Call them next week, and all bets are off. On the downswing, they want to be left alone, have trouble just getting to work, and couldn't dream of summoning the energy to leave town. The sunny possibilities of hypomania evaporate into a black cloud, and the previously overflowing glass is now much less than half full.

Differential Diagnosis: Rule These Conditions Out

- **Normal mood swings.** The person has ups and downs, but with no clinically significant distress or impairment.
- **Major Depressive Disorder.** There has been a Major Depressive Episode, which rules out Cyclothymic Disorder.
- **Bipolar I Disorder.** There has been at least one Manic Episode, which also rules out Cyclothymic Disorder.
- **Bipolar II Disorder.** Again, there has been at least one clear Major Depressive Episode, which rules out Cyclothymia.
- **Bipolar Disorder Due to Another Medical Condition.** For example, the mood swings are caused by stroke or hyperthyroidism.
- **Substance-Induced Bipolar Disorder.** Mood swings are caused, for example, by antidepressant medication or cocaine.

Diagnostic Tips

- **Normal emotional intensity.** Many people (especially creative ones) have an intense emotional life that is just part of who they are, not evidence of a psychiatric disorder.

- **Magnitude of the swings.** Be sure to reserve the Cyclothymic Disorder diagnosis for mood swings that cause significant distress or impairment but aren't severe enough to qualify for a Bipolar I or Bipolar II diagnosis.
- **Substance use.** Many people go up and down on a roller coaster of intoxication and withdrawal, or they alternate between "uppers" and "downers."
- **Late onset.** Whenever there is a late onset, always consider the possibility of a medical illness.

■ SUBSTANCE-INDUCED BIPOLAR DISORDER

291.89 If Alcohol-Induced

292.84 If Induced by Any Other Substance (Indicate Substance)

The ICD-10-CM codes for Substance-Induced Bipolar Disorder are extremely complex. See the Crosswalk to ICD-10-CM Codes for a selection of these, and consult the Resources for Codes page for guidance with the others.

Screening Question

"Have you had a lot of mood swings associated with using drugs, drinking alcohol or coffee, taking a medication, or withdrawing from drugs or medication?"

Diagnostic Prototype

Alternating highs and lows often occur as a result of taking or withdrawing from a medication or other substance.

Differential Diagnosis: Rule These Conditions Out

- **Bipolar Disorder Due to Another Medical Condition.** The mood swings come from the medical condition.
- **A primary Bipolar Disorder.** The mood swings preceded the substance use or persist for an extended period after it.

Diagnostic Tips

- **A tough diagnosis.** Establishing that a substance is causing the mood swings can be especially challenging because so many patients with Bipolar Disorders use substances to self-medicate. The following temporal factors provide clues.
- **Onset.** The mood swings start *after* the substance use and (ideally) remit shortly after the substance is stopped.
- **Remission.** The mood swings go away if the person stops the substance and completes a reasonable period of withdrawal.

■ BIPOLAR DISORDER DUE TO ANOTHER MEDICAL CONDITION (INDICATE THE MEDICAL CONDITION)

293.83 / F06.33 With Manic Features

293.83 / F06.33 With Manic or Hypomanic-Like Episodes

293.83 / F06.34 With Mixed Features

Screening Question

“Have you had mood swings in association with a medical condition, like an overactive thyroid?”

Diagnostic Prototype

Prominent mood swings are caused by the direct physical effects of a medical illness.

Differential Diagnosis: Rule These Conditions Out

- **Substance-Induced Bipolar Disorder.** The mood swings are due to the effects of a medication or other substance.
- **A primary Bipolar Disorder.** The mood swings preceded the medical illness or persist for an extended period after it.

Diagnostic Tips

- **Another tough diagnosis.** Establishing that a medical condition is directly causing the mood swings can be challenging. The following factors support a direct causal relationship.
- **Onset.** The mood swings begin simultaneously with, or shortly after, the onset of the medical condition.
- **Linkage.** There is a close relationship between the severity of the mood swings and the severity of the medical condition (e.g., worsening of symptoms with increasingly high thyroid level in hyperthyroidism).
- **Remission.** Symptoms resolve with successful treatment of the medical condition.
- **Typicality.** There is evidence from the clinical literature that the medical condition in question is known to cause bipolar symptoms in some individuals.

■ **296.80 / F31.9 UNSPECIFIED BIPOLAR DISORDER**

Use the diagnosis of Unspecified Bipolar Disorder when a Bipolar Disorder is present, but it is impossible to be specific about whether it is Bipolar I, Bipolar II, or Cyclothymia, or whether it is substance-induced or caused by a general medical condition.

■ **296.90 / F39 UNSPECIFIED MOOD DISORDER**

Use the diagnosis of Unspecified Mood Disorder (Mood Disorder Not Elsewhere Classified in ICD-9-CM) when a Mood Disorder is present, but it is impossible to be more specific on whether it is unipolar or bipolar, or whether it is substance-induced or caused by a general medical condition. See my discussion of this diagnosis at the end of Chapter 3.